WORLD HEALTH ORGANIZATION ORGANISATION MONDIALE DE LA SANTE

EM ADVISORY COMMITTEE ON MEDICAL
RESEARCH
Eighth Meeting

Limassol, 18-20 April 1983

EM/8TH.MTG.ACMR/6

16 March 1983

Agenda item 5/b.

PROVISIONAL REPORT

"TASK FORCE" MEETING ON RESEARCH IN PRIMARY HEALTH CARE

Alexandria, 25-28 October 1982

Following the recommendation of the Seventh Session of EM/ACMR a meeting of the Task Force on Research in Primary Health Care was held in the Regional Office, Alexandria, 25-28 October 1982. The List of Participants and Agenda for the meeting are given in Annexes I and II.

The objectives of the meeting were:

- To develop detailed outlines of research protocols in priority topics related to PHC.
- To suggest means for implementing these research protocols, and for for further developing research in PHC in the Region.

The meeting was opened by Dr K.S. Rao, Director, Environmental Health and External Coordination, EMRO, who, on behalf of the Regional Director, welcomed the participants and thanked them for accepting the Organization's invitation to attend this meeting.

The members of the Task Force reviewed possible research topics related to Primary Health Care (PHC) which would help the implementation of strategies for the achievement of Health for All by the Year 2000.

It was felt that uptil now PHC research has been largely a matter of description and isolated experiments in implementing the eight PHC elements presented in the Alma Ata Declaration. However, this mode of research has not served to further the spirit of Alma Ata, in that it has taken the elements as independent entities and has not approached them as part of an integrated whole i.e. the health service. In so doing, it has perhaps delayed the provision of PHC for all. The eight-element vertical programme approach to PHC research in the past has not led to the establishment of permanent comprehensive yet integrated PHC. It has not been able to influence policy and has failed to situate PHC within the socio-economic and health care delivery system development of the community.

The following four research concerns were identified:

1. PHC coverage.
2. Community mobilization for PHC.
3. Reorientation of health professionals towards PHC.
4. Factors influencing the effectiveness and acceptability of PHC manpower at the community level.

The above research concerns identify the Task Force's orientation toward PHC as an integral part of community and health service development. The research areas also reflect the Task Force's concern that PHC be broadly construed, as it was by the signers of Alma Ata. That is, PHC is an approach (not a single profession) which focusses on certain aspects of health care . It is an approach taken by a PHC worker, by a nurse, by a sanitarian, by a pharmacist, by a doctor, etc.

It was considered that overall potential for, and obstacles to the achievement of Health for All by the Year 2000 (HFA/2000), can be best assessed through health coverage studies. Recent coverage studies in some of the EM countries have indicated as major obstacles to the development of PHC, the lack of specially physician commitment, the lack of community involvement and the lack of appropriately trained and strategically located helath personnel. The outlines for research developed by the Task Force (Annexes III, IV, V, VI) relate to the above-mentioned concerns by attempting to assess these inadequacies and developing and testing methods to remove them.

MECHANISMS FOR IMPLEMENTING THE RESEARCH PROPOSALS DEVELOPED

The group recommended that the outlines it has developed be sent to selected countries to elicit their interest and to suggest names of possible investigators. Where feasible, these outlines may be sent directly to interested institutions who are considered capable of undertaking the proposed research on behalf of the Ministry of Health of the country concerned.

Once a Government indicates it would like to undertake a given project, WHO may assist to develop a detailed research protocol with the team of designated national investigators. A short-term consultant can be recruited to assist the

national team in this effort and in carrying out the research.

Due to the nature of the proposed research effort should be made to ensure that investigators composing the team are drawn from different sectors and disciplines, not health alone. Where feasible and available people who have already participated in EMRO-sponsored health services research and training activities may be included in the research teams. The detailed research protocol drawn up by the team should contain a work plan clearly identifying the separate activities (components) and expected outcomes (products) for the entire duration of the project.

On being received in the Regional Office, the proposal should be reviewed using the established procedure. After any necessary modification has been made, the proposal may be approved and funds allocated. Where a proposed study is to involve more than one country, such as in inter-country comparisons, the detailed protocol will be developed centrally. The implementation of approved projects should be closely monitored through periodic visits of WHO staff members or short-term consultants.

The group emphasized the value of research training through active involvement in a project and recommend that this approach be encouraged in all projects. The findings and recommendation of the projects should be presented through a national seminar at the end or even when a discrete part of the project has been completed.

The following table identify countries where the proposed projects could be implemented during the coming biennium.

Country	1983	1984
Democratic Yemen	Improving the effectiveness and acceptability of PHC manpower	-
Egypt	Community mobilization for PHC	Orientation of health professionals to PHC
Jordan	PHC coverage	-
Pakistan	- PHC coverage - Orientation of health professionals to PHC	Improving the effectiveness and acceptability of PHC manpower
Somalia	PHC coverage	Community mobilization for PHC
Sudan	PHC coverage	Orientation of health professionals to PHC
Syria	-	PHC coverage
Tunisia	-	PHC coverage
Yemen A.R.	Orientation of health professionals to PHC	-
Bahrain		

ANNEX I.

WORLD HEALTH ORGANIZATION

Regional Office
for the Eastern Mediterranean

P.O.B. 1517 ALEXANDRIA, EGYPT
Telegr.: UNISANTE, Alexandria

TEL. 3 00 90 - TELEX 54022 WHO UN

منظمة الصحة العالمية

المكتب الإقليمي
لشرق البحر الأبيض المتوسط

ص.ب ١٥١٧ - الاسكندرية - جمهورية مصر العربية
برقيا: يونيسانتي - الاسكندرية

"TASK FORCE" MEETING ON RESEARCH
IN PRIMARY HEALTH CARE

21 October 1982

Alexandria, 25-28 October 1982

LIST OF PARTICIPANTS

WHO TEMPORARY ADVISERS

Dr Evelyn Early
Department of Anthropology
University of Notre Dame
Notre Dame
Indianna
USA

Dr Bashir Hamad
Dean
Faculty of Medicine
University of Gezira
Wad Medani
SUDAN

Dr W.A. Hassouna
Head
Social and Cultural Planning Centre
Institute of National Planning
Cairo
EGYPT

WHO/EMRO STAFF MEMBERS

Dr T.A. Baasher
Regional Adviser, Mental Health

Dr J. Hashmi
Regional Adviser, Non-communicable Diseases,
and Acting Regional Adviser, Research Promotion
and Development

Dr D.R. Billington
Regional Adviser, Educational Development
and Support

ANNEX II.

WORLD HEALTH ORGANIZATION

Regional Office for the Eastern Mediterranean

P.O.B. 1517 ALEXANDRIA, EGYPT
Telegr.: UNISANTE, Alexandria

TEL. 3 00 90 - TELEX 54028 WHO UN

منظمة الصحة العالمية
المكتب الإقليمي لشرق البحر الأبيض المتوسط
ص.ب ١٥١٧ - الاسكندرية - جمهورية مصر العربية
برقيا: يونيسانتي الاسكندرية

"TASK FORCE" MEETING ON RESEARCH IN PRIMARY HEALTH CARE

22 October 1982

Alexandria, 25-28 October 1982

PROVISIONAL AGENDA

1. Opening of the Meeting and Introductory Statement

2. Review and selection of specific topics for research in PHC in the light of the deliberations of the recent meeting of the EM/ACMR

3. Development of detailed outlines of research protocols on selected topics

4. Mechanisms for implementing the research proposals developed, and identification of countries where they could be implemented

5. Suggestions for further development of research in PHC

6. Consideration of the draft report

   Closure of the Meeting

1. Title of the project: PHC Coverage

2. Statement of the problem

Achievement of HFA/2000 is an overall goal that all Member States of the WHO have agreed. The development of PHC is crucial to the achievement of HFA/2000. Health Services Research (HSR) can provide guidance in developing policies, strategies and plans for the achievement of health coverage within various socio-cultural, economic and political contexts.

3. Objectives of the Study

3.1 To generate information necessary for the country to develop appropriate policies, strategies and plans to achieve full health coverage through PHC by the Year 2000.

3.2 To train a core of health and non-health workers (professionals and non-professionals) in HSR in the country in the development of a health coverage study suitable to their country and based upon methodologies developed in previous regional coverage studies.

3.3 To study in more detail informal health providers, self care and referral systems within the overall context of PHC.

4. Possible Application of the Results of the Proposed Research

The involvement of the agency responsible for delivery of health services in carrying out the research is one of the main factors that guarantees the application of the results. Information generated during the study may be utilized by the health services delivery agency to introduce changes without waiting for the final report.

5. Summary of Relevant Recent Work Done

EMRO: The Health Coverage Study, Bahrain, Egypt and Yemen Arab Republic.

MOH/USAID Egypt: Health Sector Assessment of Three Zones in Greater Cairo.

6. Design of the Study and Methodology Employed.

The methodology of the proposed study is described in detail in the final report of the Three-Country Coverage Study.*

* ECTOR, Institute of National Planning, Cairo (1981)

The investigation will be subdivided into 3 parts or levels. These are: national, intermediate and local.

National level information and approach

National data, demographic, socio-cultural economic, development plans, etc. National health policies, plans, organization and management of health resources (manpower, facilities, equipment, etc.).

Intermediate level information and approach

Appropriate sample of various PHC resources (facilities, manpower, equipment, etc.). Structure and functional capabilities.

Community level information and approach

A number of representative communities to study in depth the interface between health providers and clients with special emphasis on treatment seeking behaviour, especially studying the informal provider of health care and self care.

Data gathering methods

- Published data and interviews — national level
- Questionnaires and checklists — intermediate level
- Questionnaires and participant observation — community level

7. Possible countries, institutions and individuals to be involved

Countries: Democratic Yemen, Jordan, Pakistan, Sudan, Syria, Tunisia.

Institutions: MOH + research institution (HSR)

Consultants, Experimental Centre for Intensive Training of Personnel/INP — International

8. Tentative work schedule

Development of proposal — Two week workshop

Design the study and select the sample)
Instrument development) 6 months
Plan of Action detailed)
Training of researchers

Data collection	6 months
Analysis of data interpretation Final Report writing and presentation of findings seminar	6 months
	18 months

9. Budget

$ 20 000 - 25 000 per country

Consultants

1. Title of the Project: Community Mobilization for PHC

2. Statement of the Problem

Health problems can be better met if existing health systems which are committed to PHC, involve community organizations and initiatives in the development of their PHC programme. If the PHC approach is to succeed, it must be community-based and approached via inter-sectoral cooperation. If the community provides the plans and resources for PHC, the community is more likely to consume its services.

The success of a community mobilization project is contingent on the participation of key community members. These individuals may be of or known to the Community Council. The Council may obtain the involvement of these key people by informal community mechanisms.

3. Objectives of the Proposed Study

The study aims to develop a model way by which a community sets health targets for itself, plan ways of achieving these targets and services and develops ways of monitoring the progress of this activity as it progresses. Two communities in a given country will be studied.

Specific objectives are:

(a) To assess community resources for PHC such as:

- Health manpower and facilities in the formal (clinic staff, etc.), as well as in the informal health sector (TBA, herbal pharmacist, etc.)
- Resources existing in educational and social work institutions
- Community elders, benefactors, etc.

(b) To assess community attitudes and practices such as:

- Understanding the community context and its potential for PHC.
- Providing pre/post-data for the permanent establishment of PHC in the community.

(c) To formulate a Plan of Action by the community to include:

- Training community representatives as planners;
- establishing criteria to measure outcomes;
- establishing techniques to mobilize resources including technical assistance from outside institutions.

(d) To implement a Plan for Primary Health Care in the community to include:

- Pre-testing of community health attitudes and practices, training personnel, constructing facilities, monitoring progress and post-testing community health attitudes practices and the environment.

(e) To have the community analyse their PHC Programme by discussing pre- and post-test tests findings.

(f) To construct a model of how to mobilize a community for PHC.

4. Possible application of the results of proposed research

The results will serve as a reference for future community mobilization on PHC programmes in other countries. Although a formal control group is not appropriate, given the field methodology, some idea of the programme's impact can be ascertained from comparison of the pre- and post-tests. Special attention will be given to the place, acceptability and duties of the PHC worker in the community health network so that appropriate training programmes may be devised.

5. Summary of relevant recent work done

Although there are abundant community studies, most have used demographic, mortality, morbidity and similar indices. The proposed research will provide new kinds of community development data, describing PHC within a social, developmental context.

6. Design of the Study

6.1 Hypotheses of Study

- That PHC programmes developed by communities are possible and can be successful in improving health and wellbeing.
- That PHC programmes based on inter-sectoral cooperation are possible and can be maintained.

Due to the nature of exploratory, action research, it may be possible to test the above hypothesis, using control groups.

The critical points in a proposed action design are the methodology; community involvement; basic research on health resources, attitudes, activities and inter-sectoral cooperation.

6.2 Methodology

The study will be conducted through the relevant local governmental group*.

Normally in each country two communities which are demographically or organizationally distinct will be chosen. Different land owning patterns e.g. long-term large land-holders versus new small-parcel holders, could be such a differentiation. Others distinctions could be the degree of urbanization, industrialization and presence of adult male labourers.

The research institution will cooperate to train some researchers from the community and design research instruments, which should be both quantitative and qualitative.

6.3 Setting up the Project Plan and Research Criteria by the Community

Community members will be oriented to the purpose and scope of study and trained as planners and researchers by those who are sponsoring the research.

Members of the community council will be responsible for mobilization of local planners and researchers; recruitment of personnel for PHC training programme; establishment of inter-sectoral cooperation in implementing PHC objectives. (The exact mechanism for cooperation, planning cross-sector councils, etc. will be left to the community to decide and the creation of a receptive community through appropriate informal leadership and media networks.

---

* For simplicity the term "community council" will be used throughout this protocol and will be understood to refer to the local development association, council, etc. As noted in 2.0 participation of key community members is critical to the project's success.

Members of the community council with technical assistance deemed necessary by them and the research institution would establish plans for the following four areas: Plan for research to identify base-line health indicators to be pre- and post-tested in the community;a plan of action to establish PHC training and services;a plan to monitor the programme according to community set criteria; and a plan to evaluate the programme's impact using pre-, post-data.

6.4 Basic Research on Health Resources, Attitudes and Activities

The pre and post health indicators will provide information about resources and of attitudes. The resource survey could be similar to the WHO/EMRO-sponsored/ Coverage Study* which surveyed clients, providers and facilities to ascertain spatial, temporal, typological dimensions of health resources available. The coverage study covered both the formal and informal health sectors. The research proposed therein will probe the informal health sector as well as other sectors including education, religion, production, etc. to ascertain the availability of human resources like imams, educators, union leaders, merchants, etc. to work in the PHC programme.

The attitude/practices survey should be devised consistent with the PHC objectives set by the community. Given the comprehensive mandate of PHC they will not be totally disease related. Gross measures like infant mortality will probably not immediately reflect PHC's influence and as such should be avoided. More intermediate measures are recommended such as:

- additional potable water sources;
- improved waste disposal;
- use of pre-natal service;
- incidence of pesticide spraying;
- water contact behaviour (bathing practices);
- selling household milk and eggs vs. feeding them to children;
- changed cropping practices to increase availability of nutritional crops would be more appropriate as base-line indicators in assessing PHC's impact.

* Final Report of the Three-Country Coverage Study

6.5 Inter-sector cooperation

The community will be responsible for facilitating inter-sectoral co-operation aiming to: utilize existing resources as effectively as possible while avoiding introduction of services duplicating existing ones; and by co-opting possible opposition to PHC, found particularly but not solely in the informal sector.

The comprehensive nature of PHC suggests technical and personnel programme collaboration among educational, environmental, governmental and other social service sectors. These sectors must be involved not only for their support, but to limit their potential opposition to PHC if it exists. Informal and formal health sectors which impinges upon the success of PHC programmes to which particular attention may be paid are:

- The informal health sector where physicians are relatively in- and accessible/which includes not only PHC types of services but often more sophisticated services performed with greater or lesser skill. (These practitioners have a powerful hold on the community and may be more threatened by the PHC worker than physicians - action research on inter-sectoral cooperation should generate viable ways of co-opting the informal sector).
- Personnel of the informal sector may be promising candidates for PHC training: (this needs to be carefully investigated);
- self-help, reinforced by reliance on the informal sector, may overlap with PHC concerns so as to devalue the latter's importance.*
- The formal sector is also threatened by PHC.

* Recent studies (cf. ECTOR HSRA and Coverage) suggest that a good percentage of clients use self-care as a first resort, particularly with illnesses that they perceive to be trivial. While self treatment for minor symptoms may be beneficial in its alleviation of pressure on the HCDS, it can be harmful - particularly in the case of local, endemic diseases which may be endured rather than eradicated. Here the PHC worker has a critical role to play. Research under this concern may focus on how PHC can complement or contradict self care, and the role of PHC education using the team to teach others model currently employed in illiteracy programmes).

- The formal sector is also threatened by PHC.

7. Possible countries and institutions

EGYPT: Institute of National Planning; Kafr El Shaikh School of Social Work; Ministry of Local Governments.

SUDAN: Ministry of Health and Social Welfare for the Central Region; Ministry of Agriculture for the Central Region; Faculty of Medicine, University of Gezira.

LEBANON: MOH and American University of Beirut.

YEMEN ARAB REPUBLIC: Primary health care project including UNICEF, WHO and the MOH.

DJIBOUTI

8. Tentative work schedule

1. Initial formulation of project design with community via research centre/ ministry run workshop - 3 months.

2. Training of researchers and pre-test. Recruitment of trainees - 3 months.

3. Training programme and establishment of PHC services - 6 months.

4. PHC programme operation - 1 year.

5. Post-test and evaluation of programme - to occur during last 4 months of second year, during which time lessons learned can help the adaptation of the PHC programme.

1. Title of the Project: Reorientation of Health Professionals to PHC

2. Statement of the Problem

With the introduction of PHC as a new approach and strategy to realize the goal of Helath for All by the Year 2000, serious efforts are needed to pave the way for its adoption as policy. This requires reorientation of the health and health-related systems at the various levels.

In many countries, health professionals in particular physicians need to be oriented to this new approach since they play a central and powerful role as health planners. They are the people who influence or make decisions which both directly and indirectly affect PHC. Studies are needed to:

- Investigate the attitudes, knowledge and practices of health professionals (especially physicians) to PHC, and to identify the main problems and constraints for their orientation to PHC.
- In the light of the above, design strategies for reorientation. It is envisaged that these might be short- and/or long-term action plans, which include educational and/or operational, and/or legislative components.
- Implement these plans, evaluate their outcomes and communicate the results.

The target group for any of these studies would vary according to country needs and preferences. Though some studies could be focussed on certain groups like newly graduated doctors, final year medical students, decision-makers, experienced doctors or specialist groups, it is felt that all categories of health professionals should be involved where this is possible. For example the study could cover all (or sample) physicians in a country followed by focussed studies in one region or locality of it. It

./..

is likely that in drawing action plans for reorientation, in-service (continuing) education in PHC will pose itself as one important component of the strategies adopted.

3. Objectives (They are stated using physicians as the model professional group but other professional groups may be studied)

3.1 Provide information on the current situation of the attitude, knowledge and practices of physicians to PHC.

3.2 Identify the main problems and constraints in the orientation of physicians to PHC.

3.3 Design, develop and implement strategies (within existing resources) for orientation which may include educational, operational and/or legislative components.

3.4 Evaluate these strategies.

3.5 Develop models for orientation of other physicians to PHC.

4. Possible applications of the results

The methodology and/or models if proved useful and effective can be used in the same country for regions other than the regions of the study or with the necessary modification in other countries.

5. Summary of relevant recent work done

This field as such has not been systematically addressed in this Region. Some aspects of these issues are dealt with in the recently developed WHO draft monograph on Continuing Education for health Workers. There have been studies on attitudes of physicians in the EMR but not specifically on PHC.

6. Design of the study including methodology and hypothesis

The study is designed to test the hypotheses that most physicians have a neutral or negative attitude to PHC, and that a more positive attitude can be created. Both questionnaires and direct interview will be used, to assess

knowledge attitudes and practices both before and after the experimental re-orientation programme.

6.1 The Survey

The target population: All physicians in a country or a defined geographical area within it. Depending on size and available resources a total coverage study or a representative sample can be used. Medical and social science students may act as data collectors, and thus be trained as research workers.

6.2 Management of study and development of survey instruments

The Ministry of Health and related institutions will need to be informed and their consent and cooperation (and later on commitment to design educational programmes) secured.

Questionnaires to be designed with input and advice from a statistician and a behavioural scientist. Records may be used also.

The questionnaire should assess attitudes, knowledge and practices of physicians in PHC. It may be an anonymous questionnaire containing both open ended and closed questions together with rating scales where necessary. It should be designed with a view that it is going to be used both pre- and post experiment.

An inter-disciplinary team under a suitably qualified and experienced person, incorporating advisory services of social scientists should be collected for managing the project and developing the survey instruments.

Data is collected. Alternatives and opportunities for data collection are:

- Direct interview where population is small and easily accessible e.g. within a certain confined locality.
- Meetings of general assembly of doctors union.
- Postal questionnaire (with more facility for open ended questions) where the postal service is reliable. There may be a need to assess response rate and follow a sample of non-respondents.

6.3 Data analysis

Responses need to be checked, coded and analysed. Results should be tabulated, problems identified and recommendations for action plans are made.

6.4 Survey report

A final report is compiled and discussed with those concerned, especially the Ministries of Health and Education and training institutions.

6.5 The change strategy

Formulating strategies at the local and/or national level. Changing attitude and behaviour strategies: These can be evolved by a working group made up of key persons of the Ministry and the local level professional working together with, where appropriate, medical educators from the training and educational institutions plus representatives from the social, agricultural, educational and other relevant sectors. The problems are posed, others added by participants and strategies to reorient attitudes and practices, are drawn up using an interactive workshop approach. In the process, participants will be enlightened about the issues of PHC in general and will be involved in planning . Hopefully through this process they will become committed to the implementation of the plans. People and resources to carry out the planned strategy should be defined. It is hoped that some guidelines as to how the planned activities are to be evaluated can be discussed and defined from which evaluation instruments can later be constructed.

6.6 In the region, or locality, concerned contacts are made, facilities and resources are tapped, and if necessary, upgraded to meet the needs of the second component of the study.

6.7 Evaluation of the activities may be made over 1 - 2 years period. More formative and/or intermediate level indicators should be used since it is unlikely that a significant long-term impact will be achieved in a short period.

6.8 The Final Report is then prepared, and presentation made.

7. Possible countries, institutions and individuals where this project could be implemented

Sudan, Egypt, Pakistan, Tunisia.

Sudan: Ministry of Health and Social Welfare in the Central region of Sudan, PHC Department including directors of training in the Central Ministry of Health and Director of Training in the Central Ministry of Health, Gezira.

Egypt: Ministry of Helath and Ain Shams School of Medicine, Suez Canal Medical School, Training Department.

8. Tentative work schedule

The Survey

Initial preparation, definition of target population questionnaire design and recruitment of data collectors - 3 months.

Training of data collectors, coding, pilot testing and refining of questionnaires 3 months.

Data collection, analysis and reporting - 3 months.

The change activity

Preparatory phase for implementation, workshop for training strategies, refining strategies. Designing evaluation instruments - 3 months.

Implementation and evaluation. Reporting. 12 months.

9. Budget and brief justification

9.1 Personnel

- Investigators and evaluation consultants
- Data collectors
- Perdiems for participants in Workshop and continuing education activities.

9.2 Operating expenditure

Supplies: production of learning materials
provision and distribution of learning materials
stationery

Equipment: production of duplication equipment, e.g. stencil duplicator, typewriters, etc.

Data analysis and typing of report.

Final presentation.

1. Title of the project: Improving the effectiveness and acceptability of PHC manpower.

2. Relevance to PHC of health care

At the peripheral level various factors are operating which directly or indirectly effect how well the PHC workers can do their job. A study of these factors will help bring to light some information which may be most useful in promoting PHC. A study of PHC workers' performance and working environment will furnish most of the basic information required.

3. Objectives

- To describe and analyse the tasks of PHC workers.
- To appraise degree to which tasks are being performed.
- To examine personal and situation barriers to job performance.
- To recommend methods for change within available resources.
- To implement the changes that are feasible within the available resources, (e.g. training, operational/support services).
- To evaluate the outcome of these changes and assess acceptability.

4. Possible application of results

The descriptive part of the study will serve the purpose of bringing to light the main problems and constraints of PHC work at the peripheral level and pose concrete and feasible recommendations as to ways and means of rectifying these, whether they are related to the performance and/or training of the health worker per se, or to the existing situation in which he is working. After the plans are implemented and evaluated through the indispensable support of the Government concerned, an evaluation of the outcome is hoped, to produce evidence that planned training and supervision of CHW is beneficial and worthy of replication in other places and countries of the EM Region.

5. Summary of recent work done

Task analysis have been done in Yemen Arab Republic (1980), in Somalia (1981), and in Sudan (1982), to list duties and responsibilities of various categories of health personnel and draw a competency-based curriculum and/or learning units or courses (see EMRO reports). In the Sudan and Yemen Arab Republic the list of duties and responsibilities of community health workers (CHW) and some other health workers were clearly defined. In both these countries an evaluation of CHW has been done and some reorientation of both the training and the set-up to promote PHC activities was made, at least in the former. The outcomes remain to be seen.

6. Design of the study including methodology and hypothesis

6.1 Preparatory activities

The designated investigator(s) (endorsed by the Ministry of Health) should be contacted and the implications of the study explained to him. At least a partial commitment to help in the implementation phase of the project is desirable, since it is not the purpose to file away results but rather do something with them to improve the situation.

Information regarding health personnel working at the peripheral level should be collected including job descriptions where available.

6.2 Target population

A decision on the target population is made according to the needs and/or locality concerned. These could be different in different countries, e.g. CHWS' sanitarians or village midwife in Sudan, CHWS or medical assistant in YAR, and nurses in Egypt.

6.3 Description of tasks and task analysis

Where specific tasks are defined for the health workers, a task analysis need to be made through a workshop on lines similar to the ones done in previous reviews. Where no definition of tasks exists, the workshop may begin by making these definitions before embarking on the task analysis exercises. Once the tasks are analysed into various elements prioritization is made, e.g. according to frequency of performance.

Task elements are then selected and refined and these form the basis for observational and evaluational instruments (e.g. check lists and rating scales) for assessing performance of the health worker concerned. It is to be noted that the definition of these tasks cannot be complete without the adequate definition of the conditions under which they are performed, i.e. the working environment and th standard of competence required.

When there are no job descriptions for the target population, the proposed workshop should contain not only a group from the target population but also other health personnel. This has always proved useful.

6.4 Selection of locality

Feasibility to carry out the study should be the guiding principle in deciding about the locality or region.

6.5 Design evaluation instruments

A multidisciplinary team of evaluation specialist, educators, health experts, statistician and social scientist, etc., is important at this and the following stages, which would include:

a) observational characteristics and rating scales on the work situation and the worker

b) questionnaire to the community, selected patients and/or individuals interacting with the service of the health worker in question: competence, utilization, by-pass phenomena, acceptability

c) questionnaire to health worker about his work, job satisfaction, problems encountered, achievements, drawbacks, supervision and support from seniors, what he is able and not able to do and why, etc. and own views about possible solutions to cited problems, etc.

d) examination of practice records where they exist

The questionnaire should also address the eight elements of PHC.

These instruments should be compared with direct interviews of village leaders, villagers and supervisors.

6.6 After the data has been collected and summarized explain and consult with people concerned at the local level, and if possible, secure commitment for change if found necessary.

6.7 Hypothesis to be tested (stated as a Null Hypothesis).

There is no discrepancy between what the health worker is trained to do and what he is actually doing;

and/also there is no discrepancy between what the community demands and what he is able to provide.

6.8 Collection of data and analysis

The steps recommended are: Recruit data collectors; train data collectors on the instruments and on direct interviews, and above all on the philosophy of PHC and its approaches; code the instruments; test the instruments on a small number ofthetarget population and revise accordingly; decide about sampling procedure; collect data; analyse, tabulate and report data including statistical testing of hypothesis.

6.9 Conclusions and recommendations for action plans

These could focus on:

(a) Mechanisms to improve acceptability of the health worker.

(b) Desired changes in curricula and/or training strategies of the health worker.

(c) Constraints operational in the working environment.

(d) Provision of incentives and/or improving career structure, etc.

6.10 Strategies for change

Make necessary contacts to convene a workshop attended by selected individuals from health workers concerned, some community leaders, representatives from agricultural, social and health sectors, supervisors of health workers and the relevant individuals to:

- acquaint themselves with PHC
- discuss the report and recommendations for action
- produce concrete feasible plans for solving the problems and improving the situation, including the formulation of groups or task forces.

6.11 Develop instruments for ongoing evaluation of these plans.

6.12 Implement plans and evaluate using already designed instruments.

6.13 Analyse and prepare final report and prepare presentation.

7. Possible countries and institutions

Democratic Yemen, Egypt, Jordan, Sudan, Somalia, Tunisia, Yemen Arab Republic.

8. Tentative work schedule

Preparation phases 6.1 - 6.7	6 months
Data collection, analysis and reporting	9 months
Orientation/planning workshop, implementation of plans, evluation and reporting	9 months

9. Budget

9.1 Personnel

Investigators, consultants on evaluation, data collectors, statisticians and social scientists and related personnel.

9.2 Operational expenditure

Workshop's expenses, stationery, analysis, typing, learning materials.