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Revitalizing primary health care

Primary health care was started in the Isoka District of Zambia in 1981. The programme was modified in 1984 so as to make it more effective: government support was given to local communities, illiterate community health workers were admitted to the service, course content was simplified, training was transferred from the district hospital to the health centres, and local communities and rural health centre staff were given an increased part in the training and regular supervision of community health workers. Careful planning and management has resulted in more efficient implementation of primary care. Our preliminary results indicate that it is possible for a developing country to make significant advances by using its meagre resources judiciously.

Most developing countries have been unable to invest adequately in the health sector, especially in rural areas, and Zambia is no exception. This landlocked country covers 753,000 square kilometres and has a population of nearly 7 million. Isoka District, with an estimated population of 100,000, is located in the north-east corner of the Northern Province. Because the urban areas were consuming more than their fairshare of the total health budget, the government adopted a primary health care strategy in 1980 with a view to making matters more equitable. Guidelines for the implementation of primary health care were issued to all local communities, and most districts started to organize in 1981 (1). Two years later an evaluation indicated that most district programmes were facing tremendous difficulties. Only 1183 community health workers had been trained throughout the country; of those practising, only 315 had been issued with bicycles and there was a drop-out rate of 21%. The information given to communities and their preparation for programme implementation were inadequate. Community health workers were assigned large populations and consequently often had to travel long distances and work nearly full-time. Community participation was poor and rural health centre staff were only peripherally involved in the programme. All in all, these factors prevented primary care from having a significant impact on the health status of the communities.

**Strengthening the support system for community health workers**

Since primary health care programmes are expected to be responsive to real community needs, support for them should be provided locally rather than centrally (2). This was achieved by the formation and strengthening of support bodies at the provincial and
district levels. The principal functions of provincial and district task teams, comprising health staff from all hospital departments, were supervision and project management. Teams from other government departments contributed by promoting the integration of village development. In the rural health centres, reorientation workshops were organized to strengthen supervisory functions, introduce practice-oriented teaching methods and enhance teamwork. Community leaders were consulted and were given assistance with the formation of village health committees if this was requested.

**Community motivation**

There was a need to solicit and nurture community interest, encourage support for community health workers and win public participation in the implementation of primary care. Meetings and discussions were held with community leaders. This was followed by meetings to which the whole community was invited. All matters relating to the programme were thoroughly explained and discussed, requests for volunteer community health workers were made, and the formation of village health committees was encouraged. Neighbouring communities were invited to the opening and closing ceremonies of training sessions for community health workers.

**Selection of community health workers**

People who volunteered to become community health workers were selected if they received the support of a simple majority at village meetings. Selection was open to both literate and illiterate individuals. Volunteers were expected to be able-bodied, socially stable, permanent members of the village community and prepared to work without remuneration.

The functions of community health workers were modified to cover the treatment of all common and minor ailments, the imparting of health education, the encouragement of environmental sanitation, and the maintenance of health records. Community health workers were expected to work only part-time so that they could continue with their usual household duties.

**Training community health workers**

One community health worker from each village was selected for training at a rural health centre. Training was in two modules of two weeks separated by a break of four months, during which the community health workers practised their skills and were observed by their supervisors. The first module of the simplified curriculum covered the treatment and prevention of common health problems. The second module dealt with major specific health problems and focused on community action in support of the expanded programme on immunization, maternal and child health, family planning, and the control of leprosy and tuberculosis. The community health workers educate the community on the local immunization schedule and endeavour to win cooperation for the outreach programme of the rural health centres. In maternal and child health, the community health workers liaise closely with traditional birth attendants and

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concentrate on informing the community about antenatal and children’s clinics and nutrition. The training is largely of a practical kind and is conducted in the local language (Chinamwanga). The syllabus is based on the community health worker’s manual developed at the Tropical Diseases Research Centre. Simulated practice is heavily relied upon to reinforce the theoretical teaching.

**Community health worker’s manual**

This is a reference text with pictures and is colour-coded. For example, malaria is given the colour blue and is dealt with on the blue page of the manual, where the user is directed to a treatment chart giving drug dosages for different age groups; the medicine, chloroquine, is kept in a container with a blue label. On completion of treatment a tally mark is made on the blue page of a record book to indicate the month and the patient’s age and sex. Since there are only seven definite colours in this culture some conditions share one colour and are differentiated by symbols.

**Traditional birth attendants and school first-aiders**

After community health workers were well established, two other kinds of village health workers were introduced to liaise with them in the care of children and expectant mothers. Traditional birth attendants who were already practising and who volunteered were retrained at rural health centres in safer methods of delivery, without rejecting harmless traditional practices. In addition to identifying and referring mothers who are at risk, the traditional birth attendants keep records of births, infant and child deaths, miscarriages and abortions, and motivate women to attend antenatal and children’s clinics. School first-aiders are teachers trained to function as community health workers in schools, to identify and record mental and physical handicaps, and to help in schools with the outreach programmes of the expanded programme on immunization.

**The first six months**

Six months after the start of the project, an assessment was made by teams from the Tropical Diseases Research Centre and the Primary Health Care Directorate of the Ministry of Health. It was reported that 169 community health workers were trained in three months in the northern half of Isoka District. They were thus enabled to treat most common ailments, refer serious cases to rural health centres, and provide education on environmental sanitation and personal hygiene. Staff at rural health centres, who visit over 25% of the community health workers twice a month on bicycles, have had their supervisory functions strengthened.

The records kept by community health workers during the practical training period show that 7127 presumptive cases of malaria were treated and that 1011 new pit latrines were constructed in the area, which had a population of just over 50 000. The numbers of births and deaths recorded were 231 and 83 respectively, indicating crude birth, death
and population growth rates of 28/1000, 10/1000 and 2%.

The present trend suggests that there is an encouraging degree of public participation in the programme through material, moral and financial support for the community health workers. The involvement of whole communities in the selection of the community health workers probably helped this process. The careful education given to the communities during the period of motivation appears to have been effective. During their training the community health workers were accommodated, fed, and supported in many other ways by the communities. More than 90% of villagers attended meetings held as part of the motivation exercise.

Continuous supervision and on-the-spot problem-solving by health centre personnel are now giving much-needed moral support to the community health workers. The selection of some illiterate people has raised the mean age of the workers from 25 to 42 years; this is a stabilizing factor as older persons are less likely to migrate to urban areas. Furthermore, the older workers are generally better established, carry more authority, and are less likely to demand remuneration. The lack of a bicycle does not seem to affect morale. There have been no drop-outs, whereas the previous national programme in the same district recorded a drop-out rate of over 20% within six months after the completion of training.

The conducting of training sessions at rural health centres brought the health personnel closer to the community health workers and the community itself, facilitated supervision, and was less costly than the former method. The cost per worker is estimated at US$ 51, which compares favourably with the US$140 of the earlier scheme.

The personnel of the rural health centres are contributing more effectively to primary care now that they have assumed greater responsibility in the running of the programme; for example, they regularly carry out supervisory visits. The pharmacy technician and the hospital administrator, who previously had no direct link with the programme, are now members of the district supervisory team and are thus better placed to solve problems. The improvement in the management of primary care is clearly attributable to the involvement of all health sector personnel.

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