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Working Group on Mechanisms for Community Involvement  
in a Health Care System based on Primary  
Health Care: Committing the Community to Care

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SUMMARY REPORT

There were 25 participants in the Working Group: 17 from 17 countries of the European Region and one from Canada, two representatives of WHO headquarters in Geneva and five representatives of the WHO Regional Office for Europe. Most of the participants were medical doctors (experts in public health and social medicine), the rest representing other disciplines such as social sciences.

Scope and purpose

Since the Alma-Ata Declaration in 1978, community involvement in health (CIH) has been identified as one of the cornerstones of primary health care (PHC). One of the purposes of this Working Group was to assess past activities, thereby making the issues more widely known to WHO's Member States. It also allowed the participants to analyse the implications of regional target 26, which is a mandate for all Member States to develop health care systems based on PHC through effective community representation, and supported by secondary and tertiary care by the year 1990. The Working Group also provided a forum for participants to suggest approaches and mechanisms for implementing and supporting this target in the Member States.

Definition

Although the participants did not attempt to make an exact definition of CIH, they thought that it might include the following three components:

- self-help (i.e. action carried out by lay people);
- cooperation (in the sense of participation by lay people as individuals or through the community) in the delivery of PHC;
- participation in the planning and management of PHC.

The participants were convinced that CIH (in all three aspects mentioned above) could control or increase resources for health promotion as well as for the care of the sick.

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### Discussion

The Group heard 18 country presentations, all of which shared one or more aspects of CIH in PHC. The following points in the presentations were common to some, though not to all, countries: the improvement of formal mechanisms of CIH; the growing interest of nongovernmental organizations, consumer groups, etc. in the provision of PHC; and the growing potential of new health movements and self-help groups.

Despite all the encouraging signs that CIH is increasing, a European map of CIH would still show a predominance of blank areas without remarkable involvement of the community in health. Even where CIH has been established, it could be more direct and "authentic". WHO and the Member States should therefore renew their efforts to diffuse and enrich the experiences of CIH.

The Group was concerned about epidemiological developments in the industrialized countries and in particular about the trends in chronic degenerative diseases. This is obviously a problem that cannot be solved exclusively by the established medical system, but that requires effective ways of involving those concerned (the individual, the family and the community) in a collaborative effort with professionals, administrators and politicians to promote health, to prevent disease and to rehabilitate the chronically ill both medically and socially.

Demographic studies are highlighting the aging of the population in industrialized countries and, in particular, the expected growth of the proportion of people over 80. At the same time, the potential of the traditional care providers (e.g. families and women) is decreasing owing to changing family patterns (e.g. working women, single parent families). This will, first of all, demand strengthening intersectoral cooperation (between the health and social services) and also commit the community to caring for the elderly.

After the presentations and discussion of the country reports and case studies, three subgroups separately discussed the following topics:

- the organizational structure for CIH
- education and training for CIH
- information and research for CIH.

#### Organizational structure

The Group was reluctant to single out one specific structure for implementing CIH in all countries. Emphasis was placed on the local level, however, where a local health board could be a desirable body to implement CIH. This board should be concerned with the management and development of all components of PHC, and foster intersectoral collaboration. It should have members drawn from as broad a spectrum of the community as possible. The representation of professionals or bureaucrats on the board should be balanced to avoid their views predominating. To fulfil its aims, the board should have the following functions:

- to control resources (both finance and manpower);
- to provide access to appropriate information;

- to be responsible for intersectoral collaboration (between health professionals, other sectors and community-based organizations);
- to be accountable (regular reporting).

In general, information was considered to be one of the most important resources for CIH. Therefore, pertinent information has to be made accessible to the community, and the ability of the community to collect and assess information has to be improved.

#### Education and training

Education and training are a key issue in CIH, in two respects.

- The general educational system does not always nor sufficiently transmit value systems favourable to community involvement in general, and CIH in particular, nor does it teach the means and methods required to promote community involvement. Education for CIH (not only for one's own health but also for the health of others) should become an important component in all education;
- The education and training of physicians, nurses, social workers and other key professionals neither includes nor encourages participation and sometimes transmits values and attitudes that are negative towards CIH. Their training should be urgently rectified.

#### Information and research

There is a considerable lack of research into developing models for CIH and evaluating the impact and value of CIH. Even where such research is carried out, however, the community needs to be more involved in, for instance, the definition of the research topics, the identification of the researchers or research institutes, and the selection of the methods.

The Group was aware that CIH cannot solve every problem. It was clearly understood, for instance, that disadvantaged groups and ethnic or other minorities should receive special attention from the health and social services, particularly as they may have difficulty making themselves and their problems understood at the local level. Ensuring that the community is genuinely represented is another problem. Finally, CIH may be counterproductive if community participation is used as an excuse for any failures, or there is the risk of blaming the victim.

#### Recommendations

##### National

1. Member States should analyse the community involvement in health in PHC. This analysis should include: the organizational structure, training and education, as well as research and information.
2. Member States should consider legislation that would create favourable conditions for CIH, addressing the issues of budget allocation, decentralization and community involvement in decision-making bodies concerned with the development of PHC.

3. Member States should reorganize existing structures so that they can fulfil the functions of a local health board responsible for CIH. Desirable functions include participation in decision-making, negotiation with lay people, consumer (user) and other nongovernmental organizations, and support of self-help groups.

4. Member States should be interested in raising the awareness of the community. They should achieve this by providing an independent information base at all levels (national, regional and local) that is also interlinked.

5. Member States should modify their training of physicians, nurses, social workers and other key professionals to engender positive values and attitudes towards CIH and to increase their understanding of community-oriented approaches.

6. Member States should prompt, encourage and support research on the following issues: lifestyle indicators; positive health indicators; impact of social factors on disease; registers of community health services; evaluation practices in CIH; identification of gaps in CIH; trends and contradictions inside the traditional medical services (e.g. the influence of medical technology); the appropriate use and dissemination of medical technology in prevention/rehabilitation. Particular attention should be paid to the mechanisms of CIH, resistance to CIH and the possible counterproductive effects of CIH.

International

1. A comprehensive report on CIH in PHC should be produced for action-oriented groups in CIH.

2. WHO should identify one or two collaborating centres for PHC (which in this case should be geographically well balanced) which could place emphasis on research and training in CIH.

3. Existing networks should be used and other programmes and activities closely connected with CIH taken into account (e.g. Healthy Cities, CINDI).

4. A clearing-house should be identified for information and documentation on CIH.

5. A multinational comparative research project on CIH should be initiated with a possible focus on the care of the elderly.