Helen M. Thompson

The Red Cross takes up the challenge

This article outlines how the Red Cross has been collaborating with Uganda's Ministry of Health in the development of primary health care. Strenuous efforts were made to achieve a rapport with communities and to win their participation. Red Cross cadres have traditionally been concerned with short-term relief rather than with long-term health development, and a degree of reorientation was therefore essential.

In 1979 Uganda's Ministry of Health called on nongovernmental organizations to contribute to the strengthening of primary health care in the country. In response, the Uganda Red Cross Society, with the assistance of the League of Red Cross and Red Crescent Societies in Geneva, presented a report on primary health care to the Ministry, and ensuing negotiations led to commitments from both parties.

The agreed programme was the first of its kind to be undertaken by a national Red Cross society and the first of any kind in the five-year development plan of the Uganda Red Cross Society. It was decided to work through the most active branches of the organization—those already involved in self-help activities related to community development (e.g., spring protection, environmental sanitation). A planning team, comprising Uganda Red Cross personnel and advisers from the League of Red Cross and Red Crescent Societies, travelled around the country and met Red Cross branch committees to prepare a plan.

The author is Technical Delegate for Health in the Eastern and Southern Africa Department of the League of Red Cross and Red Crescent Societies, P.O. Box 372, 1211 Geneva 27, Switzerland.

The Red Cross undertook to provide the community health workers with bicycles and, for two years, an allowance, after which the communities were to take responsibility for remuneration. Meanwhile, under the supervision of the district medical officer, each branch chose an area containing about 100 000 people in which it would work, priority being given to the most needy communities.

Lessons from community contacts

Discussion essential

The next step, and perhaps the most important, was for the Red Cross branch committees, together with the national and district coordinators and representatives from the district administration, to meet the chiefs, leaders and members of the communities, in order to discuss the concept of primary health care and details of its implementation, stressing always the community's role and responsibilities. Many such meetings were necessary over periods of up to six months, so that each community really understood what needed to be done and actually wanted to do it. As a result of the meetings, each community formed a

health committee comprising a cross-section of the people.

The Red Cross team and the district administration met each committee to discuss a questionnaire aimed at helping the communities to identify their health needs and find ways of fulfilling them. In addition, the team felt that this exercise would help the communities to define the type of person required to become community health workers. Many meetings had to be held with each community in order to develop a sufficient awareness of what was needed and of the role of the community health workers.

The discussions stimulated planners and policy-makers to reassess decisions made before consultation with the communities. For example, one community chose 12 men and 2 women as community health workers before the team had met to discuss needs. The reason for choosing a preponderance of men was that they were better able to ride bicycles. The fact that there was a predominance of obstetric problems, which might have been more appropriately handled by women than by men, was regarded as secondary. The team did not fault the community for this decision. Instead, we had to ask ourselves why we decided to issue bicycles before we had even met the community representatives and discussed their real needs.

Community health workers

The planners suggested that, for every 1000 people, communities should choose one community health worker who had completed at least seven years of schooling, in order to facilitate training and the keeping of essential records. The goal of one community health worker per 1000 people, however, soon turned out to be impractical in certain isolated communities with scattered homesteads. Here again the team learned an important lesson. Had they first walked around the villages they would have immediately appreciated that this ratio was unrealistic. It also became apparent that the educational prerequisite was a mistake, for

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one does not need any formal education in order to be a good community health worker. The educational requirement tilted selection towards young people, who were the most likely to leave their villages either to get married or to seek paid employment.

Great emphasis has been placed on the need to move away from curative, hospital-centred medicine and towards community-based, preventive measures. At the same time, insufficient attention has been given to the personnel required to implement this change, possibly because the best people for the job have the lowest academic qualifications. These people are prepared to spend time at the grass roots, and work at that level is the most essential part of primary health care.

Remote officials

Unfortunately, the more qualified a person becomes, the more remote he becomes from everyday realities. Planners, policy-makers and administrators often do not have the time to attend to implementation at the grass-roots level, and so lose touch with the needs of the people. Many seminars and workshops on primary health care are

organized and are always well attended, usually by senior officials. But how many of those present have the time to implement the knowledge and skills acquired at these sessions? Often they are too busy preparing for the next seminar!

I am not suggesting that planners, policy-makers and administrators are anything but essential. However, there is an equally important need for field workers who spend the time with people. How many planners, policy-makers and administrators are able or, indeed, inclined to do this?

But the necessity to allow sufficient time is not always understood by decision-makers, and inappropriate expectations may result. Administrators must acquaint themselves more fully with the practical constraints of implementing primary health care programmes. Even a walk around a village can result in profound changes in plans elaborated in some distant office.

A high-ranking official from one of the European Red Cross donor societies was invited to present graduation certificates to a group of community health workers. After the ceremony, he was taken on a tour of some of their villages. Impressed on seeing that certain water sources had been protected, he asked: "How much does it cost to protect springs like this?". "Approximately US$ 25 each", he was told. "Oh, no problem", said the guest, "we can protect them all for you." That short sentence could have destroyed a whole year's meticulous work aimed at helping the community towards self-reliance. It reflected a failure within the Red Cross itself to convey the message of what primary health care is all about.

The role of the Red Cross was to introduce the idea of primary health care, to motivate, and to support, but not to make decisions and take control.

One of the key lessons of our experience in Uganda is that top management must be given field exposure to the realities of primary health care if it is to understand the philosophy, goals and constraints of a community-based approach.

From relief to development

Traditionally, the Red Cross has been involved in relief activities. Relief means alleviation of suffering and a rapid response to sudden distress; it usually consists of a short-term effort bringing immediate results, but it can create dependency, stripping the recipients of their own responsibilities.

Development programmes, relatively new within the Red Cross, require slow evolution. Development is a long-term process with no immediate end-product, but it ultimately creates independence and self-reliance. There was a need to reorient the Red Cross towards this new undertaking and towards the special constraints of development projects. There was, at the same time, an understandable demand from donor societies for visible results.
Many times during the early stages of implementation there were requests for photographs to illustrate primary health care, but how can one photograph its three key elements: voluntarism, motivation and prevention?

While reorientation was taking place at the international and national levels, there was also a need for the Red Cross at district level to assume its place in the programme,

emphasizing that primary health care, although initiated by the Red Cross, was a major community responsibility. The task of the Red Cross was to introduce the idea, to motivate, and to support, but not to make decisions and take control. The people know what they want and have a wealth of good ideas: they just need to be listened to and helped to get going.

Voluntary agencies have come a long way in recent years in recognizing the kind of help that is really useful to the Third World. But too much emphasis is still put on the expert in the capital city working on new strategies and dispensing formulas from behind an office desk. Yet the voluntary agencies are often in the best position to do what is needed, for they have an ear close to the ground and can give realistic long-term support. Many of them, unfortunately, still have to convince their own donor public and they feel this must be done in a big way. If this happens, however, they become over-ambitious, distance themselves from the people they are trying to help, and consequently fail to get the required results.

The Red Cross now believes in starting small, and in working with rather than for the people. If a small project is given time, and if the work is well done, it will probably succeed, and if it succeeds it will encourage other projects of the same kind. □

Taking care to the people

Our clinic in Perari [in the Himalayas] was drawing to a close when the health worker from a nearby village asked if I would see a patient whom she had recently been treating. Grabbing my shoulder bag I followed Indra up the 1000-foot climb to her village, being thankful that it was the nearest to the clinic. We were ushered in to a small unventilated room, where a man was groaning with a lacerated, cellulitic leg. Before I could greet him he pointed warmly to Indra and commended her for the daily treatment she was giving him. Indeed, apart from giving a shot of tetanus toxoid there was little else I could add. After six months' training, illiterate Indra was competent and caring. Before she qualified, this man would have lain for many days without help, necessitating, at the very least, hospital admission. It showed me that appropriately trained village health workers acting as frontline health troops can dramatically reduce morbidity and mortality and with it the aching fear which accompanies any illness when the nearest treatment is half a day's journey, one week's wages, and a cultural chasm away.

—T. E. Lankester. The people stand up, the doctor steps down. *British medical journal*, **293**: 377 (1986).