Leadership for primary health care

Levels, functions, and requirements based on twelve case studies

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WORLD HEALTH ORGANIZATION
GENEVA
1986

The authors alone are responsible for the views expressed in this publication.

ISBN 92 4 130082 5

ISSN 0555-6015

TYPESET IN INDIA

PRINTED IN ENGLAND

85/6507 - Macmillan/Clays - 9000

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Preface

Primary health workers function at the periphery of the health services, providing essential curative and preventive care within the community. With the aim of improving the quality of such care, WHO prepared and published guidelines for the training of primary health workers.[1] Subsequent experience showed that the success of these health workers depends crucially on the support and supervision they receive; a guide was therefore published to help improve the management of health care systems,[2] particularly at the middle level. Something more is needed at the various levels of management, however, to make it really effective. This extra something is **leadership**. A publication on primary health care leadership therefore seemed a logical complement to the two books mentioned above.

In preparing this publication, the authors received the valued assistance of WHO Member States and of several nongovernmental organizations, namely the International Council of Nurses, Medicus Mundi/Misereor, and the International Federation for Hygiene, Preventive and Social Medicine. Information was thus collected from a variety of sources, the principal aim being to select instructive examples of leadership, rather than typical or representative pictures reflecting national patterns of primary health care.

The authors are particularly grateful to the Government of the Netherlands for financing this activity through its Ministry for Development Cooperation.

[1] *The primary health worker. Working guide, guidelines for training, guidelines for adaptation*, revised edition. Geneva, World Health Organization, 1980 (New edition entitled *The community health worker*, in press).

[2] McMAHON, R. ET AL. *On being in charge. A guide for middle-level management in primary health care.* Geneva, World Health Organization, 1980.

1. Introduction and background

The extension of health care to all people has been an objective of national health systems for many years and, since the Alma-Ata Conference on Primary Health Care in 1978, countries have pursued this aim with greater vigour. Scores of different strategies have been applied by countries in their attempts to implement the primary health care approach within diverse national health systems and with great variations in available resources.[1]

A common feature of these efforts, especially in developing countries, has been the training and use of community health workers (or primary health workers)[2]—typically rural men or women of limited education, who are trained for relatively brief periods of time to carry out primary health care tasks. The backgrounds, the training, the precise functions, and the management of these health personnel vary widely (*1*), but almost everywhere the community health worker serves in some type of organized framework, in which he or she is subject to leadership and other forms of influence.

All too often, the performance of community health workers in the field has been found to fall short of the expectations of primary health care planners. The concept of the community health worker performing as one member of a health team has been enunciated in many quarters, and there seems to be a wide consensus on the value of such teams for extending primary health care (*2*, *3*). Nevertheless, the reality so frequently falls short of the theoretical concept that one is forced to search for a managerial defect, which might be very widespread. Many observations have suggested that a major aspect of the problem is deficiency in the *leadership* provided for primary health workers from higher levels.

A study in 1982–83, in which WHO cooperated, examined human resource development for primary health care, as it was found in six developing countries (*4*). Here, too, a major difficulty identified was

[1] World Health Organization. *Review of primary health care development.* Unpublished document WHO/SHS/82.3.

[2] In this publication, the terms "community health worker" and "primary health worker" are used interchangeably.

inadequate teamwork and supervision. In a summary of the problems, it was stated: "The effective functioning of [primary health care] systems requires an understanding of the meaning and practice of teamwork. It also requires that team leaders are capable of leadership and effective (not dictatorial) supervision. Such qualifications seem to be rare in the countries studied. . . . Teamwork requires sensitivity to personal relationships and supervision requires organizational knowledge and skills".

In nearly all countries, there are several levels of authority and management between the local community and the central government. The number of administrative levels varies with the size and population of a country, but in most countries, as we shall see in the case studies reported, there is a framework or hierarchy for health systems based on at least four levels: (*a*) the local community (villages or towns); (*b*) the district (with populations from about 50 000 to perhaps 300 000); (*c*) the province (with populations from about 500 000 to many millions; and (*d*) the top or central government. Sometimes, a "regional" level is established between the province and the top level. Sometimes, the local level includes two subdivisions: the individual village and clusters of villages. At each level, there are usually teams of personnel, the members of which work together for health objectives. At each level, too, there is need for leadership, both horizontally for the team within the level and vertically for ensuring good performance at the level below and proper relationships with the levels above.

The exact functions of leadership must inevitably differ at the different levels. They are bound to vary also with the general political ideology and attitudes of a country. In order to acquire a better understanding of leadership roles at the various levels, therefore, WHO solicited information in 1982–83 from a number of countries, chosen to represent the various regions of the world and different styles of government. For each country, information was sought, on the basis of a suggested outline, from a person knowledgeable about primary health care. The responses varied, however, in their scope. Some described the entire national framework for the provision of primary health care, others described in detail one province or district, taken as a reasonable example of the national system; still others described in detail a specific and noteworthy local primary health care project—not intended to represent the national scene but to demonstrate achievements that were possible in one area. Summaries of these case studies on primary health care leadership in 12 countries are presented in the following chapter.

Before proceeding with these case studies, some clarification of terminology may be helpful. The term "leadership", as used here, has a broad meaning. Sometimes it may be equated with "supervision", but in fact supervision is only one function of leadership and, as we shall see, many more functions are encompassed. Leadership, as the term is sometimes used, overlaps considerably with "management", yet it does not include every detailed function of management, such as the maintenance of financial accounts or the periodic procurement of supplies. We can consider *leadership* to be *an attribute of managers,*

enabling them to provide effective management. As used in this report, leadership may be regarded as a concept roughly equivalent to "effective management".

After presenting summaries of the twelve case studies, we attempt, on the basis of these experiences, to identify and clarify the many distinct functions of leadership as it applies to programmes of primary health care. These functions must be understood and analysed as actions that *should* be carried out by leaders, but the degree to which they are actually performed in various national situations may vary greatly.

Following the analysis of functions, we offer our interpretation of the requirements for the development of effective leadership. Everyone is familiar with the cliché that "leaders are born and not made". As with many sweeping generalizations, there may be a grain of truth in this statement, inasmuch as some persons can perform leadership functions (or certain of these functions) more successfully than others. More often, however, the statement is misleading; there is abundant evidence, as we shall see, that training, organizational structure, and social environment can enhance the leadership capabilities of any person.

Presentation of these findings and analyses is especially appropriate at this time, when WHO is emphasizing the importance of leadership in progress towards the goal of health for all. In the proposed programme budget of the Organization for 1986–1987,[1] the Director-General of WHO defined six major objectives, with the comment:

> These objectives are similar to those in the programme budget for 1984–1985, with two main additions—the focusing of technical cooperation activities on the mainstream of national health-for-all strategies and the building-up of a critical mass of health-for-all leaders.

It is hoped that the various experiences reported in this publication, along with the analyses and interpretations, may help countries to achieve improved leadership for their primary health care programmes. The preparation of training material based on these analyses should be envisaged as a means of providing practical tools and methods for the development of leadership capabilities.

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[1] Unpublished WHO document PB/86–87.

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3. WHO Technical Report Series, No. 633, 1979 (*Training and utilization of auxiliary personnel for rural health teams in developing countries*: report of a WHO Expert Committee).
4. United Nations Development Programme, World Health Organization, and the Federal Republic of Germany. *Human resource development for primary health care.* New York, UNDP, 1984.

2. Case studies in primary health care leadership

The twelve case studies of primary health care programmes summarized below were designed to focus specifically on the role of *leadership*. As well as discussing the functions of primary health care leaders at various administrative levels, the reports explain the programmes of training that were provided to develop leadership and describe the personal backgrounds of education and experience of actual primary health care leaders. In addition, each case study offers a brief account of the general framework of primary health care in the country involved or in one region of the country. Finally, most of the reports include the judgements and opinions of the authors on the important requirements for achieving effective leadership; to some degree, these are implicit in the account, but often they are stated more explicitly.

The case studies are of three types. The first three reports, from Bulgaria, the Dominican Republic, and Viet Nam, are general accounts of national primary health care programmes.

Each report in the second group of case studies analyses one sample locality in a national primary health care system; the sample, or example, has been chosen to be reasonably representative of the national situation. The four such case studies concern Cuba, Finland, Papua New Guinea, and Somalia.

A third type of case study analyses one or more special primary health care projects in a country; these are not intended to be representative of the national situation, but rather to show what has been accomplished in special circumstances. There are five such case studies, concerning projects in Bangladesh, France, Kenya, Liberia, and the Philippines. The accounts from Kenya and the Philippines each describe two projects in those countries.

All the texts presented here are summaries of the original reports; in making these summaries, we have tried to be entirely faithful to the facts and ideas presented by the original authors.

General Accounts of National Primary Health Care Programmes

The first three case studies offer general reviews of the primary health care national programmes in Bulgaria, the Dominican Republic, and Viet Nam.

Bulgaria[1]

The People's Republic of Bulgaria is in Eastern Europe and has a population of about 9 million; since 1946 it has had a socialist government. The country is divided administratively into 28 districts, each containing both urban and rural communities. The Ministry of Public Health at the national level establishes basic policies, but their implementation is the responsibility of directorates of public health and social welfare in each of the 28 districts.

The general primary health care programme

The directorate of public health and social welfare in each district comes under the general control of the overall District Public Council (elected by the people) and is advised by a district medical council, including both health personnel and community representatives. The work of the directorate is carried out through three principal committees for (*a*) planning and development; (*b*) hygiene and epidemiology; and (*c*) medical services and social welfare. Health planning is based on national norms, and financial support comes entirely from the national government.

Primary health care in Bulgaria includes basic preventive (hygienic) services, treatment services, and pharmaceutical services at the local level, which may be rural or urban. It also includes, when necessary, rehabilitation and social support, health education, the participation of people in the community, and coordination with other social sectors. The highest priority goes to preventive services. The most peripheral unit for providing these services is the health centre, serving 1500 to 3500 people in rural areas and more in the cities. The staffing includes a physician, dentist, midwife, and nurse, feldschers and auxiliary personnel. The combined preventive and therapeutic work done by this team is described as a "dispensary-polyclinic service". Also, if there are 2000 or more children in the local area, a paediatrician may be on the health centre staff. Obstetric patients are served by the health centre only if the pregnancy is entirely normal; if there are any complications, the patient is referred to a polyclinic at a higher level, where an obstetrician-gynaecologist is on the staff.

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[1] Based on a case study by Professor K. Gargov, Director, Research Institute of Social Medicine, Sofia, Dr T. Kazanlakliev, Research Institute of Social Medicine, Sofia, and Dr K. Tchamov, Research Institute of Social Medicine, Sofia.

For an industrial enterprise with 1200 to 2000 workers, a team equivalent to that in a health centre is provided at the plant. Another resource at the community level is the "hygienic-epidemiological establishment", concerned with the maintenance of a healthy environment.

Serving larger populations than the health centre is the polyclinic, which may or may not be linked with a hospital. In addition to the basic primary health care staffing noted above, the polyclinic staff includes a paediatrician and an obstetrician-gynaecologist. (Equivalent "worker polyclinics" may be attached to industrial enterprises with more than 10 000 workers.) Such polyclinics are usually responsible for six health centres.

Still higher, at the level of the district, is the "district polyclinic". Here the chief physician has such heavy administrative responsibilities that he is relieved of all clinical duties. He[1] serves as a major leader of the entire programme of primary health care in the district. To some extent, however, the head physician at every health facility must also assume leadership responsibilities.

Leadership functions at various levels

In the peripheral health centres, the head physician must ensure that all preventive, diagnostic, curative, and rehabilitative services are carried out. In a village, he may be assisted by a feldscher or other auxiliary staff. If there is a hygienic-epidemiological inspectorate, he is assisted by the sanitary physician and the sanitary inspector. The head physician in a health centre or dispensary also does a great deal of clinical work, both therapeutic and preventive. He organizes immunization programmes, provides health education, and oversees hygienic conditions in schools and workplaces. He organizes and conducts epidemiological follow-up of cases of infectious disease. In towns, where paediatricians, hygienic inspectors, and others are more likely to be available, the range of duties of the health centre physician is not so great. In both town and village, however, the managerial functions of the head doctor include planning all the health activities, supervising all the health personnel, coordinating tasks with the programmes of other agencies (e.g., the Bulgarian Red Cross or the trade unions), periodically evaluating performance, and preparing annual and other reports.

At the second level, the head physician in the polyclinic is responsible not only for the work of the polyclinic staff, but also for that of the generalists and paediatricians in six health centres. He organizes and monitors their work and assigns them special tasks when necessary. He maintains contact with various popular organizations and

[1] For the sake of convenience, except when reference is made to a particular individual, personal pronouns of the masculine gender are used throughout these case studies to refer to health workers at all levels.

mobilizes their assistance in health or sanitary campaigns. He keeps himself informed about community health indices and makes plans for their improvement. Besides these leadership functions, this physician must still do clinical work in the polyclinic and serve as a consultant for patients referred by health centre doctors. In certain rural areas there may be a head physician, responsible for all health services, even without his being based in a polyclinic.

At the third or district level, the physician head of the district polyclinic must devote virtually all his time to managerial and leadership tasks. He does no clinical work and is helped by an administrative assistant. He is responsible for planning the health work of the entire district and all its component facilities, coordinating health and other sectors, allotting the funds necessary for each activity, and making periodic assessments of the health status of the population.

In 1981, an investigation was made of the distribution of time spent by primary health care managers at the district level. The findings were as follows:

	%
Organizational activities	24.46
Public information	17.34
Supervision (control)	12.66
Social activities	10.36
Self-education	9.96
Evaluation	6.83
Planning	3.44
Other	14.95
Total	100.00

All the types of activity listed above may be considered to be relevant to the functions of leadership.

Training for primary health care leadership

The training of primary health care managers in Bulgaria includes education in both clinical and social medicine. The university course in social medicine includes studies in planning, organization, implementation, supervision, and evaluation. Field practice is also part of the training, its character depending on the administrative level at which the physician will be working.

For service at the first (most peripheral) level, the training is essentially clinical and is given in an integrated polyclinic and hospital. It includes the study of medical literature, participation in clinical conferences, preparation of scientific papers, attendance at X-ray clinics, and oral examinations. It also includes, of course, clinical work in the wards of hospitals for several months under the supervision of qualified specialists.

For service at the second level, the primary health care manager must have full specialty qualifications in internal medicine or paediatrics. Beyond this, he must take training in sanitary and epidemiological work

and must participate in brief courses on management, with particular reference to coping with the tasks of primary health care. The head of a rural health service area need not have clinical specialty qualifications, but he must undergo equivalent training for administrative work.

For service at the third or district level, the chief physician must be thoroughly trained in the field of "administration and management". Candidates for such posts must first have qualifications in a clinical specialty and then undertake the training necessary for additional qualification in the field of "social hygiene and public health organization". The latter training includes studies on the organization and management of primary health care, and the trainee must pass special examinations. Most often this work is done at the Institute of Social Medicine of the Bulgarian Medical Academy.

Throughout the entire Bulgarian health system, the participation of the community at all levels stimulates health managers to seek constant improvement in their methods of work. The WHO policy on primary health care has had a definite influence on the organizational formulations and priorities in the health system. It has also influenced the continuing education of leading health personnel through both academic institutions and the facilities for delivering health services. Still further emphasis is needed on the preparation of leading personnel for the management of primary health care at its several levels.

Dominican Republic[1]

The Dominican Republic, occupying two-thirds of the Caribbean island of Hispaniola, has a population of about 5.2 million. Since 1976, a nationwide programme, identified as "basic health services", has been developed. Its main objective has been to make available to the entire rural population an array of basic health services that are essentially preventive in orientation.

The general primary health care programme

National leadership in health is provided by the Secretariat of State for Public Health and Social Welfare (SESPAS), and the country is administratively divided into six public health regions. Each region contains several health areas, corresponding to governmental provinces. In 1979, the Directorate-General of Rural Health was established in SESPAS and within this the Department of Peripheral Rural Care. This department carries major national responsibility for the basic health services programme.

The objectives of the basic health services programme are: (*a*) to give general health guidance to every isolated rural household, through visits twice a month; (*b*) to integrate various types of rural health care; (*c*) to

[1] Based on a case study by Dr Ricardo Mauricio Gomez, Chief, Preventive Medicine, José María Cabral y Báez University Regional Hospital, Santiago.

conduct a preventive maternal and child health programme; (*d*) to refer cases of illness to higher levels of care; (*e*) to give general advice in environmental health; (*f*) to provide various immunizations to children over five years of age, to pregnant women, and to other adults; and (*g*) to collect data on births, deaths, and other demographic events. Activities to fulfil these objectives are carried out by briefly trained "health promoters", who currently number 4500 in the country. The official standard calls for one health promoter to cover 80 households or about 400 rural people.

The health promoter works at the base of an administrative pyramid that starts in the villages. He comes under a "promoters' supervisor" who comes, in turn, under an "area supervisor", serving at the level of a health area or province. (These personnel are often former auxiliary nurses.) The area supervisor comes under the "regional supervisor" in each of the six public health regions. The regional supervisors report to the Department of Peripheral Rural Care in SESPAS at central government level. It should be noted that this hierarchy applies only to the preventive services provided by health promoters to *scattered* rural populations. Full primary care (including treatment of common ailments) and also secondary care for concentrated rural populations are delivered through a network of 325 rural clinics coming under a separate and parallel hierarchy. These clinics are staffed with one or two physicians each and are located in towns of 2 500 to 6 000 people; they serve as referral centres for patients seen by the health promoters. For each rural clinic there are 10–14 health promoters.

The health promoters are selected by a committee for health improvement serving in each province and region. To be chosen, the candidate must be born and reside in the community where he works, be between 20 and 50 years of age, be literate, have free time to perform the assigned work, be willing to serve without salary, and have leadership qualities. The health promoter is expected to set a personal example of hygienic living, is provided with a manual explaining the work to be done, and signs an agreement with the Committee for Health Improvement serving the region. When chosen, the health promoter is given a 3-week training course and then one week's special training on nutrition. A small monthly cash allowance is given to cover expenses.

Primary health care functions and training for leadership

The functions of the health promoters correspond to the objectives stated above. In the field of maternal health, in addition to encouraging pregnant women to obtain prenatal and postpartum care, they provide women with contraceptive supplies. They also give talks on personal hygiene and the maintenance of a healthy environment.

The promoters' supervisor must also come from the local area and must have had secondary school education. He is chosen not by the Committee for Health Improvement but by the residents of the

community served. There is one supervisor covering every 10–14 health promoters. The promoters' supervisor is an employee of the government and receives a salary. Motorcycle transport and various working materials are supplied. The supervisor trains the health promoters and distributes to them necessary vaccines and other supplies. The supervisor is stationed at one of the rural clinics, where each morning he gives health talks. He keeps records of the immunizations and of the maternal and child health work done by the health promoters under his supervision. He sends weekly and monthly reports to higher echelons. In preparation for this work, the supervisors receive a 6-week training course in primary health care.

At the next level, the area supervisor must be a person with general health knowledge, teaching experience, and a capacity for leadership. He is also a government employee and receives a monthly salary. There is one area supervisor for each province, who is responsible for the training of the promoters' supervisors. He holds monthly meetings with both the promoters' supervisors and the health promoters themselves. The area supervisor distributes supplies to the promoters' supervisors and also issues salaries and allowances to all personnel in the province. There is no specified period of training for the area supervisor, since this person is expected to have adequate preparation at the outset. Some lectures on group management, community relations, or the like may be attended.

There are six regional supervisors, all of whom have university training in education and social work. These persons are appointed by SESPAS, and carry broad responsibilities for the entire programme of peripheral rural health services. The regional supervisor trains and guides the area (provincial) supervisors. He does annual evaluations of his entire region. His immediate supervisor is the Regional Director of Health. The training of the regional supervisor is variable, depending on his background, but may cover epidemiology, maternal and child health, environmental sanitation, health education, and other related fields.

Finally, in SESPAS, the Head of the Department of Peripheral Rural Care must be a professional person with university training. He must have basic knowledge in all the relevant public health disciplines. He is responsible for the planning, implementation, supervision, coordination, and evaluation of the entire basic health services programme for the peripheral rural population throughout the country.

The basic health services programme was started in 1976 and achieved coverage of the entire peripheral rural population by 1978. Nevertheless, several problems have become evident. There is inadequate coordination between the basic health services programme and the established clinical services that operate alongside. The services of the clinics and hospitals operate in a separate framework of authority and show little sense of responsibility for the basic health services activities. The distribution of materials, starting from the central level, has had numerous difficulties. Supervision at the area level is inadequate,

apparently because of shortages of transport and time. Up to the present, there has been no evaluation of the results of the whole programme. One can only say that the services of the health promoters are apparently gaining the acceptance of communities.

Viet Nam[1]

The Socialist Republic of Viet Nam is located in South-East Asia and has a population of 51 million. After many years of warfare, national independence and unification of a previously divided country were achieved in 1975. The country is organized into 40 provinces and central cities; these in turn are composed of 481 districts. The smallest jurisdictions are communes, of which there are 8600.

The general primary health care programme

In northern Viet Nam, a network of health posts and district hospitals functioned from 1955 onwards; after national unification in 1975 the health services required corresponding development in the south. By 1981, health posts had been established in nearly all the communes in the country—in 8529 places. These posts are staffed by personnel who are selected by the community and then given training in provincial-level "secondary medical schools". At first, the health course lasted one year; this was later increased to two years and is now three years. The graduates are known as "assistant doctors".

There are approximately 15–20 communes in a district, and supervision of the commune health posts is provided by a health official at the district level. Participation of the community is mobilized both at the district and the commune levels. The general poverty of Viet Nam, and particularly shortages of transport (for referral of patients) and in the drug supply, create difficulties for the entire primary health care programme.

The Viet Nam primary health care programme calls for leadership at four levels. At the central level, all the departments in the Ministry of Health are involved to some degree in the programme. The central Ministry does the overall planning and provides general directives for the staffing of all positions and training of personnel. Efforts are being made to integrate various vertical programmes—immunizations, nutrition, malaria control, family planning—into the community primary health care services.

The 40 provinces have populations of one to three million and the provincial health director has responsibility for all health services in his province. Some time ago these provincial officials had to be appointed from among the more mature assistant doctors, but now all of them are physicians with postgraduate training in social medicine and public

[1] Based on a case study by Dr Lê Hùng Lâm, Deputy Director, School of Public Health, Hanoi.

health. (This training is now available at the Hanoi School of Public Health.) The provincial health director arranges for staffing of all the health offices at the district level and for training of all the assistant doctors, nurses, and midwives.

The 481 districts have populations of about 100 000 to 200 000 each. The top district health official serves as chief of the district health centre and is responsible for the health posts in all the communes of the district. At this level there may also be a hospital, a polyclinic, a laboratory, a pharmacy, an anti-epidemic brigade, and a resource for training primary health workers. Most of the district health officials are mature assistant doctors, some of whom have had special training at the School of Public Health in Hanoi.

At the level of the commune, with populations of 2000 to 10 000, the primary health care leader heads the local team, which may have a nurse and a midwife; the leader is ordinarily an assistant doctor. He works under the administrative guidance of the commune people's committee and under the technical guidance of the district health leader.

Leadership functions at various levels

The leaders at various levels of the Viet Nam national health system must carry out numerous activities. At the Ministry level, they must be concerned about national health policy for the whole country. The person with major responsibility for primary health care in the Ministry must work with the Director of Health Planning on the resources required for the entire primary health care programme, with the Director of Financing on the financial requirements, and with the Director of Training on the whole training programme for assistant doctors. He must try to ensure the proper distribution of drugs and supplies, arrange for the reporting of activities and the follow-up of reports, and seek to coordinate the health services with the activities of other sectors (other ministries) related to health. In addition, he must undertake periodic evaluation of the entire programme and specifically organize an annual conference for discussion about the experiences of primary health workers throughout the country.

At the provincial level, the leader must develop primary health care activities in all districts of the province. He must acquaint personnel in the provincial health office—physician, sanitarian, pharmacist, training officer—with their duties with respect to primary health care, coordinating their activities. It is his responsibility to work out the framework for referral of patients from one facility to another, to provide equipment, supplies, and transport to the district health centres, and to arrange that proper records are kept and reports submitted. He must determine health manpower needs for primary health care and give directives to the provincial secondary medical school on the assistant doctors, nurses, and midwives to be trained. Another task he must attempt is to coordinate the primary health care programme with other sectors in the province, such as agriculture, education, housing, and

communications. Finally, he must analyse periodic reports from the districts, and prepare an annual evaluation of the efficiency, effectiveness, and impact of the whole primary health care programme.

At the district level, the leader must determine the major health needs of the district population in order to plan the overall primary health care programme. He must try to update, as necessary, demographic and epidemiological data for the district and ensure that, where necessary, strategies for communicable disease control are applied. It is his responsibility to organize all health posts needed to cover the communes in the districts, and to develop arrangements for supervising them. He must ensure that the district hospital accepts and treats patients referred by the commune health posts and must organize the provision of maternal and child health services, including family planning. It is important that he should try to ensure the growth and production of medicinal herbs in the district, to back up the provision of modern drugs. Other tasks include organizing the training and continuing education of village nurses, promoting cooperation with other sectors concerned with socioeconomic development, making evaluations of primary health care activities in the districts, and reporting periodically to the provincial health director.

At the commune level, the range of responsibilities for primary health care is broadest of all. The team leader (assistant doctor) must plan for the commune the application of the directives coming from the district health office and must report on local health problems to the commune people's committee. It is necessary for him to acquire an understanding of local attitudes and customs relevant to health and collect data for health statistical reports. He must assign specific tasks to each member of the health team and ensure that all technical equipment at the health post is maintained. An important responsibility is to coordinate the work of all team members, encouraging cooperation and collective work, especially in mass campaigns (immunizations, sanitation, etc.) and it is also important to establish cooperative relationships with community organizations, such as the Women's Federation or the Youth Movement, mobilizing their help in health campaigns and other tasks. He must meet regularly with team members, offering constructive advice about their work. He is also responsible for providing continuing education for Red Cross village nurses, and he must cooperate with the health posts of other nearby communes.

Beyond all these responsibilities, the commune health post leader should learn about environmental hazards that call for correction. He must try to identify nutritional inadequacies and contagious diseases as early as possible, so that action can be initiated to combat them. He is responsible for supervising the activities of village nurses, who give advice to families concerning the construction of wells and septic tanks and on the general maintenance of environmental cleanliness. He is also required to inspect food establishments and schools.

Another responsibility of the health post leader is to ensure the provision of first aid and the earliest possible treatment of common

diseases, referring the more serious cases to the district hospital. He should collaborate with traditional practitioners to the extent feasible. It is important for him to organize a system of records on the health problems of each family in the commune, and on the health services rendered to family members at the health post or the hospital. He must supervise the services of the midwife, making certain that each pregnant woman receives proper care and that all newborn infants are immunized against tuberculosis. In collaboration with the midwife he must promote family planning services (mostly insertion of intrauterine devices) and attempt to maintain the birth rate below 1.5% per year. Periodic health examinations of children in crèches, kindergartens, and schools need to be organized. The health post leader must also supervise the assistant pharmacist, if available, in the preparation and distribution of traditional herbal medicines (25–35 varieties). He must work with team members to organize health education on nutrition, physical culture, personal and environmental hygiene, family planning, and other subjects. Finally, he must encourage people to participate in all health activities.

Training for primary health care leadership

The development of leadership capabilities, at the four levels described above, obviously requires a great deal of training. In the 1960s, the Democratic Republic of Viet Nam had already established a wide network of district health centres and commune health posts to provide primary health care. Physicians were not available to supervise these units, so that steps were taken to train a new type of "doctor-organizer". First, the task was given to the Department of Public Health Organization of the Hanoi Medical School. Then, in 1976, a School of Public Health was established in Hanoi, to train these doctor-organizers, and also to offer postgraduate training for higher-level public health leaders.

Training at the Hanoi School of Public Health includes the social sciences and health administration, as well as the medical sciences. For the training of doctor-organizers, admission is granted to assistant doctors who have worked for at least five years in the health service, following ten years of general schooling. Initially, the courses lasted only one year in an effort to meet pressing needs, but later the training was extended to two years, and at the present time it is three years. Part of the time is spent in field practice at a model district health centre and health posts associated with the school.

In each province, as noted earlier, a "secondary medical school" prepares the assistant doctors, who serve as the main primary health care leaders at the commune and district levels. Students for these schools were recruited initially (around 1960) from among nurses or midwives who had three years of experience and also from among young men or women who had completed seven years of basic schooling. Later, ten years and then 12 years of schooling were required. The

secondary medical school course initially lasted one year and (as at the School of Public Health) was later extended to two years and then three years. The assistant doctor graduate always returns to his commune of origin to work in the health post. Later, at the district health centre or the provincial health office, he follows a special course on primary health care management for one to three months. After this he receives periodic continuing education.

It may be noted that most primary health care leaders at commune and district levels are assistant doctors, although previously many were nurses with field experience. In the future, it is expected that these leadership positions at all levels will be held by physicians, as is the case now at the provincial level. These physicians must, however, be trained adequately in social medicine and public health organization, both in theory and in practice. In the same way as a teaching hospital is necessary for training in clinical medicine, a teaching health centre is indispensable for training in community medicine for primary health care.

Sample Localities in National Primary Health Care Systems

The second type of case study analyses one fairly representative locality in a national primary health care system. These accounts were submitted by experts from Cuba, Finland, Papua New Guinea, and Somalia.

Cuba[1]

Cuba is an island in the West Indies with a population of 9.8 million. Since the revolution of 1959, the country has developed a socialist political economy as well as a socialist health system. For administration of health and other activities it is divided into 14 provinces and 166 municipalities.

In order to emphasize primary health care, the Cuban health system has developed a network of nearly 400 polyclinics, reaching the entire population. Each polyclinic serves an average of about 25 000 people and is staffed with teams of physicians, dentists, nurses, and other health personnel. The physicians typically include a generalist (internal medicine), a paediatrician, and an obstetrician-gynaecologist. Each health team is responsible for a specified population in a geographic sector of the health area served by the polyclinic.

A teaching polyclinic and its leadership

One of the educational objectives for health personnel in Cuba is to modify their orientation from the traditional hospital/specialty focus towards primary health care. To help implement this concept, many of

[1] Based on a case study by Professor C. Ordóñez Canceller, Professor of Epidemiology, Director, Polyclinic Plaza, Havana.

the polyclinics have been assigned teaching responsibilities for medical, dental, nursing, and other students. This case study is based on activities in one of these "teaching polyclinics", which has been conducting such educational work since 1974. It is the Policlínica de la Plaza de la Revolución, located in the central part of Havana Province and serving a population of 28 700.

Leadership in the activities of the Policlínica de la Plaza de la Revolución is recognizable at three levels. At the first level, the Director of the Polyclinic is the Head of the Council, a body composed of the chiefs of the polyclinic's main departments (paediatrics, X-ray, etc.). Secondly there are nine "vertical teams", each with its leader; for example, the paediatric team consists of several paediatricians, nurses, and clerks, headed by a chief paediatrician. Thirdly there are "horizontal teams", consisting of all the doctors and other personnel serving one geographic sector; one physician serves as head of these sector services.

The Head of the Council is a mature physician, who is a specialist in epidemiology; after qualifying in medicine, he took graduate studies in epidemiology in Prague and London. In the Cuban health system, he has worked at the national and provincial levels, as well as currently at the health area or local level; he has been Director of the polyclinic since 1975. He has also been professor of epidemiology at the medical school of the University of Havana. As Director of the polyclinic, he draws up the work plans for each year, in cooperation with the members of the Council. Each month, the heads of each department draw up implementation plans for their departments. The Director pays periodic visits to each department head to check on the progress of the work and discuss any problems that have arisen.

The Director is also in charge of the teaching programme. This includes teaching of undergraduate medical students, nursing students, technicians, and postgraduate residents in internal medicine, obstetrics-gynaecology, and paediatrics. The instruction of medical students emphasizes epidemiology, and the work with residents emphasizes health administration.

The heads of the vertical departments are less experienced than the Director, but they nevertheless have many years of training and experience in their respective disciplines. Each of the three major clinical departments is headed by a physician-specialist, and it is noteworthy that each of these doctors also regularly spends some time in the nearby hospital to which the polyclinic is linked. Two or more research projects are also carried out each year by each department.

Nurses belong to the Department of Nursing in addition to their affiliation with the other vertical departments and also with horizontal health sector teams. The head nurse is responsible for planning, directing, coordinating, and assessing the nursing services throughout the polyclinic programme, and also for the teaching of nursing students.

The Psychosocial Department, with five staff members, is headed by a psychologist. As one might expect, the personnel of this department

have various relationships with nearby state schools, where research is carried out and psychometric testing is done. They also do frequent studies to determine how satisfied patients are with the various services of the polyclinic. The Department of Laboratory Services is headed by an experienced and trained laboratory technician. In addition to usual leadership responsibilities, he has special obligations for the ordering and maintenance of laboratory equipment and supplies. He teaches not only laboratory students but also medical and nursing students and residents in the different specialties. The Department of X-ray Services is headed by an X-ray technician with appropriate training and many years of experience.

Another member of the polyclinic Council is the Administrator, who is concerned with finances for the entire polyclinic and all aspects of physical maintenance. He is a man of 40 years of age, whose only formal training has been attendance at courses and seminars, but he has had more than 20 years of experience as an administrator in the Cuban health system. The polyclinic also has a department of statistics, headed by a statistician with limited training but extensive experience.

Training for primary health care leadership

With respect to training for leadership, the polyclinic Director holds the view that this is possible and necessary, but that it depends mainly on self-education through experience in an appropriate environment. For training in primary health care, the person must first work in a primary health care setting. He must work in the community and develop relationships with people. Formal courses can be helpful only if they are combined with such experience. Teamwork can only be learned by working in a health team. However, even while serving in a community position, as in a polyclinic, the potential leader can enhance the value of his experiences by the study of books.

He considers, too, that to enrich community participation in primary health care programmes, leaders should try to heighten the health knowledge of the people through "people's health schools". Political awareness is also important in the leader. The effective leader must not only have professional ability, he must be cooperative and disciplined, and capable of taking initiative and motivating others. A leader is an organizer, an innovator, a guide, and an educator. To have all these traits, the leader must understand his own temperament and be at peace with himself and others. He must admit his own failures and try to correct them. He must struggle constantly and must want to serve others.

It is not easy to find quantitative measurements of the effects of competent administration and leadership. At the Policlínica de la Plaza de la Revolución, however, it is reported that in 1975 about one out of 35 patients seen was referred elsewhere for further care. Currently, this ratio is one out of 100 patients seen, suggesting that the primary health care provided is more effective than that given previously.

Finland[1]

Finland is a Nordic country of approximately 4.8 million people, who live in 12 provinces, divided into 461 municipalities. Since the Public Health Act of 1972, primary health care has been emphasized and a network of 213 health centres has been established, each of which the population of one municipality or a league of two or more municipalities. The services of the health centres are financed by money from national sources and municipal revenues.

The general primary health care programme

The health centres provide, without charge, family health services (including family planning), health education, the medical services of a general practitioner, first aid, transportation of patients, school health care, dental care, and occupational health services for workers; various health personnel are also trained at health centres. A nominal fee is charged to patients for adult dental care and physiotherapy. This array of services is a combination of activities previously offered by several different agencies. The example of one health centre in eastern Finland will serve to illustrate the operation of the primary health care programme.

The principal health centre is located in Varkaus, an industrial town with a population of 25 000. The health centre is administered jointly by Varkaus and two rural municipalities—Joroinen with 6000 and Kangaslampi with 1800 inhabitants—covering a total population of about 33 000. The concept of "health centre" in Finland is an administrative one, usually including more than one physical structure. Thus in Varkaus there are four health stations, where general practitioners are located. There are also two separate laboratories and X-ray departments. Several stations provide maternal and child health care and school health services, and there are special stations for family planning and immunization services for adults. There is a station for occupational health and a department for rehabilitation and physiotherapy. Dental clinics are held in three locations and environmental controls are administered at one special station. Altogether there were more than 40 sites providing services in 1983 as part of the Varkaus Health Centre.

Along with these primary health care services, there are two small hospitals, with a total of 92 beds, mainly serving chronically ill patients and, occasionally, mild acute cases. These hospitals are considered part of the health centre organization. Also in Varkaus there is a 142-bed regional hospital, to which patients requiring secondary specialist care (internal medicine, routine surgery, obstetrics and gynaecology, paediatrics, and ophthalmology) may be sent. Patients needing more complex tertiary care are sent outside the area of the municipal league to the Kuopio University Central Hospital. The Varkaus Health Centre staff has

[1] Based on a case study by Dr P. Hosia, Head Physician, The Health Centre of Varkaus, Varkaus.

conducted some health services research in collaboration with University of Kuopio personnel.

For this comprehensive primary health care programme, the Varkaus Health Centre employs 240 health personnel, including those working in the two small hospitals. These comprise 16 physicians (in 1983), 13 dentists, 25 public health nurses, and numerous others.

Up to the late 1960s, physicians worked independently and were paid mainly directly by the patient. Now, as the physicians are part of the organization, they work for eight hours a day plus the obligatory on-call service, and are paid a fixed monthly salary. After official duties, the salaried physicians are permitted to engage in private practice, but in Varkaus very little of this is done. The role of the public health nurses has also changed; before 1972 they were employed by the municipality to furnish all types of service in a certain district, and their work was supervised by the provincial authorities. Now they have more specialized duties (child health, family planning, etc.), which they seem to prefer.

The reorganization of primary health care took place little more than ten years ago, and thus there remain various administrative problems that have not yet been solved. However, the resources in the official system have been clearly expanded, and every citizen now feels that he has access to care.

In the rural areas there seems to be a high level of satisfaction among the people, but in the towns, where there are several physicians in each facility, patients may see a different doctor at each visit and often complain of a lack of continuity of care.

Leadership functions at various levels

Provision of effective leadership in this framework of primary health care is not easy. While, at Varkaus, the Head Physician is, in effect, the general leader of the Health Centre, the personnel are divided into five different groups, each with its own special leader. The physicians, along with a psychologist and a speech-therapist, are supervised by the Head Physician. Nursing personnel come under the Director of Nursing. The Financial Manager is in charge of all office personnel. There is a dentist-in-chief responsible for all dental services, and a veterinarian-in-chief, in charge of all environmental health activities. This kind of organizational structure demands frequent and flexible cooperation among the supervisors. The closest approach to coordinated action is the Health Centre Steering Board, comprising the five leaders mentioned and chaired by the Head Physician; this board is responsible for matters of personnel management and the everyday work of the Health Centre. Various national regulations define the duties of all personnel throughout the primary health care framework.

Although the role of the Steering Board is limited, the Head Physician, as chairman, is endowed with some special authority. This may cause some difficulties with respect to functions that are the direct responsibility of the other board members—particularly the Director of

Nursing and the Financial Manager. (In some larger cities of Finland, the financial manager has acquired the major leadership role in the health centre.)

Above the level of the Varkaus Health Centre, authority and leadership come from various governmental bodies. The Board of the Municipal League (consisting of the three municipalities) has nine members and is responsible for the financial aspects of the Health Centre and for the appointment of physicians, dentists, and veterinarians. This body meets monthly and its meetings are attended by the Head Physician and Financial Manager of the Health Centre. There is also a Board of Health, composed of 12 citizens, which meets once or twice a month; all five health centre leaders attend these meetings to discuss the issues on which policy decisions are to be made.

Planning of the primary health care programme is based on a rolling five-year plan. The Government and the Ministry of Health annually confirm the five-year plan and the National Board of Health implements these plans by allocating the resources to various provinces and investments. The National Board of Health also has "national responsibility" for the health centres throughout the country.

With this general administrative structure, it is evident that effective leadership of the Varkaus Health Centre depends on good working relationships among the several professional leaders. No important decision is made by one leader without consultation with colleagues. Delicate problems may arise when there are negotiations with labour unions—for example, representing nurses or office personnel—in which case, one member of the Health Centre Steering Board may find himself or herself with split loyalties between the union and the administration.

Training for primary health care leadership

All five members of the Steering Board of the Varkaus Health Centre have had higher education and field experience, certain aspects of which were undoubtedly relevant to some tasks of leadership. The Head Physician earned a medical degree in 1974, and served for two years as head physician in a small rural health centre and for one year as a research assistant at the Department of Public Health of the University of Kuopio. He has served in his present post since 1977.

The Financial Manager has a master's degree in political science and worked as the financial manager of a central office in Sweden; he has served in his present post since March 1983. The Director of Nursing completed her nurse's training in 1965 and undertook special studies in nursing administration in 1970; in 1980 she earned a university master's degree in nursing. She worked as director of nursing in a rural health centre for two years and has been in her present post since 1975.

The Dentist-in-Chief earned his dental degree in 1963 and undertook special studies in dental public health in 1977. He has worked as a municipal dentist in Varkaus since 1964, and was appointed Dentist-in-Chief when the Health Centre started its activities in 1972. The

Veterinarian-in-Chief earned a degree in agricultural forestry in 1956, a second degree in veterinary science in 1964, and a third degree in hygiene in 1966. He worked in rural environmental health services for 13 years and was appointed to his current post in 1979.

As members of the Varkaus Health Centre Steering Board these five well-trained persons must work closely together, very often on a daily basis. In a sense, they serve as intermediaries between the policy-makers of the Municipal League and the personnel of the Health Centre. All health stations peripheral to the main health centre are visited by Steering Board members at least once a year, so that they can be kept informed about any local problems. Each year a draft rolling 5-year plan is drawn up by the Steering Board, in accordance with national directives. When the 5-year plan is considered satisfactory, it is presented by the Steering Board to the Board of Health and to the Council of the Municipal League. After this, the plan goes to the provincial authorities. In all this planning, each member of the Health Centre Steering Board has major responsibility for his or her special field. Since all planning activities involve money, the Financial Manager is consulted regularly by all the specialized leaders.

In so far as personnel management is a part of leadership, each member of the Health Centre Steering Board bears responsibility for the personnel in his/her field. Steering Board members are also concerned with the maintenance of harmonious relations among personnel and with the smooth implementation of policy decisions. In contacts with outside organizations, it is usually the Head Physician who represents the Health Centre. Relations with the province and National Board of Health, however, are usually maintained between counterparts in the same field (nursing, dentistry, etc.). Continuing in-service education is another responsibility of the members of the Steering Board, each with respect to the personnel in his/her professional discipline. Other duties of Steering Board members include the teaching of health science students, maintaining relations with other steering boards in the same province, and finally evaluation. The latter is carried out in the preparation of annual reports on all health activities and in the review of financial summaries at the end of each year.

Special training for the leadership roles of health centre steering board members has been available in Finland, but somewhat unevenly. Nurses have been able to take subspecialty training in administration for the last 15 years, but physicians and dentists only since 1981. Short 3-week courses in "health centre administration" have been offered by the National Board of Health since 1973. Sometimes health centre leaders attend short seminars on administration intended for business executives rather than health specialists. Full-length academic courses for physicians on overall health administration, however, are not available in Finland, and such training now requires study in other countries, such as Sweden or the United Kingdom.

Of the current members of the Varkaus Health Centre Steering Board, only two have had formal education in administration. At

present only the top nursing post officially requires education in administration. There is no such requirement for the Veterinarian-in-Chief or the Financial Manager. The medical and dental posts will probably require some kind of administrative education in the future. However, day-to-day experience in providing leadership is probably the most important teacher, and personal characteristics are an essential foundation for leadership skills, upon which education and experience must build. Enthusiasm for the health centre's mission is probably the main factor in ensuring effective leadership.

Papua New Guinea[1]

Papua New Guinea, in the Western Pacific with a 1980 population of about 3.1 million, is administratively divided into 19 provinces. The country's second 5-year National Health Plan (1979–83) was committed to developing a health system based on primary health care. This has been implemented through hierarchical division of each province into districts (with an average of 8.5 districts per province), each served by a health centre; each district is further subdivided into smaller health areas served by a health subcentre or, more often, by an aid post.

The operation of this system, and particularly the role of leadership for primary health care, will be described as it is found in the Rigo District of the Central Province—a district of 24 000 inhabitants. The main centre of health activities is the Kwikila Health Centre, around which are 33 smaller peripheral health units. The latter include one government subcentre, one (religious) mission subcentre, and 31 aid posts.

Primary health care leadership at the provincial level

Health leadership in the province comes principally from the provincial health officer, who is usually (in 13 of the 19 provinces) a physician (either national or expatriate), as is the case in Central Province. At the level of the health district, leadership is provided by the health extension officer, who also directs the district health centre. At the most peripheral level, primary health care services are provided by aid post orderlies.

The legislation of Papua New Guinea requires that the provincial health officer be a registered physician, with training and experience in public health administration. He is responsible for the operation of all health facilities in the province, including hospitals, for directing all environmental and disease control programmes, for supervising all health personnel, and for carrying out all related administrative functions. In the Central Province, the Provincial Health Officer is a

[1] Based on a case study by Mrs R. S. Sinclair, History Department, The University of Papua New Guinea, Port Moresby.

British physician with a postgraduate degree from the Harvard School of Public Health.

On the headquarters staff of the provincial health officer are 18 personnel, consisting of a deputy assistant secretary, five heads of specific services (disease control, nutrition, malaria, community health, and nursing), two environmental inspectors, and ten clerical and support workers. Theoretically, the deputy assistant secretary is responsible for coordination of all health activities in the province. However, because of the inadequacies of many of these personnel, the work of the provincial health officer has been described as sometimes being a "one-man-show". He is obliged to spend too much time in "crisis management" (when a nurse has not been paid, or a health centre urgently needs penicillin, etc.), and would like more time to exercise his leadership functions of making health plans and budgeting, recruiting staff, and making periodic visits to health centres for supervisory and teaching purposes (including performing some surgery).

Leadership at the district level

At the level of the health district, leadership is the responsibility of the head of the health centre. In the Rigo District, the Kwikila Health Centre is in the charge of a Health Extension Officer. This young man (25 years of age) received three years' training—two years at the College of Allied Health Sciences and one year of rural field practice; following this a fourth year of "residency" was required, consisting of six months of supervised clinical work and six months of supervised community health work.

The Health Extension Officer divides his time between managing the Kwikila Health Centre and supervising the aid post orderlies in the villages. The Health Centre alone has a staff of 32 to be supervised; one of these is designated "aid post supervisor", although, as he is disabled, he actually works as a hospital orderly. To supervise the 33 peripheral health units, the Health Extension Officer must mobilize the services of the health centre staff—nurses for maternal and child health services, a tuberculosis officer, malaria control officers, etc. To save transport costs and yet ensure that the Health Centre is always adequately staffed, he coordinates his own field visits with those of his associates. The Health Extension Officer must also make sure that adequate medical supplies are ordered for the Health Centre and the peripheral posts. Much time is spent in keeping records and sending reports to the Provincial Health Officer, but there is apparently little feedback. Recently the Health Extension Officer helped to form a Rigo District Health Committee, to plan for needed new health posts and improved water supplies.

The Health Extension Officer spends three days a week on clinical work in the Health Centre, including overseeing the hospital inpatients (there are 20 beds). He determines which patients require referral to a provincial hospital. The Health Extension Officer also tries to evaluate

the work of all staff members of the Health Centre, as well as at the peripheral health units, making suggestions for improvement. He gives periodic in-service training to the peripheral aid post orderlies (week-long courses twice a year) and has himself attended a refresher course at the provincial level for one week. Monthly staff meetings are held at the Kwikila Health Centre, chaired by the Health Extension Officer.

Along with the Health Extension Officer, the senior nurse provides leadership to the nursing staff of five nurses and two nurse aides. Their work is focused on maternal and child health services, both in the Health Centre and at the health posts. The senior "sister-in-charge", as she is called, attempts to advise all the nurses on how their work can be improved, but she refers special problems to the attention of the Health Extension Officer.

Primary health care at the local level

Information on aid post orderlies was difficult to collect, and only one could be consulted—an orderly who was considered "not a good leader in primary health care". His aid post serves six villages, but he evidently does only a fraction of the work expected. Aid post orderlies are trained for two years—one year in the classroom and one in field practice—to carry out both preventive public health work and diagnosis of disease; outreach public health work is supposed to occupy most of his time. This aid post orderly, however, spent most of his time simply waiting for sick patients to come to the aid post for treatment. He seldom visited the villages and thinks that there is nothing he can teach the people about sanitation or other matters. It was stated by the Health Extension Officer, however, that other aid post orderlies in the Rigo District were more active in community health work.

As a general observation, the author of this Papua New Guinea study concludes that virtually none of the health workers has been trained adequately to cope with all the tasks they are expected to do. The role of many health workers is ill-defined and as a result they perform only the most immediate tasks of treating the sick and neglect other aspects of primary health care.

Although all the health personnel at the three levels—the province, the district, and the local health area—have had the expected formal training, none has had specific training in leadership. It is noteworthy that a recent Central Province Health Plan calls for the creation of new positions at all three levels, in order to lighten the responsibilities of the leaders at each of these levels so that they can perform better the tasks of leadership.

Somalia[1]

Somalia, in the Horn of Africa, had a population of about five million in 1980. It is divided into 16 regions, each containing three to six

[1] Based on a case study by Dr Ahmed A. Farah, Regional Primary Health Care Coordinator, Lower Shabelli.

districts, composed of large and small villages. Each region has a regional governor and each district a district commissioner, all of these officials being appointed by the central government. A large population of nomads creates special problems for the organization of health services.

The general primary health care programme

Somalia's most important health agency is the central Ministry of Health, which controls all health facilities (hospitals and health centres) in the country. Other large semi-public bodies are responsible for a health insurance programme (CASS) and for the import and distribution of drugs (ASPIMA). Municipalities play a significant role in town sanitation. Traditional medicine is widespread and even encouraged by the government, but the private practice of modern medicine is illegal.

Each of the 16 regions has a regional hospital of 50–200 beds, but the staffing and equipment of these are very inadequate. Most of the 83 districts contain district hospitals of 10–40 beds, and their shortages of staff and equipment are extreme; some do not have a single doctor. Small outpatient clinics are also located in the districts, but only in the larger cities are they staffed with doctors; most of these units are served only by auxiliary nurses. Any serious case is referred to a district hospital. Finally, among Somalia's health facilities are several maternal and child health centres, which offer preventive services to children (including immunizations) and expectant women, and also (in the towns) contraceptive advice.

A demonstration primary health care project

In 1962, a rural health centre was developed, with WHO cooperation in the district of Balad; it was intended to serve as a field practice facility for a training programme. Owing to various logistic difficulties the project was terminated in 1966, but in 1969 it was reactivated and extended to the Lower Shabelli Region. Through a survey of the population, information was gathered on the health needs perceived by the local people. A community health committee was formed and health education was conducted by all personnel.

By 1974, an official review indicated that (*a*) the health centre and district hospital were operating, (*b*) shallow wells and latrines had been constructed, (*c*) regular village clean-ups were being carried out, (*d*) children and expectant mothers were being immunized, and (*e*) a record system of clinic cards and family folders had been established. The work in the Lower Shabelli Region covered four districts, but it was regarded as really successful only in one: the Qoryoley District. The difficulties encountered had included staff instability, inadequate training, shortages of supplies, transportation problems, excessive

concern with curative care, poor integration of services, lack of information about underground water, and (significantly for this study) inadequate supervision and follow-up.

Future health plans

In Somalia's National Health Plan for 1980–85, top priority has been assigned to the extension of primary health care. In the Ministry of Health a central primary health care office has been set up, and a corresponding regional primary health care office in every region. Assigned to each of the latter offices is a supervisory team, headed by a physician and including a senior sanitarian, a public health nurse, a nurse-midwife, and a laboratory technician. Likewise, it is intended that every district will be staffed by a district medical officer, along with a similar health team. Funds for supporting this ambitious network of primary health care services are coming from bilateral and multilateral international sources. Expatriate health personnel are working in regions where Somalian personnel have not yet been trained. Training centres have been established in the capital towns of two regions, where four-month courses on the primary health care approach are offered. It is hoped that professional doctors and nurses who have had this training will, in turn, train community health workers and traditional birth attendants in the regions and districts to which they are assigned.

The primary health care concept is being extended by visits of the regional primary health care teams to the districts and meetings with community leaders. Likewise the Ministry Primary Health Care Office is responsible for supervision of the regional teams. The regional governor is expected to integrate the entire primary health care programme with the activities of other ministries (rural development, education, agriculture, etc.). While not all 16 regions are uniformly staffed, by 1983 only one was completely untouched by the primary health care programme.

Full implementation of the primary health care concept in Somalia is retarded by the fact that a large share of the national health budget is still spent on curative medical services in the hospitals and clinics. Most health personnel have not been reoriented to the primary health care approach and the training institutions still adhere to their old curricula. The vertical programmes (on malaria, tuberculosis, etc.) are not yet integrated into primary health care activities. The various programmes aimed at international collaboration in the primary health care efforts are not properly coordinated. Health authorities have not yet been able to persuade the people of the positive role that they should play in developing health programmes. Primary health care goals can be achieved in Somalia only with changes in health manpower training, logistic support, referral arrangements, and supervision of day-to-day health activities.

Special Primary Health Care Projects

The third type of case study analyses one or more special primary health care projects in a country. Such accounts were submitted by experts from Bangladesh, France, Kenya, Liberia, and the Philippines.

Bangladesh[1]

Bangladesh, with a population exceeding 93 million, was established as a sovereign nation in 1971. For administrative purposes it is organized hierarchically into four divisions, 64 districts, 460 upazilas, and 4500 unions. An upazila (formerly called "thana") has an average population of 200 000. A union, the smallest unit for operational purposes, has a population of 20 000, comprising an average of 15 villages.

Despite much foreign aid, for the majority of Bangladeshis the standard of living appears to have declined in recent years. In 1963–64, 40 % of the rural population were categorized as poor (unable to satisfy 90 % of the FAO-defined minimum daily energy requirement) and 5 % as "extremely poor". By the mid-1970s, the percentage of poor had risen to 78.5 % and that of the extremely poor to over 40 %. Between 1962 and 1975, the per capita food intake had declined by 628 kJ (150 kcal) a day.

A special primary health care project

In order to provide better health care, and also improved general social conditions for the poor, a special project was launched in 1972 in the upazila of Savar, 35 km from Dhaka. It was started by a group of medical and paramedical personnel, who had worked together in running a field hospital during the civil war in 1971. It was called "Gonoshasthaya Kendra", which means "People's Health Centre". This facility was intended to provide both preventive and curative health services, mainly through auxiliary workers who would be trained at the Centre. In order to attract money from philanthropic sources, the leaders had to prepare a plan, but it was soon learned that many changes were necessary to the initial ideas.

The original plan, for example, expected to use voluntary workers, but it became clear that few poor people are prepared to work without pay. It had been expected that payments by the people would make the project self-supporting within five years, but it was learned that external support was needed permanently. The massive influence on health of unemployment, lack of land ownership, oppression of women, illiteracy, and commercial exploitation became increasingly obvious. In response, the People's Health Centre helped to form associations of landless peasants, women's centres, schools, and also a pharmaceutical factory.

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[1] Based on a case study by Mrs S. Chowdhury, People's Health Centre, Dhaka, and Dr Zafrullah Chowdhury, Projects Coordinator, People's Health Centre, Dhaka.

Most of the staff of the Centre were city-bred, and it took time for them to understand and work with the poor landless families. They had to learn to live in simple tents, rather than in comfortable housing. The staff decided to use the Bengali language, even though some workers preferred to use English. Family planning was at first promoted very vigorously, until the staff learned to appreciate why the people still wanted to have many children.

After some 11 years of development, the People's Health Centre has expanded into many fields. At the main health centre there are now three doctors and 60 paramedical workers, but these account for only one-third of the project personnel. The rest are employed in workshops, the school, agriculture, the publications department, and administration. In addition, there is the pharmaceutical factory, which is administratively separate.

Two daughter projects have been started—one in Shapmari, 190 km from Dhaka, and the other in Sreepur, 65 km from Dhaka. Both were started by paramedical workers from Savar, but the personnel are mainly local people; one local doctor is employed in each unit on a contract basis. At Shapmari, a weaver's workshop, a school, and an agricultural extension programme have been organized, in addition to the health centre.

Leadership functions and training

Overall responsibility for the People's Health Centre project at the three locations, as well as the pharmaceutical factory, rests with the project coordinator. Each of the health centres is now headed by a paramedical worker. Some doctors could not accept the idea of working under a paramedical person, but there are three doctors who have now settled down with this arrangement.

In the Savar area, four subcentres have been developed within 25 km of each other. Each has between five and seven paramedical workers. Two supervisors, based at the main centre, are responsible for guiding and helping the peripheral paramedical staff, although each subcentre also has a supervisor. Another supervisor is responsible for training the paramedical workers.

The paramedical workers are selected from among young men and women who have had 8–10 years of basic education, and are trained for a period of one year. Preference has been given to women, because they can give health care to women and children more effectively. In the first half-year of the training period, the trainee accompanies and assists a senior paramedical worker in village field work during the day, attending classes in the evenings. In the second half-year, the trainee works more independently in a subcentre under supervision.

Each trained paramedical worker is responsible for two or three villages with a total population of about 3000. Duties include (*a*) registration of births and deaths, (*b*) identification and follow-up of pregnant women, (*c*) identification of high-risk children, (*d*) immuni-

zations, (*e*) health and nutrition education, (*f*) treatment of diarrhoea through oral rehydration, and (*g*) family planning services. This primary health care work is done through visits to the households, made with the help of a village contact person—usually a traditional birth attendant—who has had some instruction at the main health centre.

Financing and other aspects

The above primary health care services are given free, but for curative care small charges are made. At the main health centre and the subcentres there are outpatient clinics for such care once or twice a week. All patients are seen first by a paramedical worker, who refers the difficult cases to the doctor. At the main centre there are laboratory and X-ray equipment, a small surgical operating theatre, and 15 beds. The charges made for curative care are of two types: first, there is an insurance fund to which more than 100 000 people contribute on the basis of a graduated scale of payments; second, small fees are collected at the time the patient seeks care. The poorest people pay no insurance contribution and a very small fee per consultation. The next poorest group pay a small annual contribution to the fund (for "family registration") and a higher consultation fee. The most prosperous (though still poor) families, pay the same insurance contribution as the second group and a somewhat higher fee per consultation. All patients, however, receive the same type of treatment. Altogether, these payments cover nearly 50 % of the recurrent costs of the entire health programme; the balance comes from outside funding.

The entire People's Health Centre project has had to face up to opposition from various sources. In 1977, for example, one of the senior paramedical workers in charge of a subcentre was murdered because some powerful local people thought the facility was a threat to their unlawful transactions. In another subcentre, paramedical workers have been physically attacked. Women paramedical workers have had to cope with insults from people who do not approve of their unorthodox activities. Great courage is obviously necessary in innovative work of this sort, and this depends on a spirit of solidarity with the poor and among the health workers.

The health workers must also learn to show respect for the poor. To help in the development of such attitudes, all People's Health Centre personnel, at all levels of responsibility, are required to spend 1½ hours each morning in agricultural work. Also, there are no cleaners or ancillary staff at the subcentres; the paramedical workers do everything, including sweeping the floors and washing bedpans.

The secret of leadership in primary health care is to bring together groups of health workers who can learn from the poor, understand the social, economic, and political forces operating in their particular community, and have broad skills to promote the health of those who are most sick: the poor. The diseases of poverty will disappear only when the conditions that spawn them have been eliminated.

France[1]

France, with a population of 55 million, is a highly developed country of Western Europe. For certain administrative purposes, the country is divided into 22 regions, but the major health and other social functions of government are based on the level below this, the *département*. There are some 90 departments, each of which is composed of many cantons.

This case study is focused on the department of Meurthe-et-Moselle, located in the Lorraine Region of northeastern France. In the southern part of this department is the city of Lunéville, surrounded by a depressed rural area. Within this area is a small "sector" of 15 000 people, where a special project for improving maternal and child health services was conducted.

The maternal and child health project

The central theme of the project was to seek improvement in maternal and child health through educational efforts directed mainly at three areas: birth control (family planning), motherhood, and care of the newborn. To carry out the project, cooperation was obtained at the level of the department, the general rural area (*circonscription*) around Lunéville, and the small sector of concentrated project activity. (The sector is perhaps roughly equivalent to one of the 37 cantons into which the department of Meurthe-et-Moselle is divided.)

At the departmental level, the Office of Social Hygiene was made responsible for the administration, the appointment of personnel, and the operation of the health services, as well as the organization of health and social activities in the area. The social security programme also cooperated through the Mutual Agricultural Society, organized in this area on a cantonal basis. The Society employs a certain number of polyvalent social workers, who participate in maternal and child health services.

At the level of the general rural area, responsibility was shared between a maternal and child health physician and a social worker. They both integrated the maternal and child health activities into the overall health and social framework, and supervised the personnel in the several sectors of the health area.

At the sector level, the health and social work personnel were well qualified and motivated, well known to the people and accepted by them, and had good relationships with local leaders (administrators, teachers, etc.). There is a state-run school for children 11–16 years of age, which is also used for education of their parents; this double educational programme improved parent–child relations. Above all, it is

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[1] Based on a case study by Professor R. Senault, Director General, Preventive Medicine Centre, Nancy, Dr F. Gouilly, Directorate for Health and Social Action, Department of Meurthe-et-Moselle, and Professor M. Manciaux, Faculty of Medicine, University of Nancy, Nancy.

at this local level that people live, with their elected officials (including cantonal delegates of the Mutual Agricultural Society); this is where their problems exist, including those involving maternal and child health.

There were numerous indicators of poor health conditions in the area, which stimulated development of this special maternal and child health project. The various maternal and child health educational objectives, noted earlier, were approached through discussions, travelling exhibits, public meetings, classroom exercises, and parent-student meetings on overall health. Many groups worked together in these efforts—students, elected officials, local associations, cantonal delegates, along with local health personnel and social workers and equivalent personnel from the higher administrative levels (the general health area and the department); the local press was also involved.

At first, the work was started without a definite plan, but the social workers soon saw the need for organization to cope with all the participants involved. Soon a close cooperation was achieved between the medical/social workers of the Office of Social Hygiene and those employed by the Mutual Agricultural Society; these groups collaborated, in turn, very closely with the municipalities, the directors and teachers of the schools, and the school health service. Most noteworthy were the close relations developed among the social workers, teachers, elected officials, and the medical profession from the several different agencies. The entire programme was supported by the population, and steps were taken to emulate it in other sectors of the same general health area. The doctors reported more prenatal consultations, more adolescents seeking contraceptive advice, and improved relationships between parents and children; some doctors also requested postgraduate training in maternal and child health.

Project leadership

It is difficult to identify the leadership responsible for this project, since it was so much a team effort. Most important were the field health workers and the social workers in close contact with the people. Among local leaders in the rural sector were the elected officials, voluntary agency personnel, and, most significant, the schoolteachers. The field health and social workers analysed the local situation—made a "community diagnosis"—set priorities, and mobilized resources. They coordinated the efforts of different personnel, and evaluated the whole maternal and child health programme.

At the departmental level, the leaders helped to plan the programme, including preparation of the educational material. They mobilized the agencies involved (Office of Hygiene and Mutual Agricultural Society) and the teachers of the Faculty of Medicine at Nancy. The local schoolteachers were active in training both students and parents; they integrated the project work into the regular curriculum. The school health service personnel were also very helpful. All these people

contributed to the project, in addition to carrying on their customary duties.

The field workers—both health personnel and social workers—showed their capacity to analyse a situation, their ability to talk with local people, their sense of teamwork and, above all, their professional and personal motivation. Most of them lived in the rural sector (even if they had not done so previously) in order to participate in the life of the people.

The departmental and area leaders showed competence, both technical and managerial, in delegation of tasks, and obviously had confidence in their staff. In spite of their heavy load of work, they put in the time and effort to launch the programme. They knew how to establish the necessary contacts to achieve action.

The teachers showed genuine interest in health education. They knew how to attract the attention of their students; they also knew when to seek advice from others, such as those in the school health service.

One weakness that can be reported was some lack of competence in group interactions among the field workers. The departmental leaders did not always have complete understanding of the local situation; they had no training in health education. The teachers perhaps approached problems too theoretically, but they were eager to make interdisciplinary contacts.

With respect to the requirements for leadership in this type of programme, there is a need for training of field workers in management, group dynamics, techniques of communication, etc. Supervisors need the same type of training, as well as orientation in health planning and organization. Schoolteachers should learn more about the psychosocial aspects of the subjects they teach. To some extent, these weaknesses are corrected by experience, but sound multidisciplinary education would be more effective.

Evaluation of this programme is difficult in so short a time, but it is already clear that it has supported and catalysed the feelings of children, adolescents, and adults. The subject of the project was sensitive for many people, in relation to traditional moral and religious values. Parents reacted in different ways, but some were pleased to have their children learn facts about human reproduction that they could not or did not dare to teach themselves.

Kenya[1]

Kenya is an East African country, independent since 1963, with a population of about 16 million. It is organized into seven provinces, which are in turn divided into 33 districts. This case study concerns two projects—one in Nyanza Province and the other in Eastern Province.

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[1] Based on a case study by Mr J. W. Kweri, Medical Department, Kenya Catholic Secretariat, Nairobi.

Both projects were sponsored by religious missions, which were part of the Kenya Catholic Secretariat.

Two special primary health care projects

One primary health care project covers two districts, Kisii and South Nyanza, of Nyanza Province. (These two districts compose one Roman Catholic diocese.) The population of this area is about 1 860 000. The project was started in 1975 by a Roman Catholic sister, who set out to increase the availability of preventive health services, particularly for mothers and children; she considered the previous approach of the Roman Catholic health units to be oriented too much towards curative medicine. There were 13 Roman Catholic health units in the area, at most of which the nurses had little appreciation of preventive services. The primary health care leader educated all these nurses to conduct child health clinics and expand all preventive services. She also trained a number of women as "public health aides" to do preventive work full-time—receiving full-time salaries. These aides, in turn, trained many village health workers who work on a part-time basis assisting village families in health promotion.

The visits of village health workers to families have disclosed many cases of malnutrition, mental retardation, epilepsy, and other conditions. As a result of these discoveries, special clinics have been organized for nutrition and epilepsy, and parents have been taught how to train retarded children at home. Special emphasis has been given to combating childhood malnutrition through education and treatment of complicating disorders, such as malaria and intestinal parasites.

The second primary health care project is in the Machakos District of the Eastern Province. It was started by another overseas Roman Catholic nurse recommended by the Kenya Catholic Secretariat. The exact site is the Yatta Division, a part of the district recommended by the Medical Officer of Health. Meetings were held with local leaders in that locality, and it was agreed that the emphasis should be on promoting involvement of the people in the health work. The programme was started in three villages, each of which had a small dispensary where community health workers could be trained. In this project, the community health workers were all married women with primary school education, and the training course lasted three months. Also "health helpers" were trained in a one-week course at peripheral villages. Unlike the public health aides in the Nyanza Province project, the community health workers here are part-time and are not paid.

The community health workers in the Machakos District receive regular continuing education, attend numerous meetings, and also work with traditional healers and traditional birth attendants. A study showed that about 100 community health workers are in touch with 9000 households in six communities. Some 15 000 visits had been made to these households (time period not specified).

Factors contributing to the vitality and apparent success of both these projects include their foundation in "principles of respect and love for people", a psychosocial method of adult education, the choice of trainees by the people (the training being done in the villages), continuing education, the support of village leaders, cooperation with other local social programmes, and the financial support from abroad (principally from the Federal Republic of Germany). In the Kisii District, seminars for nurses proved to be an additional advantage.

Shortcomings in both projects have been the dependence on outside financial support (particularly because preventive services do not generate income), the orientation of many nurses to curative care, the discouraging fatalism of some trainees from depressed areas, the slow progress in some efforts such as latrine construction, the persistent influence of witchcraft, and the resistance in some villages to establishing health committees.

Leadership roles at various levels

Since both of these projects are sponsored by Roman Catholic religious missions, leadership must be traced within their framework, rather than in the customary structure of governmental services. Thus, at the national level leadership comes from the Kenya Catholic Secretariat, in which the Medical Department has responsibility for health activities. The head of this department functions as overall coordinator of both primary health care projects. She makes periodic visits to them and consults with the project leader on plans. She is responsible for preparing reports to the foreign donor agencies, and handles the basic financing and accounting for them; the financing includes grant funds from the Kenyan Ministry of Health.

At the diocesan level (roughly equivalent to an official district), the project leaders make 6–12-month plans and set priority goals. They coordinate the work of team members and participate in teaching courses for training the community health workers and public health aides. They evaluate the services and propose necessary changes. They cooperate with other diocesan development personnel concerned with agriculture, water supply, literacy, the role of women, etc. They also undertake liaison with government departments in the district, and handle correspondence, salaries, and other administrative matters.

Below the diocesan level, there is the area level, consisting of a group of villages. At this level there are two leaders—one for training and the other for services. The training leader plans the training programme, organizes courses and workshops for community health workers, traditional birth attendants, health helpers, and village health workers, and makes evaluations. She meets with local political leaders, with medical and nursing personnel in government hospitals, with similar personnel in mission institutions, and with others. She also cooperates with personnel in education and other sectors. The area leader for services organizes meetings for community health workers and public

health aides, where problems are discussed and tally sheets on home visiting and other reports are collected. She visits the local workplaces of the community health workers and public health aides, discusses the programme with villagers, and refers problems to higher levels when necessary.

At the village level, the community health worker and public health aide give direct health service to families. They treat simple sicknesses with such medication as chloroquine, aspirin, eye ointment, and rehydration fluid. They give first aid for wounds and refer cases to hospitals. They teach about nutrition, improvements in latrines and water supply, and rubbish pits. They keep records on all home visits. They visit schools and treat children for scabies or ringworm, meet with mothers to discuss their children's health, and also meet with village leaders.

At the village level, there are also village health workers and health helpers. These part-time primary health care workers are essentially promoters of the use of health services, such as immunization of children and attendance at regular clinics by mothers with babies.

Training for primary health care leadership

At the national level, as noted earlier, the Kenya Catholic Secretariat (in Nairobi) contains a medical department. This is headed by a very dedicated American woman with university training in pharmacy. She has worked in Africa since 1949, and since 1959 has done administrative work. Of equal standing is a Kenyan graduate of London University, with training in economics and health administration; he worked in the Kenyan Ministry of Health for eight years before joining the Kenya Catholic Secretariat. He provides leadership in budgeting, reporting, and other administrative aspects of the programme.

At the diocesan level, the project leaders are both nurses—one from the Netherlands and the other from the United Kingdom. They have both had extensive training and experience in clinical nursing, and it is of special interest that the Netherlands nurse earned a master's degree in public health (in the USA) and the British nurse took a one-year course in her home country for "health visitors" (public health nurses).

At the level of the area, or group of villages, the primary health care leader in one project is a health centre nurse, supported by public health aides in the villages; in the other area, the primary health care leader is a community health worker with additional leadership training, supported by other community health workers.

In both projects, the leadership positions are held by people with many years of experience in similar activities in the African setting. At the local area level, there are "community health worker group leaders" who have received additional training through several workshops of about one week's duration each. These workshops were sponsored by nongovernmental organizations, including Women in Development of Women (WINDOW) and Training of Trainers (TOT). Such workshops

were also valuable in strengthening the background of Kenyan nurses who, after several years, took over leadership from the European team leaders at the diocesan level. In both projects these Kenyan team leaders are graduates of secondary schools, and each has professional training as an "enrolled community nurse".

The training of basic field workers in primary health care applies the psychosocial method of adult education. In this method, the trainees are stimulated to raise their own problems and experiences, and the trainers respond by giving possible solutions; in the course of responding they make sure that all basic subjects are covered, such as management of common diseases, environmental health, child development, family planning, immunizations, etc. They also teach about the organization of clinics and home-visiting.

Future plans call for greater effort to involve the nurses at mission health centres in the operation of the entire public health care programme. The same holds for involving the medical and nursing staffs of the rural hospitals. To simplify communication, the different terms used for personnel doing similar tasks are going to be changed, with general use of the term "primary health worker".

Liberia[1]

Liberia is a country in West Africa with a population of about two million, and is divided into five territories and nine counties. Maryland County is located in the least developed region of the country, and has a population of about 100 000, 70 % of whom live in rural areas. This case study reports experience with a primary health care project in Maryland County.

A special primary health care project

In 1977, the Government of Liberia, in collaboration with the Government of the Netherlands, decided to launch a primary health care project in Maryland County. It was estimated that previously only 15 % of the population had any access to health facilities, which included two hospitals and a few dispensaries. The new project would emphasize active participation of the local people, the training of village health workers, maximum prevention, and other policies advocated by WHO and supported by the Government of Liberia.

A Liberian physician was appointed as team leader and a Dutch physician as team co-leader. Working enthusiastically, in the first year they helped to create 46 village health committees and to train 46 village

[1] Based on a case study by Dr D. Flahault, Chief Medical Officer for Health Team Development, Division of Health Manpower Development, World Health Organization, Geneva, Switzerland, and Dr J.-J. Guilbert, Chief Medical Officer for Educational Planning, Division of Health Manpower Development, World Health Organization, Geneva, Switzerland.

health workers and several supervisors for these workers. Daily activities in the programme were based on decisions of the village health committees, and ranged from general land clearance for agricultural purposes to latrine construction, to treatment of disease. It was soon realized that only when village health workers could provide treatment for common ailments would their preventive activities be accepted.

Each year an evaluation of the project was made by a team representing the Liberian and Netherlands Governments and WHO. Early difficulties encountered were the initial absence of village health worker supervisors and the lack of preparation of the local populations for the entire programme. When supervisors were appointed, they were initially selected from the more experienced village health workers. Physician assistants working in dispensaries in the larger villages monitored the village health worker supervisors, especially with regard to clinical functions. After four years, more than 130 village health workers had been trained, and were working with health committees of 130 villages (out of 150 in the county). The dispensaries in the larger villages were renovated or expanded, and the physician assistants staffing them backed up the village health worker supervisors. A countywide water supply programme was developed, and two teams for drilling a network of pumps were trained.

At the end of the third year, 1980, a new Liberian team leader was appointed, and in 1981 the Dutch team co-leader left. In its fifth year (1982), the leaders of the project were all Liberian personnel. The physician assistants and village health worker supervisors are salaried government employees, but the village health workers are not. They spend three-quarters of their time on their customary farming activities and receive only a small monthly allowance from the government for their health work.

WHO observers have stated that "to a very large extent the obvious success of the project so far has been due to the personal qualities of the first two national team leaders. The project was also fortunate enough to benefit from an outstanding contribution from the Dutch side. In addition to their human qualities and their technical competence in both clinical and public health fields, they have all shown a rare dedication to their role [coupled with] a high awareness of their responsibilities, all of which enabled them to gain the confidence and support of the population in the villages, of their staff in the project at various levels, and of the local as well as the national authorities".

In tracing the evolution of this project leadership, one finds that for its first year the Liberian and Dutch team leaders spent most of their time talking with national health authorities and local village leaders about the goals and possible benefits of the programme. The bilateral Netherlands grant funds available were limited but important. Job descriptions for village health workers were prepared, as well as accounts of what was expected of village health committee members. A modest training centre was established, where the village health worker candidates were trained for six weeks. After much discussion, the

Ministry of Health decided to give small monthly allowances (not really salaries) to the village health workers, as well as supplies of some basic drugs. When some misunderstanding developed between the village health workers and the village people, the need for village health worker supervisors was realized, and these were chosen and trained by the team leaders from among the best of the village health workers. Eventually there was a supervisor for every 5–8 village health workers.

By 1980, the programme was reaching two-thirds of the Maryland County population, and village health committees were functioning smoothly. For common ailments, the curative care expected by the people was being provided by the village health workers, along with preventive services. The water supply programme was progressing well; 120 pumps had been installed and were being used enthusiastically. By late 1981, almost the entire county population was covered by primary health care, the Netherlands assistance had ended, and the project leadership was entirely Liberian. At this mature stage it was possible to analyse the functions of leadership in this overall primary health care project.

Primary health care leadership functions

The project leader, first of all, engages in planning. He prepares proposals for action and justifications for the funds needed, obtains necessary equipment (e.g., vehicles), and ensures its proper maintenance. He develops job descriptions, assigns the necessary staff to duty stations, and helps each health worker understand his place in the total effort.

As the project evolves, the leader has to maintain relations with higher authorities, principally the Ministry of Health, to ensure the necessary budgetary support. He also maintains relations with agricultural and educational authorities, which contribute greatly to health goals, and he fosters good general public relations, thus creating a favourable atmosphere for all project personnel. He conducts numerous meetings to monitor the progress of all activities. Under the general programme of the Liberian Ministry of Health there is a medical director for each of the eleven counties, and the project leader must submit regular reports and discuss major issues with the one for Maryland County. On a technical level, he must offer continuous guidance to all personnel, on disease prevention, environmental sanitation, and also on clinical matters. To underscore his credibility as a health leader, he assumes certain regular clinical responsibilities at one of the rural hospitals, and he sees patients referred to him by the dispensary/clinics.

Keeping in mind the need for evaluation, the leader reviews critically all reports and discusses problems at meetings. He must always consider whether the funds available are being used in the most cost-effective way.

Around 1980, the project leaders found it advisable to subdivide Maryland County into two administrative areas, each headed by a

physician assistant. These area heads make regular visitis to all dispensary/clinics, of which there were, by 1980, 23 in the County. They organize meetings with various physician assistants, village health workers, and representatives of village health committees; these meetings are also attended by specialists from the project headquarters on water supply, tuberculosis, immunizations, or maternal and child health. Meetings are also held weekly at each dispensary/clinic, and the visits of the area heads to these meetings help to boost staff morale and serve as a means of continuing education. They also provide opportunities for the area head to be consulted on patients presenting clinical problems.

Leadership is also necessary at the level of each of the 23 dispensary/clinics in Maryland County. The physician assistant at each of these units serves as the referral point for village health workers located at as many as 12 villages in the local area. Normally, there are 4–8 village health workers under one dispensary, and the physician assistant may be helped by a village health worker supervisor. As the most fully trained health person in the area, the physician assistant attends meetings of the village health committees in his area from time to time. The physician assistant also makes regular visits to the village health workers in his area, has monthly meetings with all of them, and provides them with their drug supplies. The clinical duties of the physician assistant include treatment of patients referred by the village health workers and the referral of cases beyond his competence to one of the hospitals in the County. Collaboration with and, when feasible, education of traditional practitioners in the area are also among his duties.

In spite of the heavy demands on the physician assistant for curative services, he is expected to emphasize prevention in maternal and child health, environmental sanitation, and all the customary fields. He is also expected to teach the village health workers in the course of his supervisory visits. On the other hand, he maintains contact with the hospital, to which he refers cases he cannot handle. As an employee of the governmental health services, he must report to the County Health Director; he must also report to village health committees.

At the village level, the chairman of the village health committee has a crucial leadership role. He must review with committee members their perceptions of local health conditions and needs and the appropriate actions to be taken by the village health workers.

Training for primary health care leadership

Reviewing the backgrounds of the overall team leaders of this Liberian primary health care project, it is noteworthy that all three of them are physicians with conventional medical educations. None of them has any special training in public health, management, or teaching methodology. All three, however, have experience in rural health conditions and have done a great deal of reading (self-instruction) about the problems of social development. More important perhaps, these

doctors are highly motivated to achieve the goals of the project, and are able to transmit their enthusiasm to others—to national and bilateral support authorities, to other health team members, and to the local people. The lack of formal training seems to be more than compensated by the personal qualities of the leaders; perhaps training in management would be more important for persons weak in these leadership qualities.

The educational background of the area heads and the physician assistants at the several clinic/dispensaries is basically the formal course at the School for Physician Assistants, J. F. Kennedy Hospital, Monrovia (the national capital). This institution, until recently, centred on hospital-oriented curative care, and really included nothing to prepare the graduates for their supervisory or leadership roles at the clinic/dispensaries.

The chairmen and members of village health committees have the backgrounds only of their life experience. Recently, orientation sessions of 3 days have been held in the town of Harper (the project headquarters) and other towns, to clarify their role and their relationships to the village health workers and to the official health services. These sessions were organized by the project leaders.

Although so little formal training in leadership was provided for the managers, the success of the Maryland County project may be attributable to a sort of non-formal training—namely, the self-education acquired by the persons at the top- and middle-management levels through the experience and the challenge of working in the project itself. They learned by doing.

Philippines[1]

The Republic of the Philippines is a country of 7000 islands with a population of over 50 000 000. The three main island groups are Luzon, Visayas, and Mindanao. The capital, Manila, is located on Luzon, and the sites of the two projects reported here are also on the island of Luzon. In the entire country there are 42 000 *barangays*, or villages, and the projects analysed were conducted in just two of them.

A primary health care nursing clinic

The first project was sponsored by the University of the Philippines College of Nursing and was located in Bagong Silangan—a barangay of 8000 people, not far from the major metropolitan area of Quezon City. Bagong Silangan means "dawn of a new day" and the community was started in 1968 by the transfer there of 148 families who had been periurban squatters. The project was started by the College in 1977, first

[1] Based on two case studies, one by Professor T. F. Corcega, Associate Professor, College of Nursing, University of the Philippines System, Quezon City, and the other by Professor M. Quesada, Associate Professor, Institute of Public Health, University of the Philippines, Manila, and Mrs J. C. Banez, Chairman, Philippine Nurses Association Primary Health Care Committee, Manila.

with a proposal for a mobile nursing clinic and then as a fixed nursing clinic. It came to be known as the Bagong Silangan Nursing Clinic Project, and a primary objective was to encourage maximum involvement of the community in the operation of the project. One member of the College faculty was appointed as project coordinator.

The governmental health agency responsible for the project area is the Quezon City Health Department, and the project coordinator had discussions with this agency, followed by many discussions with several of the barangay leaders. The coordinator stressed that the major objective was to have the community eventually take full charge of the health activities. Clusters of 10–12 families are known as *pooks*, and meetings were held also between the project coordinator and the pook leaders.

A major decision reached at these meetings was to train a number of community health volunteers to work in the project. The functions of these volunteers would include: health education of all families in the pook, first aid in emergencies, early detection of illness with referral of cases to other facilities, management of clinic operations, maintenance of records, performance of simple laboratory tests, and provision of general local leadership on hygiene, nutrition, and family planning. For community health volunteers to play this role, they needed, of course, to be given training.

The first group of volunteers trained were the wives of pook leaders—21 of them, trained for a period of several weeks. Curative services were also set up in the clinic, as well as through linkages with other agencies in the vicinity. In 1981 a new project coordinator was appointed (after the first one had to leave), and a large new health committee was formed, composed of community health volunteers, barangay officials, a leading schoolteacher, and various pook leaders. This committee had three subcommittees for (*a*) clinic operations, (*b*) environmental sanitation, and (*c*) health education, case-finding, and follow-up. In September 1982, plans began for the withdrawal of the College of Nursing from the project so that it would be turned over completely to the community.

In preparation for this transfer, a technical committee on the project was created to bring together representatives of the Bagong Silangan barangay, the Quezon City Health Department, and the University College of Nursing. The date for assumption of full responsibilities by the barangay was fixed as November 1983, and the College faculty was confident that the transfer would be successfully completed. This confidence was based on the deep motivation of the College project coordinator and her faculty colleagues, and their cordial working relationships with the local people. Among the latter were barangay captains but others also assumed leadership roles at various times. Except for nurses from the College of Nursing, all personnel of the project came from the local community. Drugs and clinic supplies came through the normal channels of the Quezon City Health Department. Equipment (microscope, instruments for measuring blood pressure, etc.) was donated by a group of foreign missionaries. Money from local fund-

raising activities was used for purchasing any additional supplies needed.

The project, nevertheless, had certain difficulties. The barangay captain, who is the principal local leader, had urged the appointment of a physician to the project but this could not be accomplished. Families in the barangay came from diverse ethnic backgrounds (different Philippine islands), and this caused some difficult relationships. The position of "pook leader", which was helpful at the beginning of the project, was later abolished, with the reorganization of local government in Luzon. There were some problems involving outside personnel assigned to the project.

Leadership functions

Leadership in the entire Bagong Silangan Nursing Clinic Project was a concern of three committees: (*a*) the committee of the University College of Nursing, composed of the project coordinator and five other nursing faculty members, (*b*) the technical committee, which included the Quezon City Health Department, and (*c*) the health committee at the barangay level.

The College faculty committee at first functioned as a closed group, but later it succeeded in involving the entire faculty of the College of Nursing in discussions about the project. The barangay health committee was composed initially only of community health volunteers, which created some problems in handling money donated to the project. When two local barangay officials were added to the committee these problems vanished. The technical committee is laying the groundwork for disengagement of the College of Nursing and assumption of full leadership responsibilities locally.

At the nursing clinic itself there is no doubt that the project coordinator played the major leadership role in the early years. As community health volunteers became trained and developed, her role gradually lessened, and she became more of a facilitator and resource person. She observes the operation of the clinic in order to identify further training needs of the volunteers, and provides educational materials. She holds workshops to develop skills in planning, evaluation, etc. She prepares an annual report for the College faculty, as well as budgetary proposals for logistical support. As secretary to the technical committee, she has to provide essential information to the three main parties: the community, the Quezon City Health Department, and the College of Nursing. The educational background of the project coordinator did not include specific training in leadership, but it included university-level studies in behavioural sciences, followed by a master's degree in mental health nursing. She also has experience in community health nursing.

At the community level, the president of the barangay health committee plays a major leadership role. She is a community health volunteer who has learned to prepare a meeting agenda and to chair the discussion. Because she works along with the other community health

volunteers she commands respect. Her educational background included basic education to the second year of high school. She attended five short courses given by the project coordinator on such topics as primary health care, group process, mental health problems, evaluation, etc.

The experience of the Bagong Silangan Nursing Clinic Project for five years has taught many lessons about the requirements for primary health care leadership. Many specific types of competence can be listed, for which training may be helpful—in such fields as programme planning, supervision, training, community organization, and evaluation. Fundamentally, the potential leader in a primary health care programme must acquire competence in building up mutual trust both with personnel on the health team and with members of the relevant communities.

A second nursing project

The second case study in the Philippines also concerned a primary health care project sponsored by nurses, in this case the Philippine Nurses Association. The project was based in another barangay on the island of Luzon, called Parang, a suburban area near Manila with a population of 40 000. Activities are, in fact, focused on one part of Parang, known as Purok 6, Barangay 10; in 1980, this locality had a population of 3418 people. As in the case of the previously described project, these people have been relocated from another area (where a highway was constructed).

Although there was a municipal health department in Parang, it had not started any services in the project area. There was a health centre, staffed only by a municipal midwife, and the people depended for health care mainly on seven traditional healers and birth attendants. In 1977, the Philippine Nurses Association launched the project, as its contribution to the nation's primary health care movement. A central feature of its approach was to encourage the people to be aware of their problems and to participate in social actions to solve them. Apathy and individualism were to be replaced by dynamism and cooperation.

Several objectives, such as arousing the people's interest in preventing disease and developing competence in community-selected health workers, were spelled out, and various meetings were held to discuss them. The nurse who was project director spent most of her time in the area doing this preparatory work.

Development of the project required, first of all, training and later supervision of barangay health workers. Second, it required provision of primary nursing services through clinic consultations, home visits, and referral of patients to higher-level facilities, as necessary. Third, learning experiences were provided for nursing students. Fourth, a health centre was constructed with the physical help of the people. To do this, a public lot was donated by the Mayor, and the community raised funds for the building materials. The health centre soon became the focus of activities for both training and service. Later, the building was used also

as a day-care centre for preschool children and a place for community meetings.

The scope of work done by the barangay health workers gradually broadened. They learned to prescribe medicinal herbs for common ailments. Some were trained in attending normal childbirths, while others learned to do sputum microscopy and many did immunizations. They learned to motivate and inform families about contraception and sterilization, referring them to a nearby family planning clinic. They referred patients to another clinic for cancer detection tests. Some barangay health workers showed an interest in environmental health problems and worked with the sanitary inspectors of the Municipal Health Department. One of the health workers learned a great deal about nutrition. The barangay health workers also initiated some income-generating activities, such as duster-making and holding a benefit dance. Most of them receive gifts from families they have served, especially for home deliveries. By May 1983, a total of 51 barangay health workers had been trained, and only a few had become inactive.

In 1980, a new project director was appointed, when the first director had to leave. She was a nurse who had already been working in the project as a primary health care nurse. Both of these leaders were effective because of their concern not only with health needs, but also with the housing, employment, and lifestyle of the people.

The educational background of the first project director included a university master's degree in health education after her training as a nurse. The second nurse had a master's degree in community development. This education doubtless helped to prepare them for their leadership role, especially its social and interpersonal aspects.

Among the shortcomings of the project should be noted its restriction to only a small part of the Parang barangay. The resources of the Philippine Nurses Association did not permit wider coverage. On occasion, the barangay health workers led the people in making social demands, such as a petition for an electricity supply in the relocation area. They had to learn to cope with the charge of being "subversive". There were other conflicts with a local woman leader about the management of the health centre. Finally, there were inevitable complaints by the barangay health workers about their not being paid for their work—a reaction that was accentuated when one of them was selected by the local government as a "nutrition scholar" and received an official stipend. Starting the income-generating activities, as noted above, helped to overcome these complaints.

Leadership and its evaluation

Leadership in this project came from several sources. Most important was the Philippine Nurses Association, which provided a member of its Board of Directors as the project director. The primary health nurse (who later became the second project director) supervised the barangay health workers and also worked with the faculty of the College of

Nursing of the University of the Philippines, in Manila in providing field experience to nursing students. The Organization of Barangay Health Workers was also formed, with several working committees (on sanitation, nutrition, etc.). Still another form of leadership evolved in an organization called the Movement for Health of Parang—or KP-Parang—intended to integrate several local entities.

After mid-1980, the barangay health workers assumed greater responsibility for their own work. They set their own schedule of work and the assignments for each health worker. The primary health nurse was then free to develop greater coordination with other local projects, such as that of the Population Commission, the Ministry of Local Government (programme for nutrition scholars), the Ministry of Social Services and Development (day-care centre), and the Rural Improvement Club.

In early 1982, it became feasible—through the initiative of the primary health nurse—to bring about formal integration of the health project with similar programmes of other nongovernmental bodies in the area. These included the Tuazon Community Center Foundation, the Urban Missionaries, and a group known by the acronym KAPPAG. Altogether, the integrated association, known as KP-Parang (as mentioned above), could help to avoid overlap and achieve unity, even though this very action toward unity seemed to generate some fear among local officials who issued indirect warnings on the danger of becoming involved politically.

In 1983, the Board of Directors of the Philippine Nurses Association decided to terminate the full-time services of its primary health nurse. This nurse continues as a member of the Board of KP-Parang, but the latter now has its own paid secretariat, consisting of a community health nurse, a midwife, and a social worker. By May 1983, KP-Parang had conducted four training courses for barangay health workers and 34 of them had graduated.

In retrospect, it is clear that leadership in this Philippine Nurses Association project was provided by several people at several levels. The first leadership was provided by the nurse from the Board of Directors who served as project director. She had to make the initial explorations with the barangay people and officials in the Municipal Health Department. Later her role changed to one of consultant, and she came to the local area only on invitation.

The primary health nurse stationed in the project area had many leadership responsibilities. She carried the main load of training the barangay health workers and of supervising them subsequently. She had to work with nursing students from the cooperating nursing college, and she also had to establish relationships with other local organizations.

The trained barangay health workers provided service to the people and exercised many qualities of leadership. Their role includes health assessments, nursing interventions, health education, and community organization. The interventions include advice to families on the use of medicinal herbs, home nursing procedures (such as steam inhalation),

referral of couples to a family planning clinic, and referral of serious cases to hospitals. Some of the barangay health workers handle childbirths; others have learned to mobilize people for sanitary work in the village. Finally, the important role of the Organization of Barangay Health Workers must be appreciated, both for its contribution to the personal development of the health workers and for its practical role in such tasks as fund-raising.

As a result of all the above efforts, the leadership of the project has been passed to the integrated organization, the KP-Parang. A Roman Catholic nun is now chairing the board of this organization, although the Nursing Association is still represented by one member of the Board of Directors. The KP-Parang secretariat is responsible for carrying on the programme, especially the continuing education of barangay health workers along sociopolitical as well as technical lines. The project should continue to be successful as long as it works closely with members of the community and involves them in policy decisions at all levels. The reactions of the people must also be studied as part of a continuing process of evaluation.

3. Levels and functions of leadership

Leadership is essentially effective management. Consequently, the functions of leadership for primary health care correspond closely to the tasks of management. Leadership functions are especially important for managerial tasks that are often mishandled or overlooked—such as programme planning or continuing education of personnel. They also include certain aspects of interpersonal relationships that can make management more effective.

Levels of Leadership

Every national health system is in some degree structured into administrative levels. In some countries, where there is a completely unified health system, a description of the hierarchical framework gives a comprehensive account of the entire system; Bulgaria is an example of such a country in this study. In other countries, for various historical reasons, several hierarchical structures operate side by side. In the Dominican Republic, for example, even within the Ministry of Health a special framework for primary health care in certain rural areas exists in parallel with another framework serving the total population (both rural and urban); in addition, a complete account of primary health care in this country would have to consider the services of a medical care programme under social security sponsorship and a private health care sector.

In this discussion, we shall usually be concerned with levels of leadership within the framework of a ministry of health, although sometimes within the framework of other organizations, as in the case studies from France and Kenya. The relative importance of various functions is bound to differ at different levels. At the local community level, for example, leadership of a primary health care team is especially important for achieving coordination and mutually supportive relationships among team members. This was well shown in the case studies from Finland and Liberia. The attainment of good relationships with members of the community must also be a high priority at this level. The overall planning of a programme, on the other hand, and the evaluation of primary health care performance are bound to be more

crucial functions at higher levels. Theoretically, all the functions discussed in this section should be performed at every level, but they will differ in the relative importance accorded to them.

In general, functions at higher levels are broader in scope than those at lower levels and differ from them in character. It is difficult for a person to provide leadership with respect to activities he or she has not performed in some way. Hence, leaders must generally have more experience than those they supervise, and the functions of the leadership position are bound to be of greater variety. A leader of the health team at the community level must be capable, of course, of a wide range of primary health care activities that involve direct contact with the people. At the district or provincial level, the leader must perform functions that may involve very differing needs in various communities. He or she must also be concerned about such matters as the logistics of drug and other supplies and the training of new primary health care personnel—matters that are not the responsibility of the local primary health worker. At the national level, the functions of the leader obviously include major decisions on overall health policy, formulation and defence of national budgets, and so on. In the Dominican Republic and Somalia these functions are prominent.

As discussed more fully below, the requirements in regard to training and personal characteristics must differ correspondingly at different levels. In many, though not all, health systems, there is a policy for personnel to rise from lower to higher positions in the hierarchy. In Papua New Guinea and Viet Nam, this type of policy was evident. Such mobility paves the way to leadership, by assuring that the leader is familiar with the functions concerning which he or she is expected to have mature judgement. The leader, at the same time, must be prepared to step into a lower level position, in times of emergency, to carry on the work—as seen in the Bangladesh project.

Planning and Setting Objectives

Planning the primary health care programme is, to some extent, a function of primary health care leadership at all managerial levels. At the community level, the primary health care team leader must plan each day and each week of work, perhaps arranging a different schedule for each member of the team. Plans must often be adjusted as new problems arise in the community or in the case of unexpected changes in the available resources—such as the illness of a team member or the failure of a package of supplies to arrive on time. Long-term plans may be formulated at a higher level, with certain goals being set; on a short-term basis plans must be formulated on a lower level, in accordance with the resources available locally and the various environmental conditions and constraints.

The Maryland County primary health care project in Liberia illustrates how planning may be necessary at different levels successively. Initially, planning had to be done at the national level to select the

county and win the approval and financial support of both the national government and a bilateral international agency. Then, planning was necessary at the level of the county (equivalent to a province in some other countries), in cooperation with the county government and the regular official health service of the county. Next, planning was necessary at the level of the area covered by a dispensary/clinic, since these units were staffed by relatively well-trained physician assistants, to whom village health workers would refer patients; this level would be equivalent to a district in many countries. Finally, plans had to be made at the level of each village, where a village health worker was stationed; these plans required collaboration with the village health committee, representing the local residents.

Planning carried out in a single "teaching polyclinic" in Cuba illustrates how much detailed programming of work is possible and necessary at the most local level, a "health area", even in a country where planning at the national level is very forceful and pervasive. In Cuba, the administrative levels of the health system include (*a*) the central government, (*b*) the 14 provinces, (*c*) the 166 municipalities, and (*d*) the 400 local "health areas", each served by a polyclinic. Within the polyclinic are nine technical departments (paediatrics, X-ray, etc.), each of which has to formulate a plan of work. The overall head of the polyclinic has to approve and coordinate all these plans, in addition to his role in assisting each of the department heads in designing the plans.

Planning must normally be translated into the preparation of budgets necessary to carry out the plans. When funds are derived mainly from the central government, as is customary in most developing countries, basic budgeting must be carried out at this level. Some leeway among budgetary items may be permitted at provincial, district, and community levels. A national programme leader may have more crucial financial responsibilities than this, moreover, when he or she is obliged to raise the money required for a special programme. This was the case for the projects in Bangladesh, Liberia, and the Philippines, where in each instance external fund-raising was required.

In Bulgaria, below the central government there are 28 administrative districts, and each of these is covered by a network of polyclinics and, most locally, health centres; under each polyclinic there are six health centres. A study made of primary health care leaders (managers) at the district level showed only 3.4% of their time to be spent in planning. "Organizational activities" required the greatest proportion of time (see below), and in another context these might be defined as planning. In the political setting of Bulgaria, it would appear that planning functions are explicitly a responsibility of the central government, and the districts and lower levels must be concerned about the implementation of the plans.

Almost all the countries participating in this study have formulated national health plans, which include plans for primary health care. The preparation of plans for a 5-year period or longer clearly calls for a high level of leadership, in terms of both the political judgement and the

general sophistication of the leader. Shorter-term planning is to be expected of leaders at a lower level and with less profound knowledge of the field. It can be said also that to prepare a good plan you do not need to be a good leader, but to be a good leader you must be able to prepare a good plan.

Organization for Implementation

In some ways, the organization of resources in order to implement a health plan is an indispensable aspect of management and leadership. Once human and physical resources have been organized, so that various activities may be performed, then the other functions of management can be carried out. A primary health care programme can be efficient only if it is organized in a way that permits each component part to fit together with the other parts. In the Bulgarian study, nearly 25 % of the working day of the primary health care leader at the district level was devoted to organizational activities.

Organizational leadership encompasses many activities at all administrative levels. Because primary health care involves many functions, efficient work requires their subdivision into component activities and the delegation of responsibilities for each activity. If only one or two health workers are available, the division of labour may entail simply a division of the time to be devoted to each task. In most teams there are several personnel among whom responsibilities may be delegated. In countries with a severe shortage of personnel, such as Papua New Guinea, it is a major organizational task simply to deploy personnel where they are most needed at any time. In one district, for example, there was a main health centre and 33 peripheral aid posts; there were not enough trained personnel to keep every post staffed at all times, so that the leader's task was to deploy aid post orderlies according to some schedule, in response to the local health needs.

A group of health personnel, working together, usually in some sort of a facility, constitute a team, but efficient teamwork cannot be taken for granted. The leader responsible for the organization of the team must put deliberate effort into orienting each person as to his or her role as a member of the team. To some extent, this role should be evident from the job description, but beyond this the leader should clarify elementary principles of interpersonal relationships—how each individual should try to relate to his or her colleagues on the team, in order to achieve the main goal.

Any delegation of responsibilities implies a trust that the activity will be carried out appropriately. This means that with the delegation, if it is new or different, should go some instructions explaining exactly what is expected. The hallmark of a good health team is that such instructions are minimal, because trust has been established among team members with respect to all the activities that each is expected to perform. Such mutual trust was evident in the governmental primary health care programme of Viet Nam and the church-sponsored programmes of Kenya. Successful delegation of responsibility depends, in turn, on clear

communication, so that there are no misunderstandings; in some organizations, all communications concerning assignment of responsibilities have to be in writing.

Related to communication is the need for clear job descriptions, such as those used in Bulgaria. Difficulties may develop in a health team if members are not entirely sure what is expected of them. It is not enough for a job description to be written and explicit; it must also be discussed with the team member. The primary health care leader must make certain that all the health workers understand what they are expected to do and know how to do it. Such discussion may indicate the need for training or perhaps modification of the job description until training is completed or someone else is found to perform the task.

A common problem in any organization is that individuals become accustomed to a certain place on the "organizational chart". They may resist changes that are made necessary by the departure of one or more person from the organization. The task of the leader is to make clear to everyone that an organized arrangement of persons and functions is only a means to an end at a certain time and place. If the leader makes everyone feel like a member of a team, with one overall goal, various changes in the place of team members, on occasion, should be quite acceptable.

Recruitment of Primary Health Workers

Implementation of the entire primary health care concept depends on health manpower—finding personnel who can do the job where and when they are needed. For a long time, most people in developing countries have gone without any access to adequate health care because physicians were regarded as the only personnel who could provide such care. When it was realized that health personnel with much more modest training, working preferably in teams but always in some sort of organized framework, could provide much of the necessary care, the prospect for health improvement in developing countries grew brighter.

The approach most widely applied in developing countries was to recruit candidates for training as primary health workers from the communities in which they would eventually work. Then, after training, they could be expected to return to their home communities where they would be culturally acceptable to the local people—something that did not always apply to official health personnel deployed by a national agency.

As explained in several of the case studies, some primary health care leaders at the district or provincial levels have been successful in recruiting suitable candidates, in collaboration with leaders in the local community. In the Dominican Republic, for example, primary health care leaders on the staff of the Ministry of Health stimulated the organization in each province of a committee for health improvement, composed of leading local citizens. Certain general rules were established by the official agency—that the person recruited must have been born in the community of future assignment and must reside there, that he or

she must be between 20 and 50 years of age, be literate, have the time to perform the assigned work, be willing to serve without salary, and have "leadership qualities". Actual selections were made by the committees and, perhaps not surprisingly, the great majority of those selected were married women whose children had grown up.

In the Philippines, the primary health care leader played a larger role in the selection of candidates but always acted in collaboration with the community. In the course of their work, project personnel encountered persons whom they would refer to the village leaders for possible selection. The turnover among community health workers may be high, so that there is a constant need for new recruitment.

In primary health care programmes of countries such as Bulgaria, Cuba, or Finland, where the work is done mainly by general medical practitioners, the recruitment task is naturally very different. Here the leader must select doctors who will work agreeably in a team setting. Both doctors and nurses in these more fully developed health systems must have personalities that are conducive to friendly relationships with people in the community.

Training of Primary Health Workers

After recruitment for primary health care activities, the person must be trained. Schedules and curricula for training are of a bewildering variety in content and duration, and they cannot be analysed here. Certain common features may simply be noted: the training in developing countries is usually of short duration, measured in weeks or months; it takes place in a setting (usually rural) similar to the one in which the primary health worker will be stationed; it is oriented to practical activities rather than to scientific, theoretical foundations; the teacher (or one of the teachers) is usually the person who will later supervise the primary health workers; throughout the training, stress is generally put on the development of close relationships with the community residents who are served.

These policies are well illustrated in Papua New Guinea, where health extension officers, at the district level, are responsible for training aid post orderlies to work in the villages. In some other countries, the health centre director in the district is similarly responsible for training the primary health worker at the village level.

The primary health care leader at the district, or province, or even higher level must see to it that proper teaching materials—charts, manuals, perhaps slide-shows and films—are available. He or she should try to ensure that teachers know *how* to teach, stating the learning objectives explicitly, explaining subjects as clearly and concretely as possible, and testing at the end whether the learning objectives have been attained. The "psychosocial" method of teaching, used in Kenya, appears to be successful in involving the trainees in the teaching process. To be effective, the teacher must show enthusiasm for the subject, so that enthusiasm is conveyed to the learners.

Before any training programme is launched, the primary health care leader must recognize the limits of what trainees may be expected to learn and to do. The leader should know enough about the content of basic schooling in the area to be able to assess the student's comprehension of language—in particular, slightly technical language, spoken or written. In the provision of primary health care, the leader can expect the worker to perform only to the level of which he or she is technically and cognitively capable.

The content of primary health care training must prepare the learners to deal with priority problems in the community and emphasize prevention. Although the health worker may see quick results from a curative service, a more mature outlook is needed to appreciate a preventive service. Hence, the primary health care leader must select relevant training content and stress the strategies of prevention and health promotion, even though the results are less readily visible. This was shown to be especially important in Kenya and the Philippines, where nursing personnel had been trained exclusively in hospitals. Training, of course, must cover not only personal health care procedures, preventive and curative, but also such supportive functions as record-keeping, storage of supplies, and the general principles of maintenance of a small health station.

Efficient learning activities should be chosen by the leader/teacher and preference given to field practice, rather than to classroom training. It is here that the trainee must learn about community relationships, teamwork, and the meaning of intersectoral cooperation. From the vantage point of a field station, the teacher can help each primary health worker to appreciate his or her place in the total programme. As shown in the Liberian project, this is important for the maintenance of staff morale.

Control of Working Conditions

Once the primary health worker has gone into action, the leader must be concerned about the adequacy of the work setting. In many primary health care programmes that have used briefly trained community health workers, these workers have been regarded initially as volunteers. This was found acceptable in the Dominican Republic, where the health promoters' functions were very limited, where they required only one-fourth of their time, and where compensation was given largely in terms of prestige and recognition. More often, it has been found necessary to give the primary health worker some small monetary reward, even if it is regarded as compensation for the expenses of the work. This has been the experience in Bangladesh, Liberia, and Somalia. It may be necessary to find local and voluntary, rather than governmental, funds for this purpose. Even a small expense allowance is beyond the economic means of some countries on a long-term basis.

The primary health care leader must also be concerned about the working environment of the community health worker, which includes

living quarters as well as the workplace. The maintenance of both places is a task for the worker, but the provision of basic physical structures, equipment, and furniture is a responsibility of the leader. In rural areas of developing countries, special importance attaches to sanitary facilities; the field worker should have access to a proper water supply and arrangement for waste disposal. These are important not only for the morale of the community health worker, but also to set an example for local people.

In addition to monetary compensation and satisfactory physical arrangements, a psychologically agreeable work situation must also be ensured. The field worker should not feel isolated. Through periodic reports he or she is in touch with the supervisor, but this should not be a one-way street. The leader should send back comments on reports—criticisms offered constructively or praise when it is due, as demonstrated in the Bangladesh project. There may be some method of material recognition for high-quality work, such as an increase in the expense allowance or a gift of food or an article of clothing.

The work schedule for each member of the primary health care team should not be simply issued from above, but should be discussed with each individual to make certain that it takes account of any local problems. If the community health worker has a personal or family difficulty, the leader should show sympathy and try to help in any way possible. Sometimes there are misunderstandings or disagreements between members of a team, and the leader can help to reconcile them; there are few conflicts that cannot be reduced or made more tolerable by full and frank discussion.

Not every community health worker has ambition to advance his or her position in the health system. For those who do, the system should permit career development. The appointment of outstanding community health workers as "community health worker supervisors" is one way of granting such mobility. The case study in Liberia reports the appointment of supervisory personnel from among community health workers whose work performance demonstrated their special abilities.

Supervision

Perhaps the most obvious function of the leader is supervision of the personnel in the programme for which he or she is responsible. It should be obvious from the foregoing case studies that leadership includes a far greater range of functions than supervision, and yet effective supervision is essential. Supervision must be along both technical and managerial lines.

There are three main styles of supervision, which have been classified as autocratic, anarchic, and democratic.[1] Most experience in primary

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[1] MCMAHON, R. ET AL. *On being in charge. A guide for middle-level management in primary health care.* Geneva, World Health Organization, 1980, p. 82.

health care programmes suggests the advantages of a democratic approach, in which the primary health worker is given an opportunity to participate in supervisory decisions. Yet, there may be times of crisis or great urgency, when more autocratic supervision is necessary. It is also reasonable for the style to vary over time and with the person being supervised. Some primary health workers may actually prefer "strong" leadership and feel hesitant at the beginning about participating in a decision, until they have been trained to do so—an attitude encountered in Somalia.

Exercise of the supervisory function almost invariably offers opportunities for teaching and guidance. From the viewpoint of the primary health care programme, supervision may imply control and regulation, but from the viewpoint of personnel (and ultimately programme morale) it means guidance and staff development. Every supervisory intervention should give an opportunity for frank discussion about a problem and exchange of ideas. In such a discussion, the problem exposed may be quite different from the one that stimulated the intervention—leading to a deeper understanding by both the supervisor and the supervised.

Supervision should be a continuous process, and not dependent on the emergence of some problem. Regular supervisory visits ought to be made by a leader to all the units for which he or she is responsible. Sometimes supervisory strategy may call for surprise visits, to detect conditions when deliberate preparations have not been made. Such an approach, however, may dismay and discourage the primary health worker and should be used with caution. If the supervisory visit is to be a learning experience and to provide guidance, the field health worker should know that it will take place at a specified time and be prepared with technical and/or managerial questions.

The nature of supervision depends, of course, on the level from which it comes. The discussion here has focused on supervision coming from the district level to the local village, but in a hierarchy there must be supervision also between higher levels—from the central level to the province, or from the province to the district. This form of supervision is often conducted at meetings, which may be scheduled regularly. Statistical reports, which are reviewed and commented upon, may provide a basis for supervision. The proportion of a primary health care leader's time devoted to supervision will also vary with the level at which leadership is being exercised. When the level is close to the base of the managerial pyramid, the supervisor is usually also engaged in providing some primary health care himself; when the level is near the top of the pyramid, the primary health care leader may be devoting his full time to management, a large share of which is supervision. In Bulgaria, for example, at the level of the district polyclinic (equivalent to a province), administration (or management) occupies the entire time of the Chief Physician, who is relieved of all clinical duties. It was well shown in the Philippine nursing projects that supervision had to be substantial in the early years, but as community health workers became

more experienced the need for supervision declined. Eventually, it became feasible to transfer the leadership of the projects to local health personnel.

In order to carry out the functions of supervision certain forms of logistical support, such as communications and transportation, are needed. In their absence, supervision may be episodic and ineffective. These requirements for supervision and other aspects of primary health care leadership are discussed later.

Continuing Education

Closely related to effective supervision is continuing education, inasmuch as supervisory activities should be educational. In addition, a function of the primary health care leader is to prepare specific programmes of continuing education. Thus, there are informal and formal types of continuing education.

Policies in Viet Nam illustrate systematic formal continuing education, which has been necessitated by the difficult conditions in the country. To acquire a minimum network of primary health care personnel, it was necessary to train community-level assistant doctors very rapidly; this was technically acceptable as long as they had the benefits of regular continuing education, lasting several weeks every year.

Experience can, of course, be a greater source of education, but it can also be misleading or misinterpreted. Formal teaching, combined with the lessons of experience, is better. The primary health worker should also be furnished with books and manuals. In some countries (such as Thailand), periodicals have been issued for regular distribution to primary health workers. The primary health care leader must always include continuing education among his permanent responsibilities, a need that was well recognized in Papua New Guinea.

Promotion of Community Involvement

Involvement of the community in primary health care programmes, both in policy formulation and in day-to-day operations, is a crucial feature of the entire primary health care approach throughout the world and therefore a responsibility of the leader. Such involvement is important most of all because it helps to ensure that the content and priorities of the primary health care programme are, in fact, appropriately responsive to the needs of the people. This does not mean that every articulation of a health need should be mechanistically translated into a programme. The best response to a problem of infant deaths, for example, may very likely to be a clean water supply rather than a hospital for sick children, but such strategies can and do grow out of collaboration between primary health care leaders and the community.

Community involvement is also important for other reasons. If the people participate in decision-making, they are much more likely to find

the primary health care programme acceptable and to make use of it. Local people can be very helpful in the mobilization of families to participate in preventive programmes, such as immunizations or health education, which are less obviously necessary than the treatment of sickness or injury. Finally, community involvement can stimulate all primary health workers to do their best. The primary health worker who is rewarded with appreciation and admiration from patients is likely to work hard to keep winning such approval.

The primary health care leader must therefore encourage the involvement of the community at all levels. A method reported in nearly all the country case studies was the organization of village health committees, as well as health committees at higher levels. Such committees were especially effective in Bangladesh, Liberia, and the Philippines. In Bulgaria, Finland, and Viet Nam, citizens' committees are virtually an integral part of the official health system. It is not enough to have a committee, of course; the committee must meet regularly and must be consulted on problems that arise.

In Cuba, the organization of "people's health schools" is a form of community involvement that is also an obvious channel for health education. The role of citizens' committees in the selection of candidates for primary health care training has been discussed above; this process obviously heightens the people's sense of participation in the programme.

As emphasized in one of the Philippine studies, the primary health care leader and all primary health workers must attempt to change the attitude of hopelessness that so often characterizes impoverished people in all countries. Through discussion and through health services, they must try to replace apathy and individualism by dynamism and cooperation. If this can be done, at least among some of the people, relationships of mutual trust can be built.

The primary health care leader must convey to all primary health care personnel that every interaction with a patient—at the health unit or in the patient's home—contributes to the "image" of the health programme in the community. People must be treated with sympathy and respect, whatever their station in society. It is easy for primary health workers to forget this, especially if they are tired and overworked; the primary health care leader must remind them always of the importance of kindness and courtesy. In the evaluation of primary health care programmes that primary health care leaders at higher levels may conduct, the comments and criticisms of the people are always important. Such judgements are invariably influenced by the personal attitudes of health workers, often to a greater extent than by the technical effects of the health services.

Development of Intersectoral Cooperation

Primary health workers must promote relations with other sectors of society as much as possible. This is probably more a task for the leaders than for the other members of primary health care teams. Primary

health care is more than a package of services—it is an *approach* to the attainment of health by people. Important in this approach is the recognition that almost every aspect of the social and physical environment influences health. Outside the strictly defined "health sector", most other sectors—education, agriculture, transportation, housing, industry—have great impacts on health.

The average community health worker may hesitate to enter the domain of a schoolteacher or an agricultural extension agent, for fear of being considered presumptuous. But primary health care leaders at the district or provincial levels can communicate with their counterparts in other sectors and promote cooperative relationships at the local level. As shown in the Bangladesh project, regular meetings can be scheduled at which leaders from several sectors exchange ideas on their problems and consider how they can help each other. The primary health care leader should also encourage primary health workers to show interest in the community programmes of other sectors, recognizing that intersectoral cooperation must be a two-way process.

Maintenance of Health Structure Relationships

The several administrative levels in national health systems have already been discussed. It is another of the primary health care leader's functions to maintain reasonable relations between and among them. These "vertical" relationships are not always easy to maintain because the official at the lower level may hesitate to speak or write candidly to his or her superior. It is especially incumbent on leaders in superior positions, therefore, to encourage frank communication from those below them.

If there is a policy of regular meetings that include primary health care personnel from several levels, the task of communication can be made easier. Before any such meetings agendas should be distributed, if possible, and every participant should be invited to contribute further items to the agenda. In the absence of meetings (which entail transport costs), periodic reports, both upward and downward in the hierarchy, are indispensable. Such reports depend, of course, on a regular flow of information about primary health care activities—a topic discussed below.

The case study in the Dominican Republic reported an awkward situation created by two parallel hierarchical structures, each with its own vertical relationships but with little horizontal contact between members of the two structures at the same level. In this instance, a new pyramidal structure of primary health care activities had been developed separately from the older established structure, perhaps in the interests of speed and freedom. In time, it will doubtless be necessary to merge the two.

In Finland, one local health centre was able to develop research activities by establishing relations with a university at a higher level. The university did not come under the Ministry of Health, but the health

authorities at the higher provincial level fostered this collaboration. At each level of management, the primary health care leader should encourage communication with and support from the levels below and above his own level.

Evaluation of Primary Health Care Programmes

Progress in any health programme depends on evaluation of the results of previous efforts; only with such evaluation can the leader know if established policies are working well or should be changed. Hence, evaluation of some sort is another function of leadership.

Evaluation can be made in various degrees of depth. It should not be based simply on a general subjective impression. More careful observations should be made, based on measurement of actual events in comparison with ideal standards that have been established in a programme—e.g., the number of patients seen by the primary health worker per hour, in relation to the standard. Using a more decisive criterion, the evaluator may search for information on changes in the health of the population served. Specific indicators may be formulated for all these approaches, and yet each method of evaluation has its difficulties. Subjective impressions may be misleading; consideration of the number of services provided will not indicate the quality of service; improvements in health may be real but attributable to influences outside the health programme.

Formal and deliberate evaluation of primary health care is rare, except perhaps on the basis of the subjective impression of the leader, as was done in the Liberian project. In the Cuba case study, the polyclinic leader was reported to make regular evaluations of the performance of each department, based on discussions with the department head and a review of written records. Much evaluation, however, may not be identified as such, but simply carried out as part of the process of supervision.

The maintenance of proper records can, of course, greatly facilitate evaluation, particularly to indicate the programme's work output or the utilization of services by the population. Part of every primary health care programme, therefore, should be an "information system", providing certain minimum types of information from all component units. Standardized forms can be helpful, but they should be simple and clear; no more information should be solicited than can really be used. If the primary health care leader expects primary health workers to be diligent about filling out forms, he should make some response to periodic reports based on them. Reporting requirements should always allow communication of information beyond the data included on patient care records. Special problems or activities outside the normal range of duties should be reportable.

Evaluation of certain aspects of a programme may be derived from the emergence of problems. If difficulties appear in the relationships between certain individuals, this may reflect a more basic problem in

organizational structure or in job descriptions. Likewise, feedback from the community, positive or negative, is a continuing basis for evaluation. A single complaint or grievance may not be significant, but repeated complaints demand attention. Sensitivity to evaluation, built into the daily work of the primary health care leader, is more likely to yield helpful judgements than a formal schedule of programme review and assessment.

Competence in Performing Primary Health Care Tasks

The need for the primary health care leader to be competent to perform each and every task expected of primary health care personnel may be open to question. If a person has functioned at a leadership level for many years, he or she may be out of touch with clinical skills. Yet, the leader must know enough about the full range of primary health care tasks to make judgements on their performance and to solve any problems that may arise. In Papua New Guinea, the primary health care leader at the provincial level was reported to spend a great deal of time in "crisis management"; this restricted the time he could spend in overall programme development, but it gave him a thorough acquaintance with the realities of the programme. Wide knowledge is necessary to enable a leader to cope with the diverse problems that may arise in many situations.

In the Liberian case study, competence in clinical service to patients was found to be important for the primary health care leader in establishing credibility and winning respect from the members of the team. This is understandable, but should not be carried too far. Many primary health care leaders—whether physicians, medical assistants of various types, or community health workers—may find it very gratifying personally to deal directly with patients. If too much time is spent in such work, however, other functions will suffer. Even at the level of a village, where a community health worker's leadership role is modest, services to the sick may absorb the time (and especially the interest) of the worker excessively. As a result, too little may be done in the field of prevention, as reported in Papua New Guinea and Somalia.

The other side of the coin should also be noted. Often a primary health care leader, particularly if a physician, is appointed to this role because he or she has outstanding clinical skills. These qualities may win respect for the individual, but do not guarantee that the person will serve as an effective leader. It is sometimes tacitly assumed that leadership or management will simply be learned on the job. To some extent this may happen, but many of the weaknesses seen in primary health care programmes around the world are evidence that often it does not happen, or does not happen soon enough.

Ability to Inspire and Motivate Personnel

Perhaps the ultimate function of primary health care leaders is to inspire and motivate personnel throughout the programme. In a sense, if

all the functions reviewed above were carried out effectively, this final function would follow automatically. Yet, even if several of these functions are handled inadequately, the leader can still make deliberate efforts to inspire and motivate the members of the team.

The requirements necessary for the development of "inspiring" leaders are discussed in section 4, but here we may ask about the composition, the anatomy of this inspirational quality. What does it mean? It means that the leader makes the primary health worker eager to do his or her job, and to do it well. Primary health workers are made to feel proud of their role in the programme. They appreciate their place in a team and feel personally rewarded if the efforts of the whole team are successful. A good example is given by the maternal and child health project reported in France. Primary health workers are not afraid of a good leader, but are pleased to have his or her approval. Similarly, they are eager to win the approval of the community. Their interest in their work is so great that they search for new things to do, new ways to advance the health of the people.

Undoubtedly, certain individuals are endowed with characteristics that permit them more readily to inspire personnel than others. Still, certain actions can enhance this capability. In the Philippine nursing projects the leaders felt that showing concern for the purely personal problems of primary health workers increased their loyalty and dedication to the entire programme. Repeated explanations of the contribution of each person's work to the total effort can also help to inspire devotion. Compliments for good work should be given freely, and criticisms for weaknesses should be made in a constructive and understanding way. The discouraged primary health worker is not likely to feel inspired. The field worker who feels that he or she is improving and growing in competence is bound to be motivated towards still better performance. The leader can facilitate this sense of personal growth and development through regular continuing education, as well as through the personal relationship. The leader's thorough knowledge of the team members, of their personal problems, and of any difficulties at work or at home can facilitate mutual understanding, creating a climate of confidence and respect conducive to dedicated job performance.

Finally, the inspiring leader is one who sets an example by his or her own behaviour for diligence, hard work, motivation, and integrity. This does not mean broadcasting one's personal achievements. It does mean being in touch with all team members as much as possible and being available for help, when needed, even if that entails working outside official hours or in disagreeable circumstances. It means that the leader should always function as a staunch supporter of the primary health care programme and the people working in it.

4. Requirements for effective leadership

The functions of primary health care leaders, as reviewed in the previous chapter on the basis of 12 case studies, are not difficult to analyse. The actions required to make people capable of performing these functions well are more difficult to define. Even when an attempt has been made to define these requirements, their implementation presents very great difficulties.

Variations among Countries and Individuals

Apart from the inborn personal characteristics of individuals, their preparation to carry out leadership functions depends in large part on education, the scope and depth of which varies greatly among countries. Furthermore, the sophistication to be expected of leaders depends upon the educational level and cultural attitudes of the general population, which also vary from country to country. Any formulation of the requirements for leadership, therefore, must be adapted to the conditions of social and economic development in each country.

In general, people in the economically less developed countries have lower levels of education and literacy. The requirements for developing effective leadership in the health systems of these countries are probably greater than in more developed countries. Yet, the need for good leadership of primary health care programmes in developing countries is doubtless far greater than in those with a higher educational level.

Hierarchical Frameworks and Leadership Support

The structure of a nation's health system determines the types of leaders required. In all countries, there are hierarchical structures of authority and responsibility. In Somalia, to take an example from the case studies presented, below the level of the national capital there are regions, districts, and communities; and in Viet Nam there is a national capital, below which are provinces, districts, and communes. Even in nongovernmental organizations, such as religious missions, hierarchical frameworks are found to be necessary; this was quite clear in the case

study from Kenya. The requirements, both technical and managerial, are bound to differ for leaders at each of the administrative levels.

The hierarchical structure means that the responsibilities usually broaden as one ascends to higher levels. The community leader must know enough to cope with the problems of one community; the district leader must be able to handle several communities; the provincial leader must handle several districts; the national leader several provinces. The range of sophistication required obviously expands at the higher levels. In this way the leaders at higher levels really *support* those at lower levels, in the sense that supervision is guidance and assistance. The preparation of personnel for these leadership roles at higher levels should be correspondingly more thorough.

In some health systems, deliberate efforts are made to spread the leadership responsibilities among several persons at each level, rather than concentrating them in the hands of one person. The local health centre of Finland, for example, is directed by a "steering board", composed of leading persons from each discipline (medicine, dentistry, nursing, etc.). With such collective leadership, the background knowledge of several persons can be brought to bear on each problem.

Pyramidal system structures have the potential advantage of enabling persons to gain leadership experience at the community level and then gradually to rise in the system. Such upward mobility, however, requires flexibility in the qualification requirements at different levels, and often this is lacking. Certain high-level posts may require university training, which may be quite impossible for a person from the community level to acquire. In some countries, such as Viet Nam, where university graduates are relatively scarce, experience may be substituted for academic credentials in the appointment of persons to leadership positions. In general, there is likely to be higher morale and a greater sense of solidarity in a primary health care programme if persons are appointed to leading posts from among those working within the system than if top officials are brought in from "outside" because of their formal credentials or for other reasons.

Prerequisite Education and Experience

It is seldom possible to build up a new health programme in primary health care or, indeed, in any other field, by moving gradually upward from the community level step by step. It is usually necessary to appoint personnel at all levels of the programme at the same time. Therefore, prerequisites for positions are customarily stipulated, in accordance with the degree of knowledge, skills, and general sophistication expected at each administrative level.

In Papua New Guinea, for example, the provincial health officer is usually a physician. In Bulgaria, every health centre and polyclinic must be headed by a chief physician. Specified courses of training are required for leaders at the district level in Papua New Guinea, and at the community level in almost all countries. Sometimes, a

certain number of years of experience is required in addition to formal education, particularly for posts at the district or provincial levels.

For primary health workers at the community level, formal academic schooling may not be required, except for evidence of "literacy". This is the case in the Dominican Republic, where education has been weak, especially for women. Yet even some of these primary health workers may rise to leadership positions in the community on the basis of other outstanding characteristics. The whole purpose of formal education is to communicate the lessons of the past more rapidly and systematically than they can be gained from experience. Even so, certain kinds of learning can only be acquired from experience.

For the preparation of community-level primary health workers, all the developing countries in this study have established special programmes of training. Being relatively short, these courses all tend to emphasize practical skills rather than theoretical concepts. They give instruction in both curative and preventive services, although the students seem to evince greater interest in the curative side; this, of course, is more dramatic and gives more rapid and visible results. None of the courses, however, is reported to give much attention to methods of management or leadership, with the possible exception of record-keeping and report-writing.

The top leadership positions in several of the country case studies were held by physicians or others who had, in fact, taken some formal training in public health or health care management. This was true in Bulgaria, Cuba, Papua New Guinea, the Philippines, and Viet Nam. Only in Bulgaria, Cuba, and Viet Nam, however, was such training specifically required. In Bulgaria, moreover, advanced training was required in both a clinical specialty and social medicine for the position of primary health care leader at the level below the top (the province in many countries). Specific instruction in management is often limited to short courses of a few weeks, since in many cases nothing else is available.

Knowledge of Primary Health Care Content and Problems

Whatever may be the formal requirements for becoming a primary health care leader, it is obvious that the person must have a wide range of knowledge about the components of primary health care. It may be helpful to consider this requirement under two general categories: technical and social.

The technical content of primary health care has been spelled out many times. It includes health education about major health problems, activities to control endemic diseases, maternal and child health work (including family planning), arrangements for access to clean water and for disposal of excreta and other wastes, promotion of good nutrition, immunization against infectious diseases, and treatment of common ailments. The last item requires a supply of essential drugs, an ability to give first aid of various kinds, and knowing when and how to refer

patients to other places for care. The leader must ensure not only that primary health care units under his or her supervision are provided with the necessary drugs and supplies but also that physical facilities are kept in a clean and orderly condition; he or she must be competent in handling funds and preparing budgets; and must also keep health records and apply the schedule of reporting required in the primary health care programme. Each of the above functions may be exercised in various degrees of depth, but it seems to be generally agreed that primary health care leaders—if not every primary health worker—should have some minimum competence with respect to all of these technical functions.

The social content of primary health care is somewhat more difficult to explain clearly. It includes the ability to reach out to members of the community and work with them agreeably and productively. It includes sensitivity to the many other sectors that influence health—education, agriculture, etc.—and the ability to cooperate with personnel working in those sectors. The primary health care leader must also relate constructively to the vertical levels of the health system both below and above.

Altogether the social dimension of primary health care, about which the leader should have highly sophisticated understanding, may be described as the *primary health care approach.* It implies a concern for people and a desire to help them. It implies flexibility, adaptability, and humility—the ability "to learn from the poor"—as expressed in the case study from Bangladesh. It means striving for equity in the use of resources for the benefit of all people.

Mastering this social aspect is a special requirement for primary health care leadership. It is in this area that problems and deficiencies are most frequently observed. The following sections will consider more carefully how capability in these matters might be more successfully achieved.

Adequate Resources for Leadership

Just as the delivery of primary health care requires various physical resources, good leadership makes similar demands. Since leadership requires continuing communication between the leader and the personnel supervised, the means of communication must be adequate. This requires some sort of postal system or some method of transmission of written messages. More important is equipment for telephone or radio communication; rapid communication is often essential and this normally demands a telephone network.

Transportation resources are equally necessary. The primary health care leader must be able to make personal visits to primary health care units, not only to see the programme in action, but also for face-to-face discussions with primary health workers. In the Dominican Republic and elsewhere, deficient transportation was in large part responsible for inadequate supplies of drugs and materials to field units. All too frequently in developing countries, large supplies of drugs remain in central storehouses, because the transport and delivery system has

broken down. To operate properly, vehicles require maintenance and fuel.

The primary health care leader should be entitled to personal rewards to maintain his or her morale. The psychological reward of prestige and authority is important, but it is not enough. There should also be physical rewards, in the form of adequate working quarters, agreeable housing, and a satisfactory salary. In the Dominican Republic, primary health workers at the village level are expected to be volunteers, who may receive only small expense allowances. The supervisor of community health workers receives a salary, which is of crucial importance. In the Dominican Republic, this leader becomes an employee of the Ministry of Health, thereby becoming part of the governmental structure—a source of pride.

Formal Training in Management

Perhaps the most complex issue in outlining the requirements for effective leadership in primary health care (or any other activity) is the extent to which formal training in management is required. As noted at the outset, leadership is really an attribute of management, and it may be roughly defined as "effective management". In so far as training or education is possible, it must concern the substance and techniques of management.

Management includes all the functions discussed in the previous chapter: planning, organization, training, supervision, external relationships, coordination, evaluation, and so on. One can read books about these matters and take formal courses. Yet, it is noteworthy that many of the primary health care leaders described in the case studies had received no such training. In Bangladesh, the Dominican Republic, Finland, and Liberia, the top leadership came from persons who were evidently dedicated to the objectives of primary health care, but had not received formal instruction in management. In other countries, the case studies reported that the persons providing the top leadership had, in fact, received special education in public health or a related discipline that included some managerial training. This was true in Bulgaria, Cuba, Papua New Guinea, the Philippines, and Viet Nam.

In Finland and France, the high-level leaders organized short courses or workshops on management and related subjects for primary health care leaders at the lower levels. Such short-term training programmes are widely used throughout the world in many fields. A person immersed in practical experience can usually benefit greatly from even brief formal instruction—far more so than a novice taking the same course. The question is, however, whether short on-the-job training is an adequate substitute for thorough in-depth education.

One must realize that most of the case studies reported earlier are accounts of success. They are stories of special projects, or an outstanding example of local performance in a national system, or a national overview presented in somewhat idealized terms. In almost any

national health system there are admirable local situations, where exceptional individuals are largely responsible for the achievements. The value of formal training must be examined in relation to the *average* person in the average situation. Where the individuals who must play leadership roles are not motivated by exceptional dedication or idealism, what can be contributed by training in management?

Considering the fact that the great majority of health workers—whether engaged in primary health care or in specialized secondary or tertiary care—are oriented mainly to individual patients, there would seem to be an obvious need to provide them with the skills and attitudes required by a concern for *populations*. Above all, the primary health care leader must be concerned with services intended to meet the needs of populations and with the functioning of organizations intended to implement such services.

In general, there are at least four administrative levels in a national health system, as described in most of the case studies; they may be defined as: (*a*) central, (*b*) provincial, (*c*) district, and (*d*) community. The sizes of populations and territories, of course, differ from country to country, but this hierarchical model should still be helpful. The depth, content, and duration of training must differ for preparation of leaders at each of these levels.

At the central or national level, the most frequent policy is to appoint a qualified physician as the top leader for a primary health care programme or its equivalent. (The Dominican Republic was unusual in not specifying a physician at this level, but requiring a professional person with university training and basic knowledge of public health disciplines.) Medical education, of course, is oriented overwhelmingly to the individual patient, and especially to the diagnosis and treatment of the sick. Even if a medical school has a strong department of preventive and social medicine or its equivalent (and these departments are often weak, both in staffing and in time spent on the topic by the students), the orientation of the department is mainly epidemiological and statistical; as a rule, little instruction is offered on the health care system or health services management.

The need of primary health care leaders at the national level, therefore, is for graduate study in the health sciences of populations, or what is customarily called public health. Such study would include orientation in all the content of primary health care, technical and social, as analysed earlier. In terms of the more usual disciplines defined by faculties of public health, this instruction would include epidemiology, social science, health system organization, health service management, environmental health, maternal and child health, nutrition, statistics, and health education; other subjects may also be included, but the above should be required. The usual academic institution for providing such instruction is a school of public health, but these are still rare in the developing countries. In the absence of such a university programme in the country, it might perhaps be developed in the ministry of health, preferably in collaboration with a university. The practice of sending

candidates abroad to an industrialized country for public health studies is not to be recommended (the content of training is usually quite inappropriate to the developing countries), but study in a nearby developing country might be valuable. Among the developing countries included in the case studies, schools of public health exist in Bangladesh, Cuba, the Philippines, and Viet Nam. All of them, however, probably require greater resources than they now have.

The customary duration of postgraduate public health study for a physician is one year. The technical aspects of the several disciplines could doubtless be learned in less time; the transformation of the average physician's social and philosophical orientation, however, from one focused on the individual patient to one oriented towards society and populations and towards organization and management, including all the social content of primary health care, probably requires at least a year. It is also advisable to include a period of supervised field practice in the postgraduate training programme.

At the provincial level, in most countries the population and territory covered are probably great enough to warrant similar graduate public health training. Indeed, in all but three of the country case studies (Dominican Republic, Liberia, and Somalia), the primary health care leader at the provincial level was expected to be a physician. Yet, without the graduate training described, he or she is not likely to fulfil the provincial role properly. A province or its equivalent ordinarily has at least half a million people and contains several districts or equivalent jurisdictions. In many ways, the provincial primary health care leader is more important for successful programme operation than the national director, being high enough to be concerned with questions of major policy and yet much closer to the scene of action. The managerial responsibilities are more likely to include difficult problems of resource allocation, supervision, community and intersectoral relationships, training programmes, evaluation, and so on. If the provincial leader is not a physician, the need for full training in public health is probably still as great or greater.

At the district level or the equivalent echelon, the primary health care leader is likely to be a health worker with an educational background of less than university level, but with abundant experience. In order to ensure and fortify his or her competence in management and leadership, a course of instruction lasting weeks or months might be required. This need not include the full range of public health disciplines, but would be concentrated on management—principles of organization, supervision, communication, personnel, financial affairs, evaluation, etc. Such a course could be given at the level of the province or at the national level, depending on the size of the country. The leader of a district might not be able to devote long periods of time to such studies, so that the course might be subdivided into several short periods. Continuing education should also be promoted and related to the leadership functions mentioned earlier.

At the community level, the leader of a primary health care team should receive formal instruction on management in two ways. Some of this—e.g., the maintenance of records or the promotion of community involvement—should be included in the training of basic primary health workers, even though such training is typically very brief. In addition, when a primary health worker is appointed to a leadership position, he or she should be sent for a briefing period to the office or quarters of the district leader, to learn about all aspects of management by day-to-day observation and discussion with the leader. From time to time, it would also be helpful for the provincial level staff to organize workshops of two or three days, where personnel from both the district and community levels could come for discussions of selected subjects. There might be special reason, for example, to hold a workshop on immunizations or water supplies or first aid, and in connection with these technical subjects managerial aspects could also be discussed. Workshops, seminars, and other means of continuing education should be open to field workers, as well as leaders, to enhance the general quality of primary health care.

These recommended programmes of training should not be considered as a rigid prescription for all primary health care leaders in all countries at all times. There should doubtless be variations for certain individuals with unusual qualifications or remarkable personal characteristics. However, for the average health worker, whether university-educated or not, special training in public health and/or management can have both practical and psychological benefits. On a practical level, it can provide assurance to the top programme leadership that members of the whole national health team have been offered the preparation to do what is expected of them. On a psychological level, the trained person is bound to have more self-confidence about what he or she is doing; self-confidence is necessary for enthusiasm and motivation. The trained person, moreover, is better prepared to cope with unusual problems, which may arise in any setting. The untrained or unqualified health worker hesitates to deviate from established rules for fear of making mistakes. The trained person usually knows enough to recognize a problem that demands an unusual or innovative course of action. With special training, a person of average ability can be converted to one with leadership qualities.

Leadership Training through Practical Experience

It is a mistake to balance experience against education as the best method of learning. Both are needed, particularly for a human service like primary health care. It is often said, as in the case study in Finland, that day-to-day experience is the best teacher. But this tells only half the story; experience is enlightening when it is built upon a grounding of systematic education. Those who learned about primary health care leadership in both Finland and France were already educated as doctors

or nurses or sanitarians; the same was true of the Liberian project leaders, who were physicians. To the uneducated person, experience may even be misleading; to the educated person, experience can provide deeper insight into a subject.

There is no question that field experience, whether offered as part of a formal training programme (as suggested above) or simply acquired from work, can teach a great deal about leadership. One could hardly learn the subtleties of the interpersonal relationships required in a good team-leader without serving for some time as the leader of a team. The Cuban case study speaks of self-education as the effect of experience. It also points out that reading books about a subject, while working on a job, usually provides much greater insight than the same reading unrelated to practical experience. The Bangladesh case study brings out the value of another type of experience; in order to appreciate the daily life of the poor, primary health workers are required to do the cleaning and maintenance of all health stations and health centres. No one is engaged specifically to do the dirty or menial work; everyone must participate in these tasks. This practice, as first developed in China during the 1960s, was regarded there as an "antidote to elitism" and also as a strategy for deepening the understanding of the people by higher-level professionals.

This study has focused on the preparation of primary health care leaders, rather than rank-and-file primary health workers. Yet there is obviously a reciprocal relationship between the leader and the followers. The basic training of primary health workers prepares them for their work, and the burden borne by the leader is inversely proportional to the adequacy of that training; if it is poor, the leader's tasks are all the greater. Furthermore, if the primary health care leader's guidance is effective, his or her responsibilities for leadership should become lighter as time passes and the health workers gain experience.

Personal Characteristics

The emphasis here on training and education for leadership should not lead one to infer that an individual's personal characteristics count for nothing. However, it must be realized that a person of average personal characteristics can acquire greater capabilities for leadership by deliberate training and the provision of certain resources. Individuals with certain traits can doubtless be more effective leaders than others.

This is not the place to explore the factors influencing the development of personality—genetics, upbringing, life experiences, culture, and so on. We need only say that, in any society, by 15 or 20 years of age an individual's personality is fairly well established. Changes in personality and character, of course, occur throughout life, but within limits.

Within the constraints of personality, it is possible to identify certain features of behaviour and character that are favourable to leadership. Several of these features were noted in the country case studies.

Enthusiasm was emphasized in the Finland study—in this context, enthusiasm for the primary health care concept. Self-discipline was stressed in the Cuban study; to relate positively to others the leader, this study also claimed, must understand and be at peace with himself (or herself). In the Bangladesh and Philippine situations, it emerged that the leader must have courage and must be able to cope well with opposition.

One can easily add to the list of personal characteristics conducive to leadership. The leader should be willing to take initiative and introduce new ideas; he or she should have perseverance to continue with an action that may not bear fruit immediately. At the same time, the leader must be flexible, willing to change plans and procedures when necessary. The leader, of course, must have integrity, must be just and objective in relations with all people, and scrupulously honest in dealing with money and physical resources. The outstanding leader emanates self-confidence, based on a firm grounding in the technical and managerial aspects of the programme. Because of all these traits of character the leader commands respect from others. If this respect is won readily from people who hardly know the leader and see him or her, so to speak, only from a distance, one often refers to the leader as having "charisma".

Some leaders may attempt to cultivate an air of charisma, in order to enhance their authority and power. In health work, however, such a quality may do more harm than good. In a primary health care programme, it is often necessary to change the leadership. The case studies in Liberia and the Philippines illustrated the process of transferring leadership. Many personnel changes are necessary in the normal course of events. Leadership should not be so firmly linked to a particular individual that a subsequent leader faces handicaps. In the long run, leadership in a primary health care programme should be based mainly upon sound knowledge, experience, enthusiasm, initiative, and integrity.

Environmental Influences on Leadership

Underlying the development of primary health care leadership—both the performance of its functions and the acquisition of the capabilities required for doing them—there is always a particular psychological environment. This environment may provide greater or lesser support for programme leadership or effective management, thus complementing the personal characteristics just reviewed. The psychological environment has an impact on all the people working in a programme, not only the leader, and can significantly affect their degree of motivation.

In the country case studies, at least three forms of influential environment are illustrated. In Cuba, one sees the influence of a political environment; in Kenya, the primary health care projects were clearly influenced by a religious environment: in Finland and France, a more general environment of social reform seemed influential. In a sense, a deep spirit of social reform characterized several of the case studies, especially the Bangladesh experience.

The functional tasks of leadership are much more likely to be effective in a psychological environment that motivates all persons to do their best, to work towards a goal. Basic technical and social training is essential if the primary health worker is to acquire the necessary capabilities. For the primary health care leader, special importance attaches to education about population characteristics (religious beliefs, social customs, etc.) and social and organizational structures, if managerial functions are to be well carried out. If the psychological environment is invigorating, the tasks of the leader are greatly facilitated. If it provides little motivation, the leader must be all the more forceful in inspiring primary health care team members to do their work with energy and dedication.