Primary Health Care

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Primary health care and public policy

Various efforts have been made in Ecuador to extend primary health care coverage, particularly in the rural areas. Some community health workers have been trained but they have often been poorly supervised and inadequately supplied with medicines and equipment. Severe economic difficulties and the tendency for rural communities to disintegrate, as peasants seek work in the urban fringes, have hindered progress in health matters. However, only by maintaining primary health care as a major part of the country’s development strategy can the needs of both rural and urban people be met.

In Ecuador, the major causes of mortality in the population at large are gastroenteritis and other diarrhoeal disorders, pneumonia, bronchitis, emphysema and asthma, perinatal morbidity, and avitaminosis (1); those of infant mortality include gastroenteritis and other diarrhoeal disorders, bronchitis, emphysema and asthma, pneumonia and other acute respiratory infections, and childhood diseases such as tetanus, pertussis, and malnutrition. The health problems reflect those in other developing countries where the standard of living is low and housing and sanitation are inadequate. The groups most severely affected are women and children.

The problems are particularly severe in the rural areas. For example, in 1981, when over half of the country’s population of 8 644 000 lived in these areas, only 11.8% of rural dwellers had access to potable water, whereas 83.7% of urban dwellers had this amenity (2).

The absence of services, e.g., medical care, sanitation, and electricity, and the scarcity of economic opportunities cause increasing numbers of peasants to look to seasonal migration to marginal urban areas or large agro-industrial complexes on the coast as the solution to their problems. This has serious repercussions on the traditional family and community structure in the sierra and contributes to urban health problems.

National policy has aimed at increasing access to health care in rural areas through the construction of new facilities and the appointment of highly paid medical
personnel to staff them, while paying little attention to sociocultural factors and problems of internal efficiency which inhibit utilization. Preventive care continues to take second place to curative medicine, and even the curative services are underutilized.

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nutrition, immunization, control of diarrhoeal diseases and upper respiratory tract infections, and maternity care. Not only at the national level, but also in the field, programmes are divided in order that they may address different disease processes or types of pathology. This means that patients are not perceived as persons who may have various health problems and needs. The Western model of providing health services promotes fragmentation and fails to treat the patient as a member of a family, a community, and a culture. This leads to rejection of the medical care system by the peasantry and the channelling of up to 5% of family income into the traditional health care sector.

Community health workers

Since the 1970s, various national and international organizations have attempted to implement primary health care in Ecuador by means of a strategy utilizing community health workers. In 1980 the Ministry of Health signed an agreement with the United Nations Fund for Population Activities (UNFPA) for a primary health care project designed to extend the coverage of the rural population. At the end of three years, 280 community health workers, all selected by their communities, had been trained. In 1983, an 8% dropout rate was reported over the three-year period. Due to an almost total lack of supervision in some provinces, the percentage of community health workers lost has now risen to 17%. According to statistics for the second half of 1982, 246 community health workers submitted monthly performance reports; however, this may be more indicative of inefficient reporting and sporadic supervision than actual attrition or failure to perform assigned duties. Many workers devote more hours to their tasks than they are assigned, and paperwork tends to be given low priority.

The tasks of community health workers, outlined in a policy document of the Community Development Division of the Ministry of Health, include:

— performing a community census and preparing maps of target areas to be served;

— providing primary health care services, including case-finding, initial treatment, referral, follow-up, and education in the areas of the most frequent causes of morbidity (mother and child health, nutrition and dental health), and environmental sanitation;

— providing first aid in cases of emergency and referring appropriately;

— serving as leaders in the community and as a link between community needs and government services;

— organizing health committees and assisting them in the planning and implementation of community development projects.
In order to be able to carry out these functions, community health workers attend a two-month training course taught by a registered nurse. The course is divided into two sessions of four weeks; during the one-week recess, the trainees return to their communities to fulfil agricultural tasks, and are expected to prepare community censuses and maps. This gives the student an opportunity to practise in the field what has been learned in the classroom and to receive feedback.

**Constraints**

The government has made substantial progress through incorporating primary health care into its development strategy. However, field operations have been very limited because of a lack of clear-cut political support and because of difficulties encountered in financing the programme on a large scale. A shrinking national budget and undue emphasis on the health infrastructure by both the Ministry of Health and the international financial community, as a means of extending coverage, have added to the difficulties.

The government was anxious to discover the most cost-effective way of providing a community health worker service before expanding the programme. It had the opportunity to do so through a primary health care operations research project funded by the United States Agency for International Development and carried out by the Eugenio Espejo Foundation in conjunction with the Ministry of Health. The research focused on training, supervision, and logistical support inputs of the community health worker system.

All the community health workers and auxiliaries interviewed cited shortages of medicines and supplies as the primary obstacle to performing their duties. Every health subcentre and post that was visited complained about this. It was clear that, nationally, more attention should be directed to the provision of supplies than to the infrastructure.

The second most frequently cited problem in the field was the almost total lack of supervision. The auxiliary nurses who were supposed to supervise the community health workers were not trained to do so. The current auxiliary training course includes only one hour of theory and one hour of practice in supervision. Physicians and nurses have received minimal preparation for their supervisory role. Supervision is consequently reduced to checking whether employees are on duty and assuring that monthly reporting forms are completed. There is a lack of incentives for personnel to conduct supervision and no mechanism exists to make people accountable for supervisory duties. The Ministry of Health provides no rotating funds to cover expenses incurred by auxiliary nurses on supervisory visits, and there is no incentive pay for

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those who serve in rural areas. Furthermore, no transport is available to take staff to many of the isolated villages.

**Voluntary organizations**

The shortcomings of many independent primary health care programmes can be
mitigated by close coordination with government programmes. The duplication of services and the occurrence of pointless competition can be avoided if agreements are drawn up between the parties concerned. Ideally, some mechanism should exist to monitor private programmes and prevent overlapping. This function commonly belongs to a country’s ministry of health, but due to inadequate staffing it is often ignored.

Voluntary organizations are often cautious about allowing too much government control of their programmes, perhaps feeling that it would paralyse them. However, in Ecuador these organizations have chosen to work with the government rather than in isolation.

An example of such coordination is provided by the HCJB/Vozandes Hospital, which has provided acute care for a number of years; only limited primary health care was offered until 1978, when an operating programme grant was obtained from the United States Agency for International Development. This covered the training and supervision of community health workers in the provinces of Bolivar, Chimborazo, Morona-Santiago, and Pastaza. The population served by the project was 54 000; 142 workers were trained, 57 of them being placed under the direct supervision of the hospital staff. This pilot programme was to be turned over to the Ecuadorian government at the end of the five-year period of the grant.

Implications for public policy

The problems encountered in government primary health care programmes using community health workers, and those created by the existence of numerous private programmes operating in conflict, can be traced to the lack of a clear-cut policy and consequent difficulties in financing primary health care on a broad national scale. Moreover, the absence of effective supervision and logistical support for even small pilot projects, and inconsistencies in the training and role definition of community health workers, lead to a variable quality of care at the community level.

Some groups, including physicians, view primary health care as a threat to their economic and professional interests. Community health workers and traditional birth attendants are viewed as competitors, even though private sector medicine is not expected to reach small villages in the near future. Additionally, the use of paraprofessionals is seen as the sanctioning of folk medicine, which is outlawed in Ecuador.

Whether or not the professional objections to primary health care can be overcome, the question of how to finance a large-scale programme in a poor country will remain. The tax base in Ecuador is unstable, relying heavily on export and import duties. A tax on rural property has been proposed as a means of financing rural health care.

The primary health care operations research project has determined optimal assignment patterns for supervisors in relation to
community health workers, and has refined the training model, estimated the demand for medicines and supplies, and worked out a more efficient ordering and delivery system. It is hoped that these models can be implemented to increase the programme’s effectiveness and reduce costs. If this is achieved, the adoption of primary health care as a national strategy will appear more attractive.

This project also utilizes a community diagnosis methodology developed by the Integrated Rural Development Office of the Ministry of Health as a basis for planning the new health delivery models. The methodology evaluates extrasectoral factors such as community infrastructure and modes of production in agriculture, as well as health status. This focus on community needs will be enhanced by incorporating traditional medicine into the training component of the programme and possibly by recruiting traditional healers into the course.

These interventions represent only some of the possible primary health care strategies in the rural sector. Numerous other models are employed in marginal urban areas or squatter settlements throughout Latin America. The relative emphasis given to urban versus rural development in countries such as Ecuador will necessarily affect primary care policy. Increasing attention is being given to the quality of life in marginal urban areas, but the growing migration of peasants to these areas has outstripped the capacity of industry to absorb new people into the labour force. Meanwhile, agricultural production is declining in a country whose basic economy is still largely agrarian.

The country’s development strategy needs to be reorientated towards the use of appropriate labour-intensive agricultural techniques. Economic measures should, however, be complemented by public works and social programmes if the quality of life of rural families is to improve. Only by maintaining primary health care as an important part of the development strategy can the needs of both rural and urban populations be met.

Acknowledgement

The work on which this article is based was supported in part by a grant from the Center for Human Services under a cooperative agreement with the United States Agency for International Development.

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