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Mahatma Gandhi
WORLD HEALTH ORGANIZATION
GENEVA

A47/TECHNICAL DlSCUSSIONS/z
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DISCUSSIONS
FORTY-SEVENTH
WORLD HEALTH ASSEMBLY
MAY 1994
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PREFACE This document has been prepared for the Technical Discussions on Community Action for Health. It is primarily intended to facilitate the discussions of the three working groups that will be formed within the framework of the Technical Discussions, and is designed to provide information on a selected number ofissues which are relevant to the overall theme of Community Action for Health. The issues covered in the document should help participants in their deliberations and may contribute to new thinking on the subject. The paper is thus not intended to be an exhaustive overview of the subject, nor is it intended to provide a definitive set of proposals for action.

The paper also includes a number of selected case studies ofprojects underway in all the WHO regions. The case studies have been interspersed throughout the document, and wherever possible may help to illustrate the text. Lengthier descriptions of these and other case studies are being prepared for inclusion in the final report of the Technical Discussions.

COMMUNITY A(TION FOR HEALTH

INTRODUCTION

((Community Action for Health implies a significant change in approachfor both communities andgovernment.))

((A genuine partnership between the health system and the community has yet to evolve in many countries?)

WHO Director-General, Dr H. Nakajima

Implementation 0/ the global strategy for Health for All by the Year 2000: second evaluation: Eighth report on the world health situall'on. Geneva, World Health Organization. 1993

The involvement of communities in their own health care is neither a new concept nor a new practice. People, either as individuals or as members of communities, have inevitably always taken steps to meet their needs in the areas offood, shelter, safety and health.

The approaches taken by diEerent communities and countries have often varied considerably, however. At times, they have reflected current knowledge and local concepts of the cause of the problem. At others, they have been influenced primarily by perceptions ofwhat might constitute appropriate interventions. They have also been affected by the extent oflocally available resources or those forthcoming from government and other sources. Invariably they have been determined by the type ofrelationship that existed between the community and the formal health system.

Today, some sixteen years after Alma Ata, the concept of community action is receiving greater interest and support than ever before. Governments, communities and nongovernmental organizations (NGOs) are exploring the possibility of creating innovative types Ofpartnerships for health which could contribute to making the goal of iihealth for alli, a reality.

EMERGENCE OF
THE CONCEPT
A47/TECHNICAL DlSCUSSlONS/2 3

At one time or another, most countries have alluded to the concept Ofcommunity action in planning their health systems. In 1846, for example, the American health reformer Lemuel Shattuck stated, in what was to become a highly influential report, that lcit behooves every individual citizen to seek out and remove every removable cause ofdisease and death, in whatever section of the city, under whatever circumstances, and among whatever class of citizens, it may appear? Along somewhat similar lines, in 1946, Indials Health Survey and Development Committee, under the leadership of Sir Joseph Bhore, recommended that for health care to become accessible to all people a greater and more active involvement ofcommunity was requiredf

In 1977 the World Health Assembly resolution on ltHealth for all by the year 20007, and then in 1978 the Declaration ofAlma Ata, called for international commitment t0 involving the public in the design, choice and delivery of health care and specific interventions. More recently, the United Nations Conference on Environment and Development, held in Rio de Janeiro in 1992, stressed that safeguarding the natural environment through actions for sustainable development serves human health needs; it also emphasized that equity and participation should form the basis on which planning and action in this area can be built.

On the whole, however, the theme ofcommunity action in health has met with a mixed response and despite the many instances of expressed interest, it has rarely been vigorously taken up at a central level or been systematically translated into broad national action. The few examples of practical application of the concept of community action have remained sporadic, limited in scope and not easily sustained.

On the whole, policy-makers and health care providers appear to have remained sceptical about the benelits of the community engaging itselfin health care activities. They have been even more hesitant about the communityls role in defining health problems, prioritizing them and contributing to their solution.

’ Repair 0/ the Hea/m Swvey and Development Comm/rree, Vo/. 7, Published by Manager of Publications, Delhi, anad by Manager, Government of India Press, Calcutta

COMMUNITY ACTION FOR HEALTH

Most governments have maintained the position that health and health care is best handled at a central level and that health care is a public service that can be delivered to the people only by professionally trained staff. Philosophies and approaches such as these have limited opportunities for community action for health and governments have not felt the need to encourage or facilitate greater community participation in the planning and implementation ofhealth care.

Health care has continued to be seen as essentially a question ofmedieal care and has accordingly beeen entrusted to trained health professionals, with only limited involvement Ofcommunity groups and the lay public. Meanwhile the rapid growth in, and complexity of, scientific knowledge and medical technology during the 20th century has even further justihed the greater specialization ofhealth care within the framework of medicine. This, in turn, has served to concentrate deeision-making for health within the medical profession and has contributed to a partial rejection of non-profes-sional involvement in health matters.

This hdistanceii between the lay public and the decision-making process in health matters has grown and become more problematic. For while on the one hand, health care has become increasingly political, costly and admin-istratively complex, there has also been a growth in expectations and in the capacity of the public to express itselfin this area, especially when dissatisfied with exist-ing approaches.

This development has not been lost on health planners whose appreciation ofthe role of the community has also changed. They realize that the character and distribution othealth and disease patterns have changed dramatically in the last fifty years so that different approaches are now needed in the prevention and the treatment of disease and in the allocation ofresources. In industrialized countries, noncommunicable diseases such as diabetes, coronary artery disease and cancer, as well as injuries caused by accidents and violence have increased and become far more significant than the communicable diseases that were major causes ofmorbidity and mortal-ity and around which health services were traditionally structured. The need for new approaches, especially

community-bascd ones, has been also highlighted by the rapid spread ofHIV/AIDS in both developing and developed countries.

In developing countries, where povcrty-rclated communicable diseases have still not been effectively controlled, new health problems related to lifc-stylc and living conditions are now becoming more prominent. Many of these emerging health conditions are not amenable to the curative care that is currently available, and tend to become chronic and costly.

lOS ANGELES

In response to the growing problem of violence and intentional injuries, the Los Angeles County Heatth Department Injury Prevention and Control Project established 3 Violence Prevention Coatttion in 1991 . The coalition brings together a broad mix of people and professional groups, including representatives of the lay community, Iocat business, medical professionals, law enforcement officials, NGOs, the academic community, schoots.

The Coatition was created out of a mutual belief that the current level of violence and resulting health problems in Los Angeles are unacceptable, and that the subject of violence must be brought intoawider perspectivethatengagesthecommunity more actively in its prevention. The purpose and activities of the Coalition include:

0 tracking and sponsoring legislation;
investigating the media’s role in violence;
identifying cumcutum being used by schoots;
investigating the effect of violence on the schools;
establishing a comprehensive educational campaign about the effect of violence on the community;
0 exploring community resources and programmes;
0 developing interactions between community based organizations.

As part of the project, community members are now engaged in measuring the magnitude and type of violence that occurs around them, and are developing and promoting activities and programmes specifically designed to respond to these problems. Using the specific talents and expertise of the various disciplines represented in the Coalition, steps are also under way to evaluate the effectiveness of prevention programmes and to develop initiatives that will reduce the impact of violence on individuals and families. A series of public debates and workshops has been put into motion and regular injury prevention talks are given at Iocat schools and workplaces. Already there are indications that as a result of the Coalitionts work, sensitivity to, and awareness of, the implications of violence have risen constderabty in the tocal community.

Source. Communication hem Dr Billie Weiss, Director of the lntury Prevention and Control Project, County of Los Angeles, Department of Health Services

At the same time, there is a growing understanding that many if not most of these problems could be prevented through greater public health emphasis on behavioural change and community-bascd support for action at the level of the individual. Such approaches call for a new type of partnership between the community and the formal health sector.

Parallclling many of these changes, governments and the people in both developing and developed countries have seen the costs ofmcdical care spiral. For as the technol-ogy ofmodcrn care has become more sophisticated and complex, it has also become more expensive and the task ofproviding good-quality tertiary care to all people has

MALAWI

In 1990 a vittage primary heatth care committee in Matawi received a special $5000 grant from WHO. Using this. it was able to achieve an extensive impact by finding eteative ways to tremcyctet’ the money in several heatth related domains. With technicai assistance hem th e district primary health care technical committee. Miambe Mission Hospital and the Chiteka Health Center, the vil tage primary health care committee had atready identified child he atth and illiteracy as priorities and had begun an extensive growth monitoring of under tives, was conducting functional literacy courses, and had begun construction for an under 5 clinic. With the $5000 the primary health care committee not onty completed and furnished the eti nic. but they also builta birth clinic. Theythen invested in poultryas an additional income ge nerating activity and used the meat and eggs as food supptements for feeding matnourished chtidren . They established a successful drug revolving fund for the treatment of mataria and diarrh oea. and built and maintained two protected wells.

Over the course of the period covered by these activities a reduction in child malnutriti on has been observed in Puli village and in some of the neighbouring vtttages. Diarrhoea is no l onger a serious problem and eye infections have decreased, Immunization coverage has reached nearly 100%, and the number of supervised deliveries has increased. Future plans at the P utt village primary health care committee include the production of stabs tor pit iatrines, p rotecting more wens, mamtaming a woodtot for fuel and extending functional literacy to men.

The Village Health Committee is composed of 11 women and 9 men inctuding the Chief, the Traditional Birth Attendant and several health volunteers. Capital funds are kept for the vittege by the district commissioner, but receipts from income generating activities are retained by the thtage treasurerand expended by the vitlage Chairman. This initiative appears to be susta inabte based on the successstul "recycling" of funds, participatory management and diversificati on of undertakings. The major lesson learnt here is that a little money can go far it motiva tion and management are assured. h

Source: WHO. Regional Office for Africa

become increasingly difficult. Even in developed countries, many social groups now have less access to quality health care than they did twenty years ago. Finding alternative methods ofmeeting many of their health needs, and especially preventing chronic and major health problems has therefore become a priority for all governments.

The weight of growing health care costs has inevitably been felt by the poor in industrialized countries and most people in developing countries. Often lacking insurance and social security coverage7 they have usually been unable to benefit from the progress that has been achieved in modern medical technology.

The concentration of the poor in urban areas has made this problem both more noticeable and, at the same time, more difficult to address. For while the gathering of people in given areas offers advantages for outreach, the urban health systems ofmost countries were not designed to cope with such large populations and few can increase their capacity to do so through existing infrastructures.

A number ofsocial and political changes have meanwhile made the public more aware ofits right to participate in the health development process. Improvements in the education of people everywhere have coincided with a greater exposure to communication networks that constantly diffuse new ideas and values about standards ofliving, and often quality oflife. As a result the public and, in particular, public interest groups feel more confident about the contributions that they can offer and far more able to take up technical and political issues and provide guidance on what options should be pursued.

In many situations the involvement of the community has been spurred by the fact that expressions ofconcern about health care services have remained unanswered. Gradually, special health interest groups have emerged which, although originally intended to represent special concerns and problems, have gone on to mobilize funds and technical expertise in areas such as muscular dystrophy, cancer, tuberculosis and other diseases which they felt were not receiving adequate attention. With time, these groups have begun to provide technical direction

to researchers and policy-makers, and in so doing have begun to set an agenda for partnerships based on mutual respect between the community and the formal health sector.

Thus, the urgent need for community action for health arises from a combination offactors. On the one hand, the community has gradually come to realize its need and responsibility to assume a greater share of the initiative for its own health care. On the other hand, there has been a growing awareness among health care decision-makers that without community action, much-needed behavioural changes will not occur and opportunities to prevent major causes ofmortality and morbidity will be missed.

At the same time there has been a growing recognition that much more can be achieved by pooling the energies of the community with those of the formal sector and that it may even be possible to reduce the overall costs of services. At another level, community participation in the development ofhealth-related action has been seen as having an intrinsic value for participants themselves and as providing an important catalytic base from which further development efforts can emerge.

Where it has occurred, participation in the decision-making process and in determining how resources are allocated within the health sphere has also enhanced the ptiblids sense ofresponsibility for specific projects. It has also helped ensure that peopleis felt needs are covered and that the approaches taken are consistent with local social characteristics and preferences, while building on the important indigenous knowledge base and expertise which exists in every community.

PHILOSOPHICAL
UNDERPINNINGS
A47/TECHNICAL DISCUSSIONSO 9
((To address health in a meaningful way, we must start by redefining what health is and considering the relationship between wellness and the key components of our living and working environments.))
((In many cases, solutions to our health challenges am be mounted at the local level, with people and communities taking the lead.. . .I t is within communities where collaboration cam occur most ejfeetively, where resources can he pooled most efficiently, and where the results of positive action and change are most manifestly recognised?)
US National Civil League, Health Community Handbook, 1993
Interest in community action has come about as a result ofa variety offactors. First ofall, there has been a growing realization that the involvement of the community in health matters is essential for reasons of both eHicacy and impact. Secondly, major Changes have occurred in political philosophy and practice which have favoured community action, making it both more feasible and hlegitimatehi
Of the many factors that have enhanced community action, the move towards ctdemocratizatiorf7 in national and local government has probably been one of the more important. The process has been evident in most parts of the world, and in many it has been quickly translated into both reform of the political system and programmatic action.
Underpinning many of these reforms and changes has been the post-colonial recognition of the right of all peoples to self-determination. Building on the independence movements of the 19505h it has continued since then and given rise to phenomena such as the movements for civil rights in the United States ofAmerica and against apartheid elsewhere, and to the growing political legitimation of special interest groups including those concerned with the elderly, the handicapped and people ofsame sex preference. Recognition ofthe right of all

people to pursue their self-development and well-being has been a central and dominant theme within all these movements.

In parallel, and growing from similar historical and philosophical roots, has been an increasing concern for the principles and defence ofhuman rights and dignity. Even though cultural differences still exist with respect to how these principles should be interpreted and implemented, they have received more attention during the past two decades than ever before. Indeed, it is now questioned whether there is any possibility ofmaking real advances in social development where human rights are not respected.

World opinion has also been influenced by recent events such as the Rio Declaration on Environment and Development and in particular, Principle 1 of the Declaration, which enshrines the concept that human beings are at the centre ofconcerns for sustainable development and are entitled to a healthy and productive life in harmony with nature.

Everywhere in the world there have also been signs that governments are becoming more willing to decentralize their national administrations. This gradual Change in attitude has been prompted in part by the increasing costs ofmaintaining centralized bureaucracies, but at the same time there has also been an acknowledgement of the need to titailorii policies and programmes to the characteristics and requirements of regions, districts and communities.

Another important and related ingredient has been the growing realization that highly centralized systems, and especially authoritarian ones, are incompatible with most of the opportunities that present themselves for social development. Many ofthese systems have proved insufficiently flexible to meet the challenge ofemerging social needs and have been incapable offostering the internal spontaneity required to adapt to current international economic and political conditions.

Meanwhile the growing complexity ofsociety has highlighted the special health problems of women, the elderly, the poor, refugees and displaced persons and

other marginalized groups, all ofwhich have tended to be neglected by both health and social services. In recent years these groups have won greater recognition and become more socially and politically active. Their views have done much to broaden the panorama ofpolitical interest and options to which community action initiatives can respond.

Many ofthese changes have occurred against a backdrop ofeconomic growth which has become more region-specific and has favoured some countries more than others. The gap between developing and developed societies has become even m'der, as has the diflerence between rich and poor people in most nations. Even in highly industrialized and economically developed countries, the numbers ofpeople affected by poverty have risen. The growing evidence of this gap and its implications for future global development has motivated greater international commitment to enhancing the social integration of all people and reducing the impact ofpoverty.

Reaching the poor and others who have traditionally been underserved, whether in inner city and periurban slums or elsewhere, nevertheless poses a number of sociocultural and logistical difficulties. It is now evident that many of these difficulties can only be overcome if and where there is active involvement of the people most concerned.

Just as important as this recognition ofhow to overcome the problem ofcoverage, however, has been the grovw'ng political acknowledgement of the existence and social presence ofthese different groups, and the philosophical commitment to a world order in which they all have a right to participate. These changes in political and philosophical thinking have had profound implications for how health and social development is approached, and the idea of popular involvement has become more pertinent than ever before.

In this regard there has been a growing acceptance of the role and contribution ofinongovernmental groups in health development. For a long time marginalized to a secondary position in the health arena, NGOS have now become increasingly incorporated into health activities

and their potential as partners is being built on by health and social sectors alike. Part of the reason for this evolution in attitude has been the demonstrated technical competence and political acumen of many of these groups, as well as their ability to mobilize and represent community interests.

In line with these various social developments, and the greater involvement of NGOs, has been the emergence of the concept ofmpartnershipii in health and development. A reflection of the need for other sectors to participate in health matters, the concept ofpartnership has also signalled the fact that sharing of responsibility with communities deserves to be seen in a broader light, with all parties pooling their respective resources to achieve commonly agreed upon goals.

Throughout much of the world this growing acceptance of the responsibility that communities, NGOS and others can and should share in health development has coincided with the tendency to demystify medicine and has reflected a desire to incorporate the empirical/indigenous knowledge and expertise found in many communities. There is a feeling that contemporary public health, by building on those resources, could begin to close the gap that now exist between the professional and the public worlds.

CHANGING ((It hommanity healthj cannot be attained
CONCEPTS AND until the individual has learnt to realize that
REALITI E5 his neighbour): health is a matter of as much
concern to himselfas his own, that it is his
own effort which must help to decide the health
pattern of the community circle in which he
lives and that only a combined co-operative
endeavour 0a the part of all workei’s in the
manyfielels ofaetivity in that circle can yield
results that am worth achieving. J)

Report of the Health Survey and Development Committee, Vol. 1, Published by the Manager of Publications, Delhi, printed by the Manager of India Press, Calcutta, 1946

The involvement of communities in programmes relevant to their own development is not unique to the health sector. Much the same is occurring in other social sectors, where it has already been effective in bringing about policy reform, better planning, and a more egalitarian allocation of resources. Nor, as was indicated above, is the practice of community involvement new; it has occurred throughout history.

Nevertheless, important changes have recently come about in the way in which the role of the community is regarded. These changes, together with the terminology used to refer to the role of the community in development covered, in a 1989 WHO publication which explored the different concepts, some of the reasons that have contributed to their evolution, and their implicationsf They are summarized below.

COMMUNITY PARTICIPATION

To date the term tcommunity participationh has been used primarily to refer to the thmeansh by which communities have played a role in health development; it has covered processes such as mobilizing and using the economic and social resources ofa community in order to achieve pre-determined targets. In this sense, the

thkIey, P,, Cammun/ly Invo/vemeni m Health Development An Examination of the CriI/ca/ lssues, Geneva, WHO, 1989

results ()fcommunity participation have often been perceived as being more important than the process of participation in itself.

Participation, however, no matter how and why it is mobilized, often leads indirectly to improvements in the relationship between the community and the formal sector. In many parts of the world, for example, environmental and health benefits have accrued from commue nity participation initiatives even when this participation has assumed a ttpassiveii form. This has been especially so when the activities that have been generated have been consistent with local views on needs and desired outcomes.

When participation is seen as an end in itself, on the other hand, the active input ofthe community is called for from beginning to end and not simply in terms of providing resources. Participation as an end in itself has been actively promoted in a number ofprojects, and where it has actually occurred, participation has Often taken on a life ofits own and served to enhance the self-contidence of the community. This, together with the emergence ofa sense ofcommon purpose, has helped provide a context in which other health development interventions could be initiated.

VIET NAM

Mai Cheu is a village in a mountainous area of Ha Son Binh Province in Viet Nam, with a popuiation 0t apout 3000. It has a district hospital. a communal health station and a sch ool. For many years Mai Chau suffered from a tack of re! iabie, adequate and safe water. The only sources of water were a small, polluted and intermittent stream and large wells dug to a depth of 30 metres, which also dried up periodicatiy.

tn coliaboration with WHO, which provided funds for construction materiats and technical design services, the village constructed a gravity water supply scheme using a retiabte g oode quality stream in the hills 3 kilometres north-west of the village and 60 metres above it . The wiiagers responded enthusiastically and provided free unskilled labour to install the sys tem in epite ot aiready high demands on their time torwork in agriculture. The scheme was comple ted in March 1089 after a six-month construction period and has been providing adequate, safe water ever Since. Maintenance of the system is organized and funded by the Peopiets Water Committee. The system has served as a model for the whole province and has been replicate d elsewhere in an attempt to create sources of safe and adequate water for local population s.

Soume. WHO, Regional Office tat the Western Pacific

MARGlNAl! SUBSTANTIVE AND STRUCTURAL PARTICIPATION

Pamelpation can be characterized in terms of three stages: marginal, substantive and structural (WHO, 1989). In marginal participation, community input is lllimited and transitory and has little direct influence on the outcome of the development activity? Substantive participation is characterized by the community being actively involved in determining priorities and carrying out activities, even though the mechanisms for these activities may be externally controlled. In structural participation, the community is involved as an integral part of the project and its participation becomes the ideological basis for the project itself. In this latter case, the community plays an active and direct part in all aspects of the development process and has the power to ensure that its opinions are taken into account.

SPONTANEOUS, INDUCED OR COMPULSORY PARTICIPATION

Experience has also demonstrated that participation can be characterized as spontaneous, induced or compulsory. In general, ilspontaneousli participation refers to local initiatives which have little or no external support and which, from the very beginning, have the power to be selfesustaining. llInducedll participation, which appears to be more common, results from initiatives which are external to the community and which seek community support or endorsement for already defined plans or projects. llCompulsory,7 participation usually implies that people are mobilized or organized to undertake activities in which they have had little or no say, and over which they have no control.

COOPERATION AND POWER SHARING .

Participation can also be classified on the baSlS of whether government is actively seeking cooperation or wishes to promote power sharing. Where cooperation is sought, people are usually granted the right to receive information, to protest, to make suggestions and to be consulted before decisions are implemented. In power sharing, the community is understood to have the right to share in all decision-making and has the power to veto ideas that are not in line with its own objectives.

COMMUNITY ACTION FOR HEALTH

COMMUNITY INVOLVEMENT

The concept ()fcommunity hinvolvemen? in health has evolved from a range ofexpcrience accumulated over time. The difference between involvement and participation is perhaps more one of breadth than anything else. Community involvement is defined as 9.41 process in which partnership is established between government and local communities in planning, implementation and utilization of health activities in order to benefit from increased local selfereliance and social control over the inftastructure and technology ofprimary health carei7 and as Wna process whereby communities, families and individuals assume responsibility for their own health and welfare, and develop the capacity to contribute to their own development and that ()fthe community?

Community involvement clearly presents a broader concept than participation, especially in the way the role ofthe community is seen vis-a-vis government and the development process. It is none the less susceptible to the criticism that, while bringing into focus the notion of partnership between the formal health sector and the community, the relationship is still biased in favour ofa government 01’ public sector point ofview.

COMMUNITY ACTION FOR HEALTH

The increasing popularity ofthe term hcommunity action for health responds to many ofthe conceptual and operational limitations inherent in the term hcommunity involvementii. Not only does it imply a partnership between the community and the health sector, but it goes further and also denotes a pro-aetive role for the community and the implicit objective and obligation of the formal sector to share power rather than merely to foster cooperation. In the context ofcommunity action for health the community is an agent for health and development rather than a passive beneficiary ofhealth and development programmes.

EXTERNAL OR INTERNAL FORCES

Ideally, community action for health arises from within the community itself, and is then essentially run and supewised by the community using community-generated resources, mth collaboration from the formal sector in the form oftechnical and financial support as and when required. Examples ()fthis kind ofventure are few,

i_PHl Ll PPIN ES

The smallest political unit in the Phitippines is catted a "batangay". Each of these unit s has a
poputation of approximately 5000 people with a barangay captain as head. chatting a counc il
of12 members. The City of Manila has over 900 barangays of which 248 are considered to be undetsetved in terms of heatth setvices. Att are in tow-income stum areas.

In 1982, one of these depressed barangays in the district of Pandacan, Manila, was setect ed as
an area in which to devetop an urban primary heatth care modet to be used in enhancing he alth
services in Manitats stumsi A project was developed with the Manila Health Department usi ng
the training of heatth centre statt in primarily health care activities as an entry point . The staff of
a centre serving a ctuster 0t barangays agreed to participate in a community development initiative in the target harangay.

In partnership with the barangay council, particutarty its chairman, a number of health a ctivities
were undertaken, inctuding the estabtishment ot a health committee, the construction of a health
subcentre, and epidemiotogicat mapping of the barangay. These activities soon expanded to a
broader range of community development activities including beautification programmes, garbage cottectton, income generation, the cultivation ot herbat gardens and eventually t o the
promotion of immunization and breastfeeding.

WHO’S project ended in 1987 but the batengay council’s active participation in health ser vices
continues to this day. Based on the experience of the project the City of Manila has supp orted
the extension of urban primary heatth care to other depressed batangays 0f the city.

Source: Communication from Dr Evangeline Gt Suva. Manita Health Officer, Manila Health De partment

however, and there are far more instances where com-
munity action is triggered by an agency (including a
government health agency), NGO or individual external
to the community itself, but with active community
involvement and initiative.

There are a number ofreasons for this, Often it is a
reflection of the communityk greater concern with the
symptom or presentation of the problem than with its
underlying causes and conditions. The community,
moreover, may also have learned to adapt to, and ttlive
witlfi, the problem and in so doing become relatively
indifferent to the need or possibility ofchanging it. The
community may also regard investment in curative care
as being more relevant than in investing community
resources in health promotion and problem prevention,
which are seen as iong-term and difficult to achieve.
Where communities have become indifferent to their
health problems, or where they do not. see the necessity
for investing in long-term strategies, community health
action frequently needs to be mobilized and encouraged

from the outside. Accordingly, technical and financial back-up from agencies that have experience in these areas can often be instrumental in stimulating what is seen as necessary action.

The faCt remains, howcvcr, that while many health dccision-makcrs support the principle Ofcommunity action for health, few countries have yet invested the resources and the political time that is required to the case offinancial and administrative initiatives.

UGANDA

TASO was the first organized community response to the AIDS epidemic in Uganda, and one of the first anywhere in Africa. In 1987 sixteen Ugandans who were affected by AIDS (beca use they or members ot their family were infected) decided to set up a voluntary organization to orovide psychosocial support for people affected by AIDS. Tweive ot the tounding members have since died of AIDS, but since its inception, TASO has provided counseiiing, medical care and social support to over 14000 people with HIV/AIDS and their famiiies.

The TASO Community initiatives began in 1990 when TASO staff realized that many of the clients who came for HlV/AIDS counselling had few options for ioltow-up support. TASO the n began to recognize the urgent need to empower people at the local levet so that they cout d tackie AIDS-retated problems themselves. Atter discussions with a number of community groups, TASO realized that peopie who were given the basic skills needed for home care, counselli ng and AIDS education would go on to extend TASO’s services and eventuaiiy reach out to more people and communities.

The objectives of the TASO Community initiatives are:

0 to provide AIDS education and to promote behaviour change at the grassroots levei;
- to involve the community in the care of people with HtV/AIDS;
- to promote positive attitudes at the community level towards HiV/AIDS;
0 to set up a referral system for TASO and other AIDS service organizations;
0 to support community efforts to alleviate the socioeconomic consequences of the ADS epidemic.

By 1993 there were already seven TASO centres providing services throughout Uganda. Together they have 97 counsellors, 3 supervisors, and 6 trainers. The services they provi de now reach more than 30000 people a year, and inciude counselling, condom education and distribution, home care, income-generating activities, feeding programmes and payment of orphans’ school fees. The centres have also deveioped music and drama groups, youth group s and peer education projects.

iayrgeggying Positively with AIDS", Hampton. J., Aids Support Organization. TASO Uganda, Strategies for Hope,
0, ,
develop the mechanisms needed. This is especially true in

ESSENTIAL
CONSIDERATIONS
A47/TECHNICAL DISCUSSIONSO 19
((In coping with the problem of how to stay
alive and healthy, millions ofpoor people have
little to support them but their own knowledge
and ejfm’ts.))
Oakley. P., Community lnvolvemen! /’n Hea/m Development, An Examination of
the Critical Issues, Geneva, WHO. 1989
THE NEED FOR NEW MECHANISMS
Public health experience so far points to a growing need
for new mechanisms for mobilizing and supporting
health development, and t0 the benefits that can accrue
when these mechanisms build on local capacities and
interests while still complementing the plans and provi-
sion made by central and regional level government.
Where local community concerns and human capacities
are not involved and utilized, public sector health
provision and approaches can easily prove inadequate to
meet the health care aspirations of the people, or indeed
to reach out to all segments of the community equally.
Whatever form the new mechanisms take, experience
indicates that major emphasis will need to be given to
the social and health Characteristics - as well as the needs
_ of the communities or population groups concerned,
and to providing more comprehensive and egalitarian
coverage and access to services.
In many instances it is the social and cultural characteris-
tics oflocal groups that determine the extent to which
interventions are acceptable, realistic and likely to be
taken up by the community. Tailoring action to these
characteristics, moreover, is always best done in concert
with the community.
FINANCING
The increasing costs ofhealth care have made it progres-
sively more difficult to finance health systems in the
traditional way. In many cases, administrative costs have
begun to outweigh the costs ofmaintaining the health
care infrastructures available at community level and
hnancially are further limiting the possibilities ofimprov-
ing health care coverage. Moreover, in many countries
health promotion and health care continue to be ac-

corded a relatively low degree ofpriority compared with economic development goals, which still tend to be seen as more politically attractive.

Even so, community action for health should be regardcd as a means ofrclcasing the potential for health action in every individual rarhcr than as a method Of mobilizing finances for health from within the community. Irrespective ()frhc lcvcl ofactivity in the community, the formal health sector should ideally seek to

FINLAND

A communityebased project to prevent coronary heart disease was iaunched in the county of North Kareiia in 1972. The county had 180 000 inhabitants and was characterized by low population density, iow socioeconomic status, high unemployment and a large farming and forestry sector. The frequency of coronary heartdisease was high. The initiative to dosomething about this came from the community itseit with a petition to the Governor, at! North Kateiian members of the national pariiament and representatives at many governmental and nongovemental organizations in the area.

The project involved community action using the health service structure as a backbone. The main programme activities inciuded:

0 mediaeretated and generai educational activities with local newspapets and radio;
0 production and dissemination of health education materials;
0 support to community meetings and campaigns;
0 training of doctors nurses. social workers, teachers, representatives of voluntary organiza.
tions and informal opinion leaders in the county;
0 reorienting the health setvices towards better control of hypertension and keeping hyperten-
sion register, as well as providing secondary prevention for myocardial intarction patients;
0 support for community organization activities such as heart associations. housewives groups and sports clubs;
- cooperation with the food industries such as dairies meat processing industries, bakeries and groceries;
o monitoring and evaluation and dissemination of evaiuation results to the poputation.

There has been a significant decline in mortality and incidence of cardiovascular diseases and aireduction in the prevaience of smoking, in mean serum cholesterol concentration. and in mean diastoiic blood pressure. Simiiar activities have been widely adopted throughout Finiand. The proiect was successful primatiiy because it promoted the provision of a broad range of Icommunityehased primary health care services and the involvement of various other community organizations it also benefited from the dissemination of educational messages through the mass media and through opinion leaders. all of which helped to create a sociat atmosphere that was favourabie t0 the adoption of new lifestyles.

Source: The North Karelia Projeet, Puska, P.. ed. Comprehensive cardiovascular community contra! programmes in Europe. Copenhagen. WHO Regional Oitice for Europe. 1988 (EURO Reports & Studies, No. 106 ’)

support community initiatives and commit resources to primary health care development.

Of the financing mechanisms that already exist to support community action, the funding of NGOs who invest resources in community health action has become the most common system. Initiatives which are not organized according to this type of arrangement seldom appear to receive systematic assistance from the public sector or from national health systems.

DECISION-MAKING

When partnership arrangements are being promoted between government health systems and the community, the latter should always be involved in the decision-making process. Indeed, to the extent possible, the community should be made responsible for many of the decisions that pertain to its own health development and governments should assume the role ofa partner in providing the support required. Ideally this same type of distribution of responsibility and power should also apply to the setting oflocal health priorities and the planning of project implementation. For unless the community sees itselfas having an important role in deciding upon health interventions and sees these as meeting the peoples own perceived needs, community action is not likely to be self-sustaining.

Care needs to be taken, however, to ensure that community action for health is not assumed to relieve the government of responsibility for providing primary health care at the community level. Resource support, whether in the form of human, money or material resources, remains a constant responsibility of government, and community action has to be seen as a true partnership between the community and the formal health sector. The community must take a pro-active role, but always with the implicit and explicit backing of government.

In recent years there has also been a growing realization that ifcommunities are to feel that they have a share in the hownershipii of health interventions, they must also be able to share responsibility for their management. This important requirement has often been among the most difficult for government health systems to concede

t0 the community. th unless some major degree of responsibility for supervision and management can be devolved to, or shared with, the community, health interventions arc unlikely ever to be perceived as belonging to the community, which is in turn unlikely to invest the necessary time, cftort and other resources in community action for health.

ETHIOPIA

During 1974-1991, the Tigray region was one of the areas most affected by the civil war, and government functions including health services were suspended The Tigray People's Liberation Front (TPLF) therefore introduced reforms establishing viiiage and district-Ievei governments based on direct participation of communities. Communities were given the opportunity to take a ieading role in farmland allocation, water and soil conservation programmes. and construction of ciinics and health posts. This direct participation was reinforced by drought and famine which drove the population to rely more on themselves for the promotion of health and weitare.

A primary health care system was established in which communities helped to plan, impiement and provide health services through health committees, viilage health workers (VHWs) and traditional birth attendants (TBAs). In all, 88 clinics were established and over 3000 VHWS and TBAs were trained, The VHWs were involved primariiy in malaria control, providing early diagnosis and treatment, vector control by means of environmental management and general sanitary measures. epidemic control and provision of weekly prophyiactic antimalarial drugs to pregnant women during the transmission seasons The TBAs played an especially important role since almost aii deliveries were domiciiiary. A scheme of eost-sharing in the purchase of essential drugs was also established in which community members contributed in cash or by providing community service.

Then at the end of the war there was a high rate of dropouts oi VHWs and TBAs and the challenge to the newiyeestabiished Transitional Government was how to maintain the commitment of the communities in active participatory action. WHO is now collaborating with the Tigray Regional Government and the Ministry of Health to determine which elements of the project are sustainable now that peace prevaiis. WHO is also collaborating in the development and implementation ot a community-based malaria controi project following the same approach as during the war. in which the communities are responsible for the selection, supervision and su pport ot VHWs and TBAs arid tor the implementation of programme activities. The rote oi the iocal governmentand the health sector is to coordinate and provi de technical support and drugs and since the implementation of the project in 1992, over 700 VHWs arid TBAs have been trained in prrmaryprevention and control of major diseases, with particular emphasis on malaria, and are provrding service to over one miilion people. As a result the patient toad in the clinics and health centres has already started to decline.

Sources. The Health System Alternative 01 the TPLF. 1987, Unpublished report, Ethiopia
Naticnat Organization for the Control at Malaria and Other Veetor-borne Diseases. 1993 Strengthening oi health serwces through community based malaria control activities in Tigray: project proposal. Ethiopia
Barnabas (3,, 1993. Health Care in Tigray. Northern Ethiopia (review). Unpublished report

DECENTRALIZATION AND TAILORING SERVICES TO LOCAL NEEDS

One reason for the recent trend towards decentralization othcalth services has been the growing realization that local conditions and needs are often best met when the planning and management is undertaken closer to the populations and health needs in question.

As indicated earlier, a number ()fgroups, particularly the poor, have become more sizcablc everywhere and have become increasingly marginalized from good-quality care. Women, the elderly, young people, and thc dise ablcd are also groups with specific needs, rights and a desire for action options that arc rarely being met through health systems as currently structured. Respond- ing to the requirements ofthcsc groups calls for their

SCOTLAND

In a series of economicatiy deprived areas, the iay pubiic successtuiiy stimulated academ ic research which was of reievanee to their seit-identitied health needs. The findings of th e subsequent research study proved usefui for other communities around the United Kingdom.

The initiative started in the early 19803, when a community devetopment project was set u p in a poor neighbourhood of Edinburgh. The aim was to create channeis tor peopie in the community to communicate their own health needs and concerns to policy-makers. One of the overriding worries of the residents was their damp and mouidy housing conditions. Because they tett these were adversely affecting their own and their chiidrents health. a group o f eencerned women set out to work with community development staff. One of the outcomes of their initiative was atapewsiide presentation entitled "Home Sweet Home? which went on to be proved highly educational tor the iocai women themselves since it aiiowed them to collect data and state their case in a iogical way it also required them to interview local otticiais and politicians about how housmg poticies and programmes were tormuiated. Later they went on to show their tape-slide presentation at a meeting at Edinburgh University and this went on to chatienge researchers to take up the probiems identitied in the presentation.

As a result, eontrotied research studies of damp housing and health status were cartreq o ut in Edinburgh, Glasgow and London. Tenant groups from aii over Edinburgh used the trndrnge rn their citvaide campaign for better housing and the resuits were also usedto pershade hous mg authoritiestn Glasgow and Liverpooi to renovate damp properties and monitor resrdents’ he alth.

in Gtasgow, the tenants used the research findings to enlist the support of the European Community in asoiar energy demonstration project to test ways ot creating warm. dry dwell ings with tow heating costs.

Source. Jane Jones, Dept. of Community Education, Moray House Institute. Heriot-Watt Univ ersity. Edinburgh

active participation in defining their own needs, and this is only possible when there is greater ttsocial proximityii between them and the health systems in question.

Within this context, planning at community level is an essential part ofthc challenge oftailoring services to local needs. It can help overcome some of the ditticul-tics encountered in setting local health priorities from a central level, and can also contribute to establishing a dialogue between central government and the community.

THE AMERICAS

SMALP Projects (Heatth, Environment and the Fight against Poverty) have their origin in the 1989 Conference on Cooperation for Health (ttaly), sponsored by the itaiian Government and countries in Latin America and the Caribbean, which highlighted poverty, environmentat degradation and the need tor peace in the region. Four countries, (Brazil, Cotombia. the Dominican Republic and Peru) were invited to enter into a partnership with itaty and PAHO/WHO.

tn Brazi I (Fortaleza, tpatinga and Saivador) planning at local level was done in workshops with elected representatives from the Local Health Commission. intormat heaith agents (tocat heatth volunteers) and health personnel. who:

0 analysed the health situation and identified problems and needs;
0 identified priorities and critical aspects whose modification wouid significantty affect outcomes;
0 eiahorated proposals with specific objectives;
0 formulated strategies and determined what mechanisms to use tortollow’up and evaluation of commitments.

The accompiishmerits have included the decentralization and organization of health surveil-tance activities at the local ievet, training oi community members to participate in the monitoring of diarrhoea and cholera in their community and other surveitiance measures, and the strengthening of managerial capacity at the local tevet.

in Colombia (Aguabtanca in Cali), community ieaders and health personnel formulated the goals and activities of the project and identified common needs. A eo-management model was usedte pian and impiementactivities and a series otcommunity priorities were established and aCttVtitGS implemented in primary health care, community-based rehabilitation, and the training of Iecal midwives t0t maternal and child health care activities. The Vatie University is now worttihg en a research project evaluating different methods to taciiitate community and social parttCipation and its contribution to the strengthening of the local health systems in Cali.

In the Dominican Repubtic (Satcedo) where the objective was to reorient the health services system towards a health development approach, the project focused on strengthening local

continued

EQUITY IN HEALTH

A basic principle underlying the concept and practice of community action for health is that steps must be taken to ensure a more equitable distribution in the provision otihealth care. The currently uneven coverage provided by many health systems has become both more obvious and less acceptable. Today it is seen as one otithe main obstacles to achieving health for all, and community action appears to present an important opportunity and way to redress this situation.

THE AMERICAS (continued)

health systems, defining a functional organizational structure, developing local planning and programming instruments, and establishing a network of government institutions, NGOs and community groups that could form part of the local health system and develop situational analyses with theit participation. Some of the mat n achievements of the project have bee n: the devetopmentof local capacity for concerted action and local fund management; mobilization of local human and matetial resources; strengthening of capacity for planning and monitoring by the cammunity; involvement of local government in health development; interdisciplinary a nd interinstituttonal work.

In Peru (Chortttlos district in Lima), 21 major objective was to enhance the capacity of the community to participate in decision-making on health and environment. The emphasis was o n improving knowtedge about health and encouraging the involvement of local people in healt h ehucatien activities. including the training of local health agentsto develop basic sanit ation and health promotion activities. The protect has effectively increased local capacity to mana ge and admihister health services, improve health conditions and i ntroduce environmental protec tion measures. tthasalsotocused on increasing the capacity of people to establish partnerships with .gevemmental bodies, NGOs and othets in health and environmental work. Innovative activit ies have included training local health personnel and popular health agents in conflict resol ution -- methods and negotiating skills, establishing a co-management model for health develop ment iii Chortilles, and incorporating community involvement in the basic surveillance system.

Shuttle: SMALP P(ojecti Series "Sll 06w - HSS/SlLOSH27-2993. pp 100, PAHO/WHO-ISBN 92 75 32096 9

However, while community action initiatives have the potential to mobilize and involve many sections of the population, the fact that a health initiative is community-based is not in itselfa guarantee that all needy groups in society will be reached with the type and quality of care that is needed or desired. For this to be achieved, a type of planning is needed that goes out ofits way both to address the issue ofequity in care and also to ensure that all the groups concerned are involved in the planning and implementation phases.

COMMUNITY A(TION FOR HEALTH

Most primary and secondary health care interventions inevitably involve activities that are initiated at the family level and are ultimately undertaken by women. In most countries, women nevertheless remain a relatively neglected group as regards their own health and their acknowledged role and involvement in health promotion and maintenance.

WOMEN AND HEALTH

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It is therefore important that the principles of equity 1 referred to above are visibly applied to women. Commu- i nity action for health can be one ofthe more ettective ways i ofreaching women and integrating them openly in deci- i sion-making on their own and their familyis health matters.

INDONESIA

The role 01 women in the promotion of family welfare in Indonesia was officially expanded to include heaith in 1957. when the idea of tamiiy weltare education was initially introduced by the Ministry of Health during its Home Economic Seminars held in Bojor WestJava. Laterwhen the Ministry of Health of Indonesia formulated the 4th Five Year Health Development Plan, its main objective was to tower the infant and child mortality through integrated health care at the community ievet. The woments organization, the Family Wetiare Movement (PKK) enthusiasti- catiy took up this obiective and decided to link these health etiorts with its own community work.

As a result of the planning process that then took piece with the different communities on how best to deliver an integrated package of health care for infants and children, the "Posyandu’t movement was formed and a series of integrated health care delivery posts were set up. The Family Welfare Movement, which initially started with a focus on improving the status of women, played a crucial role in converting the Posyandu i nitiative into a social movement that has gone on to encompass a large number of communities. The network of women volunteers quickly expanded and soon one volunteer was being selected from every 10 households. As a result, it became possible to expand the number of integrated health posts, with the number of volunteers selected and trained eventually reaching a total of 1.5 mitiion.

Today, members of the Family Welfare Movement conduct health awareness campaigns among the population. record vital life events, promote seit-care for minor aiiments and provide primary care including nutrition, growth monitoring, immunization, diarrhoeat disease con troi, control 01 acute respiratory intentions, and promotion otenvironmentai health. in order to make the most 01 the different resources availabie and get the support from the format sector, the Ministry 01 Heaith has worked closely with both the Ministry 01 Interior and with local government.

Thanks to these joint ettorts. lndonesia recorded a marked decline in its infant mortality rate and the accomptishments oi the PKK were internationally acknowledged in 1988 when it received the Sasakawa Health Prize from WHO and the Mauricepate Award from UNiCEF. its example has gone on to inspire interest in other countries of the Region.

Source. Primary Heaith Care in Indonesia, Ministry of Heaith Republic of indonesiai Jakarta 1980 J

YOUNG PEOPLE AND HEALTH

The energies and interests ofyoung people can be an important ingredient to community action for health. Young people are emerging as an important population group all over the world, with special health needs and social aspirations, but also with a unique potential to contribute to health development in general. At the same time, the involvement ofyoung people in health matters can offer them possibilities and options for realizing their own goals and helping to ensure their social integration within the larger health development process.

The fact that young people are at special risk ofihealth hazards connected with their behaviour and lifestyles (cg. injury, smoking, sexually transmitted diseases, including HIV/AIDS) also provides important opportunities to use community-based action to create a social climate in which their lifestyles and immediate living conditions can also be modified.

THE ELDERLY AND HEALTH

Throughout the world the numbers ofelderly people are increasing. For a variety oftechnical, social and cultural reasons, many of the problems of the elderly have not been addressed in a comprehensive fashion. Within many communities, however, the elderly represent a potential economic force and embody a corpus ofinformation and experience that can be useful to both themselves and others in the community.

Experience shows that the elderly are very willing to collaborate in community action for health activities and are usually able to devote more time than others to such action. Because many of their problems and concerns are relatively new to the health care system, the elderly are often the best placed to identify, quantify and develop responses to them. Like other groups, however, they need to do so in close partnership with the technical and service resources of the formal health care system.

JORDAN

in Jordan the Basic Minimum Needs/Oualiiy of Life project is being executed by the Noor A t Hussein Foundation which is a nongovernmental organization, in collaboration with seveiai government ministries and with iinancial and technical support from WHOA The project was taunched in 1989 with advocacy and intensive social and community preparation, organizati on and training, Viltages have obtained support from intersectorat teams, and social and i n come-generating projects have been initiated and included in ail primary health care component s in the 12 vitlages covered by the programme. The projects inciude animat husbandry, fruit an d forest seedlings deveioprnent, fish farming, production of dried yogurt, sewing and knitt ing, i mprovement of kitchens and toilets, and production of baskets and other handicrafts. Su bstan-tiat improvements in the quatity oi iiie oi the people and a change in their attitudes ha ve been reported. and they have been much more invoived in the planning and implementation of loc al development. improvements in quality of life were primarily related to housing. sanitatio n, and primary health care services, and better health status indicators.

The Jordanian experience is an example hi how change in format relations and practice can he achieved through an NGO which in turn enhanced the commitment of the formal sector, The project has effectively demonstrated the benefits of teamwork and how vittage devetopment can be improved by entrusting tocat committees with the task at iormutating needs and options for Iocai action.

Source: Communication from the Division 01 Health Systems Development. WHO, Regionai Oiii ce tor the Eastern Mediterranean

A47/TECHNICAL DISCUSSIONSD 29

POTENTIAL FOR CONFLICTS

((People must be informed payment in determining their own health as well as the health anal quality of life 0fthe community, region, and country in which they live?)

Meeting G/oba/ Challenges: A Position Paper on Health Education, International Union of Health Education and WHO, Dec. 1991

Most organizational relationships have a potential for conflict at some point in the process of their operational development. Community action for health, in which both the community and the formal health sector have to share responsibilities and work, is no exception. Many of these potential conflicts, however, can be effectively avoided or minimized by anticipatory and contingency planning, and it should always be remembered that in the case oficommunity action, there are likely to be just as many possibilities for mutually complementary and symbiotic relationships to evolve.

AUTHORITY

Community action for health, is likely, for example, to highlight questions about the relative authority and power of different parties in setting priorities, in decision-making and in allocating resources. In most societies, the formal health sector, no matter how poorly developed its infrastructure, has usually had primary responsibility for health planning, health resources development and training, and the delivery of services. Thus where there is not an explicit and mutually agreed upon understanding concerning initiatives that place greater emphasis and responsibility on the community, there is a strong potential for those working in the health sector to feel that traditional relationships and power structures are being threatened.

PRIORITY SETTING

The process ofsetting priorities, or ofselecting special themes for accelerated attention, is an important aspect of community action for health. It is one which nevertheless has the potential for misunderstanding and conflicts about how and why decisions are taken and with what authority. The health problems or needs that are considered by the community to be most urgent, for example may not necessarily be the same ones which

government - at a distance - feels should be given priority. In some cases, the needs identified by a community may relate to a particular point in time, or to social conditions and Characteristics which are unique to it, or indeed to its own particular life-styles and hence its traditional relationship with society at large. These expressed or felt needs may not be seen or sensitively understood by the health sector and, as a result, may not be perceived as warranting special action.

SOCIOCULTURAI. DISTANCE

All too often the gap between the formal health sector and a community is a result of social or cultural tidistanceii. For example, the life experience of the poor, and the ways in which they have had to adapt to their life conditions, may be so different to the personal experience of health personnel that real communication on the issues in question is difficult. Similarly, in the case of communities that are formed around special lifestyles, for example prostitution, their problems and health concerns

YEMEN

in Yemen, Local Cooperatives for Development started a socioeconomic movement from the Ozla (grassroots ievei), that was entirely managed by the community. This constituted a clear bottomeup pianning with community empowerment. in this process the villages through their eiected administrative structure at the community ievel define their priority needs. The projects aiming at improving the quaiity of tite in these rurai development programmes were planned and financed by the community in partnership with the government. A strong tradition of solidarity and cooperation ensured the programme’s success, though notormai social preparation initiatives were undertaken. There was no "model" to launch developmental activities all over the country.

The lesson derived from the Yemeni experience of comprehensive devetopment countrywide is that community empowerment is essential to development, and that communities should be supported by formal sectors. Otherwise. a conflict may arise between felt needs and perceived needs as well as between the decisionemaking process at local and national levels. A change in the distribution of power in favour of the community was evident. To this end social preparation of ait partners should be intensively launched.

To ensure harmony and support for community action, the community organizations (i.e. the Locai Cooperatives for Development) need to be trained and oriented to estabiish understanding and iirtks with the formal sectors at different levels. The roles of the different partners should be identified and practised not oniy through iegislation but aiso through a learning process in which aii parties should participate with vision and commitment. With time, the community and formal sectors as weil as other partners will realize their limitations and opportunities.

Source. Division of Health Systems Development, EMRO

are often not understood by others who have never had to deal with such matters.

INITIATIVE

At another level, conflict sometimes arises if the community feels that initiatives are being generated from outside and are not consistent with its own feelings about what is required. Equally, conflicts have often an'sen where those working in the health system consider that the community is proceeding too fast and in too tidemandingll a manner, often out-pacing the health systemis capacity to respond. The same is true ifthe community is seen to be pursuing themes and routes of action which are not consistent with national or regional priorities.

RESPONSIBILITY

Delegation of responsibility is always an area where misunderstanding can arise. In most countn'es, responsibility for health has traditionally rested with the trained professional sector, and the increasing sophistication of medical technology has appeared to justify a professional structure and approach in health care. Community action for health, on the other hand, presupposes a certain equalizing of roles and a genuine sharing of responsibilities.

Whether and to what extent conflicts arise depends on a number of questions, not least ofwhich is the particular issue that the community decides to take up and develop. It may also depend on the social structure of the community itself. For example, where the community includes a large number ofprofessional people and where there is a tradition ofinvolvement in technical matters, an alliance between the health sector and the community will be more easily fostered than where no such tradition exists and where there is an intellectual distance between the health sector and the community. Communities with no technical tradition or professional expertise may be seen as ilover-steppingli so-called boundaries of iiacceptableii behaviour, and there may again be a possibility of conflict.

REASONS FOR COMMUNITY ACTION

Where community action for health is generated because there is dissatisfaction with the performance ofthe health

sector, there is also a strong potential for conflict. This is especially true ifthc communityls action is associated with criticism ofthe health sector or ifhealth officials feel that the initiatives being proposed or taken by the community are a manifestation ofdistrust and disagreement with the role that they have played to date.

In many instances the decision to initiate new action may also be as much a political statement as the expression of a desire to address perceived health needs. Where this is so, rapprochement on how to approach selected problems may be dillicult and require considerable give-and-take by all partners. It is certainly far less problematic when community action is generated with the complete involvement of the health sector and around goals that have been discussed and agreed upon.

PACE 0F ACTIVITY

Where community action for health occurs tlspontaneouslyll around particular themes about which the community feels strongly, there may be a feeling that the matter was not being dealt with quickly enough. Where this is the case, communities may be prepared and able to provide the basis for more accelerated action. Whether the formal sector is, in turn, able to maintain an equivalent level ofattention, and satisfy the desire for urgency, may depend on the extent to which it shares the same sense ofpriorities and whether it has the resources to invest in the problem.

Formal health systems are also often caught in a conflict between establishing priorities on the basis of health themes as opposed to giving particular emphasis to geographical locations or social characteristics. Investing resources in one set ofproblems or in a particular community may mean not investing in another problem or community to the same degree. While this dilemma may be perfectly obvious to decision-makers in the health sector, it may not necessarily be so in the eyes of those who have come together around a problem which they feel deserves special and speedy consideration.

ASPIRATIONS AND EXPECTATIONS

Community participation, community involvement or community action for health have often been promoted

as much for their long-term effects as for their immediate problem-specific results. Underlying much of the political and philosophical discourse on this subject (and as referred to above) has been the belief that increased community involvement would lead to greater political sensitivity and motivation to act. This has indeed often proved to be the case and successful community action has often led to people developing even greater aspirations and expectations about what can and should be achieved in other areas oflife as well as in health. Just as with the pace that communities sometimes wish to set, so their expectations as to the intended scope and impact of their action can often exceed what the health sector believes is desirable or attainable. If these diner ences are not quickly resolved, they can lead to dissatisfaction and to decisions to seek alternative courses of action. They can also lead to a dwindling ofinterest and commitment on the part of the community, and to a reluctance to tinegotiate,7 on the part of the health sector. This is particularly problematic where the formal health infrastructure is poor and where the health sector lacks the human or financial capacity to respond to the growing requests and aspirations of the community.

RELATIVE AUTONOMY

Even though an underlying principle of community action for health is the achievement ofa degree of autonomy and self-determination on the part of the public, there are few situations in which the health sector is not requested to provide support. There are even fewer situations in which the health sector does not feel that it has an ongoing responsibility to be involved. There may be other situations in which the community believes it understands the problem better and knows where it can go for technical or infrastructure support. The consequent recruitment of private consultants, and/or the mobilization of support outside the health sector, is again open to misinterpretation and is sometimes seen as an act ofdefiance. Initiatives of this kind are often resisted by both politicians and health stat? more on the basis ofinterpretations such as these than on any technical grounds.

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THE
LIKELIHOOD
OF SUCCESS

COMMUNITY ACTION FOR HEALTH

((To be successful in community work, we need
a good sense aflaistory, humility, and a deep
respectfor the people with whom we work?
Paulo Freire

The success olkommunity action for health initiatives may well dcpcnd on the extent to which all the above and other potential areas ofmisundcrstanding and conflict can be avoided or attenuated. Among the factors that must be considered, the following are especially important from the point ofvicw ofcommunity action for hcalth.

COMMONALITY OF PURPOSE

()nc ofthc most important prcrcquisitcs for successful community action for health has been shown to be commonality ofpurposc between all thc parties concerned. To this cnd, thc carly cstablishmcnt ofa dialogue between all the parties concerned is crucial together with a sharing ofopinions on the nature ofthc problems to bc addrcsscd. In many instances, thcrc may also be a need for the parties concerned to inform and hcducatcll each other on issues ofintcrcst and to cxplain why they fccl particular courses ofaction should be taken.

KNOWLEDGE SHARING

Sharing of knowledge is always an important ingredient in thc rclationship hctwccn the community and the health scctor. This should include information not only about needs but also about alternative courses of action, the tcchnical basis for tlicm, the resources required from the community and from the health sector, and an open discussion about what resources arc likely to be available and forthcoming from cithcr or both. Under ideal circumstances plans for partnership in community action should always be founded on shared knowledge and an understanding among all parties ofthc scope that exists for developing consolidated approaches to health.

RESOURCES

The discussion ofrcsourcc needs and their availability should always try to takc into account the human as well

as the economic assets which the community and the health sector can call on, together with an estimate of what additional staffing might be needed and available from elsewhere. In this regard it is important that a broad net be put out to attract human and financial resources from other sectors, NGOs and all interested parties. Technical knowledge and staffsupport from the formal sector or government may be appropriate and available to the community in a variety ofways and care should be taken not to exclude these different possibilities. Equally, a wide range ofhuman resources is likely to be available from within the community itselfand these should be identified early, involved in the process and strengthened wherever necessary in close collaboration with government.

GOALS AND OBJECTIVES

Joint planning ofhealth activities ideally means setting goals and objectives which are not only compatible with the capacities of all concerned parties but are also achievable within a mutually acceptable period oftime. Notha ing is more likely to enhance continued commitment and action by the community than the early demonstration Ofeffectiveness and positive impact. It is therefore important to select issues on which action is most likely to succeed and to lead to other action. The formulation ofcommunity action for health will always benefit from careful situation assessments undertaken jointly by the community and the health sector, taking into account the social, cultural and economic characteristics that influence health and the scope for action at the community level.

SENSITIZATION AND EMPATHY

Experience has shown that there are many situations in which one of the parties concerned - whether within government or the community - is not fully aware of the complexities, problems and constraints faced by the other. This can be an important obstacle to dialogue and coordinated planning, and time allocated to informing everyone about the work proposed and the overall conditions affecting the others involved is time well spent. This is particularly necessary when socially marginalized and poorly known groups seek the techni-

cal involvement and support of the health sector. Just as important as sharing information abOut the background of the groups concerned, however, is the generation ofa true capacity to empathize with all the parties and understand their particular concerns.

POLITICAL SUPPORT

Ifeommunity action for health is to be an active partnership between the community and the formal health sector, strong political commitment is essential for the process to be initiated and sustained. Without this and the support ofdecision-makers in both government and the community, programmes may begin but will risk being short-lived. The continued involvement and commitment of the political leadership can contribute substantially to effective and ongoing community action for health activities.

TRAINING

Many health workers, especially those at the district or peripheral level, have not been traditionally involved in encouraging or sustaining community efforts for health, and the attitudes and skills needed to assume such responsibility may have to be developed. If community action for health is to be seriously taken up, the training Ofstaffor community initiatives will ultimately be as important as preparing staliifor other technical and administrative responsibilities.

At the same time, the formal sector should note the need for leadership development in the community itself, for there will be many instances where even though there is commitment and interest, there is nevertheless a lack of strong leadership capacity within the communities concerned. Leadership within the community is essential for the continuity and cohesiveness ofcommunity action and for a sound working relationship between the community and the formal health sector. It should be seen as part of the overall process ofempowering the community and developing the skills needed for effective partnership.

ROLE OF OTHER
SECTORS
A47/TECHNICAL DlSCUSSIONS/2 37
K115 communities continue to diversify ethni-
cally, racially, socio-economically, anal wli-
giously, programs are needed to increase
communication and appreciation among
groups and within the community as a
whole?
US National Civic League, Health Community Handbook, 1993
There are few areas ofpublic health development which depend solely on the technical know-how and involvement of health professionals. Instead, health and social development have become functions of many different and diverse inputs. This is especially true ifhealth is seen as both a result and a prerequisite of development of the community. There are many sectors which can and should play an intimate role in the process, and indeed many sectors have already contributed significantly to health development, either directly or indirectly.

EDUCATION

The role ofeducation in improving literacy and in contributing to health development is undeniable, and education has been highlighted in many national and international programmes as one of the main means of achieving better health. In the case of women, for example, Who have remained a relatively marginalized group in many parts of the world, the promotion of literacy continues to be a key and a challenge ifwomen are to assume more responsibility and power over their own health and well-being. The importance ofschools as a means ofreaching children of all ages, and in some countries, adults too, cannot be underestimated.

COMMUNICATION AND INFORMATION

Today the epidemiology of disease is pointing more and more to the role oflifestyles and living conditions in determining the health of people. Investment designed to improve these factors may ultimately be more worthwhile than investment in new and often expensive curative technologies that are difficult to sustain in poor countries and communities. Given these high costs, especially those associated with tertiary care, other

sectors can and should contribute to disease prevention and health promotion through helping to inform and educate the public about the steps that people can take to improve their own and their familyis health.

Disease prevention, for example, may ultimately depend as much on the willingness of the educational sector to become involved as on anything else. Communications and the use of new technologies must play an important role in diffusing new knowledge and values relating to health, and ministries Ofinformation will therefore

AFRICA

During the past six years Egypt, Ghana, Nigeria, Zambia, Zimbabwe have been coiiaborating with WHO to enhance woments heaith status and quaiity of life through an initiative which rests on three piiiars: functional literacy, viable economic activities, and community-based he aith services. Functional literacy has proved to be the key element in a process of empowermen t which equips women with health iiteracy skitis to monitor, for exampie, child growth and development and adopt positive health behaviour, economic and numeracy skiiis to engage i n economic activities and keep records and accounts, and probiem-soiving skiiis to heip the women overcome the myriad oi health and other probiems they face in their everyday life.

One of the most innovative aspects oi the projects to date has been the breakthrough made in providing loans to the poorest and most disadvantaged women for economicaiiy viable projects, and at the same time ensuring that concerns for women’s health and social devei op- ment are addressed. For the first time, heaith needs are assessed as part of the loan app lication. and participants are encouraged to open individual and group savings accounts to tackie t he identified priority health problems iaced by individuals, families and the community.

The results of this initiative have been very encouraging. Evaluations have shown 100% completion rates oi functional literacy classes, clear improvements in the heaith status of participating women and their children. and positive changes in the household income of women involved in smali-scaie economic enterprises. Within the communities women partioi- pating in the projects are regarded as health and economic advisers and rote models to ot her women in the community. The spin’oits are felt by entire communities who are now taking i t upon themselves to organize tor environmentai sanitation, manage village pharmacies and shops, construct latrines. day-care centres and heaith posts.

in one country iocal leaders have said:

"Today the project women have improved social interactions within and outside the communi ty. They are now effective social organisers and leaders. At pubiic functions they appear dis tinct to action and eomportment with other women".

"in the village schoois, children of functionally iiterate mothers are known to be the br ightest, wear the cleanest clothes and are aiways in their shoes. They are called ismart chitdren’ ."

become key partners in the wider process ofhealth development. Communication networks and especially television systems, have improved their coverage greatly in recent years and can be particularly effective in areas and communities where literacy levels are low.

AGRICULTURE

The agriculture sector has traditionally been closely involved in community development and has played an important role in promoting health. One reason is that improving agricultural productivity has often been a higher priority for rural communities than health per se and it has also been an area in which technology transfer and knowledge sharing have been necessary ingredients in the success of'projects. The relationship between the formal sector and the community, moreover, has not been the same type of client-provider relationship that has so often characterized the health field. The involvement of farmers, their families and communities in defining problems and working with the agricultural sector to address them, moreover, has been recognized as indispensable for success.

In many areas, meanwhile, food production and distribution have made, and continue to make, a critical contribution to the achievement of child survival goals as well as improving health status in general, and have therefore received considerable support from people at the community level and from community leaders.

TRANSPORTATION

Community action around transportation issues has been successfully implemented in a variety ofsettings and is widely seen as an important base from which to generate initiatives in other areas, including health. Creating transportation networks is one of the ways in which communities can enhance their relationship with the outside world and ensure easy access to the essential services provided by different sectors. Ensuring that women can get to clinics for prenatal care, that drug supplies are readily available, and that ambulance services can reach people, is as important as setting up clinic facilities and health senices in the first place.

COLLABORATION

Despite the apparent need for greater collaboration between sectors, such collaboration, although frequently advocated, has often remained more an intention rather than a reality. While most sectors share a common understanding ofthe overall goals of development, few have organized their contribution according to coherent intersectoral plans that stress the rationalized use of resources.

Community action for health could provide an important opportunity for developing this theme. Many ofits activities necessarily cut across sectors and involve workers at the grass-roots level where territorial and resource conflicts do not apply to the same extent as at other levels. People working at the community level often routinely interact with all sectors, and in many countries the same person(s) may be working in various sectors. Field-level cooperation between different departments oflocal government also provides opportunities for intersectoral collaboration and the possibility ofjoint problem-solving. Just as in the case of the relationship between the health sector and the community, however, the likelihood ofcooperation between other sectors and the community will depend on whether common goals and objectives can be set and shared. For other sectors to become involved in supporting community action for health, the health sector must itself become more active in advocating and providing leadership.

IMPLICATIONS
FOR RESOURCE
ALLOCATION

KThis argument, however, must he considered in relation to the current distribution of health resources within a particular country and should not be interpreted as throwing the onus of providing the resourcesfor health care entirely upon local communities?

Oakley, Pl, Community /nv0/vemenl in Health Development, An Examination of the Cr/t/ca/ Issues, Geneva, WHO, 1989

At a time ofglobal economic recession, scarce resources and spiralling health care costs, the question ofhow, to whom and on what basis, to allocate resources has become increasingly complex. Part of that complexity has resulted from some of the same historical and social processes mentioned above, and which have helped influence other aspects ofhealth development.

DEMOCRATIZATION

The process ofpolitical democratization, for example, has meant a wider participation by different groups in both national and local political dccision-making. It has meant a greater sharing ofknowledge about how and why resources are allocated and a greater transparency in the evaluation of that allocation. Improvements in education and communication have also meant that the lay public is better prepared than ever before to become engaged in the debate about where to allocate funds and technical resources.

DEMANDS ON GOVERNMENT

Special interest groups and communities have also become more vocal everywhere in making demands on the government with regard to how they themselves should be supported. In many countries where govern-ment continues to be the main source of funding sup-port for social development initiatives, this has meant that government is increasingly called on to provide the back-up required for community action for health. To do so it also has to engage in a new type of dialogue with community groups and be able to listen to the different positions and concerns represented by them.

INTERNATIONAL ORGANIZATIONS

Most ofthc issues rcfcrrcd to above have implications for the work ofintcrnational organizations. Ifthosc issues arc to be promoted at a global level the international organizations will need to work with countries in translating them into policy and action strategies. In so doing the organizations concerned will ideally need to incorporate many of these ideas into their own programmes ofiwork.

For this to happen, international organizations m'll first need to rc-asscss their cooperation with countries and formulate new models ofaction. Among the steps that they may wish to initiate is ensuring that communities cntcr at an early stage into situation assessments, planning and discussions with government as equal partners and as an important intellectual, as well as a manpower, I'CSOUFCC.

For these reasons, the role ofintcrnational organizations in the area ofcommunity action for health will need to include advocacy, research and evaluation. Moreover, organizations will need to collaborate much more closely with national and international NGOs, as well as with governments. National governments and agencies - no matter how much they arc committed to this idea - do not always havc the structural platform from which to promote such new ideas and practices even within their own countries, let alone internationally. Political and technical support, as well as intellectual stimulation for new ideas will always be necessary from international organizations.

W

AGENDA FOR ACTION

If community action for health is to be furthered and if national and international bodies are to take up the challenge of reinforcing the work that has already been started in this area, a number ofvital questions remain to be considered.

HOW BEST TO STRENGTHEN PEOPLES' EFFECTIVE PARTICIPATION TH ROUGH, AND AS PART OF, THE HEALTH-FOR-All STRATEGY?

If community action for health is to be truly promoted, it must be done through a strategy which seeks to achieve equity and provides a strong technical platform on which to build. The fact that the community takes on initiatives for health will not, in itself, ensure equity; efforts will need to continue at all times to ensure that all segments ofsociety have a say in their health care. Special efforts, for example, will be called for to include marginalized groups and the socioeconomically deprived; women and mothers and their children will also need to receive special attention, as will young people and the elderly.

HOW BEST TO ENCOURAGE THE COMMUNITY TO ENTER INTO A VIABLE AND SUSTAINABLE PARTNERSHIP WITH THE FORMAL HEALTH SECTOR?

Many recent changes in lifestyle and living conditions have not only produced new patterns of morbidity and mortality but have also made it imperative for the public to assume a new type of responsibility for both its own well-being and for its rights,

HOW BEST TO FACILITATE THE FORMAL HEALTH SECTOR'S ACTIVE INVOLVEMENT IN ENHANCING COMMUNITY INITIATIVES FOR HEALTH?

In spite of the commitment of Member States to the goal of health for all, and despite a growing acknowledgement of the necessary role of the public in the process of attaining it, relatively important organizational and administrative changes may be needed within the formal sector for this to become a reality. The acceptance ofthe principle of community action for health implies the tacit agreement of the formal health sector to share responsibility with the community and it must be able to concede to the community the right to participate in decision-making and priority setting.

HOW TO EN$URE THAT DEVELOPMENT ACTIVITIES ARE VIEWED HOLISTICALLY, AND HEALTH TRULY SEEN AS ONE OF THE INTEGRAL AND ESSENTIAL COMPONENTS OF THE DEVELOPMENT PROCESS?

It is in this widcr social context that community action for hcnlth will assume its true valuc. Evcn so, every effort will hnvc to bc madc to cnsurc that it becomes a fundzr mcntnl part of, and a way oliachicving, sustainable development. For this to happen, the entire health care team will nccd to be involved, and all lcvcls otistaff will nccd to understand, and be able to contribute to, the national commitment to community action for hcalth.

ll'hcy will also nccd to understand the rcasons and values hchind thcir countryk commitment and, together with till hcalth dccision-nmkcrs from the peoples, rcprcscnta-tivcs to thc scnior mcmbcrs ofthc hcalth ministry - will need to be kept informed about evolving nccds and progress achieved in various new initiatives.

In practical terms, it may be necessary to organize oricntdtion and training programmes for hcalth staffso as to foster the requisite attitudes, values and skills. Skills in such areas as situation analysis and group-bascd priority setting, working, with othcr sectors, and commu-nication, for example, are essential to district and local lcvcl health development. In this regard, handbooks, nmnunls and guidelines on the subject ofcommunity action and how to cnhnncc working relationships with the community will be uscful in promoting and sustain-ing this area of health dcvclopmcnt. WHO and other intcrmtional agcncics and groups could play an impor-tant role in developing, training, programmes and in prcparing thc appropriate documentation, cspccially if this could he donc in collaboration with local statliand thc public.

HOW TO TRANSLATE' SCIENTIFlC DATA INTO THE TYPE OF INFOR-MATION THAT (AN BE USED BY THE COMMUNITY IN REACHING TECHNICALLY VALID DECISIONS TOGETHER WITH THE HEALTH $ECTOR?

1n the partnership cnvisagcd between the community and the health and other sectors, the technical resources olithc health sector should be incrcasingly geared to the needs otithc public and to the joint dccisiowmaking that is sccn .is part olicommunity action for hcalth. Hence the growing need for a health empowerment ofthc commu-nity which builds on intorimtion, education and com-

munication efforts by the public health sector. A theme common to all community action activities will be the need to identify the person or organization that can act as a trigger or initiator (and often a technical resource) for bringing the community together around the issue of their own health and well-being. The trigger may often come from within the formal health sector, but it may more often come ftom an NGO. It will therefore be important to recognize and foster that the relevance and significance ofNGOs as a handamental part of all community action initiatives.

Because health and overall development are mutually complementary and interdependent the community will also inevitably need to take a more holistic view ofits needs than has been the case to date with vertical health systems. Close cooperation between different sectors is indispensable for effective development, and the health sector should accept that it cannot be responsible for all activities even though these may be intimately connected with health and quality oflife.

HOW BEST TO ENSURE THAT RESOURCES CAN BE GENERATED AND SUSTAINED IN SUPPORT OF COMMUNITY ACTION FOR HEALTH?

The question of the resource support that is needed for health development is a fundamental one, regardless of how or by whom it is generated. Community action is no exception and those managing the formal health system should not regard community action as a method ofi’elieving the health sector or government of the responsibility for providing support. Nevertheless, letting the community raise its own funds, may help ensure its sustained involvement in activities that respond more specifically its OWn aspirations and needs. It is therefore essential for the government sector to establish mechanisms that permit joint support and make resources available directly to community health enterprises themselves. Ideally, international agencies and donor organizations will also be able to adhere to this principle and ensure that peripheral priorities are taken into account by earmarking funds to encourage community action for health as part of their aid projects.