Partnership of the community in support of health for all

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SUMMARY Health for all is a people-based approach to health which considers the community as its focus. Community partnership is an important principle of health for all. This paper describes the many aspects of community partnership and gives examples of community partnerships initiatives in the World Health Organization Eastern Mediterranean Region, such as the basic development needs approach. The main agenda of community partnership for health for all is discussed and some opportunities conducive to community partnership in the Region are outlined.

Introduction

When Member States of the World Health Organization (WHO) Eastern Mediterranean Region endorsed the concept of health for all founded on primary health care, they accepted its principles, strategies and priorities, which are based on community involvement. The health-for-all movement, with primary health care as the main vehicle of delivery, stresses the principles of equity, intersectoral coordination, appropriate technology, political commitment and community partnership. Community partnership concerns the "all" of health for all; in other words, health for all can only be achieved by involving everyone. Indeed, it is sometimes claimed that the outstanding thinking that evolved from health for all was the notion of community involvement resulting from community mobilization and organization. Since the Alma-Ata Declaration on primary health care in 1978, the world has changed; developments have taken place which affect primary health care and health for all and which highlight the importance of community partnership.

The WHO Eastern Mediterranean Region comprises diverse and complex cultures, which have thousands of years of inherited beliefs, values, concerns and history. This strong heritage is witnessing at present a new wave of Westernization/modernization and different lifestyles patterns, which create unprecedented behavioural challenges; thus contrasting values, mores and lifestyles are now evident. For example, with the transition, the rules of the state are now being challenged. The transition is seen not only in the epidemiological, political, economic and social arenas, it is also happening in the arena of governance and in the decision-making processes. The changes include an increase in overall life expectancy, a shift in epidemiological patterns, with the emergence of chronic diseases that require long-term care and follow-up, increases in the cost of health

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care, ageing populations and rapid urbanization with a shift towards nuclear families. Such changes affect health delivery and health care, inviting greater community involvement.

All the changes and challenges being witnessed at present affect the overall environment, which influences the relation between the health care system and the community at large. This means that the context in which the health services function is predominantly determined by the community and, therefore, community partnership is vital for creating a conducive environment to achieve health for all.

Content of community partnership

The components of community partnership are determined by the national and local social, political and economic circumstances, and by the expectations, needs and abilities prevailing in the locality. It is essential to see the components as a continuum of community organization, mobilization and involvement.

Community organization is about creating self-awareness as an active entity. Although communities have implicit systems that have always existed and survived, from the point of view of health services at least, a community should have a representative body to liaise and communicate with. This gives the community an explicit and functional structure.

Community mobilization is more than simply motivation to participate in a particular health activity. It is the process that allows the community to influence all aspects of health care delivery through its physical, social, economic and spiritual potential. Community involvement is the expression and outcome of commitment and ownership by the community. It shows how the community is empowered to take decisions about its affairs. Community involvement is reflected by all the achievements made in the decision-making with regard to management, organization, resources, econ omics and delivery of health-for-all programmes.

It is worth noting that the three terms — organization, mobilization and involvement — are generally used interchangeably to represent the whole continuum. This is because each one affects the other two in many intricate ways within the community.

Essential elements of community partnership

Community partnership, the core of a new epidemiology: social positioning of health

The health and well-being of a community are affected by the social milieu within which people live. Thus, with community partnership, the focus of interventions is shifting from individuals to people. Recently a "new epidemiology" — the epidemiology of every day life — has evolved which addresses the social environment and etiology of issues such as poverty, inequality, discrimination, social capital and social harmony and their relation to risk factors and risk conditions that determine health. This new approach aims to understand the impact of social organization, social structure, and the policies that shape them on the health of the public. It is about how society and different forms of social organization influence health and well-being. There is a move away from focusing on sick people to focusing on positive health. This new epidemiology studies the social context of health-promoting and health-damaging be-

haviour and how behavioural interventions might benefit from deeper integration in the social organization.

Community partnership — a "learning-by-doing" process

With social positioning of health and through community partnership, individuals, communities and sectors such as the health sector learn how to appraise real life situations together. The different partners learn how to identify their individual needs and problems, and then they work together to solve them. The process brings confidence in tackling further problems, whether acute or chronic. Sectors learn how to work closely with communities and "people", to take part in true dialogue which then translates into sustainable action. The process can be seen as "democratizing", since it allows people to practise their rights in health and development through mutual understanding, sharing of information and responsibility and working together.

The community — a dynamic entity

Communities work differently from hierarchies and government administrations. With time, they develop their own implicit and explicit systems. These systems reflect the different interests, conflicts and priorities, which change with time and generations. Accordingly, the skills, knowledge, values and practices of the community also change with time. The pace at which communities develop differs from that at which health services evolve. Thus, matching community development with health services development is complex, and the more so with each new generation. This shows that community partnership as a relationship between formal (static) authority and (dynamic) community should be understood as an ever-changing process. Understanding these characteristics will reduce areas of conflict between community and government and enable priorities to be more easily matched. It will also allow control over programmes and plans, and enable lines of authority to be harmonized between the two. Community partnership should thus encourage and foster the partnership between people and governments.

Sustained support from all levels

Community partnership is a long-term investment, of mutual benefit to health providers and planners on the one hand and to the community on the other. Government can support community partnership by developing policies which enable people to change their lifestyles and achieve better health through their own action. All forces will thus be mobilized to address the health problems common to all society and enhance the achievement of health for all. Influencing the stakeholders who shape public policies, such as policy-makers, legislators, influential groups, syndicates, media, and religious and community leaders, is a prerequisite to community partnership. It is evident that community partnership needs sustained support from all levels.

Assessment of community partnership

Assessing community partnership can be a complex and tedious undertaking but it is a capability that countries need to be familiar with. It is essential in order to build up the confidence of those involved in mobilizing the community and to encourage them to identify the strengths to build upon, the weaknesses to correct, the entry points to use and the opportunities to seize. The methodology of assessment may use a combination of tools. The findings of the assessment should be disseminated to and used by all partners involved in evaluation. It is an-

ticipated that the evaluators will be a group that represents all interested parties, namely the community, the providers and other stakeholders such as planners. The presentation of the assessment should be designed so that it can be easily understood.

Different formats have been developed to measure community partnership descriptively. The range and scope of community partnership can be assessed through the consideration of certain issues, such as the leadership role of the community, community organization, resource partnership, community needs assessment and managerial processes in support of community partnership. In order to assess these major issues, researchers have developed different forms of ranking scales. Rankings are usually descriptive and thus should be developed within the context of the specific locality. To be more meaningful, evaluators should study the trend of the performance of each major issue over time and see whether progress has been achieved and to what extent. This trend analysis will allow strengths, weaknesses, opportunities and risks to be identified. Correction and improvement can then be initiated. The important thing is that we accept the idea of assessing the progress of community partnership based on agreed upon, ranked criteria. We carry out the assessment, learn from it and act on it.

Spectrum of community partnership — a means or an end?

The second evaluation of the implementation of the Global Strategy for Health for All by the Year 2000 showed that there is an acquired attitude of considering the State as responsible for providing the totality of health services. The evaluation also showed that:

- diverse organizations, such as women's organizations, are becoming more and more involved in health affairs;
- ad hoc partnerships in support of some programmes, such as immunization and training of traditional birth attendants, have been instrumental in making health care accessible;
- some countries have experience of information sharing and involving communities through area development committees and boards, which are examples of community organizations supporting health action in the locality.

Community partnership is sometimes regarded as a way to achieve the preset targets of health projects or services. In this way of thinking, community partnership is a temporary activity linked to available resources, time and locality. The role of the community in the setting of targets, strategies, operational aspects, resources and assessment is nonexistent. It is a passive role, one which does not involve taking part in the operational aspects of predetermined functions. This is an example of the use of community partnership as a means and, as such, community partnership is ad hoc and short-lived.

In contrast, community partnership may be thought of as a process of empowerment of the community and of building up its capacity to decide and experience its full rights in overseeing the formulation of policies, planning, development, implementation, achievements and progress in all activities that concern and affect the quality of its life. This latter concept is in line with the concept of civil service, where all employees are supposed to be accountable to the public they serve. In the WHO Eastern

Mediterranean Region, both types of partnership are encountered. However, in practice, community partnership is most often used as a means rather than an end. A promising example of community partnership as an end is the basic development needs (BDN) approach.

The following are examples of community partnership initiatives. They are intended to illustrate the variety of ways in which community partnership can be effected, with special reference to real experiences in the Eastern Mediterranean Region. They indicate that experience in community mobilization exists in the Region and this can be built on to attain health for all with the full involvement of the people. It is important to encourage countries to consider how to promote and launch community participation so that communities become full partners in health action.

Basic development needs and similar development approaches

The BDN approach, which has been adopted by 12 countries of different social and economic circumstances in the Region so far, aims at improving the quality of life of communities and individuals through a comprehensive development process planned and managed by the community itself.

BDN is based on a triad: organizing the community, building up its capacity, and mobilizing its potential and resources to ensure self-reliance and self-management. It shifts the focus onto community leadership and sustainability and away from short-lived interventions. With BDN programmes and initiatives, the accessibility of and coverage with health care services increases, and morbidity and mortality decrease. It has also accommodated concepts such as poverty alleviation and "healthy villages" and enriched them with a community methodology that puts harmony and balance into social and economic development. This is what is sometimes called "development with a human face".

People are the key element in this change process. They decide upon the change, design it, manage it and carry it out. In turn, this increases each individual's perception of "self", and each individual's perception of the community's own identity.

The organization of the community may take a variety of forms. An important and standard form is a village or area development committee, which is a body selected or elected by the community. The committee is responsible for liaison between government sectors and nongovernmental organizations on the one hand and the community on the other. It should have some control over all development inputs and channel them towards the identified priority areas. The committee, as an organized body, ensures that local activities are sustained. Partnership of the community becomes easy and is built into local activities. Community partnership is sustained from within the local committee structures and by leaders in the community.

The Eastern Mediterranean Region has witnessed other community-based initiatives similar to the BDN approach, such as *el-touiza* (community solidarity) in Morocco and *el-ta'awin* (cooperation) in the Republic of Yemen. In both of these, the community is at the centre of the initiative.

Community health workers

The term "community health workers" includes many local terms used for community-based health care providers in the Region. The range of activities carried out by these workers depends on the social and

cultural circumstances of the community and the links between the community and the health system. Experience with community health workers in the Eastern Mediterranean Region has been evolving since long before the Alma-Ata conference on primary health care in 1978. Some countries had embarked on training community health workers as extension agents to increase accessibility to and coverage by health care. Other countries had focused on traditional health workers, such as traditional birth attendants, *hakeem* and local healers. Tapping such traditional resources means that use is made of community-based workers who are already accepted by the community and have long been familiar with it. One of the main functions of community health workers is to motivate and mobilize the community. The proper orientation, continuing training and support of these community health workers are essential to ensuring that they are able to carry out their functions in this regard. Four relevant regional examples exist.

In Saudi Arabia groups of "Friends of Health Centres" comprise people devoted to supporting and promoting health. They come from different walks of life and usually have no training in health care delivery. Rather, the groups promote and support healthy lifestyles and also promote health as an important issue on the agenda of politicians and decision-makers. Their contact with health services is usually at several levels of care; of particular interest is their participation in the managerial processes of the health centres. Other countries have sought to mobilize the community through volunteers, mainly part-time workers who are traditional or trained health workers, and sometimes activists, often women, who are members of unions or nongovernmental and other philanthropic organizations. Volunteers may come from a variety of backgrounds and interests but they are basically prime movers in their communities. The primary health care centres usually provide technical support to the volunteers, as is the case in the Islamic Republic of Iran. In Oman, the community is mobilized in various health programmes through community support groups. In Pakistan, thousands of community health workers are being trained at first-level health facilities to provide care and to liaise with their communities so as to ensure their involvement in health matters. This is a national initiative focusing on deprived rural and slum areas.

These and other similar community health workers form a base from which to initiate community partnership.

Action-oriented school health curriculum

In this approach to community partnership, the school is regarded as an asset and can be used as an agent for change. The schoolchildren are taught by trained schoolteachers how to address health and health-related issues at home, in the community and at school. The children are also taught how to advocate better and healthier lifestyles through, for example, campaigns against tobacco and drugs. The experiences in Bahrain, Pakistan and the Syrian Arab Republic are excellent examples. The interface between the health system and the community through the school has the dual advantage of both involving the new generation and fostering long-term commitment from it. The widespread presence of schools, their leadership role (in the present and in the future) and their access to all families are all opportunities for the school to mobilize and involve the community.

Nongovernmental organizations

Nongovernmental organizations are well equipped to work in close contact with communities. There are many national nongovernmental organizations working in the Region. In Egypt, for example, there are about 15 000 registered nongovernmental organizations. The work of many of these includes the delivery of primary health care services to the urban poor and periurban dwellers. However, most of their work is dependent on the individual motivation of community members. Nongovernmental organizations usually have strong relations with women's unions and youth federations, among others. Their widespread presence at the grass-roots level, their experience and their commitment allow them to play an important role in community partnership. A striking example of the potential of nongovernmental organizations can be seen in the experience during the conflict in Lebanon. The community took over full responsibility for health care provision with the result that health indicators in Lebanon remained among the best in the Region. A similar experience has been witnessed in the BDN areas in Somalia.

Women's health clubs

This initiative was started in Egypt by the Ministry of Health and Population in collaboration with local government. It aims to give more say in health affairs to women, a vulnerable group in society who are also the greatest beneficiaries of any improvement in health care management. The clubs provide more access to health care and a forum for exchange of concerns, priority problems and decisions related to the health status of women. It is an enabling forum for women, in particular, and the family, in general. Eventually, it will contribute to democratizing health and community partnership.

Main agenda of community partnership for health for all

Health goals to be accomplished through community partnership should be part of the mandate of the movement of community partnership, especially so when health for all is the vision. Community partnership should cherish the mission it has to accomplish through setting short-term and long-term goals. This paper will not discuss the details of these goals; however, at this juncture it is vital to highlight the directions of the goals community partnership should strive to attain, which are the following:

- Investment in factors which will address social and economic determinants of health and achieve the best health gains for the community.
- Creation of positive, health-enhancing and supportive living and working conditions and physical environment with clean, healthy and safe air, water and land for a better quality of life.
- Creation of opportunities for all individuals, families, groups and civic organizations to access information, develop and maintain the capacities and skills needed to thrive and meet life's challenges and to make choices that enhance health.
- Reorientation of health services systems in order to provide equitable and appropriate quality services for all people.

It is important to clarify the purpose of community partnership. Indeed, the priorities will differ from one setting to another in accordance with the socioeconomic pattern of the country or locale in question, as

well as with time. The main agenda of community partnership for health for all which is in line with the above-mentioned four directions includes: development and health, helping people help themselves (centring on people), development of the primary health care infrastructure, integration, bridging the gap between community and health services, sustainability of health care and sound financing, health promotion and protection, and quality health care techniques, methods and tools.

Development and health

It is now more evident than ever before that improving health status starts largely outside the hierarchical set-up of the health services. Improvement in public health is affected by many partners, but especially by the community. Poverty, the most important factor affecting health, has to be addressed through long-term and medium-term development approaches. The experience gained and methodologies developed so far in community development show the strong links between health and development. However, health indicators have undergone a shift, from measurement of disability, morbidity and mortality towards measurement of quality of life. Such a measurement is broader than a measurement of health status. Community partnership and involvement are vital to making this measurement work and to achieving a better quality of life.

Centring on people

Health is one of the most important parameters in determining quality of life. People are the most important asset in the fight to attain better health for themselves. Major achievements in health status were brought about when simple and appropriate technologies, such as oral rehydration therapy, were introduced because people were themselves the main actors concerned. The role of communities in the health sector needs to be reviewed in order to further improve community management of health programmes. Community partnership is basically about helping people to help themselves.

Development of the primary health care infrastructure

By this is meant not only the physical infrastructure but also the human, organizational and managerial structure, together with the norms, knowledge and practice of the system. The scope of primary health care development is wide and complex and extends beyond the mere medical arena to involve many other partners whose potential should be tapped prudently to achieve sustainable health for all. Primary health care addresses a wide range of health determinants, such as poverty, illiteracy (especially among women), increased population growth, unemployment, migration from rural to urban areas, drug addiction, environmental issues and epidemics. Existing primary health care systems do not take these health determinants into account and therefore require reorientation. Community partnership can play an important role in this and in making the primary health care system effective in tackling the determinants. Once community partnership is well established, the primary health care infrastructure will be equitable, sustainable, adequate, continuous and transparent.

Integration

A community has a comprehensive view of itself and its needs. The priorities of the community usually extend over several lev els of bureaucracy and several sectors. There is now more awareness of the impor-

tance of integrating health into overall development. The forms of integration are various and may concern organizational or technical aspects, or operational delivery of services. For example, the community can support the integration of the notion of cure into that of overall well-being, which includes health promotion and protection as well as improvement of the quality of life of individuals and communities.

Bridging the gap between community and health services

There is a distinct differential between the interests and concerns of a community on the one hand and those of the health services on the other. There is also a distinct differential between the health actions and health concerns of the health services and those of the community. The complexity and dynamics of the community warrant the effort and time spent in social preparation and laying the foundation for a lasting social contract between the community and its health services. The contract should be based on interdependence of the health services and the community. The era of independence of health care from the community is gone. Now, health care is striving to attain user (community) satisfaction; this is a step in the right direction. The community usually has multiple individual interests as well as a common one. Through community involvement, it is possible to reach a balance between the interests of individuals and of the community.

Sustainability of health care and sound financing

Increasingly it is being recognized by the countries of the Region that health care is an expensive service that requires serious consideration, analysis and review with regard to the current policies of health care financing. The need to reduce the cost of health services has never been greater than at present. The role of government as the sole provider responsible for health care is now shifting more towards that of a coordinator, evaluator and broker. Health financing is shifting from the public sector as the main provider of health services to involving the private sector, through mixed financing schemes.

Various approaches are being explored to provide alternative forms of health care financing, covering all its aspects — preventive, promotive and curative — but that are at the same time affordable. Community partnership can provide for a sustainable financing system, such as income-generating schemes, revolving funds and schemes centred on religious foundations. Indeed, the primary health care concept emerged in response to the need for an affordable health care system based on community collaboration and participation, which enhances self-reliance.

Health promotion and protection

Health is a human right and a responsibility to which the community should contribute. In view of current demographic and epidemiological changes, it is now essential that people become involved in health promotion and protection and are encouraged to lead a healthy lifestyle. The experiences of disease prevention programmes in mobilizing the community should be extended to address the emerging burden of noncommunicable diseases, drug trafficking and addiction, alcoholism, sexual promiscuity, violence and accidents. All of these have a strong social etiology which calls for a strategy to mobilize all the potential of communities to take action against the increasing threat posed by these new epidemics.

Quality health care techniques, methods and tools

Quality health care is an important attribute of any public health action. The quality health care approach recognizes that client or customer satisfaction is a vital aspect of the health care system and the most important indicator of quality. Now we have an opportunity to make use of the present interest in quality by both health professionals and community members to highlight elements of community involvement that are built into quality health care. Raising public awareness of the importance of quality of care will lead to the forming of public opinion on the subject and, in the long run, will ensure the much desired contribution and say of the community in health issues.

Conclusions

Health for all is a people-based approach to health which considers community as its "centre of gravity". Community partnership should address the factors determining health status, which are a product of a complex array of social factors, such as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, equity and reorientation of health services. It should enable people to have increased control over their health and to improve it, emphasizing positive, life-enhancing matters, not just the removal of negative aspects. The focus is on developing people's capabilities, skills, knowledge and resources; it is on strengths not weaknesses or problems. In this way, community partnership enhances health care delivery. It is important to be clear that our concern is with "health", as distinct from other worthwhile social and justice endeavours. Basically, efforts are geared to those outcomes that can readily be accepted as having primarily a health dimension, in particular physical and mental health.

A clear policy regarding community partnership, especially its role in support of health for all *vis-à-vis* overall development, should be formulated in the Eastern Mediterranean Region. It is of paramount importance to encourage influential decision-makers who shape public policies and relevant stakeholders to recognize the role and contribution the community can make in attaining health for all and to ensure their (decision-makers and stakeholders) commitment to supporting and encouraging initiatives in this regard. Major socioenvironmental risk conditions, such as poverty, low social status due to occupation and/or education, work structure and unemployment or underemployment, discrimination due to gender, inadequate housing and homelessness, and natural resources depletion (e.g. food stocks), should be addressed with the understanding that they are of a long-term nature but still have a bearing on health status.

On the other hand, health professionals involved in mobilization of the community should start with a clear vision and policy regarding the role of community. They should seek to understand the community and its subtle processes. Based on this understanding, the next move is to be understood by the community through respect, humility, and candidness. By building the trust of both parties, it is possible to synthesize initiatives for change in a way that ensures community involvement.

In the Eastern Mediterranean Region, the agenda put in front of community partnership is both important and challenging. A breakthrough might be achieved by tapping the social, religious and historical assets the Region has inherited. Successful

approaches should build on what communities already accept as a belief, tradition or culture. The following are some of the opportunities that are conducive to community partnership, through which health for all can progress.

Religious tradition

There is a great precedent for community partnership in the Eastern Mediterranean Region, historically, socially and religiously. One example is the *shura* system. *Shura* is a basic Islamic principle to ensure that the views of the community are taken into consideration in all affairs pertaining to the life of the society. *Shura* ensures transparency and accountability of the leadership to the people. The applications of *shura* can be immense, covering all aspects of present day democracy and, according to Islamic scholars, go far beyond. The argument in favour of *shura* is that it does not end at voting for representatives but goes further in following up their activities and in the continuing involvement of the public. Entry points to launch and strengthen community partnership can be sought through *shura*. Needless to say, this system covers all walks of life in a society, whether social, economic, political or otherwise. The *shura* system also allows for *al-takaful*, i.e. mutual community solidarity and support.

Other entry points are the economic principles in Islam, such as *zakat*, *waqf* and *sadaqat*. The Church has similar entry points and a rich tradition in providing community support within its constituency. There is a wealth of historical experience in the Region that can be used.

Focus on the conceptual, social and spiritual dimensions of primary health care

Primary health care should not be restricted to or equated with medical care only. This is a severe handicap to primary health care and health for all, the more so in the Eastern Mediterranean Region which is very rich in values and principles that favour solidarity, equity, social justice, community partnership and human integrity and dignity. The fact that the primary health care approach is endorsed by all Member States and that it has now been operating for some 22 years should give us an opportunity to maximize the primary health care principle of community partnership. Community resources should be identified and studied. An inventory of nongovernmental development structures, agencies and organizations in each country of the Region should be conducted, documented and used. Social scientists should be involved in developing effective methodologies and approaches for promoting community partnership that will change the perceptions of communities and lead to their taking greater responsibility in promoting health. Social scientists should be members of the health teams responsible for the planning, programming and assessment of health services, particularly in relation to community involvement. Social institutions such as the Red Crescent and Red Cross societies, nongovernmental organizations, pensioners, active community leaders and local bodies should be briefed and involved in health promotion activities in their catchment areas. Also different types of community health workers and "friends of health" in the catchment area of the health facility can spearhead community partnership after being appropriately trained.

Investment policies

A variety of options are currently being debated as possible ways and feasible mechanisms of introducing a cost-recovery system and other means of generating funds for the health sector. The options include

the involvement of the private sector, health insurance policies and out-of-pocket, cost-sharing and co-payment systems which directly involve communities. Community partnership can be promoted as a strategy to ensure the cost–effectiveness of health for all. This can be achieved through greater transparency of health administrations and participation of the community in health decisions, which will result in more appropriate and acceptable health services, thereby avoiding waste. There is a consensus among development planners that investment in the social sector, including health care, is as productive as in the industrial sector when regarded over a longer time, and that the products, in the form of human development and a healthy population, can be projected as being marketable, just as can industrial products. The best investment is in people. The introduction of health financing policies requires well studied and well designed norms and rules which regulate the application of procedures for payment for health care. Through community partnership, such norms and rules can be refined, agreed upon and applied. It is important that the State and community both have a role in monitoring the quality of health for all.

Research on the different aspects of community partnership, organization, achievements and impact is a prerequisite to a better understanding and effecting of community partnership. Dissemination of research findings and information sharing as well as developing guidelines and strategies to enhance community partnership in support for health for all is a prime responsibility of policy-makers.

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The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

Source: Declaration of Alma-Ata, article IV