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VILLAGE HEALTH WORKERS AS MEDICINE SELLERS?

SJAAK VAN DER GEEST

Anthropological-Sociological Centre, University of Amsterdam, Oudezijds Achterburgwal 185, 1012 DK Amsterdam, The Netherlands

SUMMARY

The Bamako Initiative proposed improving the sustainability of primary health care in Africa by requiring payment for health services; in particular, for drugs. The suggestion that the sale of drugs should be put into the hands of village health workers was almost unanimously rejected, however. The author argues that it is worthwhile, nevertheless, to explore the feasibility of this idea. The cautious commercialization of the sale of medicines by village health workers may prove advantageous for the entire community.

KEY WORDS: Bamako Initiative; Primary health care; Village health worker; Essential medicines; Economic rationality.

INTRODUCTION

Three issues in Third World health care have been the subject of considerable criticism and pessimistic reports over the past years: primary health care (PHC); village health workers; and, essential drugs. This article deals with all three issues and is nevertheless optimistic. It suggests that allowing village health workers to profit from the sale of drugs may render PHC more sustainable. But what are those pessimistic comments?

Primary health care

The problems related to PHC are manifold and have been described in numerous publications. Here the focus is on only one of them: the financing of PHC. On the one hand, health policy-makers argue that PHC should be rooted in and should express self-reliance. On the other hand, PHC is often only possible thanks to money from abroad. This contradiction is the main threat to the future of PHC. In keeping with the principle of self-reliance, foreign donors are inclined gradually to withdraw their financial support for PHC. However, for two main reasons, such a withdrawal will probably lead to the collapse of many PHC programs. In the first place, governments have become used to external subsidies for PHC and are not ready completely to take over that responsibility. In the second place, most governments are hardly interested in funding PHC with their own limited means. PHC was regarded as a useful

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slogan for international consumption. It 'showed' a country's determination to strive for 'Health for all by the Year 2000', thus enhancing its chances for foreign aid. For internal policy, certainly in rural areas, PHC was, however, rarely seen as a priority. Usually its political pay-offs for the government proved limited, as PHC does not present itself as an impressive government achievement and does not create the goodwill politicians need (Salim, 1988). Moreover, the political clout of rural populations tends to be limited and, unlike urban groups and the military and police force, they can rarely put pressure on national governments, nor do they pose a threat to them (Van der Geest *et al.*, 1989).

Village health workers

The community health worker or village health worker (VHW) has also proved a somewhat doubtful invention. The problems facing VHWs are similar to those affecting PHC in general. The idea of selecting people and training them to carry out basic health care tasks in their own community looks excellent. In the realization of this plan, however, many problems arise. One is that the position of VHWs becomes ambiguous. Do they stand for their community or do they represent the interests of the government embodied in the nearby health institution? Will they be staying in their community or do they consider their training a useful stepping stone toward employment outside the village? The rate at which VHWs leave their posts after 1 or 2 years appears to be very high. It has been suggested, therefore, that it would be better to spread basic health knowledge over more members of the community.

Another problem is the remuneration of VHWs. Should they be paid? By the community? By the government? Or should they work on a voluntary basis? The answers to these questions depend of course on how the position of VHWs is viewed, by themselves as well as by the community.

The lack of support is another factor detrimental to the functioning of VHWs. Without professional supervision and material supplies, they feel frustrated and unable to carry out their tasks. It is particularly inconvenient that they do not receive a regular supply of medicines. They feel their credibility is harmed if they cannot even provide the community with the most basic requirements (Walt, 1988a,b; Put, 1990). It is not surprising, therefore, that reports on VHWs often present a gloomy picture. Sauerborn *et al.* (1989) write that VHWs in Burkina Faso are hardly consulted by their community for common health problems. That situation is likely to prevail in many other countries as well (Bender and Pitkin, 1987; Berman *et al.*, 1987; Heggenhaugen *et al.*, 1987; Jancloes, 1984; Jobert, 1985; Matomora, 1989; Robinson and Larsen, 1990; Sauerborn *et al.*, 1989; Skeet, 1984; Vaughan and Walt, 1983; Walt, 1988a,b; Walt *et al.*, 1989).

Supply of medicine

Criticism on the supply of medicine is multifaceted (Melrose, 1982). One of the main objections is that the accessibility of drugs is determined by the

interests of producers and sellers rather than the needs of local populations. Good affordable drugs may not be available, whereas there is an abundance of expensive, non-essential and hazardous ones. The WHO Action Programme for essential drugs was designed to alleviate this situation (WHO, 1977), but its effect on the actual distribution and rational use of drugs seems to have been minimal. A recent evaluation revealed that the plan was widely 'accepted' by national governments and is quoted in their national policy plans, but that very little could be said about its impact on actual health care (LSHTM/RTI, 1989). Various observations from the field suggest, however, that the impact is negligible (Kanji and Hardon, 1992; Hardon *et al.*, 1991).

The link between drugs and PHC is particularly problematic. Their curative nature gives drugs an uneasy position in the PHC philosophy, which emphasizes prevention. Their uneasiness increases when villagers indicate their lack of interest in prevention and keep asking for drugs and other curative services (Stone, 1986; Abel-Smith and Dua, 1988). As we have seen, VHWs who do not dispense medicine are not taken seriously (Patterson, 1985; Vogel and Stephens, 1989; Bennett, 1989; Haak, 1988; Kapil, 1985; Waddington and Enyimayew, 1989). Usually, people are more willing to pay for drugs than for preventive health care. The preference for medicine thus poses a threat to PHC. It does not lead to greater self-reliance through preventive action, but to an increased dependence on means that have to come from outside (Van der Geest *et al.*, 1989). Health workers try to take advantage of this by using drugs as an incentive to join PHC or by making people support PHC through payment for medicines. The Bamako Initiative is an example of the latter tactic.

THE BAMAKO INITIATIVE

At a meeting of African ministers of health in Bamako, September, 1987, UNICEF launched a plan to rescue faltering health care services in Africa by selling essential drugs. They planned to set up a 'revolving fund' from the proceeds and use it to buy new drugs and to finance other PHC services (UNICEF, 1988a; Monekosso, 1989; Ofosu-Amaah, 1989). The plan meant a radical break with the past. Until recently, in most African countries, public health care was free of charge and in spite of numerous problems financing the system, governments were reluctant to change this position. The dark side of this 'free' health care was well known, however. In many countries, the government-run health care system found itself in a deplorable state due to inefficiency, mismanagement and lack of funds. There was often a shortage of medicines and medical personnel in the rural health centers. The paradoxical result was that 'free services' proved to be more expensive for the population. People were frequently forced to buy medicines in the commercial circuit and to travel long distances to find a nurse or physician. Even PHC, designed to make essential care directly available to the population, was in danger of collapsing under the weight of the financial and managerial crisis. The Bamako

Initiative planned to face this situation realistically and to give up the ideal of free medical care.

The plan has evoked many reactions. Some critics fear that the poorest people will suffer because they will be unable to pay the prices (Editorial, 1988; HAI, 1989). Chabot (1988) believes that the measure will alienate the VHWs from the local people. UNICEF (1988b) refers to a number of PHC projects in African countries where—it claims—such a model of internal financing has proved quite successful but others believe that those examples are rather questionable. Many critics hold the view that these cases form a far too narrow basis for such a drastic operation (Chabot, 1988). Finally, nearly everybody is doubtful about the management of such a 'revolving fund': how can one prevent the proceeds from being used for other purposes than PHC?

Health Action International (HAI), an organization representing about a 100 consumer groups across the globe, expressed its objections, and proposed conducting preparatory research on the pros and cons of the plan before implementing it (HAI, 1989). HAI formulated six objections. Three of them, in particular, are crucial. They deal with:

1. The problem of management: will the proceeds from the sale of medicines indeed be reinvested in PHC?
2. The problem of pricing: will it be possible to prevent medicine prices from being raised to make more profit?
3. The problem of the 'rational use of drugs': will it be possible to prevent overprescription and overconsumption?

All three questions represent real dangers arising from the Bamako Initiative. They have one common denominator: they all refer to the possible negative influence of commercialization on the quality of medicine use. Commercialization may indeed take place in the context of the Bamako Initiative if:

— VHWs do not turn over the proceeds from medicine sales but keep them for private use;
— the prices are raised to increase profits; and/or,
— too many and excessively expensive drugs are prescribed and sold, again to make more money.

All the criticism and confusion about the objectives of the plan led to a conference in 1989 in Freetown, Sierra Leone, which was jointly organized by HAI, OXFAM and UNICEF. During the conference, UNICEF and representatives of non-governmental organizations (NGOs) discussed their points of disagreement. The conference seems to have been quite successful in bringing the parties closer to each other. They reached agreements on various points, including the following: communication between UNICEF and NGOs on the Bamako Initiative is to be improved; the poorest segment of the population is to be exempted from payment; the quality of PHC and 'rational use of drugs' are to remain primary objectives; independent researchers are to evaluate the results of the cost-recovery projects. This 'reconciliation' has not, however,

answered key questions about the possible effects of commercialization in the wake of the Bamako Initiative. Before addressing that issue, some personal views on profit-making and non-profit-making in health care, based on research in Cameroon, are presented below.

MEDICINE PROVISION IN CAMEROON

The field research in Cameroon took place in 1980 with a brief follow-up in 1983. Its purpose was to describe and understand the problems of distribution and use of pharmaceuticals in the widest possible context, including kinship, economics, politics, local perceptions and 'traditional medicine'. The research dealt with pharmaceuticals passing through official channels as well as through informal ones. It was carried out at different levels of organization, ascending from peripheral family and village life to divisional and national centers of health care and administration. This meant that research activities took place not only in village homes and kiosks, at local markets and health centers, but also at hospitals and pharmacies and in the offices of the Ministry of Health. Research techniques consisted of participant observation, interviews, collection of case histories, and the study of health reports, files and financial accounts. The research confirms HAI's doubts in several respects. One of its chief conclusions was: one cannot expect health care workers to allow community interests to prevail over their own (which include the interests of the nuclear and larger family). This conclusion is hardly spectacular. Yet many policy-makers seem to assume health workers do put community (including state) interests first. And if this is not the case, they assume inspectors do. This research showed, however, that health care workers agree that they should first see to their own interests. This socially-accepted attitude gravely affects the quality of public health care (Van der Geest, 1981, 1982, 1988, 1991).

To summarize briefly some of the main findings, doctors and nurses in government hospitals and health centers were supposed to dispense medicines free of charge to their patients. In actual practice, however, 'free medicine' was often not available and patients were forced to go and buy medicines elsewhere, sometimes far away at a pharmacy in a provincial capital. The 'free distribution' of medicine thus turned out to be extra expensive. The shortage of medicines in government institutions could be explained as the result of a queer combination of private enterprise in a non-commercial context. The formally non-commercial status of the public health institutions enabled the workers to maximize their profits. At all levels of medicine provision (ordering, distribution, prescription and actual dispensing) the people involved were able to take advantage of their position. At each 'link' of the distribution chain, irregularities occurred which increased shortages and benefited the workers.

At the same time, the government sector exhibited an enormous sluggishness, which was also the result of its non-commercial status. For the employees, it seemed more important to follow the numerous bureaucratic trajectories than to deliver the requested medicine as quickly as possible. As a result, the

supply of medicines to rural health centers was very inefficient. Consultants who evaluated the Ministry of Health in 1979 made the shocking discovery that it took 8 months to 2 years for medicine to be delivered after it was ordered by the Ministry. In the private sector, however, the same procedure was completed within 3 weeks. The consultants concluded that the absence of commercial incentive was the main cause of the poor functioning of the Ministry's medicine supply system. No-one in that system had a *personal interest* in the improved functioning of the distribution. Whether the drugs arrived on time or not did not really matter to them personally. The idea of urgency, which was clearly present in the private sector, was lacking in the public one.

It was estimated that rural health centers received only about 65% of the drugs they were supposed to receive. A considerable part of the 65% was given to relatives and acquaintances of the health workers and to local dignitaries. Some workers also sold medicine clandestinely to medicine vendors, or used it outside the center in a parallel private health service where patients had to pay for it. Exact figures as to how much medicine was actually used in the appropriate way are impossible to give and will differ considerably from center to center. A likely estimate is that in the majority of cases in Cameroon less than half the medicine intended for free distribution among patients did in fact reach those patients. Rural government health centers which were without the most necessary medicines also lost their attraction and were hardly ever consulted by patients during the periods of shortage. For the people in the area, a medical treatment without medicine did not make sense, so they stopped coming as soon as they heard there was no more. The lack of medicines could thus lead to a general stand-still of a rural health service (Hours, 1985; Waddington and Enyimayew, 1989).

The inefficiency of government institutions was in sharp contrast with the situation in the private hospitals and health centers, which depended on their incomes. There medicine was usually in constant supply. The same applied to private church-run institutions which, in a formal sense, were 'non-profit' oriented but clearly needed a fair profit to keep functioning. Their profits mainly derived from the sale of medicines and from operation fees, two concrete elements of health care people were most willing to pay for. Medicine was sometimes sold with a profit margin of 400%, although the official margin was only 50%. It was of vital importance for private institutions to prevent shortages in their drug supply.

There was a similar, but simple, commercial attitude among informal—illegal—medicine vendors who did their best always to have a supply of the most desired medicines. Thanks to the commercial alertness of the vendors, antibiotics, antimalarials and analgesics were available in small kiosks even in remote villages.

Comparing the inefficiency of the government supply system with the relative efficiency in the private sector, one can only conclude that a prompt and regular supply of medicine is more likely if the provider derives personal benefit from the distribution; or, to put it in clearer terms, if he can make a profit by selling medicine.

THE DILEMMAS OF VILLAGE HEALTH WORKERS

VHWs are expected to play a key role in PHC at the local level. They should inspire the people of the community to carry out preventive and curative activities on their own. In addition, they have the task of offering simple curative services and teaching people to live a healthy life. In the area of Cameroon where the research was carried out, no such VHWs had been appointed by the government. There were only nurses attached to health centers, who had the task of educating people on health matters and performing curative services. Their usual complaint was that they were unable to carry out the former task. People were not prepared to listen to them, they said, because they could not even supply them with drugs (Petit, 1985). For the same reasons, they were also unable to perform their curative task well. A nurse without medicines was generally regarded as 'useless'. It should further be taken into account that medicine is a means of communication. It creates a space in which health matters can be discussed and concern about patients can be expressed.

From the viewpoint of the community, one might say, a continuous stock of the most needed medicine is a prerequisite for any health worker, including a VHW, to function satisfactorily.

How can a constant stock of medicine be guaranteed? It has already been noted that a regular supply of drugs is unlikely to work if drugs are provided by the state and distributed free of charge. But similar problems occur if the health worker is to sell the medicine and hand over the proceeds to an institution that uses them for buying new medicine. What remains the same in both options is that the health worker does not really benefit by strictly following the rules. The profit incentive is lacking. It may be more profitable for health workers not to hand over all the money, but keep some of it and spend it on urgent private matters. Relatives, friends and important others might be expected to approach them for—free—medicine. It may be more in their interests to comply with such requests than to turn them down. The latter reaction could harm their position in the community where, by definition, blood is thicker than water and where no one can afford to rebuff the local leaders.

It is not difficult to imagine that a health worker *would* find an excuse for not giving free medicine away if the medicine belonged to him. He would probably be quite inventive in avoiding such requests or evading them in an acceptable way. At the same time, people in need of medicine would most likely anticipate this type of reaction and be less inclined to ask for medicine. They are aware that it is more difficult for a medicine seller to give away medicine than for someone who distributes drugs that belong to the state. So both sides will be less inclined to act in the style of the traditional gift culture.

During the research, several subtle techniques were observed whereby entrepreneurs used to avoid requests for gifts. The local pharmacist, who was known to be well-to-do, realized it would be hard to turn down requests for medicine from his many relatives and the poor residents of his village, which was about 50 km away. His tactic was to stay out of their sight. He rarely showed himself

in the pharmacy and instructed his personnel to respond to requests by saying it was not possible to give free medicine because 'le patron' was not there. The Bamileke of Cameroon, famous for their success at trading throughout the country, have various techniques for refusing requests for gifts. In one of their shops was displayed a framed sign: 'Pour le "bon" venez demain'. The capitalist spirit had already taken possession of that shop. Someone crossing the threshold of a Bamileke store knows everything in it is only for *sale*. The rules of the gift culture do not apply there, but are still valid in the government health center. In contrast, Chabot and Savage (1983) and Chabot *et al.* (1990) describe a system of medicine distribution under the supervision of village health committees in Guinéa-Bissau which functions well. In many cases, nonetheless, traditional values of communal responsibility do not seem to work well in modern health care situations.

Applying the Cameroon lesson to VHWs, a regular supply and a constant stock of medicine are better guaranteed if VHWs can buy and sell their own medicine. Financial control becomes superfluous, as mismanagement would be to the VHWs' disadvantage. This solution to the dilemmas of VHWs may look obvious, but policy-planners have rarely suggested it. To them, a medicine-selling VHW is still anathema. Even in the discussions pertaining to the Bamako Initiative, a significant step in the direction of commercialization, this solution was never taken into serious consideration (see also Raikes, 1984; Cross *et al.*, 1986; Stinson, 1982). Apparently, health care authorities fear they will lose control over PHC, but isn't PHC meant to be under the control of the community? Another concern is that linking the VHWs' income to the sale of medicine will lead to such abuses as overprescription and the neglect of activities that are not profitable. How likely is it that these undesirable side-effects will indeed occur?

ECONOMIC RATIONALITY

The prediction that VHWs will prescribe excessive—and perhaps even erroneous—medicine, if they can make a profit, originates from a one-sided concept of economic rationality. This concept suggests that economic transactions are always based on 'negative reciprocity', i.e. efforts to maximize profit at the expense of the other. This style of trade may be rational when the partners have no other relationship than the trading one and are not apt to meet each other again. In such a transaction, only short-term benefits are envisaged (Harris, 1987). That situation certainly does not exist in the case of transactions between VHWs and members of their community. Their interaction is characterized by 'balanced reciprocity' (Sahlins, 1974) and long-term benefits. The 'trading partners' meet each other continuously in different settings in the same community. Their relationships are typically 'multi-stranded', i.e. people are linked to each other through many different activities and interests (Veen, 1979). It is in everyone's interest not to put each other at a disadvantage. Transactions are marked by mutual trust.

There is still another aspect to be taken into account. People are more inclined to do business with a trustworthy person if the quality of the product for sale is difficult to assess. Plattner, who discusses the social aspects of economic transactions, cites the well-known slogan, 'If you do not know cars, know your dealer' (Plattner, 1983). Uncertainty about the quality of a product is also evident in transactions involving medicine. If health is concerned, it is advisable to rely on someone you know and who wants the best for you. If the medicine does not work, you can go back to that person, explain your problem and ask for some other medicine. Unlike the medicine hawker, trekking from village to village, who may never be seen again, the VHW is a typical example of the category of people one can trust.

The economic rationality of VHWs selling medicine to the members of their community is embedded in long-term and multi-stranded social contacts. The function of the VHWs may grant them both prestige and material benefit. If they want to keep their position as a VHW, they will do their best to deliver good services to their co-villagers. Commercialization at the level of the village community is certainly not the 'evil' critics as well as advocates of the Bamako Initiative seem to believe it is.

VILLAGE HEALTH WORKERS AS MEDICINE SELLERS?

The weak spot in the argument so far, is that it is not easy to find successful examples of this experiment. There are very few PHC projects where the distribution of medicine has been systematically privatized and put in the hands of VHWs (Bennett, 1989; O'Connor, 1980; Nugteren, 1987; Stinson, 1982; Varkevisser, 1982; Vaughan and Walt, 1983). One can only refer to a long list of unsuccessful projects with a non-privatized system and to discussions on economic rationality and reciprocity in small-scale communities.

Nonetheless, this article has sought to demonstrate that it is at least plausible that the problems mentioned at the outset will largely solve themselves if VHWs are given the responsibility and the benefits of medicine distribution. Supervision to guarantee the investment of the profits in new medicine becomes superfluous because it is in the VHWs' own interest to do so. In the light of the above discussion, it can be said that price rises are less likely to occur than may have been initially thought. It is true that VHWs may have no real competitors in the selling of medicine, which gives them a monopolist position in their community, but there are counterbalances. If the members of a community are informed about the prices of the medicine available from the VHWs, they are in a better position to refuse to pay exorbitant prices for them. The information about prices could easily be given on a poster displayed at every VHW's post. The poster should give information on the prices and the common ailments the medicine can cure. In addition, village health committees could also keep an eye on the process. It has already been suggested that the right to function as a medicine-selling VHW should depend on the VHW's performance. The most effective control over medicine selling will therefore come from

within those VHWs who are keen to keep an attractive job and retain their respected position.

The third problem, the risk of overprescription, is more complex. The provider and the receiver of medicine may both be inclined to turn to polypharmacy. Prescribing various kinds of medicine is often regarded by patients as a sign of the health worker's concern, and is welcomed as an unambiguous confirmation of their ailment. This risk can only be diminished by public education on the 'rational' use of medicines. A poster could play a role in such a campaign. Better information on the correct medicine use for common ailments plus the fact that most medicine consumers are poor and have to be economical make one slightly optimistic that overprescription *can* be prevented to a large extent.

The trickiest problem lies in the limitation of the types of medicine VHWs are allowed to dispense. Coordinators of PHC projects are often inclined to exclude antibiotics, and certainly injectable medicines. One may wonder how realistic this standpoint is, given the fact that antibiotics are freely available in the informal market and injections are becoming part of the general self-help culture (Reeler, 1990). More than 10 years ago, Werner (1979) defended the idea that it would be better to teach people how and when to use antibiotics or to give injections than to forbid people to use these popular elements of modern health care. VHWs would again lose much of their credibility if they could not respond to people's requests for antibiotics and injections. Their delicate and somewhat contradictory task would be to dispense antibiotics and administer injections when necessary, and at the same time to call for extreme caution in the use of these and other potentially hazardous medical interventions.

Summarizing, one would be in favor of experimenting with a cautious privatization of medicine distribution in PHC. After they have proved able to carry out the job, VHWs should be given the opportunity to buy certain essential drugs at central pharmacy stores and to retail them to the members of their community. The profits should be partly invested in new medicine and partly serve as a salary for the VHWs' health activities in the community. That salary, complemented with the income from ordinary economic activities (e.g. farming), should be high enough to enable VHWs to do their work. This remuneration and their respected position in the community should be sufficiently attractive to VHWs to motivate them to carry out other health activities which do not yield immediate benefits. VHWs who fail to carry out these additional activities should lose their right to sell medicine. In this way, PHC may indeed be financed by the sale of drugs and thus be made more sustainable, as has been suggested in the Bamako Initiative. The complicated and expensive control measures proposed by Bamako advocates to safeguard the correct financial management of the proceeds, become superfluous in the experiment described in this article.

One is aware that there are other objections to the Bamako Initiative which have not been discussed here. One is that villagers in Africa may not have the money to pay even the lowest prices for medicine (Editorial, 1988; HAI, 1989; Kanji, 1989; Waddington and Enyimayew, 1989). In spite of this, one expects villagers to be better off with a reliable local medicine seller than with

'free' medicine provided by the government. The latter option will almost certainly turn out to be the most expensive. Essential drugs, if purchased in bulk, will always be much cheaper than medicines in the ordinary commercial sector, even if VHWs were granted a 300% profit!

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