Annex 4

RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON INNOVATIONS IN PRIMARY HEALTH CARE WITHIN THE COMMUNITY

1. INTRODUCTION

Under the chairmanship of Dr Mohammad Isa, Director-General of Medical Care, Ministry of Health, Indonesia, a full day was spent on technical discussions concerning "Innovations in primary health care" in a wide variety of community settings in the countries of the Region. Dr U Mya Win was elected Rapporteur. The annotated agenda approved by the Regional Committee was the basis of discussion, which was planned as follows:

(1) Review of some innovative approaches in primary health care in countries of the Region;

(2) Analytical review of country experiences in the extension/extension of the innovative approaches from pilot areas to country-wide application; and

(3) Formulation of conclusions and recommendations.

The basic purpose of these discussions was to analyse a wide range of examples of innovations in primary health care in the Member States, and to identify the circumstances surrounding the initiation and maintenance of these innovations as a basis for encouraging countries to expand these innovations both in scope and in terms of the numbers of communities that are involved.

2. CHAIRMAN'S OPENING ADDRESS

In his opening remarks, the Chairman sought to focus the attention of the participants clearly on the task they were expected to accomplish. He suggested that the examples of innovations described in the working paper (SEA/RC37/15) should be considered together with any other examples that were reported with a view to identifying the specific factors and circumstances that enabled these innovations to take root and establish themselves. An attempt should be made to identify as clearly as possible the factors that determine why some of the innovations succeed while others do not. These examples could throw light on how to expand the approaches so as to cover a wider range of populations.

If we are to reach the goal of health for all by the year 2000, total dependence on the conventional delivery systems may not be enough. It is therefore important that communities and bureaucracies be encouraged to be as innovative and as creative as possible and that all of the resources available within the community itself be mobilized as completely as possible. The great value of these innovative approaches is that they provide examples of the active involvement of the people. But, the Chairman observed, people will make such innovative contributions only when they are totally convinced that these are of positive benefit.

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The Chairman concluded his introductory remarks by asking the participants to describe innovations in primary health care at the country level and then to use these as a basis for seeking answers to five critical questions:

1. Developmental Process: Why, how and under what circumstances did the innovation commence?
2. Resource Utilization: What resources were needed and where did they come from?
3. Role of the Community: What specific roles did the local communities play in initiating and sustaining the innovation?
4. Social, Economic and Cultural Characteristics of Communities: Is innovation easier in some types of communities and contexts than others? and,
5. Role of Government: What positive, supporting roles did the government play?

3. REVIEW OF EXPERIENCES OF COUNTRIES IN INNOVATIONS IN PRIMARY HEALTH CARE

Each of the five questions noted above was approached through a substantial review of experiences in innovations.

4. ANALYTICAL REVIEW OF INNOVATIVE APPROACHES IN PRIMARY HEALTH CARE

4.1 Developmental Process

The group considered the various aspects of the developmental process, starting with the factors that led to innovation, and agreed on specific factors, which are described below.

One factor that led to innovation was the unique geophysical situation of a country or a community. Nepal is a landlocked country and Maldives is a sealocked country, and these characteristics have led to the development of mobile health teams, introduction of walkie-talkie radio communication or shortwave radio transmission and similar innovations. In Maldives, again, because of its unique high water-table, latrine development was different from that in other countries.

A limitation of resources was another factor that was responsible for innovative approaches. For instance, in Thailand drug cooperatives had emerged, and income-generating activities were undertaken in Indonesia.

Availability of technology was also a factor responsible for producing innovations. In Thailand, for example, people constructed jars to collect rain water instead of using water tanks.

Scarcity of human resources is overcome by training and utilizing the appropriate people in the community. Monks in Thailand, imams in Bangladesh and school teachers in Maldives were trained and utilized to deliver primary health care. The training of school students in Indonesia as "mini-doctors" and their utilization as agents of change in health status was noted.
Competitions have been used to encourage the health manager to obtain better results in health programmes. The stratification of health centres in Indonesia and competitions organized in other countries connected with village health programmes were noted.

Voluntary resources placed at the disposal of the community were sometimes accompanied by technology or innovative ideas too.

The reluctance of medical doctors to serve in rural areas in Nepal and the brain drain in Sri Lanka promoted the training and utilization of auxiliary health workers. The shortage of services in the dry zones of Burma was responsible for the innovative category of the "ten-household health worker". In India, the high incidence of injuries caused by burns in Bombay stimulated a voluntary agency to start an active prevention programme.

With better communication and transport facilities, people started bypassing the lower-level referral facilities in Sri Lanka and Thailand. To some extent this was being contained in Thailand through an innovative strategy called the "green line referral" system.

Village committees were started in many countries to deal with health problems. In due course, these committees had to acquire expertise in other sectors too, such as in water supply and sanitation. The family health programme, which originally promoted contraceptive methods for women, was changed to apply to both men and women.

Experiences from various countries showed many starting points that could be responsible for innovations in the community. The common starting points are listed below:

<table>
<thead>
<tr>
<th>Starting Point</th>
<th>Example</th>
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<tbody>
<tr>
<td>To solve problems</td>
<td>Use of auxiliary health workers, mobile health teams</td>
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<tr>
<td>After acceptance of a new technology</td>
<td>The training of traditional birth attendants</td>
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<tr>
<td>After a technology has failed</td>
<td>The change from pit latrines to ash latrines in Maldives</td>
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<tr>
<td>As an experiment or by the expansion of a programme</td>
<td>A leprosy control programme may develop into a disease control programme and finally into a development programme</td>
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In Thailand, some innovations originated from the Government and political commitment from the highest national level led to 1984 being declared Primary Health Care Year. At the intermediate level, the Government of Gujarat State in India approved a scheme of health centres and handed it over to the community to maintain the facility.

The expertise of the technocrat or the bureaucrat in charge of health programmes can also lead to the introduction of innovations, such as biogas plant production in the village.