Medicus Mundi Schweiz

Netzwerk Gesundheit für alle
Réseau Santé pour tous
Network Health for All

MMS Bulletin #95

Armut und Gesundheit

Approach and first results of a pilot project in Naryn oblast

Community Action for Health in Kyrgyzstan

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The Kyrgyz-Swiss Health Reform Support Project (KSHRSP) is funded by Swiss Agency for Development and Cooperation (SDC) and is implemented by the Swiss Red Cross. It started in January 2000 and is currently in its third phase. The Project was mandated by the Ministry of Health to develop a model of Community Action for Health for rural areas and integrated into the health care system. A pilot has been developed during the last three years in Naryn oblast.

The main goal of the Kyrgyz-Swiss Health Reform Support Project is to support the health reform of the country in one of its remote regions, the Naryn Oblast. Main elements of the project are Health Promotion through Community Action for Health (CAH) in the Naryn Oblast, the support of the national policy development regarding health promotion, hospital infection control and health care waste management, the reconstruction of four territorial hospitals and the oblast merged hospital in Naryn Oblast, and the support in reorganisation of the Naryn oblast health services.

The Community Action for Health pilot was started in one rayon of the Naryn oblast in 2002 (Jumgal rayon) and extended to all other four rayons in the beginning of 2004. The main goals of the approach are to enable village communities to act on their own for improvements of their health, and to integrate Community Action for Health into the health system, i.e. to transform the health system (Primary Health Care and health promotion structure) in such a way that it supports the Community Action for Health process and learns to identify and to react to people's priorities.

"What do you need to stay healthy, to live a healthy life?"

The process starts with an elaborate analysis of the health situation in each village by the people using a tool specifically designed for this purpose according to principles of PRA (Participatory Reflection and Action, formerly called Participatory Rural Appraisal). The project trains Family Group Practice/Feldsher-Accoucher Point staff, usually one per village, who facilitates people's analysis by using this tool. The analysis is done in small groups of about ten people called together from neighbouring households for a session that lasts an average of 1 or

2 hours. As many group sessions as needed are done to provide most households a chance to participate. Following the training project staff supervises the trained Family Group Practice/Feldsher-Accoucher Point staff for one or two weeks in order to ensure the quality of their facilitation. Crucial is to guide people through the process without influencing the outcome.

The tool centres on the question "What do you need to stay healthy, to live a healthy life?" This focuses the discussion on the determinants of health rather than on treatment of diseases. The people list these determinants on a sheet of paper. When they have finished the facilitator shows a list of the main elements of Primary Health Care as outlined in the WHO declaration of Alma-Ata and asks the group to compare it with their own list. Invariably, the people have named all or most of the elements in their own list: healthy nutrition, clean drinking water, education, hygiene and sanitation, special services for mothers and children including pregnancy care, vaccinations and family planning, provision of essential drugs and basic treatment. Often they have named more than these, like sport, clean air, etc. As for control of endemic diseases, the facilitator asks the group to list the most common and important diseases in the area. The group then ranks them and identifies the five diseases that are most burdensome for people in this village.

The determinants of health and the most important local diseases are then listed along the side of a big sheet of paper. Two lines are drawn to mark a system of co-ordinates, the vertical axis indicating the degree, between 0% and 100%, to which a given determinant or disease is present in the village. The group discusses and assigns to each issue a percentage value. At the end a line is drawn connecting the individual estimates. The result is a graph profiling the village's health situation as seen by this group of people that includes the key elements of the Alma-Ata declaration on Primary Health Care. Such an analysis is done up to 100 times per village, depending on its size, in average involving members of about 70-80% of households. Sessions with only women and only young people are done as well. This process of analysis lasts about a month in each village.

At the end of each session the facilitator asks what people think they themselves could do to improve the situation. The need for a united effort is being discussed to address these issues and consequently the idea of forming some sort of village organisation, a health committee, that could plan and co-ordinate people's actions. Also, criteria that leaders of such an organisation should possess are identified.

The results of the analysis are compiled on village, rayon and oblast level in two categories: determinants of health and burdensome diseases. The project then supports village health committees to act on those diseases that the compilation on oblast level shows to be priorities for most villages.

Each village elects a village health committee (VHC) through representatives of neighbourhood blocks and forms action groups for each campaign issue who plan, implement and monitor the activities. For improvements of health infrastructure village health committees can apply to a

small grant fund of the project. The project also provides continuous organisational capacity building for the village health committees with the aim of developing sustainable organisations that can become a permanent partner of the health system for health promotion and may later also include non-health issues in their agenda. An organisational structure has been developed that avoids overburdening of the board of the village health committees and involves many people into the activities, providing a base from which future leaders can emerge.

The results of the pilot:

Analysis and formation of village health committees: At present there are 119 village health committees in Naryn oblast covering 109 of 111 villages with a population of about 160,000. The time needed to do the analysis and establish village health committees in the four extension rayons was four months. The analysis involved over 27,000 households (80%) in these four rayons. Main diseases prioritised were: anaemia, hypertension, brucellosis, influenza, women diseases, alcohol abuse, and dental disease. Main health determinants prioritised were: access to drugs in villages, clean drinking water, improved nutrition, bath houses (banyas), information, sanitation, access to treatment. Village health committees could, as expected, not be formed in rayon centres, as this approach does not lend itself for urban areas. It has been therefore developed only as a model for villages.

Integration into the health care system: The process is presently on two levels integrated in the health system, on village level through training of Family Group Practice / Feldsher-Accoucher Point (FGP/FAP) staff and close collaboration between them and the village health committee; and on rayon level through the Health Promotion Units (HPU), a new health promotion structure with two people per rayon. The Health Promotion Units are being piloted by the project and the Ministry of Health in Naryn oblast. Integration on oblast and republican level has not yet been achieved. 161 FGP/FAP staff were trained in facilitating the analysis, most were very able to handle the instrument developed for the purpose. Further FGP/FAP staff is being involved in the training for the campaigns on health issues.

Most staff like the new way of working with the community as a partner and see the benefits of community action. The ten staff members of the Health Promotion Units were trained as trainers for FGP/FAP staff. They have developed considerable skills in training, supporting and monitoring village health committees and FGP/FAP staff. One can conclude that the Community Action for Health model on rayon level is functioning and has been successfully integrated into the health system.

Community Action: Campaign strategies have been developed and implemented on control of anaemia (through improvement of nutrition), iodised salt promotion, brucellosis control and control of alcohol abuse. Participator Action Research is an integral part of all campaign strategies.

For iodised salt promotion village health committee tested salt in a large majority of households, controlled salt at retailers regularly and distributed test kits to all retailers for use at whole sale markets. Prevalence of iodated salt in households rose from 67% (2002) to 92% (2003); country wide it remained almost unchanged during the same period (69% and 72%, respectively). The costs for the campaign were 2000 USD.

For improved nutrition village health committee distributed seeds of beans, red beet and carrots to around 30,000 households; as beans were unknown they provided training in planting, cooking and preserving them. The costs amounted to 5000 USD.

To reduce alcohol consumption village health committees analysed yearly alcohol consumption and costs with over 60 % of families, compiled the results on village level, facilitated a discussion on which new traditions in relation to alcohol the village community would like to adopt and currently implements a campaign on these new traditions. A family in average spends about 1000 Som per year on alcohol, a village in average 5000 USD and the whole oblast about 450,000 USD. These figures, researched by the village health committees, have helped to change attitude to alcohol and prepare people for change. The costs for this campaign were 3600 USD.

For Brucellosis village health committees distributed the information material developed by the project to all households. This year an intensified campaign involving will focus on 4 key measures to prevent human contamination from animals; village health committee involve all school parliaments in this. The incidence rate has not fallen so far. Human brucellosis will not decisively drop as long as veterinary brucellosis is not controlled. The project works with other donors on advocacy towards the veterinary department for a reform of control measures. The costs for the brucellosis campaign were 51,000 USD, most of it for printing brochures, one for each household.

Campaigns strategies for control of hypertension, dental diseases and women diseases are under development. In all campaigns village health committees cooperate with other formal and non-formal organisations in the village.

12 village health committees have started a small grant project this year in the extension rayons, most repair their banyas. In Jumgal rayon 7 banyas are repaired or under repair, one flour mill was installed, one water system repaired, and one ambulance car purchased. Most village health committee find it difficult to collect the needed 20% local contribution, as it needs time to gain trust for a new organisation.

Organisational capacity building: Regarding organisational capacity building the process is at the beginning and organisational skills are still weak. Currently most boards of village health committees meet when the Health Promotion Units visit them monthly. Some are already regularly meeting by themselves. All have started a small health fund with money from selling the seeds and have learned basic accounting. Only in Jumgal rayon there is a Rayon Health

Committee (RCH), a federation of village health committees of the rayon. Its objective is to coordinate actions, advocate on rayon level for village health committee issues and mobilise resources.

Community Action for Health: Beyond the pilot

The structure of the village health committee has been designed in a way that allows other health initiative groups to link with it. An agreement has been developed with the Rural Hygiene and Sanitation Project (RHSP, funded by DFID), to integrate their Initiative Groups as an action group into the village health committee. This is presently being tested. Similarly, a process has been worked out with the Village Investment Project (VIP, funded by World Bank) on linking the two processes.

The costs for the Community Action for Health process are low and seem within the possibility of the health care budget of Kyrgyzstan. The yearly costs for the health system to maintain the basic structure and functions of a Community Action for Health process on rayon (Health Promotion Units) and oblast level (OCHP) would amount to an estimated 1.6% of the health care budget of Naryn oblast of 2004. This would include personnel costs and a working budget to maintain regular support for village health committees and FGP/FAPs. It would not include the initial set-up of village health committees (estimated at 120 USD per village health committee) and the marginal costs for the campaigns (see above). A possible scenario could be that these costs would be borne by other donors interested to implement the approach in other oblasts.

In order to sustain the process beyond the support by the project structural, budgetary and functional adjustment of the Oblast Centre for Health Promotion (OCHP) are needed to enable it to be trained in guiding, training and supervising the Community Action for Health process in their oblast. Also, ways must be found that will make it possible to develop the skills of the RCHP in supporting and overlooking the Community Action for Health process in all oblasts that will adopt it. Close cooperation with the forthcoming capacity building project in health promotion financed by Swedish International Development Agency (SIDA) should be crucial for this. Presently the extension to Talas oblast has started with support from KSHRSP. Collaboration with other projects has begun who are interested in implementing the Community Action for Health process in other oblasts, with KSHRSP providing the necessary training.

Health Promotion: Empowering People and Communities

WHO defines Community Action for Health as "collective efforts by communities which are directed towards increasing community control over the determinants of health, and thereby improving health." (1) The underlying concept of health promotion is one that seeks to enable people to gain control over their health. It is based on the assumption that a multitude of individual, social, economic factors influence people's health, over which people have only limited control but are able to gain more control. It therefore believes that people and

communities are capable of analysing the factors influencing their health and of planning, implementing and monitoring actions directed at improving them. Empowerment of people and communities is seen both as a means and as a goal of this process. The document that most closely reflects this understanding of health promotion is the Ottawa Charter of the WHO. It defines health promotion as "the process of enabling people to increase control over determinants of their health, and to improve health" and states that "at the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies."(2) This points to the implications such a process has on civil society building. Strengthening civil society and good governance is an implicit goal of the Community Action for Health approach developed in Naryn oblast.

The concept further rests on the principle of health promotion as an essential and integral part of Primary Health Care as outlined in the Alma Ata Declaration of WHO. It also rests firmly within the concept of the MANAS health reform programme of Kyrgyzstan.

Among the main goals of the national MANAS health reform that started in 1996 are strengthening of Primary Health Care and of health promotion. Family Group Practices (FGPs, units with doctors) or Feldsher-Accoucher Points (FAPs, units with paramedics) are Primary Health Care providers existing in most villages. It is in principle acknowledged that health promotion is an essential task of FGPs and FAPs besides providing basic primary care; they are supposed to spend a considerable amount of their time – up to half – outside the clinics interacting with the population on preventive health. However, while a clinical retraining programme of doctors and nurses as family practitioners is well under way a concept for the role of the FGPs/FAPs in health promotion has yet to be elaborated. The Community Action for Health (CAH) component of the KSHRSP is a pilot project that introduces the above outlined concept of health promotion in Kyrgyzstan and in its process helps to reorient the roles of FGPs/FAPs and communities in health promotion. The approach has been developed in close consultation with the Ministry of Health, staff of Family Group Practices, the Family Group Practices Association (FGPA), and the Republican Centre for Health Promotion (RCHP).

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Notes:

(1) Health Promotion Glossary, World Health Organisation 1998, WHO/HPR/HEP/98.1

(2) Ottawa Charter, WHO, 1986

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