COMMUNITY ACTION FOR HEALTH

(Working Paper for the Technical Discussions)
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1. INTRODUCTION

It has been identified in the Eighth World Health Situation Report (1992), which is based on the Second Evaluation of Health for All (HFA) Strategies, that in spite of achievements in the health status and health care coverage, viewed nationally or globally, there is still a wide gap as shown by disaggregated information. The development and implementation of policies, financing, organization, and management of health and health-related programmes are further complicated by the fast changes in the global political and socioeconomic situation and epidemiological transition that have taken place in recent years in all countries, especially those in the South-East Asia Region (SEAR). Changes in the epidemiological situation have also been linked to changes in lifestyle and worsening environmental conditions, coupled with rapid population growth.

Therefore, Member States have been urged to maintain a high level of political commitment to social equity and leadership for accelerating the implementation of national strategies and to pursue vigorously actions aimed at strengthening the management of health systems based on primary health care (PHC). In this regard, emphasis is laid on efforts to maintain collaboration with all health and health-related sectors and to develop effective mechanisms for their sustained support. One of the effective mechanisms would be to strengthen district health systems based on primary health care and identify appropriate targets for integrated delivery of essential elements of primary health care and implement them until all districts and all elements are covered (World Health Assembly resolutions WHA39.7, WHA41.34, WHA42.2, WHA45.4 and WHA46.17; SEA Regional Committee resolutions SEA/RC40/R5 and SEA/RC41/R4).

While the basic principles and concepts of Health for All and Primary Health Care are still alive, yet there is an urgent need for new orientation in approaches and strategies. This requires that the health sector pays more attention to the intimate relationship between health and development, and intensifies community action for health.

The concept of ‘Community Action for Health’ (CAH) had its roots decades back. Different terms are used to reflect people’s role in health development, such as community participation, community involvement, community action and social control. These are loosely used to indicate the varying degree of action by the community, starting from self-action to full control by the community as a whole.

The term ‘community participation’, as defined in the report of the International Conference on PHC, held in Alma-Ata in 1978, refers to the process by which individuals and families assume responsibility for their own health and welfare as well as for those of the community, and develop the capacity to contribute to their own development and of the community. This enables them to become agents of the development instead of remaining passive beneficiaries of development aid.

The term ‘community involvement’ is preferred rather than ‘community participation’ as the former reflects the need for a deeper and personal involvement. A WHO study group observed,
in 1989, that community involvement in health (CIH) is essentially a process whereby people, both individually and in groups, exercise their right to play an active and direct role in the development of appropriate health services, in ensuring the conditions for sustaining better health, and in supporting the empowerment of communities for health development. CIH also implies a partnership being established between individuals, community groups and organizations (government and non-government) in planning, operation and control of health activities using local, national and other resources.

From the above flows 'community action for health', which, in effect, lays emphasis on individual and group action side by side to attain an acceptable level of health of both the individual and the community.

The attempt here is to assimilate what is community action, what are the key factors which facilitate or hamper such community action, and how to deal with them; and not to come up with specific and explicit definitions for these.

2. ENTRY POINTS FOR COMMUNITY ACTION FOR HEALTH IN SOUTH-EAST ASIA

The recent trends in political and socioeconomic systems and disease epidemiology in SEAR countries had a profound effect on community action for health. Generally, there is a genuine desire among people to participate in, and contribute towards, overall health development. The entry points for community action for health vary from country to country. The process of development of CAH is a continuous one with several entry points, based on experiences gained in implementation within each country and elsewhere.

It can be identified from the experience of SEAR countries that there are two main areas of entry points in regard to CAH, viz., health or health-related development, and social development with health as an integral part.

2.1 Health

Many health development schemes in the countries of the Region are initiated and supported by either government and/or nongovernmental organizations (NGOs), utilizing community health volunteers in both rural and urban areas; some of them have resulted in successful experiences in strengthening community action for health.

Health committees have been established at the neighbourhood, ward and village levels in urban and rural areas for planning, coordination and implementation of health activities. Their effectiveness depends on many factors such as pattern of administration, decentralization of authority and responsibility, support from within and outside the community, process of selection of priorities and political power structure that prevailed at the local level. The capability of the local leadership and the strength of the local administration at the village/community level form the key for success or failure of community-based activities.

Another feature of promoting CAH is the involvement of mothers groups/mothers clubs in organizing activities in support of family planning, maternal and child care, and prevention and control of diseases affecting them.

Drug cooperative schemes managed by the local community helped in providing cheaper and effective essential drugs at the doorsteps of the community simultaneously ensuring the quality
of care. Such schemes have been initiated in several countries such as Indonesia, Myanmar, Nepal and Thailand.

The active involvement of sex workers, community support groups, religious leaders and NGOs, in collaboration with the Governments of India, Myanmar and Thailand, in the prevention of epidemics of AIDS/HIV infection recently is another example of entry points for CAH.

To cite, the "Little Doctor" or "Dokter Kecil" programme of Indonesia trained school children to serve as prime movers and motivators for changes, promoting better health in the school, the home and the community. Child-to-child and child-to-family education programmes are the other useful entry points.

Community health volunteers (CHVs) have been utilized as valuable human resources for health development providing information on health promotion and disease prevention, simple curative care for common diseases, and appropriate care during pregnancy and childbirth. In most countries, CHVs have contributed significantly to national health development efforts. The profile of CHVs as well as their training, duties and responsibilities vary from country to country.

Implementation of integrated health care packages at the service delivery points has strengthened CAH. The packages improve access of the local community to health care and also provide mechanisms for functional integration and fora for frequent interaction between community and health care works facilitating a sense of partnership and providing supportive environment for community action. Better results in health care coverage and equitable health status can be achieved through packages addressed to women and children who require frequent contacts for various health interventions, such as immunization, maternal care, family planning, nutrition education and growth monitoring, diarrhoeal diseases, ARI control, etc.

Young or old, government or non-government, political or non-political, individuals and community are motivated and fully involved for action on mass health-related intervention campaigns such as promotion of mass sports, mass campaign for no-smoking, awareness of drug abuse, control of pollution, accident prevention, campaign for anti-alcoholism, etc.

Different modalities have been initiated by Member States for alternative health care financing, such as creating capital and revolving funds, initiating cost-sharing or health insurance schemes, establishing subsidized pay-for-service or health cards for the poor, etc. However, these initiatives are still in the developmental stage and need further review to replicate on a wider scale.

2.2 Social Development

Progressive improvement in living conditions and the quality of life enjoyed by the society and shared by its people that will lead them to an economically productive and socially satisfying life, is the ultimate goal of development. Only when people have an acceptable level of health can individuals, families and communities enjoy the other benefits of life. Based on this concept, initiatives for social development, with health as an integral part, are undertaken in all SEAR countries. These initiatives usually focus on certain areas such as literacy, housing, income generation, employment for poor, etc. The following are a few examples of such large-scale social development which are being used as entry points for community action for health.
The Family Welfare Movement (PKK), a network of women’s organizations in Indonesia, extends from the national level to the village level, with the objective of improving the status of women and their families. Health and health-related intervention activities at the community level are usually organized through these women’s groups supported by volunteers, in partnership with health workers.

The basic minimum needs (BMN) approach for improving the quality of life has been used in Thailand as part of its national socioeconomic development plan. To bring effective intersectoral action for health at the community level, four major ministries, i.e. Agriculture and Cooperatives, Education, Interior and Public Health, jointly provide support to this strategy. A mechanism has been developed to enable local communities to assess their situation in respect of basic minimum needs indicators, identify problems, discuss possible solutions and prepare their own plans. Solutions which cannot be implemented at the local level by the people themselves are negotiated with the local authorities and technical and financial support is provided.

Poverty alleviation programmes, addressed to urban and rural poor, have been initiated in many countries such as Bangladesh, India, Indonesia, Nepal, Myanmar, Sri Lanka and Thailand. These programmes aim at alleviating the poor from the trap of the vicious circle of poverty, malnutrition, disease and despair that saps their energy, reduces their work capacity and limits their ability to plan for the future. Health is usually put as an integral part of these initiatives. The success of Grameen Bank in Bangladesh has shown women as the most effective point of entry for an improved standard and quality of living. Improved nutritional and health status of the community is seen as a benchmark for further investments. The programme involves the people in a long-term learning process through participatory efforts and joint experiences. People gradually build up their own organizational and managerial skills and knowledge, enabling them to foster a sense of solidarity and self confidence.

The Poverty Alleviation Programme (Jana Saviya), launched in Sri Lanka since 1989, is another social development initiative. The programme is targeted initially to the poorest of the poor by providing them access to resources so as to initiate income-generating and health development activities. The process is initiated in such a way as to transform them from being mere survivors to prime movers in their own development. Health is an integral component in the Jana Saviya Movement, with priority attention being given to underprivileged children, pregnant women and lactating mothers.

3. KEY FACTORS IN PROMOTING COMMUNITY ACTION FOR HEALTH

From a review of the many examples from SEAR countries, the following important key factors in promoting community action for health emerge:

3.1 Sustaining Political Commitment

In countries where substantial progress in community action for health is seen, political commitment for involving the people in the frame of equity and social justice is clearly reflected in their national health policies and health programmes. The policy statements are translated into strategies with broad guidelines of action, with adequate resources. In some countries, institutional focal points in community participation are established in the national health
management system. Commitment is maintained through regular follow up, monitoring and evaluation. These efforts have contributed to further development of CAH schemes.

3.2 Decentralization

In most of the countries, appropriate administrative and organizational mechanisms have been established for effective administration and management at the local level aimed at accelerating the process of social development. These mechanisms also ensure active involvement of the community at various stages of development. Local community representatives and officials representing different sectors undertake decentralized planning to respond to the local needs. This planning process creates the potential for coordinating inputs of different sectors, maximizing the use of available resources, avoiding duplications and gaps. It is seen that planning and implementation by local-level development committees has generated tremendous impetus for community action. Strengthening the capacity of leadership role of local bodies has resulted in further progress in development. Delegation of financial responsibilities is another fillip to local management capabilities.

3.3 Promoting Leadership Role of Health Care Personnel

Health care personnel at all levels have either been trained or reoriented on new interventions such as oral rehydration, multidrug therapy, immunization, safe motherhood, and other child survival intervention activities. They are also oriented on how to work with communities. The leadership role of health care personnel is an important function in the success of CAH. Their training provides them with the commitment, advocacy and courage to undertake challenging tasks in harmony with the communities - sharing the knowledge and skills in a partnership pattern.

3.4 Enhancing Community Awareness, Organization and Leadership

Increasing community awareness and creating active and effective mechanisms for community organization have been used and continue to be valid as main strategies of health and social development programmes in the Region. The level of awareness of the community in respect of knowledge, attitude and practices on promotion of health, prevention and care for common health problems, is an important key factor for CAH. Community awareness is linked to the availability of information and the level of literacy, particularly among women who play an important role in health care, to the family and the community.

By 1990, most SEAR countries had achieved adult literacy rates of over 70 per cent, whereas some are still below the global target of 50 per cent. There is also a marked gender literacy gap. With the global Education-for-All initiative, most of the countries have initiated the universal primary enrolment programme and the adult female education campaign. These will have a potential impact on the enhancement of women's status by equipping them with basic knowledge and skills. In most countries, increased efforts are also on to strengthen and improve education for health so that the community is well informed about the interventions and their advantages.

Other means of conveying information on health and health development are also important. Technological advances in communications, increasing availability of communication facilities, such as radio, telephone, television, video machines, satellite TV, speed post, letter publication media, improved means of transport and construction of roads, inter-city mobility, etc., will bring information on health much more readily and rapidly to people, and this will help in improving health and in increasing accessibility to health care.
In this context, the role of NGOs assumes increasing importance, particularly in view of the limitation of governments to cope with the total health needs of the unserved and the underserved population. There are many successful examples of community health programmes in which NGOs and/or other voluntary groups have collaborated with government agencies and the local community by being actively involved in policy formulation, planning, implementation and evaluation of health and health development programmes.

The NGOs function in almost all countries of the Region, and most of them have an independent entity. India has more than 6,000 NGOs, and Bangladesh has more than 400 functioning in the health sector alone. Indonesia, Nepal, Sri Lanka and Thailand also have NGOs active in the health sector.

NGOs generally have greater flexibility and freedom to experiment and innovate. NGOs, such as professional and social associations and societies, service institutes, research societies, etc., have a higher degree of technical expertise and accountability. Their service is more geared to assist the decision-making process, rather than to direct involvement in the community action for health. Voluntary NGOs emerge for a social cause and the main aim is to reach the unreached. Their uniqueness, creativity and willingness to work in remote and difficult locations give them more credibility.

They work closely with the community and thus understand the community and adapt themselves easily to the local situation. By involving the community for health action, valuable experience is gained, which greatly enhances their potential for providing services to the underprivileged.

The problems faced by NGOs stem from their individuality, their inclination to adhere to their original objectives, their limited area of functioning and uncertainty of funds, which makes it difficult for them to expand the area of their operation.

3.5 Using Multisectoral Approaches

Often, health development is spoken as being inseparable from national development. In this respect, it is important to examine the occasional conflict of interest between health impacts of ecological and environmental issues on the one hand, and economic development on the other. The survival of the human race itself can be jeopardized from the harmful effects of these ecological and environmental crises, such as pollution, deforestation and rapid industrialization. There is no doubt that industrialization is the key factor for economic development. However, balancing these issues is the real challenge.

The term "health" should not be seen from the negative aspects of the term "disease". 'Health service' is mostly understood as taking care of diseases, which is usually identified as the primary responsibility of the health sector. However, the determinants of diseases such as social, economic, political, environmental, personal behaviour and lifestyle, etc., are beyond the domain of the health sector. Others have to share the responsibility. In the light of the limited resources that can be catered from general public sources, the role of ministries of health is vital in advocating equitable sharing of responsibilities with other sectors as well as with the community.

The involvement of all sectors in a joint multisectoral approach for development is more acceptable and attractive for the local population. This could also be observed in such social
development schemes where health was an integral part, such as poverty alleviation and income generating schemes. The trend was also observed in the direction of development of CAH from the purely health initiative to a multisectoral movement. While the multisectoral development approach is extremely important for the promotion of CAH, mechanisms for bringing about different sectors to work jointly are, however, still a challenge in many countries.

4. STRATEGIES FOR STRENGTHENING COMMUNITY ACTION FOR HEALTH

To achieve the universal goal of Health for All in the light of changing and challenging political and socioeconomic environment, all SEAR countries are required to strengthen and mobilize community action for health. The following are some of the most vital strategies:

4.1 Sustaining Political Commitment

It needs to be stressed that sufficient attention should be paid to the implications of changes in the socioeconomic and political arena as well as their consequent effects on health systems. New opportunities, such as the trend for more democratization and decentralization, the shift from drive for pure economic growth to balanced human development with social equity and justice, the trend for restructuring of health systems with concern for cost containment and improved quality and sustainability, etc., which could help strengthen CAH, are opening up in Member States.

All countries are urged to reaffirm their commitment for CAH as a fundamental principle of health development. Sustained commitment should lead to determined action ensuring public policies supportive of peoples' right and duty to involve. Existing health and health-related policies and strategies and plans of action should be constantly reviewed in the context of political and socioeconomic changes and disease transition. Realistic policies and strategies should be evolved to overcome the impediments and enable the community itself to come forward for greater participation and active involvement.

The capacity of the national health system for supporting CAH needs to be assessed and strengthened with appropriate resources. Concrete strategies and plans of action for health development need to be undertaken to bring about CAH. Monitoring and evaluation based on clear indicators is required as an integral part of broad planning. Priority attention should be diverted for reaching the services to the underprivileged and the acceleration of existing successful approaches and interventions.

4.2 Strengthening Community Action for Health within the District Health System

Within the overall national health system, the district health unit with a well-defined population is an ideal place for developing and supporting CAH. It includes all health institutions and individuals (government, nongovernment and private) providing health care to the district population, together with health-related sectors.

Decentralized decision-making process at the district level, with the involvement of community representatives, has the potential for mobilizing and coordinating local resources for the preparation of local district-specific plans of action. Improvement of management and performance of health care workers at the district level is essential for gaining the confidence of the local communities.
It also brings them in close contact with the people in their own environment creating conditions supportive for the development of partnership and stimulating community action for health. In order that district health personnel are adequately equipped to cater to the health needs of the population, it is important that they receive appropriate training.

Most countries have been developing policies and plans of action for the development of appropriate human resources for health, and to enhance the capabilities of health care personnel for initiating and stimulating community action for health. There are still some gaps between policy perceptions and performance. The balance and relevance of human resources for health exist in almost all SEAR countries. The role of health workers has mostly remained affiliated to vertical programmes – either health promotion or disease prevention.

The structures, roles and duties of training institutions, including those for the medical profession, need to be reviewed, revised and strengthened with adequate technical expertise and resources, so that their education programmes meet the desired aim of advocacy for health, sensitizing and mobilizing all potential forces in the community, and organizing and supporting communities for action.

Training of health workers, including health volunteers, should be practical and participatory. Field visits for observation and study of innovative approaches within the country should be included in the training. Community-based education should be incorporated in the basic training of all categories of health workers. National training institutes and WHO collaborating centres and NGOs need to be involved in the development of training programmes, including training materials.

4.3 Empowering the Community for Action

Empowering the community, enabling itself to take care of its own health needs, is a long-term learning process. Results might not be achieved overnight; however, gains are more lasting and do contribute to overall community development.

An essential prerequisite for sensitizing the community for action is to build awareness of various options for health activities by the community. Health personnel may use various communication methods and channels to disseminate the alternatives. “Awareness creation” deals with the value judgement of the individual as well as of the whole community. Peer pressure for accepting health intervention is more important than interpersonal communication.

The community has to be motivated by showing the positive and negative impacts of various interventions to deal with major health and health-related problems faced by the community. They are also to be shown how to plan, implement and evaluate these through the “learning-by-doing” process.

Sharing and exchange of experiences between the communities alike is also an important step for increasing awareness. The TCDV (Technical Cooperation among Developing Villages) programme of Thailand is trying to achieve such approaches.

In most cases, people in most need, i.e. the poor, women and children, are usually less organized and less vocal. For CAH to be more lasting and productive, an appropriate administrative mechanism and organizational arrangement should be established, ensuring representation by different community groups. It has to be built around the usual networking in the community.
and not be imposed from outside. The important role of women in health and development needs to be ensured and supported.

Training of community leaders and volunteers on management skill, including enhancement of their leadership role, is required. Health care personnel have to change their usual role of service provider to that of facilitating and advisory role for community efforts and to support them in undertaking collective responsibility for planning and implementing local health initiatives.

It has been recognized that given the commitment and the role of NGOs and other community organizations, there is a crucial need for real partnership between them and the Member States in order to achieve the goal of Health for All. NGOs should be encouraged and supported to sustain their commitment to the implementation of the strategies for HFA and to establish appropriate coordination mechanisms at the grassroots.

Public development programmes, including health, should be so oriented as to encourage the formation of more NGOs and other community organizations. They should exploit as much as possible the positive attributes of NGOs, especially their uniqueness on social cause, creativity and ability to work in hardship conditions.

4.4 Linking with Other Development Sectors

The development of community action for health is more effective by linking it with broader action for social initiatives in a coordinated effort. This approach is more appropriate as it addresses a wider context of essential basic needs of the community such as water supply, sanitation, health, education, food production, employment, income-generating activities, etc. Health workers have to be aware of the activities being carried out in other sectors in the same locality and elsewhere and be able to identify entry points that can be linked with health action.

Decentralized planning and management of development programmes, including health at the district level, with full involvement of community representatives at all stages, is more likely to bring together linkages for broader social development approaches. National policy and directives should be supportive in strengthening mechanisms for the coordination of sectoral activities for joint actions.

The trend for decentralization in health management with delegation of responsibility and authority from the centre to regions and districts is already widespread in most SEAR countries. This process, which has been taking place in some countries, has made it possible to reshape the existing health information systems leading to better planning and management at the local level. However, a similar process is necessary in other developmental sectors for better results.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

Even after the implementation of various health policies and plans based on HFA/PHC principles with considerable success, it is realized that there are still some gaps in achieving the health status in different countries and even in different areas within the countries. The experience of countries has shown that only through active involvement of the people and genuine support for CAH will it be possible to achieve the goal of HFA, in the frame of equity and social justice. Keeping this in view and in the light of the above discussions, a number of possible actions can be suggested with respect to effective community action for health.
5.2 Recommendations

(1) **Review and advocacy for HFA and PHC**

In the light of the changing political and socioeconomic scenario and the epidemiological transition prevalent in Member Countries, constant review and advocacy for its continued commitment for Health for All and primary health care is the need of the hour. Priority attention should be paid to health activities targeting the underprivileged population. The policies and directives should also provide an appropriate administrative and organizational mechanism for improving the planning and management capability of the local community.

(2) **Improving planning and management capability**

The strengthening of district health systems is essential for improving the planning and managerial capability of local-level health managers enabling them to better manage health activities within limited resources. Towards this endeavour, health care interventions need to be modified to suit local conditions as much as possible, at the same time not losing the quality of health care, in order that the procedures are simplified. Also, it is pertinent that supervisory and support mechanisms within the district health systems are strengthened to improve the performance of integrated health care packages. The establishment of an appropriate information system sustainable at the local level is equally crucial for improving planning and managerial capacity at the district and below.

(3) **Undertaking In-depth case studies**

It is felt expedient that in-depth case studies for strengthening CAH need to be undertaken, with particular reference to the emerging areas of concern, such as community organization, alternative sources of health care financing, improvement of local planning and management (including local accountability), and appropriate transfer of technology.

(4) **Facilitating effective collaboration with NGOs**

It has been recognized that NGOs and other community organizations have to be in real partnership between them and the Member States in order to achieve the goal of Health For All. Mechanisms facilitating effective collaboration between them should either be established, strengthened or reviewed so that coordinated efforts can accelerate community action for health. Public development programmes, including health, should be so oriented as to encourage the formation of more NGOs and other community organizations and be able to exploit the positive attributes of NGOs as much as possible.

(5) **A fresh look into new ways of analysing problems**

The present concepts and strategies of PHC and HFA still remain valid. However, a fresh look into new ways of analysing health problems, types of expertise and organizational structures, mechanisms for interacting with other agencies and scale of global actions, is necessary. The support of UN and bilateral donor agencies will enhance the potential of Member Countries in the process of health development.

(6) **Mobilizing international technical and financial assistance**

The mobilization of international technical and financial assistance should be relevant to national health policies and programmes of Member Countries. Coordinated efforts should be made to equip governments with the capability to absorb and assimilate donor-supported activities within their set national developmental aims and activities.
WHO should enhance its leadership role in its advocacy of PHC and HFA concepts and principles. WHO, its Member Countries and the international community should continue to monitor the outcome of the efforts of achieving HFA/2000 and beyond, and be prepared to assist the countries most in need. WHO should coordinate with the international community in facilitating the dissemination of information, exchanging of experience on community action for health in strengthening planning and managerial capabilities, developing appropriate methodologies and implementing health programmes.

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