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Adapting the Training and Visit System
for Family Planning, Health, and Nutrition Programs

Richard Heaver

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ABSTRACT

In agriculture, the Training and Visit System (T&V) of extension has proved a successful managerial approach for dealing with geographically scattered outreach operations; developing and adapting techniques for locally varying conditions; and changing the behavioral patterns of large numbers of poorly educated field staff and beneficiaries. Mass family planning and health programs present all of these challenges. This paper is a first attempt to explore whether T&V can be adapted to meet the technical, managerial and behavioral needs of population, health and nutrition (PHN) programs, while remaining cheap enough to be widely replicable.

The paper falls into three parts. The first part on theory looks at the similarities and differences between managerial tasks and practices in agricultural extension and PHN, and taking into account the differences, suggests a "model" T&V system for PHN. The system that is put forward is not a blueprint, but a starting point for further adaptations appropriate to the resources and PHN delivery systems of any given country.

The second part of the paper moves from theory to practice; it looks at three PHN outreach systems in India, the Philippines and Indonesia. The Indian program already has many of the managerial characteristics of T&V. But while it appears to be more effective than the programs in Indonesia and the Philippines, it is also a more intensive user of human and financial resources. So, while the case studies support the potential usefulness of T&V-type management systems, they also raise the question whether these are necessarily resource-intensive, or whether resources can be diluted without undue loss of effectiveness--a question which can only be settled by experiment with alternative approaches. The third part of the paper therefore proposes some alternative approaches to making outreach programs more cost effective, and outlines some of their theoretical advantages and disadvantages.

For PHN specialists unfamiliar with agricultural T&V, a brief outline of the system is given in Annex 1.

EXTRACTO

En el sector agrícola, el sistema de extensión mediante capacitación y visitas ha resultado un enfoque administrativo eficaz para realizar las operaciones de extensión en zonas ampliamente dispersas, elaborar técnicas que se adapten a las diversas condiciones locales y modificar las características del comportamiento de grandes cantidades de personal local de extensión y de beneficiarios con muy bajo nivel de educación. Los programas de planificación de la familia y de salud en gran escala plantean todas estas dificultades. El presente estudio constituye el primer intento de explorar si el sistema de capacitación y visitas se puede adaptar en la forma necesaria para satisfacer las necesidades técnicas, administrativas y en materia de comportamiento de los programas de población, salud y nutrición, manteniéndolo al mismo tiempo lo suficientemente barato como para repetirlo ampliamente.

El estudio se divide en tres partes. En la primera, de carácter teórico, se examinan las similitudes y diferencias entre las tareas y prácticas administrativas de extensión agrícola y las de los programas de población, salud y nutrición, y, teniendo en cuenta las diferencias, se sugiere un "modelo" de sistema de capacitación y visitas para estos últimos. El modelo que se propone no es un plan detallado, sino un punto de partida para incorporar luego las adaptaciones que se ajusten a los recursos disponibles y a los sistemas de prestación de servicios de planificación familiar, salud y nutrición de un país dado.

En la segunda parte del estudio se pasa de la teoría a la práctica; se examinan los sistemas de extensión en las esferas de población, salud y nutrición existentes en la India, Filipinas e Indonesia. El programa de la India ya tiene muchas de las características administrativas del sistema de capacitación y visitas. Empero, si bien parece ser más eficaz que los programas de Indonesia y Filipinas, también exige un uso más intensivo de recursos humanos y financieros. Por lo tanto, aunque los estudios de casos prácticos corroboran la posible utilidad de los sistemas administrativos basados en capacitación y visitas, también hacen que se plantee la cuestión de si éstos requieren forzosamente un uso intensivo de recursos, o bien si los recursos se pueden diluir sin una merma indebida de la eficacia, una cuestión que sólo puede dilucidarse mediante el ensayo de los diferentes sistemas. Por consiguiente, en la tercera parte del estudio se proponen otros posibles métodos para hacer que los programas de extensión sean más eficaces en función de los costos y se esbozan algunas de las ventajas y desventajas teóricas.

Para información de los especialistas en programas de población, salud y nutrición que no estén familiarizados con el sistema de capacitación y visitas en el sector agrícola, se ha incluido una breve reseña del mismo en el Anexo 1.

Le système de formation et de visites dans le cadre de la vulgarisation agricole a fait ses preuves en tant que méthode de gestion applicable à l'exécution de programmes extérieurs géographiquement éparpillés, à l'adaptation de techniques aux conditions locales et à leur diffusion et à la modification du comportement d'un grand nombre d'agents d'exécution et de bénéficiaires peu instruits. Les grands programmes de planning familial et de santé posent exactement les mêmes problèmes. Ce document tente pour la première fois de déterminer dans quelle mesure le système de formation et de visites, tout en restant assez bon marché pour être reproduit à grande échelle, peut être adapté aux besoins des programmes de population, de santé et de nutrition sur les plans de la technique, de la gestion et du comportement.

Le document comprend trois parties. La première, de caractère théorique, examine les ressemblances et les différences existant entre la vulgarisation agricole et les programmes de population, de santé et de nutrition pour ce qui est des tâches et des pratiques de gestion. En se fondant sur les différences, elle propose pour ces programmes un système "modèle" de formation et de visites. Celui-ci doit être considéré non pas comme un cadre définitif, mais comme un point de départ pouvant servir à la mise au point de formules adaptées aux ressources des services de population, de santé et de nutrition de chaque pays.

La deuxième partie du document passe de la théorie à la pratique en examinant trois programmes extérieurs de population, de santé et de nutrition (en Inde, aux Philippines et en Indonésie). Le programme indien présente déjà plusieurs des caractéristiques gestionnelles du système de formation et de visites. Il apparaît plus efficace que les programmes indonésien et philippin, mais il met aussi davantage à contribution les ressources humaines et financières. Ainsi, tout en confirmant l'utilité potentielle des systèmes de gestion de type "formation et visites", ces études de cas posent la question de savoir si ces systèmes consomment nécessairement beaucoup de ressources, ou si l'on peut diluer celles-ci sans trop réduire l'efficacité, question à laquelle on ne pourra répondre qu'après avoir expérimenté diverses autres méthodes. La troisième partie du document propose donc d'autres façons de rendre les programmes extérieurs plus rentables et présente dans leurs grandes lignes certains de leurs avantages et de leurs inconvénients théoriques.

Le système de formation et de visites dans le cadre de la vulgarisation agricole est récapitulé brièvement à l'Annexe 1 à l'intention des spécialistes des programmes de population, de santé et de nutrition auxquels il n'est pas familier.

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SUMMARY AND CONCLUSION

I. Theory

Training and Visit (T&V) has been adopted as the extension method in more than forty agricultural projects in about twenty countries, and has influenced many others. It has proved a successful approach for introducing behavioral change on a mass scale in situations where field staff and clients are poorly educated and geographically scattered, and where techniques must be developed and constantly readapted to meet locally varying conditions. The challenges facing mass population, health and nutrition (PHN) programs are similar---though more intense, since innovations in PHN affect the personal rather than the economic life of the family, so that adoption is more threatening to cultural norms; and since the beneficial impact of better practices (especially preventive ones) shows up less clearly in PHN than in agriculture, making adoption and diffusion less automatic. The paper suggests adaptations to the T&V system that would be needed if it were to be applied in the context of PHN programs.

The six main elements of a T&V system for PHN are summarized below. Where there are significant differences from T&V in agriculture, these are noted.

1. Concentration on a small number of key tasks. The tasks chosen would a) be few and simple enough for poorly educated village health workers (VHWs) to understand and remember, and b) blend tasks which are of high priority in epidemiological terms with tasks which are of high priority in terms of clients' felt needs. While task concentration is recognized as a need in the PHN literature, it is seldom practiced; VHWs are overloaded and must often attempt to communicate innovations which clients have little incentive to adopt.
2. A performance reporting system concentrating on key tasks. Reporting systems in current use take up too much of VHWs' time and collect data which are often not processed and used. The primary purpose of a T&V reporting system would be to motivate both VHWs and clients by demonstrating progress. This would be a departure from T&V practice in agriculture, where written reporting has been unnecessary, since the results of adoption are plainly visible in the fields.
3. Regular, frequent home visits. Since staff are scarcer and messages change less frequently than in agriculture, visits might be monthly rather than fortnightly. Predictable routines for home visits are followed in few PHN outreach systems, but have great potential both for building the confidence of clients and for increasing the accountability of VHWs to supervisors.
4. Concentration on selected clients where interventions can have maximum impact on reducing fertility and mortality. Scarcity of field staff and the need for regular follow-up visits to build confidence before adoption and to reassure and reinforce after adoption, argue for concentration of care on pregnant women and mothers with small children,

since it is in these groups that mortality is highest and the need for family planning education greatest. This is, of course, a different client group from T&V in agriculture.

5. Regular, frequent field supervision visits focused on support rather than inspection. Regular supervision is missing in most PHN outreach programs. The system would ensure that a supervisor would spend not less than a day each two weeks supporting each VHW individually on the job.

6. Regular in-service training. Monthly training sessions for VHWs, supported by two monthly workshops in which senior staff and researchers would develop new extension recommendations, would have several functions---disseminating new technical messages and IEC techniques; reinforcing existing knowledge; giving VHWs feedback about performance; and sharing and solving problems encountered in the field. Such training is not available in most PHN programs.

II. Practice

Field visits were made to health and nutrition outreach programs in India, Indonesia and the Philippines. The India program, which had many of the managerial characteristics of T&V, clearly outperformed the others, which relied on volunteers with limited training and infrequent supervision. At the same time, both the Indian program and the model T&V system for PHN put forward in this paper, are more intensive users of financial and human resources than the Indonesian or Philippine programs. The paper does not recommend programs based on paid workers rather than those based on volunteers; what is appropriate will depend on the cultural and administrative context, and the resources available. However, it does note that effective supervision of large numbers of volunteers can be prohibitively expensive; that tightly managed T&V-type programs may be considerably cheaper than well supported programs based on large numbers of volunteers; and that T&V-type programs, while more costly than poorly supported volunteer-based programs, may nevertheless also be much more cost-effective.

III. Implications

None of the elements of the 'model' T&V system outlined in the paper is new to PHN. However, these elements are seldom introduced as a package or system so that they are mutually reinforcing. This has been the key to T&V's success in agriculture, and would be worth systematic experiment in PHN. In some countries, for example in South Asia, the field staff resources are already available for such an experiment to take place. Other countries cannot afford the large network of full time extension agents on which T&V has traditionally relied in agriculture. But in these countries there may be scope for cheapening the design of the T&V system through employing paraprofessionals as VHWs, and through limiting the task by restricting the full range of services to fewer priority clients in the first years of development, while still retaining the basic managerial principles of the system.

CONTENTS

Part One: Theory

	<u>page</u>
1. The Market	1
2. Extension Tasks	2
3. Developing Extension Messages	7
4. Visiting	8
5. Training and Supervision	12
6. Summary and Issues for Discussion	14

Part Two: Practice

7. Comparing Performance	18
8. Tamil Nadu, India	20
9. Cebu and Iloilo, Philippines	26
10. East and Central Java, Indonesia	29
11. Comparing Human Resource Use	35

Part Three: Implications

12. Alternative Approaches to Making Outreach Programs More Cost-Effective	40
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Annexes

1 The Training and Visit System of Agricultural Extension	47
2 Message Selection Scale	49
3 ORT Behavioral Profile	51
4 Sample Questions for Determining whether an Outreach System has the Prerequisites of Effectiveness	54

PART ONE

1. THE MARKET

The market for extension advice in agriculture has by definition been farmers. In practice, it has consisted mostly of adult males who are not in the poorest segment of the population, since the very poor are often not farmers, but landless laborers or providers of marginal services in the informal sector. There is some tendency for T&V contact farmers to be larger than average--a bias which, in agriculture, may be defensible in policy terms. Governments are concerned with production as well as equity, and concentration on larger farmers is likely to yield more output per extension worker because one adoption decision by a large farmer leads to a greater increase in the marketed surplus than the same decision by a smaller farmer.

In the PHN sectors, by contrast, policies usually stress the provision of service where the human need is greatest. Health problems are concentrated around pregnant women, babies and small children, so that the major client group is not men^{1/} but mothers and mothers-to-be. Health problems are also concentrated among the poor, who often cannot afford enough of the right types of food, and whose malnourishment increases susceptibility to disease. The market for government PHN services is characterized by relative lack of demand, especially where the emphasis is on education and prevention rather than cure. Lack of interest in government PHN services often coexists with expenditure of relatively large sums (in cash or kind) for care from non-government sources.

However, lack of effective demand for government services can mask significant potential demand in several ways. First, there can be a desire for better PHN care, but insufficient awareness of what services are provided. Second, there can be both desire and awareness, but a client may not have the money to pay for care, or the time to visit a clinic. Third, even where time and money allow access to government PHN services, the services available may not answer felt needs. In each case, demand for care is not lacking, but latent. Instead of an absolute lack of demand, there is a lack of demand for services at the place, time or price currently provided, or in the form currently presented.

Put in this way, the "demand problem" in PHN is not unlike that in agriculture where extension services are ineffective. Agricultural advice is seldom in demand where it is dispensed inconveniently in an office, rather than conveniently in the fields; or where recommendations do not make sense in terms of farmers' priorities and perceptions. These are two demand problems that T&V has been able to solve in agriculture.

While a latent demand for the right type of PHN service can be assumed, making this demand effective (i.e. presenting PHN-related behavioral changes as worthwhile enough to adopt) is likely to be much harder than in agriculture, for three reasons. First, resistance to advice will be greater, since behavioral change in PHN affects the personal rather than the economic life of the family, and is therefore more threatening to

^{1/} Although in many cultures womens' attitudes to innovation are strongly influenced by men.

cultural norms. Second, while effective extension advice must be tuned to clients' perceptions and behavior, clients are less well understood in PHN than in agriculture. Women and the very poor have until recently been at the periphery of development thinking, which long concentrated on men, and on male farmers. Field staff incentives often reinforce this bias. Male beneficiaries are visited because they are better educated and have higher status than women, while the poor, who are uninfluential and often less visible because they live away from village centers and tarred roads, have often been ignored altogether.

Third, and most important, the link between better PHN practices and better health is much less obvious than that between better farming practices and higher yields. Extension advice in agriculture (e.g. for fertilizer use) tends to produce clear and positive results visible not only to the contact farmer but to those in neighboring fields. By contrast, extension advice in PHN is typically preventive, and leads to a non-occurrence not obviously linked to the advice. Since no one can predict whether the condition which the advice was designed to prevent would actually have occurred for any given client, the impact of better practices shows up less clearly and tangibly for the client than it does in agriculture. To the extent that benefits are less obvious, both adoption and diffusion are more difficult to achieve.

Each of these factors makes the job of creating market demand in PHN more difficult than in agriculture, and makes PHN more management-intensive. It requires more time and skill devoted to understanding and gaining the trust of the client; more time and skill put into presenting new technology persuasively; and more time and skill spent tracing and communicating results. These needs have important implications for the choice of extension tasks, and for managing the development and delivery of extension messages.

2. EXTENSION TASKS

Discussion in the PHN literature has paralleled the T&V system's approach to task analysis in most respects. It is widely accepted that mass PHN care needs to concentrate on a few interventions which are simple and beneficial from a client as well as a professional perspective. Some researchers in health care have in fact gone well beyond current practice in T&V in terms of developing systematic criteria for extension message selection--see for example, Annex 2's "Message Selection Scale," developed for AID health projects in Honduras and The Gambia.

However, practice lags far behind theory. Despite the rhetoric stressing simplicity, there is no clear consensus about what a primary PHN service should supply. It is common for village health workers (VHWs) to be burdened with more tasks than they can understand and remember, let alone perform; and it is common for VHWs to be asked to promote behavioral change which clients have no incentive to adopt. A T&V system in PHN must therefore be built up from the bottom based on the sorts of tasks that it makes sense to ask a poorly educated VHW to perform.

2.1 Types of care: curative, preventive, responsive. T&V stresses the need for initial extension messages to be perceived as clearly profitable, in order to gain the confidence of clients and the credibility of the service. Substantial evidence from the field indicates that in health care, basic curative services must be provided if VHWs are to be seen as credible. This is because clients' felt needs are for curative services, where treatment immediately and perceptibly alleviates an immediate and perceptible problem. Curative care must therefore be made available side by side with preventive care, if clients are to build the confidence necessary to adopt preventive measures with less obvious benefits.

The need for basic curative services has two implications. First, VHWs must be involved in the distribution of drugs, and, in the increasing number of countries where user charges are levied, the handling of money. This is a managerial complexity not present in agriculture, where T&V extension staff give advice only and are not responsible for input delivery. Second, the demand for curative care raises an incentive problem which must be anticipated in the design of a T&V system for PHN. VHWs will rationally concentrate on the curative services which clients want, and neglect preventive measures, unless the management system builds in some counter-incentive. Both factors reinforce the case for giving VHWs only a few simple curative tasks, so that preoccupation with drugs and curative care does not crowd out preventive care. It also has implications for training, supervision and performance measurement, discussed below.

Providing curative care is only one example of responding to clients with services that they want--critical in building the confidence in the extension service which is needed if clients are to adopt the preventive innovations which professionals want for them. While limiting the set of core tasks for VHWs is important (see 2.2), this core must not be rigidly defined, but responsive to local felt needs. For example, the CIMDER program in Colombia was able to respond to villagers' priority felt need for clean water supplies by designing a chlorinator for village wells made from locally obtainable plastic bottles pierced with holes in the right size and location to release regular amounts of chemical into the water. Building this sort of responsiveness into the extension system has managerial implications for research, training and supervision, also discussed below.

2.2 Grading and phasing PHN tasks. PHN interventions can be roughly graded into three groups according to the degree to which they answer felt needs and promise results. The following might be a realistic set of tasks for VHWs with limited training:

(1) Basic curative care. Curative tasks for VHWs should be strictly limited to first aid and to a very small number (3-4) of prevalent diseases whose symptoms are easily recognizable and which common generic drugs can cure. VHWs should carry a very limited number of drugs. VHWs should also be trained to recognize or suspect the presence of 2 or 3 common diseases which need referral to higher levels of the health service. From a confidence-building perspective, VHWs must know when to refer more complex cases or they will themselves treat them inappropriately and visibly fail.

