MOH/UNICEF - Uganda

A QUALITATIVE ASSESSMENT OF PRIMARY HEALTH CARE IMPLEMENTATION IN UGANDA

**Case Studies of Five Non-Governmental Programmes:
Perspectives on Community Participation with
Possible Lessons for Policy Guidelines**

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August, 1994

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Ministry of Health
Entebbe,
UGANDA

in
collaboration
with

UNICEF
Kampala,
UGANDA

August, 1994

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ACKNOWLEDGEMENT

We are grateful to the Ministry of Health and UNICEF for entrusting us with the task of carrying out the rapid assessment and for the support given during the exercise. Much guidance and support was received from the Study Advisory Committee members: Mr. J.K. Gaifuba (ADMS - PHC/HEd, M.O.H); Dr.S. Etyono (Coordinator/NHFTF, MOFEP); Dr. J.N.S. Jitta (Director, CHDC); Dr. I. Rizzo (Senior P/Officer - Health, UNICEF); Mr. A. Kyeyune (Exe.Sec., UCBHCA); especially during the proposal, field planning, and post-fieldwork debriefing stages.

At the CHDC, Dr. Barton's indispensable advice and guidance throughout, from proposal development through design to study write-up, is much appreciated. Dr. G. Turyasingura and Mrs. A. Katahoire helped prepare earlier drafts of the proposal and study instruments, while later, Dr. G. Wamai ably assisted with the training of interviewers and supervisors: they all made our work of principal investigators considerably easier. We are equally grateful to Mr. A. Mutumba, Administrator of CHDC, and Ms. M. Nakuya, Assistant Administrator, for all the help in budgeting, administrative and logistical matters connected with the study; and to all drivers from UNICEF and UEDMP, who handled the vehicles so ably, thus managing to transport us safely to and from all destinations.

Special thanks go to the district authorities in Kasese, Masaka, Mbale, Pallisa and Arua; particularly the DMOs and their health team members who facilitated our introductions to the DAs, DES's RC 5 chairmen or their representatives, NGO representatives of the PHC programmes, and lower RC officials. Our ultimate thanks, however, must go to all key informants and focus group members, who gave us all the information about their projects and experiences on or about PHC in their community, district, or in the country. We were greatly assisted by a team of competent and dedicated supervisors and interviewers on whom much of the success of the field exercise depended, and to whom we are most indebted.

Finally, we also wish to profoundly thank Mrs. B. Okumu, Ms. D. Nakakawa, and Mr. J. Busuulwa, for helping with all secretarial, data entry and computer layout work; and Mr. D. Bagenda for assisting with data preparation for final analysis.

EXECUTIVE SUMMARY

BACKGROUND

The Ministry of Health (MoH) requested the Child Health and Development Centre (CHDC) to carry out a study of five "successful" programmes which have been implementing CBHC/PHC activities in the country, with a view to identifying factors which promote PHC and to derive information which will be of use in formulating national policy and guidelines for implementing PHC, particularly at district level and below. The five programmes were selected not only for their known "good" history, or their being "worthy of emulation", but also in order to represent the many other programmes operating in the country (`spread around the country') on a regional basis. Programmes were selected from the five districts of Kasese, Masaka, Mbale, Pallisa and Arua, and all of them non-governmental programmes namely, Kasanga CBHC; Kitovu CBHC; Mission: Moving Mountains CBHC; PACODET CBHC; and Kuluva PHC, respectively.

OBJECTIVES OF THE STUDY

General Objectives

a) To analyse strategies and identify the contributing factors for a successful implementation of PHC in the country.

b) To gather and analyse information about PHC in Uganda that will be of use in formulating national policy and guidelines for implementation of PHC at district level and below.

Specific Objectives

a) Carry out a qualitative case study of small select group of PHC projects widely distributed throughout the country that are known to the Ministry as "good" projects.

b) Assess the projects on the following selected PHC parameters drawn from the 1978 Declaration of Alma Ata:
   - i) History/evolution of the project.
   - ii) Linkages between the community project and government health system.
   - iii) Community participation in planning and implementation.
   - iv) Self-reliance, self-determination and replicability.
   - v) Integration of national and international objectives.
   - vi) Linkage of project with community development.
   - vii) Cost the community can afford.
   - viii) PHC elements (components) being implemented.

Of the above PHC parameters to be assessed, **community participation** was a major focus of attention, being one of the four key pillars of PHC; others being, **political will or commitment**; **intersectoral collaboration**; and (affordable) **appropriate technology**. Community participation is further considered to be the cornerstone of PHC, and a major factor in the successful implementation of PHC as most evidence both from the literature and case studies shows. Being at the centre of the whole process in the development and success of PHC, the concept of community participation thus required a conceptual framework for its analysis.

METHODOLOGICAL APPROACH

The study design was a cross-sectional/retrospective (historical) case study of projects within the five programme areas, based on intensive site visits using qualitative or **rapid assessment** methods. Data collection strategies included key informant interviews, focus group discussions, unstructured observations, check lists, documents and a general PHC literature review. Key informant interviews were carried out with project personnel, programme implementers, DHT members, policy makers, etc. Focus group discussions were held with community leaders and beneficiaries/community members. A total of 123 key informants were interviewed plus 180 other people who took part in 16 focus groups. Most of the data was qualitative, using relatively small purposive samples. Each case study at site took approximately one week (5 - 6 days) to complete.

MAIN FINDINGS

- Four of the programmes were initiated with external assistance, or had some expatriate involvement. Only PACODET was indigenous or had an entirely local beginning, with no substantial external support. While most of them had a needs assessment done initially with external involvement, only PACODET carried out its own local one without outside participation. Two of the externally supported programmes had some evidence of shifting towards greater local control, whereas the other two had shown a lesser degree, and were rather leaning more towards continued external support; and while the four externally suported ones had evaluations done by external teams, PACODET had not had one. The different projects set up within programmes had operated for between two and ten years, all involved in curative, promotive, preventive aspects of health care or PHC. CBHC activities also included wider community development aspects such as income-generation, building schools or health units, maintenance of roads, and water supply activities.

- Close linkage of programmes with the government health system was not clear, except for the overall supervisory role of the DMO's office. No clear guidelines were available, especially with regard to PHC activities; programmes therefore operated mostly independently of the system. On the whole, the articulation of

PHC/CBHC activities appeared rather poor in the districts. Some referrals were made to functioning health units and hospitals, though the roles of CHWs within the referral system were not well-defined, or apparently not well-accepted especially by government health staff. Training activities were coordinated in some districts, and DHT members were often main facilitators for some of the programmes.

- Community involvement and participation in planning and implementation ranged from taking part in needs assessment to actual planning, monitoring and evaluation in some cases. Other aspects included selecting and supporting their CHWs and TBAs, contributing materials, food, or direct labour contributions like taking part in construction of health units or protecting water sources. Levels of participation generally ranged from collaboration in communal activities, taking part in local needs assessments, decision-making, to some level of project control and community empowerment. Three of the programmes had clearly shown some degree of community involvement, while communities in the remaining two still seemed to look forward to continued support from outside, whereas PACODET personnel were in full control of their own development activities.

- Initiatives for self-reliance and sustainability included `cost-sharing' schemes or cost-recovery measures through payment of fee-for-service at health units; income-generation at project level; communal crop-farming and animal husbandry; cooperative schemes; or managing revolving drug funds, etc. However, efforts at replicability were hampered by a number of factors including over-dependency on external assistance for long, low awareness, low economic base or low production level leading to, or exercebated by general poverty, famine, and other external factors like insecurity, or poor social and physical infrastructure.

- Programme objectives generally matched with national objectives such as `serving the poor and the unreached'; `promoting general health and preventing disease'; `promoting self-reliance and community development'; `complementing services of the government in promoting PHC'; `holistic evangelism',etc. However, national versus international objectives were not so clearly laid out or integrated, except in form of the real or implied undertakings to supplement government (national) efforts in delivering health care, some of which efforts are easily quantifiable.

- Four of the programmes indicated that their activities were aimed at community development through CBHC in order to promote PHC. Such activities include food production and nutrition projects, water supply, sanitation, road maintenance, and income-generating activities. However, linkage or collaboration with government and other development programmes or sectors, like extension services were generally not strong at the district level.

- Payments for services, material or cash contributions were made upon agreed terms, or on the basis of what an individual person, family (household), or community group could afford. Some communities had dificulty contributing, either because they were poorly mobilised (low awareness), expected external assistance to continue, or because they were genuinely unable to afford. Where contributions or payments were agreed upon, they constituted the community's realised level of `affordable cost', that is either material, cash or in kind.

- PHC elements (components) being implemented received different levels of emphasis varying from programme to programme; for example, some starting with curative services from a hospital base then moving on to promotive, preventive, educative, or including rehabilitative services. In all of them, basic activities like immunization, MCH/FP, nutrition, water and sanitation, control of endemic or epidemic diseases, and general health education were undertaken. CHWs or TBAs were selected, trained and deployed to work in the local communities to deliver appropriate messages and services, including in most cases the treatment of common diseases. Apart from being taught the basic elements or components of PHC, they were taught a whole range of topics, mainly geared to preventive measures, and personal or community development initiatives.

SUMMARY & CONCLUSION

The lessons learned from experiences in other countries as well as in Uganda based on the accounts of the five case studies suggest that PHC **is a feasible strategy**, but requires time in order to produce results. PHC isssues include wider issues than just health. There are political, economic, socio-cultural, religious, organizational, educational (formal or non-formal), and equity issues involved. All these require political, economic/financial, administrative or organizational decisions, as well as commitments to be made. Issues of equitable resource allocation and empowering local communities to take responsibility must be addressed, and these start with political commitment, and putting into effect the vital processes for decentralization, and early ensuring of self-sustainability.

Success factors include: political commitment; effective mobilization (through exemplary leadership) for creating awareness; availabilty of funds, supplies, equipment and logistics; good cooperation and coordination in the districts; community involvement in resource mobilization; community recognition and support of CHWs and TBAs; appropriate training; security; good infrastructure /communications network; and presence of income-generating activities, amongst many other factors. Constraints to success consist of the very opposite of the above success factors, that is their absence, often leading to failure.

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to translate the usual political commitment rhetoric to actual , and to accord `health for all' through PHC, the highest velopment terms. Rural or peripheral populations in particular in resource allocation, in order to redress the glaring existing y, budgetary allocations or disbursements for development of have to increase substantially in order to invest fully in PHC, of external aid input initially to back some of the more .

nsaries or aid-posts should be strengthened with the necessary plies, equipment and logistics to serve as focal centres for ral pathways need to be clarified to take account of the role of he system.

e personnel - from doctors to auxiliary staff, should receive n courses on PHC strategies and management, and be for community development, or of handling comunities. s and trainers' courses should be undertaken to create a pool ns for PHC and other development activities. Suitable programmes should be devised to promote PHC in schools or ssional institutions.

DHT members should be responsible for supervision and co-ordination of PHC, in collaboration with NGOs and other sectors. However, they should not assume the role of `managers' of the projects but facilitate the process of the communities' reponsibility and control over their health care and development.

5. PHC workers like CHWs and TBAs, as well as other recognised traditional healers or practitioners should be integrated into the health care system, but issues of their selection, training, support or remuneration, and supervision should be left to the particular communities to decide and manage.

6. Cost-effective measures should be undertaken to ensure optimum use of resources through maximum community involvement and participation in the efficient use of donor funds, as well as community-generated resources in direct financing or support of their own health care. Cost-sharing or recovery schemes should be devised to suit local demands and affordability, to ensure self-reliance and sustainability. Those at most risk or vulnerable groups should be identified and mechanisms for exemption from payment be devised to cater for their needs.

7. Existing community structures, as well as new administrative or institutional ones such as clans, religious, economic, educational and other interest-groups, should be encouraged to undertake mass mobilization for health and develomental activities to promote PHC, and to help attain sustainability and self-reliance at the local level.

8. Appropriate legislation, policies and guidelines should be formulated from time to time, to take into account the new health policy based on the PHC strategy, in specific areas like financing health, or cost-sharing; intersectoral collaboration; decentralization of services; external aid/donor assistance use or coordination; partnerships in PHC; integration of services, as well as additional issues or insights on enhanced community participation, etc., that require further consideration and clarification through new policies and guidelines.

9. On-going research into specific policy or other operational areas, which are key to planning, implementation, monitoring and evaluation of PHC services should be identified and carried out periodically at national, regional or district levels, and institutions for essential national health research (ENHR) or health systems research (HSR) be strengthened, through funding and capacity building support. Community members should be involved in all stages of data collection, monitoring and evaluation of all activities; and the dissemination of such study findings must be done at district and lower levels to benefit the local community.

KEY ABBREVIATIONS

ADES	Assistant District Executive Secretary
AMREF	African Medical and Research Foundation
AVSI	(Italian NGO) - International Service Volunteer's Association
CBHC	Community Based Health Care
CHDC	Child Health and Development Centre (Makerere University)
CHW(VHW)	Community Health Worker (Village Health Worker)
CIDA	Canadian International Development Agency
CRWRC	Christian Rural World Relief Committee
CUAMM	(An Italian NGO - a Medical Collegiate Institution)
DA(CGR)	District Administrator(Central Government Representative)
DANIDA	Dannish International Development Agency
DC	District Council
DCBHCA	District Community-Based Health Care Association
DDC	District Development Committee
DES	District Executive Secretary
DHC	District Health Committee
DHE	District Health Educator
DHI	District Health Inspector
DHMC	District Health Management Committee
DHT	District Health Team
DHV	District Health Visitor
DLTCO	District Leprosy and Tuberculosis Control Officer
DMO	District Medical Officer
DNO	District Nursing Officer
DRC	District Resistance Council
ENHR	Essential National Health Research
HSR	Health Systems Research
HUMC	Health Unit Management Committee
IGAs	Income-generating activities
MIVA	(An Italian NGO)
M:MM	Mission: Moving Mountains
MOH	Ministry Of Health
MOLG	Ministry Of Local Government
MOPED/MOFEP	Min. Of Planning & Econ. Dev/Finance & Econ. Planning
NGO	Non-Governmental Organization
NHFTF	National Health Financing Task Force
NRC	National Resistance Council
OXFAM	Oxford Committee for Famine Relief
PHC	Primary Health Care
Rcs	Resistance Councils, eg. levels I, II, III, etc.

RUWASA	Rural Water and Sanitation Project
SWIP	South West Integrated Programme (UNICEF assisted)
TBA(s)	Traditional Birth Attendant(s)
Ths	Traditional Healer(s)
UCBHCA	Uganda Community-Based Health Care Association
UEDMP	Uganda Essential Drugs Management Programme
UNEPI	Uganda National Expanded Programme of Immunization
UNICEF	United Nations (International) Children's (Emergency) Fund
VHC	Village Health Committee
WHO	World Health Organization

CHAPTER 1

1.0 INTRODUCTION

1.1. BACKGROUND

Historically, the health care system of Uganda was one of the leaders on the continent of Africa, especially in its community orientation. The community focus was supported by a very extensive and effective health infrastructure. Following its peak in the 1950s and 60s, nearly two decades of civil disruption and economic decline have immobilized and incapacitated this infrastructure. As a result, most of the gains in community health were dissipated. Immunizable diseases like measles and tuberculosis, plus other preventable conditions or diseases like respiratory infections, malaria and diarrhoeal diseases became leading causes of mortality, particularly in children under five years.

In 1987, Uganda became a signatory of the Alma Ata Declaration on Primary Health Care (PHC)*[1]. Since then, attempts have been made to develop a National Primary Health Care Plan of Action (MOPED, 1990). In 1987, the Government appointed a Health Policy Review Commission under Prof. R. Owor as chairman, and in the health policy that was to follow, priority was to be redirected towards community-based health care (CBHC) activities, especially in promotive and preventive health care, thus re-orienting the whole health system to PHC, by emphasizing community participation. The main health programmes under the new policy have focused on: accelerated immunization; control and prevention of endemic diseases; health education; essential drugs supply; maternal and child health/family planning; nutrition; water and environmental sanitation; treatment of common illnesses; health care research and training; and rehabilitation of health infrastructures (MOPED,1990). In terms of adopting national PHC elements or components for Uganda, the MOH added other strategies to the original eight adopted in Alma Ata, namely; oral/dental health, mental health; and community based rehabilitation.

1.2. RATIONALE

The Uganda Ministry of Health (MOH) has a determined policy to improve the health of the majority of the population, by emphasizing primary health care as it was articulated in the Alma Ata Declaration. This approach is somehow different from the current centralized government health system in that, it now places increased responsibility for health directly in the hands of the community. In order to carry out this objective, the MOH has identified the need for a verified set of PHC guidelines for the evolving national health system.

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1 For a full text of the Alma Ata declaration and definition of primary health care, see appendices.

Planners in the MOH who are responsible for developing PHC policy guidelines for implementation have also recognized that, there are already quite a number of individual projects or programmes around the country that are promoting PHC even without national guidelines. At present, however, how well they are adhering to the specific objectives for PHC as stated in the Alma Ata Declaration is not well known. Of particular relevance to Uganda, even less is known about how the "good" programmes have achieved their success. To prepare effective guidelines for helping members of the government health system to implement PHC therefore, more information was needed about ways that community participation has been successfully promoted and supported by different communities in this country.

According to the `Background to the Budget, 1991/91', the main focus of health care in Uganda should be to ensure the provision of promotive and preventive services, with the development of an integrated and multisectoral PHC strategy. Under this system, health centres are to be developed as the basic health units around which primary health care activities are to be carried out with full participation of the local community. In the PHC approach, therefore, an increased proportion of responsibility for health care is shared with communities.In realization of the need to understand the processes involved to develop full community participation, the MOH called for a study of five "good" (successful) PHC projects `spread around the country', worthy of emulation - that is, *replicable*. Accordingly, with UNICEF assistance, it commissioned the Child Health and Development Centre (CHDC) to carry out the study. Projects were selected from the districts of Kasese, Masaka, Mbale, Pallisa and Arua, to represent the `spread around the country', and more specifically on the basis of their known history of "success".

1.3. OBJECTIVES OF THE STUDY

1.3.1. General Objectives

a) To analyze strategies and identify the contributing factors for a successful implementation of PHC in the country.

b) To gather and analyze information about PHC in Uganda that will be of use in formulating national policy and guidelines for implementation of PHC at district level and below.

1.3.2. Specific Objectives

a) Carry out a qualitative case study of a small select group of PHC projects widely distributed throughout the country that are known to the Ministry as "good" projects.

b) Assess the projects on the following selected PHC parameters drawn from the 1978 Declaration of Alma Ata.

i) History/evolution of the project.
ii) Linkages between the community project and government health system
iii) Community participation in planning and implementation.
iv) Self-reliance, self-determination, and replicability.
v) Integration of national and international objectives.
vi) Linkage of project with community development.
vii) At a cost the community can afford.
viii) Number of PHC elements (components) being implemented by project.

1.4. ANALYTICAL FRAMEWORKS FOR COMMUNITY PARTICIPATION

One of the very central issues in the process of improving community health is the search for ways to achieve effective and sustainable analysis of stages of community involvement. Community participation (CP) is defined differently, and in accordance with the particular context, or aspect of development that one is concerned about. According to Susan Rifkin (1980), CP is seen as the key to PHC; and for planners, it has been applied using three main approaches, namely: the **medical approach**, which has its roots in the medical model of health care based on the view that health is essentially the absence of disease. The **health planning approach**, which is based on the view that health is essentially the result of the appropriate delivery of health services, and that good delivery must be based on proper planning by ensuring community members get access to service because they have great need for the service, but not enough financial and other resources to meet them. Finally, the **community development approach**, which firstly grew out of a tradition - of community development - which defines health in the context of promoting better living conditions, like housing, agriculture, education, employment opportunities, etc.; secondly, as a consequence, this approach believes that not all health improvements necessarily start with health service activities; and thirdly, this approach relies on a decision-making process which focuses on community wants rather than planners' needs - a "**bottom-up**" rather than "**top-down**" process.

In offering a definition, Rifkin et al, (1988) defined CP as: *"... a social process whereby specific groups with shared needs living in a defined geographical area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs. In the context of PHC, this process is one which focuses on the ability of these groups to improve their health and health care and by exercising effective decisions to force the shift in resources with a view to achieving equity".* Rifkin went further to develop conceptual and analytical frameworks to assess participation in health programmes by use of indicators, which would tell us whether such participation has become narrower, broader, or remained unchanged over time. The development of the indicators would depend first on a clear understanding of the use of the terms `community' and `participation'. According to Rifkin, the factors which influence participation are: (1) **needs assessment**, (2) **leadership**,

(3) **organization**, (4) **resource mobilization**, (5) **management**, and (6) **focus on the poor**. For the first five of the factors, a continuum can be developed to show narrow, wide or unchanged levels of participation within a particular programme, or between programmes over time. Community participation was defined as: "*...a process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet those needs.* ***In the context of PHC, this process is one which focuses on the ability of these groups to improve their health and health care and by exercising effective decisions to force the shift in resources with a view to achieving equity.***" (p. 933, emphasis added).

Another very interesting analysis of stages of community involement which can be mentioned, was developed by Were (1990), and some of the ideas in it will be used in the analysis of the following five case studies. The analytical framework developed by Dr. Miriam Were describes four levels of community participation: **(1). Increase of User Response** (Level I) -- This is the most elementary level: programme content and details of administration are worked out by others (non-community members); people are actively mobilized to make more use of available services. This can be a starting point, but it does nothing for capacity building in the community. (2). **Community Collaboration** (Level II) -- There is some development of community skills and solicitation of community input, but minimal; programme content is worked out elsewhere (`we know what people need'); on the positive side, the community is invited in for working out some of the implementation, in response to the question, `How can we do this programme here ?'. This level is not always bad, but is usually condescending and widespread support and sustainability are unlikely. (3). **Community Involvement Based on Local Needs Assessment and Community Decision** (Level III) -- Communities are assisted to develop significant skills of analysis, problem identification, defining alternative strategies, choosing the path of action, etc.; the questions raised with the community are more challenging at this level: `What are the problems ?'; `What can be done by the community ?'; `What can others outside the community do to help the community solve the problem ?'. Clearly, this level has more capacity building potential if handled properly, and people are not stampeded. However, it may not move communities out of their current state if they do not get access to more resources. (4). **Community Empowerment** (Level IV) -- At this level the community becomes `aware' enough to eventually assume control of the development process; the questions to be addressed are now being raised by the community. The issues may arise while going through the steps used in Level III, but in a much more conscious environment. These questions ask about the `why'; eg. `why are we poorer than others ?'; `why do we have more problems ?'; `what can we do to change this ?'. How far one goes with this process depends on a number of factors and the preparedness of everyone involved to negotiate new areas. (Were, M., "Challenge to Capacity Building at Community Level", Invited Commentary, NCB-II Regional African Meeting, Ibadan, 5 - 12 October, 1990).

CHAPTER 2

2.0. LITERATURE REVIEW ON PRIMARY HEALTH CARE

2.1. BRIEF HISTORICAL BACKGROUND: Trends towards Adopting PHC as a Global Movement, and Specific Efforts Leading to the Declaration of Alma Ata

Although PHC as a strategy has been in existence for less than two decades since it was adopted, issues and concerns about social equity objectives in health have long historical origins which date back to over a century and a half in Western society - to the industrial revolution - in Europe. After the second world war, efforts were made to set up vertical disease control measures, or campaigns to combat some diseases such as malaria and smallpox. By the 1960s, however, increasing concerns were being directed at issues of rapid population growth, and problems that accompany such uncheked growth, particularly in the developing world.

The PHC movement was thus perceived as a renewed interest in issues of health equity, and as part of a broader `basic needs' strategy in international development. In the 1970s, there was growing dissatisfaction with the socio-economic and population policies, and measures for growth which would have brought about benefits to the rural populations. The shift to a basic needs approach, therefore, laid the fertile ground required for the PHC movement which placed emphasis on basic health services as well as clean water, food, housing, and clothing for the most disadvantaged people usually left behind in the development process.

Lincoln C. Chen (1988) observes:
"... the historic understanding of the PHC movement underscores several points. PHC cannot be viewed in isolation from broader socio-economic or political developments nor can its time context be limited to Alma Ata. ... PHC combines elements of basic health services with broader community development concerns. As such, its emergence, growth, or decline would be imbeded in broader movement related to socioeconomic development strategies in developing countries." (p.s26)

He also considers the question of time; advocating in particular for longer time perspectives to allow for human and organizational capacity to develop for such concerted efforts:

"Ten years may be a long time for a programme but is very brief for a historical movement with antecedents over a century old. Brief time horizons often lead to the launching of `crash' programmes, a characteristic of many PHC derivatives. Longer time perspectives would shift PHC strategies for immediate concerns over

technology delivery to structural issues such as building human and organizationl capacity in developing societies and reorienting and reorganizing nascent systems." (p.s28, emphasis added).

A Major Global Study before Alma Ata

In 1974, a joint WHO/UNICEF study was conducted which resulted into the production of a major document which undoubtedly set the scene for Alma Ata. **(Newell, 1975)**. Prior to that study, it was observed that during a period of 25 years, individual groups and some countries had made attempts to address the question of social inequity in health and other developmental aspects which were regarded as true 'global efforts' in PHC. A group of people were asked to write down what those efforts were, and to document the process in each country. This resulted into the volume **Health By the People**; drawing examples of experiences from China, Cuba, India, Guetamala, Iran, Indonesia, Niger, Tanzania and Venezuela. The accounts were so exciting that the editing author, Prof. K. W. Newell remarked;

"My reaction on reading these accounts was one of excitement. Excitement that such victories in the health field have been won in many geographical regions, in countries with widely different political systems, and in some of the poorest rural populations of the world. ***By use of well-accepted - almost conventional - simple health techniques and the provision of food, education, and assistance in improving productivity, the health of communities has improved dramatically and visibly and in a way that makes one optimistic about the potential for continuing change.***" (p.191, emphasis added)

However, he cautioned on the question of goals and measuring of success, or use of indicators, usually in terms of indices like infant mortality rate, disease prevalence, or the number of immunizations given. He also noted that the authors of the accounts had `gently but forcefully' reminded the reader that in order to really understand those achievements, one must accept the community's goals, for their goals usually include wider issues, stating;

"They do not question the fact that infants need food, pregnant mothers need to be delivered, immunizations are useful and prevent illness, or that sick people need treatment. On the contrary, they emphasize that these are some of the expressions of community action and that they will inevitably follow if you proceed in a reasonable way and take the wider issues into account."

The wider issues according to the accounts include: "productivity and sufficient resources for food and education; a sense of community responsibility and involvement; a functioning community organization; self-sufficiency in most areas and minimal reliance on outside resources; understanding the uniqueness, pride and dignity of each community; and, the feeling that people have of a true unity between their land, work and household". (p 192).

These issues truly place the PHC approach in a whole context and content, thus making it potentially feasible as Newell observed, that the primary health care system could not be thought of only as an appendage to the existing health service.

The country accounts reported many similarities in the processes and scope of community action such as the formation, reinforcement, or recognition of a local community organization. Such community organization appeared to have five main functions: laying down priorities; organizing community action for problems that could not be solved by individuals eg. water supply or basic sanitation; "controlling" the primary health care service by selecting, appointing, or "legitimizing" the PHC worker; assisting in financing services; and linking health actions with wider community goals.

The community health worker (CHW)

A common element of the accounts was the use of a primary health worker who did not fit into the expected description of a doctor or a nurse. This person was frequently a villager selected by the community and trained locally for a period that could be as short as 3 - 4 months initially, an unpaid volunteer, or a person who possibly was partially or totally supported by the village people in cash or kind, and with responsibilities for aspects of promotional, preventive and curative health. The CHW described in the accounts would be the main source of a PHC service: `he is community-based and community controlled but also a health team member,' and, `responsible for the mechanism governing the referrals to more specialized sources of help, and is the recipient of training, support, drugs, equipment, and ideas coming to the community' (p.194).

Integration of the " total health " approach

In all the accounts, there was no separation of the promotional, preventive, and curative actions at the PHC level, and the persons attending preventive and promotional services were often population selected, but such integration did not mean that all health actions were to be integrated in a single person at the village level. For example, there will be activities that are most suitably dealt with by women whereas others are best carried out by men; and in communities which are heterogeneous, there may be a need to cater for unique solutions, by having more than one primary health worker in the community to deal with cultural, or other traditional matters, like in family planning issues etc.

Issues of self-sufficiency and viability (sustainability) in PHC

Curative health services may be an entry point to, as well as financial mechanism for gathering local support for a more widely based programme, Newell noted, but the nature and the expression of the service are best decided by the community. The arguments for linking curative, promotive, and preventive actions appear to be overwhelming, but those for a linkage between **financing** and services were not so clear. One author emphasized the need for a service to be self-sufficient by a fee for service, while at the same time accepting the principle of differential payments according to wealth.

In relation to the issue of financing Newell observed that there was confusion, coupled with the clash of politics, practicability and technical decisions. It was, therefore, `absurd' according to him, to discuss the financing of primary health care as a self-sufficient entity, and as if there were no health resources or other national health expenditures. He suggested four inter-related solutions: to re-allocate resources more equitably between all segments of the population; to introduce a programme of self-reliance and self-sufficiency to all segments of the population (urban as well as rural); to reserve a large proportion of national health funds for the development and capital costs of the primary health care services; and, to redesign the existing government-supported (and other) health services to give them a more clearly defined supporting role in relation to the wide primary health care base.

The manner in which the above steps can be taken is clearly a matter for the countries themselves and one that should be consistent with their own image and their political heritage, Newell suggested. As to the question of the social viability of communities, he thought it may be either a national or international one; that is, dependent upon their local (national), or international capacities for resource mobilization and control, or management strategies.

Re-designing the health service education system for PHC

Newell suggests a redesign rather than a shake-up of the system.

"What is required is much more fundamental than a new curriculum for the primary health care worker, a move of training institutions to the periphery, or an adapted community health doctor or nurse. If rural and community development is to be a series of progressive changes rather than a convulsive jump, the persons involved with health will also have to be able to change, improve and adapt themselves in step with community organization." (p.198).

The issues which existed in the accounts of early PHC initiatives then, are the same issues which still have to be contended with today: as a major issue is the need to redress inequities in health care and other development aspects, as well as the allocation of resources to meet those needs.

2.2. ALMA ATA AND AFTER: International and Regional Efforts and Experiences

The International Conference on Primary Health Care took place at Alma Ata, in former USSR, in September, 1978, where representatives of 134 sovereign states or governments articulated their historical concensus on the international goal of Health for All by the Year 2000. A major focus was on health equity and social justice between and within nations, which in turn gave impetus to many PHC initiatives in following years. Primary Health Care was defined as:

"... 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 care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."

National Policies

The conference urged all governments to formulate national policies, plans of action, and strategies to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. Furthermore, it would be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally. Most importantly however, there should be full participation by individuals and family or community members, in taking more responsibility for their own health and overall development in the community.

2.2.1. The Chinese Experience

In 1983, five years after the Declaration of Alma Ata, the WHO organized an Inter-regional Seminar on PHC which took place in China from 13 to 25th June. Its objectives were: (a) to explore some aspects of experience in primary health care in China, with particular attention to: the three-level network of the health care system; the people's involvement in, and management of, health care; health manpower development; financing of health care; and, (b) to draw conclusions applicable to the development of primary health care in other countries.

Implementation: a difficult task

At the end of the seminar, the participants reiterated the definition of PHC in the Declaration of Alma Ata. However, they realized that the implementation of PHC had proved a difficult task; that even when the concept of PHC was clearly understood, confusion had arisen when it came to applying its principles in actual country situations. **There were many obstacles to be overcome in the political, technical, and management processes involved in the implementation of PHC and through it the achievement of the social target of "health for all by the year 2000".**

Seminar participants observed that China had clearly demonstrated that "health for all" could be achieved, and some general factors had emerged as having been `a significant contribution'; which were: i) that, China had demonstrated a **tremendous political commitment** to the task of changing the quality of life of all its people and especially of the

availability of a system of referral ensuring access to more highly trained staff capable of dealing with a wide range of specialized health interventions that require technology that is not easily provided at the community level.

- **Priority to underserved areas**

In order to achieve total population coverage and the goal of "health for all by the year 2000", priority should be given to underserved areas and to high-risk groups in the population; the support of the progressively more sophisticated higher levels of the system ensures that health care of the highest quality is made available and accessible to all, when needed, thus giving a balance between quality and quantity.

The seminar finally made specifically far-reaching and wide-ranging conclusions and recommendations on people's involvement in and management of health care; health manpower development; and financing health care, all based on the Chinese experience. The participants reportedly became deeply conscious of the unique opportunity they had had to study a primary health care system at work, not only to the benefit of all the people of China, but also to the potential benefit of millions of people far beyond the Chinese borders.

2.2.2. Some PHC Derivatives

Ten years after Alma Ata in March 1988, the WHO again sponsored a follow-up meeting, **`From Alma Ata to the Year 2000: A Midpoint Perspective'**, at Riga, former USSR (now in Latvia). The Riga meeting `reviewed progress and problems experienced in pursuing PHC', and considered reassessment that might be necessary in order to proceed more effectively toward the goal of health for all. The reaffirmation at Riga concluded that the concept of PHC **`had made strong positive contributions to the health and well-being of people in all nations'**, and that **`the remaining problems called for political commitment including making permanent the principles and spirit of health for all'.** According to the meeting, **PHC advocates an equity-oriented health strategy focusing priority on the most appropriate health technologies for the most common health problems in communities of greatest need.** The decade of the 1980s had witnessed the emergence of several derivatives, and several efforts were launched at different levels, among them **`Selective'** PHC, and the **`Child Survival and Development Revolution** (CSDR).

While selective PHC assesses diseases according to the magnitude of their burden and the feasibility of their technologic control, advancing a cost-effectiveness framework for prioritizing intervention strategies, the CSDR focuses on a few simple, low-cost, effective health technologies for promoting a `breakthrough' in child survival. The latter is based upon the selective approach by focusing on a target population (children) through mass application of specific paediatric technologies popularly known by the acronym GOBI - **growth monitoring, oral rehydration, breastfeeding and immunizations**, and later

additional acronyms FFF - putting emphasis on **family planning, female education** and **food supplements**.

Parallel to the Riga meeting in March 1988, was a gathering of the Task Force for Child Survival sponsored by WHO, UNICEF, UNDP, World Bank and Rockefeller Foundation on `**Protecting the World's Children: An Agenda for the 19990s**' at which the Declaration of Talloires was issued. The meeting set afresh massive targets for the year 2000, including the global eradication of polio; universal childhood immunization by 1990; reduction of infant mortality to 50 per 100,000 live births, and under-5 mortality to 70 per 100,000 children; 90% reduction of measles and 95% reduction of measles mortality.

In reaction to the paediatric focus of PHC and the CSDR, two international initiatives to address women's reproductive health problems were launched in 1897, namely, the `**Safe Motherhood**' and the `**Better Maternal-Child Health through Family Planning**' at a conference which highlighted the neglected problem of maternal mortality and the significance of family planning as critical maternal and child health measures.

According to Lincoln Chen, the issues sorrounding the various PHC strategies are their efficiency and effectiveness in meeting the ultimate objectives of `health for all'. However, few resources have been invested to investigate the achievements of various approaches and many of the strongest proponents of various strategies are agencies that dispense large resources, he observed.

2.2.3. The Africa Region

Within the continent of Africa, **AMREF** organized a conference in Nairobi in April 1989 with the objective of bringing together about 200 managers of community-based health care projects in twelve eastern and southern African countries to discuss their successes and failures. The theme of the conference was "Lessons Learned in Primary and Community-Based Health Care". In the background to the conference it was observed:

"Over the past decade (1978 - 1989), primary health care (PHC) has become widely institutionalized in Third World countries. Experience has led to substantial improvement in technical capability for developing PHC resources and responding to the health, and in some cases the development needs of those communities out of reach of traditional health services. Despite practical experience, programme performance has not changed much in the design and the implementation of PHC.

Many programmes have been shown to be constrained by characteristics of the particular country or region in which they are operating. ***A growing body of literature demonstrates that the context of PHC - the political, administrative, economic and community settings in which programmes are designed and carried***

out, and the strategies and processes involved in their implementation - exerts important influences on programme outcomes". (p.1, emphasis added).

Conference participants arrived at some concensus on various issues which included the following:

- **Health For All by the Year 2000: need for active community participation and social mobilization**

"Given the stage at which the majority of countries in eastern and southern Africa were in their overall development and in their implementation of PHC/CBHC, it was unrealistic to expect that the region will have health for all by the year 2000...It was perhaps easier for the region to strive for health for all through active community participation and social mobilization. ***It was recognized that PHC/CBHC was the only way by which the region would achieve "health for all."*** (p.141, emphasis added).

- **Status of PHC/CBHC in the region: long time needed to realise it**

It was noted that countries around the region were in various stages of implementing PHC/CBHC, and a number of countries had guidelines while others did not. The majority of the programmes were still at an "experimental level", with NGOs playing a major role and donors prominent in financing projects. A lot still remained to be done to ensure the programmes' replication in other areas, and in such a way that the communities involved would sustain them, and run them as their own.

"It was recognized by participants that it takes a long time to realize the impact of PHC/CBHC and hence we needed to be patient. It was dangerous to hurry communities and to expect immediate demonstration of success." (p.142, emphasis added).

- **Community participation: cornerstone of PHC/CBHC**

"Community participation and involvement was the cornerstone of PHC/CBHC implementation. It was essential to actively involve communities at every stage from the organization of ideas to planning, implementation and evaluation of any programme so that communities would see such programmes as their own. This was one way of ensuring sustainability of programmes." (p.142).

- **Intersectoral collaboration: a key issue for successful implementation of PHC/CBHC programmes**

PHC/CBHC was about overall improvement of health of all people and it was evident that no one sector could implement it alone. Conference participants acknowledged that intersectoral collaboration was a key issue of PHC about which little was being done, as people did not know how to collaborate with each other. The issue of intersectoral

collaboration would remain central to the successful implementation of PHC/CBHC programmes, it was observed.

"It was necessary to ensure active participation and involvement of all sectors from the inception of programmes. Collaboration was easier at the peripheral level and much more difficult at the central level. Policies that would facilitate collaboration needed to be put in place." (p.142).

• **The role of community health workers: need for wider role as change agents and motivators for overall development.**
The role of CHWs in PHC/CBHC was recognized as important, but it was observed that CHWs tended to occupy themselves more with health than other CBHC activities. There was a concensus that they needed to play a wider role, as change agents for overall development, and as motivators. However, it was also noted that CHWs played different roles in different situations depending on the tasks and communities in which they worked. Therefore, it was difficult to standardize their criteria of selection and their training curricula; and the training needed to be done in the same community in which they intended to work. Furthermore, the CHWs needed to work together with the extension workers as a team, and the other extension workers could in turn be trained as CHWs.

Remuneration of CHWs was to be decided on by the communities themselves, but it was evident that there needed to be a way of compesating them for their time spent on their prescribed roles and responsibilities, which often were so heavy as to negate the spirit of voluntarism. Community support could be in kind or other ways possible, but income generating activities were to be best encouraged.

• **Sustainability: due consideration in implementation of PHC/CBHC programmes**
This was the most important issue addressed by the conference, since, it was noted, many programmes had been started without building in issues of sustainability from their inception. Sustainability, it was felt, should be given due consideratin in implementation of PHC/CBHC programmes.

• **Other issues:**
The conference also looked at other issues and made some recommendations. Communities were to actively participate in the **information**, **education** and **communication** (IEC) process; schools were looked at as partners in social mobilization for PHC/CBHC activities, along with other sectors. Child-to-Child programmes needed to be started in all countries. **Cost-sharing** in health was accepted as inevitable, with communities needing to play an active role in health-care financing. **The Bamako Initiative** was welcomed as a strategy that would enhance PHC and ensure cost-sharing and contribute to sustainability. It was meant to support curative services in particular, and to let people to co-finance them (also Paganini, A.,1993).

The **role of donors** was also looked at, and it was the concensus that donors needed to understand the communities they aimed to assist and should not be in a hurry to get results. **Inputs into the communities needed to be at a level that the communities could handle, and it was necessary for donors to phase out in a manner that would not disrupt programmes they supported.**

Finally, conference participants noted that in many PHC/CBHC programmes there was inadequate **monitoring and evaluation** of programmes, and many did not institute adequate supervision at various levels of implementation. Where it was done, there was no feedback given to communities. A number of programmes were started without baseline data and so it was difficult to assess their impact. The importance of **operations research** in PHC/CBHC was also recognized.

2.2.4. Developments in Uganda

The history of health services in Uganda dates back to 1902, when the then Protectorate Administration established the Medical Department to take charge of all health matters. The first Hospital was established at Mengo in 1897 by the CMS missionaries, and Mulago Hospital was set up in 1907 as the first Government hospital for the `natives'. Other Government hospitals and dispensaries were gradually established at provincial and district headquarters. Throughout the intervening years, the Central Government has encouraged the local or district administrations to participate in the running of services, particularly in the field of public health and environmental sanitation. The Local Authorities Acts of 1964 and 1967 transferred a number of social services, including health services to local authorities, and the present Ministry of Health was developed in 1961 from the former Medical Department of the Social Services Section in the then Protectorate Administration.

Uganda was a signatory at the Alma Ata Declaration on Primary Health Care as a strategy for attaining `Health for all by the Year 2000', and in 1987, Government appointed a Health Policy Review Commission whose terms of reference clearly indicated that Government would like the new health policy to be built on the PHC strategy. According to the Commission, although PHC has been practiced in Uganda since the arrival of Sir Albert Cook (founder of Mengo Hospital), the emphasis had been on curative rather than on promotive and preventive health care (Owor,1987). Most of the recommendations of the Review Commision were accepted by Government in its White Paper, especially those aspects which now emphasise the orientation of the system towards preventive and promotive services.

The Medical School which was first opened in 1924, produced its first graduates in 1927. Prior to that, medical orderlies or auxiliaries were trained at various government and mission hospitals. By the early and mid-60s, however, there were early advocates of a more appropriate health care system, that is, of *"... the study of how the fundamental knowledge embodied in medicine and public health can best be applied to the benefit of a*

community", who had already identified the need for, ***"the medicine of poverty"***, in a sympossium held at Makerere, to share experiences and ideas on **indigenous solutions** to health care, and to formulate appropriate answers. The result was `**A Primer on the Medicine of Poverty**' which in effect, set the local scene for a primary health care orientation not only in medical education, but also in the actual delivery of heath services (King,1966). In particular, those advocates highlighted the important roles played by auxiliary staff in delivering good health services in rural areas in the early 1960s (Turya, 1990b). In the ensuing years, national health services in Uganda became among the best in Africa, but were disrupted and marginalized in the 1970s and early 1980s due to civil unrest and economic decline (Barton and Bagenda; MOH,1993).

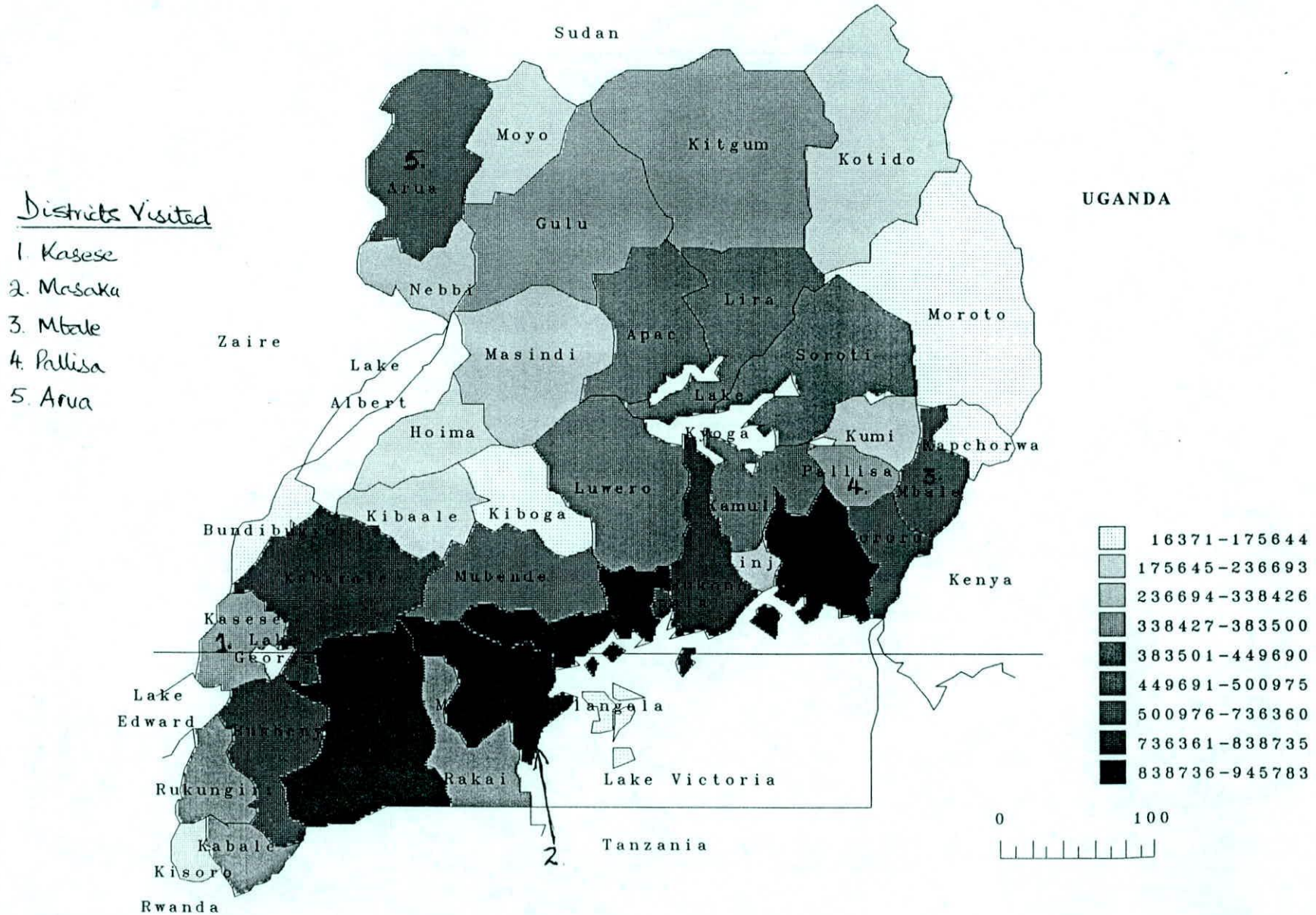
In 1983, the Government adopted PHC as the only practical strategy to enhance or accelerate the process of essential health care accessible to all, through full community participation, but there was need to first set clear strategies and guidelines for policy to implement PHC, both by governmental as well as non- governmental agencies throughout the country. Such a policy would give lead to the many issues that have been identified from within or outside the country, which include: resource allocation; decentralization of services; intersectoral collaboration; community participation; sustainability; integration of services, etc., amongst others.

On its part, the Ministry of Health has gone ahead to establish a section specifically for PHC implementation, and over the years, both MOH and NGOs have started PHC/CBHC projects, and similar efforts have been made to rehabilitate the existing infrastructure to support PHC, and to orientate all training programmes toward that strategy. Similarly, in addition to the original eight essential elements of PHC adopted at the Alma Ata conference, three other elements were identified and considered appropriate for inclusion; namely, dental /oral health; mental health; and, rehabilitation of the disabled (Owor,1987).

In reorienting the health system to primary health care, and in line with the commitment of the Government to "Health for All by the Year 2000" through the PHC strategy, the MOH aims to develop aspects of PHC hitherto regarded as `under-emphasised', that is, areas which accelerate preventive and promotive activities, and those which enhance communities' role in improving health. This means the reallocation of effort and resources towards preventive and promotive activities (MOH, The Three Year Health Plan Frame (TYP), 1993/94 - 1995/96).
Six main areas in particular are to receive emphasis during the next three years, namely: **immunization** (raising full rate to over 40% of child population); reaching 52% of "adult women" by **family planning**; introducing **health education** in the school curricula, universities, and organising health promoting activities; improving the **control of communicable diseases** with a major emphasis on HIV/AIDS and malaria; improving the **nutrition** status of the population; and undertaking cost-effective **water and sanitation programmes**. The above activities are regarded as not only health activities, but also as

multisectoral ones which fall under several ministries, which also entail considerable efforts in coordination, as well as in mobilising communities into action, especially at district or local community levels (MOH, TYP, 1993).

Total Popn 1991 : persons



CHAPTER 3

3.0. METHODOLOGY

3.1. DESIGN, STUDY POPULATION AND SAMPLING

The study design was a cross-sectional/retrospective case study of five projects based on intensive site visits using qualitative or rapid assessment methods. Specific data collection strategies included focus groups, key informant interviews using semi-structured interview schedules, questionnaires, unstructured observation, checklist, plus documents review. Focus group discussions were held with community leaders and beneficiaries, and key informant interviews were carried out with project personnel, community health programme implementers (e.g. DHT members). Most of the information collected therefore, was qualitative, with few quantitative aspects, using small judgmentally derived samples. Data collection was carried out by two teams of six and seven persons respectively, including one principal investigator (PI) as team leader, a supervisor, and the rest - interviewers. Those selected as interviewers were persons with known skills in interviewing, observation and documents review methods. Field work started simultaneously, and Team A worked from 12th - 24th July, while Team B covered from 12th July - 1st August, 1992. Team A covered the districts of Kasese and Masaka, while Team B covered Mbale, Pallisa and Arua districts. Each project case-study took approximately one week to carry out an indepth coverage. A total of 123 key informants were interviewed, plus at least 180 other people who took part in focus group discussions in about 15 groups.

Major Sources of Information

Category	Potential sources	Method used
Policy Makers/Planners	DAs,DES/ADES,RC 5,4,3, Councillors, etc.	Key informants
Implementers/Providers	DHT, health staff, Dept/Sector staff,etc.	Key informants
Donors/Funders/Project	Donor/NGO/Funders' reps, Project leaders, etc.	Key informants
Beneficiaries/Users	Community leaders, Actual/potential users.	Key informants & Focus Gps (FGDs)

3.1.1. Focus Groups.

Participants for the discussion groups were recruited on judgmental basis from amongst the CHWs, TBAs, community leaders or ordinary community members who were available. All groups included a mixture of ages, while some were gender separated, and discussions were conducted either in English or local language and tape recorded for later transcription, after obtaining permission from the participants. The groups had on average 8-12

participants per session (with few spill-overs), and discussions were moderated by an experienced member of the team, assisted by a human recorder, using a prepared topic guide to focus them on the objectives of the study.

3.1.2. Key Informants.

Key informants were selected for their knowledge of the local area, project history and issues, or their connection with primary health care/community development activities in the area or district. They included policy makers and programme implementers at district, sub-county or parish levels, representatives of NGOs, project leaders, RCs, and rural/community leaders or elders.

3.1.3. Documents & General Literature Review.

Only a few documents on each project were reviewed for additional information, for example on specific activities; objectives; funding; plans of action; management structure or policy shifts. Most project personnel were unable to release documents. The general literature review yielded much more useful information on experiences from around the world.

3.2. QUALITY CONTROL AND DATA ANALYSIS

Draft instruments for various categories of respondents were pretested by the principal investigators, and were later field-tested with the team before final versions were made. Interviewers were selected from amongst responsible and mature individuals with interviewing and research experience; and supervisors were selected from a pool of persons who had worked as field supervisors, or as exemplary interviewers in past CHDC research projects. All were then trained together for three days, including one day of field practice as a team. Training was conducted by the two principal investigators and an experienced researcher who had a considerable background of research and field management in several surveys.

On the field, regular meetings were held between the principal investigators, supervisors and interviewers throughout the data collection period at the end of each day to edit and collate the information and to plan ahead. In addition, the principal investigators and supervisors met regularly to arrange data for preliminary analysis and to check on the quality of work and field procedures. Data entry involved processing on the ASKSAM programme for open-ended data, with relatively few quantitative aspects.

For analysis, attention was focused on analysing qualitative themes and emerging issues from the information obtained and their implied meanings for PHC policy and guidelines in the country and districts. Of particular importance were the processes involved at each stage of programme development, perceptions of the different respondents, and factors that led to success or failure of projects or constraints to full community participation. The report

contains a descriptive summary of comments and observations as a series of linked case studies, including quotations of comments or observations from some respondents on PHC.

3.3. ETHICAL CONSIDERATIONS

During previsits, DMOs, RC Officials, project leaders and NGO representatives were informed, permission sought and objectives of the study were explained. At the time of the study, community leaders or RC1 representatives helped as guides to the teams, and in locating selected communities or individuals as arranged by project workers. When focus group discussions were to be held or key informants to be contacted, consent was obtained of the group or individual, not only to take part but also allow to tape it, whenever necessary. Participation was voluntary and confidentiality of information given was assured, by telling the respondents that they were free to refuse to be interviewed, or to decline from taking part in discussions.

3.4. LIMITATIONS TO THE STUDY AND PROBLEMS ENCOUNTERED

3.4.1.Non-representative Sample

The largest source of potential bias in the study was related to the small size of the sample and its judgmental selection. Only five out of nearly 40 districts were selected; this number was intended to reflect five major administrative regions of the country but two of the programmes were from one region - Mbale and Pallisa, with the latter having near-identical features of some northern distrits which had insecurity. The Kuluva programme was not originally selected, but was a replacement for the one originally selected, from within the Arua Municipality area. However, the purpose of the study was not to make a total quantitative description of the range or prevalence of PHC in Uganda. Thus, its findings may not be easily generalizeable to the whole country, especially in the absence of government-initiated programmes from the study.

3.4.2. Problems of Inconsistency/Variability

It becomes difficult to ensure comparability of qualitative information collected by different teams in different locations. Despite training to minimize the problem of inter-observer variability, the small size of the sample would still exacerbate the issue, as well as intra-observer variability. All attempts were therefore made to obtain a fairly consistent representation of the whole range of information which was collected by the different interviewers.

3.4.3. Problem of Reliability of Information

Logistics and the perceived urgency of the study precluded full translation of forms into all languages and pretesting of all versions of the forms to maximize uniformity, thus possibly

compromising reliability of instruments. However, in order to maintain reliability, all team members were involved in the pretesting and field trial, prior to the main fieldwork.

3.4.4. Response Bias

Prior announcement or pre-arranged visits and non-participant observation methods were bound to bias the activities under observation. Triangulation of data collection through contacting a variety of information sources and using different methods of data gathering helped minimize this problem. Equally, the speed of the study helped in that people had less time to prepare for the visits beforehand.

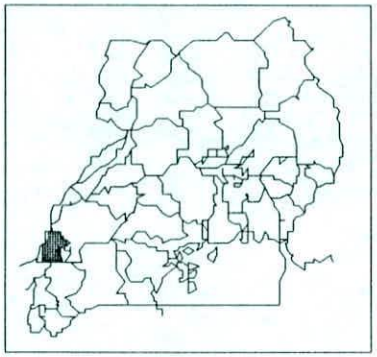
3.4.5. Substituting

In Arua, the original programme selected, under Arua Diocese, was not ready, as most of its expatriate staff went on leave in Germany. However, the DMO's office then substituted the Kuluva Programme, whose team very eagerly agreed to host the research team, at very short notice. Initially included, was a government-initiated one under the DMO's office, but the substitute one was an NGO programme. This change meant therefore that there would be no government-initiated programme in the study, which would have been compared with the NGO programmes.

3.4.6. Instruments

Some of the interview schedules were too long and interviews could not easily be completed at one go. Besides, some questions were rather difficult to phrase and required repeating by the interviewers, thus leaving a wide range of possible ways of interpretation, and consequently less-standardized forms of analysis.

Total Popn 1991 : persons



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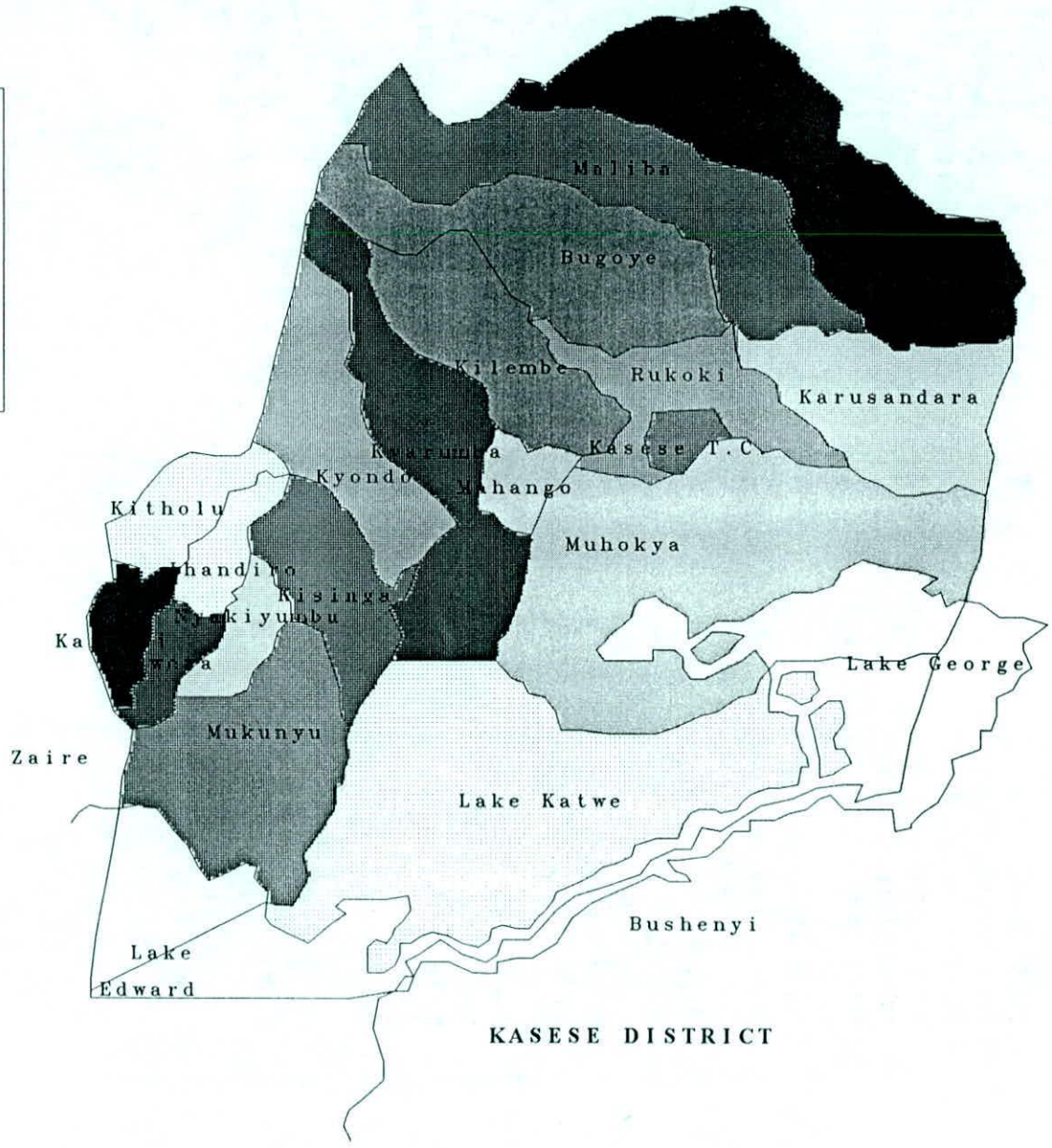


CHAPTER 4

4.0. CASE STUDY I: THE KASANGA CBHC PROGRAMME

4.1. LOCATION Kasese District, Western Region.

Project headquarters are at Kasanga in Bwera sub-county of Bukonjo County, about 30 kms from Kasese District headquarters.

4.2. DISTRICT AND PROJECT CONTEXT

4.2.1. Geography/topography.

Kasese district is situated in the Western Region at 30° longitude on the equator. Total land area is 3,205 sq. kms, making it one of the smallest districts in Uganda. It borders on the district of Kabarole to the north and east, Bushenyi to the south, and the Province of Katanga in Zaire to the west. It has two counties - Bukonjo and Busongora, a total of 20 sub-counties and 96 parishes. Kasese is a mountainous district which hosts the famous Ruwenzori Mountains ("Mountains of the Moon") on the border with Zaire, and also the Queen Elizabeth National Park which has many varieties of animal and bird species. It has an annual rainfall of between 1000-1250 mm; six rivers and two lakes - George and Edward, within its boundaries. It lies at an approximate altitude of 1585m - 3962m above sea level with characteristics of a savannah type of climate.

4.2.2. Population.

Total population in the 1991 census was 349,555 people (Female 178,763, male 170,792) of mainly two ethnic groups Bakonjo and Basongora with many Rutoro speaking and other ethnic groups. Of that population, about 14,000 (4.1%) were under one year; 64,605 (19%) were under five years; 78,206 (23%) under 15; and 80,000 (23.3%) were women of reproductive age 15-49 years. The population (land) density is 126 per sq km, and infant mortality rate (IMR) was 103/1000 (1991 Population and Housing Census, MoFEP).

4.2.3. Economy, trade and industry.

The district's economy is based mainly on agriculture, with 86% of the people engaged in it growing beans, maize, cassava, potatoes (Irish and sweet), bananas, groundnuts, peas, millet, etc., as food crops. Cotton, coffee and sugar-cane as cash crops; fruits, vegetables and onions, etc. Four percent of the population undertake livestock farming; and the rest - 10% are in the industrial sector. Industrial establishments include Kilembe Mines for cobalt and copper, sulphur, etc; Hoima cement factory, and other factories for soap, foam and food processing. Kasese also has trading links with Zaire and enjoys a growing tourist industry.

4.2.4. Health units, and services.

There is no government hospital in Kasese district, but two private ones - Kilembe Hospital and Kagando Hospitals run by the Catholic and Anglican churches respectively. There are 19 health centres, dispensaries and sub-dispensaries, many of which were constructed through self-help efforts of the people under the direction of the DMO's office.
Leading causes of disease (morbidity) and mortality include malaria, diarrhoeal diseases; anaemia; respiratory infections, cholera, meningitis; tuberculosis and HIV/AIDS.

4.2.5. Roads, communications and infrastructure.

There are 173 kms of tarmac out of 315 kms. Because of the difficult terrain, access is difficult and people are reportedly building a number of roads through self-help efforts.

4.2.6. Education.

There are 148 government aided primary schools and 22 private ones; eight government secondary schools and four private ones. There is one TTC for Grade III teachers and one technical institute.
(Source: Above information, except Population Census Results, from: `District Profile'; *The Monitor,* **No.99, Kampala, October 19 - 22, 1993**; and, **Uganda Districts Information Handbook; Fountain Publishers Ltd., Kampala,1992).**

4.2.7. Major forms of PHC programmes/projects in the district

Priorities in primary health care delivery in the district, according to DHT members included: immunization; provision of clean water supply/protection of unsafe sources; control of diarrhoeal diseases and epidemics; environmental sanitation and hygiene; and training of staff for CBHC/PHC activities. The following programmes/projects were already involved in CBHC/PHC activities in the district.

Kasanga CBHC Programme

- DMO's PHC Programme
- Uganda Red Cross Society PHC Programme
- Integrated Rural Development Programme (IRDP)
- South West Integrated Programme (SWIP)
- Bugoye Project
- Seventh Day Adventist Save Life Project.

4.3. PHC PARAMETERS.

4.3.1. History/evolution of project and objectives

Kasanga CBHC programmes which started in 1979 cover the whole of Bwera sub-county, which has a total of 28 parishes. Each parish has its own CBHC project. Initially, a needs

assessment was reportedly carried out by the initiators of the Kasanga CBHC Programme - the Virika Missionaries of Fort Portal. Its policy was to serve the poor and provide services in areas "where others had not reached." It started with curative services initially, and now implements all PHC components for promotive and preventive health care, and also supervises and evaluates all CBHC activities within the programme including work done by CHWs and TBAs. This is done through a Project Advisory Committee (PAC) which includes all parish chairmen and village health committee (VHC) members. The latter body is usually formed at the time of project inception and comprises 6-8 people including a chairman, secretary, treasurer and one TBA, and they meet once a month. Besides implementing all eight PHC components, the programme aims at encouraging the community to utilize the health services; trains CHWs and TBAs to work in the community, and encourages community participation and self-reliance through income-generating activities to raise the people's standard of living.

4.3.2. Linkages with government health system

Referrals are made to Kasanga dispensary, Bwera health centre and Karambi dispensary or to Kagando hospital. Cases referred to the hospital include meningitis, cholera, AIDS, tuberculosis, major surgery or serious injuries, complicated deliveries and mental disorders. Referrals are equally made from health units to CHWs for follow-ups, health education or water and environmental sanitation activities. The DMO's office coordinates all PHC activities and mobilization for it; or makes supervisory visits/follow-up of activities under MOH vertical programmes like CDD, EPI, supply of equipment and drugs; or helps in times of outbreaks of diseases or epidemics. Feedback is given in form of monthly reports or verbally during supervisory visits by members of the district health team (DHT) which include the DMO, and others - DHI, DHV, DHE or DNO.

Training courses are often organized for project members or workers ranging from CHWs, TBAs and other trained health workers in conjunction with the DMO's office, UCBHCA , NGOs, SWIP, or vertical programmes, CDD, EPI etc.

4.3.3. Community involvement and participation

According to project leaders and other key informants, community members were involved in the needs assessment and initiation of activities, planning, implementation, monitoring and evaluation in varying degrees. They also identify, select and actively support CHWs and TBAs for training, and recommend them to work with the project; also select and support their project leaders.Community members also contribute to or help construct structures like health units, e.g., dispensaries, aid posts and water sources; or in setting up income-generating activities for their projects. Direct contributions in form of cash, materials, food, or in form of labour and training support are also mentioned. Time spent in meetings or health education sessions and mobilization of other members of the community, voluntary work constitute the other forms of participation, according to some community members.

4.3.4. Self-reliance, self-determination and replicability

Most projects under the Kasanga Programme try to be self-reliant through cost-sharing/cost-recovery or fee-for-service initiatives. Clinical treatment fees range from 300/= per visit, while income-generating activities established, include grinding mills, oil pressing, sale of various items through hawking, and handicrafts; all meant to raise funds and sustain the projects.

4.3.5. Integration of national and international objectives

The Kasanga CBHC Programmes aims at `serving the poor and reaching the unreached'. Activities are geared towards effective community participation in primary health care through health promotion and disease prevention, plus those aimed at raising income and the standards of living. These objectives are in tune with national objectives, which are equally geared towards participation of community members in their own health care through PHC, and raising general standards of living through increased production and income. Government efforts are therefore complemented by NGOs or churches like the sponsors of Kasanga CBHC Programme, in partnership with the district and local communities.

4.3.6. Linkage of project with community development

Community members were reportedly involved in identifying and initiating projects which link up with health and non-health development activities, e.g., schools, agricultural and veterinary projects, roads and income-generating or commercial activities, linking up with PHC activities under the programme.

4.3.7. Cost the community can afford

Most payments for services and cash or materials contributions to project activities are generally agreed upon by community members themselves. As such, they decide on the levels they can best afford at any one time or state of project development.

4.3.8. Number of primary health care (PHC) elements being implemented

All the eight components of PHC are reportedly undertaken under the programme, and community gets involved in planning, implementation, monitoring and evaluation of activities. Health education activities are generally undertaken during immunization, MCH/FP, nutrition and water and sanitation sessions. While control of endemic diseases and treatment of common diseases and injuries are undertaken as special tasks or as the individual condition requires. CHWs, TBAs, vaccinators and other project or government health workers undertake activities in partnership with the local community. Drugs are supplied through the DMO's office, and through the Joint Medical Stores programme of the Church organizations (UCMB and UPMB). Referrals are made for mental, dental/oral and rehabilitative services to Kagando or Kilembe hospitals.

4.4. REPORTS FROM FOCUS GROUP DISCUSSIONS AT PROJECT SITES

I. PROJECT: NYAKAHYA CBHC PROJECT - Bukonjo County
Name of community: Nyakahya .
Focus group participants: community: women's group, & male community leaders.

History, Aim and Objectives Of Project
Project was started in 1985 by a group of community leaders following a request from the Parish Sister expressing the need to start a CBHC project. This idea was passed onto the people who responded positively to the objectives of starting another "Kasanga" at Nyakahya, namely, to reduce infant and maternal deaths in the area through immunization and other services. One of the first activities of the community was to make cash contributions and materials and to pay a little fee for immunization and antenatal care. The Kasanga programme donated some agricultural implements and inputs to encourage the community to improve on cash and food crops and keeping animals like pigs; and setting up drug kits. A health unit was then constructed through joint community and programme inputs.

PHC/CBHC Activities and Community Participation
Since the Kasanga programme was already well-known, the community leadership of a few committed people responded quickly and a village health committee was formed soon after the project was initiated. The community gave material support and took part in constructing the health unit and carrying out other developmental projects like schools on self-help basis, brick-making, piggery and handicrafts - some of them with assistance from the programme. The village health committee was transformed into a full CBHCA for the area, and it met once a month.

CHWs and TBAs
The Community selected people to be trained by the Sisters at Kasanga as CHWs. Their duties include health education, immunization and growth monitoring, environmental sanitation (home improvement), food and nutrition, education, antenatal care and natural family planning advice only. They also handle drugs and treat minor illnesses and injuries. CHWs were not paid any money and no immediate plans were in hand, although some members felt an allowance would help them. Their work has had a positive effect, e.g., a reduction in mortality and morbidity, fewer cases of measles, malnutrition, tetanus; cholera was controlled, and a general improvement on health status of the people of the area had been achieved.

Constraints/Other Issues
The groups expressed concern at having CHWs and TBAs work without remuneration and protective wear. They reportedly walked long distances during the course of their work and sometimes at night to escort patients to Kasanga. There was also lack of equipment and shortage of drugs. They suggested some kind of remuneration and providing CHWs and TBAs with gumboots, and lamps or torches through community contributions, or protecting water sources in case of need.

II. PROJECT: BUGOYE CBHC PROJECT - Busongora, County
Name of Community: Bugoye
Focus Group Participants: Opinion leaders/elders - men and women

History, Aim and Objectives Of Project
The project was started in January, 1991 by Dr. Baluku of Uganda Red Cross and Sister Vicky, a Church Missionary at Kasese Diocese. Its objectives were to prevent diseases through community interactions addressing safe water, using latrines, food hygiene and good nutrition. The community was involved at the initiation through the RCs who were asked to mobilize and create awareness alongside Dr. Baluku and Sister Vicky. Sensitization and awareness was carried out in the churches and other community organizations as well. Some community members were then identified to train and help in carrying out a needs assessment with information obtained from the health inspectorate.

PHC/CBHC Activities and Community Participation
Activities being carried out included health education; immunization; curative services; antenatal care, and rehabilitative services for the disabled - with assistance from Red Cross. Immunizations and antenatal care activities were scheduled but health education and other preventive measures were undertaken whenever necessary. The community was actively mobilized to participate through the RC system mainly and other

community leaders, with encouragement from the district administration as well. They selected trainees for community health work; contributed funds for income-generating activities, e.g., bee-keeping, contribute labour during communal services, e.g., road construction and protecting water sources and feeding the CHW trainees during the training sessions. A health committee reportedly was formed at RC 3 level, and village health committees were due to be formed.

CHWs and TBAs

These were selected by the community and trained by Sister Vicky, health unit staff and the DMOs office. They were awarded certificates from UCBHCA. While CHWs were not paid, TBAs were given token contributions, e.g., food, or a goat, etc., by appreciative individuals or families. The group felt that CHWS should work voluntarily but receive tokens or be supported with proceeds from income-generating activities like brick-making.

Constraints/Other Issues

Transport was a problem as well as lack of a nearby hospital. There was lack of trained personnel, especially from the local areas (Busongora), to run the local dispensary. Other problems affecting the whole community included general poverty, lack of productive cash crops and effects of famine and inflation affecting income. Despite all these, the community paid a local developmental tax to help with priority needs; a maternity unit and schools.

4.5. PERCEIVED DETERMINANTS OF PHC.

4.5.1. Factors promoting success of projects

The following factors were perceived as contributing to the success of projects by the key informants, CHWs, TBAs and community members:

a) Mobilization - involving good non-coercive approaches to create awareness and arouse community members' interests. This would involve RCs, project leaders, DHT members, NGOs, extension workers, chiefs, the churches, elders, CHWs, TBAs, etc.

b) Perceivable or visible outcomes - `good results speak for themselves.' For example, protection of water sources or provision of water to a community which lacked it can have positive response from that community.

c) Recognition of CHWs and TBAs - by community members, DMO's office or other health workers. Coupled with community support, incentives and supply of kits by DMO's office or sponsoring agency, such recognition leads to increased commitment.

d) Good cooperation and coordination - between programme, DMO's office, district administration and intersectorally (or between departments). Facilitates efforts and enhances team spirit between different sectors and with local community leaders and consumers.

e) Orientation of health staff to PHC - especially government trained health staff working in health units or hospitals. Equally, DHT members expressed the need to train in primary health care strategies and management of PHC programmes.

f) Regular training workshops, seminars or courses - for CHWs, TBAs, trained health workers, community leaders, VHC members, development workers, etc., to raise awareness/knowledge, give skills and provide continuing education.

g) Good communication network, roads and infrastructure - to facilitate access to rural communities, health units, markets, or transfer of information or knowledge.

h) Encouraging/establishing income-generating/self-reliance projects - ensures confidence in the people and enables them to control their own programmes; it also forms the basis for sustainability of projects.

i) Availability of funds/resources, supplies and equipment - from Government or non-governmental sources. Ensures continuity and keeps the morale of the workers and community members at high level.

j) Regular monitoring and evaluation of activities - especially involving local community members. Ensures community involvement and participation through local control and empowerment over their projects.

4.5.2. Factors leading to failure, and constraints

According to key informants, the following were major factors contributing to failure of project activities, or were real constraints to achieving better results:

a) **Lack of funds, supplies and equipment**: most respondents - policy-makers, DHT members, project leaders, CHWs and TBAs repeatedly reported lack of funds, supplies or equipment as a major constraint leading to failure of projects. Budget allocations or funds particularly from MOH or local administration were not readily available or voted for PHC activities apart from those for vertical programmes like CDD or EPI. They called for financial votes specifically for PHC/CBHC activities at the district level to supplement efforts by programme sponsors, to cater for drugs, supplies, equipment and incentives for staff.

b) **Poor leadership/mobilization**
In order to create sustained awareness and interest, key informants underscored the need to select (elect) committed leaders from community members themselves, who are capable of mobilizing the people and involving them at all stages of project development. Formal leaders like RCs or chiefs, and also health workers, should be good mobilizers and willing to work at community level, with community representatives, CHWs and TBAs.

c) **Lack of cooperation and coordination**; at the levels of the DMO's office, district administration, NGOs, sub-county and lower levels, there is need to establish multi-sectoral cooperation and coordination of efforts to avoid duplication, competition (rivalry) or mutual suspicion. Development and health workers at the local level should work together to facilitate integrated development, planning, implementation, monitoring and evaluation of projects.

d) **Lack of political commitment from district administration and politicians**
Key informants identified the need for genuine commitment at the district level and from local political leaders to PHC in order to mobilize both local and outside resources towards health promotion and disease prevention, e.g., for water sources, to improve roads and infrastructure, construct health units, etc., through self-help efforts, or to set up income-generating activities.

e) **Poor infrastructure**: A general lack of basic infrastructure - access roads, markets, schools, health units, etc, were mentioned as hindering factors to the success of projects. Both local and external resources are required from central and local governments and through local self-help efforts.

f) **Insecurity**. At the time of the study, some incidents of insecurity were reported which were disruptive to development efforts. Key informants therefore mentioned such incidences of instability as major constraints in their efforts for promoting PHC and community development.

4.6. COMMENTS AND RECOMMENDATIONS OF KEY INFORMANTS

- **On PHC in general**

"Government should continue emphasizing PHC; it should be strengthened the more. District should budget for PHC and existing PHC should be strengthened by a district evaluation exercise. It is the only way we can fight health problems. Government at all levels should give first priority through budgeting for it, and training." (DHT member)
"There is need to improve the relationship between MOH and projects ..."
"Developmental efforts are lacking in most PHC projects, there is need to improve intersectoral collaboration." (Project leaders)

- **Starting and Maintaining PHC**

"Be ready to plan, implement, monitor and evaluate together with the community. Baseline surveys should be done with community. Decide on how best the community should be approached. Use their priorities as an entry point." (DHT member)

- **Mobilization and creating awareness**

"If awareness is created, people are able to start and maintain the programme ... enough time is a key factor for proper sensitization." (DHT member)

"Contact opinion leaders, and carry out a baseline ...", and, "Take time creating awareness, ensure that community identify their own problems."(Project leaders)

- **Community involvement and participation**

"Create awareness so that people know what they are joining "; "Communities should be organized to take bigger part in implementation." (DHT members)

"Encourage involvement of urban and rural people. Leaders should not leave it to a particular category of people to participate ... let them do the thinking and choose

what they want to do. For example, why should they put a fence around a spring if they did not ask for it?. " (Project leaders)

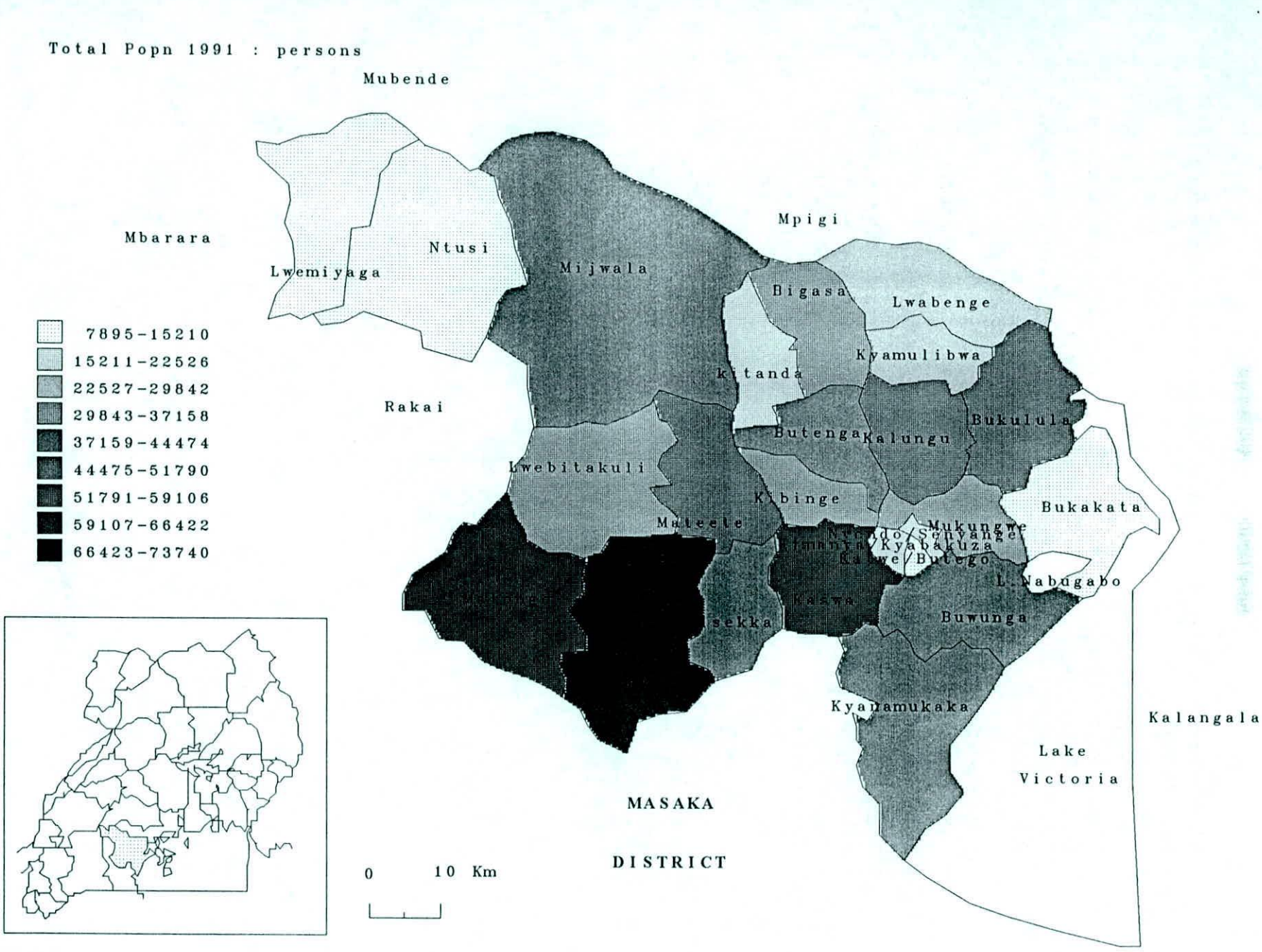
- **Remuneration of CWs/TBAs**

"Community should budget for their workers. There should be a degree of collection and accountability so as to generate more funds." (Policy-makers)
"Should be encouraged and motivated since they are performing duties of PHC workers." (CHW/TBA)

- **Sustainability**

"Community is capable of sustaining the project if they are involved right from the beginning"; "People should know why they should donate. " (DHT members)

"Can be done through income-generating activities like rearing pigs, planting trees for selling and planting vegetables. " (CHW/TBA)
"Possible through instilling a sense of self-reliance at individual and community levels. " (Project leader)


Total Popn 1991 : persons
Mubende
Mbarara
Mpigi
Rakai
Kalangala
Lake
Victoria
Ntusi
Lwemiyaga
Mijwala
Bigasa
Lwabenge
Kyamulibwa
kitanda
Bukulula
Butenga
Kalungu
Lwebitakuli
Kibinge
Bukakata
Mateete
Mukungwe
Kyabakuza
L.Nabugabo
Buwunga
sekka
Kyanamukaka
7895-15210
15211-22526
22527-29842
29843-37158
37159-44474
44475-51790
51791-59106
59107-66422
66423-73740
MASAKA
DISTRICT
0
10 Km

CHAPTER 5

5.0. CASE STUDY II: THE KITOVU CBHC PROGRAMME

5.1. LOCATION:

Masaka District, Central Region, Project headquarters are at Kitovu Hospital, Masaka, about 5 kms from Masaka Municipality.

5.2. DISTRICT AND PROJECT CONTEXT

5.2.1. Geography/topography.

Masaka district lies on the Western fringes of the central Buganda region. It shares boundaries with Mubende to the north, Mpigi to the north-east, Kalangala to the east, Rakai to the south and Mbarara to the west. Total land area is 10,611 sq. kms, with six counties and 21 sub-counties. Masaka district is famously known in Uganda for its arch built where the Equator line passes. It lies at an altitude of 1219m - 1524m above sea level, and temperatures are moderately high with plenty of rain.

5.2.2. Population and demographic indicators.

The total population as per the 1991 Population and Housing Census was 837,736 people, (sex ratio M/F = 97.9/100). Of that, about 34,000 (4.1%) were aged under 15. Population (land) density is 151 per sq. km; infant mortality rate (IMR) 107/1,000 and total fertility rate (TFR) 7.5. Most of the people are Baganda, and members of other ethnic groups like the Banyankole, Banyarwanda, Barundi, Bakiga and Banyoro.

5.2.3. Economy, trade and industry.

Masaka is one of Uganda's leading districts, in agricultural production with the average person predominantly a peasant earning a living from the land. Leading crops include coffee, bananas, maize and a variety of horticultural crops like pineapples and passion fruits. Cash crops include coffee, cotton and maize. Among food crops are beans, cassava, groundnuts, soyabeans, sorghum, millet, vegetables,onions, tomatoes, etc. There is also cattle ranching, and fishing activities on Lake Victoria. There are over 250 registered primary societies with Masaka Cooperative Union at the district level. Industries include manufacture of cassava starch, curry powder, animal feeds, soft drinks, processing of tea and coffee, etc.

5.2.4. Health units and services.

Hospitals include Masaka government Hospital, Kitovu and Villa Maria Hospitals, Kako and another privately run Masaka Hospital, all run by churches. There are five health

centres, seven dispensaries and 43 sub-dispensaries in the district, and it is planned that people have to pay a user-charges in most health units.
Leading causes of morbidity and mortality include malaria, AIDS ("Slim Disease"), respiratory tract infections, diarrhoeal diseases, measles and anaemia, according to key informants.

5.2.5. Roads, communications and infrastructure.
The road network is mixed with a good tarmac highway which runs from Kampala through the district to Mbarara and the Tanzania border. The other roads are a mixture of bad and good, beyond the highway.

5.2.6. Education.
The district reportedly has 296 government and many private primary schools. There are 43 secondary schools and only about a dozen which are grant aided by government. There are three teacher training colleges and two technical colleges one of which is private. Only 30% of the teachers manning the district's primary schools are qualified.
(Source: Above information, except Population Census Results, from: `District Profile'; *The Monitor,* **No.110, Kampala, November 26 - 30, 1993; and,** ***Uganda Districts Information Handbook,*** **Fountain Publishers Ltd.,Kampala, 1992**).

5.2.7. Major forms of PHC activities in the district.
According to DHT members, the district health programme priorities include: provision of clean water supply; increase in all immunization coverage; prevention of common diseases through health education; increase of supply of drugs to health units; improvement of personal hygiene and sanitation; provision of more MCH/FP outreach services; nutrition education; improvement of housing standards (home improvement campaigns); conducting CBHC seminars and training on more regular basis; home visiting and regular follow-ups. Besides the district's vertical programmes from DMO's office and district administration health services, the following are some of the programmes which operate in Masaka.

Kitovu CBHC Programme (Municipality)
- Kitovu Hospital CBHC Programme (rural)
- World Vision - three projects
- Redd Barna Project
- Medical Research Council (U.K) Project
- The Uganda Red Cross PHC Programme
- Kyamulibwa AIDS Research Project
- Katimba Project.

5.3. PHC PARAMETERS

5.3.1. History/evolution of project and objectives

The Kitovu CBHC programme started in 1982 after a needs assessment by Kitovu Hospital staff. It is located within the Hospital but has a separate management. Its catchment area is the Masaka municipality area, and has 11 CBHC projects developed in phases since 1983. It was being funded by the Scottish Catholic International Aid Fund (SCIAF) based in Scotland, and affiliated to the Catholic church. Funding started in 1990, and was to continue for the next three years. SCIAF monitors the individual project through a village health committee and a committee of the chairmen of the various VHCs led by Project Coordinator, Sister M. Quinn.

Objectives of the programme are to reduce general morbidity and mortality within the area; create awareness and increase utilization of health services; promote self-reliance and encourage income-generating activities; and generally promote health and prevent disease and home accidents.

5.3.2. Linkages with government health system

Referrals from CBHC projects are made to Kitovu or any of the Masaka Hospitals as the case may require - mainly for major forms of treatment and dental, mental or rehabilitative services. CHWs or TBAs refer patients for any of the major conditions, accidents or difficult labour cases. TBAs stated that they also referred first and multiple pregnancy cases, those with ante or post-natal haemorrhages; pregnancies of under 16s, short stature and of those women above 35 years or with a previous scar. Support for them includes supply of delivery equipment.

The DMO and other health team members are responsible for overall supervision and coordination of PHC services in the district. They also help train CHWs and TBAs for the projects under the CBHC programme, and providing some logistics, e.g., transport, supply of vaccines, latrines slabs or materials for spring protection, etc., besides technical advice.

5.3.3. Community involvement and participation

Community members were reportedly involved in various ways and were equally contributing by taking part in specific activities like construction of latrines, maintenance of water sources and other forms of manual labours. Focus group discussions from two of the projects indicated that the community was not initially involved in their needs assessment phase or in the selection of CHWs. Being a largely urban community of business minded people, the nature of participation was reportedly on more or less an *ad hoc* basis.

5.3.4. Self-reliance, self-determination and replicability

Efforts were being made to encourage community members to become self-reliant by setting up income-generating projects, notably tailoring. However, indications so far were

that, community members still looked largely to external support to sustain their activities(focus groups).

5.3.5. Integration of national and international objectives

Objectives of the funding agency (SCIAF) and the long term objectives of Kitovu CBHC programme are generally to promote general health and prevent disease in the area, and to promote self-reliance, which are in keeping with long term goals of PHC in the country. However, the level of community involvement and effective control of their own programme being so low at the moment, requires a real shift towards more active encouragement and ensuring of community participation, on the part of the benefactors - especially during the remaining three year phase.

5.3.6. Linkage of project with community development

The programme has its own community development activities, e.g., tailoring, construction of improved (fuel saving) stoves, drama and music groups, etc., which it also funds together with community members. There was some indication that the programme had links with either government-initiated or sponsored development programmes in the community. Linkage with other CBHC programmes includes with SWIP and other development agencies in the district. The programme is also reported to be an active member of UCBHCA.

5.3.7. Cost the community can afford

It was fairly clear that the community had depended much on the assistance given from outside in its funding of project activities, e.g., protection of springs, or receiving largely free services from government units. A large proportion of the population was unable to afford cost of treatment, according to focus groups.

5.3.8. Number of primary health care elements being implemented

The Kitovu programme initially started with curative and immunization services, then introduced other PHC components - health, education, maternal and child health /family planning; food and nutrition (including a nutrition rehabilitation unit at Kitovu Hospital); water and sanitation with SWIP, World Vision and Redd Barna; prevention of endemic diseases; essential drugs. Other components - dental/oral health, mental health and rehabilitation were equally being developed mainly through a referral system and network in collaboration with other Hospitals, health centres and a nearby government rehabilitation centre.

5.4. REPORTS FROM FOCUS GROUP DISCUSSIONS AT PROJECT SITES

I. PROJECT: SENYANGE B CBHC PROJECT - Kitovu CBHC Programme
Name of Community: Ssenyange B
Participants: Community Leaders.

History, Aim and Objectives Of Project
Project was started in 1986 by sister Margaret Quinn (or "Namakula" - Kiganda name). The objective was to uplift the standard of living through the provision of safe water for drinking; immunization of children and pregnant women; encouraging use of available health services and care of pregnant and nursing mothers. Sister "Namakula" created awareness through the Church (Tadeo Church) and also attended RC 1 meetings, where she explained to the community the objectives and need to train CHWs, who were then selected and trained by her. A village health committee was formed in 1989 - years later than the project because CHWs were still being trained, and there was need to create enough level of awareness to allow for the formation and training of the village health committee.

PHC/CBHC Activities and Community Participation
Health activities included health education, nutritional education (food production and nutrition), antenatal care/MCH/FP; immunization, environmental sanitation activities - latrines, good hygiene and home improvement; safe water use and protection; and community-based rehabilitation of the disabled. The community is involved in some development projects which where already funded by Sister `Namakula's project - namely, a tailoring project, constructing improved stoves (fuel saving); and through drama/music groups. Most residents are reportedly business people who contribute some money for drug kits mainly. [There was apparently no specific role played by the community in the implementation of the project which relied largely on external support or a single strong benefactor, according to focus groups].

CHWs and TBAs
These were selected by the RC1s of each village by voting after they were nominated by the RC executives. After selection they were sent for training and started their voluntary work, while the programme gave them hoes, soap and other forms of support to start their own income-generating activities. The group felt that government would do well to introduce paying for the CHWs and TBAs since they did a lot of good work or should give them a suitable package of incentives.

Constraints/Other Issues
The group was concerned about the non-payment of CHWs, lack of drug kits for CHWs and delivery kits for TBAs. There was also lack of transport and support from government health units - staff did not recognize importance of CHWs; there was no apparent confidence on the part of the community as well. The group also asked for assistance for slabs from DMO's office to help in construction of better latrines. Concern was expressed about the AIDS epidemic which is a major problem in the area.

II. PROJECT: SENYANGE B CBHC PROJECT - Kitovu CBHC Programme
Name of Community: Senyange B
Participants: Community, men and women.

History, Aim and Objectives Of Project
Community did not know exactly when the project started, but said it was started about three years ago. Sister M. Quinn brought the idea to the community, and they became aware of some of the objectives which were protection of water sources and promoting construction and use of pit latrines. They gave the impression that they were not involved initially, saying: "*We know that the project belongs to Kitovu programme*," and that Sister Margaret selected the first group of CHWs at Kitovu. The community was not aware how the project was mainly funded.

PHC/CBHC Activities and Community Participation
The CHWs help people to keep their homes clean by encouraging activities like cleaning the homes; providing themselves latrines, boiling drinking water and good storage; child care and feeding; and promoting both personal hygiene and environmental sanitation by using refuse pits. They contributed food, stones and manual labour whenever called upon especially during spring protection activities. There was reportedly no elected health committee they were aware of, but only one made up of CHWs/TBAs and RCs together to run health affairs.

CHWs and TBAs

The CHWs were selected by the community after Sister Quinn had explained to them the importance of having CHWs and their role in community health. They were selected on the basis of merit for work and good behaviour. The TBAs were mainly from amongst these who were already carrying out deliveries, i.e., traditionally. They work voluntarily but the group suggested having them remunerated by the government or to be supported from income-generating activities.

Constraints/Other Issues

The group wondered why government health units paid very poor attention to patients' needs as compared to NGO health services, and yet both received drugs from the same source. Why did government units run short of drugs when NGO units did not?, they asked. The other constraint was general poverty and their inability to run the project on their own resources. They therefore, felt that CHWs should be catered for, that is, remunerated and income-generating activities be set up to raise funds to support them and to help them run the project in the long run.

5.5. PERCEIVED DETERMINANTS OF PHC.

5.5.1. Factors promoting success of projects

a) Long experience with community: according to some key informants, a long experience on the field working with communities is a necessary factor to the success of a project.

b) Availability of funds, materials and logistics: good funding and donor support were mentioned by DMT members and policy-makers as strong elements for motivating community members, or incentives.

c) Religious or spiritual attachment to CBHC activities: DHT members and policy-makers mentioned the importance of the spiritual element or message to be given as part of CBHC/PHC activities for promotion of community participation.

d) Community trust and support: gained through close working relationship and mutual trust between project workers and the community is a sure path to success of programmes - and leads to high degree of community participation.

e) Cooperation and coordination of activities: especially between DHT members, district personnel and NGOs working on PHC projects is necessary for success, and developing community support.

f) Transfer of skills and ownership to community members: the community needs to be trained and given skills to manage their own projects through involvement in identifying their needs, planning, implementation, monitoring and evaluation at all stages of project development, according to key informants.

g) Availability/development of infrastructure: means for easy communication, transportation and access to services need to be developed to facilitate use and participation in service delivery.

h) Limiting to small, manageable size: projects should be feasible or viable, not too large to manage, according to some key informants.

i) Presence of technical staff: both local and expatriate technical expertise is required initially.

Mbale town has several small-scale industries like rice mills, posho mills, and soap factories. There are also a textile mill, and several oil mills. Open air markets are very popular throughout the district. There are nearly 300 registered primary societies with Masaba Cooperative Union and Bugisu Union at the district level.

6.2.4. Health units and services.

The district has two hospitals - Bududa with 104 beds, and Mbale Hospital which is also the regional hospital for eastern Uganda, with 320 beds. There are 13 health centres, dispensaries and sub-dispensaries. The main problem remains inadequate drugs and medical personnel. Leading cause of morbidity and mortality, according to DHT members and other key informants are: malaria, diarrhoea, respiratory tract infections, AIDS; STDs, anaemia, and worm infestations.

6.2.5. Roads, communications and infrastructure.

The road network in the district is a mixture of tarmac and murram. The main road is the tarmac highway passing through the district from Tororo running up to Soroti. The other tarmac road is from Mbale to Sironko, and graded murram roads connect Mbale town to other growing trading centres or towns in the district, plus feeder roads going to several other places, especially those going up the mountainous areas which nearly become impassable during wet periods.

6.2.6. Education.

In education the district's top institution is the newly established Islamic University in Uganda (IUIU) with about 400 students. There are two technical colleges; four teacher training colleges, and one district farm institute. There are 23 government secondary schools and 23 private ones; and there are 433 primary schools in the district.
(Source: Above information, except Population Census Results, from: `District Profile'; *The Monitor*, No.112, Kampala, December 3-7,1993; and, *Uganda - Districts Information Handbook,* Fountain Publishers Ltd., Kampala, 1992).

6.2.7. Major forms of PHC activities in the district.

Mbale district administration health programme priorities, according to the DMO, include the following: provision of more MCH/FP services (outreaches, etc.); increase in immunization coverage (targets not indicated); community mobilization for general health education; improvement of clean water supply - protection of springs, boreholes, etc; improving pit latrine coverage, and promoting VIP types; and training of CHWs and TBAs. In addition to the district health services and vertical programmes of MOH, e.g., CDD, EPI, UEDMP, etc., the following organizations operate in Mbale district in direct delivery of health care, and in particular in areas of PHC or CBHC.

The Mission: Moving Mountains CBHC Programme

- Catholic Church PHC Programme
- Church of Uganda Health Services
- Uganda Red Cross Society PHC Programmes
- YMCA Health Programme
- Muslim Supreme Council Health Programme
- Christian Children's Fund
- Buhugu PHC Programme
- Bumbo PHC Programme
- Nampanga Family Helpers
- Bamusikye Women's Child Clinic
- Sira Family Helpers

6.3. PHC PARAMETERS

6.3.1. History/Evolution of Project, and Objectives

The Mission: Moving Mountains CBHC programme was initiated in 1987 as an NGO interested in community development. It started CBHC activities in Nabongo and Lwangoli areas in 1990 after long periods of raising community awareness through sensitization, needs assessment and training activities for development workers, community health workers, TBAs and village health committee members. Another area of CBHC activities was started in Namawanga sub-county in 1991 with the same steps of raising community awareness, needs assessment and training, all with community members participating. The project is funded by Mission Moving Mountains home base in the USA whose emphasis is on spiritual development through interdenominational evangelism and CBHC through community development, disease prevention, increased food production and income-generating activities. The concept of total or holistic self-care and development is emphasized.

Expatriate consultants are supported through the home churches in the USA, while the Uganda trainers are supported through funds from OXFAM. Substantial funding for small activities comes from the community itself, and sustainability efforts are a strong point. There are also national CBHC facilitators and trainers on its team.

Broad programme objectives include training CHWs, TBAs and community leaders to solve their own problems with their own resources; teaching the truth of scripture and its impact on life ("whole health"); to encourage the population to fight poverty with emphasis on women's activities, empowering the community to facilitate their own development and uplifting their standards of living.

6.3.2. Linkage with government health system

The programme has drawn a policy document/plan of action for PHC and is a district member of the CBHCA; it trains CHWs and TBAs as a major facilitator for TOTs and consultants to the national CBHCA. Referrals from programme staff, CHWs, TBAs trainers, etc., are made to the government health units like Muyembe Dispensary, Kolony (private) and hospitals like Mbale and Tororo. Among cases referred are severe diarrhoea, dysentery, birth complications, major accidents, mental disorders and chronic medical or surgical conditions. Referrals to CHWs and TBAs from government health staff are equally made for assistance depending on the particular needs of the patient/client.

The DMO takes overall supervisory responsibility on all PHC activities in the district and reports are made periodically. Training needs of CHWs, TBAs and other programme staff are also coordinated through the DMO's office. Joint training courses include formal training of programme staff at institutions under MOH programmes, TOTs, EPI workshops/seminars and other programmes run by the MOH or UCBHCA, including use of their training manuals or curricula.

6.3.3. Community involvement and participation in planning and implementation

The community is reportedly involved at all stages, according to key informants, for example, during introduction, they took part in the needs assessment and identification of priorities and in the baseline survey in which they took part. They selected their own leaders and members to be trained as CHWs or those who were already TBAs, and who were of exemplary behaviour or trusted by the community. Support from the community is typically solicited or facilitated through mobilization, education and creating awareness over a long time. The process of planning, decision-making and implementation of programmes by community members starts with identification of problems which they submit to the local development committee for further discussion,prioritization and deciding on a plan of action to be ratified by community members as a whole for implementation. Decision-making is a collective effort followed by community action by all - RCs, chiefs, trainers, CHWs, development workers, and community members.

6.3.4. Self-reliance, self-determination and replicability efforts

Funding sources include those generated as community resources, e.g. from local crafts, agricultural produce, animal husbandry, etc. Periodical collections are made by every eligible person - 1000/= or 500/= by both men and women per year, respectively. Other community income-generating projects and cooperative schemes are also undertaken and the revolving funds well kept and accounted for by the executive. Such project income-generating activities (IGAs) include quarrying of stones, concrete, brick or block-making; credit schemes, selling agricultural crops and women's projects. Money is generated from the products and there is a bank account (of revolving fund) which is controlled by the development committees to sustain projects.

MAKERERE UNIVERSITY

Child health and Development Centre

P.O. Box 6717 Phone: 541684/530325 Kampala (U) Fax: 531677

Our Ref:

Your Ref:

February 3, 1995.
Date:

Dr./~~Mr./Mrs./Ms~~ A.L. Abongomera
Acting ACMS (Planning)
Ministry of Health
P.O. Box 8, Entebbe

Dear Sir,

RE: **FINAL REPORT OF 'A QUALITATIVE ASSESSMENT OF PRIMARY HEALTH CARE IMPLEMENTATION: CASE STUDIES OF FIVE NON-GOVERNMENTAL PROGRAMMES', (AUGUST 1994)**

Enclosed, please find a copy(ies) of the above study report which was commissioned by the Ministry of Health, with assistance from UNICEF, under the National Task Force for Health Financing, in 1992, as a rapid assessment study, to help draw policy guidelines on PHC.

A Preliminary Report was submitted in October 1992, and all useful comments from Study Advisory Committee members, as well as other individuals which were gratefully received assisted greatly, not only in the preparation of **'National Guidelines for Community Participation in Primary Health Care'**, which were produced by the Primary Health Care Coordination Unit (MOH) in 1993, but also in the revision and/or re-writing of both subsequent Intermediate and Final Reports.

I therefore trust and hope, that the report will still be useful in partly shaping not only policy guidelines on community participation, but also in other areas such as health care financing. Please feel free to give us your comments and suggestions for any future research directions.

Yours sincerely,

JNSJitta

Dr. J.N.S. Jitta
DIRECTOR, CHDC.

6.3.5. Integration of national and international objectives

As an international NGO, the M:MM has objectives of promoting community development mainly through community-based evangelism to improve health and standards of living. These objectives have been blended and are matched with the national objectives for PHC, of involving the local communities in their own health care development.

6.3.6. Linkage of project activities with community development

There are several examples of community development activities which the programme undertakes with the communities. Community members identify and initiate specific projects to link with health activities, e.g., water supply through tube-wells and boreholes. Tube-wells - a technology which was adapted from Zimbabwe through an NGO - Water Aid, are cheaper than boreholes. Other community development efforts include clearing and grading of paths and feeder roads, building primary schools and church buildings; health units; planting trees and environmental protection activities. There are also general agriculture and agroforestry activities, e.g., improved food production and soil management, control of pests, cooperative activities or credit schemes, etc. The programme provides materials and logistics, while community members provide resources, labour and give time for collective activities.

6.3.7. Cost the community can afford

The M:MM programme promotes self-reliance through community development as a main objective. It prepares communities within its project areas to use their own resources and to manage them by themselves. Money contributed for development and fees paid at health units are agreed upon by the people themselves. There are efforts aimed at sustainability of projects by community members in form of annual cash contributions, credit schemes and other income-generating activities all of which are to get services within reach of the ordinary person at a cost he/she can afford.

6.3.8. Number of primary health care elements being implemented

Programme places much emphasis on health education and water and sanitation; immunization; maternal and child health/ family planning; nutrition; control of endemic diseases and treatment of common illnesses and injuries. CHWs and TBAs are trained to deliver simple appropriate messages based on 13 points of a good home including: good houses, kitchen, a dish rack, bath shelter, rubbish pit, latrine; livestock or animal house; clean compound; a garden; clean water storage using the three-pot system, etc. Equally messages for control of diarrhoeal diseases and use of sugar and salt solution, ORS or home available fluids to manage diarrhoea in the home were given to the people by CHWs and TBAs. In food and nutrition activities, better storage was emphasized - raised granaries or the "wise Joseph's sack" to store cereals or legumes. Increased food production and proper feeding practices had reportedly reduced cases of malnutrition in project areas.

Essential drugs were, however, not handled by programme CHWs or TBAs and where there is need, patients are referred to health units. Equally, referrals are made to appropriate health units for cases of mental disorders, dental/oral treatment or for rehabilitation of the disabled.

6.4. REPORTS FROM FOCUS GROUP DISCUSSIONS AT PROJECT SITES

I. PROJECT: NAMAWANGA CBHC PROJECT - Bunghoko County
Name of Community: Nabweya
Focus Group Participants: Community leaders, mixed; female and male.

History, Aim and Objectives Of Project
Project started in June 1987 by Mission: Moving mountains with the aim of preventing diseases, keeping homes clean and helping members in times of difficulty. It also teaches proper agricultural methods to prevent soil erosion. A village health committee was formed at the inception of the project and it meets monthly.

PHC/CBHC Activities and Community Participation
The project has mainly addressed itself to prevention of diseases through immunization, treatment of malaria and other diseases, construction of latrines, rubbish pits, child growth monitoring, prevention of AIDS by sticking to God's word and family planning. The community plays a major role in agriculture and caring for their homes, and is highly receptive to health education activities and other community development projects. The community funds its own activities with a revolving fund, e.g., the women's rotating fund, with only advice and support from Mission Moving Mountains. Income-generating activities include group farming activities which have resulted into increased earnings for the family.

CHWs and TBAs
There are CHWs who were selected by the community by voting. They are volunteers who must be residents with exemplary behaviour and receive token assistance from the community in form of food in appreciation for their work. Their main activities include teaching on hygiene, visiting homes and pursuing preventive activities in the local area. TBAs are identified for their being well-known in the community, and then given additional training.

Constraints/Other Issues
Among the problems encountered in the project were getting few drugs at the local health unit; lack of water and transport problems due to difficult terrain (hills) and remoteness (rural/isolated areas). Requirements include creating more income-generating activities on longer term basis to help sustain the project, initially with outside assistance either from government or sponsoring NGO.

II. PROJECT: LWANGOLI CBHC PROJECT - Bunghoko County
Name of Community: Lwangoli
Focus Group Participants: Community members, men and women.

History, Aim and Objectives Of Project
Project was started in September 1988 by the local people and Gombolola Chief with the intention of helping the community in the sub-county to get medicine as there was lack of health facilities in the area. The community was involved in the initiation by providing labour and contributing money and bricks to build the Aid Post. The first village health committee was dissolved and a new one elected in 1992 by members of eight villages.

PHC/CBHC Activities and Community Participation
The community members take part in digging pit latrines, keeping the area around the Aid Post clean and helping with plastering and putting shutters. They also solicit funds for the Aid Post and other projects in the area like a nearby primary school built by the parents. The community is taught and takes part in preventive activities like immunization, constructing latrines, dry racks, clean water supply through protection of water sources, and use of three pot system for water storage. Days are chosen for particular activities, e.g., clubs,

etc. No substantial external funding has been injected into the project except development funds at the RC3 level.

CHWs and TBAs
Selected by the community for good behaviours and exemplary character, e.g., cleanliness in the home and having the necessary elements of a good home. They are volunteers who are then sent to Mission: Moving Mountains for training, and taught about prevention of diarrhoeal diseases, malaria, clean homes and food hygiene and production. Referrals are made to Lwangoli Aid Post, soon to be functioning as a community health unit within the project, but on a self-help basis. TBAs are from among those already in the community and receive additional training.

Constraints/Other Issues
Problems mentioned included lack of funds, storage facilities for drugs, equipment for sterilizing instruments and needles, and lack of transport to Mbale or better health units. The community has addressed some of their problems through RCs to the local government, especially finding markets for farm products like cotton, etc.

III. PROJECT: NABONGO CBHC PROJECT - Bulambuli County
Name of Location/Community: Muyembe
Focus Group Participants: Community leaders and development workers, male and female.

History, Aim and Objectives Of Project
Project initially started in 1981 but practically started functioning in 1991, initiated with assistance of Mission: Moving Mountains. It was started through calling meetings with RCs and then the community with the following objectives: to uplift the women's standard of living in the village; to sow God's word and to teach farming methods which were inadequate. During initiation and mobilization, the community agreed to select CHWs.

PHC/CBHC Activities and Community Participation
Health activities started with construction of pit latrines, drying racks and rubbish pits as good preventive measures. Safe drinking water was undertaken with protection of water sources and assistance from Water Aid with the sinking of tube wells. Community meetings stressed the need for each community member to care for the home environment with good housing, kitchen, compound, latrine, etc. One participant observed that diarrhoea which used to disturb the people no longer did so, and over half the people in the area practice correct use of sugar and salt solution (SSS) to prevent diarrhoea. Other health activities include immunization, maternal and child health and family, and treatment of common illnesses and injuries. People are encouraged to contact CHWs for help and discouraged from going for traditional cures or consultations.

CHWs and TBAs
Every village selected its health workers who were known for being active and could move around the village easily. They visit homes and teach preventive measures, agriculture, as well as encouraging spiritual and physical development through reading the bible, games, and other income-generating activities like poultry and animal husbandry. Each CHW is in-charge of 20-25 homes and ensures that each home has grown enough food and grows proteins and vegetable foods. TBAs are identified and given additional training by the programme.

Constraints/Other Issues
Some community members are slow to respond and are not clean in the homes but home visiting is to be stepped up, to help especially the poorer families some of whom were most hit by Karimojong raiders. Insecurity had been curbed, people were slowly recovering and hoped to participate more fully in developmental activities.

- **Starting and Maintaining PHC**

"Before commencement, local communities should be allowed to identify their own health problems and plan how to overcome them on their own. Any external assistance should be supplementary." (DHT member)

"Start in a small way, say in a village or RC1 level. Approach opinion leaders, teachers, church leaders, etc., within. These people should act as agents to pass/sell the ideas of PHC/CBHC to the people. Mobilization should begin at village level." (Project leader, Nabongo, CBHC Project)

- **Mobilization and creating awareness**

"There should be clear policy made for PHC. The various roles should be clearly stated in the policy. There should be proper mobilization of different parties and resources, plus education of the community which should be taken seriously."

- **Community involvement and participation**

"There is need for community participation through involving people. They should be made to contribute and feel that the project is their own property."(Policy-maker)

"When community members participate in an issue they regard it as their own rather than its being imposed from outside. Create a sense of ownership" (Project leader)

- **Remuneration of CHWs and TBAs**

"I would suggested that whatever the remuneration, it should come from the local community because they know the performance of each CHW and would reward according to one's performance."(CHW)

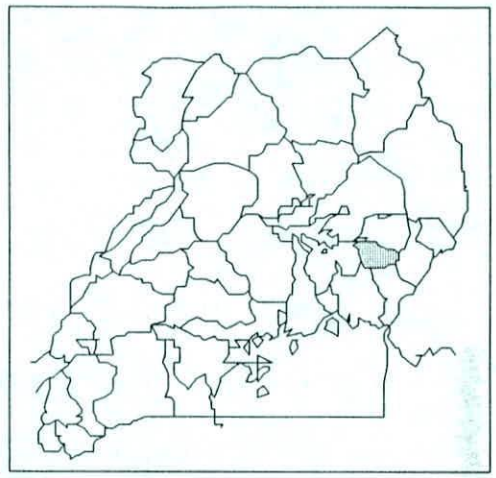
"Issues should be left to the community to either pay them in kind or in terms of money. One time gifts can also do, but only knowing that such appear only once in a blue moon."(Policy-maker)

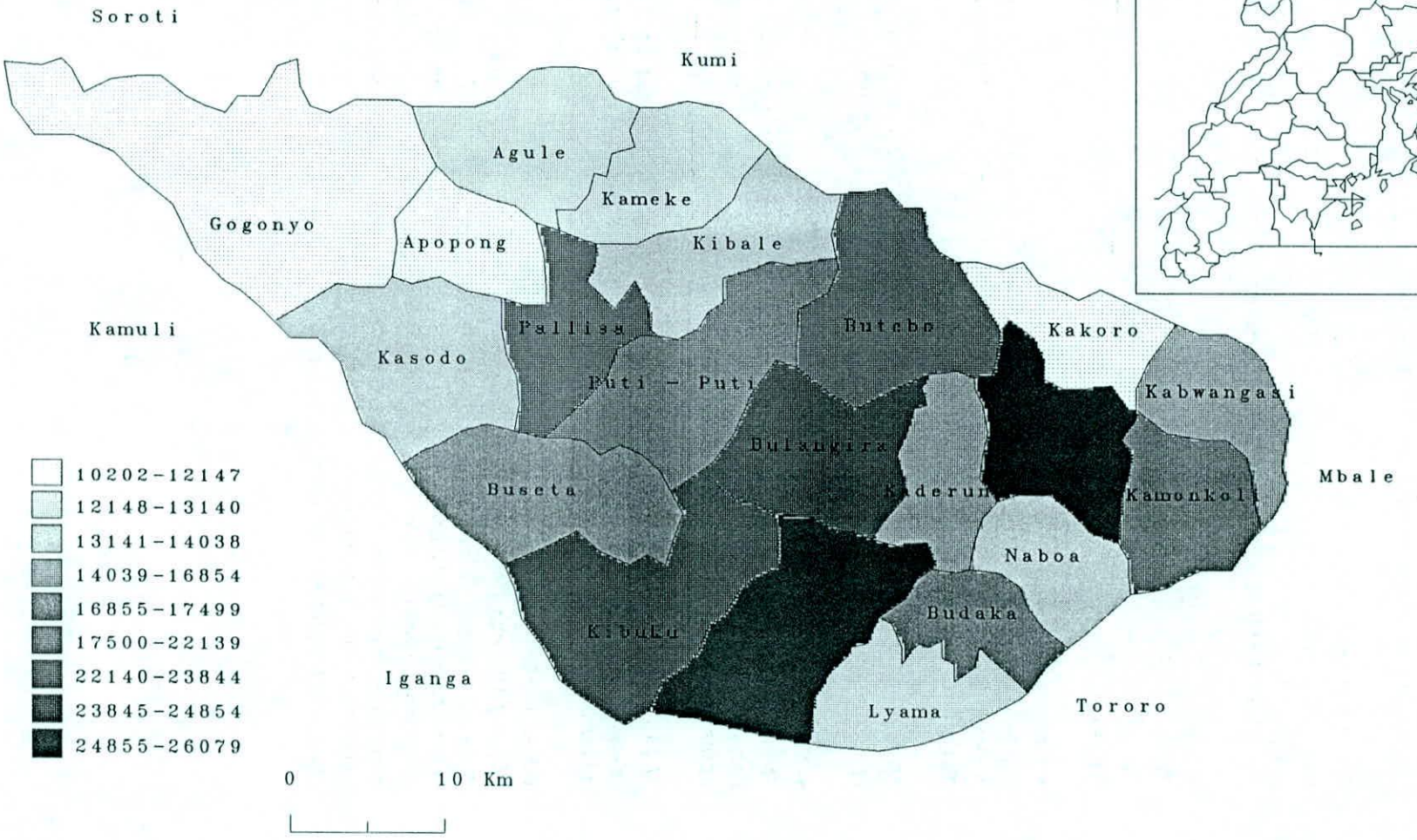
- **Sustainability**

"Even if Mission: Moving Mountains goes away, the knowledge we have got. CBHC is for the community. We shall manage our own project well." (CHW).
"I would suggest the following: training of more indigenous (local) people; generating interest in the community so that they remain fully involved in all stages; encouragement of more income-generating activities so that funds generated can support the project; there should be a linkage between local projects with the government health sector." (Project leader).

Total Popn 1991 : persons

PALLISA DISTRICT





CHAPTER 7

7.0. CASE STUDY IV: THE PACODET CBHC PROGRAMME

7.1. LOCATION:

Pallisa District, Eastern Region. Project headquarters are located in Pallisa county about 25 kms from Pallisa town which hosts the new district headquarters; or about 40 kms from Mbale.

7.2. DISTRICT AND PROJECT CONTEXT

7.2.1. Geography/topography.

Pallisa district lies at an approproximate altitude between 1097m - 1219m about sea level with an equatorial climate. It was part of the old Tororo District. It borders with the districts of Mbale in the east, the new Tororo district to the south, Iganga to the south-west, Kamuli to the west, Kumi and Soroti to the north. Total land area is 1,919 sq. kms, with four counties and 17 sub-counties.

7.2.2. Population and demographic characteristics

The total population at the 1991 Population and Housing Census was about 360,000, most of them rural dwellers, only about 3000 were urban dwellers. Of those about 14,000 (4%) were under one year; 66,000 (19%) under five years; about 80,000 (23%) women of reproductive age (15-49 years). (No figures available for under 15). Sex ratio M/F = 94.3/100. Population (land) density 228 per sq. kms. Infant mortality rate (IMR) was 124/1000, and total fertility rate (TFR) 6.5. (Uganda Population and Housing Census, 1991 Results). The main ethnic groups in Pallisa are Bagwere and Iteso, who speak Lugwere and Ateso respectively, and other ethnic groups, the like Basoga, Jopadhola, etc., as well.

7.2.3. Economy, trade and industry

Mainly agriculture with emphasis on food crops which include rice, cassava, sorghum, sweet potatoes, groundnuts, beans, soyabeans, cowpeas, sim-sim and maize. Cash crops are cotton, and in recent years, rice as well. There is also animal husbandry and fishing activities. Rice growing is increasingly taking over from cotton as the chief cash crop. Cattle rearing was popular among the Iteso but herds were depleted by warring and raiding forces. Pallisa does not have any industries, except old cotton ginneries, rice milling machines, brick-making, pottery, pit sawing, carpentry and black smithing. Trading or business, is popular in the district.

7.2.4. Health units and services

One government hospital is at Pallisa with a total of 109 beds, which has recently been rehabilitated, and about 30 other health units. There are four health centres at Kameke, Kibuku, Kamuge and Budaka, and of the 33 health units, 12 are run by NGOs. According to DHT members, the leading causes of morbidity and mortality included malaria, acute respiratory infections, diarrhoeal diseases, malnutrition, anaemia, worm infestations, tuberculosis, and skin infections.

7.2.5. Roads, communication and infrastructure

The district has 365 kms of poorly attended to feeder road network with another 96 kms of trunk roads, and a number of buses pass through the district to and from neighbouring districts.

7.2.6. Education

There are around 170 primary schools on paper, but on the ground some of them have crumbled over the years, and children in some places study under trees, lacking both scholastic materials and teachers. There are 11 secondary schools and an old teachers' college at Kabwangasi. Most children remain at home chasing birds away from the rice fields; and illiteracy is at a high level.

(Source: Above information, except Population Census Results, from: `District Profile'; *The Monitor*, No.01, Kampala, January 4 - 7, 1994; and, *Uganda Districts Information Handbook,* Fountain Publishers Ltd., Kampala, 1992).

7.2.7. Major forms of PHC activities in the district

According to the DMO's office, Pallisa District Administration health programme priorities include the following: intensifying immunization to improve coverage; providing adequate supply of water and protection of sources; improving latrine coverage and sanitation standards; creating more awareness on health issues through education; controlling endemic diseases like malaria, diarrhoeal diseases; TB and AIDS; and encouraging CBHC activities to promote health and prevent diseases.In addition to MOH vertical programmes on immunization, essential drugs, CDD, etc., the following PHC activities operate in the district:

PACODET CBHC Projects

- Kasodo Project
- Karekerene Project
- Kibale Mothers Self-Help Project
- Lyama Project
- Komeruka Project
- Kabwangasi Project
- Christian Children's Fund
- Bulangira Project

- Kadimukoli Project
- Nabowa Project

7.3. PHC PARAMETERS

7.3.1. History/evolution of project and objectives

The programme is located about 25 kms from Pallisa town in Kapuwai and has spread to 15 surrounding communities, each with its own CBHC activities. It was started in 1986 by the Kapuwai Students Progressive Association of Pallisa for purposes of stimulating, promoting and coordinating all voluntary efforts of rural communities in the district for their total development. The association was born on the religious principles of `Love your neighbour as you love yourself', and `Equality', and members base their success on commitment, and survival on community education mainly. The organisation is involved in programmes that provide services and all resources are utilised for that purpose. The projects are initiated at the request of the people and their full participation is expected. To date there is an active participation of over 100 volunteers. The catchment area has a population of around 60,000 people in the 15 communities (projects). It is entirely funded by the community except for some assistance by EDF (European Development Fund) to construct the health unit.
The project has management committees to coordinate the 15 projects, headed by Mr. S. Okurut the CBHC Coordinator and chairman of the Pallisa Community Development Trust (PACODET), which is the umbrella body of CBHC activities. The programme aims at having village health committees (VHCs) at parish, sub-parish and then village levels and sub-county level committees. At present the programme covers the sub-counties of Pallisa, Kibale and Butebo. Since CBHC as a process takes time and ideas are taken up gradually, there is equally a long process of raising awareness and allowing people to change from the old ways of doing things. The programme does not collect money from the people until they know what they want it for, and once they agree, they contribute equally. The programme also had the unique arrangement of having a Patron, Mr. Okodoi, former Permanent Secretary of Cooperatives (now deceased), who was a strong resource person and advisor; plus a council of elders for ideas.

Programme objectives are: overall goal of developing self-reliance, mainly through health and economic development. More specifically, fighting ignorance, poverty and disease,through community involvement and participation ; providing maternal and child health and family planning services; immunization, research and community based rehabilitation of the disabled.

7.3.2. Linkage with government health system

A policy document was being prepared by the project leaders and coordinators together with community leaders. It would reportedly follow the MOH or government plan for PHC in the country, and ideas from UCBHCA on CBHC activities, including its curriculum. The

programme links with the DMO's office and receives logistical or technical support as required (although it operates virtually independently), as far as equipment for immunization are provided; monthly returns and reports are submitted to the DMO's office, and DHT members pay supervisory visits. Referrals from project areas are made to Pallisa hospital, or to Kapuwai from other units. Referrals to the hospital included serious cases of injuries, difficult labour/deliveries, mental disorders, epilepsy cases, etc., which the CHWs and TBAs cannot manage on their own. Referrals to the Kapuwai health unit on the other hand come in from several smaller units like Kamuge, Kawakwi, Kituba, etc. and even from across the border in Kumi district.

Courses were often arranged in conjunction with the DMO's office, the UCBHCA headquarters, using government staff like midwives or DHT members as facilitators to train CHWs or TBAs.

7.3.3. Community involvement and participation in planning and implementation

The community is reportedly involved in planning process through identification of their problems (needs assessment), looking for possible solutions, drawing action or implementation plans, and carrying out actual implementation. Resources are mobilized through equal contributions agreed upon by popular consensus payable on an annual basis as membership fees, plus a fee-for-service in all health units. A steering committee is elected to control the resources and manage project activities.

The process: after creating awareness in a particular community, a project committee is formed and activities start after election of exemplary people to train as CHWs and TBAs. Community support is given to those who fulfill their selection criteria including being exemplary, humble and honest and respecting community views at every stage. Community participation is solicited of members on the basis of equal participation, equality and promoting cooperation for development and spiritual development. All activities required to be undertaken including contributions in cash, materials, labour and time for meetings, etc. Income-generating and community development activities are emphasized.

7.3.4. Self-reliance, self-determination and replicability

Efforts aimed at self-reliance and sustainability are in form of raising finances through the sale of farm products, user-charges, membership fees and other forms of contributions. The community managed to raise some Shs. 3,000,000/= for the new health centre, through such means. Some donations have come from EDF or from MOH through the DMO's office. Operational costs for all activities, however, come from the community itself, through their revolving fund, sale of donated items, etc. Long-term plans are for increased contributions from community, a cost-sharing scheme and income generating projects for sustainability. Replications have occurred and communities have expanded to 15 with a coverage population of 60,000 people, extending beyond the initial area.

7.3.5. Integration of national and international objectives

The PACODET programme is entirely indigenous and has not had much of external collaboration or dimension. Its objectives are purely locally conceived and in tune with national objectives for promoting PHC under the new health care policy.

7.3.6. Linkage of project with community development

Community development forms a strong basis of the PACODET CBHC programme. Community members came together to decide on what to carry out, e.g., cleaning wells or springs, digging or cleaning roads, building community structures like schools, etc., plus health related project activities and those for socio-economic development - in agriculture, education, communications and transport, animal husbandry, income-generating plants, cooperatives or commerce, etc.

7.3.7. Cost the community can afford

Community members decide by consensus how much to contribute annually, or on ad hoc basis, and for treatment at health units. Usually, on an equal basis, what they decide is what the community can afford.

7.3.8. Number of primary health care elements being implemented

All eight components of PHC are undertaken by the programme and handled by CHWs and TBAs, except for mental, oral/dental or rehabilitative services which at the moment are referred to Pallisa hospital or the other nearby health units.

7.4. REPORTS FROM FOCUS GROUP DISCUSSIONS PROJECT SITES

I. PROJECT: KAPUWAI CBHC PROJECT - Kibale County

Name of Community: Kapuwai

Focus Group Participants: Community members and laeders, men and women.

History, Aim and Objectives Of Project

Project was started in 1986 by the Pallisa Students Association comprised of youths from various schools. They had realized that there was a lot of diseases and poverty among the population. They solicited the cooperation of their elders and together they bought land for the association on which they started building a health unit. They started making bricks and people spent their time and energy to get the work started off. The building is nearing completion with some donation from EDF (European Development Fund) which was used to roof the structure. Objectives of the project included: uplifting the living standards of the entire community through voluntary efforts; fighting disease and poverty; helping the youth remain in the local area instead of going away to towns, etc. According to key informants before the project started, many children used to die of diseases like measles, and women in pregnancy or child birth due to having to go long distances to the hospital.

PHC/CBHC Activities and Community Participation

Following the teaching and appeals of the youths and elders to raise awareness, RCs and the general community found the idea very useful and together they started mobilizing the people - without any force and people started doing voluntary work and contributing money besides responding to health education

messages to keep homes clean; boiling drinking water, immunizing children and pregnant women; attending antenatal clinics and going for treatment at the local health unit. The response has been dramatic and both youth and adults have been selected for training as CHWs or TBAs or on other roles in developmental work, e.g., making bricks or handcrafts, or farming activities for both food and cash crops. Community contribution to the project is very high and the leadership is highly motivated by the support shown by all age-groups ranging from youths to elders, male and female, in all activities. They are confident about sustaining the project with their own resources but need support in developing the infrastructure. They have local health committees to manage each CHBC project.

CHWs and TBAs

These were selected for training at Kapuwai Health unit which is run by a medical assistant and a midwife with some help at times from the DMO's office at Pallisa. They work on a voluntary basis but are supported by the community in kind, e.g., getting meals during the course of their work or while training in phases. Their activities include going to outreach units for immunization sessions and health education during the sessions and home visits or treating simple conditions and making referrals to Kapuwai Health Unit. The TBAs carry out deliveries reportedly more confidently after training.

Constraints/Other Issues

Major constraint is long distance to the district headquarters at Pallisa especially delivery of materials like cement, timber, iron sheets and also drugs. Equally, payment of workers is a problem and in the long run CHWs and TBAs would need remuneration. Roads also needed repairing and the local government administration would need to assist, as well as drilling a borehole in the area. These would go a long way in supplementing the community's own efforts in CBHC/developmental activities, according to discussion groups.

II. PROJECT: KANYUM CBHC PROJECT - Butebo County

Name of Community: Kanyum Parish

Focus Group Participants:(a) Community leaders/development workers - men and women. (b) Community members, men and women.

History, Aim and Objectives Of Project

Project was started in May 1991 by members of the Kanyum Christian Association which was formed to tackle local developmental problems. The Association has a number of aims, among them promoting growers cooperative activities and promoting religious harmony. One area of need was to have access to a health facility for treatment of the sick, especially children and the elderly who had to be taken over 25 kms or more away to get treatment. They had heard of the Kapuwai project where people had organized themselves and were not only getting good treatment but were also able to reduce childhood morbidity and mortality from vaccine-preventable diseases like measles which were major killers of children in the area, and abortions in pregnant women. They went to Kapuwai and were not only assisted to get treatment and immunizations but were in addition helped with training of their own health workers and TBAs. A health committee has been formed which works closely with the CHWs and TBAs.

PHC/CBHC Activities and Community Participation

Besides promoting general developmental self-help activities like brick-making and growing cash and food crops which they market and use for food, they mainly carry out health promoting and disease prevention activities like immunizations and general health education - cleaning water sources and environmental health activities. The project is entirely run and supported by the community who contribute in any way possible - cash contributions (shares) paying for services, labour and other material contributions on equal basics. There is a growing number of people joining in all these activities on self-help basis which has promoted unity among them, young, old, men and women. They also receive encouragement from the RCs and local administration.

CHWs and TBAs

They were selected by the community and sent for training at Kapuwai and now conduct health education and immunization services. The TBAs help with deliveries and care of the nursing mothers. Family planning activities are increasing and awareness to child spacing is increasing. Training activities are being intensified with recruitment of more CHWs and TBAs. The groups felt that CHWs and TBAs should be remunerated by the community itself.

Constraints/Other Issues

Water is a major problem as sources are far and unprotected. Requires help from the local government or other outside support. Roads are in poor shape and hinder easy movements say to fetch water or to get essential supplies like drugs and other items which are often in short supply and require good storage facilities. Community now looks beyond their own resources to tackle some of these issues, although primarily well prepared and determined to sustain the project through their own efforts because of the enormous benefits they have derived since they joined together to improve their welfare.

III. PROJECT: AKIPANY CBHC PROJECT - Butebo County

Name of Community: Akipany

Focus Group Participants:Community leaders and development workers(mixed)

History, Aim and Objectives Of Project

Members started the project in 1991 after experiencing a lot of suffering, with the aim of fighting the diseases which had been killing children, e.g., malaria, diarrhoeal diseases, the six killer diseases, and diseases or conditions associated with child bearing. Another objective was to fight poverty which according to them `still exists.' They started teaching people in the home, and in gatherings especially about the need for immunizations, and setting days for other types of activity, e.g., making bricks, collecting stones and sand, and environmental health/home improving, water sources protecting/cleaning, and latrine digging activities, etc. A health committee of seven was selected which meets whenever necessary.

PHC/CBHC Activities and Community Participation

A number of activities are carried out for health in addition to other self-help developmental ones: maternal and child health and family planning advice; water and sanitation; treatment of minor illnesses; nutrition; education and immunization activities. Other areas of education include AIDS awareness. The community participated at all levels and make use of the Kapuwai Health Unit (at present the nearest) but are making bricks and collecting stones and selling to raise funds for a health unit. Income-generating activities include crop farming for both consumption and to earn money. No outside assistance has been received; the community is entirely contributing and supporting the project, but would welcome help especially from the Agricultural Development Programme (ADP). Activities by women include tree-planting and vegetables, cleaning water sources, etc. There is also school construction, rehabilitating of feeder roads, and tree-planting by secondary school students during holidays.

CHWs and TBAs

These were selected by the community from those who had interest and the ability and work voluntarily. They are assisted in kind only, e.g., during the course of their work or during training, but groups felt they could do better paid as they spent a lot of their time away from their own homes. They should be supported with transport and protective wear like `gum-boots or good shoes' to cover the long distances; or be paid wages according to the group.

Constraints/Other Issues

Most constraints are in raising awareness or fighting ignorance, making people involved in self-help activities and to complete constructing the Health Centre at Kapuwai and eventually a nearby health unit. They would like to be assisted with agricultural inputs like good seeds, crop spray pumps, drugs and hoes. Transporting and marketing of cash crops is a major constraint as well. Training more health workers

7.6. COMMENTS AND RECOMMENDATIONS OF KEY INFORMANTS

- **On PHC in general**

"In general, PHC has been going on but people were not aware, especially health workers themselves. Therefore, awareness for them should be put into serious consideration by the MOH. In every seminar carried out in the country PHC should be included." (DHT member)

"It is a bit difficult to get it going - best done using education and takes a bit of time. People respond differently, some are fast. It is therefore a programme that takes a bit of time with problems during its infancy. In communities like ours, few people have travelled beyond their own areas so it is difficult for them to appreciate new ideas. They may see no need to improve them, but PHC will need patient education of the masses and periodic introduction of new ideas."(Secretary, Kobuin CBHC Project)

- **Starting and Maintaining PHC**

"Before a person starts, he/she should first win the community; they should work unitedly in order to make a successful project. Should be willing or ready to lose their precious time for the community activities. Select work days in a week for the project" (CHW)

"Come together with the community, teach them so as to create awareness and not to force people but to let them realize their problems. Let the community select its own leaders. There should not be any favouritism but talents and participation should be at heart. Let the community form its own committee for guidance." (Women's Coordinator, Kapuwai CBHC Project).

"Starting is simple - every community has a problem though different ones. There is need to isolate or identify the felt problems of the community then look around for influential people to make them see the problem. Once this is done, you can come through easily. When you have educated members plus those who are influential, you necessarily have a group of innovators ready to start the project. When a new idea comes and the educated people pick up the idea it becomes easily followed by the administration, e.g., chiefs. All this needs a language of educating the group. That way, the idea comes to stay in the community." (Secretary, Kobuin CBHC)

- **Mobilization and Creating Awareness**

"Educate and get people interested in identifying their problems. Set up projects, e.g., brick-making for income generation. Have meetings and a general assembly.

Educate with role taking on the job and encourage equal participation. "(Chairman, Pallisa CBHC)

- **Community involvement and participation**

"People should be encouraged to take part fully in PHC activities so that they realize its importance. Once people take part in any activity, there is usually an element of ownership. People can easily participate in these activities as long as they are explained the need but not forced. "(Treasurer, PACODET)

- **Remuneration of CHWs and TBAs**

"The local community should be the ones to remunerate the CHWs because they serve them and know them better. This can be done in material form but not necessarily financially. "(CHW)

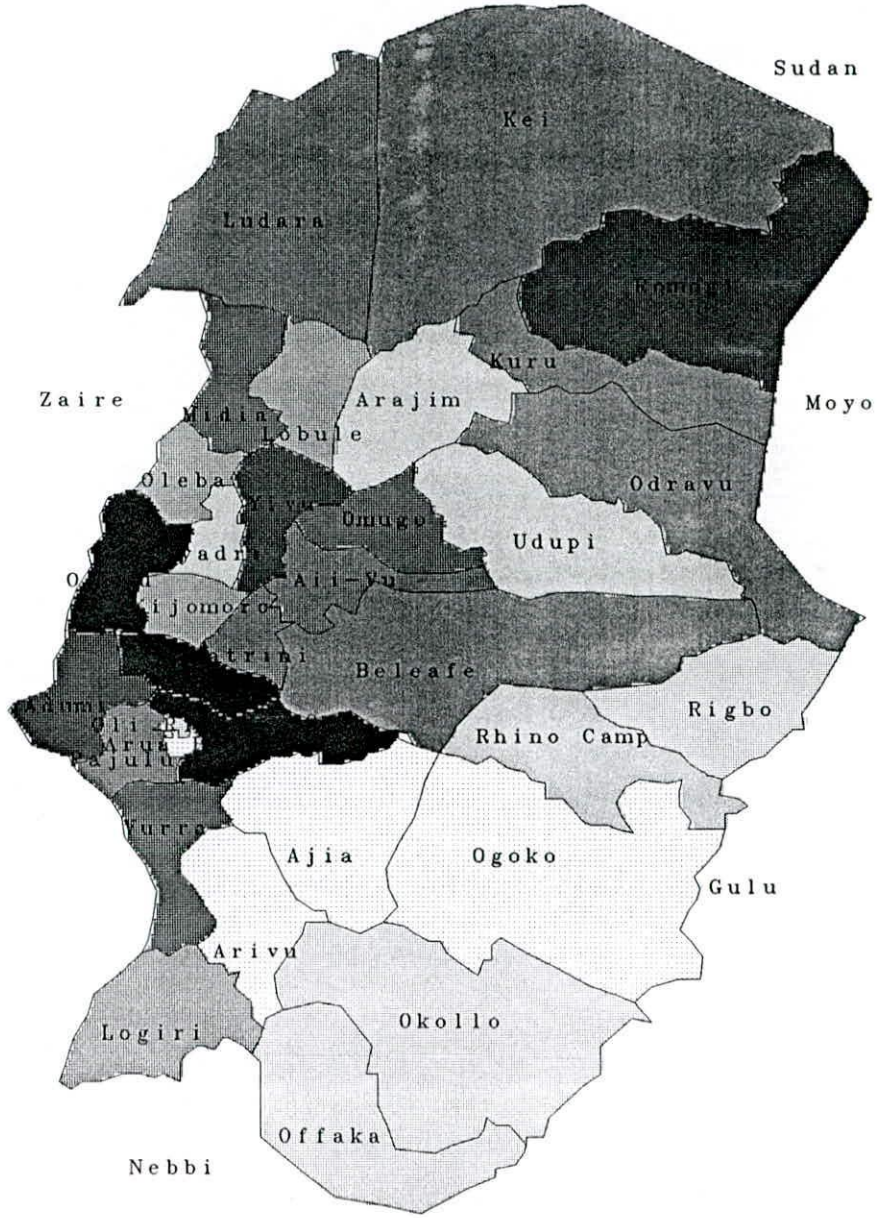
- **Sustainability**

"This goes with the acceptability of the project. Once people have accepted it, they will be willing to sacrifice. Once they see the value, they will protect the project and they will pay anything into the project for it to survive longer. It needs commitment through training and becomes part of the person's life. "(Secretary, Kobuin CBHC).

"The community should be encouraged from the beginning to have ownership of the PHC projects. This will ensure sustainability. " (DHT member).

Total Popn 1991 : persons

ARUA DISTRICT



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CHAPTER 8

8.0. CASE STUDY V: THE KULUVA PHC PROGRAMME

8.1. LOCATION:

Arua District, North-Western Region. Project headquarters are at Kuluva Hospital, Vurra County, about 15 kms from Arua Municipality, on the Arua-Pakwach Road.

8.2. DISTRICT AND PROJECT CONTEXT

8.2.1. Geography/topography.

Arua district lies between latitudes 2° and 4° to the north of the equator, at an approximate altitude between 945 metres and 1219 meters above sea level within a modified equatorial zone. It has good rainfall and moderately high temperature all around the year. Arua is a border district with the country of Sudan in the north and the Republic of Zaire to the West. Nebbi district is to the south, Moyo district to the east, and Gulu district to the south-east. It is part of the former West-Nile District (now North-Western Region). Total land area is 7,830 sq. kms, and it has eight counties (including Arua Municipality) and 31 sub-counties. Arua district has many rivers which all run into the Rive Nile on its eastern border, some forest reserves, and a few small mountains.

8.2.2. Population and demographic characteristics.

The population of Arua district was 637,941 according to the 1991 Population and Housing Census results, of whom about 30,000 were urban dwellers and the rest rural. There are several main ethnic (linguistic) groups in Arua district which include the Lugbara/Aringa (largest group), Kakwa, Alur, Madi, Kebu, Nubians, Somalis and other groups from Zaire, Sudan and other countries.

Of the over 600,000 population, around 26,000 (4.1%) were under one year; 120,000 (19%) under five years; 154,000 (24%) under 15, and around 150,000 (23.4%) women of reproductive age (15-49 years). The sex ratio M/F = 93/100. Population (land) density was 82 per sq. km. Infant mortality rate (IMR) - 137/1000; TFR - 6.65 (Uganda Population and Housing Census, 1991, Results).

8.2.3. Economy, trade and industry.

Arua is an agricultural district, and the leading food crops include cassava, millet, beans, peas, sorghum, groundnuts, potatoes, simsim and maize. Bananas are also now being increasingly grown. Tobacco tops in the list of cash crops, with the district being the largest producer in the country. The other two main crops are cotton, grown mainly along the Nile

banks and then simsim. The livestock population is rather small, but there is considerable fishing along the Nile, and some fish farms in many homes.

8.2.4. Health units and services.
There are four main hospitals, two of which are privately run by church missions. They are relatively well staffed with doctors and drugs available. They are the newly refurbished Arua Hospital (government), Maracha (Catholic), Yumbe (government) and Kuluva (Church of Uganda). There are eight government run health centres and other health units, besides those for church institutions and other NGOs.

Leading diseases and conditions causing morbidity and mortality include: diarrhoeal diseases, malaria; respiratory infections; tuberculosis ; malnutrition; anaemia; worm infestations; meningitis epidemics; sleeping sickness; river blindness; guinea worms; bilharziasis (schistosomiasis); and tropical/skin ulcers.

8.2.5. Roads communications and infrastructure.
Roads which were at their worst have been rehabilitated over the last three years, to the Zaire and Sudan borders, and the main Arua-Pakwach road, plus a few others including feeder roads. In the villages, however, people walk long distances, load trucks, or ride bicycles for visits or trading.

8.2.6. Education.
The district has well-established schools and most of the primary schools are either stone or brick built. By the end of 1992, there were 333 primary schools of which 20 were privately owned. There were government aided secondary schools and 20 other privately owned ones, and two technical schools. At least, 70 percent of the teachers were reportedly trained, and school enrolment in 1993 was reported to be fairly high.

(Source: Above information, except Population Census Results, from: `District Profile'; *The Monitor,* No.90, Kampala, September 17 - 21, 1993; and, *Uganda Districts Information Handbook,* Fountain Publishers Ltd., Kampala, 1992).

8.2.7. Major forms of PHC activities in the district.
According to the DMO's office in Arua, the district health programme priorities were: raising the levels of immunization coverage; improvement of MCH/FP services; training of TBAs and CHWs; rehabilitating and equipping of health units; supply of safe water through protection of springs and digging boreholes; supply of essential drugs; health education with emphasis on AIDS; control of guinea worms; and establishing of school health services. Programmes operating in the district for the delivery of PHC or CBHC include:

Kuluva PHC Programme

- Christian Rural Service (in conjunction with Kuluva PHC Programme)
- CUAMM CBHC Programmes (in conjunction with DMO's PHC Programme)
- Maracha Hospital CBHC
- CARE-Uganda PHC Programme (under West Nile Community Self-Reliance Project)
- World Vision (also in conjunction with Kuluva PHC Programme in Anyiribu Development Project)
- Save the Children Fund (Aringa and Koboko counties)
- Lutheran World Federation (LWF)
- Islamic International Relief Organization
- Koboko Development Trust Fund (still new)

8.3. PHC PARAMETERS

8.3.1. History/evolution of project, and objectives:

The Kuluva PHC Programme was started in 1985 by the Diocese of Madi and West Nile (Church of Uganda). Although the diocese covers the districts of Madi, Arua and Nebbi, practically the programme only operates in certain communities in southern Arua, and Nebbi districts through an arrangement between the DMO's office and other PHC/CBHC non-governmental organizations, which also have their own areas of operation within the region. It is located 15 kms away from Arua town in Vurra county, and based at Kuluva Mission hospital. The project has been funded by NGOs, first, the Christian Reformed World Relief Committee (CRWRC) which is now scaling down its funding activities, and recently by OXFAM. The PHC building was funded by CIDA. In 1989, the World Vision International joined the Kuluva programme to start a CBHC project in one of the communities in Anyiribu Parish. In all, there are seven communities in Arua district and four in Nebbi district under the Kuluva PHC programme. The population covered under the programme has not been determined and not clearly defined by area. The project was initiated with direct encouragement of the Kuluva hospital authorities through the Medical Superintendent, Dr. David Morton, and is headed by a Project leader, Mrs. Margaret Ejoga, a registered nurse/midwife.

Programme objectives include: reducing child and maternal morbidity and mortality rates through immunization and MCH/FP services; training CHWs and TBAs, village health committee members, and creating awareness in the community; prevention of disease through behavioural change; improving agricultural production and food supply to families to improve nutrition and reduce malnutrition, raising the communities' general standards of living.

8.3.2. Linkage with government health system

Programme was started by the Kuluva hospital administration itself after many years of curative care service to the population of Arua. As a new project, there was no defined policy but according to Dr. Morton, a document was being prepared by the Board specifically for the PHC programme by CRWRC, part-sponsors of the programme, the Uganda Protestant Medical Bureau (under which Kuluva Hospital operates) and OXFAM, and in conjunction with UCBHCA. Workers for the programme (PHC workers or CHWs) are trained at the School of Nursing of Kuluva Hospital. Monitoring and evaluating activities are carried out by the programme staff (Project leader, etc.), and the returns are submitted every three months.

Referrals by PHC Programme workers are made directly to Kuluva hospital, or in some cases to Arua Hospital - of those cases that may not be managed by CHWs.
The DMO's office does overall supervision of all health services in the district including the private hospitals and their related projects and beyond that, the MOH at Entebbe, DMO's Office staff (DHT) carry out regular supervisory visits - usually once a year or whenever necessary. Feedback was reportedly made or given either on the spot (verbally) or within about a month of the visit, in a written form. Training activities are often carried out jointly with DMO's office, the UCBHCA facilitators, or from other vertical programmes, e.g., UNEPI, for TOTs or refresher course, for CHWs, TBAs and other health care staff.
CHWs under the programme policy do not handle essential drugs or first aid kits but are encouraged to make immediate referrals to the nearest health units or Kuluva Hospital, and mostly to concentrate on raising awareness to disease prevention and health promotion. [This in itself is not an easy process to accept, and may further alienate the CHWs from the community, that is, the community may not be easy to convince to take part in activities without concrete help].

8.3.3. Community involvement and participation in planning and implementation

As far as possible, the community is involved early, normally initially through their local leaders - both formal and informal, e.g., RCs or Chiefs, elders, etc., in identifying problems, setting priorities and planning for action - usually collective action - depending on the tasks at hand. Other areas of involvement include: choosing not only their leaders, but from amongst themselves people to be trained as CHWs; identifying TBAs; and selecting village health committee members, etc. Once these are selected or set up, plus the existing structures like the church, women's group, etc., they reach a consensus on resource mobilization and specific tasks for particular groups or the whole community members. Elders or clan leaders play a vital role in rallying community support and participation through contributing cash, materials, labour or time for voluntary activities, etc. In some instances some compulsion becomes necessary according to project leaders, and it often works.

8.3.4. Self-reliance, self-determination, and replicability

The project aims at self-reliance and self-determination by the local community, plus the possibility replicating of project activities in newer areas. So far, not much has been achieved in these directions. Generally, some community members viewed the Project as one that would deliver donations, and little by way of self-reliance was seen. As one programme manager observed: ***"So long as the donors are there, there is no problem, but the moment they pull away, it will fail."*** (Regional Health Visitor). Much remains to be done to develop this through awareness raising and the mobilization of resources from the people themselves. One estimate by a project leader put contributions by way of community resources to be at around 40% of operational costs, including inputs from labour materials, and income-generating activities, etc.

8.3.5. Integration of national and international objectives

The programme is supported by at least four international level NGOs or aid agencies: OXFAM, Christian Rural World Relief Committee (CRWRC), CIDA and World Vision. This international dimension is substantial and their objectives diverse, derived as they are from the development agendas of these bodies. The national objectives for primary health care are geared to placing responsibility for health care delivery, promotion and disease prevention in the hands of the local community. The integration of those objectives calls for a shared responsibility between government, aid agencies and the community - in a useful partnership.

8.3.6. Linkage of Project with community development

Community members were generally involved in activities other than just health care and development, like agriculture and food production, road maintenance, construction of schools and church buildings, etc. In addition, activities include income generating projects and cooperative societies which are becoming immediate concerns especially since the entry of World Vision. People are being made aware of their development needs and ideas, including raising literacy levels among adults, and women's activities through Christian Rural Service (CRS). Equally, community members were willing to contribute resources to community development efforts. Cultivating further these aspects and integrating them into PHC activities would ensure better sustainability.

8.3.7. Cost the Community can afford

The idea of involving the communities in development activities is something rather new, and most key informants felt that the communities were generally poor. Response is slow and people expect to see more "tangible" things or to get some handouts. The idea of paying for services at health units, especially government health units, has not gone very well, and requires much discussion. More effort is required to cultivate the spirit of self-reliance and self-determination.

8.3.8. Number of primary health care elements being implemented

Most of the components were undertaken by the programme, especially those aimed at promoting health and preventing disease. General health education activities were carried out in health units, as well as in homes by CHWs, TBAs, etc., who were selected with the help of clan leaders so that they know their areas well and are close to the people. In immunization activities, they took part in mobilizing the community, immunizing and giving appropriate health messages. Women are encouraged to attend MCH/FP clinics by CHWs and TBAs who work closely with midwives and staff at the health units. Nutrition activities were particularly geared to infant and child feeding, plus maternal nutrition activities, as well as food production for the family. CHWs and TBAs are also involved in growth monitoring of under-fives and carry out nutrition education. Referrals are made to Kuluva Hospital of cases of malnutrition for further management (rehabilitation) and parents' education. In water and sanitation and control of endemic diseases activities, community members carry out construction tasks of water sources, latrines, cleaning bushes, control of diarrhoea activities, and other communicable disease control. Referrals are made by CHWs and TBAs to health units for treatment of diseases and injuries, as under the programmes, they are not allowed to handle drugs. No mental health services existed, but cases were referred through Kuluva and Arua hospitals, just as oral/dental services. In the area of rehabilitation of the disabled, Kuluva Hospital has a special programme in conjunction with the nearby government rehabilitation centre at Ocoko.

8.4. REPORTS FROM FOCUS GROUP DISCUSSIONS AT PROJECT SITES

I. PROJECT: NYIO PARISH PHC/CBHC PROJECT - Vurra County

Name of Community: Nyio - Vurra

Focus Group Participants:(a) Community Leaders,(mixed); (b) CHWs and TBAs.

History, Aim and Objectives Of Project

Project was first initiated in 1984, but collapsed due to change of government (coup) in 1985. In 1987, the RCs and health workers of the area revived it, and a course was conducted for health committee members within the area itself by the Kuluva PHC Programme team. The objectives of the project were to build a health centre on a self-help basis; promote health education in homes and prevent childhood diseases - the six killer diseases, through immunization and general hygiene; to foster general development in the area, establish cooperation with traditional practitioners and TBAs, and to identify right people to carry out community health care activities - CHWs or TBAs for training.

PHC/CBHC Activities and Community Participation

PHC has played a key role in reviving the project and solicited community involvement through raising awareness to the needs - e.g the nearest health units were, Kuluva hospital and Vurra sub-dispensary, which were both over 5 kilometres away. Members agreed to make bricks through community effort and provided materials like grass for roofing, poles and money to construct their local health unit. Activities included immunization activities with help from the Kuluva PHC team, construction of a house for the TBA, home visiting and health education, and MCH/FP (maternity and antennal) services or referrals to Kuluva hospital. A village health committee was formed and met regularly to supervise CHWs and TBAs.

CHWs and TBAs.

These were selected from amongst the community by members themselves from hard working regular community members who do voluntary work but are rewarded in kind by the community as a whole or individually. However, the group felt that if there were to be any regular payments for them, then it should come from government as a regular salary. They felt that as a community they were yet too poor to sustain the CHWs and the project as well.

Constraints/Other Issues

There was general lack of food - famine had occurred in the area and much time was spent on cultivating field or looking for food. Generally incomes were low and no savings to realize any meaningful contributions for general welfare. Water was a problem with no boreholes or good sources of protection. The group expressed desire for help in getting a protected spring with help from outside, and to set up an apiary project, and planting eucalyptus trees as income-generating activities.

II. PROJECT: ANYIRIBU RURAL DEVELOPMENT PROJECT - Madi County

Name of Community: Anyiribu

Focus Group Participants: (a) Elders (clan leaders) and formal community leaders, (b) CHWs & TBAs.

History, Aim and Objectives Of Project

The Anyiribu Rural Development Project was started in October 1989 through the Church of Uganda Diocese Kuluva PHC Programme by World Vision. The latter used the PHC Programme to add developmental activities to the health programme which was being supported by Kuluva hospital and the Christian Rural Services Scheme. Objectives included the promotion of health education in the community establishing a dispensary/health unit for curatives services, to construct a school for primary education and to promote cooperative activities for general development. The community was involved in project initiation by participating in needs assessment meetings and identifying local problems. A village health committee was formed by village clan leaders including both men and women, and meets monthly.

PHC/CBHC Activities and Community Participation

Activities include training health committees, CHWs and TBAs, health education to the community by the CHWs on environmental sanitation, prevention of diseases through immunization, drinking safe water and proper storage, proper nutrition and food hygiene, family planning, and prevention of AIDS and other communicable diseases. There are mobile ante-natal clinics from Kuluva, and activities to protect water sources and using the three pot system for storage,and activities to prevent malaria, and epidemic diseases like meningitis. The community participates in meetings and communal activities which include construction of primary schools (three so far), farming - cotton, beans, simsim etc, bee keeping/apiary; tree planting; making vegetable oil from shea nuts, handicrafts by women and livestock husbandry. Religious activities (Sunday school) for children for spiritual development are equally undertaken seriously by the project.

CHWs and TBAs

CHWs are selected by the community and work voluntarily. They conduct health education activities - environmental sanitation and home improvement; control of diarrhoea, treatment of minor illnesses and injuries; immunization; and promoting boiling of drinking water and use of three pot storage system; latrine use, construction of bath shelters, drying racks, and advice on good nutrition, family planning and preventing/guarding against AIDs and STDs. The groups felt that in future, when the project will have improved its resources, CHWs should be paid allowances from community resources and TBAs requested for longer training period than what they get from the Kuluva PHC Programme Project Leader, at the moment for only one week.

Constraints/Other Issues

Lack of a health centre for the project (still under construction) lack of adequate food due to recent prolonged drought; common eye diseases, destruction of crops by vermin - baboons and monkeys, and

vectors. There is scarcity of water and no reliable body of water nearby - real need for a working borehole. Generally the community's level of education is very low, they are poor and cannot afford sending their children to school as the cotton is not promptly paid for by government. Members pinned a lot of hope on the assistance they were receiving from World Vision which casts doubt on the long-term sustainability of the project. But efforts were being made to institute income-generating activities, according to the participants.

III. PROJECT: MVARA PHC PROJECT - Oluko Division

Name of Community: Edroze, Mvara

Focus Group Participants: (a) Community leaders (mixed); (b) Women's leaders; CHWs and TBAs.

History, Aim and Objectives Of Project

Project was started in 1989 at the initiative of the DMO who sent two health workers to a TOT course at Maracha Hospital CBHC Programme. They started with creating awareness in the community and set up further training programmes at Kuluva which then resulted into establishing interest and community cooperation to start them on project. One area of need was to afford cost of treatment generally at Arua Hospital and other fee-paying health units and hospitals in the District. The community eventually realized the need for them to get their own treatment cheaply and to take part in preventing common diseases and reducing deaths from preventable causes, especially among young children and mothers. The community eventually started with their own resources of 25 members initially contributing money - 200/= each, and contributing other resources like food, labour during communal farming activities, protecting springs and maintenance, clearing and constructing structures like markets to sell food crops etc. Some external support came in form of logistics and transport; training and subsistence allowances, etc, from Kuluva Hospital PHC Programme. The project has a village health committee which meets four times a year.

PHC/CBHC Activities and Community Participation

Major activities for health include maternal and child health/family planning activities, health education, immunization; water and sanitation- boreholes and spring protection; food production and nutrition education promotion. These activities and sessions are known to the community before hand and actively supported by RCs, the district administration, and the DMO's office. The community participates in construction of latrines, bath shelters, good homesteads etc, at individual/family levels, and communal activities which include farming activities mainly -food and cash crops, small businesses in food and essential commodities and keeping animals etc, to generate funds for paying school fees, poll tax and for project activities.

CHWs and TBAs

These are selected by the community members and trained by the parent programme at Kuluva. CHWs are mostly engaged in health promotive, disease prevention programmes and do not handle drugs, but are advised to refer to health units. TBAs who are 17 in the area carry our deliveries and coordinate with other NGOs or health programmes engaged in MCH/FP activities for referrals or antenatal, natal or postnatal services. CHWs and TBAs are also active in family planning activities and educates on AIDS and other STDs.

Constraints/Other Issues.

Major ones include lack of resources or poor base, and inadequate logistical support for continuity. There is some lack of commitment and involvement on the part of the community and some leaders who need to go out and mobilize the community for greater involvement and participation if the project is to be sustained. Group members suggested the need for more logistical support from Kuluva if the project is to be fully developed and training, while strengthening other areas of income-generating activities for sustainability.

8.5. PERCEIVED DETERMINANTS OF PHC

8.5.1. Factors promoting success of Projects

a) Training and availability of staff: the training provided to CHWs and TBAs and availability of staff for PHC were some of the factors mentioned for success of the projects. Training of village health committee members was equally mentioned.

b) Financial Support and donations: several NGOs or and agencies support the programme and key informants mentioned such support as being vital. The agencies involved include CRWRC, OXFAM, CIDA and recently World Vision, plus well-wishers, both local and external, who also gave donations to the programme.

c) Motivation/incentives to staff and general support: the staff are well supported logistically and with some incentives which factors go a long way to bringing about good results.The medical superintendent in particular did a lot to facilitate PHC work.

d) Cooperation and support from Government Health Department.
The regional staff and DMO's offices were cited as very supportive and interested in the PHC programme. Regular supervisory visits and logistical support did a lot for its success.

e) Improvement of infrastructures and logistics
Local administration authorities had contributed by improving some infrastructures thus facilitating work of the programme. Generally, the local government has given supplies and there was general improvement of overall health services in the district.

f) Mobilization of community
There was general mobilization through community leaders, elders CHWs, health committees, etc. that lead to the perceivable growing community awareness, confidence and positive attitudes.

g) Good supervision
Programme leader pays constant visits and supervises activities with her team.

8.5.2. Factors leading to failure, and major constraints

a) General lack of funds and adequate resources for PHC. No budgets especially for PHC, thus depending on external support - drugs supplies and equipment not readily available, or no transport.

b) General poverty in the population: there was reportedly little production of food due to famine in the district.

c) General breakdown of health services or facilities
Most structures were broken down or are in disrepair, and staff were not available in some health units.

d) Frequent epidemics
Meningitis and other communicable diseases were reportedly common, and there was lack of logistics or vaccines to combat such epidemics.

e) Difficulty of mobilizing the community, and poor voluntary spirit
Community support was slow in coming due to lack of mobilization strategies, and people were not keen to offer their `voluntary' services.

f) Lack of guidelines or enforcement
The MOH has no clear guidelines or policy to enforce measures to enhance community involvement and participation in PHC, according to the staff.

g) Shortage/ and lack of clean water, especially in dry season

h) Unrealistic expectations from some people: the feeling that programme is unable to deliver "tangible" things or not offering free benefits.

i) Lack of markets to sell produce, e.g., cash crops: the Rural Farmers Scheme had failed the farmers in particular, by not paying them or issuing only promissory notes which were reportedly not honoured.

j) Inadequate training of some staff to manage PHC activities.

8.6. COMMENTS AND RECOMMENDATIONS OF KEY INFORMANTS

- **On PHC in general**

"MOH should give guidelines which should enable people to act at grassroots levels to plan what they want. The programmes should be horizontal rather than vertical. Such a policy should show clearly the role played by each of the actors, e.g., DHT, Community, MOH, and other initiators should also be indicated." (DHT member)

"It is a good approach but the problem is sustainability; only if there are income-generating activities. It should also include literacy campaigns." (Regional Health Visitor).

- **Starting and Maintaining PHC**

"Most important to sensitize and let them identify the problem and see a need for the problem. They can freely participate in solving and maintaining the project."(DHT member).

"The community should be made aware and they should form committees, e.g., for water, through mobilization. Starting a PHC project depends on available logistics and components to implement." (DHT member).

- **Mobilization and Creating Awareness**

"I think anybody who is starting a project should create awareness of the people in the community, then make them find out the most felt needs, then they make a workplan." (CHW)

"Be careful how to enter the house of a person ...create awareness longer than building up structures ... be patient because there is possible disagreement before agreement. Those already sufficiently sensitized should be mobilized to form committees, and followed up to see they are meeting regularly." (CHW).

- **Community Involvement and participation**

"In communities where PHC has been created people have to understand it and they are involved in the activities. Other people find it difficult to accept that the participation is for their own development" (CHW).
"Participation of the communities is going to be a bit fairer where they, other than technical personnel, are involved in identifying their own problems." (Project leader).

- **Remuneration of CHWs and TBAs**

"There should be remuneration for CHWs in form of materials like bicycles, or cash." (DHT member)

"The respective health committees should decide on it." (Policy-maker)

- **Sustainability**

"We have to begin from community level to make them able to sustain the programme, so that when there is sustainability on their part, there will be no need for downflow of support. Sustainability at project level will require change from free service delivery, to fee-paying

(cost-sharing) services. I would suggest that the board will take the responsibility of sustaining the programme on that basis. " (Diocesan CBHC Coordinator).
"Our programme is under the Church of Uganda and it is still green. It is a result of others coming to give ideas on PHC and even funding. There should now be an emphasis on income-generating activities in the catchment area of the project so that it can go ahead and not be seen as an outside project" (CHW).

CHAPTER 9

9.0. ANALYSIS AND DISCUSSION

9.1. PHC PARAMETERS

9.1.1. History/Evolution of Programmes and Objectives.

Matrix 1. Showing summary of background, objectives, coverage and organizational structures of programmes.

Name/Funder/ Date started	Policy/Main Objectives of Programme	Population/ Areas covered	Structures/ Organization
1.Kasanga CBHC Programme/ Virika Mission Sisters & Mission Sisters England. Catholic(UCMB)/ (1979)	- To serve the poor and `unreached.' - Provide services; promote health and preventive health care	28 parishes in Bwera sub-county	28 CBHCs; CHWs/TBAs/VHCs (supervised by Project Advisory Committee, PAC).
2.Kitovu CBHC Programme/ Scottish Catholic Int. Aid Fund(SCIAF) Ug.Cath.Med. Bureau(UCMB)/ (1982)	To reduce general morbidity/mortality; - Create awareness and increase use of health services; - Promote health & self-reliance; - Encourage income-generation.(IGAs)	Masaka municipality, (11 CBHCs since 1983).	VHCs.CHWs & TBAs: and a Committee of Chairmen.
3.Mission: Moving Mountains CBHC Programme/ Miss: Moving Mountains(USA); Oxfam & Water-Aid./(1990)	- Spiritual development and CBHC thru' community development; - Disease prevention - Increased food production.	Nabongo & Lwangoli areas since 1990; Namawanga sub-county, since 1991.	Expatriate consultants & local trainers; project leaders/ development/CHWs/ TBAs/development & VH committees.

4. PACODET CBHC Programme/ Entirely funded thru' community efforts, plus a small EDF grant (started, 1986)	- Started initially as Kapuwai Students' Prog. Association to: stimulate, promote, & coordinate voluntary efforts of rural community development; and self-reliance thru' health/economic development.	Population of 60,000 in 15 communities/ projects.	Patron (honorary position; Chairman & project executive; project development/health committees; CHWs & TBAs, etc.
5. Kuluva PHC Programme./ Christian Reformed World Relief Committee (CRWRC); Oxfam; & CIDA./ (started, 1985) Under Diocese of Madi/West Nile (Church of Uganda)	-To reduce child/ maternal morbidity and mortality thru' immunization/MCH/FP services; -Training of CHWs, TBAs, and VHCs; -Creating awareness in community; -Disease prevention; -Improving food/ agricultural production & nutrition	Communities located in Nyio (Vurra); Mvara (Ayivu); & Anyiribu (Madi); and parts of Nebbi.	Project Head/Medical Superintendent of Kuluva Hospital; Project Leader; Diocesan Coordinator; PHC/CHws/TBAs; VHC/Dev. committee.

The history or evolution of a programme has a lot to do with the course the programme ultimately takes. In that sense, the actors at play in the initial stages will to a large extent determine future directions of a programme, as is clearly shown in the accounts from the five case-studies. Programmes which started largely with outside support have a particularly difficult task of passing on the control, or empowering the local community. But where control and empowerment is within the initial grasp of the local community, prospects are much better.

Four of the programmes were initiated with external assistance - that is, with expatriate involvement, (Kasanga, Kitovu, M:Moving Mountains and Kuluva). Only PACODET in Pallisa was initiated entirely locally, with no substantial outside assistance or support. The four externally assisted programmes were set up either alongside curative health services which had operated for some time, (Kasanga, Kitovu, Kuluva), or purely to promote health through CBHC/community development activities, (M: Moving Mountains).

PACODET started with a small health unit built entirely by the community, and had a strong features of charismatic personalities who had the determination to fight preventable (immunizable) diseases, and to alleviate suffering within the community, and vision to generally develop the area: thus health care activities became part of overall development.

Needs assessment

All programmes reportely had carried out a **needs assessment**, with the first four having had initial expatriate involvement, while only PACODET had the local people doing their own needs assessment and prioritization of needs.

Degree of local control

Operationally, Kasanga and M: Moving Mountains, among the externally funded ones had shown evidence of shifting towards greater local control, while Kitovu and Kuluva programmes had on the other hand, shown a lesser degree of such control: indeed during focus groups, some community members expressed reservations about sustainability of their projects on the cessation of outside support. Specific programme evaluations were carried out in four of the five programmes(M: Moving Mountains, Kitovu, Kuluva, Kasanga) by outside teams from UCBHCA and UNICEF, while PACODET had no external evaluation done. It was also reported that the evaluation reports were favourable and had made recommendations on how to improve the individual programmes.

Period and nature of PHC implementation

Programmes had been on the ground for between two and 10 years, all variously involved in curative, promotive and preventive aspects of health care including: immunization; health education; maternal/child health/family planning; treatment of common diseases; nutrition; water and sanitation; etc.- all PHC components. In addition, other CBHC activities emphasizing community development, including aspects like income-generation, and building structures like schools or health units were also undertaken as part of some programmes' developmental packages to promote, or to go alongside PHC.

9.1.2. Linkage of Programmes with Government Health System

Matrix 2. Showing linkage with health units, referral paths, and supervision within Government system.

Programme	Types of Linkage/Referral	Health Units	Type of Supervision
1.Kasanga	Serious cases,eg. meningitis, cholera, AIDS/ HIV, TB,Surgical cases; Complicated deliveries; Major injuries,etc. (Referrals by CHWs/TBAs)	Kasanga Disp; Bwera H/Cent. Karambi Disp; Kagando Hosp.	DMO has overall charge of services, eg. EPI,CDD,EDMP, etc. PHC activities; Training,W/shops.
2.Kitovu	Major illnesses/accidents; Difficult labour/complications/first or multiple pregnancies; or short stature mother; under-16 or above-35 mothers, or previous scar. Dental & mental cases,etc. (Referrals made by CHWs & TBAs, to health units)	Kitovu,Masaka & other hospitals nearby.	DMO and other DHT members are responsible for overall supervision and coordination of PHC services in the district. Training of CHWs,TBAs and CBHC activities; supplies/logistics.
3.Mission Moving Mountains	Policy document/Plan of Action for PHC. Membership of UCBHCA & district CBHCA(consultant/advisory roles to UCBHCA,ie. TOTs, policies,etc.) Referrals made by CHWs, TBAs, for serious cases, birth complications, accidents,mental disorder chronic conditions, and diseases, etc.	Governement & private health units,eg.Muyembe dispensary, Mbale, Tororo Hospitals, Kolony Centre, etc.	DMO takes overall responsibility for all PHC activities in the district, & gets regular reports Training of CHWs,TBA Other programme needs; TOTs,EPI/CDD workshops/seminars; plus other MOH or UCBHCA activities.
4.PACODET conducted	Policy document being prepared: to follow MOH/ Govt. policy/plans on PHC Ideas from UCBHCA eg. curriculum for CHWs/TBAs; & CBHC activities. Links with DMO office, & logistical/technical support, etc.	To Pallisa Hospital from Kapuwai and other health units within the area Referrals from several other units,eg.Kamuge Kituba, etc.	Courses often in conjunction with DMO's offices, using UCBHCA materials, with help of Govt. staff like midwves, or other DHT members as key trainers of CHWs/ TBAs, VHCs etc.
5.Kuluva	The Kuluva programme was started by the Hospital	Referrals by PHC workers,ie.	The DMO's office has overall supervisory

	authorities, after many years of delivering curative services to people of Arua, Nebbi and others beyond. As a new project, there was no defined policy, but a document was being prepared by the Hospital board. Emphasis would be placed on health promotion, nutrition and disease prevention.	CHWs,TBAs, etc. are made to Kuluva, Arua & Nebbi Hospitals or other health units. PHC workers,or CHWs were not allowed to use essential drugs under current program policy.	role for services in the district. Kuluva is run under the Uganda Protestant Medical Bureau(UPMB) under licence by the MOH. DHT members assisted with training courses jointly with UCBHCA facilitators,and staff of Kuluva Nurses'School w/shops or seminars.

Most programmes had no clearly stated `linkage' mechanisms with government run health services within the districts, except those arranged with DMO's office. No clear gudelines were available, although in theory DMO offices were stated to be responsible for co-ordinating all curative services and PHC activities, both governmental and non-governmental. In actual terms, programmes were largely run independently of, or without close MOH control, but `supervisory' visits were supposedly paid by DHT members to individual projects. There was equally little or no control from district or local authorities, with few or no details on extent of both central and local government budgetary allocations for PHC. Generally therefore, articulation of PHC/CBHC programmes was rather poor at the district level, especially in the absence of any prior experience of managing resources for PHC, or in particular, in translating the philosophy and essence of `transferring' responsibility of health care and development to the people.

Referrals were made to existing government health units, or to other non-governmental units, although in some programmes, those made by CHWs or TBAs were not evidently common, or readily accepted by the government health workers. The M: Moving Mountains and Kasanga programmes had a reasonably functional referral system for CHWs and TBAs between the projects, and goverment health units. In Kitovu and Kuluva programmes, there was much less evidence of the system operating closely involving CHWs or TBAs; while the PACODET programme had devised a close relationship with the DMO or Medical Superintendent in Pallisa Hospital and other health units.

Training activities were officially co-ordinated by the district medical/ health office and often DHT members were among the main facilitators. However, each programme had its own approach in terms of content or period of training; most however, used UCBHCA training materials. While some training courses lasted only a week, others ran for much longer. Support from the DMO included: drug supplies; vaccines;

bicycles to be used during immunization in outreach areas; plus other equipment and supplies. Immunization (UNEPI) vehicles were provided to the Kasanga and Kitovu programmes.

9.1.3. Community Participation and Involvement in Planning and Implementation.

In the Kasanga programme, community members reportedly were involved in their needs assessment which was conducted with assistance from expatriate staff. According to key informants, community members were also involved in all stages of planning, implementation, monitoring and evaluation. In addition, they also selected and actively supported their CHWs and TBAs, as well as their project leaders. Community contributions include, constructing structures like health units, water sources, or setting up income-generating activities. Other contributions at individual level included cash donations, materials, food, or direct physical labour.

In Kitovu, community members took part in specific activities like construction of latrines, maintenance of water sources, and other forms of manual labour. According to the two focus groups however, community members were not initially involved in needs assessment, or at the selection of CHWs. Community involvement was clearly not easy to achieve among the largely urban population.

In M: Moving Mountains, the community was reportedly involved in all stages,- at the introduction of the programme, during needs assessment/prioritization and in subsequent phases, with their leaders, taking part in a baseline survey as well. They selected their own leaders, and others to be trained as CHWs, TBAs, or development workers. Such people were selected for their exemplary behaviour or trust by the local community. Decision-making was reportedly a collective effort, usually followed by collective action, involving RCs, chiefs, trainers, CHWs/ TBAs, development workers and general community.

According to PACODET key informants, community members were involved in the planning process right from needs assessment, implementation, monitoring, evaluation, etc. Resources were mobilized by allocating equal quotas agreed upon by everybody or family unit, for membership fees, fee-for-service in health units, or for specific activities. Committees managed or controlled the resources under a strict system of accountability. Community participation was reportedly based on equality, with emphasis on promoting cooperation for community development,including spiritual and material development.

In the Kuluva programme, the community was reportedly involved through their local leaders - both formal and informal, in identifying problems, setting priorities, and planning for action, etc. They also selected project leaders and people to be trained as

CHWs, as well as identifying TBAs who were already known for their role in the area, or according to clans. Resources were mobilized for specific tasks once agreed upon through concensus, within groups or in the whole community. Elders and clan leaders in particular played a key role in mobilizing, or rallying support towards specific project contributions, in cash, materials, or through voluntary labour.

Levels of participation

Generally in all programmes then, community involvement and participation in planning and implementation ranged from active mobilization to real community collaboration in needs assessment, monitoring and evaluation of programmes, and control of resources, for example: contributed time; materials; cash; labour; income generation and other communal activities. Levels of participation according to Were's scale (see Analytical Framework), would seem to have ranged variously between level II (community collaboration), through level III (community involvement in local needs assessment and decision making); to level IV (community empowerment).

In Kasanga, the community seemed to have reached a high level of involvement in decision making and they reportedly took part in needs assessment. In addition, community members had acquired or developed some skills in choosing paths of action and doing a number of things for themselves in order to generate income, eg. grinding mills, oil pressing, hawking, etc. However, they had not reached a full capacity, being hindered by a number of factors, some of which were beyond their own means, such as roads, communications and basic infrastructures.

In Kitovu, although community members reportedly were involved in various ways by taking part in specific activities, there were equally reports of their not having been involved initially in their needs assessment, according to focus groups. In addition, it was found out that the level of participation was low among the largely urban population. It was difficult to get them to mobilize more of their own resources: perhaps a seemingly condescending or possibly paternalistic approach was detectable. Thus community involvement hovered around level II.

In Mission: Moving Mountains, community involvement was reportedly high with for example development workers, CHWs, project leaders noting that most funding activities were undertaken by community members, with M:Moving Mountains mainly playing a facilitating role, by providing back-up training and technical resources. Focus groups also noted the high level of involvement, though there were some constraints and setbacks, mainly insecurity and poverty. Community awareness and motivation was however high, and more resources are required in order to empower the communities further. Some of the communities reached level III, while newer ones were still at level II.

The PACODET communities became aware early enough to assume control of their own development process. This was partly due to historical factors - the fact of their common suffering and timely collective response to that need. As already noted, effective and dedicated local leadership, plus the enthusiastic community response fortuitously worked in their favour, motivating them to take on the responsibility for their own development. Awareness had been raised to high levels, and people began to answer their own questions, and to seek local solutions. New ideas began to be sought; local solutions were never lacking: thus, leaders and the whole community were willing to learn and negotiate new areas. The challenge clearly remained of being able to maintain their high level of achievement - between levels III and IV, among the several communities/projects now cropping up or being replicated. That requires creating increased capacity to cope with the demands.

In Kuluva, the level of community participation was generally low, considering the rather low tempo of mobilization, the low coverage (thinly spread), and general support given to the PHC workers. Also according to focus groups and key informants, there were additional problems of general poverty, food scarcity or famine complicating the issue. Community members often expected programme funders to give free things or expected material support in order to induce participation. However, in the Anyiribu project, there were indications of increased community collaboration (level II), and prospects for more involvement in local needs assessment and decision making (level III), particularly with the cooperation of elders (clan leaders).

9.1.4. Self-Reliance, Self-Determination and Replicability Efforts.

Self-reliance and determination efforts are in a way a reflection of the level of community involvement or participation in programme activities. Initiatives for self-reliance include introduction of cost-sharing or cost-recovery schemes through payment of fees for sevices at health units; income-generating activities at project level, ranging from hawking, handicrafts, communal farming, to animal husbandry, cooperative ventures and saving schemes or revolving funds. Community members contribute as individuals or collectively, running drug funds, or by contributing materials for construction of units, water sources and physical labour through voluntary efforts.

Sustainability efforts through self-determination are of a varied nature in the five programmes. Evidently, the PACODET programme had shown the most promise of success in that, whereas no substantial outside support had been injected into it, community members had been highly sensitized to the control and sustainability of their projects through enlightened and exemplary leadership. In the other programmes like M: Moving Mountains, Kitovu and Kuluva where there was a scaling down of external funding, sustainability efforts became most crucial and vulnerable. In the M: Moving Mountains programme, community members seemed better prepared to

sustain, while in Kitovu and Kuluva programmes, fears were expressed as to what would happen following cessation of outside funds. In Kasanga, where the communities met most of their financial obligations while the funding agency assisted in activities like training, and setting up of income-generating activities, there were seemingly better prospects for sustainability.

9.1.5. Integration of National and International Objectives.

The Kasanga programme was set amongst other things, `to serve the poor and reach the unreached'; thus complementing government/ national efforts to involve community members in their own heath care activities. In Kitovu, objectives of the programme, according to the funding agency (SCIAF) were: `to promote general health and prevent disease and promote self-reliance, in keeping with long term goals of PHC in the country'. This too is a major complementary role to government/national efforts towards health care delivery. Objectives of the Mission: Moving Mountains as an international NGO were, for the promotion of community development mainly through CBHC evangelism (`holistic' approach), to improve health and raise standards of living. These are clearly noble and lofty ideals which in no small way contribute to supplementing and integrating PHC efforts, especially where national resources are so thinly spread. Programme's strategy to integrate health and general development is especially timely and most crucial for PHC, especially for developing rural (or `poor') areas.

Of the five programmes, the PACODET programme objectives were purely local, and thus a truly `indigenous' one coming from the community, in their own efforts to complement government services. As such, they were in tune with the integration of PHC policy, particularly in regard to community involvement and empowerment, and long-term sustainability prospects. However, the programme needs to forge a yet closer collaboration with the district health services in order to operate within the required MOH standards and objectives, and also to fully benefit from its supervisory and reporting/information system, and other forms of technical support.

In the Kuluva programme, at least four international agencies were involved, each possibly with its own agenda for PHC and aid policy. It depicted the most diverse outlook in terms of the `partnership' dimension involving government, NGOs and community in development. Integration of these objectives could pose a real challenge to the responsible Ministry (MOH), and policy-makers or implementers in terms of articulating local and 'external' priorities, and in re-structuring long-term policy measures for sustainability of local projects. Equally, such multi-level collaboration efforts could have either positive or negative effects on the local community's long-term capacity to handle its self-reliance and sustainability efforts, depending on how the process is implemented or handled.

9.1.6. Linkage of Projects with Community Development.

The community development process as an important aspect of health development was clearly emphasized and was a main thrust of the M: Moving Mountains programme and all its CBHC activities were integrated or linked with PHC. Training of development/health workers was a strong aspect of the programme. Development activities included food production and nutrition, water and sanitation, roads, and income-generating activities. The Kasanga and Kuluva programmes on the other hand, emphasized community development efforts through the repair of roads, building schools and health units, protecting water sources, or co-operative activities. PACODET had a very strongly integrated developmental approach, and with more time, the programme would likely gear even more efforts into community development, by involving the youth, women, men and elders. In Kitovu, community development activities reportedly included income-generating activities like tailoring, construction of improved (fuel-saving) stoves, drama and musical activities to raise funds. Linkage with government and other development programmes were reported eg., with SWIP, and other NGOs. However, there would be need to let the community assume a bigger role in deciding their own priorities.

Community development (CD): a vital process for PHC

Since community development is an important process in PHC, it is imperative for programmes to integrate it in all activities that are designed to strengthen community participation. Governmental and non-governmental agencies should join hands with communities as partners in development, through multisectoral collaboration involving health, education; housing; water and sanitation; agriculture; roads and communications, etc., together with develoment groups for improvement of health, social welfare and raising general standards of living in the in the community.

As a method as well as process, community development should be promoted and learnt by all those persons involved in various aspects of development work. Community development is the connerstone around which the main pillars of all PHC development efforts - **political commitment, appropriate local technology, multi-sectoral collaboration, and community participation** - should be built up, provided or harnessed.

9.1.7. Cost the Community can Afford.

Payments for services, material or cash contributions by community members to project activities in Kasanga, Mission: Moving Mountains and PACODET were made upon agreed terms, or on the basis of local affordability, by the individual, family (household), or as a community group. Communities in the Kitovu and Kuluva programmes had difficulty contributing, either because they were rather not well mobilized (motivated) to do so, and expected sponsors to continue with supporting them, or because they were genuinely unable to afford.

Affordability seemingly remains a relative term, and is best defined by the community concerned, and on its own terms.

9.1.8. Number of Primary Health Care Elements/Components being Implemented.

In Kasanga, all eight elements in the Alma Ata Declaration, plus dental/oral, mental and rehabilitative health were reportedly undertaken. Health education activieties were usually taken up during all immunization, MCH/FP, nutrition, or water and sanitation activities. Control of endemic diseases and treatment of common ones were undertaken either as special tasks or, as the individual case necessitated.

The Kitovu programme started as curative service from the hospital before going out to the community to promote PHC activities, with all components incorporated: health education; MCH/FP; food and nutrition(including a nutrition rehabilitative unit at the hospital); water and sanitation (undertaken with SWIP, Redd Barna and World Vision collaboration); control of endemic diseases; and essential drugs. Dental/oral, mental and rehabilitative services were being developed through a referral system involving collaboration with other hospitals and other health units.

The M:Moving Mountains programme placed much emphasis on preventive services and in particular, total physical, material and spiritual development through community development and evangelism. In order to undertake health education, water and sanitation, immunization, nutrition, and maternal and child health activities, CHWs, TBAs and development workers were trained in communication skills in to appropriately deliver preventive and promotive messages. These were based on 13 points of a `good' home. There was no attempt, however, to undertake a whole PHC 'package', involving all eight or 11 components. CHWs or TBAs (many of them combined both tasks), did not handle essential drugs, but made appropriate referrals, including for dental, mental or rehabilitation services.

In the PACODET programme, all eight components of PHC were undertaken and carried out by the CHWs and TBAs - chosen and supported by the community, except for dental/oral, mental and rehabilitative sevices where referrals were made to Pallisa Hospital, or beyond.

In the Kuluva programme, while curative services remained available in the hospital, PHC activities were purely promotive, preventive, plus developmental. CHWs and TBAs were not allowed to handle drugs, at least initially. However, given the resources available mainly from outside, all aspects of PHC strategy were being undertaken, though apparently thinly spread over too large an area.

9.2. PERCEIVED DETERMINANTS

9.2.1. Success promoting features of projects

According to the views of key informants, CHWs, TBAs, and focus discussion groups, the following factors contributed to the success of projects:

a) Effective mobilization and creating awareness

This aspect involves the use of good, non-coercive methods, and taking a long time of patience for creating awareness and arousing interest in community members. This might involve people of diverse positions and backgrounds - eg. RCs, chiefs, clan leaders/elders, religious leaders, extension workers, teachers, project leaders, DHT members, CHWs/TBAs; as well as special groups of the youth, women, men's farming groups, etc. Creating awareness itself is a long process which varies from project to project, or community to community.

However, according to project leaders, it must be done for as long as possible, or until at least some community members show readiness to proceed; who would then become the exemplars to set up initial activities with. A minimum period of at least six months was recommendeded for mobilization/creating awareness, and for achieving better results.

b) Effective and dedicated local leadership

Though not mentioned directly at every programme location, good leadership was seen to be, or was at least implied in the statements of all groups, as most necessary. In particular, groups from Mission: Moving Mountains and PACODET programmes, felt that leadership was vital for project success. In PACODET programme especially, group members said that a number of people from within their community came up, and provided the right leadership at the right time, with the right commitment to develop the area. Charismatic leadership was a special feature of PACODET, coupled with commitment to build local capacity to manage their own affairs, plus an experienced back-up from its former Patron.

c) Availability of funds, supplies and equipment, plus logistics

Groups from the Kitovu and Kuluva programmes in particular, mentioned financial support or donations from outside agencies as factors contributing to success of their programmes. However, though others did not mention so specifically, active support in all forms - materials, equipment, logistics, etc., whether from DMO's office, the local authorities or NGOs, was a major contributing factor to success.

According the to Kasanga key informants, availability of funds/resources, supplies and equipment, either from government or non-governmental sources, ensures continuity and keeps morale of the workers and community members at high level. Transportation and other logistical support from DMO or other district sources were cited as important inputs adding to facilitation of activities.

d) Cooperation, coordination and support for activities within the districts

Some groups had experienced improving or increasing cooperation from health or non-health staff in the districts, and called for more interdepartmental/sectoral coordination of activities to promote PHC within the district. Support from the DMO's office in particular, local administration staff, RCs, chiefs etc., were also specifically mentioned. In Arua, regional and district-based administrative or technical health staff were, in particular, commended for their very supportive attitude and practice towards CBHC/PHC activities and implementation. This same sentiment was equally echoed in Mbale where reportedly, there was increasing cooperation and coordination of activities through a strong DCBHCA, plus some needed technical support and collaboration.

e) Community involvement in resource mobilization and control for self-reliance:

This refers in particular to local resources, and more specifically to those activities which call for community involvement in decision making, needs assesment, planning, monitoring and evaluation. According to several groups, such community involvement in the identification, allocation, use and control of resources from the community's own resources as agreed upon by them, is very crucial to achieving self-reliance and long-term sustainability. Above all, accountability and transparency of leaders in control of community resources is a crucial factor in establishing trust and confidence of community members.

f) Recognition of CHWs, TBAs and other PHC workers

It is most important that this group of workers is recognized and supported by not only community members who usually select them, but also by the DHT, health staff, district authorities, and other sectors. Such recognition is manifested in concrete and practical terms, through support, incentives, supply of kits, materials,etc., which increase self-esteem and commitment. In addition, some kind gestures, gifts, appreciation, commendation or praise can do a lot to raise their morale. Regular support and supervision, coupled with good and consistent follow-up systems for them, as well as arranging regular visits for these workers to other projects, or being visited by outsiders were mentioned as contributing to success of a project.

g) Reorienting and training of health/non-health staff for PHC

Government and non-govermental health staff, especially those working in heath units should be oriented to, or specially trained for PHC. Apart from key informants, DHT members were among those who strongly supported the idea of training for PHC, especially for themselves. In Masaka they requested for training in management strategies for PHC, while in Mbale, the DMO considered himself already an expert in the area of PHC, which factor he claimed enabled him to further facilitate training activities for CHWs/TBAs in the district. The regular training of CHWs, TBAs, and health committees were equally mentioned by several of the key informants as important factors affecting success. TOTs in particular, were also mentioned by Mbale key informants (project leaders and DHT), as very important aspects to build a cadre and capacity for CBHC/PHC in the district. Non-health or other sector staff, especially those carrying out extension services were equally mentioned for training in PHC.

h) Security

Security was mentioned in particular in Kasese, Mbale and Pallisa districts where some instances of insecurity had occured. Political insurgency and cattle raids resulted into severe disruptions, especially in Mbale and Pallisa districts, leading in some cases to displacement of people and cessation of health services. It was indeed partly out of such an experience that PACODET members decided to rally together and initiate preventive and curative health care activities in the community. In Mbale, Karimojong warriors (cattle raiders) equally wreaked havoc on the people in the north of the district with similar consequences. All groups appreciated the need to keep security as a prerequisite to enhancing development efforts.

i) Political commitment, organizational structures and mobilization

A major pillar of PHC is known to be political will or commitment; at least it was one of the requirements stated during the Alma Ata conference. Governments were required to commit themselves politically, as well as with resources to promote PHC as a strategy to achieve `Health for All' by the year 2000. Whereas at the national government level such commitment has repeatedly been affirmed at many fora or platforms, it has hitherto not been matched with equal action in terms of committing resources, which action would underscore the importance attached to the political will. However, recent developments to effect the decentralization of services to the district level, are in the right direction towards fulfilling that political will. At the local level of organization, the administrative structures through the RC system were singled out to be a strong factor in facilitating development, and many PHC workers, or health committee members were themselves RC members.

Apart from the RCs, other community- based structures like health and/or development committees, cooperative/credit societies, self-help or income-generating groups, clans and associations, etc., were among those mentioned as most effective for furthering project successes through concerted community participation.

j) Good communications and transport network: good roads and infrastructure help facilitate movement or access to rural communities, health units, schools, and markets. They also help in quick transmission of information or knowledge.

k) Perceivable or visible outcomes: `good results speak for themselves'; eg. the protection of a water source, or provision of water to a community which lacked it before is a powerful stimulant to participation.

l) Establishment of income-generating/self-reliance projects: ensures confidence in the people and enables them to gain control of/be empowered over their own programmes thus enhancing/leading to sustainability.

m) Other factors mentioned for success included exhortations: like,`keep the project small, to a manageable size'; a project should be feasible or viable, ie. not too large to manage. There should be good record keeping, and effective referral and follow-up systems for CHWs, TBAs and other development workers.

9.2.2. Major constraints or factors leading to failure of projects.

The factors that led to failure of projects, according to key informants or focus groups were almost the exact opposites of those that led to, or ensured success.

a) Lack of funds, supplies or equipment: and no budgetary allocations, of inadequate resources for PHC, especially in the districts. All these showed lack of commitment according to several key informants.

b) Inadequate training, and lack of staff to promote and manage the delivery of PHC services: both nationally and particularly in the districts.

c) Low levels of awareness, knowledge and illiteracy among the majority of the populations for whom the services are meant: it was reportedly difficult to introduce new ideas among such populations.

d) Poor management and mobilization, or lack of motivation to do such work which is almost voluntary: it is a slow process soliciting/arousing compliance or cooperation from the community.

e) Frequent disease epidemics - not enough capacity to cope: in terms of personnel, logistics, vaccines,etc.

f) Unrealistic expectations from some community members or beneficiaries: eg. they expected tangible things to be given or donations (Kitovu, Kuluva).

g) Lack of markets/outlets to sell produce: eg. cash crops ; the Rural Farmer's Scheme had failed or frustrated the farmers, who instead were issued promissory notes or chits which were not honoured (Arua).

h) General poverty among the people: often made worse by factors like famine or little food production due to weather failure, etc. (Arua).

i) Poor communications and infrastructures: poor roads or lack of transport (Kasese, Pallisa, Arua).

j) Lack of cooperation/coordination between government departments and NGOs.

k) Cultural practices which hindered development or those which led to risky behaviour: eg., too much drinking or wastage of resources during ceremonies - marriages/weddings, circumcisions, etc. Sexual misbehaviour common during such occasions, and over-drinking of alcohol often led to violence or accusations of witchcraft, and other superstitions (key informants, Mbale).

l) Gender inequity: discrimination based on gender; eg. cultural practices which lead to inequity in education of boys versus girls; or excluding women from taking part in developmental activities by their spouses, or in general practice enhanced by negative tradition (Mbale).

m) Lack of basic necessities: eg. water during dry season (Arua).

n) Insecurity was mentioned in Kaşanga, Mbale and Pallisa as a major hindrance to all forms of development efforts.

9.2.3. Matrix 3. Summary of Critical Factors Influencing Community Participation in the Five CHBC/PHC Programmes as reflected in the Findings.

A. Within the Community

1a. Presence of functioning structures for community action eg. RCs, CHWs, VHCs, IGAs, cooperatives, etc.	1b. Absence of/poorly functioning structures.
2a. Positive socio-cultural attitudes or norms towards community participation in development activities.	2b. Negative attitudes or socio-cultural norms towards community participation in development.
3a. Availability of/willingness to avail resources to sustain community participation.	3b. Absence of resources to sustain community participation.
4a. Community had experience of significant successful community participation in the past.	4b. Community has not experienced significant success in community participation efforts.
5a. Presence of motivated leaders and local change agents; capable of fostering the participation of most disadvantaged sections of the community in development activities.	5b. Absence of motivated leaders capable of fostering the participation of the most disadvantaged sections of the community in development activities.
6a. Existence of adequate capability to manage overall community participation efforts.	6b. Lack of capability to manage community participation efforts.
7b. Positive demonstration of effects of successful community participation efforts within communities.	7b. No positive demonstration of successful community participation efforts within communities.

B. Outside the Community

8a. Availability of resources to support community participation efforts - from MOH, District Administration, NGOs,etc.	8b. Lack of resources to support community participation efforts.
9a. Local Government supportive of community participation in development activities.	9b. Local Government not supportive of community participation in development activities.
10a. Elite groups in the area (eg. district, county/subcounty,etc.) support community participation.	10b. Elite groups are hostile to community particpation efforts.
11a. Promotion of authentic community initiative and efforts in achieving full community involvement: eg. by NGOs, or government agencies.	11b. Absence of authentic community initiative and efforts in achieving community involvement by programmes or govt. agencies.
12a. Existence of change agents who/ which effectively strengthen community participation in development efforts.	12b. Absence of change agents who/ which can effectively strengthen participation in development efforts.
13a. Prevailing national ideology/ (objectives) and policies which are supportive of community participation in development efforts.	13b. Non-supportive policies of community participation in development activities.
14a. Presence of peace or security.	14b. Absence of peace or insecurity.
15a. Good infrastructure - roads, transport, access to services,etc.	15b. Bad infrastructure - poor roads transport, access to services,etc.

[Adapted with modifications after: Diaz, R., Advisor, UNICEF (ESARO), 1986].

9.3. INFORMATION CONCERNING THE CHWs AND TBAs INTERVIEWED.

9.3.1. Number, age, education, training and service of CHWs and TBAs.

Total: CHWs 28, TBAs 6. = (34). (Male 23, Female 1).

Most CHWs were male, and all TBAs female; they all worked part-time, spent between 2-4 days a week and between 2-10 hours a day. Occupations ranged from peasant farmer/agricultural worker to paid skilled jobs like technician, teacher, copy typist, religious leader/evangelist, nursing aide, health assistant,etc.

Training periods were varied, between one month to six months. CHWs had more formal education than TBAs, ranging from primary five to senior four level, and most had worked for between one year and up to more than three years. Age of CHws was from lowest range of 20 years to highest of 50; while TBAs were from lowest of 28 to highest of 64 years.

9.3.2. Training Methods, Topics and Trainers

Methods: the most commonly used training methods include lectures; group activities/tasks; role playing; demonstrations/field observations/practicals; drama and music; story telling; home visiting, etc. Most of the training was carried out invariably within a local community location.

Topics: those covered included generally: health education; MCH/FP services; immunization; food and nutrition; common diseases and their management; essential drugs; diarrhoea and management of dehydration;personal and environmental hygiene and disease prevention; AIDS education; safe water supply, storage and treatment,eg. 3 pot system; community mobilization; self-reliance and income-generation; plus, monitoring and evaluation.
For TBAs specifically, the topics covered include: fertilization; the pregnant woman; detection of anaemia; pelvic assessment; detection of foetal heart; labour - normal and abnormal, excessive bleeding, complications,etc.

Most programmes use the UCBHCA curriculum, and in addition use PHC manuals/materials which are either available on the market, or are approved publications.

Trainers: mostly drawn from amongst programme staff - project leaders; DHT members; UCBHCA facilitators; other health care staff, eg. Medical Assistants, Nurses/Midwives, etc. Trainers who are also project leaders supervise a number of CHWs or TBAs who work in their project areas, which may be a sub-county or several parishes.

9.3.3. Selection of CHWs/TBAs; size and definition of communities covered

Method and criteria for selection: the most common method of selection is by the community as a whole, followed by health committee, and only rarely by RCs, clan leaders or, programme directly. Selection is commonly based on having good character or exemplary behaviour, and being humble and

honest; being a resident of the area; respecting community views, or one who promotes harmony for development; preferably with some formal educational background at P7 and above.

Communities covered by CHWs/TBAs: varied widely; figures given were between 50 - 100 households, or between 300 - 2000 people per CHW/TBA.

Definitions of `community' by Project Leaders/Managers.

> *"A group of people who work together to achieve a common goal; or living together with same interests and share common services or problems, or who have the same problems and successes".*(Kasanga).
>
> *"A group of people living together in the same geographical area or environment, who share common problems, culture, beliefs,services or language". A community may consist of 50 - 300 homes/households, or up to 3000 people.* (M: Moving Mountains).
>
> *"A group of people in a given area, living together under similar conditions, with similar interests or problems, under the influence of the same natural factors, and working for a common goal". It may constitute one or several divisions of betwen 1000 to 4000 people.*(PACODET).
>
> *"A group of people who share the same interests, cultures, ideas, problems; who know which area belongs to which group, or are in one area for a purpose, work or plan and decide together for the common good". May constitute a county, sub-county, parish or sub-parish, with a defined demonstration unit.* (Kuluva).

From the above definitions, there is a common basis for establishing more spefic groups for pursuing activities to promote their needs, taking decisions and establishing mechanisms to meet the needs. In the context of PHC as put in Rifkin's definition, the process for doing so should enable those groups to undertake activities to improve their health and health care by exercising effective decisions, and to avail resources in order to achieve equity and enhance acessibility to services, especially of under-served populations.

CHAPTER 10

10.0. CONCLUSION, LESSONS LEARNED AND RECOMMENDATIONS

10.1. SUMMARY & CONCLUSION

♦ Four of the programmes were initiated with external support which came through church/ religious affiliation, or non-governmantal sources. The projects were begun primarily to support or complement already existing services, for example, curative ones, with the aim of promoting PHC/CBHC activities alongside them. They all had needs assessment done with external collaboration, and after some time, had external evaluations carried out. The PACODET programme was initiated entirely by the local people, who carried out their own needs assessment, based on their own experiences of ill-health and disease, both during and after periods of insurgency.

♦ Most of the programmes had been in existence for periods of between two to ten years, and were all engaged in preventive, promotive and curative health care. Most programmes also maintained close links with DMOs' offices, and obtained logistical/supervisory support from DHT members. The four programmes which had church-related backgrounds were typically either hospital-based and urban (Kitovu); or were from a hospital base but essentially rural (Kasanga, Kuluva); or had health service delivery tied to/closely associated with community development (Mission Moving Mountains). The fifth programme (PACODET) began with active community participation to improve their own health care and other forms of community development activities.

♦ No information was readily available on the extent of external funding, and there was apparently little or no direct control from MOH or district authorities. In a few cases, the financial support was being scaled down in order to increase community contributions. Few or no details on central or local government support were available for PHC activities, though in some districts, money was reportedly allocated. On the whole, articulation of PHC/CBHC activities was generally lacking from both policy makers and service providers, mainly due to the absence of a strong mechanism to coordinate these efforts.

♦ Community participation and involvement in planning and implementation ranged from active mobilization to community collaboration in needs assessment, monitoring and evaluation, and control of resources to varying degrees. It occurred mostly in form of contributed time, materials, cash or labour. Income-generation was also common, apart from other community development activities. Community participation was fairly strong in three of the programmes, and associated aspects of successful community control were fiscal integrity, managerial transparency, and organizational responsibility based on commitment rather than status or popularity. Factors that led to success of programmes

included: good level of mobilization; regular training and seminars for CHWs and TBAs; availability of funds, supplies and equipment; good/committed leadership; teamwork; transport and logistical support; technical support/collaboration; community incentives and support; accountability; transparency; political commitment and support; security; sustained/continuing education and creating awareness; and finally, a high level of community resource mobilization, management, control and responsibility over resources.

♦ The best scope for sustainability of programmes was clearly manifested in those communities where the people had been actively involved in the initiation of programmes, and where as a result, PHC/CBHC ideas and concepts were largely well internalized. In the community-initiated programme where there was strong involvement, the community had acquired significant local knowledge concerning their needs in health and development, and had developed local mechanisms to mobilize resources, which they themselves fully controlled.

♦ Future directions to self-reliance and sustainability of projects clearly depend a lot on the level of community involvement; internal capacities; and extent of government or outside sources of funding support. But community involvement or participation being not cheap or easy to achieve, requires considerable personnel time, a relatively long time frame and substantial training and supervision costs. Thus continuing to give support services will be necessary to sustain that participation.

♦ There is clear need to set up policy guidelines and directions for PHC that take account of people's active involvement, through the empowerment of community members to take control of their health and development activities. In particular, there is need to identify and recognise the major actors as equal partners in development, and set out clear terms for such collaboration at national, district and lower levels.

♦ In terms of policy implications, there is need to restate or translate the political will and commitment rhetoric to PHC into reality, at the national, regional or district levels. Real translation involves committing both financial and human resources, through actual allocation, availability, training and deployment.

♦ There is need to forge a meaningful partnership between government, the community, and external donors or providers, with most management skills being devolved to local communities towards local control, responsibility, and accountability.

♦ At both the central and district/local government levels, basic infrastructure, marketing and communication means be developed, with community involvement and support, to ease accessibility to services, as well as to promote local development.

♦ Finally, there is need to promote interdepartmental/multi-sectoral collaboration between all actors - local, national, international - in a kind of **partnership**, in order to achieve the integration of PHC objectives, with room for flexibility in the system, and allowing for the achievement of real local community aspirations in taking responsibility and control of their own development.

10.2. LESSONS LEARNED AND FUTURE CHALLENGES

o Lessons learned from the foregoing accounts of experiences of PHC/CBHC in some parts of the world, as well as in Uganda (as portrayed in the case studies) suggest that, despite most of them now yet being at an `experimental level', PHC **is a feasible strategy**, which requires time - a long period of time requiring much patience - in order to produce tangible and sustainable results.

o PHC issues include **wider issues than just health**, and these `wider issues' include such matters as the production and resources to obtain sufficient food; education of the population in order to increase that productivity; security and political stability; a sense of responsibility and involvement; a functioning community organization; self-reliance and sufficiency; minimal (limited) reliance on outside resources; and recognising the dignity of each community. In effect, measures of the success of PHC should not simply stop at looking for indices like falling infant or maternal mortality, disease prevalence, or increased rates of immunization. The PHC approach is thus one of `total health', that is, one in which promotional, preventive, curative actions and rehabilitative services are not separated, but become more **integrated**.

o PHC activities take place and are carried out within a **political context** and with a political content (environment) included. In that sense, PHC cannot be viewed in isolation from the broader socio-economic and political developments of the particular country, and different countries have different contexts, or systems which affect that development. It is thus the duty and onus of the political authorities to provide the necessary atmosphere to enhance this development, through the provision of resources and the right environment for increased production.

o In terms of health care delivery, there is an important issue of **social equity**, that is, health needs must be addressed in such a way as to eliminate unequal access to health care, by bringing about **social justice** to all. Furthermore, PHC in that context combines elements of both basic health services and the broader concerns of community development, including socio-economic development and marketing strategies. For example, through the use of simple health techniques and the provision of food, education, and assistance in improving productivity, it is possible to improve health of communities dramatically, as shown in some of the country experiences from around the world, and this

is also possible in Uganda given time, and an enabling political as well as economic environment, as some of the case studies have clearly indicated through their own efforts, and unique experiences.

o The **processes and scope of PHC activities** include the formation, reinforcing and recognition of **local community organization structures** which will lay down priorities, and organize community action to solve community problems, and appointing or making legitimate the role of the PHC worker, namely - **community health worker** (CHW). The CHW becomes an important person on the new PHC delivery team, along with the **traditional birth attendant** (TBA), and even the local traditional healer or herbalist, all of whom should constitute part of the referral network, which system requires the recognition of these cadres as quite important for the success of PHC by all the other `modern' health care personnel.

o Through the same processes and mechanisms, other activities for **financing the services** should be worked out (may include re-visiting the Bamako Initiative, etc). This financing however, has to be decided by the country according to the viability and capacity at the local (national), as well as the international levels; in terms of available resources, and arranged with the agreement of the local community in a tripartite **partnership of government - donor/benefactor (external or local) - community**. This kind of partnership should provide for **resource mobilization and control, training and management strategies** which will bring the best results to the greatest number of the people.

o There is need for **equitable re-allocation of resources** between all segments of the population, and the introduction of self-reliance and self-sufficiency programmes to all segments of the population, with steps taken in accordance with national, as well as the international resources available to supplement both government and local efforts. Furthemore, in order to enable local communities to assume even more responsibilty and control of their resources for development, the central government authority structure - both political and economic - should be **devolved** to local authority through the **decentralization of services**, to allow for, or to empower local communities at district and lower levels to manage PHC and other development activities by themselves. Decentralization ensures faster decision-making by removing obstacles created by the usually long procedures for policy-making and implementation at the national level. However, there is need for **coordination** at the central level to ensure that the resources are not only appropriately utilised, but also that all segments of the population do ultimately benefit.

o In order to ensure the proper internalization and adopt appropriate practice of PHC as a new strategy for health care and community development, there is need to **redesign and re-orientate the education of health/medical and all development workers**, in order to properly integrate it into the overall political and economic development scheme of the country. This calls for redesigning of the curricula for such professional groups - doctors,

nurses, allied health personnel - as well as others like teachers, agricultural extension, social and community development workers, etc.

o Integration calls for **collaboration across and between various sectors** - of both government and non-governmental departments or agencies. These intersectoral activities should be coordinated down to the lowest community level, through the various government/administrative layers and the evolving local structures for development, including the resistance council structure.

o **Sustainability** is a most crucial aspect which deserves all due attention because of the need to ensure programme survival, and continued enhancement of community self-reliance. It calls for training of adequate personnel at various levels, continuing education, supervision, and good management. Furthermore, in order to ensure its continued existence, there is need to monitor and evaluate performance regularly, and to carry out appropriate operational/applied research for the most effective and efficient activities to ensure it. The issue of **health financing** has yet to be reconsidered, taking into account the capacities of the district authorities and local communities. It may be necessary to adopt a local version of the **Bamako Initiative** to address this issue, along selective lines to ensure equity, or to consider other alternatives to financing primary health care.

o Ultimately, all PHC strategies and the activities to promote them depend on total **community involvement** leading to full **participation**. Community participation is the connerstone of PHC, which involves amongst other things, the application of appropriate and affordable technology, and mobilization of local resources. It depends on several factors, amongst which from the community's perspective are the following: involvement in **needs identification, assessment and prioritization**; **participation in planning, implementation, monitoring and evaluation**; **provision of good and honest leadership**; local **community organization and structures** for local support; community **resource mobilization**; sound and transparent **management system**, etc; all these being composite parts of the **participatory processes** necessary for development, including participatory applied research. At the national, district and local authority levels, community participation depends on **political will**; **security**; ensuring an adequate and **equitable allocation and distribution of resources**; **transferring the necessary political and economic mechanisms** to **empower** the communities to **decide on and control** the best possible health care system for themselves and their other development activities; and the freedom to select the most **accessible and/or affordable or appropriate technologies** for delivery, as well as availing **local providers** of services from among themselves.

10.3. RECOMMENDATIONS

10.3.1. General Recommendations

1. There is an urgent need for a serious and determined **political and financial commitment** to the task of changing the quality of all the people, especially that of the rural population at the periphery, where the majority of the people live, but where resources are currently least allocated.

2. Health must be given the highest possible priority at all levels - national, regional, district, and at the local community. It should embrace the curative, promotive, preventive and rehabilitative aspects equally, and should include services which deal with broader aspects, or main problems which affect the social and physical environment, eg. improvement of water supply, sanitation, food and nutrition, housing, etc., in collaboration with other key sectors.

3. Decentralization of services should be accelerated to strengthen district health systems in order to integrate the health sector with all aspects of economic and social development to facilitate the people's involvement in the financing as well as management of their health care.

4. There is need for **concerted intersectoral action by the many sectors** to undertake joint activities to raise the level of health of the people, and the provision of basic necessities of life, such as food production, clothing, housing, and needs for education, literacy, provision of water supply, maternal and child health/family planning services, income-generation, etc. Women in particular, should be empowered to make decisions affecting their own health and that of the family, and to take more responsibility in community development matters.

5. A collaborative partnership between government, NGOs, aid agencies or donors and the local communities should be formed or forged, in order to take into account the needs of the communities, and avoid duplication or conficting interests. However, donors should not expect quick results from given agenda, but be prepared to wait and phase out as soon as the community shows indications that it is ready to take control of its programmes, but such phasing out should be carefully done so as not to disrupt the transition to full community control.

6. There should be **active involvement and participation** of the people in the provision of health services and management through mass campaigns. Such participation will make people contribute to the integration of health programmes and promote intersectoral collaboration at all levels for overall development

7. All aspects of development for health - from mass mobilization for prevention, development of health centres, the emergence of CHWs/TBAs, and the combined use of traditional and western medicine, plus other forms of health care agencies and networks, should take into account of, or constitute part of the **appropriate technology** which is scientifically sound, socially acceptable and affordable to the nation, districts and local communities.

8. Necessary legislation and policy guidelines for proper implementation and integration of PHC in overall health and development activities have to be made or issued from time to time by MOH in order to ensure coordinated planning, implementing, monitoring and evaluation strategies. Policy implications and specific guidelines may be drawn for particular aspects such as, community participation and empowerment; health financing/cost-sharing; intersectoral collaboration; decentralization/devolution of services; external aid/donor assistance coordination; financial and human resource availability; training and orientation of health staff; forging partnerships between government, communty and external providers; provision of infrastructures to enhance accessibility; strategies to promote self-reliance and sustainability; etc.

Similar policies or guidelines in areas other than health - agriculture/veterinary, adult literacy, commerce and industry, communications, culture and community development, education and sports, environment, finance, information, housing, labour and social affairs, transport, etc., should equally be formulated to promote PHC, in conjunction with the Ministry of Health.

9. There is need for further **operational or partipatory research studies** to support policy measures and guidelines on an ongoing basis, and to monitor and evaluate progress in the experiences of governmental or non-governmental programmes, nationally, regionally or at districts level. Essential National Health Research (ENHR) and similar health systems research institutions should be strengthened to support such policy research undertakings, and into cost-effective initiatives. Communities must be involved in all study phases - eg. baseline surveys, and all results of such surveys should be fed back to the community.

10.3.2. Specific Recommendations

1. Peripheral services, eg. health centres, dispensaries or aid posts should be strengthened with necessary inputs, drugs, supplies and equipment, and by the setting up of easy channels for referrals from the lowest levels, CHWs, TBAs, etc., to the highest possible level.

2. The cadres of CHWs, TBAs, and recognised traditional practitioners should be officially integrated into the health care delivery system, but the mechanisms for their recognition, selection, training, supervision and remuneration be left to the particular communities to decide and manage. However, CHWs should serve as community animators and not be attached to particular health units or clinics.

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FIELDWORK TEAMS

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1. Dr. Jessica M. Kafuko, Principal Investigator.
2. Mr. Josephat Mafigiri, Supervisor.
3. Ms. Immaculate Nakiyingi, Interviewer.
4. Ms. Connie Balayo, Interviewer.
5. Mrs. Gladys Rukidi, Interviewer.

NB. One team member did not turn up.

Team B (Mbale, Pallisa & Arua Districts)

1. Mr. John W. Arube-Wani, Principal Investigator.
2. Ms. Margaret Kebege, Supervisor.
3. Mrs. Joyce Asia, Interviewer.
4. Mr. Enoch Ezati, Interviewer.
5. Ms. Rose Kabasinguzi, Interviewer.
6. Mr. Kenneth Khana, Interviewer.
7. Mr. John Wakida, Interviewer.

APPENDIX 1

DECLARATION OF ALMA-ATA

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

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 care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

* * *

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

APPENDIX 2

PHC ORIENTED PROJECTS RAPID ASSESSMENT

Interview Schedule for Policy Makers-District Level
(DA, DES, Chairman RC 5, Chairman DHC, DCBHCA)

A. Background Information

1. Date ...../...../1992
Time started.....Time finished .....
2. Name of
Interviewer.....
3. Name of Person Interviewed.....
4. Location of
Interview.....
5. District
.....

B. [Note to Interviewer:
Introduce yourself and explain the purpose of the study. Take note of special instructions, e.g., probe. Use extra sheet if necessary and record verbatim what the person interviewed states]

1. Is there Government/MOH Primary Health Policy you are aware of? Yes/No .....

2. If Yes, do you have a copy? (Ask to see the copy) (Take details).....
.....
.....
.....
.....
.

3. What are the key elements of the government PHC policy as understood by you?
.....
.....
.....
.....

4. Are there any guidelines for implementing PHC activities in this district? Yes/No .....

5. If Yes, what are they? (ask to see document or plan) (Give details) .....

6. Is there a district PHC Unit? Yes/No/Don't know
.....
7. If Yes, where is it based ?

.....

8. Who are the members?
.....

Name	Agency Represented
.....	.....
.....	.....
.....	.....

9. Is there a district chapter of Uganda Community-Based Health Care Association? Yes/No/Don't know
.....

10. If Yes, where is it based?
.....
11. What Agencies are represented?
.....

12. Is there a workplan for PHC activities for

a) The District PHC Coordinating unit/office? Yes/No
.....
.....

b) The DCBHCA? Yes/No

.....

13. If Yes, request for copies of each. Copy availed.
a) District PHC office? Yes/No
.....

b) DCBHCA? Yes/No

.....
.....
14. Are there any mechanisms to monitor PHC activities in the district? Yes/No
.....
.....

15. If Yes, what are they?
.....
.....
16. What is the approximate or total budget allocation for
a) District PHC implementation"?
.....
.....
b) District CBHCA
.....

17. Where are the funds located from?
a) District PHC Unit/Office
.....
b) DCBHCA
.....
.....

18. What proportions of total district development plan allocation for:

a) The District PHC implementation unit
.....

b) DCBHCA
.....

19. What proportion of the budget allocation is contributed by the Uganda Government (MOH)?
.....

20. How many PHC projects are in the district?
.....
21. How many projects are registered with the DCBHCA?
.....
22. What is the registration/membership fee?
.....
23. How often does the District CBHCA meet?
a) monthly

b) quarterly
c) half-yearly
d) once a year
e) other (specify intervals)
.....

24. Has there been PHC evaluation in the District?
Yes/No/Don't know
.....
25. If Yes, when was it last done?
.....

26. Which organization(s) agency carried out the evaluation?

Name/Title	Agency/Location

.....
27. Was there any feedback from the evaluation team?
Yes/No/Don't know
.....
.....

28. If Yes, what recommendations were made?
.....

29. Are those recommendations being effected in the District?
Yes/No .....

30 If Yes, what aspects?
.....
31. If No, what has delayed their being effected?

32. What plans are there to use the results of the evaluation for PHC activities in the district?
.....
33. What in your opinion, are the features of "successful" PHC projects in the districts and elsewhere in Uganda?
.....

34. Can you name some of these "successful" projects?

Name	Location
.....	.....
.....	.....

35. What factors do you think contributed to their success?

.....
.....
36. What factors contributed to failure of projects?
.....
37. How can they be overcome?
.....

38. Finally, what additional comments and thoughts would you give about:

a) PHC in general
.....
b) Community participation
.....
c) Sustainability of projects
.....
d) Remuneration of VHWS
.....

e) Recommendations to persons or projects considering starting PHC activities

APPENDIX 3

PHC ORIENTED PROJECTS RAPID ASSESSMENT

Interview Schedule for DHT Members

A. Background Information
1. Date ...../...../1992
Time started.....Time finished.....
2. Name of Interviewer .....
3. Name of Responde.....
4. Title.....
5. District.....

B. [Note to Interviewer:
Introduce yourself and explain the purpose of the study. Take not of specific instructions were indicated, e.g., Probe widely. Use additional sheet if necessary to record verbatim what the person interviewed states]

6.What is the total population of the District? (quote the source of data)
.....
.....

7. What population is:

	number/ percent
a) under one year of age	
b) under five years of age	...../.....
c) under fifteen years of age	...../.....
d) women in the reproductive age (15-49 yrs)	...../.....

8. What is the size of the district? (get a copy of the map of the district)
.....
.

9. Do you have a copy of the Government/MOH PHC policy?
Yes/No
If Yes, get a copy)
.....
.....

10 What are the main or top five problems of the district that are related to health?

a).....
.....

11. What are the priorities in health for the district? (give a brief outline)
.....
12. Does the District Development Committee (DDC) have a district implementation plan? Yes/No (If Yes, get a copy)
.....
.....

13. What are the plans related to PHC?
.....
14. Who prepared the policy or guidelines (details)?
.....
15. What proportion of the total district budget allocation is for the Health Sector? (State in figures if easier to remember)
.....
16. What proportion of the health sector budget goes to PHC Implementation?
.....
17. What is the composition of the DHT?
.....
18. How often does the DHT meet?
a) Once a week
.....
.
b) Once a month
.....
.
c) Other (state how often)
.....
.

19. Is there a District Health Management Committee (DHMC)?
Yes/No .....

20. If Yes, what is its composition?
.....
21. When was it formed?.....

22. How often does it meet?
a) Once a week
b) Once a month
c) Other (state how often)

.....
.

23. What are its main objectives?
.....
.....
.....
.....

24. Is there a DCBHCA? Yes/NO
.....
.

25. If Yes, what is its composition?
.....
26. When was it formed?
.....
.

27. How often does it meet?
a) Once a month
b) Once in three months
c) other (state how often)

28. What are its major terms of reference?
.....
29. What are its objectives for the year (if different from terms of reference)?
.....

30. What kinds of relationships exist between the DHT, DCBHCA, DDC and the District Council (briefly describe nature, quality, quantity of areas of cooperation, overlap of roles, etc.)?
.....
31. How many PHC projects are in the district?
.....
32. Which ones are they?
.....

33. What kind of support does the DHT give to individual PHC projects in the area?
.....
.....
34. What role is played by DHT members in the training of PHC

workers in the district?
.....

35. What is their role in the supervision of PHC programmes or projects in the district? If so, give details

36. What form does this supervision take? (probe)
.....
37. How often is it done, and by who?
.....

38. How is the health sector in the district involved in the implementation of the eleven components of PHC (briefly described how)?
a) Health education
.....
.....
b) Immunization
.....
c) Maternal and Child Health/Family Planning (MCH/FP)
.....
d) Provision of food and proper nutrition
.....
e) Water supply and sanitation
.....
.....
f) Prevention and control of endemic diseases
.....
g) Treatment of minor illnesses and injuries
.....

h) Provision of essential drugs
.....
i) Mental health
.....
j) Dental/oral health
.....
k) Rehabilitation services
.....
39. How is the community being involved in PHC implementation?
.....
40. What are the main obstacles to PHC implementation in the district?
.....
41. How can they be overcome?

.....
.

42. What about the factors leading to success?
.....
43. Has there been any evaluation of PHC activities in the district? Yes/No

44. If Yes, when was it done .....

45. Which person or agency did it?
.....

46. What was the outcome?
.....
47. Is a report available? Yes/No

.....
(If Yes, get a copy)
.....

48. Were the results utilized or not? Yes/No
.....

49. If Yes, in what way(s)?
.....
50. Finally, what additional comments would you like to make about PHC programmes in the district or in the country in general?
.....
a) What thoughts about PHC in general?
.....
.....

b) Community involvement and participation
.....
c) Sustainability
.....

d) Starting/maintaining PHC programmes
.....
.....

e) What recommendations would you make to persons or projects considering such an activity?

.....

APPENDIX 4

PHC ORIENTED PROJECTS RAPID ASSESSMENT

Interview Schedule for Community/Village Health Workers

A. Background Information

1.Date ...../..../1992 Time started .....

Time Finished .....

2. Interviewer's Name .....

3. Project Name .....

4. Project Location (sub-county/county,etc) .....

District.....

5. Name of Person Interviewed .....

6. Location of Interview .....

B. [Note to interviewer:
Introduce yourself and explain the purpose of the study. Take note of special instructions, e.g., Probe. Use additional sheet if necessary to record verbatim what the person interviewed states]

1. Age ..... 2. Gender .....

3. Literacy/education
a) P1 - P4 [ ] S1 - S4 [ ]
b) P5 - P7 S5 and above [ ]

4. other occupation(s)
.....

5. Other community roles (e.g., RC, Clubs, etc.)
.....

6. Marital Status
a) single/unmarried/separated

b) married/
c) other (specify)
7. Age of own children (if any)
.....

8. How long have you worked for the project?
a) under one year (specify in months)
b) 1 - 2 years [ ]
c) 2+ - 5 years [ ]
d) over 5 years [ ]

9. How were you selected or by whom?
.....
.....

10. How long were you trained?
.....
a) 1-3 weeks (state phases, etc)
.....
.
b) 1 month (state phases, etc)
.....
.
c) Over 1 month - 3 months (state phases, etc.)
.....
.

11. Where were you trained?
.....
.
.....

12. By whom were you trained?
a) Name of trainer
.....
.
b) Title
.....
.
c) Organization
.....
.

13. What methods of training were used?
a) Lectures

b) Group activity
c) Role playing
d) Demonstrations
e) Other (specify)

14. What topics were covered?
a) .....

15. What are the objective of the project?
.....
.....
16. How big an area are you responsible for?
a) a village
.....
b) a parish
.....
.
c) sub-county
.....
17. How many households are there?
.....

18. What is the number of: (Estimates only)
a) Children under 1 year of age
.....
.
b) Children 5 years and under (including (a) above
.....
c) Children 15 years and under (including (a) and (b) above
.....
.....
d) Women between 15-49 years of age
.....
.....

19. What are the main PHC activities you carry out? (describe each) [Interviewer to note: Tick the elements mentioned but do not read out]

a) Health Education
.....

b) Immunization
.....

c) Maternal and Child Health/Family Planning (MCH/FP)
.....

d) Food and nutrition

.....

e) Water supply and sanitation
.....

f) Prevention and control of endemic diseases (types, etc.)
.....

g) Treatment of minor illnesses (Mention types)
.....

h) Provision of essential drugs
.....

i) Other (specify)
.....

20. What are the main health problems in your area?
.....
.....

21. What are the five most prevailing diseases in the area?
a) Affecting children?
.....

b) Affecting women?
.....
.....
c) Affecting men?
.....

d) Affecting old people
.....

22. What are the main causes of death in the area for
a) children?
.....

b) pregnant women
.....

c) all age groups
.....

23. Is there other village health committee in your area?
Yes [ ] No [ ] Do not know [ ]

24. If Yes, who are its members?
.....

25. How were they selected?
.....
26. For how long?
.....

27. How often does it meet?
a) weekly/twice weekly
.....
.

b) monthly/twice monthly
.....
.

c) every quarter
.....
.

d) every half year
.....
.

e) other (specify intervals)
.....

28. What is the role of the village health committee in PHC implementation?
.....

29. Who are your three most immediate supervisors?

Name	Cadre/Title
.....	.....

30. How often are you supervised?
a) weekly

b) monthly
c) quarterly
d) other (specify intervals)

31. Do you get any feedback from the supervisors? Yes/No

32. If Yes, how soon after the supervisory visit?

33. What form of feedback do you get?
a) personal discussion
.....
.
b) written report
.....
.
c) other (specify)
.....
.

34. Do you make any reports? Yes/No
(If Yes, ask for a copy)
.....
.

35. How often do you make them?
a) weekly
b) monthly
c) quarterly
d) other (specify intervals)
.....
.....

36. What is the nearest health unit to which you make most referrals?
.....
..

37. How far is it from your area?
a) 0-5 kms (return)
b) 5-10 kms (return)
c) over 10 kms (return)

38. What services are offered at that health facility?
.....
.....

39. What conditions are referred there?
.....
.....

40. What other assistance or support do you receive from that health facility?

41. Are you remunerated for your work as village health worker? Yes/No

42. If Yes, who is responsible?
a) Individual (State who)
.....
.
b) Cadre/Title
.....
.
c) Organization
.....
.
d) Community
.....
.

43. In what form are you remunerated?
a) Financial (cash)
b) Materially (state form)

.....
c) Other (specify)
.....

44. If No, do you work voluntarily? Yes/No
(probe)
.....

45. In your opinion, what means of remuneration would you prefer most?
.....
.....

46. What problems do you encounter while carrying out or activities?
.....

47. How do you try to overcome them?

.....

48. Do you have a workplan? Yes/No

49. If Yes, for what period of time? (ask for copy or details)
a) monthly
.....
.
b) quarterly
.....
.....
c) six months
.....
.
d) one year
.....
.
e) more than one year
.....
.

50. How do you hope to work in the next 12 months?
.....
.....

51. What would be the optimum catchment area per village health worker in terms of:
a) Population (number of people)
.....
b) Number of households to be reached?
.....
.....

52. How much time a week do you spend on village health worker duties?
a) In actual terms
.....

b) Officially
.....

53. Do you have a job description? Yes/No
(if yes, get a copy)

54. Do you have a drug kit? Yes/No.

55. If Yes, what is its composition?
.....
.....

56. What would be the "ideal" composition for a drug kit for a village health worker? (list them and amount)
.....

57. Finally, do you have any questions or thoughts about:
a) PHC in general
.....

b) Community participation in PHC
.....

c) Remuneration of VHWs
.....
.....

d) Sustainability of your project
.....

e) Recommendations to persons or projects considering such an activity, etc.
.....

APPENDIX 5

PHC ORIENTED PROJECTS RAPID ASSESSMENT

Interview Schedule for PHC Projects Leaders

A. Background Information
Date ...../...../1992 Time of starting Interview .....
Time of finishing interview .....

1. Name of Interviewer .....
2. Name of Respondent .....
3. Name of Project .....

[If more than one project, the programme leader is requested to choose among his/her PHC/CBHC projects the one he/she considers representative. The entire study is addressed to the same project]

4. Location/sub-county/District
.....
..

B. [Note to interviewer:
Introduce yourself and explain the purpose of the study. Take note of specific instructions where indicated, e.g., Probe widely. Use additional sheet if necessary to record verbatim what the person interviewed states]

1. History of the Project

1. Who initiated this PHC project in this community and when was this?
.....

2. Was there a needs assessment carried out? Yes/No

3. If Yes, who conducted the needs assessment (persons or agency)
.....

4. Is a copy available? Yes/No

5. If Yes, what was done with the results
.....

6. Were they presented to the community? Yes/No

7. If Yes, who were the representatives of the community?
.....
.

8. Was the community involved in any way in the needs assessment or other? Yes/No.

9. If Yes, how and at what levels (probe for full answer)
.....

10. Who is funding the project at the moment?
.....

11. What are the major achievements of the projects so far? (probe widely)
.....

12. What do you think contributed to the success or achievements of the project? [probe widely]
.....

13. What are some of the major problems (probe)
.....

14. How do you plan to solve them? (probe)
.....

15. What significant shifts if any, have there been in the project since its inception? i.e.,
a) In funding
.....

b) Philosophy (or ideas)
.....

c) Organizational structure
.....

d) Services
.....

e) Operations (logistics, etc.)
.....

f) Any other

16. Is there a policy guiding the project in its PHC implementation? Yes/No

17. If Yes, is it documented: Yes/No (If Yes, ask for the copy)

18. Who prepared the policy (document)?

.....

a) Ministry of Health
b) Donor Agency
c) UCBHCA/DCBHCA
d) Developed by Project
e) Other (specify)

.....

19. Has there been any evaluation carried out since the project started? Yes/No

20. If Yes, when and by whom?

.....

21. Is copy of evaluation available? Yes/No
If yes, as for copy)

.....
.

22. What were the findings of the evaluation? (in brief)

.....

23. How were these findings utilized?

.....

24. Are the project activities monitored in any way? Yes/No

25. If Yes, how?

.....

(Obtain a copy of monitoring forms - blank or completed)
[Details]

.....
.....

II <u>Linkage of PHC Project with Government Health System</u>

1. Is there any relationship between this PHC project and the Government health system? Yes/No

2. If Yes, what is the nature of the relationship?

(b) VHWs

.....

(c) Others (specify)

.....

.....

III Community Participation in Planning and Implementation

1. What do you define as the community in this project? (Probe)

.....

.....

2. What is the size of community served by the project?

3. What is the role of the community in the planning process of PHC activities (probe)

.....

.....

4. What is the planning process here for PHC?

.....

5.What individual or group makes final decisions regarding the project activities?

.....

6.What are the structures of the PHC project (probe for physical, functional, organizational, other structures)

.....

7. At what levels within the structure is the community represented and how many members of the community are at each level (probe in epth for strength/roles)

Levels Roles Numbers present/active Total No. in Project area

e.g., VHC .....

.....

8.How is the community involved in the implementation of the eleven components of PHC? (briefly describe how)

(a) Health education

.....

(b) Immunization

.....

(c) Maternal and Child Health/family planning (MCH/FP)

.....

(d) Provision of food and proper nutrition

.....

(e) Water supply and sanitation

.....

(f) Prevention and control of endemic diseases

.....

(g) Treatment of minor illnesses and injuries

.....

(h) Provision of essential drugs

(i) Mental health

.....

(j) Dental/oral health

.....

(k) Rehabilitative services

.....

9. What contributions are made by the community members in terms of: (probe)

(a) Finances

.....

(b) Materials

.....

(c) Time

.....

(d) Labour

.....

10.How are these resources (community contributions) generated (probe)

.....

.

11.How are they controlled by the community (probe)

.....

12.Who decides or decided on how much contribution the community should make?
.....

13. What is your assessment regarding the level of community involvement at the moment?
.....

14. What problems does the project face in trying to involve the community (probe)
.....

15.How do you think this can be improved upon? (probe)
.....

16.What is the best way to gain community support?
.....

IV Self-Reliance, Self-Determination and Replicability

1.From what sources are most of your project activities funded? (probe)
.....
2. How much of it is contributed by the community for operational costs? (probe), e.g., annually, for particular activities, etc.)
.....

3. Are there any income generating projects being run in order to support the PHC project? Yes [ ] No [ ] Do not know [ ]

4. If Yes, what are these projects?
(a).....
.....

5. What is the community's role in their implementation? (probe)
.....

6. Is the PHC project linked to any other community development efforts in this area? Yes [ ] No [ ] Do not know [ ]

7.If Yes, what community development efforts? (Name them)
.....

8. What is the nature of the linkage with each community development activity? (probe).

.....

9. Are there any efforts to help sustain your project through local community efforts? Yes [ ] No [ ] Do not know [ ]

10. If Yes, what are these efforts? (probe)

.....

11. Finally, I would like to invite your own additional comments about these questions or opinions generally, especially your thoughts about:

(a) PHC

.....

(b) Community/community participation

.....

(c) Sustainability of your project

(d) Starting/maintaining PHC programmes anywhere

.....

(e) Recommendations to persons or projects considering such an activity, etc.

.....

APPENDIX 6

PHC ORIENTED PROJECTS RAPID ASSESSMENT

Interview Schedule for Major Donors, NGOs (Internal/Local and External/ International)

A. Background Information

1. Date ...../...../1992 Time started .....
Time finished .....

2.Interviewer

Name.....

3.Project Name .....

4. Name of person interviewed .....

5. Location of interview .....

B. [Note to interviewer:
Introduce yourself and explain the purpose of the study. Take note of special instructions, e.g., probe; use additional sheet if necessary to record verbatim what the person, interviewed states]

1. What are the main objectives of your organization in general?
.....

2. What are the objectives with this (particular) project?
.....
.....

3. When did the funding start for this project?
.....

4. When will this support or funding end?
.....
.....

5. What prompted your organization to fund the project?

6. How much financial assistance is your organization offering the project per year?

7. How often does the project receive the funds?
a) once a year
b) every six months
c) quarterly (every three months)
d) other (specify) .....

8. Are funds being utilized for the purpose they are intended?
Yes [ ] No [ ] Do not know [ ]

9. If No, (a) why not?
.....

(b) what for?
.....
.....

10. In your view, what are the main achievements of the project?
.....

11. Does your organization carry out any monitoring/evaluation activities totheproject?
Yes [ ]
No [ ]
Don't know [ ]

12. If Yes, how often?
.....

13. Do you give a feedback of these monitoring/evaluation activities to the project? Yes [ ] No [ ]

14. If Yes, in what form?
(a) verbal communication
(b) written report
(c) other (specify)
.....
..

15. When was the last evaluation done?
.....
16. What were the results and recommendations?

17. If No, what plans are there to evaluate it?
18. What provisions are made to foster sustainability and self-reliance of the project? (probe)

19. In your organization's view, what is the future of this project in form of sustainability and self-reliance efforts once your support comes to an end?

.....

20. What are the main problems of the project?

.....

21. What other projects are receiving assistance from organization?

.....

22. In what form?

.....

(a) financial (indicate estimates)

.....

(b) Materials (indicate type)

.....

(c) Other (specify)

.....

23. What other kinds of community development projects is your organization engaged/involved in?

.....

24. Where are they sited?

.....

.....

25. Finally, what additional comments or suggestions would you like to make about:

(a) PHC in general?

.....

(b) Community and community participation in PHC and community development?

.....

(c) Sustainability of projects?

.....

(d) Starting/maintaining PHC programmes?

.....

(e) Recommendations to persons or projects considering such an activity?

.....

.....

APPENDIX 7

PHC ORIENTED PROJECTS RAPID ASSESSMENT

Primary Health Care Facility Information Check List

A. Background Information

1. Date ...../.....1991 Time started .....
Time Finished .....
2. Interviewer's Name .....
3. Respondent's Name .....
Title.....

4. Facility Name .....

5. Location of Facility .....
District .....

[Note to interviewer:
Introduce yourself and explain purpose of study and confidentiality of information. This is a facility-based information check list to be done with person in charge of facility who may or may not be the project leader]

B. Availability of Specific Health Programmes

1. Catchment Area (Background)
(a) Size .....
(b) Population:
(i) target area .....
(ii) service/people reached .....

(c) Population density (if known)
.....

(d) Nature of terrain [flat/mountainous/other (specify)
.....

(e) Average walking distance from which most patients come
(return) ..... (miles/kms)

2. Services Offered by Facility
(a) Ambulatory Yes/No
(b) General curative services Yes/No

(c) Antenatal care (ANC) Yes/No
(d) Delivery care (Natal) Yes/No
(e) Postnatal care (PNC) Yes/No
(f) Growth Monitoring Yes/No
(g) Expanded Programme on Immunization (EPI) Yes/No
(h) Family Planning (FP) Yes/No
(i) "Under Fives" clinic Yes/No
(j) Feeding programme Yes/No
(k) Nutrition rehabilitation Yes/No
(l) Other(specify).....

3. Outreach Services
(a) Antenatal, natal, postnatal Yes/No
(b) Curative Yes/No
(c) Family Planning Yes/No
(d) Health Education Yes/No
(e) Immunization Yes/No
(f) Growth Monitoring Yes/No
(g) Nutrition surveillance Yes/No
(h) Others (specify)
.....
.....
.

4. In-patient Curative Services
(a) General medical care Yes/No
(b) Surgical care Yes/No
(c) Obstetric/Gynaecological care Yes/No
(d) Paediatric care Yes/No
(e) Trauma/Orthopaedics Care Yes/No
(f) Other (specify)
.....

5. Specific Preventive/Health Promotive Services
(a) Health Education Yes/No
(b) Family Planning (FP) Yes/No
(c) Environmental Sanitation Yes/No
(d) Immunization (EPI) Yes/No
(e) Growth Monitoring Yes/No
(f) AIDS education Yes/No
(g) Drug/alcohol education Yes/No
(h) Sex education Yes/No
(i) Breastfeeding/weaning promotion Yes/No
(j) Mental services Yes/No
(k) Dental/Oral services Yes/No

(l) Rehabilitative services Yes/No

6. Specific Organization and Management Support
(a) Training and supervision Yes/No
(b) TBA training Yes/No
(c) VHW training Yes/No
(d) Programme monitoring and evaluation Yes/No
(e) Drug supply system Yes/No
(f) Transport support (patients and staff) Yes/No
(g) Repair and maintenance workshop Yes/No
(h) Other (specify)
.....
.....
.

C. Health Facility Management

1. Staff

Cadre of staff	Num Established	Num. Stationed	Num Present
a) Doctors	.....		
b) Health Visitors	.....		
c) Medical Asst	.....		
d) Administrators	.....		
e) Nurses	.....		
f) Midwives	.....		
g) Health Inspectors/Assistants	.....		
h) LaboratoryTechnicians/ Assistants	.....	.....	
i) Dental Technicians/Assistants	.....		
j) Auxiliary Nurses	.....		
k) TBAs	.....		
l) VHWs	.....		
m) Other (specify)	.....		
TOTAL	.....		

2. On-the-job Training and Supportive Supervision
(a) Any training courses attended during past year Yes/No
(b) Number of courses if attended
.....
.
(c) Health manuals/books available for facility Yes/No
(d) Health manuals/books available for personal use Yes/No

(e) Supervision of work at facility done Yes/No
(f) Any supervision during last three months Yes/No

3. Availability of Management Schedules
(Enquire whether standard treatment schedules are available for the conditions mentioned below)
(a) Diarrhoeal disease Yes/No
(b) Acute Respiratory Tract Infections (ARTI) Yes/No
(c) Malaria Yes/No
(d) Antenatal Care (ANC) Yes/No
(e) Delivery (perinatal) care Yes/No
(f) Postnatal care (PNC) Yes/No
(g) Childhood malnutrition Yes/No
(h) Other priority disease/conditions (specify)
.....
.....

4. Availability of Immunization Schedules (verify types of vaccine)
(a) BCG ..... Yes/No
(b) DPT .....Yes/No
(c) Polio .....Yes/No
(d) Measles .....Yes/No
(e) Tetanus .....Yes/No (for females aged 15-49 years)

(f) Other (specify), e.g., epidemics
.....
.....
.....

5. Coverage (%) by type
(a) BCG .....
(b) DPT .....1.....2.....3.....
(c) Polio.....1.....2.....3.....
(d) Measles .....
(e) Tetanus (females aged 15-49 years)
(f) Other (specify, e.g. epidemics)
.....
6. Transport Support
Does the facility have (circle appropriate response)
(a)A functioning vehicle? Yes/No
If yes, how many .....
(b) A vehicle undergoing repair? Yes/No.....
(c) A functioning motor cycle? Yes/No.....

(d) A motor cycle undergoing repair Yes/No .....
(e) One or more functioning bicycles? Yes/No.....

7. Drug Management
(a) Where do you order drugs from?
i) Central Medical Stores (CMS) Yes/No
ii) Joint Medical Stores (JMS) Yes/No
iii) District office (DO) Yes/No
iv) Other (specify)
.....
.....
.....

(b) When did you last order drugs?
.....

(c) Have you received your order? Yes/No

(d) How much time/delay usually goes by between the order and its arrival?
i) No delay
ii) One month delay
iii) Two months delay
iv) Three months delay
v) Other (specify time interval)
.....
.

(e) Do you receive a pre-packaged drug kit? Yes/No

(f) If Yes, how often?

.....

(g) Are the drugs enough to treat the common conditions in the area? Yes/No

(h) Do you develop schedules of planned activities? Yes/No
(If Yes, ask to see the one for the present period)
(Brief details)
.....
.....
.....

8. Finance

(a) What is the total budget for your facility?

.....

(b) Do you have budget breakdown by line items? Yes/No
(If Yes, ask to see)

(c) If No, what are the major recurrent financial expenditure items of your facility per year?

.....
.....
.....

Item Expenditure	Amount per year
i) Staff salaries	.....
ii) Travel Allowances	.....
iii) Transport (actual running costs)	.....
iv) Maintenance & repair	.....
v) Drugs	.....
vi) Other (specify)	.....

.....
.....

Approximate total annual budget.....

(d) Do you have any discretionary funds? Yes/No/Don't know

(e) If Yes, where do they come from?

.....

(f) How much is available for facility use?

.....

(g) What are they used for?

.....

(h) Do you charge any fees for the services or drugs at your facility?
Yes/No

(i) If Yes, what services do you charge for?

.....

(j) What other sources of income are available for the facility?

.....

(k) What was the income to the facility during the past 12 months?

.....

(l) Do you retain such income in the facility? Yes/No
If Yes, what is it for?
.....
.....

(m) If No, to what other use is it put?
9. Questions/Comments or suggestions from person interviewed (if any)
.....
.....
.....

APPENDIX 8

MR. STANLEY OKURUT - Chairman, PACODET

Background

Our aim is to penetrate the community and they become receptive so that they are able to take some of the activities on their own. And there is readiness on our side; to support them. This principle of CBHC is actually a process and I must tell you that there are many things yet lacking but which we know, must receive attention. Today, we are telling you that we have spread in such a way that we are touching the five sub-counties of Pallisa District with Population Catchment area of about sixty thousand. There are only 15 CBHC projects serving these areas, on average each project is serving 4,000, so they still need to awaken the community because this is a big number so that we come up with more of these projects. The CHWs who will be involved will have a manageable size of population they can reach and educate.

Today at the coordination level, we have the project committee in these various areas and since they are still 15 and in a way scattered, we coordinate them. But we are planning in such a way that we strengthen these projects which are very far and in different sub-counties to come up and acquire skills, and strengthen them, so that they are able in future to build other projects which are mushrooming in their areas. As such there will be a village committee, then you move to Parish Committee whereby each parish has a population of about 2,000 so each sub-parish will aim to have this type of committee. Now, when these sub-parishes have committees from these mushrooming committees, they should be able to come up we connect to the sub-parish committee. This is to provide Linkages with other local administration and other sectors in development because in these committees, RCs will be involved, other specialties in other fields will also be involved; so that they are able to provide ideas from the village county up to the top authority. So from the sub-county upto the county and eventually, we shall have a committee coordinating the whole district; CBHCA committee that is coordinating all these areas for development. So that is the strategy we have laid. It is like building the house, you normally put in the policies in various places. So this missing gap have to be filled with what is required of them. CBHC process is a slow process, and it needs a lot of patience because it aims at reaching the real people you need. History has taught us for a long time that when you are poor you remain poor and die poor; but through CBHC, we are trying to say that when you are poor, it is not that you are born poor and you die poor. You can change your destiny (that trend) you can change your destiny by getting involved in this development. So it really seeks the vulnerable groups, and all of us who get involved in cherishing these strategies, how to identify ourselves to the vulnerable groups and help them ride other than exploit. Exploitation has been the order of the day, right from the national to the local level and in this way we cannot break ignorance, poverty and disease; if we do not reach this very grassroots who need to be assisted, usually they are too desperate they say "but we cannot", you see my position, if you came to my home you see the way I sleep, I think I am not able to give the money." But what we have always said even when we initiated, we said, "Come the way you are, say that you have nothing to give what are you able." In the initiation phase, some members were saying when we found that it was actually difficult, we sat in a general meeting and said how much money are we contributing to start with, and generally to consider everybody's view, they said Shs.100/= only to start with. This was accepted and generally cherished., so every member thought he could afford. So everybody registered. That was the beginning. Now we said

that we have contributed Shs. 100/= it is not enough to get this and that. Now how shall we get the bricks?

Some people said - "Me, I have the energy I think I can make bricks when costing you cost what I can put in, in energy." So the principle of equal participation came in, whether you are lame, blind, rich, we still say that you can still give Shs.10,000/= , we do not know what motive you are giving it. But when it gets to contribution we infact contribute equally. So this principle got caught up by the community; and is actually picking up. And from a number of areas, a number of people realized the strategy it has been taking that identifies with the poor. Initially, some people said that let's watch, what will the poor do? because a number of us, after these institutions like the University, we came back here when we were not being employed by any organization, so they were really wondering that even those who are involved are not getting money from anywhere. The conception at first was, "these learned fellows have acquired more wisdom of coming of manipulate, so that when we collect the money, they are able to take off with it." This type of information was always provided by those who know.

How was this over overcome?
It was overcome through sharing all the work, so that whatever was involved, everybody is aware. So there, people understood that it was genuinely for their development.

So this was the background I had to tell you about this project. And the fruits, of that type of strategy, are: the immunizations as people have been monitoring, that when we started, the children between 2-5 years who were attending immunizations were over 70% of the total number of children who would come for immunizations. The second year, the percentage came to 31%. And today, it is about 8%. And this 8% is being contributed by these areas we are just reaching. But in most of these areas as per summary forms, we no longer have the 2-5 year children involved, we have some few 1 and 2 year children undergoing immunizations, the concentration on the children who are between 0-1 years. So we are actually able to see the progress, and just as members are contributing, greater awareness in the need for immunization has arisen and when we realized that people have woken up to realize that immunization was very important, it was time to take a withdrawal tactic slowly while encouraging them to come and take the activity themselves. So there is time when we get it but when we see the community coming up, receiving the idea and getting it, we slowly withdraw. And when they start complaining that the thing is no longer regular, we tell them that there is a problem and tell them to get organized and do some of the things themselves; there we come up with the Community Health Workers and the TBAs. We have the TBA who has trained but she isn't around this time may be something has happened to her. So this has been our secret.
Our numbers are actually not reflected in the way we have attended, but there are more people who are involved. The testimony of it is just the one we are doing. We haven't got any financial assistance from outside to undertake this type of work. the only assistance we have got is materials. The timber and the bricks and everything that is available, we locally provide, and it is the committee which provides. so whatever, is involved, the committee takes interest in protecting it.

This is the background information. It involves school children, elders, businessmen, intellectuals, everybody, in this type of things. Sometimes this type of education even involves intellectuals. There are people who are so learned that they are not educated. But we are very happy and

privileged that amidst us, we have people in a large number who are learned, like our Patron; who actually has been a source of education to us, we are not providing him education, but he is providing us.

APPENDIX 9

Data Sources

1. Kasese (Kasanga PHC Programme)
   - Policy makers (District level) 6
   - District Health Team (DHT) members 6
   - Project leaders. 3
   - Community Health workers (CHWs)/TBAs 5
   - Other Key informants 3
   - Focus Group discussions. 3

2. Masaka (Kitovu PHC Programme)
   - Policy Makers (District level) 5
   - District Health Team (DHT) members 4
   - Project leader 2
   - Community Health workers (CHWs). 3
   - Other Key informants 5
   - Focus Group discussions. 2

3. Mbale (Mission: Moving Mountains CBHC programme)
   - Policy makers (District level) 4
   - District health team (DHT) members 5
   - Project leaders. 6
   - Community Health workers (CHWs)/TBAs 10
   - Other Key informants 4
   - Focus Group discussions. 5
   - Health care facility check list. 2
   - Donors/NGO interview 1
   - Few Documents. 1

4. Pallisa (Pallisa CBHC Programme)

   - Policy Makers (District level) 4
   - District Health Team (DHT) Members 4
   - Project leaders. 7
   - Community Health Workers (CHWs)/TBAs 10
   - Health care facility checklist 2
   - Other Key informants 1
   - Focus Group Discussions. 4
   - Few Documents

5. Arua (Kuluva PHC Programme)
   - Policy makers (District level) 3
   - District Health Team (DHT)members. 6
   - Project leaders. 5
   - Community Health workers(CHWs) 5
   - Donors/NGOs. 1

- Other Key informants 1
- Focus Group Discussions. 5
- Few documents