HEALTH DEVELOPMENT STRUCTURES IN DISTRICT HEALTH SYSTEMS:

The Hidden Resources

Division of Strengthening of Health Services
World Health Organization
1994
HEALTH DEVELOPMENT
STRUCTURES IN
DISTRICT HEALTH SYSTEMS:

A Multi-country Study of
Situations, Problems and Prospects

*Summary and analysis of study reports submitted by Principal Investigators*
ACKNOWLEDGEMENT

This multi-country study was supported with funds provided by the Danish Development Agency (DANIDA).
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1 INTRODUCTION

1.1 Background to the study

There is wide agreement that strengthening district health systems (DHS) is the most appropriate way to promote primary health care. This allows decision-making and support to be brought as close as possible to the implementation level and permits analysis of needs and adoption of solutions that can be applied to a defined area and population. A district health system consists of three main interrelated components which are: Health Service Facilities (HSF), Health Service Management Structures (HSMS) and Health Development Structures (HDS).

Health Service Facilities

- District hospitals
- Health centres
- Health posts
- etc.

Health Services Management

- District Medical/Health Officers
- Heads of health centre
- Heads of health posts
- etc.

Health Development Structure

- District councils, district development committees, district health committees, etc.
- Subdistrict councils, committees, etc.
- Village councils, committees, etc.
- Special purpose (interest) bodies at the various levels of districts, such as women’s, farmers’, labour, etc. councils.

While HSFs and HSMSs have been the subject of considerable study, HDSs are relatively recent and have not received due attention in the Health for All literature, despite their proliferation. For example, it has been reported that almost all of the 4,000 or so districts in the African Region of WHO have health committees which are sub-committees of district development committees (WHO, 1989).

The purpose of this multi-country study was to describe and analyze HDSs within the DHS in several countries and assess their actual and potential contribution to health development within these systems.

HDSs, which are usually formed as part of a decentralization of the health system, often take the form of health/development committees, councils or boards. In addition to these officially formed HDSs, in many districts, other groups and organizations have direct roles in health or health-related development. HDSs may include development committees, health committees and councils at district,
subdistrict and village levels and special interest bodies at various levels of districts, such as women’s, farmers’ or youth councils.

A planning meeting for the above study was convened by WHO in Geneva from 25 February to 2 March 1993, and attended by principal investigators and resource persons who would contribute to the study. General guidelines for the studies were produced during this meeting. The idea of general guidelines was to define common features to allow comparison between countries. These guidelines, however, allowed for variations in the individual countries studied so that local conditions could also be reflected.

The principal investigators and resource persons met again in October 1994 to finalize the report and agree on the key conclusions to be drawn from the study.

This report summarizes the separate country reports, draws out common themes and provides an analysis of the situations, problems and prospects of district health development structures.

1.2 Research problem

Health development structures have received little serious attention in the Health for All literature. It is not known to what extent communities in various countries are involved in these structures generally. It is likely that in some instances such structures can strengthen community representation, in others they can further marginalize the poor and powerless in terms of their contribution to health development. The lack of knowledge about the precise operation of HDSs suggested a need for information on the formation, composition, representativeness and functioning of these structures in relation to health development.

1.3 Objectives of the study

The general objective of the study is to describe and analyse health development structures within the district health system in several countries and assess their contribution to health development within these systems.

The specific study objectives of the individual countries vary depending on the focus of the study in each country.
2 STUDY PROPOSAL

The individual countries' study proposals were framed within the design produced at the Planning Meeting in Geneva. However, the emphasis of this study varies from country to country. These variations can be found specified in the summaries of individual countries' study reports in part 3.

2.1 Backgrounds

2.1.1 Countries and study districts

The study was conducted in eight countries (Colombia, Indonesia, Jamaica, Nigeria, Philippines, Senegal, Sudan and Yemen) from five WHO Regions (AFR, AMR, EMR, SEAR, and WPR). In addition, this summary includes a study on a very similar subject conducted in Tanzania in 1991. The titles of individual country studies and of principal investigators and resource persons are listed in Annex 1.

Table 1 provides details of the study in terms of the regions studied, its population and whether it is urban or rural. The population of the countries varies from less than 3 million (Jamaica) to 180 million (Indonesia). The population of the study areas varies from 30 000 (the smallest of seven municipalities in Bulacan in Philippines) to 6 million (Kennedy area in Bogota, Colombia). There were three urban (Kennedy area and Barranquilla in Colombia, Zone 6 in Kingston & St Andrew in Jamaica) and seven rural (Blitar in Indonesia, Santa Cruz in Jamaica, Odogbolu in Nigeria, Fatick in Senegal, Getaenna in Sudan, Dhamar in Yemen and Iringa in Tanzania) study areas. In the Philippines' study the seven municipalities selected in Bulacan Province includes both rural and urban areas.

2.1.2 Description of health service decentralization and HDS selected by each study site

In Colombia health services have been decentralized since legislation was passed in 1990. Through the process of decentralization, about 1000 municipalities were officially created. By 1993, however, only 14 of these municipalities had received certification for functioning as decentralized health organizations (local health systems) with political, fiscal and administrative autonomy.

Through 1990 legislation participation in health service organization decision-making at all levels was give to the Committees of Community Participation (CCP). Colombia's study concentrated primarily on these CCPs, but it also looked at Local Community Councils, Inter-institutional Committees and the Southwestern Autonomous Committee.

Indonesia has a sophisticated and well-developed system of health service decentralization. The main health development structures are: women's organizations (e.g. Family Welfare Movement), Village Community Resilience body, Dasa Wisma volunteers and health cadres (e.g. Posyandu programme). From these HDSs Indonesia included the following in the study: Village Community Resilience Body, Family Welfare Movement and Posyandu and Health Cadres.
### TABLE 1: Populations, study areas and types of community in individual countries

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>POPULATION</th>
<th>STUDY AREA(S)</th>
<th>POPULATION</th>
<th>RURAL OR URBAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLOMBIA</td>
<td>30 million</td>
<td>Kennedy area</td>
<td>1.5 million</td>
<td>Urban</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Barranquilla</td>
<td>500 000</td>
<td>Urban</td>
</tr>
<tr>
<td>INDONESIA</td>
<td>180.4 million</td>
<td>Blitar</td>
<td>1 million</td>
<td>Rural</td>
</tr>
<tr>
<td>JAMAICA</td>
<td>2.4 million</td>
<td>Kingston / St Andrew</td>
<td>660 000</td>
<td>Rural</td>
</tr>
<tr>
<td></td>
<td></td>
<td>St Elizabeth</td>
<td>145 000</td>
<td></td>
</tr>
<tr>
<td>NIGERIA</td>
<td>90 million</td>
<td>Odogbou LGA</td>
<td>182 000</td>
<td>Rural</td>
</tr>
<tr>
<td>PHILIPPINES</td>
<td>62 million</td>
<td>Bulacan (7 municipalities)</td>
<td>1.6 million</td>
<td>Rural/Urban</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(30 000 - 140 000)</td>
<td></td>
<td>Urban</td>
</tr>
<tr>
<td>SENEGAL</td>
<td>7 million</td>
<td>Fatick District (4 arrondissements)</td>
<td>200 000 (rural)</td>
<td>Rural</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2 municipalities)</td>
<td>20 000 (urban)</td>
<td>Urban</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(13 rural communities)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUDAN</td>
<td>25 million</td>
<td>Gataenna (5 localities)</td>
<td>75 000</td>
<td>Rural</td>
</tr>
<tr>
<td>YEMEN</td>
<td>11.6 million</td>
<td>Aanis District</td>
<td>190 667</td>
<td>Urban</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wassab Assafel District</td>
<td>111 645</td>
<td>Rural</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Dhamar Province)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TANZANIA</td>
<td></td>
<td>Iringa Region (10 villages)</td>
<td></td>
<td>Rural</td>
</tr>
</tbody>
</table>

**Jamaica** has a somewhat decentralized health system, particularly primary health care, and is guided by a health policy which is reviewed every five years. Their HDSs were classified in three main groups:

1. **Public sector** (ministries, parish councils, district health management teams, hospital boards, training and financial institutions, Bureau of Women’s Affairs).
2. **Private sector** (private sector organization, council for voluntary social services, health insurance companies, religious organizations).
3. **Community groups** (community health committees and councils, neighbourhood watch, citizens associations, local disaster preparation committees, friends of hospitals and health centres).

The Jamaican study compiled an inventory of the main health development structures in each study area (health district) and then selected four of these for detailed study. In the Santa Cruz area they selected the Glenco Citizens Association and the Southfield Community Health Committee in that district. In Kingston/St Andrew they selected the Gordon Town Disaster Preparation Committee and the Blue Mountains Health Committee.
Nigeria has a national health policy which identifies PHC as the cornerstone of the country’s health system. For this study the researchers identified five main groups of HDSs:

1. Government PHC structure;
2. Non-governmental organizations with some relationship with the government;
3. Religious organizations and youth clubs;
4. Touts and beggars; and
5. Schools.

A purposeful sample of identified active structures was selected for inclusion into the study.

The Philippines’ health system was decentralized in early 1993; the hospitals to the provincial governors and rural health units to the municipal and city mayors. This study concentrated on municipal health boards and provincial health boards.

In Senegal the health system has been decentralized as part of the administrative reform adopted in 1972. At the time of the study there were 45 health districts. The study concentrated on non-formal and non-governmental organizations. Researchers asked the heads of rural development centres in the study area—Fatrick—to list all the associations in the study area that could have an impact on health. 550 relevant associations were selected. From these a sample of 300 was chosen. Six groups were identified from the associations: Women’s Development Group, Sporting and Cultural Association, Economic Interest Group, Parents and Pupils Association, Committee for Management of Wells, and others.

The Tanzania research was conducted as part of a study on Village Health Committees and Village Health Workers. The activities of these are very much concerned with health development so it has been decided to include the research in this current analysis.

In Yemen in the 1970s, the local cooperatives played a decisive role in overall development including health. It has its root in the Yemeni culture and every person in every village participated in his local community development. This study is conducted at a time when revitalization of the Local Cooperative Committees (LCC) is considered.

Since 1992, health system in Sudan is based on the Health Area System (HAS). Getaemma Health Area was selected for this research because HAS policy had already started there and it represents a rural setting with settled population and high literacy rate. Three main categories of HDS were identified:

1. District or rural councils and their sub-committees;
2. Youth and women organizations; and
3. Popular committees in the villages.

Each of the study countries selected different HDSs as the focus of their research. This in part reflects the differing definitions used by the researchers in the field, but also reflects the different health systems and local conditions in the study. The Indonesian, Philippine, and Tanzanian studies focused on local structures established by the central government. The Sudan, Senegal, and Jamaica studies concentrated on local health action groups, as well as formal organizations that are outside the
"official" health system. The Nigerian study included formal government, non-government and community organizations and groups such as beggars who are unorganized.

2.2 Study designs

2.2.1 Introduction

The research is based on a number of studies conducted in different countries. A principal investigator was appointed in each country and he/she worked with a research team that consisted of people with a stake in local health development. Visiting resource persons supported principal investigators and their teams.

2.2.2 Core research design

The research design is based on a case study methodology that allows the compilation of a detailed and comprehensive picture of the pattern of formal and informal organizations, networks and opportunities for collaboration and participation in working for health development within the district health systems (WHO, 1994).

2.2.3 Focus of individual countries' studies

The HDSs studies within each country are described in 1.2 above.

2.3 Methodologies

2.3.1 Data collection and methods of analysis

Data were derived from three main sources: written documents (policies, service plans, minutes of key meetings, etc.), interviews with key informants (local people, health service personnel, etc.) and mapping of collaborative links for health development within the district using the key informants involved in health development structures to ascertain the perception of patterns between various entities. Direct observations and participation in meetings, workshops, and other activities undertaken by the structures were carried out during the study period. Focus group discussions were also used to clarify specific issues.

2.3.2 Description of data collected in each country

All countries used existing data to describe the features of their chosen study area. Interview schedules or self-completion questionnaires were used to collect data on the functioning of the HDSs and the activities and perceptions of the people involved in them about the effectiveness and potentials of the structures. Most countries also analyzed relevant policy documents. A summary of the research methods used by each country is provided in Table 2. The studies differ in the extent of data collected and level of analysis performed.
| Country and Study Area | HDSs Studied                                                                                           | Type of Data Collected                                                                                                                                                                                                 |
|------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------Adam
<p>| COLOMBIA               | Committee for Community Participation (CCP) and their Local Community Council (in Kennedy and SWZ)     | Existing descriptive data and analysis on study areas; survey of members of the committees and SWZ; self-completed questionnaire (CCP = 70, Health Workers = 103, IIC = 40, excluded neighbours = 19); SWOT analysis of the committees was conducted; focus groups = 8, meeting observations = 20. |
| Barranquilla-Southwestern Zone (SWZ) | Southwestern Autonomous Committee (SAC, NGOs); Interinstitutional Committees (IIC)                     |                                                                                                                                                                                                                     |
| INDONESIA Blitar       | National government established HDS; Family Welfare Movement (PKK); Village Community Resilience Body (LKM); Posyandu (integrated community health post). | Existing data in the study area, review and analysis of all relevant documents, 11 focus group discussions with people from (1) health sector, (2) non-health sectors, and (3) community key persons in district, subdistrict and village level, field observation. |
| JAMAICA Santa Cruz     | Glenco Citizen Association; Southfield Community Health Committee; Gordon Town Disaster Preparedness Committee; The Blue Mountain Health Committee. | Inventory of HDSs in the study health districts/zones were made. From these, four well-functioning HDSs were selected and interviews held with key people associated with these. Documentation on these HDSs were also examined, focus group discussions held and several of their activities observed. A data collection instrument was used to record information gathered. |
| Kingston/ St Andrew    |                                                                                                         |                                                                                                                                                                                                                     |
| NIGERIA Odogbolu LGA   | Government PHC Management Committee; community development councils (apex organizations for district development committees and village development committees); Better Life Programme (women's organizations); social clubs/youth organisations; religious organizations; cooperative societies; NGOs; schools; beggars and motor park touts. | Existing descriptive data on study area; review of all relevant policy documents; census of the development structures; five interview schedules exploring aspects of HDS (N = 157); focus group discussions to clarify information from interviews. |
| PHILIPPINES Bulacan    | Government run health boards; municipal health board and provincial health board.                       | Existing descriptive data on study area; interviews with key people associated with health boards (N = 40).                                                                                                                                                                      |</p>
<table>
<thead>
<tr>
<th>Country and Study Area</th>
<th>HDSs Studied</th>
<th>Type of Data Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>SENEGAL Fatick District</td>
<td>Information associations; 6 types were identified; women’s development groups; sporting and cultural associations; economic interest groups; parents’ and pupils’ association; committee for management of wells.</td>
<td>Existing data on the study area; analysis of policy documents; census of all HDS by heads of rural development centres; 300 out of 550 associations listed were studied; interview schedule was developed and used with officers of the associations.</td>
</tr>
<tr>
<td>SUDAN Getaenna</td>
<td>District or rural councils; youth and women’s organizations; popular committees in the village.</td>
<td>Existing data on the study area; key informants (N=104) identified; interview schedule was developed.</td>
</tr>
<tr>
<td>YEMEN</td>
<td>The local Development Associations (LDAs) in two districts of Dhamar Province (1 urban district—Aanis and 1 rural district—Wassab Assafel)</td>
<td>Questionnaires were developed for the LDAs, for health staff in the area and other sectors (agriculture, education, housing); focus group discussions.</td>
</tr>
<tr>
<td>TANZANIA Iringa</td>
<td>Village health committees; village health workers.</td>
<td>Existing data on the study area; multi-stage sampling to select villages (N=10) within divisions and wards; in each village 20 key informants were interviewed; in 5 wards 4 PHC committee members were interviewed.</td>
</tr>
</tbody>
</table>

3 IMPLEMENTATION OF THE STUDIES IN COUNTRIES

3.1 Progress reports

The Principal Investigators involved in this study project agreed to submit progress reports each month on their studies to WHO/HQ. The purpose was not to report progress on research findings but to keep in touch and to let WHO know what activities had taken place.

The Principal Investigators or Resource Persons were adhering to this recommendations to various extent. The most active ones reported three to four times during the study, most others reports one to two times. The extent of report varied as well. Some of them were actually preliminary results, however, most gave short information about activities which were completed on the field.

Although most of the countries involved were not able to submit their final report by the end of 1993 as originally planned, all but one submitted its final report in the beginning period of 1994. Yemen’s report was delayed until August 1994 (due to the difficult political situation), but still in time to be included in the analysis. As far as multi-country study experiences go, the 100% reporting with such relatively short lag time is considered very good.
3.2 Summaries of the final reports

3.2.1 COLOMBIA

Colombia submitted the final study report to WHO/HQ in January 1994, titled "Negotiation structures within the decentralization process of health in Colombia". The two case studies presented were:

Case I: Kennedy Local Health System, Bogota
Case II: Southwestern Zone LHS.1, Barranquilla

In Colombia decentralization of health services began in 1990 after the relevant legislation was passed. Through the process of decentralization, about 1000 municipalities were created. However, by 1993 only 14 of these municipalities had received certification for functioning as decentralized health organizations (Local Health Systems) with political, fiscal and administrative autonomy. Committees of Community Participation (CCP) had responsibility for ensuring participation in decision-making relating to health services.

Case I: Kennedy Local Health System, Bogota (See Table 3)

The Local Administrative Board is in charge of the local government of Kennedy. Two councillors who are integrated with it, are from the neighbourhood and locality, elected by the direct vote of the inhabitants. The local Mayor is appointed for a period of three years and has restricted financial authority.

The Kennedy Local Health System (LHS) has adopted a strategy which aims to integrate the health system. It has three components: health services to people and the environment, social participation and interactive management. The LHS financing remains with the District Secretary of Health.

Committees of Community Participation (CCP)

In 1989 the Committee for Community Participation were established and superseded the existing committees in all of the Primary Attention Units (PAU). The expectation was that the community organizations would strengthen themselves and enter into a process leading to co-partnership with the health services. This did not seem to happen because the centralist structure of the state left no space for cooperative management. Later in 1990 the Law 10 established decentralization and the representation of the CCP on the Board of Directors in the Health Organizations.

The Local Community Council is formed with the representatives of each CCP (1 from the community and 1 is the director of each PAU). They have two or three meetings a month, involving an average 32 members of the community, plus health officials, town councillors and the Local Mayor.

Composition and representation

In Kennedy LHS, there are 11 CCPs that relate to the Primary Attention Units. CCPs consist of community representatives and the medical director of a health organization. In many cases the Primary Attention Unit coverage extends to the neighbourhood where it is located, so many of the
neighbourhoods that should do not, in fact, have representation. The functions of the CCP cover health planning, environmental surveillance, negotiations with other sectors, assessing public opinion and encouraging training and research to assist decentralization, improve community participation. They do not have administrative or legal power. They are consultative bodies. The CCPs are designed to be representative of different organizations that interact in a particular area including the political and administrative sector, health services, education, the church and users of health services.

Work methods and resources

Each CCP of the Primary Attention Unit has a meeting once a month. Some have more active members than others. They have a strong institutional presence in the locality and the vision and ability to respond to local issues associated with health services.
Development of a health plan

The report describes the role of the CCP and the LCC in developing a health plan for the Kennedy area. The impetus for a health plan came from the Director of the LHS in 1992 when an overall development plan for Kennedy was being prepared by the local government. The plan was based on technical information and public opinion. Key health issues identified by the community were: the need for better security from the police; the development of roads and footpaths; improvement in basic sanitary services, including enclosing of sewers, garbage collection; and better and more accessible medical services. The budget required for the desired reforms was the equivalent to 40% of the total budget for the area. The CCP played a role in negotiating an allocation of 17% of the budget. This included some allocation to community development. The researchers believe the process was significant because it was the first example of participative planning in the Kennedy area.

Other collaborating structures

In order to develop coordination between organizations, an Interinstitutional Committee has for eight years attempted to unite organizations from all sectors. However, even though the institutional activity is extensive, the coordination is not.

Inhibiting factors in interinstitutional coordination were identified by the researchers as:

1. Various institutions in the local area have different degree of decentralization
2. Institutional jealousies
3. The lack of commitment of the officials, partially because of unstable employment.

The lack of coordination produces overlapping service provision and training in some sectors.

Case II: Southwestern Zone LH 1, Barranquilla (See Table 4)

In Barranquilla a decentralized system of local government based on Local Community Boards failed to operate successfully. In 1993 an alternative model, based on Local Administrative Centres (CAL), was established to coordinate local development and participation. A committee for participation and development was established in each CAL. The intention is to get government closer to the people and their needs, however to date much work remains to be done.

The Metropolitan Administrative Department of Health (DAMESALUD) is the governing body for health policies on the municipal level and in 1992 it became an instrument of decentralization. Dependent on the Head Mayor its objective is restructuring, however, design and execution or assignments of responsibilities, have not been finalized. At the moment of this study, DAMESALUD had not presented an agreement for restructuring the Local Health Systems. All its efforts are dedicated to forming itself and functioning as a decentralized entity. DAMESALUD is committed to the development of Local Health Systems in conjunction with national and municipal organizations.

Community participation is supported from the central level through an office that assesses the functioning and educational programs for the Committee of Community Participation. This office deals directly with the 25 Committees of Community Participation in the city.
Table 4: HEALTH DEVELOPMENT STRUCTURES
SOUTHWESTERN AREA, BARRANQUILLA CITY STUDY (COLOMBIA)

<table>
<thead>
<tr>
<th>Level</th>
<th>Political Administrative Structure (PAS)</th>
<th>Health Services Structures (HSS)</th>
<th>CCP Negotiation Structures created by Law 10/90</th>
<th>NGOs</th>
<th>Interinstitutional Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>PRESIDENT Congress</td>
<td>Ministry of Health</td>
<td>National Committee for Community Participation</td>
<td>(national - international)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GOVERNOR Departmental Assembly</td>
<td>Departmental Secretary of Health</td>
<td>Departmental Committee for Community Participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District</td>
<td>MAYOR District Council</td>
<td>District Secretary of Health</td>
<td>District Committee for Community Participation</td>
<td></td>
<td>Inter-institutional Committee</td>
</tr>
<tr>
<td>Local</td>
<td>Action Community Board</td>
<td>Director of Health Centres</td>
<td>Committees for Community Participation (CCP)</td>
<td>Southwestern Autonomous Committee</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Action Community Board</td>
<td></td>
<td>Neighbourhood NGOs: women's groups; child care; sports; theatre groups; youth groups; mutual aid; cooperatives</td>
<td>Operative interaction with one of outside and institutional Entities</td>
<td></td>
</tr>
</tbody>
</table>

In 1990 an Interinstitutional Committee was established linking 30 organizations operating in Barranquilla. This group's interest was to strengthen the strategy of Primary Attention in Health and adopt it as one of the bases of operation. Community participation was strengthened through proposals formulated by these organizations, by simplifying transactions, establishing efficient programs that improved the credibility of institutions in the eyes of the people, and improved the mechanisms of intersectoral and interinstitutional coordination.

Committees of Community Participation (CCP)

The CCPs in this area were created in 1989. There are 25 CCPs in Barranquilla. Composition and representation: According to the study, the most important presence is that of the Community Action Board, the Neighbour Health Association, professionals and ex-union officials. The church and the educational sector do not have a strong presence. There is direct participation from the community.
Functions can be grouped as follows:

1. Internal administrative and training functions that ensure the committee continues to function.
2. Support to the organized health services to ensure they do not become non-functioning because of the absence of provisions or lack of infrastructure.
3. Organizing the people for health campaigns such as a neighbourhood clean-up project or coping with an outbreak of cholera.

Work methods and resources

In general the CCP uses traditional work methods where those that make the decisions are some of the members of the Board of Directors. Meetings are once a month. The meetings are utilized more for resolving operational problems than for future planning. They make operative evaluations, more because of the demands of the central level, than because of their own motivation, and generally this falls on the medical director or the organized body. Most training is for members of the committee rather than for the community.

Interaction with other levels

As there is no organized Local Health System, the CCP is not able to work with it for the development of this sector of the city. The CCP is not represented on the Community Municipal Council, and there is little communication between them. Because the CCPs have little formal power they are not able to be very effective in encouraging health development in their local area. Most decision-making occurs at the central level and local health services are not organized in any coherent manner.

Southwestern Autonomous Committee (SAC)

The SAC was created in 1990 during a meeting of health groups in Barranquilla. The groups proposed the creation of a network to solve local health problems. The network was to include existing organized bodies, those of the state, and various community organizations that had functioning health stations. In the proposal, there was a provision for the concept of the Local Health Systems and the groups decided to promote this idea under the title of "Health Network, LHS 2000".

Composition and representation

The SAC is an organization of organizations. It consists of 13 organizations, including a Community Action Board, women's committees, housing and cooperative committees. Organizations come from 11 of the 26 neighbourhoods that make up the southwestern zone. Each organization sends delegates to the committee which is the peak decision-making group. Each organization elects representatives.

The central function of the SAC is to promote the development of the "Health Network, LHS 2000" strategy, which would provide integrated health care to the Barranquilla population. Other functions are to offer training to the communities on health management, women and health policies, and community health and healthy municipalities, and develop programs and plans for local development.
Working methods and resources

Organizationally the SAC is divided into four Task Commissions, which are: Environment Health, Political Administrative Affairs, Human Development and Self-financing Commission. SAC has been able to establish participative decision-making. All the people, who are involved in the SAC and its organizations, work on a voluntary basis. The SAC has no resources for its functioning.

The SAC mainly relates to the Interinstitutional Committee. It has had no relations with the Municipal or National Community Council. The SAC is involved in negotiation with the state in relation to two proposals, one which is the "Health Network, LHS 2000" and the other with a proposal for better water distribution.

Neither of these projects has met with much success, for a variety of reasons including lack of commitment from the DAMESALUD (Department of Health), jealousy between institutions, lack of immediate political gain for key officials and the weak institutional position of the SAC.

The effects of the SAC’s work appears to be:

1. Establishment of commitment to the creation of a health network and LHS.
2. Recognition of the concept of planning for development that involves training of the local people and their leaders.
3. The projects associated with housing and the health stations run by the constituent organizations of SAC contribute to health development within the community.

Key participants attitudes towards the HDSs

The Colombian researchers reported on a survey of the attitudes of principle participants in the committees described above. The main findings are summarized here.

State Health officials and the Community Representatives were asked to respond to a survey. Community Representatives and Health officials identified ensuring a sanitary environment and improving the operation of the health services as health priorities.

Most of the respondents in both areas saw improvement in health services and in environmental health issues as the responsibility of levels of government higher up than the local health centres, CCP or local government.

The committee members did not see negotiation with other organizations as a key part of their role. The Bogota CCP members were most likely to see their role as organization, coordination, planning and promotion; the Barranquilla SAC as achieving a sanitary environment and the Barranquilla CCP as collaborating with the PHC services. Training and education was mentioned by all three groups of members.

Many of the committee members reported that much of the energy of the committee had been taken up with maintaining their group, developing collaborative mechanisms, and dealing with problems to do with personal interest, leadership and poor communication and participation. Health officials in both Bogota and Barranquilla identified many problems they had experienced in working with
community organizations. These included perceived apathy, lack of clarity, disorganization, conflict and stagnation.

Concern was expressed about the need for training health officials and the community representatives. Some of the respondents from community organizations believed health officials were not skilled in working with communities and had not developed ways of doing this effectively. The committee members felt they needed training in areas such as leadership, management, health legislation, planning, and human relations.

When asked about the strengths of the committees, the community representatives mentioned attitude (interest, good rapport) first, and after this the organizational aspects and training. The health officials identified training as a principal strength.

The health officials as well as the community representatives identify the principal weakness as lack of economic and human resources. They also mentioned other aspects such as apathy, lack of interest and commitment.

The community representatives identified their principal opportunities as coming from decentralization and management of the budget. the negotiation relating to the LHS 2000 and the Kennedy Health Plan were also highlighted as important opportunities. The health officials identified non-governmental organizations and the community organization and their desires to work together as a key opportunity.

Threats to coordination were seen as the apathy of the population, the absence of training, failure of decentralization policies, lack of resources, and the potential effects of the new legislation in the health sector, that may encourage privatization of health services and so disrupt existing public health services.

Main conclusions relating to health development

The researchers made the following main conclusions:

1. Different actors within the system have different understandings of health. Others are based on health promotion in local communities.
2. Conceptual, technical or organization skills are not available in the local areas to establish a plan for environmental health and to create effective collaborating structures with other levels of government.
3. The health sector, which has the most experience and systematic ideas about health, has not taken the initiative and leadership to devise a plan to improve the environment.
4. Although the collaborative structures are just beginning to develop, they have the capacity to empower the community.
5. The CCP as a collaborative structure does not have sufficient power because not all relevant organizations and sectors in the area are represented. A delegate from the mayor’s office with the capacity for decision-making, has not been part of the CCP because there are so many of the CCPs. The CCPs are advisory and consultative, so their views may or may not be taken into account.
6. The Local Community Council in Bogota is very strong, because it is a network allied to other health organizations giving direct services and it constitutes an alliance between the Community Representatives and the Health Officials.

7. The traditional role of the Community Representatives has been providing and distributing supplies and equipment. This role has begun to evolve to the level of planning.

8. The Community Representatives have received training in self care, taking an active role in programmes and the use of health services. They need more training in dealing with and influencing organizations.

9. The major weakness of the CCPs is their lack of representativeness.

10. The representatives of the community that participate in the CCPs, do not have separate meetings, but always meet with health officials. so, the initiatives of the Community Representatives in research, planning and evaluation are usually sporadic and fragmented.

11. The influence and power of the representatives in the CCPs is small because of their weak contact with the community. Their strength is still based on the close contact with the health service structure. This alliance has resulted in health obtaining extra resources in Bogota.

12. The majority of the health officials are experienced primarily in the areas of clinical medicine. They have much less experience in local development and how it relates to health. Training for directors in health management has just begun. The health officials do not appear to have a coherent and consistent vision for the strategic development of health in their local areas. They are also constrained by the lack of resources.

13. The political administrative structure could have considerable influence over health development since they control the budget. they should be encouraged to develop their technical political judgement more towards health and human development in their local areas.

14. The opportunities for collaboration in Barranquilla are very low because a functioning political administrative structure does not exist.

15. The opportunities for collaboration are drastically diminished at the district, municipal, departmental and national levels, where officials have little contact with the community.

16. The real threats to a coherent and consistent process for negotiation are the centralist tradition, the precariousness of the health budgets and weak interaction with the other development sectors that are related with health.

17. Effects of collaboration in Bogota

The process of collaboration has equipped the representatives of the CCP with more competent skills, knowledge and with the capacity to take action. They constitute an influential group at the issue levels of decision-making in the community. The process of collaboration also provided more competence in concepts, methodologies and management skills related to health promotion for the health officials that were directly involved with it. For the political sector in the local area this process of collaboration in producing a health plan was a learning experience in the planning of resources. The negotiation process also established bridges between these three structures, which previously were isolated. As yet, similar processes of collaboration have not happened at a higher level.
18. Effects of the collaboration in Barranquilla
Apart from the small resources for the support of primary health care services, the
process of collaboration in Barranquilla has had little effect. Services to the people
have not improved. Attention to the environment had no sustainable effects. Effects
on the health structure resulted in health officials beginning a self-teaching process
about negotiating plans and proposals in health.

Recommendations

The main recommendations made by the Colombian researchers were:

1. A campaign should be conducted to inform the different players about the importance
   of health development.
2. Future action should build upon the diagnosis that has already happened.
3. There should be more coordination between state, private and community bodies, and
   sectors such as housing, production, commerce and finance should be involved in
   reducing structural factors affecting health.
4. The committees for community participation should have more power and become
   more representative.
5. There should be more training for health development.
6. The quality of information used for making decisions should be improved.
7. Expectations created amongst community representatives should be met.

Next Steps

1. Action-research to develop skills, instruments and methodologies to promote strategic
   local health planning and managing each structure (HDSs, PAS, and HSS).
2. Action-research to develop strategies in order to ensure that HDS and LHS can
   survive within the new social security and privatization policies.
3. Workshops and publications to improve the knowledge of Colombian HDSs.
4. Development of a National Inventory of HDSs and promote their interactions as a
   network.
5. Development of a network between groups (health workers, NGOs) supporting HDSs
   in the country.

3.2.2 INDONESIA

Indonesia submitted the final study report to WHO/HQ in March 1994, entitled, "Health Development
Structures in District Health systems-Indonesia case study".

The Indonesian case study focused on a description of the functions of:

1. Village Community Resilience Body/Board (LKMD)
2. Women Organization, i.e. Family Welfare Movement (PKK)
3. Integrated Community Health Post (Posyandu), which represents the operational
   activity of LKMD and PKK in the field of health.
These structures are found across Indonesia and were established as an initiative of central government.

**The Village Community Resilience Body (LKMD)**

LKMD is a board or body of, by and for the community in which community participation can be adopted in the development process to synchronize government policies and community demand on the basis of mutual cooperation in all aspects of life covering ideology, politics, economic, social cultural, religion and security.

The objective of LKMD is to assist local authorities at village level to encourage and stimulate the community's participation in the development process. The members of the LKMD are people living in the village. The LKMD Board consists of about 10 people which represents the informal leaders such as religious leaders and professional leaders such as teachers.

The LKMD is able to plan and implement the village development including health development. It works through the activities of Integrated Community Health Posts (Posyandu), Village Drug Store, Community based Health Insurance, etc., and programmes such as latrines and the provision of clean drinking water.

The members of the LKMD are volunteers. Limitation of knowledge, education and skill of the Board, as well as spare, influence the LKMD activities. The LKMD is supervised from the central to the subdistrict level. The task of this supervisory team is to monitor and evaluate the activities of LKMD in its respective programme.

**The Family Welfare Movement (PKK)**

Family Welfare Movement (PKK) is a community development organized by the female community to create a prosperous family as the smallest group in the society through providing guidance and encouragement, on the basis of a community movement. The movement and its establishment has been directly encouraged by the central government to implement its policy of "Pancasila" (five basic principles).

The objective is to assist the government in relation to the improvement of family life in the society on the basis of the Five Basic Principles, by participating in the process of development. There are four working groups in the PKK and group number 4, is responsible for health functions including, conservation of environment and education of families about healthy lifestyles. Related to the health services, there is an activity called "Posyandu", which is a health services unit provided by the community. Its goals are to reduce infant mortality and improve the health and nutritional status of children under five years as well as that of pregnant and lactating mothers.

The PKK is organized and managed by the PKK mobilizing team, whose members belong to the community and are willing to participate voluntarily in the development programme. The team was set up from the central, provincial, district, subdistrict and village levels. The PKK movement has been declared by the government and it gives politically, economically and socially influence to the process of the community development.
Positive factors influencing collaboration between health sector and the PKK movement includes the fact that understanding of the organization's objective by the health sector and the PKK movement is the same. Both sectors are aiming to promote family welfare and improve health status. Collaboration between the PKK movement and formal district health services is officially sanctioned and encouraged.

Factors encouraging the participation from the community group as member of the PKK were stated by the researchers as the responsibility of the wife of the village’s head and the motivation of the community leaders to encourage the members of the PKK to participate in the development programme and the involvement of the cadres in doing their job.

Factors inhibiting participation from community group or member of the PKK movement were identified as the lack of awareness and knowledge of the community group or member of the PKK about health matters; the economic and education status of the cadres of the PKK, the volunteer status of the cadres of the PKK and high drop-out rate.

The most important factor in sustaining the effectiveness of the PKK movement is the continuation of the PKK's cadres. The potential work of the cadres is important factor for the success of the PKK movement. On the other hand, they are volunteer and have lower economic status.

The Integrated Community Health Post (Posyandu)

Integrated Community Health Post is a health service activity provided by the community for the community, supported by the health centre staff. It provides five health programmes: family planning, maternal and child health, nutrition, immunization and diarrhoeal disease control to woman and children in the village. Posyandu has become a forum of communication where mothers are brought together to share relevant experience. The Posyandu is not a part of the provision of Health centre services, but it is a part of the PKK activities.

The historical background showed that 15 years ago there were several health services posts in the village, which were managed by the community using voluntary workers, assisted by the health centre. Since these village posts work with the same people, it was decided to integrate them. The majority of the cadres working in this programme are women and members of the PKK.

The tasks of health cadres are:

1. Encourage local participation in specific programme
2. Collect and record data
3. Direct service delivery
4. Educational activities.

Because the cadres are voluntary and without salary, they have to be dedicated to their work in the community. The cadres generally have low educational levels, economic status, knowledge and skill. Some training has been conducted to overcome this problem, but the drop-out rate is still high.

The researchers report the Posyandu as being well accepted by the community and as having the backing of community leaders.
The most important factor in sustaining the effectiveness of the Posyandu are the cadres, so their training is an important part of future strategies for improving the operation of the Posyandu.

The Posyandu was declared by the President of the Republic of Indonesia as a National Strategy for the improvement of child health. So there is strong political support for this structure. The support of health sector comes through health workers who facilitate the Posyandu, support facilities and drugs as well as health promotion activities. Other sectors such as the National Family Planning Coordinating Board provides contraceptive and drug. The community itself provides support through funds.

The problems in developing of Posyandu were identified by the researchers as follows:

1. The full coverage of populations is still to be achieved
2. The activities still depend on the involvement of the Health Centre staff
3. The awareness of the community is not good
4. The potential work of the cadres is still lower
5. The quality of services is still sub-standard
6. Supervision, training and management are still inadequate.

Conclusions

Based on the above analysis, the Indonesian report concluded:

1. LKMD, PKK and Posyandu are an integral part of the comprehensive community development, which is the responsibility of the Ministry of Home Affairs. However, the technical aspects of those structures are the responsibilities of respective individual department.
2. LKMD, PKK and Posyandu have a potential power to influence health development within the framework of District Health Management.
3. The effects of the LKMD, PKK and Posyandu in health development can be seen through the results of working group nr 4, in PKK and LKMD and the results of the Posyandu.
4. Positive factors influencing and facilitating the success of the implementation of these structures are supervisory mechanism of the operation, the commitment of people who are responsible for the managerial aspects, supporting facilities as well as the participation of the community itself.
5. Inhibiting factor in facilitating the success of those structures is the low level of awareness and knowledge of the community toward health matters and the voluntary workers.
6. The cadres are the workers in these structures and large number of them has been used. Their functions are direct service, educational activities and encouraging community participation. The problem is, that because they are volunteer, drop out is high.
7. A high level of political commitment and support at the local level has been useful to these health development structures.
Recommendations

Based on the findings and conclusions the Indonesian report made recommendations as follows:

1. Effective working mechanism should be established and sustained by the governmental agencies involved in the community development at various level of administration.
2. Because these health development structures use intersectoral approaches, the coordination at the lower level of the government administration should be strengthened through functional channels and a coordinating board should be strengthened at various levels of administration to ensure effective coordination.
3. Training in all sectors should include health, especially for the training of cadres in the community.
4. The community should be involved in every phase of programme development
5. Development of incentive package programme should be considered for the cadres.

Next Steps

The report will be distributed to the National Department of Health and health-related sectors. It should contribute to the understanding of the concept of HDSs and the subsequent development of health development within the district health system.

The researchers also plan a follow up study which will investigate the feasibility of a "Revolving Reward Package" for the local health workers.

3.2.3 JAMAICA

Jamaica submitted their final report to WHO/HQ in July 1994, entitled, "Health development structures in district health systems: study of situations, problems and prospects in Jamaica". Some key health development structures which impact on the health district were described. These structures have been well recognized over the years as promoting health development and have been encouraged by government. They are Parish Councils, community health committees and district health management teams.

Parish councils came into existence in 1956 and have their origins in the Municipal Boards of the British Colonial system. Parish Councils are formal operational bodies of the Local Government Ministry. Their counterpart in the capital metropolitan area is referred to as the Kingston and St Andrew Cooperation. They consist of representatives of political electoral districts. These electoral districts do not coincide with the geographic boundaries of the health districts and one health district may have several local political representatives with an interest in its operations.

These parish-based structures are each headed by a mayor who chairs a formal statutory meeting each month, adhering to the agenda set by the Secretary (or the Town Clerk in the case of Kingston/St Andrew Cooperation).
The roles and functions of the Parish Council are modified from time to time to reflect the mandate of successive political parties in power. Nevertheless, their role as representatives of the interest of their constituencies at the grassroots level has been consistently recognized and encouraged. One of their main interests is health care. Along with representatives (usually the medical officer of health) of the Parish Health Department, the Parish Council forms the Local Board of Health for airing and solving health problems including various environmental health concerns in the parish. The Local Board of Health grants licenses to barbers and butchers and gives approval for the operation of hotels, restaurants, meat shops, and markets. All building plans are approved by this Board before construction commences.

In collaboration with other agencies the Parish Council carries out its functions through several Committees which undertake responsibility for: administration of poor relief; various aspects of public health; public cleansing and sanitation; some water supplies; markets; abattoirs; cemeteries; beaches; emergency relief; maintenance of public parks, gardens, playing fields; children’s homes; infirmaries; homes for the aged; roads; town planning; and public excreta disposal systems. The potential for more meaningful contribution of Parish Councils to health development at the local level needs to be exploited further, but the researchers give a word of caution as the political plurality of the councils sometimes results in arbitrary changes in philosophy, priorities and geographic focus which may not coincide with health development interests.

Community Health Committees were born out of the philosophy of democratic socialism which expounded on the right of citizens to participate in their development and their right to social services such as health care. In some instances the committees superseded community councils which were identified with party politics. It was intended that these committees would facilitate expression of community participation in tandem with the new primary health care thrust in the 1970s and the process of decentralization which was initiated at that time. Each of the 370 health centres was expected to have a health committee associated with it. This has not materialized, however, and after much fanfare and publicity associated with their launching they have gradually been dying through lack of interest, and in some instances, lack of participation of health workers. It is estimated that some 70 health committees show some sign of activities. Roles of these health committees were enunciated as problem identification and problem solving, health development and community development, promotion of skills training; for example leadership and income-generating activities; promotion of intersectoral collaboration at the community level.

District Health Management Teams were initiated in the late 1980s and consisted of staff health workers within the health district. These health workers were trained in management and team building between 1988 and 1990. Over 90% of these teams function within the 78 health districts. Very few invite community participation. The excuses given include mistrust of community members who may leak confidential matters discussed at their meetings and inability of community members to understand technical health issues which are discussed at these meetings. No formal mandate, guidelines or budget have been given to these teams and they find themselves engaging in fund raising along with monitoring and evaluation of health district programmes and carrying out minor repairs and deployment of staff within the district.

This study was not specifically aimed at these well-reorganized entities, although two health committees were studied.
The study was based on case studies from one rural and one urban parish.

1. **St. Elizabeth**  
   Santa Cruz Health District: Glencoe Citizen Association  
   Southfield Health District: Southfield community Health Committee

2. **Kingston/St. Andrew**  
   Zone six: Gordon Town Disaster Preparedness Committee  
   Blue Mountain Health Committee

Inventories of health development structures operating at the health district level were made in each of the study areas. It should be pointed out that the health district in the Jamaican setting is a small operational area usually with a population of about 30,000. This is in contrast to the WHO health district which is much larger. In the Kingston metropolitan area health districts are referred to as zones, each of the six zones having a population of 60,000 to 150,000.

The level of activity of the community structures were ranked into one of four groups. To be included in the top rank a structure had to hold meetings regularly according to a planned schedule, have at least one-third of the membership participating actively and show signs of working with the health centre in attempting to meet specific objectives. After this ranking exercise the four health development structures listed above were selected as the focus for detailed study. The first two are in the Parish of St. Elizabeth which is in the southern area of Jamaica. It is said to be the bread basket of the country, so farming is the main occupation, followed by mining.

Santa Cruz, the location of the first HDS studied is a fast-growing town with a population (in 1983) of 23,000 which has grown significantly since then. A major problem is the shortage of water.

The **Glencoe Citizen Association** was formed in October 1991 and in January 1993 added a Neighbourhood Watch function to its activities. The membership at the time of the study was 46, which represented more than 50% of the households in the community. The stated objectives of the association are:

1. To assist in the development of the Glencoe Community and its environs.
2. To implement programmes to achieve community goals.
3. To foster good relationships within the community.
4. To make representation and recommendations to appropriate authorities as a united body.
5. To be aware of problems in the community and to assist in finding appropriate solutions (including health problems).
6. To identify funding and/or initiate fund-raising ventures to assist the needs of the community.
7. To increase an awareness and deeper appreciation of their independence.

The association receives most of its funding from outside the community by soliciting contributions and fund-raising activities. It is hoping to build a community centre in the near future. Most of the members of the association are professionals -- teachers, nurses, salesmen and bank clerks. Home owners rather than tenants tend to join. Half of the members are active and tend to contribute most to the association and its achievement.
While the association has no formal links it does have many informal links with other organizations. Members of the association also belong to other religious, social and commercial organizations and use these networks for fund raising and other activities.

In the three years since its formation, the association has improved the system of garbage collection in the community, improved the supply of water and organized community events.

The Southfield Health Committee was established in October 1984. It consists of 42 members, most of whom are low-income farmers or workers, but also includes a significant number of middle-income people. The committee appears to be representative of the community. Deliberate steps were taken to ensure that this happened. The committee members are reported as being friends and committee members commented they feel like "another member of the family". The committee has close links with the Southfield Health Centre and the Health Department, including the Parish Medical Officer. The president of the committee is highly influential and respected. The vice-president is a nurse at the health centre and she has tremendous influence on the group who accepts her as the final authority. Power within this group is somewhat dispersed and decisions appear to be taken in a democratic fashion. Statements on expenditures of funds collected and generated are given at the meetings.

The researchers reported that this health committee has been the most successful of the Jamaican health committees established in the early 1980s. Major achievements have been disseminating health information, developing the facilities of the health centres (e.g., building a fence, installing a demonstration kitchen, water tank, refrigerator), identifying local health problems and provision of resources for poor people. Of the committee the researchers comment:

"The Southfield Health Committee certainly is a model health development structure. It expresses the fact that ordinary people can do much to improve the health situation of their community, if organized and committed, and if given the chance and stimulus to do so".

The second study was the Kingston/St Andrew area. In 1991 it had a population of 660,600 and is the capital of Jamaica. Zone 6 (population 65,290) is a heterogeneous health zone containing rural communities in its hills and urban areas on the plains. It contains seven health centres. The researchers chose to look in detail at the Gordon Town Disaster Preparedness Committee. The membership covers people from each church, school and political party within the area and a doctor and nurse from the health centre and representatives from the police and fire brigade. The main purpose of the committee is to prepare the community to deal with disasters, especially hurricanes. The association functions are maintaining health and sanitation, purification and storage of water, distribution of medication and shelter management. The committee has a strong network of links to other organizations on both a formal and informal basis. These links are maintained through reports, newsletters, joint participation in training, simulation exercise and drills and through personnel who report back to other groups. The committee has made a deliberate attempt to include a wide cross-section of the community, including the political parties in an effort to balance influences and power and to gain acceptance and cooperation of the relevant sectors.

The committee undertakes preventive activities such as promoting terrace farming to reduce landslides and potential flooding and organizing training. They have reduced the number of new houses built on the river bank and constructed sewer systems (latrines) for the needy. Additionally, they have
increased awareness of earthquake, hurricane and flood preparedness and management. The researchers concluded that the committee has fostered more self-reliance, confidence and independence among community workers. In recognition of the initiative and outstanding performance of this structure, the National Office of Disaster Preparedness developed formal linkages after one year of operation.

The final health development structure studied was the Blue Mountain Health Committee. It contains a mix of community people and health centre staff. Their activities relate to identifying and solving local health needs, increasing community awareness of health education issues, providing education related to environmental, ecological, and industrial health issues, mobilizing the community for specific health programmes and monitoring and assessing PHC programmes. This committee has also carried out infrastructural repairs on the health centre. The committee has formal links with many groups in the community. The impression of the researchers was that the various organizations (e.g. Lions Club, Red Cross, Mothers’ Union, Youth Fellowships) were aware of the others’ activities and avoided duplication of activity. This was largely made possible because of the overlapping membership. The committee has been particularly successful at involving young people in its activities.

Conclusions

The researchers noted a number of general points that were evident from the health development structures they studied. Participation in the structures tended to exclude the elite in the community. Members felt that these people could, potentially, contribute to the stability and sustainability of the structures. With the exception of the Blue Mountains Health Committee, most had not involved young people. In fact, the average age of the membership was 55. Health workers were reported as key actors in the development and sustainability of the structures. Often well-functioning health development meant that there were health staff who worked overtime to give their support. The staff felt they were not given a clear mandate to be involved in health development and that the role of the District Health Management Teams could be strengthened and clarified so that they could act as a link to the various health development structures in the community. This would include involving community members on the DHMT.

All the structures studied make some attempt at planning their activities at set intervals and monitoring their achievements as they implemented. There appeared to be no attempt at systematic community diagnosis to guide them, however.

The case study of HDS made it clear that they did contribute significantly to health in their district. The contributions fell into the following categories:

1. Training and education for staff and community
2. Refurbishing and maintenance of health facilities
3. Environmental health activities, especially providing sewerage disposal systems and clean water supplies
4. Provision of health care supplies and pharmaceuticals
5. Provision of food, furniture and clothing to the poor
6. Monetary contributions to health centres.
Some health centre staff reported feeling ambivalent about receiving gifts and money because they believed it could mean the government could escape its responsibilities.

Overall, the network of health development structures was reported by the researchers as having considerable potential to increase community involvement in health and further health development. The factors listed that were seen to contribute to their success were:

**Leadership** - a variety of styles were reported and the researchers concluded that the style was less important than the presence of a good committed leader.

**Role of health workers** as catalysts is important in keeping the group functioning and focused and linking it with other structures and with higher echelons of the health system.

**Specific project activity** is important to unify the group and give it a sense of purpose. Groups with no specific project or programme tend to dissipate.

The group should not be too large so that they are able to maintain cohesion. A membership of 30 to 50 was mentioned as a desirable size, which seemed to work in the settings studied. The group should also be broadly representative of its community and not aligned to any particular political party. It was also noted that marginalized people in communities tend not to be involved. For instance, squatters will feel no sense of ownership or commitment to the community. The geographic distribution of members of the group and the infrastructural development, such as electricity, telephone, and transportation also contributed to the success of some groups, while impeding others.

**Resources** should be available to “lubricate” the participatory process and give the group a sense of "going somewhere".

The researchers made the following recommendations based on their findings:

1. Health workers, particularly professionals, need to have more exposure to district and local health systems and the associated issues. This needs to be included in basic courses and not left to on-the-job training or during post basic training. Emphasis during training must be on the demystification of health care, good communication skills and community mobilization.

2. There needs to be more involvement of the health team as a whole. More health workers need to become rank and file members of health structures not just members of the executives. This will give the group greater esteem and sustainability. The involvement of traditional healers and birth attendants hitherto discouraged now needs to be encouraged and recognized as valuable community resources.

3. An improvement in the general literacy levels in the communities would enhance health development by increasing the capacity of community members to understand messages, learn new skills and change attitudes and behaviour.

4. Special training (in management leadership, skills) for selected community members to provide a pool of resources for networking, dissemination of messages and from which leadership for health development structures would be likely to emerge.
5. The District Health Management Teams should be given recognition and a greater degree of autonomy, backed up with a budget or an imprest, and clear guidelines on their roles and functions.

6. All District Health Teams in the country should immediately invite and select representation from the community and/or significant health development structures in the district. The concept of the district health systems needs to be explained to the committees and the community at large in a way that they will understand.

7. National and local health development structures, as well as the District Health Management teams need to implement the much spoken about "bottom-up" planning by collaborating with the community in carrying out community diagnosis, identification of problems, prioritizing the problems and formulating the strategies for implementation.

8. The Health Department needs to carry out further research into the apparent high prevalence of hypertension in St. Elizabeth (Southfield Health District in particular). Continual monitoring of indicators and risk factors should be carried out in collaboration with the structures and appropriate intervention made.

9. Reports on each health development structure should be forwarded to the Health District Management Teams and further collated and forwarded to the Parish Health Department on a quarterly basis.

10. The networking between health development structure needs to be strengthened. This process could be initiated with a meeting of all such structures in the district or parish for the purpose of putting the necessary mechanics in place. An annual meeting thereafter could help to maintain the linkages.

11. An effective, appropriate, cost-effective sustainable communication system needs to be installed in all health districts. This should be further linked to the Parish Health Department. This system would enhance the dissemination of information, assist with disaster management and help to strengthen networking.

12. A strategy for involving existing district structures which are not traditionally viewed as health-related should be considered. "General-purpose" citizens groups could be persuaded to form health sub-committees and hence put health development activities on their agendas. This may be a feasible alternative to the formation of new "health-dedicated" structures such as health committees which have been very difficult to sustain in some areas.

13. Some innovative and creative strategies need to be developed for attracting the youth into health development structures.

14. The role of the Parish Council in supporting the district structures in health development needs to be reviewed with the aim of obtaining greater commitment and giving the Council more "teeth" and resources to carry out its mandate and strengthen its role as a health development structure itself.

15. For the future, the researchers should hold workshops in Jamaica to inform relevant sectors on the findings of this study with the aim of rekindling interests in health development structures and exploring their potential for facilitating the achievement of Health for All. Further, more in-depth study needs to be undertaken to unravel the psychological factors which bind members of successful health development structures and sustain them. This could suggest general guidelines of the operations of HDSs.
Next Steps

Presentation of the findings of this report to persons at all levels of the health system could rekindle interest and enthusiasm for health development structures at health district level. This may result in the recognition of these structures as key actors in the process of achieving Health for All.

Medical Officers of Health, in particular, could benefit from examination of the relationship between the Southfield Health Committee and the health centre and seek to replicate this positive experience in their area.

The report also demonstrates the health development contributions of structures which are not traditionally regarded as health development structures (e.g. the Gordon Town Disaster Preparedness Committee and the Glenco Citizens Association). These structures represent viable alternatives to community health committees which may be more difficult to sustain in some areas. Health district managers could find that "piggy-backing" health to the agendas of these other non-health dedicated structures, which are already well established, could suffice in meeting the health objectives.

It is hoped that this report will also stimulate further examination into the role of community health development structures in cost recovery and health financing. It was evident that all the structures studied managed funds which they generated by various means. These funds were used to provide various needs identified, including health-related commodities and activities. Substantial contributions (infrastructure, supplies, training, health education, latrine construction) were made by these structures which made up for the formal budgetary shortfalls and the lack of resources in the communities.

These structures could be used to manage the fees collected at each health centre if and when a fee collection system is formalized. This system would allow for ready access to funds at the local level where it is required rather than making contributions to the Consolidated Fund which are governed by Government's Financial Administration and Audit (FAA) Act with its very stringent, inflexible and bureaucratic regulations.

3.2.4 NIGERIA


The main objective of this study was to examine the role of community structure in the promotion of community participation and involvement of health-related sectors in the effective planning, management and implementation of PHC at district level in Nigeria.

In Nigeria's study three methods of data collection were used (review of documents and interview of key informants and focus group discussion). Five sets of questionnaires were used in studying: (a) the government officials in the local government, including all the elected officials, the district health supervisors and the heads of the 11 health facilities in district, (b) the non-governmental officials
serving in the village and community development councils, as well as those in the Better Life programme, (c) the religious groups, youth clubs and their social organisations, (d) beggars and motor park touts, and (e) secondary schools.

A purposeful sample of identified organizations was selected for inclusion into the study. It was based on a set of criteria which ensured a measure of objectivity in the study.

The important identified health-related development structures were as follows:

1. Primary Health Care Management Committee (a government organ set up to facilitate the implementation of PHC at district level and to ensure community participation and the involvement of health-related sectors, e.g. agriculture, education, public works, NGOs, religious and social groups).
2. Community Development Councils (apex organizations for district and village development committees).
3. Better Life programme (women’s organization set up by wives of politicians in power to enhance the socioeconomic status of women living in the districts and villages).
4. Social organizations (including age groups, youth clubs, religious groups).
5. Cooperative societies (which include farmers, traders and workers).
6. NGOs.
7. Schools.
8. Beggar and motor park touts.

The following analytical themes were identified from the study:

1. Patterns of evolution of HDSs.
2. Composition of HDSs, leadership style and operation.
3. Involvement of HDSs in health development, including the factors influencing this involvement.
4. Capacity of various structures in health development.
5. Opportunity or potential for collaboration between the various structures and with the health system.

Development structures have a long history in Nigeria; many of them, such as Age Group Associations, cooperative societies and religious organizations predate colonialism (i.e. before 1990). In fact, these development structures made an enormous contribution to pre-colonial community development in the southern parts of Nigeria, including the establishment of schools, health institutions and markets. More recently, the number of development structures has increased phenomenally due to the realization that government resources alone cannot meet the social needs of the people.

The National Health Policy of 1988 includes a proviso for community participation within the planning stages. It also recommends the involvement of all health-related sectors in the planning and management of PHC. Therefore, the establishment of the PHC Management Committee in 1992 in Odogbolu District is in line with the 1990 National PHC Approach Guideline. The PHC Management Committee was involved in the identification and prioritising of the health and health-related needs in Odogbolu District (including water and electricity supplies, repair of health centres, provision of
drugs, provision of good sanitation, control of stray animals such as dogs, construction of roads and maintenance of vehicles).

The role of the PHC Management Committee also included planning, budgeting and management of PHC, identification of the training needs of health workers, provision of logistics support for the implementation of health programmes (EPI, family planning, AIDS control, ORT, etc).

In recent times several formal development structures in the different committees in Odogbolu District government are being organized and brought under an apex group called the Community Development Councils (CDCs). The CDCs have the advantage of being able to mobilize and encourage the smaller community development committees and village development committees to embark on projects that are of direct benefit to the various communities. In addition, the CDCs serve as coordinating bodies and provide technical advice to the smaller groups. The CDCs handle both the State and District government grants allocated to different communities for development projects such as slaughter houses, town halls, community drainage system to prevent flood during rainy season.

The Village Development Committees have useful links with the PHC system through the following activities.

- Drug revolving fund (DRF) as part of UNICEF Bamako Initiative
- Construction of VIP latrines for the improvement of sanitation
- Construction of deep wells for provision of water supply
- Maintenance of maternity centres and their use by mothers and children
- Health education on the use of mosquito nets to prevent malaria

Better Life programmes were involved in cottage industries which have an impact on the health of the people living in the district.

More than half of the religious, youth and social clubs included in the survey had no formal interaction with the PHC system in the district. It was found that many of these groups and social clubs have not been properly educated by the health workers with respect to the principles of community participation in PHC activities.

An interesting finding from the school survey was that there were no social clubs or committees responsible for the promotion of health in these secondary schools.

In Odogbolu District it was obvious from the findings of the survey that except for the Village Health Committees, the Community Development Council and the Better Life programmes of women's organizations and the government establishment of PHC Management Committees, community participation by other development structures in the effective functioning of the health system appeared minimal.

The study reports that the potential of most of these HDSs has not been tapped for the following reasons:

1. The top-bottom planning approach, dominating until 1988 had not given the older development structures their rightful place in district health planning; hence, the
objectives and functions of identified development structures in health and health-related matters appeared to be tangential.

2. The Local Government Area officials had not properly enlightened the members of the development structures on their role in the overall improvement of primary health care. Health-related matters were regarded as government responsibility and not that of the people.

3. The composition of the primary health care management committee did not include representatives of important development structures that could enhance primary health care in the local government area.

4. The review of documents revealed that the local government area officials possessed inadequate knowledge about primary health care.

5. The local government area did not allocate enough grants to health matters, which consequently affected the effective promotion of primary health care.

Based on these findings, several recommendations following focus discussion with various groups, were made for the effective functioning of the primary health care system in the Local Government Area:

1. The composition of the Primary Health Care Management Committee should be enlarged so that it includes also other agencies and organizations (NGOs, School of Health Technology, some development structures with health-related activities, etc.)

2. The Primary Health Care Management Committee should liaise with the College of Health Sciences of Ogun State University, which runs a Community-based medical education programme. This collaboration in form of partnership would ensure sustainable health system research activities.

3. It is important for the Local Government officials to develop a strong political will to promote primary health care and to show commitment to the implementation of primary health care and other health-related matters. To achieve this, periodic advocacy workshops or meetings between PHC workers and LGA officials are recommended.

4. It was also recommended that adequate funding should be made available by the LGA authorities for implementation of Primary Health Care programme. Funds are also needed for the further training of health workers in order to re-orient them towards effective implementation of the PHC concept.

5. The Local Government should improve its information about Primary Health Care concepts, practice and implementation. The health staff in the Local Government Council should be encouraged to collaborate with some of the development structures in the Local Government Area so that they could include primary health care in their programmes. Health staff could also join some development organizations with good health activities to ensure better direction in community participation in PHC activities.

6. It was suggested that the Primary Health Care Management Committee should encourage educational institutions to form clubs and committees for the promotion of Primary Health Care.
7. Funds should be made available to ensure regular meetings between the Primary Health Care Management Committee and other health-related sub-committees to mobilize and encourage Development Structures in the Local Government Area.
8. The results of this study and the recommendations would be made available to the team conducting the second research in Odogbolu LGA on "The Role of Health Centres in District Health Systems".

Next Steps

The next phase of this study should look into the ways of encouraging many NGOs to form partnership and linkages with identified development structures which have important health-related activities. This would ensure sustainability of the role of these health development structures in Odogbolu District. In addition, a broad-based PHC management committee of board with enlarged membership should be reconstituted.

The report of this study has revealed that a more effective district health system, based on the PHC approach, could be established in Nigeria if there is better collaboration between government health department and community development structures that have health-related functions. Some of these development structures need to be more informed and educated concerning the principles and practice of PHC activities that they can better serve their communities.

3.2.5 PHILIPPINES

The Philippines submitted the final study report to WHO/HQ in May 1994, entitled "A Study on Health Development Structures in the District Health System in the Province of Bulacan".

In the Philippines, the decentralization in the health system started in 1959, when the Department of Health created regional health offices. With the implementation of the Local Government Code of 1991, the Department of Health devolved in 1993 the basic health services, the hospitals to the provincial governor and the rural health units to the municipal and city mayors.

This study was conducted in seven municipalities in the Province of Bulacan. The study was confined to formal government organizations relating to health services. The following bodies were studied:

1. Municipal Health Board
2. Provincial Health Board, and
3. Provincial Health Office

The study did not look at the role of non-government and other informal organizations in health development.

Municipal Health Boards

There are seven Municipal Health Boards within the study area. The creation of the Municipal Health Boards is one of the provisions of the Local Government Code of 1991. The majority membership of all these Boards comes from the public sector (mayor, representative of the Department of Health,
Rural Health Physician). About 90% of the members are professionals. Only the NGO representative has a broader agenda concerned with social and health development. The consumer of health services is not represented. On four boards other government agencies are represented, which broadens the available expertise in the social and economic sector.

The functions range from planning, budgeting, programme implementation, monitoring and evaluation of the health system in the locality. The majority of those Boards in the study areas provide management support to the operations of the health service system. However, in four municipalities there was an overlap of planning and budget activities of this Board and the Rural Health Unit.

The members have not received any training relating to their role. Their activities are based on their own understanding of the creation of the board under the Local Government Code. This has created confusion and duplication of activities.

The Municipal Health Boards function independently of each other without coordination with neighbouring health boards or with the Provincial Health Board.

**Provincial Health Board**

The Provincial Health Board has been established to provide support to the devolved facilities, particularly the hospitals. It is chaired by the Provincial Governor and the members are all professionals with management expertise. NGOs are also represented. The members have not undergone formal training in their role. The concerns and activities are directly related to the planning, budgeting, monitoring and evaluation operations of hospitals in the province. Since its creation it has met regularly once a month. It functions independently from the Municipal Health Boards, but there is a link between these two boards through the Provincial Governor and the Municipal Mayors who chair the respective health boards. With the independent stands taken by both boards, the concept of integration of curative and public health programmes has been lost.

**Provincial Health Office**

The Provincial Health Office is a unit under the Provincial Government. It is the implementing arm of the Provincial Governor in implementing the policy decisions recommended by the Provincial Health Board. The Provincial Health Office has unofficial linkages with the rural health unit, especially on technical matters. This was a carry-over of the pre-devolution activity of the Provincial Health Office.

**The strengths of the HDSs in the study areas**

The health board, with the chief executive of the municipality/province as chairman and a health professional as vice chairman, exercises broad powers and influence in the operation of the health system in the locality. The political support is assured since the local chief executive is also the board chairman. The vice chairmanships being occupied by the Provincial Health Officer and the Rural Health Physician ensures the implementation of the board's resolutions on technical matters involving the hospital and rural health units respectively. The devolution of health services to local government units from the safety net of national health appropriations provides the local chief executives a new
health frontier in which they can innovate, reorganize, and restructure existing health facilities for more effective, efficient and economical health services.

The weaknesses of the HDSs in the study areas

The health boards were created by the Local Government Code to perform a vital function in the devolution of health services. In practice, however, the local chief executives have operationalized the health boards differently. Implementing rules and regulations were not provided by the Department of Health on how to operationalize the health boards. Except for the basic knowledge in management, the members did not receive any orientation on their role. Some of the Municipal Health Boards are duplicating the programme management and the implementation activities of the local health units. There is a need to delineate management support to the system and programme management which is the responsibility of the Rural Health Unit and/or Hospitals. To prevent confusion and duplication of activities, the relationship of the Provincial and Municipal Health Boards, the Provincial Health Office and the Rural Health Units needs to be defined.

Consumers are not represented on the boards. Except for the NGO representative, all members come from the public sector and are professionals. The consumer’s experience and information would constitute a vital link in the planning and implementation aspect of the system and the programmes.

Since the Chairman of the Board is a politician, the risk of the health boards being politicalized or health programmes being based on political interests, is always an ever present possibility.

Conclusions

The health boards will be effective as a health development structure needs to the institutionalized in the health system. Increasing the managerial capacity of the members will enhance the board’s ability to deliberate and respond to management issues and problems within the context of Provincial Health Systems. This will facilitate the re-integration of the public health and hospital services this the health system will provide a range of promotive preventive and curative activities in the devolved health facilities.

Wider involvement of the consumers, private health sector, and non-government organizations in the operation of the health boards will be needed to effectively and efficiency respond to management and operational issues raised/met by the Provincial Municipal Health system.

Recommendations

Based on the findings, the Philippine report made the following recommendations. There is a need to:

1. Conduct orientation/training of the members of the health boards.
2. Formulate more specific guidelines/criteria on the membership and operation of health boards.
3. Increase the membership of the boards to include the Consumers Group and representatives of other development units in the locality.
4. Delineate the management activities between the Municipal Health Board and that of the Rural Health Unit in the area of programme planning and implementation.
5. Establish a clear relationship between the Provincial Health Office and the Provincial Health Board on the one hand and the Rural Health Unit and the Municipal Health Board on the other in terms of provision of technical assistance such as clear channels of communication.
6. Provide the health boards with adequate administrative support and funds.
7. Train extensively the Department of Health (DoH) representative on the various health programmes implemented by the agency through the Provincial Health Office and the Rural Health Units, since the DoH representative should be the expert on health on the health board.
8. Ensure public health and hospital services are integrated. A District Health Board would be one means of linking the province and municipality.
9. Create an Oversight Committee at the national level by the relevant departments (Health, Interior and Local Government) to monitor and provide clear guidelines on the role, scope of authority and responsibility of the local health boards.

Next Steps

This study has brought to light the inadequacy of the creation of the Health Board by the law. It shows the issues and problems of the Health Boards that need to be rectified by the national and local government.

The Department of Health, Department of Interior and Local Government and the Provincial and Municipal Governments took cognizance of the issues and problems of their Health Boards and are taking action accordingly.

Training local executives and members of the board has been initiated together with formulation of a manual of procedures in the operation of the board, duties and responsibilities of the different members of the Board. Also, a review of the memberships in the process.

A quick response unit on devolution was set up in the Department of Health in collaboration with the Department of Interior and Local Government to attend and institute appropriate measures to operation of the Health Board and delivery of health services on the nation-wide basis.

Follow-up needed:

1. Assessment of the technical capability of the service units to deliver the health services needed by the population.
2. Identification of areas for collaboration in health development with NGOs, especially among underserved and unserved populations.
3. Determination knowledge, attitude and practices among population in responding to their health needs to be on input to planning of health development.
4. Determination of perception of health personnel on the activities and needs of HDSs in a formal health structure.
3.2.6 SENEGAL

Senegal submitted the final study report to WHO/HQ in October 1993, entitled, "Presentation, Analysis and Interpretation of the Results of the Study on Community Organizations Contributing to Health Promotion".

This case study in Senegal forms part of a wider approach to strengthening the effectiveness of district health systems. The study concentrated on describing the organization, mode of operation and principal achievements of the informal community associations, that contribute to improving the health of people in the district of Fatick. The formal existing development structures are briefly presented at the introductory phase of the study.

Formal Development Structures

**Community councils and administrative Committees**

As a result of the Administrative and Territorial Reform Launched in 1972 (Law 72.02), a managerial community body called Community Council was created for community development purposes for each type of newly created administrative units.

Consequently, there is a rural community council at the rural community level (headed by the president of the rural community); a urban community council at the municipality level (headed by the mayor); an arrondissement council at the arrondissement level (headed by an elected president) and a regional council at the regional level (headed by an elected president). In Fatick District there are 13 rural councils, two urban councils, three departmental councils, four arrondissement councils and 13 rural community councils.

These community councils are normally responsible for organizing, planning and coordinating all development activities within their areas. Their members are democratically elected by the population they serve. Administrative development committees have been created as well through the 1972 law to enhance the development activities mainly by supporting and assisting the individuals and organizations within the communities. Similarly, at the regional, departmental and arrondissement levels respectively, there is a regional development committee (CRD), a departmental development committee (CDD) and an arrondissement development committee (CLD). Their members are officials appointed in the areas for each type of committee. The councils have representatives on those committees headed by the administrative authorities (representing all ministers) appointed there.

All of these official structures are supposed to be responsible for organizing, promoting, coordinating and supporting development activities, including health in their areas of responsibility. Only a very few of them, however, are currently effective in terms of tackling health or health-related problems. All of them are very bureaucratic organizations which are struggling with the heavy constraints that exist in developing countries and which jeopardize their effectiveness and efficiency.

**The Health Committee**

The health committee is a community based organization created so that every health facility can mobilize commitment to involvement in the solving health problems. The members are selected from the population living within the areas that encompass the given health facility. In the Fatick District there are 28 health committees, including the district health committee composed of representatives
of other health committees created at the health post or the health centre level. Unfortunately, these committees have limited their actions to the collection and management of the fees charged to the users of the public facilities. The money collected is also used solely to assist the functioning of the health facility at which it is collected.

Informal development structures

The types of association studied were selected on the basis of criteria connected with their possible contribution to the health of the people. Out of the 643 community associations listed in the study area, Fatick district, 550 were identified as associations carrying out activities directly linked with health. These groups of various associations were identified: Women’s Development Group, Sporting and Cultural Association, Economic Interest Group, Parents and Pupils Association, Committee for Management of Wells and others. Of these 550 associations, 300 were studied.

The oldest-established of these types of association dates back to 1953. However, most of them were created with the introduction of the reform of the territorial and local administration which established decentralization as a policy. Most of them have a legal status and get supervisory support from the ministries responsible for supporting the population.

The main objectives pursued by these associations are concerned with improving the quality of life of populations by increasing the possibilities open to them. Education, social conditions, health, culture, sport, drinking water, livestock rearing, the living conditions of young people and agriculture were the main areas mentioned.

The associations studied were small, flexible bodies, easy to manage, covering villages or municipal wards. The average number of members per association was about 100. This confers a certain advantage in management terms, but is also a major inconvenience as regard to obtaining funds from membership dues. Many organizations studied complained of the inadequacy of their financial resources. Most of their funds came from membership dues and sale of their own products.

Almost half of the persons questioned were members of more than one association. Most of the persons belonging to several different associations hold responsible posts, like chairman or treasurer, in them. All the associations are directed by officers forming an executive body, which in most cases is composed of a chairman, a treasurer, a general secretary and an auditor. In about 80% of cases these are elected by a general assembly.

All organize meetings, including general assemblies held at least once a year. The frequency of meetings is about once a month with an average attendance of about 70 members and they are mostly held for information purposes, to reach agreement on decisions or to submit accounts. The subjects most frequently discussed are connected with the objectives pursued by the associations and are concerned with a search for funds, ways and means of development, the efficient running of the association, the solving of specific problems and the submission of accounts and the programming of new projects. Thirty-five different types were listed as activities of the organizations. The main ones were those connected with children’s schooling, agriculture, sport and culture, health, water, livestock rearing and commerce.
The greatest achievements of these associations are mainly concerned with the construction and equipment of facilities such as schools and dispensaries. Achievements in areas specifically connected with health were reported by about 60% of the associations studied. They concerned environmental sanitation, the purchase of medications, the organization of chloroquine distribution for pregnant women and children, annual contributions to the running of health huts, campaigns of vaccination as part of the Expanded Programme on Immunization and the construction of health infrastructures.

Many links exist between the associations and other groups at the local, regional and national level. At the local level, they are primarily relationships of exchange, mutual assistance or consultation, whereas at the regional and national level they are, above all, relationships of technical support and assistance from the official services to these associations.

The major constraints, difficulties and problems encountered by these associations are all connected in one way or another with the inadequacy of their resources, particularly their financial resources. That is why one of the most frequently mentioned future plans was the development of their means of raising funds.

This study demonstrated the dynamism of the associations studied and the quality of their organization and their mode of operation. What is striking is their number, their diversity, and the focus of their aims and objectives on development activities which include health as a state of well-being.

These associations form an important addition to the activities of the health committees, which are more concerned with obtaining funds for health care centres and using them to strengthen the effectiveness of those centres. Health promotion activities were almost nonexistent and that has always been considered as one of the most serious shortcomings in their mode of operation. The health committees concern themselves more specifically with the selection and recruitment of community staff to support State-employed staff and with the provision of support to technicians in educating the populations and making the more aware of health programmes.

Conclusions

The Senegal researchers concluded the following:

1. The decentralization launched in 1972 with the reform of territorial and local administration and applied in the Fatick region since 1984 has affected the commitment of the populations to organizing themselves in order to take charge of their own development in a spirit of self-determination and independence. All the associations studied were organized to carry out activities which until very recently were entirely the responsibility of the State and to a lesser degree, the local authorities, and were carried out by their technical departments. All the associations studied operate on the basis of resources obtained locally through the dues received from their members or from the sale of their own products.

2. Development is necessarily a process and is most effectively carried out by the beneficiaries and not only result from a project funded from outside. Indeed, none of the projects financed from outside and carried out in the district has lasted as long as the structures created spontaneously by the populations themselves in response to their
own identified need. These associations carry out their activities as part of the natural process of socioeconomic development.

3. The transfer of certain duties performed by the technicians to the population is working well in this district, at least as far as concerns the principles and methods and mode of organization and functioning of these types of association. Only those associations of rural people with low levels of literacy have been investigated. They have all reproduced the classical structural and functional patterns usual for this type of organization.

Recommendations

On the basis of these results and conclusions it was possible to formulate a few general recommendations as follows:

1. The community organizations should be used as the basis for funding development programmes by the NGOs, donor agencies, and others funding development projects. They are concerned with development and are operated by and for the local population. Money put into these organizations should then increase their potential and effectiveness.

2. The regional committee, headed by the governor (responsible for organizing and supporting all development programmes financed by the government or by donors) should coordinate the community organizations’ activities, evaluate their achievements annually and reinforce supervisory support and technical assistance.

3. As part of the decentralization process, regulations and procedures for official recognition of these organizations should be decentralized to the regional level and limited to the strict minimum.

4. In view of the very small number of organizations that have placed their funds in a bank account, in rural areas, a bank for the local population, with readily available access to banking services, should be established.

5. Considering the advantages associated with the small size of this type of community organization, the consolidation of a number of organizations should be avoided. Other ways of solving the problems of financial constraints that a small organization may encounter must be explored.

6. Further studies, focusing on specific sectoral research on each type of organization are necessary to enable more precise analysis and more pertinent recommendations.

Next Steps

The findings of this study have already been used by Dr Adoulaye Diafate, Chief Medical Officer, District of Guinguens, Fatick Region, for his doctoral thesis. The thesis was not only successfully defended, but it increased the number of officials interested in the organizations concerned with the study.

The findings are also being used as a framework by a USAID project manager in the municipality of Rouga in Souza Region to implement a socioeconomic development project which includes health.
Within Fatick District the research teams are still trying to implement the recommendations made. It is also necessary to find ways and means to follow up on the study over time by tracking the evolution of their organization, made of functioning and achievements. Thus a process of following them up will also allow a comparison among themselves and an assessment of the trends of each of them.

3.2.7 SUDAN

Sudan submitted the final study report to WHO/HQ in March 1994, entitled, "Health Development Structures in District Health Systems - A Multi-Country Study of Situations, Problems and Prospects. Report on Sudan Study Conducted in Getaenna District, Central State, Sudan".

The government in Sudan adopted the Health Area System (HAS) as the key strategy for health care delivery in 1992. This strategy depends in part on the mobilization of the communities in the HASs.

In each district (health care) a Health Area Management Team is responsible with the Rural Council authorities and other partners, for planning, implementing, and evaluating health services delivery in their district. As the government adopted the decentralization policy, the Federal level was left with responsibility for national planning and the provision of support to states in the formulation of their own plans. The State Ministry of Health is responsible for the implementation of its health policy. The role to be played by the communities had been emphasized by the policy-makers. Both WHO and UNICEF are playing a major role in supporting integrated PHC implementation as stated in the HAS policy, when this study was conducted, further decentralization was happening, with one aim of this being to give more scope for community involvement.

Getaenna Health Area was selected for this research because the HAS policy was already being implemented there and it represents a typical rural setting with settled population and a high literacy rate. Five localities were selected in this area as the focus of the study.

The HDSs identified in Getaenna are in two main categories. In the first category there is the District or Rural Council. In the second category there are several Youth and Women Organizations, besides the popular committees in the villages. The District Council has 40 elected members representing the different popular committees. It has seven sub-committees. The District Council is responsible for policy-making in public and developmental issues that are brought to its attention as recommendations from the sub-committees. It also allocates the budgets for the different departments, monitors implementation and receives regular reports from its sub-committees. The District Council meets once per month and the sub-committees twice a month.

The second category of organizations includes:

1. The District Youth Executive Council, which consists of 15 elected members.
2. District Women's Committee, which consists of 12 elected members. There is a Women's Committee in each village.
3. Working Women's union, which has all working women as members.
4. General Agency for Students Activities, which consists of university and high school students.
5. Getaenna Province Advisory Committee in Khartoum, which is a supporting body, giving advice to the Getaenna Province Commissioner and the Getaenna District Council. This is an influential body, because some of its members occupy high government posts at federal level.

Popular Committees and the Province and District Councils were introduced in 1970, but for the last 23 years very little change has happened. The strategy of work and system of elections or nomination of the leading figures are the same.

The current practice of the government is to mobilize popular committees, youth and women organizations and the communities in general to be directly involved in public issues and improvement of public services. Current health policy aims mainly at equity of distribution of health services, especially in the areas of child and mother care, improvement of EPI coverage, training of village midwives, propagation of health education messages through community promoters and more involvement of community members, popular committees, women and youth organizations in analysing their health problems and identifying health needs. The federal PHC Directorate sees the support of HDSs as crucial to improving health at the district level.

A questionnaire was administered to key informants (N = 104) in five localities. These key informants were members of HDSs or outside of them but interested in public work. In some cases, they were health sector personnel.

Findings

The Sudan researchers reported their findings of the study under the following headings: responsibilities, membership, formation and evolution, mode of function and resources, relations with other organizations and levels, influence and relevance, potential of the structure for health development.

Responsibilities

The most common objectives and specific tasks of the HDSs cited were environmental sanitation, rehabilitation of existing health facilities, health education, health area development, healthy community, control of epidemic diseases, provision of drugs and financial support to health services. The diversity of answers indicates the absence of clearly formulated and implemented short- or long-term objectives.

When asked about the functions in practice for health promotion in the area, the majority of the respondents gave more than one function covering the following areas: environmental sanitation, health education, local council’s regulations and orders, supporting health facilities.

Over half of the respondents declared that they played a role in policy, planning, decision-making, budgeting and delivering services through participation in open discussions in general meetings of their district or village committees. The rest of the respondents gave a diversity of answers or did not identify any kind of role.
The recent approach adopted by the government to delegate more power to the districts has started to motivate people to take part in the running of public services in their localities. This was reflected in the fact that over 50% of the respondents said that they took part in policy-making and planning. That was not possible 10 years ago. The questionnaire used in this study did not, however, collect details on the type of policy-making or planning. It may also be that a majority gave a more positive answer than is actually the case.

About 54% said there were budgets for health promotion in the area, but the rest ruled that out. The responses do not conform with reality. Budget allocations are centred at the state level.

About a third of the respondents said there was a difference between the declared health policy in the district and that actually implemented.

The majority of respondents said sources of funding were self-help, donations and subscriptions and only 15% referred to government.

**Membership**

The answers to the question of who are the members of HDSs, showed a diversity of perceptions. They ranged from an open membership for all interested citizens to a membership which is restricted to selected groups. However, about 80% of the respondents said there were prerequisites for selection of members. The majority of them put citizenship, honesty and acceptability by the community as essential criteria for membership.

**Formulation and evolution**

When asked what processes were followed in the establishment of each HDS, almost half of respondents related the establishment of their structure to a series of village or district conferences. The rest of them related it to village youth initiatives, to previously established popular committees and to instructions from province commissioners. It was found that only small changes had occurred in the last two decades in the establishment and working of these structures.

**Mode of functions and resources**

The organizations function mainly through meetings and discussions, but also by regulations and local orders and by reports. Frequency of meetings ranges from weekly (27%) and half-monthly (14%) meetings to monthly (35%) meetings, some of them (9%) on demand or request. The majority of the meetings were chaired by the elected chairperson or his deputy. Over 90% stated that the discussions were formal, giving equal changes to the members.

No structures at village level had staff other than the elected members who in the majority of cases kept their own records and correspondence. The district council had enrolled government staff who performed all secretarial work.
Relations with other organizations, structures or groups within the district

Over 90% stated that their structures had relations with other organizations or structure working in the same locality or district. About 60% had relations with all organizations and committees in the locality or district. The majority of respondents related the formal links to mutual functions in the areas of community development, public work, mainly collaboration and similar objectives. In response to the question about formal links, the majority related them to kinship, to common needs and to financial support. The researchers concluded that these answers point to a lack of formal links between the organizations under study. All of them may work for similar aims, but coordination is lacking. It is clear that informal links are maintained through personal relations.

Relations with other levels

Almost 90% of respondents stated that relation within the district or villages were informal. The majority mentioned that there were formal relations with state and national levels. These formal relations were mainly with the organizations’ or structures’ headquarters at state and national levels. This indicates that different organizations and structures at peripheral level could have links with state and national levels, by-passing district and province levels. The types of these formal relations were not clear from the answers. It might be through orders or instructions passed from higher relations were not clear from the answers. It might be through orders or instructions passed from higher levels to perform certain delegated functions or activities and not vice versa.

Influence/power

In response to the question about who holds most power in the structure, about half of respondents said the chairperson, about 10% said the secretary and about 30% none. Some opportunities to redistribute the power were mentioned, such as selection of the right person in the right position and changing the chairperson or secretary by voting. Only a minority said regulation may block this redistribution.

Relevance and potential of the structure for achieving health development

Almost all (95%) of the respondents perceived that their organization’s or structure’s contribution could promote health status in the area or village. The contributions or perceived impacts were varied, but the main areas were: promotion of environmental sanitation, health facilities rehabilitation and training of health promoters and volunteers.

The majority of respondents said their organizations always consulted with health or medical personnel.

Respondents believed their organization’s contribution to health development could be increased through more financial support, provision of vehicle equipment and supporting training. Other areas mentioned were: coordination between structures and government departments, health education, provision of drugs and vaccines and implementation of joint programmes.

There were many aims which had not been achieved. The main ones were: increasing the number of health cadre in locality, health facility rehabilitation, provision of vehicle and establishment of a rural
hospital, provision of safe drinking water, vaccination, provision of drugs, health awareness and construction of hygienic latrines.

Conclusions and recommendations

The Sudanese researchers concluded their report as follows:

1. Health development structures studied were started in Sudan around 1970 by the Sudanese Socialist Union, the one party that ruled the country until 1985. The main idea was to mobilize young people and women in the area of community development and propagate socialist philosophy. These structures flourished at that a time due to the strong political commitment and support. In spite of the change of governments, these organizations and structures exist under the same names and functions. Due to the prevailing tight economic situation, a great deal is expected from these structures. In health, the government adopted PHC and the Health Area System policy as the key strategy for HFA-2000. Involvement of and interaction between the three partners, health sector, community and other health-related sectors, are seen to be the main approach to improvement in health given the prevailing economic situation and limited resources.

2. The inherited spirit of self-help, extended family ties, tribal affiliation, especially in rural areas, greatly facilitates the functions of these DHS. There is need to translate the political commitment, especially at state and province levels, to actions that could have more effect on improvements in health. Great efforts are needed to convince policy-makers at these levels in all sectors relevant to health that interaction between formal and informal organizations is important. Leadership development programmes in the form of PHC crash courses were conducted for orientation and training of members from these sectors, in the hope that they could be an extension to the health area management teams and facilitate or make easier the implementation of the HAS policy. The economic situation necessitates generating local resources by the communities and making use of the local prevailing inherited habits of self-help which are not only socially accepted, but are characteristic features in all rural areas. Health promotion cannot be an isolated goal. The PHC approach aims at comprehensive community development which encourages communities to bring about the required socioeconomic development. In theory, this coincides with the formulated national strategy of the country, but the latter is far too ambitious compared with the available resources. The declared "motto" calls for self-reliance: "We eat from what we cultivate and wear from what we manufacture". This is actually what makes things more difficult. The development structures are also engaged in other developmental activities related to other sectors, especially education and social welfare, which could have some effects on health development, but their efforts are not coordinated and in most cases not jointly planned resulting in overlapping and wastage of valuable resources.

3. Getaenna being a typical settled rural community with high literacy could not be considered as a typical representative of all districts. There is a wide range of variation, some districts have less potentials for development and the organizations and structures there are less active. In HAS, policy assessment of health needs is our major concern. If a community’s priority problem is safe drinking water, our role is
to help them plan to reduce the impact of their problem. In the end, the main objective is to achieve comprehensive socioeconomic development in the health area. Needs and priorities may change with time.

4. The main inhibiting factors for the proper interaction between the three partners (health sector, community, and other health-related sectors) can be summarized as follows:
   - Lack of coordination of functions and activities and collaboration between the different organizations/structures and government sectors and between the structures themselves.
   - Lack of clear objectives and strategies. Each structure follows regulations and orders from higher levels. These structures lack trained cadres who can define needs, set priorities according to available resources and follow up with implementation.

5. The main facilitating or encouraging factors were identified by the researchers as:
   - The inherited spirit of self-help, together with the Islamic teaching relating to cooperation between relatives and neighbours, support of the needy and sick and importance of hygiene.
   - The general feelings that there is a gap in resources and no other feasible alternative solution than community participation to bridge this gap.
   - The under-utilized potentials and enthusiasm of youth and women organizations for better living and health conditions.

The encouraging factors that might make the role of these structures more effective were identified as:
   - The political commitment by the government and its adoption of PHC and HAS policy as the main strategy for achievement of HFA-2000.
   - Decentralization policy and the new sub-division of states to suit geographical, historical and social conditions and at the same time to reduce the large size of old states and make communication and management more easy. This might bring the policy-makers and executing bodies more in contact with the communities.
   - The feelings of satisfaction expressed by community and other health-related sector representatives in all health areas planning workshops conducted for their participation in these planning exercises. The awareness of the future role expected of community and other health-related sector representatives in implementation generated a new spirit could be reflected in future collaboration, coordination and joint planning between these structures. This was what happened in the first leadership development PHC crash course in which the attendance was 100%.
   - Care had been taken to focus on the communities and develop the required interaction between them and the other sectors in planning or HAS policy implementation.

6. Important factors for sustaining the effectiveness of health development structures were identified as:
   - Promotion of the spirit of ownership in these HDSs as regards health programmes.
Conducting more PHC leadership development crash courses so as to orient and train more community and other health-related sector representatives in the PHC concept and implementation.

Further developing or creating interest in PHC and HAS policy through training of health promoters and volunteers.

Utilizing the potentials of the role of youth and women in effective health development.

Making health promotion part of overall socioeconomic development as planned in the national strategy.

7. Collaboration across sectors

> No major hindering factors for collaboration across sectors were identified by the researchers. They did, however, mention that the demands by communities for curative services and common failure to identify health needs can obstruct the process of collaboration.

The encouraging factors were summarized by the researchers as:

> All the organizations and structures under study have common, similar goals, i.e., improvement of health situations.

> The prevailing economic situation necessitates collaboration across sectors.

> More emphasis is being put on the potential role of the local councils under the new decentralization policy run by elected community representatives and are expected to facilitate collaboration across sectors.

8. There is a general awareness of the deterioration of services, especially at rural level, and of the inadequacy of resources. Involvement of local development structures in all stages from problem identification, needs assessment, prioritization, planning, monitoring and evaluation is important. The impact can be reflected in both generation of additional resources and in performance of functions and activities that lead to improvement of health.

9. If the present situation continues without effort to strengthen weak areas, the process of improvement in health will be very slow. The HDSs have lots of potential to affect an improvement in health. This can take place through a process of motivation and encouragement of these structures by utilizing the potential of young people in the improvement of environmental sanitation and control of communicable diseases, the training of women promoters to increase EPI coverage or the proper home management of diarrhoeal cases or respiratory infections in the under-fives, involvement of school teachers and pensioners in health education, etc. All of these functions are feasible and can be performed by the communities without additional funds. In all the HASs orientation and planning workshops conducted, the ideas presented above were discussed in groups and have been adopted and included in their plans of action. Follow up by the PHC network, especially at the province and district levels, can be very important.

Next Steps

The report will be used to strengthen the relationship of the Health Management Teams with the respective health development structures.
The Yemen study was submitted in August 1994. It was delayed because of the civil war that had taken place in that country in the same year. The study was entitled "Co-operatives Experience in Yemen".

The study was conducted in the Dhamar Governance where one urban district, Aanis, and one rural district, Wassab Assafel, were selected. The population of Aanis is 190,667 and that of Wassab Assafel is 111,645.

The structure of the LDAs (see Table 5) and its interrelation with the State formal hierarchy shows that the LDAs are far grassrooted. The representatives of very 500 villagers/citizens are the critical mass representing people and interacting with the State’s sectors and institution at the relevant level.

**INTERRELATION BETWEEN COOPERATIVES AND THE STATE**

<table>
<thead>
<tr>
<th>Level</th>
<th>Cooperative</th>
<th>Formal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CENTRAL</td>
<td>General Confederation for Yemen Development Authorities</td>
<td>- Leaders - Cabinet</td>
</tr>
<tr>
<td>LIWA (Governorate)</td>
<td>Cooperative Coordination Council</td>
<td>- Governor - Governorate Council - Ministries Office</td>
</tr>
<tr>
<td>KADA’A (District)</td>
<td>Nahya Assembly</td>
<td>KADA’A Director</td>
</tr>
<tr>
<td>NAHYA (Subdistrict)</td>
<td>Cooperative Committee</td>
<td>Nahya Director</td>
</tr>
<tr>
<td>OZLA (Village group)</td>
<td>Every 500 villagers elect one representative</td>
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</tr>
</tbody>
</table>

The Ozla (a group of villages) has a LDA committee which identifies and follows up implementation of the different development programmes. The Ozla committee decides on priorities and presents them...
to the subdistrict (Nahya) LDA Assembly. At this level the different projects of the subdistrict are again submitted to the governorate LDA Coordination Council where support of the governor and ministries offices is solicited. At this stage a comprehensive developmental plan is formed which is submitted by the governorate to the centre. The subdistrict assembly is responsible for supervising monitoring, follow-up and maintenance (sustaining) of projects.

Composition and hierarchy of the LDAs at the different levels:
The village development committee was introduced recently to support elected representatives in coping with the people's initiatives and ensure ownership by the people. Five members are elected to support the representative of the 500 citizens. This committee supervises implementation and organizes collective work as well as managing and financing the projects.

The Nahya's (subdistrict's) Assembly:
In a secret ballot seven members of the Administrative Committee are elected. The seven members select the chairman and general secretary. The distribute responsibilities among themselves. The Committee is elected for three years and its responsibilities are in collecting revenues, drawing plans, supervising and monitoring developmental projects, promotion of cultural activities and providing recreational facilities for youth, etc.

The Government Council:
The Council consists of the chairman of all Nahyas (subdistricts). The council elects its general secretary and assistant general secretary in addition to other technicians, such as engineers, lawyers, etc. The role of the Council is to support the subdistricts cooperative committees in drawing their plans and follow-up with central authorities' approval and financing of the governorate's projects.

The National Confederation of Yemen Development Associations (CYDA):
The CYDA is formed of three representatives from each subdistrict (Nahya), the chairman, the general secretary and a third member. In secret ballot they elect eleven members to form the Administration Council of CYDA for a period of three years. The general secretaries from the different governorates are added to the council. The chairman, general secretary and deputy general secretary are elected. The CYDA meets annually to discuss constraints and their solutions, as well as assessing progress and financial accounts.

It is clear from the function of the different levels of the cooperative movement that health is dealt with as part and parcel of the overall development of the local area. In this way health activities are more sustainable and well integrated with the other sectors' plans.

The study considered the potential for cooperatives (recently renamed as local development associations) to contribute to health development. These cooperatives have formal administrative structures and there is a "General Confederation for Yemen Development Association" (CYDA). Most of them started in the 1970s. The activities organized by the cooperatives are:

1. Religions affairs
2. Education
3. Health
4. Municipalities, transportation, electrification
5. Agriculture
6. Culture and tourism
7. Youth and sport
8. Communication

The researchers highlighted the following achievements of the cooperatives as being particularly relevant to health development: road construction and maintenance, education, water, and health services.

The researchers note that community participation in Yemen cooperatives was seen in three ways: partnership with government in the form of voluntary financial or work support for health development purposes; representation of community interests in particular development projects; and empowerment through the development of skills and capabilities which enable the community to manage its own affairs.

Factors facilitating the development of the cooperatives were noted as: the fact that they are a means of implementing democracy; that they do link the interests of the State and local community in a mutual way; that they provided a means of political expression at time of repression; that competition between villages encouraged action through the cooperatives; and that the State does not provide all services.

Factors impeding the development of the cooperatives were identified as: the high illiteracy rates which increased the Sheik's (religious leaders) power and control; the unclear boundaries between the activities of the State and that of the cooperatives; the democratic operation of the cooperatives has affected their democratic basis and sustainability; and government sectors tend to be organised vertically rather than horizontally, which reduces the opportunity for integration.

The researchers identified the following key lessons from their study of the cooperatives:

1. There is no clear national policy to support the cooperatives. Government agencies are organised vertically and this does not help them integrate with local organizations in a horizontal way. The lack of clear central policy has resulted in patchy development of cooperatives.

2. Community participation has advantages beyond financial ones. These need to be encouraged by changing the role of health workers so that they shift from being in control to being facilitators of local development. Local people should be encouraged to shift from being passive recipients of services to initiators and partners in health development. If these shifts in roles happen then partnerships and trust should develop.

3. A shift to a partnership approach implies an acknowledgement of the capacities of local communities. Health development should build on these.

4. Health development requires a willingness to adopt the needs and priorities identified by a community. The researchers recommended that the State should be encouraging and motivating and particularly encourage responsibility and personal initiative in communities.
Next Steps

The report will be summarized and discussed with the Ministry of Health officials who are interested in building links with the Ministry of Local Administration. The latter is responsible for the Local Development Associations.

WHO Regional Office for the Eastern Mediterranean will be requested to conduct a workshop on the types of partnership with LDAs for health development. WHO Regional Office will also incorporate the cooperative movement within its collaborative programme with Yemen during the 1995-96 biennium.

3.2.9 TANZANIA

Tanzania's study was conducted separately from this multi-country research project. However, the subject of the study is so close to this study on HDSs, that it was decided to include the essential findings of the Tanzania report into this review.

Tanzania’s study concentrated on the Village Health Committees (VHCs) and Village Health Workers (VHWs). The national PHC strategy in Tanzania emphasizes strengthening of a national health culture aimed at community-based health care through involvement of the community and their health workers. In order to achieve this, the government introduced the VHCs to support preventive aspects of health care.

The focus of Tanzania's study was determining the performance of VHCs and VHWs in relation to PHC activities and determining the factors that affect this performance.

The study selected 10 villages in the Iringa district, following a multi-stage sampling procedure. Over 200 people were interviewed within the villages, including members of the VHC, leaders not belonging to the committee, and randomly-selected village members.

The study report summarized the main findings as follows:

1. Only four out of 10 Village Health Committees had held at least three meetings over the past six months and in only three of the villages at least half of the VHC members interviewed had attended the meetings.

2. No difference was observed in the number of fields on which VHCs took decisions, but those VHCs meeting most frequently also carried out more decisions.

3. Most of the decisions were taken and implemented in areas related to sanitation. The next largest group was on MCH. Only 5% of the decisions were related to support for VHWs or about their management, which confirms the assumption that VHCs are weak in performing management functions.

4. The VHCs were ranked into three categories on the basis of number of meetings held, attendance at meetings, number of decisions implemented and time spent by VHC members on VHC activities. The VHCs were ranked as follows: three good, five average and two poor.

5. Size of the villages was not associated with the differences in VHC.

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6. The VHWs concentrated on MCH and sanitation and far less on health education. The first-aid activities were almost negligible, perhaps because of the lack of first-aid supplies.

7. There was no clear difference between better and worse performing VHCs with respect to VHC members' knowledge on the duties of VHC and VHWs. Only management duties were mentioned more frequently by better functioning VHCs.

8. According to the VHWs, VHC members and village government leaders, only in the four best functioning VHCs the VHWs had received a remuneration.

9. The functions of the Ward PHC Committees to support PHC had been formulated in too general terms.

10. Villagers appeared to appreciate sanitation activities of the VHC most. A remarkable observation was the low appreciation of women for MCH and health education activities carried out by the VHC members. These may be seen as the primary responsibility of health staff.

11. VHC members made the following suggestions to improve their own performance: more training from Village Councils and Ward PHC Committees, some incentives and opportunities to improve their own management skills and to be able to carry out management activities.

12. VHC members also made the following suggestions to improve the performance of VHWs: incentives, training, equipment and support/supervision from VHC and health staff.

4 ANALYSIS OF MAIN THEMES

"There are few areas of public health development which depend solely on the technical know-how and involvement of health professions. Instead, health and social development have become functions of many different and diverse inputs. This is especially true if health is seen as both a result and a prerequisite of development of the community." (WHO, 1994, p. 37)

4.1 Introduction

This multi-country study is part of the continuing work by the Division of Strengthening of Health Services, WHO, Geneva, to develop a better understanding of the ways in which district health systems work. It has been recognized that, although health development structures are wide-spread and crucial to promoting health, there are few systematic studies of their situation, problems and potentials. Many of the HDSs described involve community people in activities relevant to health organized through different forms of local structures. They also reflect collaboration between the health sector and other sectors, such as education, agriculture, urban and rural planning. Health development requires health sector personnel to work outside their established hierarchies and organizations and to develop networks and forms of collaboration that are significantly different to traditional working patterns in the health sector. The Technical Discussions of the Forty-seventh World Health Assembly noted (WHO, 1994, p. 40) that community action for health could provide an important means of developing collaboration between sectors. It also noted that such collaboration has often remained more an intention than a reality. The current studies, then, come at a crucial stage in the development of ideas about community action and collaboration across sectors to promote
health. They are able to shed some light on the benefits and potential benefits that may be gained from these structures, as well as illuminating the challenges and problems that may arise.

The countries studied in this report differ markedly in terms of their social, cultural, political and economic setting. The focus of their research also differed. Nonetheless, common themes can be drawn out and some general lessons relating to the operation of health development structures noted. The variations between the countries and their precise research methodologies have been presented in earlier sections of this report. The countries included in the study are in very different regions of the world and have a range of different political structures. Most of the studies cover rural districts in developing countries (Indonesia, Jamaica, Nigeria, Senegal, Sudan, Yemen and Tanzania). Five (Colombia, Jamaica, Senegal, Philippines and Yemen) study urban areas. All the study areas are comparatively poor and characterized by basic public health problems such as lack of clean water, high levels of infectious diseases, poor waste disposal systems, high infant mortality, lack of local knowledge about risks to health and comparatively sparse provision of health services. In other words, all the study areas faced multiple health problems and had limited outside and internal resources available to deal with these problems. There was, therefore, strong motivations for taking action to improve the health status of the population.

There has been little research on the role of community structures in health promotion. One exception is a German study (Trojan et al., 1992) that suggested reasons for the absence of research on this topic: the fact the structures consist of lay organizations and do not include health professionals; they do not have any direct responsibilities for health; the structures are often overshadowed by larger institutions; and, finally, the fact that medical definitions of health do not consider the contribution of such social structures to health. These factors are likely to be similar throughout the world.

4.2 Overview of the HDSs studies

The researchers in each study selected the exact structures that would be the focus of their study. What seems to be confirmed in reading the separate country reports is that there is a wide variety of arrangements that can be counted as local health development structures. The structures actually selected by the countries fell into one or more of the following groups:

1. Government-created structures involving the health sector and those sectors relevant to health (Philippines, Colombia, Nigeria).
2. Non-government structures that are generally nationally or regionally organized and may include "apex" groups which are organizations of organizations (Colombia, Indonesia, Nigeria, Yemen).
3. Formally constituted local groups including religious, youth and women's and traditional organizations (Senegal, Sudan, Nigeria, Jamaica, Indonesia).
4. Community/village health/development committees (Indonesia\(^1\), Jamaica, Tanzania, Nigeria).
5. Informal groups who have the potential to contribute to health but are not organized (Nigeria).

\(^1\) Integrated community health posts (Posyandu).
Thus, HDSs are groups and organizations, government or non-government, formal or informal that can be used to bring about socioeconomic and health transformation in a given area. It was beyond the resources of any of the studies to look at structures in each of these five types described above.

Health has long been recognized as being about all aspects of life (work, leisure, family life, friends, emotional well-being, the physical environment, education, housing and transport). This broad definition opens up considerable scope for health development while at the same time making the task of health development complex. Each study demonstrated this as they described the complex networks and patterns of relationship and organizations that operate at a local level, let alone those that operate between localities, districts and higher levels of administration and social organization.

4.3 Establishment of HDSs

The detailed descriptions of each country study shows that the establishment of these HDSs is varied. Broadly speaking, there are two ways in which HDSs have been established. Those formed within, or by, government tend to have been deliberately established to perform a health development function. They will, at some point, have been officially formed. The other way in which HDSs are established is through an evolutionary process whereby a particular organization has developed over time, often without any explicitly stated health development function. Of the latter type, some reflected organizations traditional to the local culture - such as the age groups in Nigeria or religious groups in Sudan - others were of more recent origin in the community such as the well management committees in Senegal or the disaster preparedness committee in Jamaica that had been formed by a local headmaster after the 1988 Hurricane Gilbert disaster. The HDSs studied in Indonesia were established by the central government as a model for rural areas across the whole country. They appear to be compatible with traditional village organization. In the Philippines the HDSs were bureaucratic structures which did not appear to have strong links with other sectors, less with the communities.

In the Jamaica, Nigeria, Sudan and Senegal studies the picture of local groups painted a more fluid picture in which there were may local networks that overlapped and intersected at a number of points. While there was little formal organization of the groups, those described appeared to be representative of the style and culture of the area.

4.4 Activities of health development structures

The HDSs described in this report cover a very wide range of activities. They can be grouped and listed as follows:

4.4.1 Health service activity

In this category, activities take the form of either self-help or voluntary work providing services or servicing on structures that advise or manage health services. The service activities can be divided into those that are primarily curative and those that are mainly preventive.

All of the HDSs studied had some role in supporting or providing services. For Colombia, this involved planning the work of the "Primary Attention Units". In Indonesia, this included traditional birth attendants and the work of the Posyandu (Indonesian integrated health posts). In Jamaica, this
includes a community health committee which provided fencing, a kitchen, water tank and refrigerator for a health centre and engaged in significant health education activity. For Nigeria, the work of primary health care management committees were studied. In Senegal, local organizations raised funds for the local health post, purchased medication, including a pharmacy kit for schools. The Sudanese study was conducted within the context of the Health Area System that has recently been established as a means of decentralization in the country. The Philippine study looked at committees that have a management role for the local health services.

In Senegal, HDSs conducted an EPI campaign, in Sudan, they aimed to contribute to local health education with campaigns such as the one to eradicate harmful traditional habits, including female genital mutilation. In Tanzania, health education work conducted by the Village Health Workers under the auspices of HDSs included nutrition, information about locally prevalent communicable diseases, family planning and immunization. The Nigerian report noted that HDSs were well suited to provide health education and encourage local people to learn new ideas about health because they are close to and usually a direct part of the community. The new ideas may, therefore, have a greater acceptability than if they were coming from an outsider. The Tanzania Village Health Committees were also responsible for reporting on epidemics. In Indonesia, the Village Community Resilience Board (LKMD) is responsible for promoting community awareness about the importance of cleanliness in homes and public places.

Most of the health education or disease prevention activity described in the studies were concerned with providing information to people about ways in which they could change their behaviour so as to be more healthy. Little of the community action was of a social action type where the group was involved in lobbying for change or challenging the activities of bureaucracies. At least one exception was the activities of the Gordon Town Disaster Preparedness Committee (Jamaica), which had ensured a reduction of new houses built on the river bank and introduction of terrace farming to reduce landslides and potential flooding.

Another important area of activity connected to health services, is the training activities organized by HDSs. In Jamaica, this included first-aid, cardio-pulmonary respiration (CPR) and simulation exercises for diseases. Other structures were responsible for training local health workers.

4.4.2 Management of health services

A number of the studies identified management of health services as a role of health development structures. This was seen in terms of making services responsive to identified community need, making decisions about the balance between curative and preventive services and deciding on the best way to use resources. The Sudan study noted that communities are often conservative in their attitudes to the activities health services conduct often expressing a preference for curative services.

The Philippine study focused on the municipal and provincial health boards. It found that the provincial health board was most concerned with management of hospital services while the municipal board dealt primarily with the management of broader public health issues. None of them had community representatives on them. So while they may have fulfilled the role of management reasonably well, they did not allow for community input to management of the services.
In Indonesia, the "Posyandu" - a health service unit provided by the community for the community, have been managed at the local levels.

In Tanzania, the Village Health Committee was responsible for managing VHVs, including receiving reports from them, selecting new ones and dealing with unsatisfactory performance.

4.4.3 Planning and policy development

Planning and policy development activities are closely connected to management functions. Good management is usually based on well thought out plans and strategies. Reorienting health systems to a primary health care and health development approach requires particularly good planning and policy development processes. Each case study in this report demonstrated this to some extent. In the Sudan, for example, 53% of respondents in community organizations felt they played a role in local policymaking and planning.

All the countries had experienced some formal government process of decentralization of health services. Decentralization does not, necessarily, mean the same thing in each country. The countries also had different traditions relating to decentralization. In Senegal and Jamaica, for instance, the process had started in the 1970s, while in the Philippines, the process was only a few years old and was part of the process of devolving government administration.

Many of the studies recognized the importance of developing local health plans that involve different government sectors and community organizations. Generally, however, little progress has been made towards developing one. The Colombian case study described in detail the efforts in the Kennedy LGA in Bogota toward the development of such a plan and the plan in the Barranquilla area to develop a local health network to encourage health planning and development. A number of the studies showed that HDSs were mechanisms by which local people can have a significant input to local planning. One of the main objectives of the Village Community Resilience Body (LKMD) in Indonesia was to assist the local authority with policy development related to promoting the health and well-being of the community. In Indonesia, planning appears to be a quite centrally controlled process with the potential for local communities to have some input to their local area planning. The community health committees in the Jamaican study had a direct role in identifying local environmental health problems and then working out how they should be solved. The problems were mainly to do with the provision of effective sewerage systems and clean water. None of the case studies documented instances of a structure whereby local communities could contribute in any significant way to policy development at regional or national levels.

4.4.4 Provision of infrastructures for health

These activities included measures to improve environmental health such as HDSs that provide an abattoir in Nigeria, drinking water in Senegal, building pit latrine in Tanzania and Jamaica. They might also include development of the social environment such as the work of the Family Welfare Movement in Indonesia that encouraged local people to plan for a healthy life by saving money.

A good example of the broader role of local organizations comes from the Nigerian Better Life for Rural Dwellers programme which is primarily concerned with developing cottage industries. This sort of development contributes to the economic well-being and so ultimately the health of the community
(World Development Report, 1993). In developing the industry, the organization has also ensured that the cassava and pepper grating machines are more hygienic when they make the staple food garri.

4.4.5 Encouraging collaboration across sectors and with communities

An overview of the studies suggests that the HDSs studied have considerable potential to bring together different sectors of government and different levels of government. Local groups tend not to see issues in terms of sectors but rather in a more holistic way that integrates rather than segregates issues, a horizontal rather than a vertical view. The following quote from the Senegal study illustrates this well:

"The main aims and objectives pursued by these associations are all concerned with improving the quality of life of populations by increasing the possibilities open to them. The specific domains concerned, by order of importance, education, social conditions, health, culture, sport, drinking water, livestock rearing, the living condition of young people and agriculture".

In Colombia, the study of the Kennedy area in Bogota showed that the existence of a committee to coordinate activities does not guarantee that this happens. One has existed in that study area for eight years and still has not, according to the researchers, managed to coordinate local planning. Various factors were mentioned as restricting the coordination between sectors. These included the fact that the member organizations did not have the same degree of decentralization and so the officials had different degrees of decision-making power, the absence of a strategic plan for the area, a division between the politicians and the technocrats, a sense of competition between the organizations especially for resources; and a lack of commitment by the officials to coordination. The Colombian researchers did note that workers at the operational level appeared to be able to coordinate more effectively than those at management levels.

The Senegal study mentioned in its recommendations that the regional development committee should take on the role of coordinating the activities of the community organizations it studied. While it is not stated, it is assumed that this committee already coordinates activities across different sectors.

The Jamaica study selected HDSs that were functioning very well. The researchers reported that they had strong formal and informal links with other organizations and structures. This network of links was seen as making each structure more significant in health development than if they had operated in isolation.

Fund raising

An important capacity of HDSs is their ability to act as fund-raising agencies for their communities. In no case was this function the only one performed by the structures, but it was often an important means by which health development strategies were implemented. The studies reported that funds were raised by HDSs to build or equip local facilities or to maintain particular PHC programmes.
4.5 Issues affecting the operation of HDSs

4.5.1 Resource availability

The main resource available to the HDSs are the people involved in them and their actions to support health development. There does not appear to be a particularly desirable size for HDSs. This will depend on the particular function of the structure and its mode of operation. Obviously, a certain critical mass is necessary for the structure to be effective in taking action.

Overwhelmingly the most frequently mentioned block in all studies was the lack of resources to do health development work and to support the operation of HDSs. This seemed to be the case wherever the particular HDS was funded from.

The Colombian and Philippine studies, which concentrated on structures closely associated with the formal health sector, saw one of the key resource problems as managing to shift resources from curative medicine to health development and health promotion. Those studies that looked primarily at local structures described the ways in which they spend a significant amount of their time fund-raising. The Senegal study noted that the typical small (under 100 members) organizations that they studied rarely received funds from outside their own structure. Often the structures were engaged in raising money for their local health services. Lack of funds means that the local people doing health education or helping to organize people are volunteers which means they may not be in a position to give as much time or effort to their role as they would like. The Yemen study of cooperatives indicates that from 1978-1981, the government contributed only 1% of road construction costs. The rest was raised locally.

A number of studies pointed out that decentralization of health services and the greater emphasis on community action in health development has coincided with a recessionary situation in their country. The report from the Sudan, for example, makes the point that a good deal is expected from informal structures in their country because of the tight economic situation. The Colombian report notes that there is a danger that the State will abandon its responsibilities for the health of its people and expect them to be more responsible for their own health even though they do not have the resources to be responsible. The Jamaican study reports concerns from health workers that the work of local organizations to raise money for the health services may absolve the government from its responsibilities. Despite this, one of the motives for involving a wealthy local landowner in one of the Jamaican organizations studied was to increase the resources available to the group. This pressure, may result in a decrease in the representativeness of the organization. The Nigerian reports noted that cooperation has become even more necessary because of the dwindling government resources, especially in the health area. The Colombian study noted that the trend towards privatization of health services may risk disintegration of the existing fragile Local Health System in their case study area.

There are likely to be problems in seeing community action and collaboration as cost-saving exercises. Evidence from studies of deinstitutionalization in countries such as the UK and Australia suggest that community networks often do not provide the care the policy rhetoric suggests they would. Collaboration may, in the short term, require more resources from the health sector. Time and resources need to be invested in establishing mechanisms of collaboration and supporting community people in their endeavours. Recession and the tightening of international money markets mean governments worldwide have less money to spend on services. Informal HDSs may be one way in
which the gap between supply and need are met. This raises important issues about the responsibilities of governments to provide adequate services for their population. The question is, should HDSs be seen as replacements to government efforts or a means for mobilizing additional resources?

4.5.2 Health sector coordination

Few of the case study areas reported having a comprehensive local plan for health development. While many of the organizations studies were carrying out work that they considered contributed to health, a number of the researchers mentioned that their efforts could be more effectively coordinated. Most importantly, there was often weak or non-existent links between the community structures and the formal health sector. In Indonesia, where the HDS had been established by the government, the links appeared to be stronger. Here the HDSs supported the work of the health services through, for instance, the Dasa Wisma welfare programme whereby the volunteers reminded women in the group of 10 households they were responsible for visiting the health post for check ups. Similarly, in Tanzania, the VHW had formal links with the health service. In both these cases, the health professionals assisted with the training of volunteers. The Jamaican report emphasized that health professionals could be an important catalyst in starting and maintaining HDSs. Often, however, this relied on them doing it in their own time and with little support or incentive from the health departments.

The Colombian case study provides an excellent example of the difficulties of coordination between different parts of the health sector and between different sectors. In both case study sites – Kennedy local government area and Barranquilla - considerable difficulties in coordination were described. Gray (1989) reviews evidence on building collaboration between different stakeholders. She concludes that for collaboration to be successful, collaboration should be characterized by five features:

1. recognition by stakeholders of their interdependence
2. a way of dealing with differences constructively
3. development of joint ownership of decisions
4. the existence of a shared vision
5. acceptance that the process of collaboration is a developing and changing one.

The area of collaboration between agencies for the purposes of health promotion is much discussed in terms of rhetoric, but its practical application has been given little research attention.

4.5.3 Representativeness

Participation of local communities is generally seen as crucial to health development. Oakley (1989, p.2) described the purpose of health development as seeking "innovative and flexible procedures, taking into account the knowledge already possessed by local people. Participation in this sense is concerned with the production of knowledge, new directions and new modes of organization".

The studies in this report did not have the resources to collect data in relation to how representative the community structures were of their communities as a whole. This is an important question. Criticism is often made of community participation in HDSs by claims that the local people involved are not representative of the population as a whole. This argument ignores the fact that even the involvement of a few local people ensures more local input than does planning and development
which consists only of professional workers who are usually outsiders to the community. One of the problems the Philippine’s study noted was that 89% of the people on the Municipal Health Boards were professional medical and allied health staff. There was just one representative from a nongovernment organization. Clearly such a group would have difficulties presenting a health service users' view. The researchers felt that such a view would be necessary in planning health services. The studies in Sudan, Senegal and Nigeria demonstrated that a wide range of local people were involved in many different types of health development activities. Conyers (1982) discusses the issue of representativeness in relation to social planning in developing countries. She points out that ensuring representativeness is problematic given internal community conflicts and divisions. Sometimes, communities are composed of conflicting groups based on such dividing factors as clan or linguistic groups. However, this should be seen as a challenge to rather than as an argument against representativeness.

Within each community, there are also likely to be many who are not involved to any great degree in health development activity. This may be because they do not feel they have anything to contribute because they do not see how their skills could make a contribution. Others may have a wish to contribute but feel inhibited for a range of social, economic and cultural reasons. Others may have no desire to participate in activities beyond their own home environment. Often people who do become involved in community action for health are not the most in need. They are more likely to be people with economic security and higher levels of literacy and education (International NGO-PHC Group, 1994). People who are involved in one local structure are likely to also be involved in another. A number of the studies noted this. There appear to be people who are particularly likely to be active in local groups. Evidence suggests this is usually a minority of any given population and may well be the better-off members of a community. Representativeness depends on how a broader cross section is attracted to the organization. The crucial factor may be that the overall pattern of organizations in the area should be representative of the general population make-up. Generally the government-created structures were less representative than the local, informal groups.

It was beyond the resources of this study to determine how many people within the study areas were involved in some form of HDS. This will be an interesting line of inquiry for future research. Detailed local studies could assist in determining the untapped resources and skills in local communities and determining how these could best be utilized. They could also determine what approaches have been used to involve those who are traditionally less likely to become involved in community action. The Colombian study quoted information from a local NGO that suggested that more than 80% of the families did not participate in solving their problems at a community level. Reasons for this were suggested as: mistrust in the leaders, absence of training, unfriendliness between neighbours, lack of community meeting places, lack of resources from organizations to motive people and the fear of political manipulation. If the poorer (and usually) sicker members of the community are not represented, then it is less likely that their perspective will be presented in local health plans and so limit their ability to address issues of equity.

Some of the studies did note specific problems of representation. The Colombian study noted that the average Committee of Community Participation that they studied had five active members. The largest was 11. The study also noted that the committees had better contact with the health services than they had with the community.
The Indonesia report noted that the village health workers or cadres are nearly always selected by the village head and that many are relatives of his or of other leaders in the community. Similarly, the Posyandu are established by consultation between the health authority and the village leaders.

The Jamaican study noted that the HDSs generally did not involve the local elites (who could be useful because of their resources) or the poorer marginalized members of the communities. They also noted from the interviews with members of the organizations they studied that efforts were made to make the structure membership as representative as possible. This study also noted that there are a number of environmental factors that may affect people’s participation in HDSs. These include the availability of transport, whether or not people feel safe moving about their community and the amount of free time people have.

The Nigerian study was the only one which attempted to consider the role of people who were not organized within some structure in the communities. The Nigerian study noted that the group of beggars they interviewed did not have much notion of their role in contributing to health and that this role was, in any case, severely limited by the extreme poverty, handicap and poor living conditions. Given resources, however, they do have the potential to improve their health. If authorities could discuss their situation with them they are likely to be the best people to suggest solutions to their health problems.

In general, the informal HDSs do provide a vehicle for community participation. Those outside the formal government organizations are generally better placed to do this than are government-created structures.

4.5.4 Skills for collaboration in health development

Another factor that came up in each study was the question of skills for collaboration. This was raised in relation to the skills of community people and those of health sector personnel.

Skills of local people to participate in HDS

The case study areas were generally characterized by high levels of poverty and multiple threats to the health and well-being of the local populations. Literacy rates varied. In general, local people had had few opportunities to develop the skills necessary for working collaboratively with different government agencies and a range of local organizations. Given the range of health development functions that might be performed in a local community, the skills needed could be extensive. For those performing primarily health education activities, they include knowledge of diseases, ways of preventing them, basic understanding of drug therapies, understanding of the threat of environmental hazards and knowledge of how the health system operates. For the activities to do with organizing health development, the skills required may be more complex and will include conflict resolution skills, budgeting knowledge, personnel management, planning, strategy development, and skills for organizing their own communities to take actions to promote health and evaluation. The studies in this report suggest that most of the action to promote health currently is in the form of health education. Far less is concerned with social action to change physical, social and political living conditions that commonly cause illness. The work of educators such as Freire (1973) and Werner (1980) is particularly important for encouraging those involved in community organizations to develop the analytical skills and ability to take the forms of action that are required to encourage structures to
change. Also, those organizations whose relevance to health development is less immediately evident may need some training that relates their activity to health. This is especially the case as a number of studies noted that local people stated that they did not see health development as their concern but rather believed it to be the responsibility of the State-run health authorities.

Appropriate styles of training based on adult learning principles have been outlined in the report of a WHO Study Group on Strengthening the Performance of Community Health Workers (WHO, 1989). Training should build on the inherent strengths of the community. These strengths are discussed further in section 6.1. In the Sudan report, their experience with training was detailed. Primary health care leadership courses had been run and achieved full attendance and were very popular. In Tanzania, better training for both Village Health Committees and Village Health Workers was seen as very important. Management skills, in particular, were highlighted as important for the Committees.

Skills of health service personnel to encourage participation and collaboration

If health officials are to work effectively with local communities and encourage them to take action to promote health, then they have to have the necessary motivation and training. Few instances were reported in the case studies of health professionals supporting development work. There were, however, a number of instances of them supporting health workers in their curative and health education role. If local HDSs are to be enhanced and used effectively, then health professionals will have to understand the dynamics and operation of the full range of local organizations. They will also have to develop the skills to work effectively alongside them. Perhaps the greatest skill required here is listening and learning to appreciate indigenous knowledge as both legitimate and complementary to technical knowledge.

4.5.5 Political context and political and bureaucratic support

It was evident from a number of the study reports that the particular political context of the country was important in determining the operation of the HDSs. For example, there is the contrast between Indonesia where a less-flexible, highly structured and centrally-determined health system supports uniform HDSs which appear to leave little room for locally-created structures and the case of Colombia where the political system is more flexible, and where HDSs are varied and have to conduct on-going negotiations with the political sector in order to gain resources and legitimacy. In other situations, political changes within countries mean that the relationship of the HDSs with the government sector change over time. This was the case in Yemen, where cooperatives have become more or less important in providing local health facilities, depending on the policies of the central government. It is important to take into account political contexts when determining the role and functioning of HDSs. These structures are very dependent on political circumstances.

A number of global economic and political trends were also noted as likely to affect the operation of HDSs in the future. These trends include a shift towards greater focus on individual, family and community responsibility for health; and moves towards the privatization of health services with a parallel emphasis on efficiency above other goals. On the other hand, global trends likely to be more supportive of HDSs, could include the desire for increased participation, decentralization and a continued emphasis on the PHC approach.
Obviously local health development is likely to be most effective where there is strong political and bureaucratic support for it. A decentralized health system is likely to be more capable of supporting local health development than a centralized one. All the countries in this study had policies to bring about decentralization, but they differed in the extent to which the policies had been implemented. In Colombia, for instance, while the legislation to bring about decentralization had been passed in 1990, by 1993 the policies had only begun to be implemented. In Indonesia, support to local structures is mandated and legislated for. A Presidential decision stated "All activities in the village should use the LKMD Board for the process of decision-making". This is strong support that may encourage local action for health but also may stifle initiatives within communities that result from grassroots action and organization because these would not be the centrally preferred form of development.

The Sudan report suggests that local organizations such as youth, and women’s popular committees have flourished since they were established in 1970 because of strong political support.

The Nigerian report paints a picture of lack of support for informal structures from the health sector. The report says, for instance, that the local health professionals do not even know about the groups and clubs in their areas. While the local government does have a Primary Health Care Committee, there has been little effort to involve local people and more inhibiting than encouraging factors in relation to their involvement were identified.

The Philippine study found that while the local health boards had been set up to devolve health service management this had not really happened because they had an unclear role and did not have sufficient resources. Despite this, those boards, judged by the researchers to be operating best, had developed some links with local structures such as farmer organizations, Rotary and women’s organizations.

In Senegal, the researchers concluded that the health sector could do more to work with local structures. They also noted that the policy of decentralization that applied in the Fatick area since 1984 had encouraged the local community to organize. The report emphasized that development is most importantly a process that should be motivated from and driven from within a community. They felt that the regional development committee could play a greater role in coordinating and monitoring the activities of the local groups and in providing training and technical support. They also warned that the regulations surrounding the operation of these groups and organizations should be kept to a minimum.

4.6 Factors contributing to successful health development structures at a local level

The following factors are suggested by the studies reported here as contributing to successful local health development. The evidence to support these comes from the conclusions made by the researchers in the separate country reports.

4.6.1 The local community has a sense of ownership of the structures and sees the links between their activities and health development. This is most likely to happen when the HDSs have developed from the grass roots and so reflect local tradition and culture. The local structures should reflect and support community strengths.
A clear theme emerging from the studies was the importance of building on the inherent strengths in local communities. Typical comments related to this from the reports was the Sudan report which noted the "inherited spirit of self-help, extended family ties, tribal binding" that could, in the view of the researchers, be used to great effect in health development. Similarly, the Colombian report notes that the local people are characterized by traits that relate directly to health development. These include their love of children, large extended network of friends and families, and their creativity and resourcefulness in dealing with crises. The Jamaican report observed that many of the effective links between organizations were based on friendships and a local spirit of cooperation. The message from the reports was that people themselves are a crucial resource for health development that currently is not utilized as much as it could be by the formal health sector.

Alongside this message is a related one that emphasizes the importance of building on the existing community infrastructure, rather than trying to establish a new and separate one that has no local credibility or roots. The Senegal report stressed the importance of this. It described the wide range of local organizations that had been largely overlooked by the health services. It was also clear from the reports that some of the communities studied were more stable than others. The Colombian areas studied were characterized by high levels of dislocation and violence. This contrasts strongly with the village structure in Blitar in Indonesia where a strong community structure with defined hierarchies was described. The Jamaican report noted that HDSs were not as strong or effective in inner urban areas as where community organization for health is less common and violence was a major problem. The HDSs appeared strongest in rural areas. The principal investigators agreed that donor agencies and governments should recognize and utilize the network of local organizations. These groups may well prove to be a more sustainable base for health development than new structures imposed from outside the communities. Areas with organized HDSs which can articulate local needs and priorities should be in a strong position to receive direct support from donors.

Communities are rarely homogenous. They may be divided along class, culture, religious and gender lines. Good development structures will need to be capable of negotiating these differences and ensuring that all voices in the community are heard. All the reports suggest that the crucial role of women in development is now well recognized. Women's groups play a key role in promoting health within households and local communities. The role of women in HDSs is important and should be maintained and strengthened.

A further challenge in strengthening the capacity of community structures is the need for negotiation between the concept of self-reliance and the possibility of too greater expectations being placed on the resources of a resource-poor community. Van der Geest, Speckmann and Streetland (1990) discuss this problem in relation to primary health care. They suggest that an emphasis on self-reliance reflects western cultural values of individualism. Further they say that the notion may not always be liked by villages who may feel it is a euphemism for leaving them to fend for themselves. This suggests that those involved in health development should ensure that the views of outsiders are compatible with those of local people in terms of concepts such as self-reliance. Certainly the health professionals in the Jamaican study were concerned that community fund-raising may "let the government off the hook".

The traditions of community cooperation described in the separate country reports provides a good basis for public health action. Tesh (1988) noted in relation to the USA that the strength of the philosophy of individualism makes the implementation of disease prevention policies difficult. She
describes a concentration on the importance of the rights of the individual over and above those of the community as a whole. In more traditional societies it is possible that the cultures are more concerned with collective needs than with only those of individuals. The conclusions from some of the studies in this report indicate that this may be the case. If so this is an important feature of the communities for those concerned with health development to build on.

In the studies in this report only the Nigerian one targeted marginalized groups for more in-depth consideration. They interviewed beggars and found that they had some motivation to take part in health development. If only the most powerful groups in a community are involved in health development then existing patterns of equity may be reinforced. Formal bureaucratic mechanisms are the most likely to exclude the least powerful in a community who are likely to have very few skills at negotiating with officials. The literature on participation stresses over and over that participants should not be only those who already have some power to participate while the least powerful are marginalized (Dwyer, 1989; Bracht and Tsouros, 1990; Yeo, 1994).

There is an extensive literature on the many issues that affect types and levels of participation. A distillation of issues from this literature and from the studies reported here suggest the following factors are important in determining the levels of participation in health development:

1. The complexity of the social structures and organizations in a community. Generally rural communities (see, for instance Senegal) offer more opportunities for informal participation. In large urban areas participatory mechanisms are complex and less accessible (see, for example, the Colombian experience).
2. The degree of heterogeneity in a community in terms of class, culture, religion, values and such factors. Generally the more homogeneous the community the easier it would be to ensure representation.
3. The degree to which communities feel they can control events and affect the health of their community. The Disaster Preparedness Committee in Gordon Town, Jamaica, prepares the community to manage events (disasters) and attempts to mitigate the effects of these events. A community that feels powerless to affect events is unlikely to be willing to participate.
4. The tradition of participation and community involvement in health related matters in the region.
5. The willingness of the health sector to support participation for health development. This means ensuring that the community can see how they will benefit from their participation (as opposed to the health sector personnel who may benefit, for example, from gaining endorsement for decisions they have already taken). Participation should be more than manipulation and rubber-stamping of decisions and aim at mutually beneficial partnerships (Arnstein, 1969, Brownlea, 1987).

4.6.2 Decentralized health services that encourage local people to play a significant role in health service management and in determining their direction and planning were considered by the researchers to be an important contributor to health development. Health professionals should make a conscious effort to develop partnerships with local communities. The formal health sector should support the HDSS with technical and training support and use and develop the networks of local organizations for a variety of health development purposes. These purposes include: gaining
information on local health problems and the community's ideas for their solution; encouraging community action related to local health issues; and encouraging community self-reliance.

Policies that aim to create an environment which legitimises collaborative health action are likely to set the scene for a decentralization of health service management. Each of the countries in this study had such policies but they had been implemented with varying degrees of success. There also needs to be strong commitment and recognition of the value of developing partnerships with local communities and for searching for innovative solutions to a community's problems. Health professionals need to feel that their work with communities is recognized and encouraged. They should be rewarded for such activity. The sense of the studies reported here is that this is generally not the case. Few instances of strong partnerships between community people and health professionals have been reported. A good example was in the Jamaican study where a nurse had been very influential in the formation and progress of the Southfield Community Health Committee. She was described as being "greatly loved and respected" by the members. Another effective partnership was reported by Nigeria, where the local university trained students at the district health level and believed this was important, in part, because it exposed students to community organizations and their potential to contribute to health development.

The principal investigators have concluded that an important challenge for the formal government health sector is to recognize the value of the more informal and community-created structures that have the capacity of contributing to health. They believe that it is important that all health professionals and health workers should come to appreciate the existing role and future potential of HDSs. They recognize that in order to achieve this it will require health service staff, trained as they are, to see their role as that of exclusively providing services, shift to appreciate and value working in partnership with local groups. For some people this will be difficult and they may be resistant to change. The process of change for individuals would be assisted by the existence of an organizational culture that explicitly supports health workers in developing links with community groups and in facilitating health development "outside" the formal district health services. It was also recognized that working more directly in health development will require health workers to develop an understanding and acceptance of the political context in which they will be operating.

Health service personnel often find it difficult to devote much time to the notion of health development. The report from Sudan noted that one of the factors inhibiting collaboration across sectors was the community demand for curative services. This demand is difficult to satisfy even when health service provision is extensive. On the other hand, the researchers noted that the areas with the worst health status and social conditions had no health services located in them. Given such a situation it may be difficult for health service planners to devote much attention to health development. While they may know it is likely to have an impact in the long term it is difficult to keep that perspective in mind when there are so many immediate and obvious needs to be met. One solution may be to have particular staff within the district health system designated as having responsibility for health development and encouraging planning across sectors. The feasibility of such a model could usefully be explored.

The development of effective partnerships with community people and organizations takes considerable time to develop. It certainly will not happen overnight. This means district health systems have to expect that their workers will take years to develop these partnerships and expect that they will have to put time and effort in to maintaining and developing community networks. In the
Philippines and Columbia, for example, the planning committees described had a very short history and so perhaps could not be expected to be functioning effectively.

Evidence from two Australian studies (Walker, 1992, SACHRU, 1994) suggest that community health centres in that country have developed extensive networks of links with other government and non-government organizations. Walker (1992) stressed that the links between organizations served as mediating structures to link people and their agencies in coalitions of interest. The South Australian study (SACHRU, 1994) reported that health workers found the links with other organizations important to their work but that they were stronger in relation to continuity of care than they were in relation to health promotion activities.

Health systems should promote the importance of community structures to health development. To some extent these structures are currently invisible to the health system. This was well illustrated in the studies in this report by the fact that some studies did not include them while those that did commented that the role of these structures in health development was not recognized by the formal health system. Strengthening their capacity would mean promoting health. This could be done by providing them with appropriate training, additional resources and formal recognition of their role. This support to community structures would be, in effect, an investment in health. There was evidence from those studies that looked at community structures that these structures had an untapped capacity in relation to health development. This capacity could be developed if health was put more centrally on their agenda. Trojan et al.'s (1992) study of community structures in Germany also concluded that a special effort should be made to spread the idea of health promotion to grassroots groups. They suggest the establishment of a special fund that would enable local groups to conduct projects that they can not fund themselves. Such a programme, they argue, would be an incentive for innovation and new ideas.

A variety of training and skill development needs were identified through the analysis of the study reports. These may be summarized as:

1. Training relevant to health development for staff within the health sector. This training should be tailored to the particular needs of specific groups. For instance, the Board of Management in the Philippines' study had very well developed financial and general management skills, but did not have a strong health perspective or understanding of the processes of health development. By contrast, local community health workers with low literacy levels may understand well the dynamics of their community and its relationship to health, but need assistance in using their local knowledge and experience in a formal planning process. Whatever the particular needs training should be aimed at enabling the formal health sector to support and work effectively with HDSs. It may be that this training is best conducted by people outside the health sector. The aim is not for the health sector to take over the organization of HDSs, but rather learn how to work with them.

2. Training for people within identified HDSs. It was noted that the HDSs identified had very different levels of operation and expertise. Some of them had demonstrated the capacity to develop a plan, sort out key issues and take action (Senegal, Jamaica and Yemen provided particularly good examples of such structures) while other structures were more fragile. These latter structures had considerable potential that had not been fully developed in relation to health. Here some local training on defining health
issues, setting priorities, organising action and ways of building partnerships could considerably enhance the capacities of local community groups. In some cases training and skills development may be important to ensure that people working within these structures appreciate the contribution they may be able to make to health promotion.

Health policies should also offer strong endorsement to the perspective that is based on social, economic, political and environmental understanding of health and disease. The principles of PHC provide such a framework. Brown (1992) draws the distinction between health policies and policies for health. She makes the point that the former are usually concerned with the provision of sick care while the latter have a far broader mandate and often are formulated outside the health sector. The role of the health sector is to identify the need for healthy public policy and to organize communities to lobby for its introduction. This role should be endorsed in health policy statements. The role will not, of course, always be uncontroversial. In South Australia, where a Social Health Policy has been adopted by the State government, community health centres still find that their lobbying activities done in partnership with a local community (for example against the opening of a tannery that the residents believed would be very polluting) are not always welcomed by the State government. Health professionals have to become adept at negotiating such contradictions.

Policies need to be supported with resources. In the Colombian case study in Barranquilla the Southwestern Autonomous Committee which was formed in 1990 by two non-government organizations to create a health network strategy receives no resources from the health system. While, as the Senegal report pointed out, a balance has to be struck between promoting self-reliance and dependence on outside resources, HDSs are likely to need some resource input from the health system if they are to develop effective collaborative networks.

4.6.3 Some of the case studies suggested that using the resources of community HDSs was a way of coping with diminished resource availability. It is not desirable that HDSs are supported primarily as a way of cutting costs.

HDSs should not be supported primarily because there is a potential for cost cutting. Many of the reports noted that the prevailing economic conditions necessitated collaboration. This assumes that partnerships with communities and collaboration will result in reduced costs. This is not necessarily the case. Establishing networks and partnerships takes time and the benefits may take a few years to be realized.

A few studies noted a trend towards privatization within their countries. It was unclear what the relationship between private-for-profit health services and HDSs might be. If market-oriented systems arise in the future this topic will require more attention.

In times of diminishing resources organizations have a tendency to turn inwards and focus on internal matters. They may be reluctant to make the effort to develop collaborative networks. Health services, in particular, may retreat to concentrate on "core" business which is usually curative activities. Health promotion and disease prevention are often seen as optional undertakings.
4.6.4 There is collaboration across sectors (including the local administrative structure) and involvement of local groups and organizations in developing a local health development plan which combines technical and local knowledge to define problems and solutions appropriate to the local area.

In the Sudan, Senegal, Indonesia and Nigeria the local groups and organizations were performing functions from a range of different areas as described above. A variety of formal mechanisms for coordinating health development across sectors and with the community were demonstrated in these structures. It was noted that integrated planning approaches aim to be as inclusive as possible and the studies reported here do include community and other sectors’ interests more than in the past. Such mechanisms require political and administrative support (Hancock and Duhi, 1987) if they are to function effectively. Even if coordinating structures are established it may also be difficult to ensure the effective involvement of local people in the structures established. Such things as meeting styles may be off-putting and alienating to people not used to coping with them. This has been shown to be the case in similar projects in Australia (Cooke, 1993) so in countries with lower literacy rates and less opportunities for education such alienation is likely to be more of a risk.

Local government structures potentially have much to contribute to the coordination of local health development. Jamaica did explore the role of local government (Parish Councils) and proposed that they be strengthened for greater contribution to health development. The geographic boundaries of the Parish Council constituencies, however, do not coincide with those of the health district and this could be an obstacle to the coordination of developmental efforts. In the Kennedy area of Bogota, however, the Local Health System boundaries are the same as those of the health area. It would be useful to explore the role of local government in more detail in the context of health development. The report from the Sudan commented that the new emphasis in their country being put on local councils (which contain elected community representatives) was expected to facilitate collaboration across sectors. The Nigerian report used a local government area as the basis for its study area. The WHO Healthy Cities project has encouraged local governments across the world to become involved in health promotion activities (Kickbusch, 189; Ashton, 1990; Tsouros, 1990). Countries interested in encouraging health development structures should assess the capacity of local government to contribute especially in the role of coordinating activities at the local level and make the necessary policy changes to facilitate this role.

A number of studies mentioned the role of local health plans in encouraging collaboration. Much of the effort of the Colombian HDSs had gone into devising such a plan. The researchers concluded, however, that only slight progress had been made and that there needed to be more coordination between sectors and between the informal sector and formal sector. This is what was attempted in the Colombian area of Barranquilla, where thirty-one organizations, government and non-government have designed and decided to implement the Health Network 2000 project. According to the researchers this committee keeps operating because of the efforts of the NGOs but does not get sufficient political or bureaucratic support. The Indonesian study reported that the Blitar area’s health development was primarily centrally planned. There was some scope for local planning but primarily within the overall national, regional and district framework.

The studies in this report suggest that there should be some form of local health development plan. The size of the region to be planned for would depend on particular local conditions and the extent of decentralization. The features of the planning process would be:
Establishment of a local committee with representatives of different health related sectors and local organizations. The Committee's establishment and function should be endorsed by local political structures and relevant departments of each sector.

Agreement that the health plan would focus on health promotion, encouraging collaboration across sectors and encouraging community action for health.

Compilation of a description of the local resources for health development, including a listing of the organizations involved or with the potential to be involved in HDS's, existing initiatives in the area of health development and the existing strengths of the community.

Clear definition of local health issues based on consultation with a range of local organizations and groups. A range of methods can be used to do this, including surveys, group discussions, analysis of data on local health status and demography, etc. The process should maximize opportunities for community people to participate in ways in which they are able.

Decision on the priority order of the issues identified.

Drafting of strategy plan for each identified health issue.

Decision about which HDS is to take responsibility for each aspect of the plan.

Implementation and evaluation of the plan.

The plan should be revisited annually to check its on-going relevance and probably subjected to a major revision every five years.

Such planning processes are easier to implement if different sectors have the same level of decentralization. This is, however, often not the case. It should be recognised that planning is not a substitute for action. Planning, especially that between sectors, should be kept simple and done in the knowledge of the local resource constraints - resource-based planning. There is a danger that the production of a report becomes the main outcome of a planning exercise. In fact planning should be a dynamic process which should be well documented or recorded. The main advantage in terms of encouraging local collaboration would be agreement that particular issues were the most important ones for the given area and agreement on a plan of action with allocated responsibility.

Given the complexities of improving health in situations where there are many different levels of administration and government and a complex network of local structures that have an impact on health development, it appears important to pay more attention to the links and dynamics between these different sectors, levels and structures. Research on these should document the interactions between the various structures, gain a view of the perspectives of different people within them and develop mechanisms of assessing their actual and potential contribution to health development.

4.7 Conclusion

The studies reported here provide support for the idea that community organizations with HDSs perform important functions for people's well-being and are a "hidden health promotion system" (Trojan et al, 1992, p.454).
5 Principal Findings and Conclusions

5.1 Understanding Health Development Structures

This research was launched with a working understanding of what was meant by a Health Development Structure. This initial statement can be found on page 1. The statement was deliberately couched in general terms and explained as broadly as possible so that the researchers would not feel constrained by a more specific definition. The original protocol for the research defined the district health system as consisting of three main components: health facilities, health management and health development structures (HDSs).

An overall conclusion of the research is that HDSs are generally widespread and can be identified, at times in considerable number, in districts. There is, however, a wide range both of types and functions of HDSs which makes it impossible to talk in terms of a universal definition. In the individual country research reports the following main characteristics of HDSs were reported:

- they can be organizations, groups or recognized bodies;
- they can be both informal or formal;
- they can be found at the district, subdistrict and community level;
- they can be more directly linked to the existing district health system (e.g. health committees) or they can be less directly linked with this structure (e.g. community groups, religions groups, etc).

Some of the HDSs identified (district councils and health groups, for example) are largely a part of the existing district health system and their performance and viability will often be influenced by the performance and viability of the health system. Many other HDSs, however, came from larger traditions of local level community organizations and action and have survived and continued to function irrespective of the ups and downs of the district health system. Indeed, the majority of the HDSs owe their origin to age-old community tradition of mutual support and cooperation and have a long history of community action. Often structures at this level have continued to exist despite the vicissitudes of development policy and performance at the national level.

To give a flavour of the kinds of HDSs that exist, the following is a sample of the HDSs identified by the different country studies:

| Community Groups | Social Clubs |
| Community Organizations | Cooperative Societies |
| Village Councils | Women's Development Groups |
| Health Committees | Economic Interest Groups |
| Mutual Aid Groups | Youth Groups |
| Religious Groups | |

An important conclusion of the research was the appropriateness of the use of the term "health development structures". The term was used deliberately because of its overall, general and umbrella nature which suggested something "structured", "with shape", "developmental" and "participatory". All of these, as those in the list above, are structures, but structures with different forms, purposes and membership. It is an inexact term, but it proved useful for the research in terms of its all-
embracing nature. Sometimes the word "structure" has created problems because of the usage in connection with the other components of the district health system, namely "health services" and "health management".

In terms of their involvement in health, HDSs studied during this research appear to undertake a wide range of activities. These activities have been summarized in section 4.3 as part of a categorization of HDSs based upon activities undertaken. Where they can, HDSs interact well and support the work of the district health service; they can mobilize local people for health care activities and, where resources are available, they can contribute directly to health service delivery at the district level. In more general terms HDSs also have an educational function in terms of the population they represent. They can also often be involved in broader socioeconomic development initiatives at the district level and they can take on an advocacy function in terms of promoting awareness of local health problems.

Finally, and while not suggesting that it would be either appropriate or possible to offer an universal definition of a HDS, the following statements from three of the country based studies help to give some idea of the nature of HDSs:

"A HDS is a social structure—either an organization, committee or any kind of group—created formally or informally within and by a given community, to engage people of common interests to work together on community health or health related problems and to effectively solve these problems beyond the health services". [Senegal]

"Any group, body or organization which interacts with the health care system in such a way as to promote the improvement of the health status of the population". [Jamaica]

"HDSs are community groups or organizations that can contribute to intersectoral socio-economic and health system development". [Philippines]

5.2 Main Findings

This multi-country study of health development structures within district health systems has shone much light on the situation, challenges and prospects of these structures in terms of their ability to contribute to health development.

5.2.1 Situation

Most significantly, this study has shown that significant structures performing health development activities do exist at the district level. Many of the studies revealed that organisations outside the government health sector were performing important health development functions. The organisations outside the formal government structures are very often invisible to the formal health sector. This means they are, to a large extent, an under-utilized resource. In many health districts the numbers of these organizations can be quite considerable. For example, both Nigeria and Senegal documented around 500 HDSs within the district health areas they studied and the other studies similarly reported upon the existence of a significant number.
It would appear that to date few studies exist of HDSs. Hence this multi-country study offers a unique opportunity to derive lessons from a systematic study of these structures in different countries. The meeting of principal investigators held in October 1994 concluded, on the basis of the research, that the HDSs constitute an important community network of organizations that is capable of contributing significantly to health promotion and that district health services should both document the HDSs which exist within their districts and also seek to establish a working relationship with them. The HDSs identified in this study have been divided into five groups (see section 4.2).

The health development activities that HDSs carry out were varied. Some HDSs work directly with the district health services and their activities included fund raising, health education and information provision. Others related more to the management of health services and to planning and policy development. Others provided particular infrastructures for health (e.g., provision of water supplies or building of pit latrines) or helped in the development of collaboration mechanisms that operate across sectors.

Finally, this research suggests that there are multiple ways in which HDSs can evolve and operate. The discussion of the definitions in 5.1 above demonstrates that flexibility in understanding is important to allow the development of HDSs that are tailored to the needs of particular communities. Local political, economic, cultural and social circumstances will shape the exact nature of HDSs and the ways in which they interact within the district health system.

5.2.2 Challenges

As well as recognizing the potential of these HDSs, the principal investigators and resource persons noted that their use and development by the health sector presents a number of challenges. The following issues, which were identified as significant in the operation of HDSs, contribute the major challenges to their future development:

- Resource availability, including human and material resources to enable HDSs to maintain a minimum of structure.
- The willingness and commitment of district health services and management to work in partnership with HDSs.
- Ensuring the representativeness of a HDS in terms of the population within a given area. It was noted that these structures at the moment tend not to include the poor and marginalized in particular communities and may have a tendency to be dominated by the more elite members of the community. This problem is not unique to HDSs; in fact, ensuring the representation by the poorest section of a society is a challenge for all development initiatives. Encouragingly, it was noted that women’s groups seem to be a significant part of HDSs in many countries, and it will be important to ensure that women maintain a central presence in the activities of HDSs.
- The development of appropriate skills among people within HDSs and in their district health system to ensure that the full potential of these structures is realized. Those HDSs working outside of the health system may need training in the ways in which their organization can best support health development. Those within the health sector may require training in the best way for their existing structures to work with and develop new HDSs in their community.
The unique political, social and cultural context of a country and district will shape the evolution and operation of HDSs. In particular, the strength of political and bureaucratic recognition and support to HDSs is likely to be crucial in determining their effectiveness in working with the formal government health sector. The principal investigators strongly reinforce the notion that decentralized health systems are most suited to support the work of HDSs.

5.2.3 Prospects

The potential for HDSs to contribute to health was felt to be considerable by the principal investigators in this study. Their reports indicate that they are already planning to take action based on their individual research. These plans are detailed at the end of each country report. They endorsed the view that these HDSs are a resource that has been largely invisible to formal health systems. Making these structures more visible to the health sector and developing networks and partnerships between the various HDSs could provide a significant, untapped resource for health development at the district level. This research suggests these HDSs are already contributing to health at a local level, but that mostly these contributions are low key and undramatic. Taken together, however, they represent an important community resource. It was felt that some relatively modest investment in the existing network of HDSs could result in significant returns.

Evidence can be drawn from the country reports concerning a number of critical aspects related to district health systems: sustainability, integration, equity, and participation. While none of the country studies focused in particular upon these four aspects, inevitably they touched upon them and the following comments can be made:

Sustainability

What is meant by this is not the issue of sustainability in relation to the sudden withdrawal of external support of funding, but more the maintaining of momentum and of action designed to promote health development. In this respect country studies underlined the generally strong sense of commitment of members to HDSs, a commitment which can be a result of a sense of ownership of the structure, and also of a sense of solidarity which can give additional strength to the structures’ functioning (Senegal). It seems sustainable structures are more likely to be those that have evolved from local momentum, rather than those imposed by outsiders.

HDSs can also enter into a more functional relationship with the district health service with a view to providing support (Nigeria). Furthermore, HDSs can contribute personnel and supplies to support district health services and even take responsibility for covering for district staff in their absences (Jamaica). Strong and reliable HDSs at the district level can be an invaluable support for health services which may face demands beyond the capabilities of their resources as is so often the case.

Integration

HDSs often have quite a broad view of health and their activities can lead them into promoting development on a broad front. Indeed, members of HDSs can often be members of other development structures. In general terms, HDSs can function as a kind of umbrella structure encouraging
coordination with other sectors. Within the health services HDSs, by their use of a range of those 
services, can facilitate better coordination between different sectors within those services (Senegal).

Equity

In terms of HDSs and district health services, equity refers both to extended coverage (access) and 
to the quality of this coverage. In the first instance, by informing members about health services at 
the district level, HDSs can bring previously excluded groups within the reach of these services. More 
generally, through the association of HDSs with the poor and the widespread existence of such 
structures in several countries, inevitably HDSs will help many people gain access to existing services 
(Philippines, Indonesia). Indeed in many areas it is the HDSs which are the basic source of health 
services where these services cannot be provided by the formal sector. Finally, the work that HDSs 
often do in monitoring the performance of district health services and of lobbying for their greater 
effectiveness can lead to a greater equity in the distribution of those services (Nigeria, Jamaica).

Participation

The studies suggested that, to a considerable extent and by their very nature, HDSs could be useful 
vehicles in the wider concern to promote people's involvement in district health services (Senegal, 
Colombia). Indeed, there was a general conclusion that HDSs had considerable potential to promote 
greater local involvement. But the process had to work both ways and district health service staff had 
to be "open" to the ways of involving HDSs. It would be important, however, to ensure that local 
participation was not merely in terms of consulting resources, but that it also involved the members 
of the HDSs in policy formulation and decision-making. This is not an easy process, however, and 
care must be taken to avoid clientelism or the hijacking of HDSs by small unrepresentative groups.

5.3 Next Steps

5.3.1 Within the Countries

Each country report has specified the use it will make of the research nationally. These details are 
provided at the end of each country summary in section 3.

A summary of these actions indicates that each principal investigator intends to disseminate the 
findings from their study widely. Most plan some more research which will build on their existing 
study. Training also features prominently as part of their future plans. Generally the focus of the 
training will be on health sector staff and their awareness of and capability to use these structures who 
seek to promote HDSs. Indonesia already has a proposal to develop a reward system for village health 
workers. This system is aimed at increasing the sustainability of the system by encouraging workers 
to stay as volunteers for longer periods than they do currently.

5.3.2 Research

The present study suggested a number of areas which warrant further research. These are listed below 
and all contribute to a better understanding of local HDSs as an invisible resource for health 
development. It is recognized that this research agenda is substantial and will take considerable time
and resources to implement. Given this it will be important for national health systems to determine the crucial research questions in light of the particular development of HDSs in their country.

- Development of guidelines for making a district inventory of HDSs.
- Determination of the factors that make for successful HDS. This would include some criteria for monitoring and evaluating the contribution of HDSs to health development.
- Study of how HDSs operate within a network of local HDSs. This should include documentation of links between these HDSs inside and outside the formal health system.
- Documentation of the extent and representativeness of local involvement in HDSs including an analysis of the characteristics of those people who are involved compared with those who are not. This research could study the reasons why people do or do not become involved in local HDSs.
- Determination of the factors that have led to the creation of local HDSs.
- Analysis of the perceptions of health service personnel towards informal HDSs. This research could explore whether they appreciate the untapped potential of these structures, identify the blocks they can see to involvement with the community structures and determine what additional skills the health service personnel need.
- Research on the operation of local, collaborating planning for health development. Such research could start with a consideration of examples of such planning and attempt a meta evaluation of its effectiveness.
- Consideration of effects of the trends towards privatization and the introduction of quasimarkets within public health systems on health development structures at a local level.

5.3.3 WHO

The meeting of principal investigators and resource persons held in October 1994 recommended a number of areas in which WHO could further support the development of HDSs. These were:

1. Advocacy to increase the awareness of the potential of HDSs to support the work of district health systems among health policy decision makers at all levels. This could include publishing a report on the multi-country study, a chapter in a book on community involvement in health and a "popular" version of this study. This advocacy would include the provision of information about the actual and potential functions of the HDSs, detailing the need for training to develop and support HDSs at the district level and encouraging integrated, intersectoral planning for health development in districts.

2. Encourage WHO Regional Offices to recognize the importance of HDSs within their regional plans.

3. Provide support for the principal investigators as they implement the findings of their research within their countries. This support could include encouraging continued contact and exchange between the group that has planned and implemented the research reported here and supporting countries in developing appropriate materials for training and institutional development.
4. Provide support to conduct the research agenda suggested in the previous section. This support should include a consideration of the findings of this research and a subsequent determination of the priorities for research.

5.4 Concluding Comments

This study is unique in that it has identified and characterized the role of development structures within district health systems. The countries involved have drawn up inventories of health development structures and documented their current and potential health development function. The study is an important first step in furthering understanding of these structures.

The major finding of this study has been that significant numbers of HDSs do exist at the district level. These structures are found within the formal health sector (village health communities, for example) and outside in structures generated from the local community (women’s, youth and traditional organizations, for example). Together these HDSs form a significant hidden resource that could be tapped for the purposes of health development. The study has shown that the structures already perform a variety of functions that contribute to health. Their potential to do this to a greater degree is, however, considerable. Fostering and encouraging this potential promises to reward any health sector investment. Attention should, therefore, be paid to ways in which district health systems can re-orientate their work so that they encourage and support these HDSs.

This study indicates that the HDSs appear to be important in ensuring that local health development is sustainable, promotes equity, encourages both the integration of activities and the participation of local people.

Our current era is characterised by declining resources for health service development, increasing decentralization of services, which often places more responsibilities on individuals and families, privatization of health service provision and a continuing attractiveness of quick-fix vertical programmes designed to tackle specific diseases. This study suggested that district health systems may be able to tap into these HDSs as a means of harnessing community resources for the purposes of health development. There is not doubt that these structures represent a resource that has been largely unrecognized by district health systems.

In terms of developing a stronger relationship between district health services and local HDSs, the country studies would appear to confirm that there are a number of concrete actions which could help develop this relationship:

1. The undertaking of an inventory of existing or potential HDSs within a particular district;
2. A more detailed understanding of how they could contribute to health development at the district level;
3. The formulating of linking mechanisms between the district health service and local HDSs; and
4. The determining of the kinds of support which the district health service could give to local HDSs to enable them to be more effective in the promotion of health development.
Health development structures are a reality of the district health level and, it could be argued, represent a major opportunity for district health services to extend their work and to build a more participatory and sustainable service.
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