Partnership work: the health service–community interface for the prevention, care and treatment of HIV/AIDS

Report of a WHO Consultation
5-6 December 2002
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*Geneva, 5–6 December 2002*

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Afterword to the case presentations

Dr Walid El Ansari and Dr Hedwig Goede
Better collaborative interaction between the health services and the communities could help to address the challenge of scaling up HIV/AIDS services at the community level.

A consultation on Enhancement of the Health Services/Community Interface for HIV/AIDS Prevention, Care and Treatment was held from 5 to 6 December 2002 at the headquarters of the World Health Organization (WHO) in Geneva, Switzerland. The consultation was convened by the HIV department of the Family and Community Health Cluster of WHO. The participants at the meeting included partners from United Nations and other international organizations, experts and activists from nongovernmental organizations (NGOs) working with HIV/AIDS, HIV/AIDS researchers, advisers on HIV/AIDS from the WHO regional offices and staff from other departments at WHO headquarters undertaking related work or having relevant expertise.

The aim of the Consultation was to identify roles for WHO in enhancing the interface between the health services and the communities. This aim was expressed through the following specific objectives:

1. to review the previous and current work by the United Nations that is relevant to the health services–community interface;
2. to identify the opportunities and constraints of the health services–community interface relevant to HIV/AIDS; and
3. to identify the roles that WHO should play to enhance the health services–community interface for HIV/AIDS.

This report comprises three main sections. The first section addresses the challenges and opportunities for collaborative interaction and partnerships between health services and communities. This section includes chapters of the original background paper from the meeting and of the presentations made during the meeting. These include a review of previous relevant work, highlighting the practical and operational underpinnings of collaborative efforts, and a discussion of the potential challenges as well as the successes that might be expected when fostering partnership development for addressing HIV/AIDS.

The second section presents and analyses six “on-the-ground” case-studies presented by the participants at the meeting. They describe partnership efforts for the prevention, care and treatment of HIV/AIDS and represent a range of collaborative initiatives from different countries and continents as well as global endeavours. They reflect various issues pertinent to the stated aim of the consultation, such as interaction between health services and communities, collaboration, synergy and the need for innovative models for service delivery.

The third section presents the outcomes of the meeting. The participants identified three categories of strategy. These categories were:

- strengthening the capacity of the health care system to interact with communities;
- strengthening the capacity of communities to interact with health services; and
- strengthening the processes and methodologies for change.

Within these categories several mechanisms that could enhance the interface between health services and communities were identified. The participants identified clear and crucial roles for WHO in putting the strategies into action and recommended some concrete steps to be taken by WHO to move the interaction between health services and communities forward.
Glossary

The definitions given below apply to the terms used in this report. They may have different meanings in other contexts.

**AIDS-competent community:**
one whereby people are able to assess accurately the factors that may put them or their communities at risk of infection, and act so as to reduce those risks (UNAIDS, 1997; Lamboray & Skevington, 2001).

**Collaboration, partnership and joint-working**
are used interchangeably to refer to:
collective actions by individuals or their organizations for a more shared communal benefit than each could accomplish as an individual player (El Ansari et al, 2001).

**Community:**
a group of people living in close proximity to one another who have formed relationships through several overlapping and interacting social networks and through a shared sense of needs and local common good (adapted from Eng & Blanchard, 1991).

**Community capacity in health:**
the characteristics of communities that affect their ability to identify, mobilize for, and address social and public health problems (McLeroy, 1996).

**Community empowerment:**
a social action process that promotes participation of people, organizations and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life and social justice (Wallerstein, 1992).

**Community involvement:**
a deliberate strategy that systematically promotes the participation of the community in its own health development in order to benefit from increased local self-reliance and social control over the infrastructure and technology of health care (adapted from Kahssay & Oakley, 1999 and Fonaroff, 1983).

**Community structures:**
a wide range of organizations, formal and informal groups and networks within the defined community.

**Competent community:**
one whose members can collaborate effectively in identifying problems, can reach consensus on goals and strategies, and can cooperate in the actions necessary to acquire resources to solve those problems (Cottrell, 1983).

**District health system:**
a self-contained segment of the national health system consisting of a well-defined population living within a clearly delineated administrative and geographical area, whether urban or rural (WHO, 1995).

**Health service structures:**
those structures within the local health system that provide promotive, preventive, curative and palliative services by formal (professional and para-professional) health workers.

**Interaction:**
reciprocal action or influence.

**Interface:**
the point where interaction occurs between the health service structures and community structures.

**Synergy:**
increased effectiveness or achievement produced by combined action or cooperation.
REFERENCES


Recent years tremendous progress has been made in the treatment of HIV infections. This has led to a reconsideration of how the HIV epidemic should be dealt with and to increased political will and commitment to tackle the epidemic in a comprehensive and scaled-up manner. This is expressed most clearly in the Declaration of Commitment issued by the United Nations General Assembly Special Session on AIDS (UNGASS) in July 2001. The commitment invested in fighting HIV/AIDS has also raised a number of old questions such as:

- How can more people benefit from better treatment and more effective prevention?
- How can HIV/AIDS services be made accessible where they are most needed, given the serious constraints on resources?
- How can the benefits from the many examples of small-scale success be increased to a global scale?

Considerable knowledge has been gained about what technical interventions are necessary to address HIV/AIDS. The most pressing question now is how the available interventions can be brought into practice in the many countries and communities that urgently require them. Given the scarce resources and overstretched health care personnel in countries with a high burden of HIV/AIDS, the provision of conventional health services seems unrealistic and unlikely to meet the needs of the steadily increasing number of people requiring HIV/AIDS services. WHO is exploring alternative approaches to service provision to increase access to HIV/AIDS services and to enable the health service to become a strong partner in the prevention of HIV. The answers to the problem of scaling up services could lie in an enhanced framework for better collaborative interactions between health services and communities. Therefore, the concept of the interface between health services and communities needs to be appropriately explored.

The following trends and global strategies provide strong indications of the need for such work.

In recent years, HIV/AIDS has been transformed from an uncontrollable disease into a manageable chronic condition for those who have access to antiretroviral therapies. Next to prevention, care, support and treatment are now recognized as the elements essential for the control of the epidemic. This knowledge has created opportunities for the development of new comprehensive approaches in response to HIV/AIDS. As a consequence of the advances in antiretroviral therapy, a new stage of the epidemic has been reached, with the focus moving towards the integration of care and treatment with prevention. However, to date, most people who need HIV/AIDS services still do not benefit from this progress and HIV prevention programmes have not been strong enough to reverse the tide of the epidemic.

The Declaration of Commitment issued by the UNGASS calls for the strengthening of the health systems for implementing comprehensive strategies in the expanded global response to HIV/AIDS (UNGASS, para 55). The Declaration also supports actions to strengthen family and community-based care and to support the individuals, households, families and communities affected by HIV/AIDS (UNGASS, para 56).

The impressive record of civil society groups in responding to HIV/AIDS has consolidated the recognition that their full involvement and participation are crucial. The global community therefore assigns key roles to the communities, civil society actors, families, young people and people living with HIV/AIDS in the comprehensive approach to addressing HIV/AIDS prevention, care and support (UNGASS, paras 31 & 33).

It is recognized that the lessons learnt during 20 years of effort in response to the HIV/AIDS epidemic have presented “an important opportunity not only to provide better care for people living with HIV/AIDS, but also to improve health systems and the provision of health care for all” (WHO, 2002).

The health service–community interaction refers to the relationships between the health service structures (such as health centres) and the community organizations and groups. The potential of the interface has been discussed in depth in previous WHO work on community involvement in health. The attention given to the interface for HIV/AIDS is based on the realization that all available resources need to be mobilized and harmonized in order to address the challenges presented by the HIV/AIDS epidemic, not least the problem of providing access to antiretroviral therapy for all those who need it.
Interface: relevance and problem statement

The relevance of the interface is based on the notion that collaborative interactions between different actors may lead to synergistic results. To mount an effective response to the huge HIV/AIDS epidemic, maximum synergy obtained through strategic linkages and relationships between the various actors is critical. Much has been said about the need for collaboration with the relevant sectors and with all segments of society. The lessons learnt suggest that broad national partnerships can generate successful responses to HIV/AIDS.

We argue that an integral element of such broad partnerships is founded on the interactions between the health services and the communities that are served. This is a particularly important facet that warrants more attention for three main reasons.

Firstly, experience suggests that the responses from health service provision structures and those from communities may complement, hinder or strengthen one another. The intention is to move beyond complementary results and foster synergy.

Secondly, an important determinant of community capacity is the community’s ability to form links with the outside world in general and with institutions and health services in particular. A partnership between the local community organizations, agencies and consortia and the health service structures will inevitably strengthen the community capacity for addressing HIV/AIDS and for health development in general.

Thirdly, now that programmes for care and treatment have been established, good relationships and regular contact between the health care workers and the people and families living with HIV/AIDS are becoming increasingly important. Similarly, the successful implementation of the more technical preventive interventions, such as prevention of mother-to-child transmission using antiretroviral drugs, requires optimal contact and connections between health workers and clients. The quality of the interactions between the health services and the communities affects the relationships between health workers and clients. This is especially true for societies with a collective culture, where the formal and informal social and traditional organizations and their leaders exert a strong influence on the individual’s health perception and health-related behaviour. In addition, given the chronic nature of the disease, a continuum of care from homes to facilities needs to be assured.

However, there is evidence to suggest that collaborative interactions between the health services and the communities are often not realized. It is therefore opportune and essential to review previous work in the area of the interface, to identify both the prospects and constraints for such an approach, and to suggest potential roles for WHO.

References


Section 1
Structural and operational underpinnings of partnership work

AN INTRODUCTION TO THE STRUCTURAL AND OPERATIONAL UNDERPINNINGS OF PARTNERSHIP WORK

Dr Walid El Ansari

The devastating magnitude of the HIV/AIDS epidemic necessitates a systematic and harmonized fight against the disease aimed at prevention, care and support. Building on effective partnerships at all levels appears to be the best way forward. The potential benefits inherent in collaborations between the formal health systems with their trained personnel, facilities and knowledge on the one hand, and the communities with their structures, capacities, wisdom and promise on the other, are enormous.

However, partnering for health is an art, and collaboration is a growing science. Marginalized communities who are struggling for their day-to-day survival and health workers who are overstretched in their struggle against HIV/AIDS should not be functioning unguided among the maze of factors and literature that relate to partnership work. To facilitate the building and maintenance of partnerships and to provide broad overviews of what collaborative work entails, this section addresses the structural and operational underpinnings of partnership work.

There are distinct sets of essential ingredients for successful partnering and well defined clusters of critical dimensions that are necessary for collaboration. There is also a body of work and literature by the United Nations that addresses a range of factors, aspects and challenges relevant to the interface between health services and communities. Because collaborative interaction between the health services and the communities is being increasingly considered as a potentially helpful mechanism for responding to the growing needs of both the communities and the services, stakeholders are required to be increasingly well informed about such partnerships.

When confronted with the tremendous challenge of responding to the HIV/AIDS pandemic, community members, health workers and agencies from other sectors will need to be increasingly aware of other partnership experiences, of initiatives being taken elsewhere, other collaborative work and efforts, other literature that describes successes and challenges, and other factors that represent constraints and opportunities for the health services–community interaction. All of these merit serious consideration by those working in partnership-based programmes at the district, municipal, national and international levels.

DISTRICT HEALTH SYSTEMS AND PARTNERSHIPS FOR HIV/AIDS PREVENTION, CARE AND SUPPORT

Dr Prosper Tumusiime

The advent of the HIV/AIDS epidemic in Africa in the 1980s gave rise to various myths and an association with specific groups of the population, namely sex workers and long-distance truck drivers (Bwayo et al, 1994; Godfrey-Faussett et al, 1994). At that time it was a new disease whose origin and characteristics were not known. Although little could be done about the people who were affected, the situation was not perceived to be of great health importance because the cases were few, isolated and limited to those regarded as “careless and immoral”. At that time, HIV/AIDS was more a subject for research than for health interventions aimed at prevention, care and support. By the end of the 1980s, however, it emerged that the situation was of serious health concern in terms both of morbidity and mortality and of socioeconomic impact (UNAIDS,1999; Booyseen et al, 2002). The health service delivery systems started to experience an increasing burden of AIDS cases that threatened to take over most of the available beds, health personnel time and health facility resources. Unfortunately, this coincided with the
deterioration of health systems, resulting in inadequate financing, poor infrastructure, inadequate logistics and supplies and ultimately in a decreased capacity to provide the basic health services.

The increased number of persons infected with HIV/AIDS and the diversity of the groups at risk called for a different response from the health system to address the issues of prevention, care and support. As more and more people suffering from the terminal stages of AIDS were taken to their villages before they died, their families and communities also had to grapple with the new situation of caring for relatives who were terminally ill with AIDS.

This chapter will address the following four questions:

◗ What adjustments, if any, did the health systems make to cope with the HIV/AIDS epidemic?

◗ What are the requirements for addressing the HIV/AIDS epidemic in terms of prevention, care and support, especially at district and sub-district level?

◗ Who should be involved and how?

◗ Given the present circumstances, what can best be done at community level to fight and contain this epidemic?

Health systems coping with the HIV/AIDS epidemic

Initially, before the HIV/AIDS epidemic blew out of proportion, the health system responded to the needs of patients by providing treatment and care for the various symptoms they presented (mostly diarrhoea, meningococcal meningitis, skin disease, Kaposi sarcoma and tuberculosis (TB)). Because of the long hospital stays needed and the increase in the number of new TB cases associated with HIV/AIDS, the health facilities were increasingly occupied by patients with HIV/AIDS-related diseases or infections. HIV/AIDS, therefore, competed with common diseases such as malaria and respiratory tract infections, and stretched the capacity of the health facilities trying to respond to the high demand. Often, the number of health personnel available was less than the minimum required to provide basic health care and the additional demands of caring for patients with HIV/AIDS meant that the health personnel tended to be overworked and prone to burnout.

One significant coping mechanism was to shift the burden of caring for the HIV/AIDS patients to their relatives in their homes. This strategy has since been extended in some areas to supervised home-based care which includes training of family home care givers and community volunteers and supervision by health staff (UNAIDS, 1999). Home care programmes, however, are still generally pilot schemes rather than being institutionalized in the general health delivery system. In some cases, the organization of home care has been left to NGOs or faith-based organizations. Some countries in Africa have also started using institutionalized palliative care systems, albeit on a small scale.

Initially, prevention activities mostly involved provision of information, education and communication (IEC) using print and electronic media; these were later augmented by dance and drama, peer education, voluntary counselling and testing, blood screening, treatment of sexually transmitted infections (STIs) and promotion of safer sex (using condoms). Where these preventive measures have been used effectively, there has been a significant decrease in transmission rates. However, such successful prevention programmes are more the exception than the rule. Services such as voluntary counselling and testing, condom supply and distribution and blood screening need to be scaled up to reach the target population (Contact Group on Accelerating Access to HIV/AIDS-related Care, 2001). In addition, services such as antiretroviral therapy that are required following a positive diagnosis, need to be catered for if these measures are to be useful. For example, for the distribution of condoms to be effective, it is necessary to have in place an appropriate distribution system.

Requirements for HIV/AIDS prevention, care and support

An effective programme for HIV/AIDS prevention, care and support requires a functional health system that is well synchronized from the national level to the district level and through to the community. Each level must be...
able to play its part and to contribute to the functioning of the other levels. This will require appropriate links, clear functions, roles and responsibilities, and sufficient capacity to carry out the relevant functions. Thus the health system at the national level should provide an appropriate and enabling environment with good policies, plans, guidelines and technical support. Equally, the intermediate (provincial and regional) levels should have the capacity to supervise, monitor and support the district and local levels. It is the district level that should make the final link with sub-district and community levels through the health infrastructure and other health-related as well as political and administrative structures. In order for such links to be sustainable, they should be deliberate and institutional, build on existing structures and aim at building community capacity. The peripheral health centre would be the physical structure linking the health services and the community. To provide this link, the health centre must have suitably trained staff who are oriented to community health service support. However, most such health centres are not appropriately oriented, nor do they have adequate health personnel and other resources. The health centre also requires support and supervision from the higher-level health facilities such as the district hospital.

However, this arrangement is not fully institutionalized in most countries although NGOs and community-based organizations (CBOs) are involved in many HIV prevention, care and support activities, especially at community level.

Most government structures, especially the administrative and political ones, go as far as the community level. These government structures have long been known and used by other programmes for planning and budgeting and as centres for extension workers (i.e. the programme agents who reach out into the communities; examples in the agriculture sector are well known). In addition to these structures, the health sector has management boards and committees for the health facilities, which include community representation. All these structures provide opportunities for mobilizing community involvement in the various health programmes, including those relevant to HIV/AIDS.

In the first instance planning in the health sector has mostly involved the health teams at the district level and there has been little involvement of the lower structures (i.e. the health facilities or the communities). Sometimes when planning takes place at the lower levels, it is not in concert with the overall planning process and implementation may be disjointed. The capacity for planning, even at district level, is inadequate and the situation is worse at the lower levels. It is also true that in the health system the capacity for participatory planning is even more lacking, especially for the health structures that form the links with the communities. Inevitably, the lack of such skills for participatory planning will hamper the development of community capacity, community mobilization and community involvement. In some cases, it is the NGOs that have some knowledge and skills in participatory planning methods (Guijt, 1996). But unless an opportunity is created for such capacity to benefit those who lack it, the impact of the NGOs' capacity will remain unnoticed. It is now necessary to strengthen the partnerships between governments, NGOs, CBOs and the communities, and for institutionalized mechanisms be put into place to allow maximum benefit to be gained from the various efforts being undertaken for HIV/AIDS prevention, care and support.

Full partnership with the communities, however, can be achieved only when the communities in question are well informed, have the capacity to assess the problem and are able to identify what they can do to solve it. Communities do have the requisite potential; they only need to be facilitated to use it.

**Partnerships at district and sub-district level**

With the decentralization policy in force in most African countries, the district or equivalent local authority is the centre stage for the implementation of the programmes of the health services or of other sectors. This is the level at which all sectors converge and are coordinated at their implementation stage. The coordination may be mainly administrative, but in addressing issues related to HIV/AIDS there have been attempts to form a coordination committee or body to try to bring the efforts of the various sectors together (UNDP, 2001). In addition to the specific HIV/AIDS coordination mechanism, there is usually a development committee at district level that coordinates the plans of all the government departments. In addition to the government departments, a number of NGOs operate at district and sub-district level. Whereas some of these NGOs operate individually, in other instances, bodies have been established to coordinate NGO activities at district level in NGO forums. Sometimes the NGOs are incorporated into the planning and management structures of the district, in which case their programmes will be integrated into the district plans.
Enhancing community-level action for HIV/AIDS prevention, care and support

There is an increasing burden on the communities to cope with HIV/AIDS prevention, care and support (Russell & Schneider, 2000) in areas with weak health systems and increasing poverty. The need to provide support to these communities is now greater than ever. Some attempts to support the communities have met with success; however, these attempts have been largely ad hoc and not conducted in a synchronized and institutionalized manner.

The existing planning and administrative structures together with those for health service delivery should be strengthened and harmonized to enable them to support bottom-up planning for HIV/AIDS prevention, care and support. Planning for HIV-related activities should also be integrated into, and become part of, the overall health planning of the country. This will avoid duplication of effort, minimize wastage of resources and lessen the strain on the already overstretched health staff. Because HIV/AIDS prevention, care and support require a multi-sectoral effort, the sectors concerned must be involved at all stages of planning to ensure consistent and effective implementation.

It will not be possible to implement a successful HIV/AIDS programme if the health system itself is unable to deliver even the basic health services. A strong component of the HIV/AIDS prevention and control programme aimed at strengthening the health system must be core to the programme. For example, even if antiretroviral drugs are affordable, their use requires a robust system to ensure appropriate distribution, use, monitoring and quality assurance. Condoms are a well-known and effective preventive measure, but they must be readily available to people when they need them.

Information is a very powerful tool for promoting behavioural change. However, this information needs to reach the appropriate targets and be in a form that will be understood. The methods commonly adopted for disseminating information, and for education and communication, tend to favour people in urban areas, the well-to-do and those who are literate. The high rates of poverty and illiteracy in the countries of Africa mean that members of rural communities need specially tailored IEC methods. Information on HIV/AIDS is best disseminated through the local community structures in forms appropriate to their cultures.

Challenges

The HIV/AIDS epidemic, especially in sub-Saharan Africa, is continuing to grow and to devastate the population and to damage the socioeconomic development of the affected nations. It is an emergency that cannot wait. Given the weak health systems currently in place, and while attempts are being made to revamp the health systems, a deliberate move is required to address the suffering caused by HIV/AIDS, sometimes through parallel systems. These should be seen as temporary measures and an attempt to reintegrate the parallel systems into the normal health systems should be made as soon as possible.

The health service delivery systems should be able to support the communities in building their capacity to participate fully in the interventions necessary for HIV/AIDS prevention, care and support. However, the health service delivery systems are hampered by inadequate financial resources, a fragmented infrastructure, poorly motivated and inadequate health personnel, and poor or nonexistent procurement and distribution systems. This makes it difficult for them to provide effective support for programmes for the prevention and control of HIV/AIDS.

The efforts at building community capacity have been made mainly through NGOs and CBOs, which are usually under the direct supervision and control of their donors or parent organizations. Unless these organizations are coordinated at the district level, integrated into the district
Structural and operational underpinnings of partnership work

The magnitude of the HIV/AIDS epidemic is so great and so devastating that there must be a more systematic and harmonized way of fighting the disease. The best strategy seems to be one aimed at prevention, care and support, building on effective partnerships at all levels and particularly at district level (i.e. the level of implementation). While the ad hoc interventions are in place to deal with the emergency, the move towards institutionalization should be initiated, capacity should be built at all levels and coordination and partnerships should be strengthened, especially at district level. A deliberate effort should be made to empower the communities by building their capacity to participate fully in HIV/AIDS prevention, care and support activities.

References

Box 2: Recommendations: time to institutionalize

While the HIV/AIDS epidemic still calls for an emergency-like response, it is time to start to institutionalize the programmes for HIV/AIDS prevention, care and support and to integrate them into the existing health systems and other development programmes. For this to happen we need to re-orient health service structures and health care personnel and to increase their capacity to handle the programme and to support other lower structures. A deliberate effort is required to build the capacity of the communities and to enable them to be fully involved in all processes, from problem identification to participation in the formulation and implementation of suitable solutions. Appropriate mechanisms to foster partnerships between government, NGOs and the community need to be identified and these, as far as possible, should utilize existing structures.
Background of the review

The health sector has been confronted with the tremendous challenge of responding to the HIV/AIDS pandemic with its ever-increasing number of people in need of services (UNAIDS/WHO, 2002; WHO, 2002). The collaborative interaction between the health services and the communities is being increasingly considered as a promising potential mechanism for responding to the growing need for health services.

United Nations agencies as well numerous NGOs and donor organizations are making great efforts in promoting and providing technical and financial support to countries in the area of the interaction between the health services and the communities, i.e. community involvement in health in general, and community mobilization and partnership-building in response to the HIV epidemic in particular.

To obtain useful pointers for the identification of appropriate roles for WHO in improving the interaction between the health services and the communities, previous and current schemes developed by the United Nations that demonstrate the significance and value of a collaborative interaction between the health services and the communities were reviewed. The objectives of this review were to determine what work had already been undertaken in the domain of HIV/AIDS and in the domain of district and community health in general. This was a necessary prerequisite to identifying previous and existing work and to identifying gaps in the work that might require and benefit from supplementary action. This chapter summarizes the findings of the review.

Findings

A variety of United Nations agencies are involved in activities related to the interface for HIV/AIDS. Some examples are:

- work by the UNDP on participatory tools for strengthening community responses to HIV/AIDS (UNDP, 2000);
- work by the International Labour Organization (ILO) on human capital for HIV/AIDS (Cohen, 2002);
- guidelines produced by WHO’s regional offices such as Building blocks (PAHO, 2000) and Planning and implementing HIV/AIDS care programmes: a step-by-step approach (Narain et al, 1998);
- work by the World Bank on involving NGOs in HIV/AIDS programmes and on mobilizing rural workers (Schapink et al, 2001; World Bank–Actafrica, 2002); and

In addition, other work relevant to the interface, but not specific to HIV/AIDS, was identified. This included:

- work by WHO on district health systems (WHO, 1995), community involvement (WHO, 1991), health promotion (WHO, 1998) and on building community capacity to address various health problems;
- work by the World Bank on services for low-income countries and the poor (www.worldbank.org/hmp/hsd) and on the provision of services by civil society organizations (CSOs) (McLeod & Tovo, 2001); and
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The UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) which includes work on participatory training for health workers to improve their interactions with clients and families (Haaland & Vlassoff, 2001) and community-directed treatment of diseases (WHO, 2000).

Although all the above-mentioned efforts are valuable, the most relevant and comprehensive work relating to the health services–community interaction is WHO's work on district health systems and on community involvement in health and the work by UNAIDS on local responses. This work is briefly discussed below.

1. District health systems: providing a framework and structures for the interface

Since the 1980s, the work undertaken by WHO on structures and programmes for local health systems has been mostly within the framework of district health systems (WHO, 2001). During this period, HIV/AIDS was emerging as a pandemic and work was therefore instigated on supporting the affected countries with the establishment of national AIDS programmes (WHO, 1988).

The district health system, globally the most widely available sub-national health system, provides the mechanisms (and structures) necessary for the realization of the plans and interventions of the national AIDS programmes. More importantly for the subject of this review, it offers a potential platform for the overall arrangements for the interface between the health services and the communities. WHO regional offices already have specific programmes in place to support countries in the development of their district health systems.

The district health system recognizes both the health services and facilities and the community structures as integral components (Kahssay & Baum, 1996). By definition, a district health system encompasses all the players and structures in health development and health service delivery (for any given district). This includes the formal health workers, health centres and posts, families, traditional health providers, and a variety of CBOs such as women’s groups, youth assemblies and faith organizations. The district health system therefore offers opportunities for building an enabling environment for the interface between health workers and community organizations. In addition it offers opportunities for attention to be given to issues related to the interface such as the community financing scheme that has been introduced as the Bamako Initiative in west and central Africa (UNICEF, 1995) and stewardship roles for the health system that reflect the role of the local government in health (WHO, 2001).

The local government serves as the interface between communities and government. Experience has suggested that local government has the potential to facilitate the involvement of communities in health and health services (WHO, 2001). The influence of local governments in health services is far-reaching: it is the local government, not the ministry of health, that “hires and fires” local health staff. The review undertaken for this WHO Consultation suggested that local government, given its influence on local health decisions, deserves more attention as a stakeholder in health generally, and in HIV/AIDS in particular.

Within the framework of the district health system, the service structure at the interface between the health services and the local communities is the health centre, defined as all front-line facilities for the provision of a variety of health services (WHO, 1997). It is the health centre with its front-line workers that is able to maintain both an ongoing dialogue and functional partnerships with the communities. Table 1 outlines the three components of a district health system.

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1 The district health system is defined as a self-contained segment of the national health system comprising a well-defined population living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, nongovernmental, private or traditional. It has the following three components: health management, health facilities and community groups and organizations, previously named health development structures (WHO, Global Programme Committee, 1986).
Community health workers (CHWs), who originate from within the community, do not necessarily belong to the formal health services, but are briefly trained and are supported in their activities by the formal health structures. CHWs have the critical role of bridging between the community and the formal health services. They exist in various forms in many countries, have increased the coverage of primary health care services, and are the foundation of community-based actions of many vertical programmes (Kahssay et al, 1998).

2. Community involvement in health: a basic principle for health development
Considerable efforts in conceptualizing and promoting community participation have been made since the 1980s (Oakley, 1989) and the concepts and practices have been reviewed by Kahssay & Oakley (1999). The work on health promotion, with its focus on the wider determinants of health, is an area that has strongly encouraged multisectoral collaboration and partnerships between health services and communities. World Health Assembly resolution WHA 51 on health promotion urges all Member States to consolidate and expand partnerships for health, to increase community capacity and to empower the individual in matters of health (WHO, 1998). Community involvement as a principle is based on community ownership of the health services. It is about developing “people’s services”. A WHO Study Group on Community Involvement in Health stated that, to be able to meet the target of health for all, it is necessary that: “...radically different forms of health care are put into practice, permitting the development of health services that are people’s services...” (WHO, 1994).

Although much work has been done on fostering community participation in addressing various health problems and implementing health programmes, this review suggested that limited efforts have as yet been directed towards building the capacities of the health providers. A shift in focus is therefore required (see Box 3).

Box 3: Shifting the focus
After many years of experience with community involvement in health (CIH), experts recognized that:

«Any major advance in the implementation of CIH as a principle of health development could come about only when health services fully understood the value of CIH and were prepared to meet its challenge.»

An expert committee meeting on community involvement in health recommended that the focus be shifted from «encouraging communities to participate in health» towards “preparing health services for community involvement in health”. Efforts to build the capacity of health providers to work with communities should be emphasized. (Source: WHO, 1991)

3. Local responses for HIV/AIDS: providing a participatory process for building community capacity
In the mid-1990s UNAIDS and WHO instigated the District Response Initiative in six countries, with support from the German organization, the Deutsche Gesellschaft für technische Zusammenarbeit (GTZ) (UNAIDS, WHO & GTZ, 1997). This initiative aimed to strengthen the capacity of the districts and was taken beyond the strict health sector. The initiative focused on multisectoral collaboration to assess the situation within the communities and the planning of appropriate responses. This initiative

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Table 1. The three components of a district health system

<table>
<thead>
<tr>
<th>Health services management</th>
<th>Health service facilities</th>
<th>Health development structures</th>
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<tbody>
<tr>
<td>District medical officers</td>
<td>District hospitals</td>
<td>Farmers’ associations, women’s</td>
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<tr>
<td>Heads of health centres</td>
<td>Health centres</td>
<td>groups, village organizations,</td>
</tr>
<tr>
<td>and posts, etc.</td>
<td>Health posts</td>
<td>faith-based organizations,</td>
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<tr>
<td></td>
<td></td>
<td>etc.</td>
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<td></td>
<td></td>
<td>District councils, district</td>
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<td>health committees</td>
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was developed further into the Local Response Initiative led by UNAIDS, which contributes substantially to building and enhancing the community capacity for addressing HIV/AIDS in many countries in Africa in which controlling HIV/AIDS is a priority (UNAIDS & TANESA, 2000).

A local response to HIV/AIDS is defined as “the involvement of people where they live — in their homes, their neighbourhoods and their workplaces” (UNAIDS, undated). Such a response can be viewed as a strategy for developing a process that involves people in building partnerships and an enabling environment with the aim of increasing local competence to respond to HIV/AIDS. It builds on theories of action learning and participatory methods (KIT/UNAIDS, 2002). Local partnerships are viewed as being critical for effective local responses. Figure 1 illustrates the three groups of key players in the local response, namely, the communities and key social groups, the service providers and the facilitators.

People living with or affected by HIV/AIDS (PLWA) and their NGOs have made significant contributions to community capacity building and are recognized as critical partners in the local responses. A special programme, Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA), has been established by UNAIDS, and aims at promoting the involvement of PLWA in community action as well as in planning and policy development (UNAIDS, 1999b). The involvement of PLWA in services enables important links to be built between the communities and the services. This can be most readily accomplished if there is concurrent development of capacity among PLWA to enhance their communication with, and influence on, other parts of the local community. Thus the work on building the capacity of PLWA for interacting with health providers and with other community groups is a critical component of building community capacity for the interface and for responding to HIV/AIDS in general. UNAIDS has documented many cases worldwide of community processes and action led by or involving PLWA (UNAIDS 1999c, 1999d, 2000). Such positive experiences in local response for HIV/AIDS could be documented, and adapted to different contexts (see Box 4).

Figure 1. Stakeholders in local partnerships

| Key social groups
| Service providers
| Facilitators/catalysts

The health service structures and delivery models that are related to the interface derive from the primary health care approach, and have been described in previous work on the framework of district health systems. The work on the processes for the interface is grounded in the efforts on community participation and brought into more practical detail in the initiatives on health promotion. What is evident from the many expert meetings and documents on the subject is that the interface between the health services and the local communities has been a principal concern in previous work.

The local response initiative is a remarkable scheme that focuses specifically on HIV/AIDS prevention and care; it offers many experiences and strategies for linking a variety of service providers (among them the health service providers) and communities specifically to address the problems of HIV/AIDS. On the basis of transformation theory and participatory methodologies, the local response initiative provides the processes and methodologies needed for the local interface (collaboration, partnerships and joint working). An important feature is that it acknowledges the difficulties in getting local stakeholders to interact with each other and therefore makes use of facilitators in the process. The local response initiative has been implemented over the past few years in many countries where controlling HIV/AIDS is a priority and has been useful in building capacity in local communities.

Gaps in the work

From the review of the relevant literature, three important gaps in the work were identified.

The first was that within the local response initiative, no specific attention has been paid to the interface between health services and communities. Health workers are just one group in the category of service providers. Although it is legitimate to regard the various service providers (social, legal, education etc.) as important stakeholders in HIV/AIDS, it may be equally justifiable to suggest that health service providers are in need of special attention. This is because health service providers differ from all other service providers in that, historically, they have dominated the health agenda. Joint work on health, collaboration and sharing responsibility with communities is now urgently required from health service providers to enable them to respond appropriately to HIV/AIDS. Such a relationship of shared responsibility and joint work between

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**Box 4: Local response development and dissemination**

"Models used in earlier HIV/AIDS prevention programmes assumed that people will respond effectively to HIV/AIDS, if only they have access to adequate information and technology. It is now recognized that information and technology are necessary, but not sufficient conditions for an effective and sustained response. There are limits to what people can do on their own and therefore the need to create an enabling environment through partnerships between key social groups, service providers and facilitators or catalysts, is evident.

Key social groups are different groups at community level such as women’s organizations, water or health committees, people living with or affected by AIDS and specific organizational groups. Service providers at district level and below are not limited to the health sector, but also include other sectors such as education (schools), agricultural services and the administration as a whole. They may also be NGOs, religion-based organizations or the private sector. Finally, facilitators or catalysts facilitate the process in which partnerships are formed effectively. Such facilitators may come from any of the key social groups or from outside.

At present, many good experiences in local response development actions tend to remain local and fragmented. Even when they are documented, practical application and adaptation to another local context is often difficult. A toolkit has been developed to facilitate such application and adaptation by those who need and use the tools."

health services and communities is completely different from the traditional one in which decision-making is unilateral. Moreover, health service providers differ from all other service providers in terms of the range and frequency of their interactions with the communities and clients on health issues. The efforts to improve access to preventive services, to care and to antiretroviral treatment are expected to increase the interaction with PLWA, their families and communities.

The second gap that has been identified is that little work has yet been undertaken on enhancing the capacity and expertise needed by health workers for interacting with the communities. The emphasis so far has been on augmenting the capacities of the communities and families for disease prevention and care. Relatively little effort has been directed towards enabling formal front-line workers to work jointly with the communities.

The third gap is that the work undertaken by WHO that is relevant to local health systems and partnerships, and the experience gathered in this area by many other health programmes, has not yet been systematically reviewed. Such a review is necessary to explore past experiences and to decide whether they can reveal opportunities for improving and expanding the community care of HIV/AIDS patients. Similarly, the many case-studies on HIV/AIDS reported in the UNAIDS Best Practice Series have not been reviewed from a health system viewpoint to identify health service–community partnerships and the factors that are conducive to building such partnerships.

Advancing the work
For health generally, wide experience with the interface has been gained worldwide. However, our review suggests that the following actions may be needed to fill the gaps in the present body of work, and could contribute to advancing the efforts undertaken to date.

- A detailed analysis of the lessons learned by the local health systems that are pertinent to the interface between the health service and the community could prove useful for application to HIV/AIDS. Likewise, a comprehensive analysis of the many cases described in the UNAIDS Best Practice Series with a specific focus on identifying health service–community partnerships, and the critical factors that contribute to such partnerships, could be useful for reorienting the health services towards collaborative interaction.
- Additional and focused attention on the health service providers, together with the recognition of the broad range of other service providers as stakeholders in the local response, could enhance the support from the United Nations for the local response initiatives.
- Development of an overall strategy and actions aimed at re-orienting health care systems to encourage community partnerships, as well as the building of capacity for partnership and joint work at local community level with mainstream health service providers, is desirable. Such changes in the health care system could advance not only the work on HIV/AIDS, but also that in other areas of health. The lessons learned from HIV/AIDS have created opportunities for changes in health service provision.

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Structural and operational underpinnings of partnership work


HUMAN CAPACITY DEVELOPMENT: A PARTNERSHIP RESPONSE TO HIV/AIDS

Ms Sue Lucas

Human capacity development (HCD) is an innovative approach to addressing HIV/AIDS that goes beyond technical solutions and service provision and builds on the existing strengths of both people and communities. It does not replace service provision, which will always be an essential part of any response to the epidemic, but it enables service provision to be both appropriate to and complementary to the responses made by communities. It is community-led rather than commodity-led. The aim of HCD is to create “HIV/AIDS competent” communities and organizations (Campbell, 2001) that are able to acknowledge the existence and impact of HIV care for those who are affected or infected, to change in order to address the epidemic and to measure the changes taking place.

The key elements of a human capacity development (HCD) approach are a working culture of facilitation (Campbell et al, 1998) and the building of a shared vision. Rather than imposing external solutions, HCD is based on community responses to HIV/AIDS. Facilitation teams enable a continuous process of learning from local action and responses, reflection, action, learning and further reflection. The process of learning together validates and encourages community responses. Through participation in facilitation teams and in shared learning with communities, organizations find out how the way in which they work can be adapted to complement and enable community responses, rather than, as is sometimes the case with expertise-led interventions, hindering and undervaluing them.

Facilitation teams (Rader et al, 2002) stimulate local ownership of both the problems that HIV creates for communities and of the solutions to these problems. Solutions are therefore not externally imposed by any party. Facilitation teams create and share knowledge of effective responses, and draw community members and service providers into the process. Teams are not static, but rather are dynamic in nature. They can function in a variety of environments from the international level to the local level. Members are self-selecting, and participate as individuals, not as representatives of organizations. One of the limitations of the current technological approaches to HIV is that scaling up of service provision has proved to be very difficult. An HCD approach builds on community capacity by facilitating transfer of learning and action from community to community. This “horizontal learning” occurs between communities in the absence of external stimulation (Salvation Army Africa Regional Programme Facilitation Team, 2002), but not fast enough to match the speed of the spread of HIV. Facilitation teams stimulate assessment, design, process analysis and evaluation of patterns of response locally and elsewhere. A key way of working is through learning from and valuing local strengths. This strategy is a means to a more effective process and outcome. Links can be made in all directions, so that for example policy-makers, who may be from government or international institutions, can share learning (Lucas et al, 2002) with communities to improve the ways in which relationships function and services are provided.

A satellite meeting at the International AIDS Conference in Barcelona (UNAIDS/TND, 2002) agreed on a framework to show how HCD can bring together communities, individuals and families (these three groups having being identified as “spheres of action”) to learn with service providers and policy-makers. Although each of these groups has a key role in the overall response to the epidemic, there
has so far been little collaborative interaction between them. Enabling shared learning that focuses on the community sphere, in which the transmission and the impact of HIV are seen, increases understanding in all spheres, of the role and strengths of the others, and enables a more holistic and integrated response.

The challenge to organizations is to change their way of working from one of expertise-based interventions to one of facilitation and community leadership. The shift in perspective is illustrated in Box 5 below. An HCD approach would also require a shift towards equal partnerships, working with rather than for communities, clients and “target groups”, as well as addressing several spheres of action (see Figure 2).

<table>
<thead>
<tr>
<th>Box 5: A shift in perspective</th>
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<tr>
<td><strong>From</strong></td>
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<tr>
<td>We believe in our own expertise</td>
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<tr>
<td>We control a disease</td>
</tr>
<tr>
<td>Responding to need</td>
</tr>
<tr>
<td>You have a problem</td>
</tr>
<tr>
<td>Provision of services</td>
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<tr>
<td>Mobilizing external expertise</td>
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<td>We instruct and advise</td>
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The Salvation Army has been working using this approach since the mid-nineteen-eighties. They started with the home care programme in Chikankata, Zambia, in 1987. This was the first home care programme for people with HIV in Africa that built on the capacities of families and communities to care. The programme, developed from Chikankata Hospital, established community teams to support families caring for the sick. Competent communities were soon discovered, and the care/prevention linkage was a source of energy and hope.

During 2002, the Salvation Army and UNAIDS/Technical Network Development have been working in partnership to establish HCD approaches. Other institutions and international donor agencies, including the World Bank, the United States Agency for International Development (USAID) and the Department of International Development of the United Kingdom (DFID) have been involved in discussions and several international meetings have been held, including the meeting in Barcelona in 2002 and a donor workshop in London in 2002. The key points learned from the experience of working with an HCD approach in practice are that effective responses to
HIV are people-driven not commodity-driven, that technology, money and information lend support to, but cannot be a substitute for people-driven responses, and that to create a country-wide response, an approach of facilitation that builds on strengths and engages people within their own communities is required.

References


COLLABORATIVE INTERACTION WITH THE COMMUNITIES: CONSTRAINTS AND OPPORTUNITIES FOR THE HEALTH SERVICES

Dr Hedwig Goede

Collaborative interaction between health services and communities has long been a concern of the health sector. Since the 1980s, the concept of community involvement has been generally accepted as an important component of health practice. Many valuable experiences have been gathered that demonstrate that a radical reorientation of health service practice is required for the institutionalization of community involvement. However, it was noted that after a decade of experience the necessary radical reorientation was still being underestimated (Oakley, 1989; WHO, 1991).

HIV/AIDS has led to numerous new experiences being gained in community health action based on partnerships and joint working (UNAIDS, 1999, 2000; UNGASS, 2001) and is calling more strongly than ever for a radical reorientation of health care delivery so that treatment can be brought within reach of the millions of people who need it (WHO, 2003a). Despite the considerable progress that has been made to date, some constraints on the interaction between the health services and the communities still need to be addressed if collaboration between communities and health services is to become normal practice. This chapter discusses these potential constraints and presents some promising examples of the health service–community interaction, that have been reported in the literature.

Constraints: health care model and capacity of the health services

Over the past two decades health care models and various local structures that facilitate community involvement and support the functional linkages between health service structures (district health systems and health centres) and community organizations (community health workers) have been promoted (WHO, 1991, 1994, 1995, 1997; Kahssay, 1998; Kahssay et al, 1998; Kahssay & Oakley, 1999). However, the following factors within the health care system restrict the ability of these structures to perform effectively in collaborative interactions with communities.
The biomedical orientation of the health care system. The medical model, which tends to overvalue biomedical care, is still the prevalent model in health care. Community involvement has been recognized as a challenge to traditional health service practice (WHO, 1991) and the health sector has not been able to move as far as other development sectors in the institutionalization of community involvement at the national policy level (Kahsay & Oakley, 1999). The biomedical orientation of health care also leads to an overemphasis on acute, episodic care. Chronic conditions, including HIV/AIDS, require different management that necessitates a long-term, trustful and partnership-based interaction between the health professionals, the clients and their communities. A new innovative chronic care model has identified three entities each with distinctive roles in care that need to be firmly connected: the health care organization, the patient and the community (WHO, 2002).

The strong hierarchical structure and non-participatory culture of the health care system. Local health workers have reported feeling frustrated about their lack of opportunity for input into decision-making about policies affecting their work (Vlassoff & Fonn, 2001). Health workers are generally unaccustomed to dialogue and partnership approaches at the workplace and remain reluctant to involve the communities in decision-making or to recognize them as full partners in the services.

Gender-based policies and approaches emphasize the importance of involving individuals, both men and women, in health services and promote interaction with diverse societal groups (WHO, FCH/RHR, 2001, WHO, 2003b). Therefore, gender-based approaches can be viewed as important tools to enhance participation of communities in the health care system. There is additional justification for gender sensitivity in the interaction between health services and communities dealing with HIV/AIDS. This is because of the gender-based power differentials in sexual relationships that may influence the vulnerability of women. However, the importance of gender as a factor in health and services has not yet been fully taken into account.

Attitudes and practices of health workers towards communities. Health professionals, by virtue of their position in health organizations, have considerable power to determine the health agenda (Robertson & Minkler, 1994). Mutual recognition of capacities and worth is a key requirement for collaborative efforts; however, there is evidence to suggest that professionals significantly undervalue the expertise of communities (El Ansari et al, 2002) and are often not even aware of the existence of community organizations and their health activities (Kahsay & Baum, 1996). Formal HIV/AIDS programmes sometimes operate without any feedback from the villages they serve and without establishing any links between the formal health services and the community home care system (Singhenetra-Renard et al, 2001). This unilateral determination of the health problem and its prevention or treatment is recognized as deeply embedded in the culture of modern medicine (Lopez Acuña et al, 2000). Studies of various programmes have reported that formal health workers initially resist the involvement of community members in care and treatment (TDR, 2000; Kironde & Nasolo, 2002). Furthermore, there is evidence that attitudes and practice of formal health workers showing a lack of respect for the community’s role in care create serious barriers to the performance of community members trained as “community caregivers” for PLWA (Uys, 2002). Conversely, in community-based HIV/AIDS programmes, transferring nursing skills to the families and communities, rather than requiring nurses to perform all the necessary tasks, has been recognized as an approach that contributes to the extension and sustainability of HIV/AIDS community care (UNAIDS & SANNAM, 2003). Poor-quality interactions present major barriers to the use of health services. Clients have reported being treated without respect by health staff, which they feel originates from the staff adopting a superior position as professionals (Onyango-Ouma et al, 2001). When social distance is considerable, as with poor and marginalized people, the lack of respect and the feeling of being badly treated by workers in social institutions is profound (Narayan et al, 2000; WHO, World Bank, 2002). Being a patient with HIV/AIDS exacerbates these problems. The enormous stigma attached to HIV/AIDS is accompanied by large-scale discrimination against PLWA in health facilities and by society in general (UNGASS, 2001; UNAIDS, 2002).

Lack of resources and incentives for local community level structures. The roles of the district health system and its peripheral structures are constantly emphasized in the public health literature. The Commission on Macroeconomics and Health identified the “close-to-client” services as the priority level for tackling HIV/AIDS and other important diseases affecting the poor (WHO, 2001). However, primary health care activities such as working in and with communities lack recognition. For example, the performance of nurses in South Africa is measured primarily on indicators of biomedical care (Petersen, 2002). Moreover,
there are strong suggestions of a serious misfit between the burden of work and the resources available to the health centres at district level (WHO, 1999). Therefore, community services have inadequate resources not only in absolute terms (because of the limited resources available in a country), but also because relatively more resources are directed to the secondary and tertiary levels of care.

**Gap in professional training.** A considerable gap needs to be bridged between the demand for new roles to be taken on by health workers and formal training (Guldan, 1996). The core concepts of the curriculum that provide health professionals in primary health care with skills for partnerships are the strategies of networking, negotiating, sharing power, and critiquing partnerships (MacIntosh & McCormack, 2001). The changes required for taking on the new roles involve the re-socialization or re-professionalization of professionals (Stewart, 1990). Addressing the problems of HIV/AIDS has exerted great pressure on training needs, because it requires health workers to go beyond their routine approaches (van Praag et al, 1997). In addition to training in new skills, institutional factors need to be tackled by means of strong leadership to encourage and enable health workers to make a real change in their practice and behaviour (Woodward, 2000).

**Constraints: community capacity**

The concepts of community capacity, empowerment, competence and readiness share some characteristics, but differ in others (Goodman et al, 1998). Community empowerment, viewed in its wider definition as a social-action process aiming towards increased individual and community control (Wallerstein, 1992), places emphasis on a collaborative interaction between health services and communities and challenges the conventional relationship between communities and professionals (Wallerstein, 2002). It is therefore an important concept in the discussion of the interface. UNAIDS defines an AIDS-competent community as “one whereby people are able to assess accurately the factors that may put them or their communities at risk of infection, and act so as to reduce those risks” (UNAIDS, 1997; Lamboray & Skevington, 2001). An AIDS-competent community will be empowered and have some general capacity to address community problems as well as specific capacity to address HIV/AIDS.

**General capacity and community empowerment.** Communities sometimes lack the level of empowerment and capacity that would enable them to collaborate as equal partners with health services. Leadership, inter-organizational networking and negotiation skills, as well as expertise in community organization and resource mobilization, are examples of the range of dimensions and competencies identified as being determinants of community capacity (Goodman et al. 1998). There is a need for those communities with little experience in community-based action and frail organizations to build and enhance their general capacity. This is particularly relevant for the marginalized populations and vulnerable groups at a high risk for contracting HIV/AIDS. The HIV/AIDS prevention movement has been successful in tailoring programmes to communities that are defined on their risk for HIV (Freudenberg & Zimmerman, 1995). In addition, the gay community has played a leading role in providing both prevention and care services. In the first years of the epidemic, in particular, the available HIV services were owned and managed by gay communities. However, at-risk populations and vulnerable groups may lack the type of social interaction and sense of community that could lead to community action. Experiences from Thailand suggest that creating a sense of community through social and political activism as with the western gay community may be more difficult in Asian countries (Scott & Rosko, 1999). In Madras, India, experience of working with the community of sex workers has shown that in some societies, vulnerable communities may be too powerless, isolated and marginalized even to act as a community. Hence, comprehensive structural changes are required to address the lack of empowerment before sex workers are able to act individually or collectively to prevent HIV/AIDS (Asthana & Oostvogels, 1996). In South Africa, experiences with sex workers confirm the influence of conditions such as poverty and sexual inequality on bringing community participation into practice in marginalized populations (Campbell & Mzaidume, 2001).

**Specific HIV/AIDS capacity.** There is evidence of a wide gap in some communities between the knowledge and skills available at the community or home level and the daily tasks that need to be performed in caring for someone with HIV/AIDS in homes and families. At the start of the epidemic, the AIDS activists from the western gay community were the best informed, educating not only the community members but also the professionally trained health workers (Cain, 1993). They had considerable capacity and impact. However, in other settings, insufficient capacity at community and home-care level was being associated with lack of support and supervision from formal health workers. For example, family members caring for AIDS patients often have little or no knowledge or experience of the skills...
needed to provide care, how to manage symptoms such as diarrhoea, dehydration and pain or how to take precautions against transmission. They are sometimes even unaware of the diagnosis of their ill relatives (Ndaba-Mbata & Seloilwe, 2000). Gaps in knowledge have also been identified as regards mother-to-child transmission and the available preventive interventions (Nyblade & Field-Nguer, 2001). Further constraint is the focus on individual knowledge and behaviour change without building the capacity at the level of society. For instance, in the past, changing individual behaviour to prevent HIV has received more attention and support than changing societal factors (O’Reilly & Piot, 1996). Changes in individual behaviour are difficult to sustain when the societal factors that influence the behaviour are not simultaneously tackled. This is because the individual, societal and institutional levels of capacity are mutually dependent and are therefore of equal importance (Fukuda-Parr et al, 2002).

Constraints: processes and methodologies for linkages
A body of literature is available on the processes that promote the building of partnerships based on community involvement and participation, and on processes for enhancement of community capacity for health. In addition, numerous manuals and guidelines that focus on developing various HIV/AIDS competencies are available, most of which have been produced by NGOs, and by various United Nations agencies. However, several factors restrict the gains that might be predicted.

Application of participatory methods in the training of health professionals. The application of participatory methods in the training of health workers for partnership fostering, such as the use of role-modelling of partner skills in nurse education (Petersen & Swartz, 2002), and improving health workers’ gender sensitivity and relations with clients and communities, have been effective in bringing about the desired changes and increasing job satisfaction (Onyango-Ouma et al, 2001). Relevant methods are based on the principle of joint learning where all participants, community members as well as the “educator”, “facilitator” or “health worker”, learn together. These techniques address the entrenched belief in professional dominance and lay the foundations for partnership building and work. However, these participatory approaches are not fully institutionalized in professional education and training although they have been applied to a limited extent in professional education and training. It is likely to be difficult for health workers to learn to use participatory methods when working with communities if they have not experienced these methods during their professional training.

Frameworks for tools and methods. Frameworks by which the numerous tools and models necessary for the participatory methodologies, joint working and partnerships for addressing HIV/AIDS can be arranged, categorized and catalogued are lacking. These tools and models are therefore dispersed and difficult to access. There are many success stories of local partnership processes for addressing HIV/AIDS, but there has been little effort to critically review and document the features of the different methods applied in such local partnerships, or to measure community participation and institutional changes that are conducive to partnership work. Transferring the experiences from local responses to other settings has proved difficult; deliberate efforts and specific tools are required to support this process (KIT/UNAIDS, 2002). Institutionalizing the application of methods used to create effective partnerships on a larger scale is still complex and the scaling up of efforts to combat HIV/AIDS is a difficult task for the individual NGOs leading the local processes. One way in which some countries have been able to scale up has been the adoption by governments of NGO methodologies for building community capacity and generating community action for HIV/AIDS (De Jong, 2001).

The health service–community interaction: opportunities
A variety of experiences related to the interface between health services and communities in HIV/AIDS prevention and care suggest important opportunities for enhancing the interactions. The Consultation identified the potentials of such interactions for several key areas relevant to the problems of HIV/AIDS.

Key areas for the interface
Partnerships and collaborative efforts between different stakeholders have proved effective in responding to a broad range of aspects of HIV/AIDS. However, within this broad range, some areas (for example blood safety) seem to be less amenable to collaboration between health service structures and community organizations than others. The following areas are particularly sensitive to the health services–community interaction and are therefore key fields when considering the interface.

Voluntary counselling and testing. Increasing access to voluntary counselling and testing (VCT) is an important area that requires good collaboration between the health services and communities. The management and delivery of VCT services can either be jointly planned and implemented by the formal health workers and PLWA or may be implemented by one partner and supported by the other. Such collaboration enables both the coverage and the quality of VCT services to be increased.

Community and home care. Family, friends and community members provide most of the care to PLWA in the home. The carers need support from the formal health services, and links between facility-based, home-based and community-based services are required to maintain a continuum of care. Support, advice and supervision from health service structures for carers in the community and in homes is an important area of the interface.

Antiretroviral treatment and adherence. Community organizations may take action to increase local access to antiretroviral treatment. Family members and community volunteers play a critical role in supporting individuals with several aspects of treatment. Families and community members may play a role in helping patients to meet nutritional requirements and to adhere to their antiretroviral drugs. The risk of viral resistance when antiretrovirals are not properly used and the chronic character of the treatment are reasons why assistance in adherence can be considered as a critical contribution to effective treatment. Communities need to build specific capacity, knowledge and expertise for implementing and supporting antiretroviral treatment. Close collaboration between the health services and communities, family and friends is a prerequisite for the success of antiretroviral treatment.

Human rights — reducing stigma and discrimination. Human rights approaches to HIV/AIDS prevention and care provide the foundation for addressing the issues of stigma and discrimination. Furthermore, human rights approaches may provide a sound basis for gender-based action by recognizing gender differentials in power and rights as related to risks, prevention and access to care for HIV/AIDS. Health services and communities are mutually dependent in reducing stigma. Particular individuals who “wear two hats”, such as a nurse who discloses that he or she is seropositive, are in a unique position to play a critical role in reducing discrimination at the level of services as well as at the community level.

Responsiveness of and demand for services. The range of services available to individuals is often not fully utilized. The creation of an informed demand for the services and raising the responsiveness of such services are as important as the services themselves. Communities, especially PLWA organizations, can influence the quality and priority of services through dialogue and partnerships with the health services.

Social support, networking and intersectoral action. The interface with the communities offers the health services increased access to other sectors. This is because communities frequently have a variety of concerns that extend beyond health and therefore their organizations are often already involved in collaborative efforts with different sectors. The communities and the health services could derive mutual benefit from one another’s networks and linkages to help address a variety of issues ranging from prevention and treatment of HIV/AIDS to nutrition and care of orphans.
Lessons learned
Some useful lessons have been learned from the experiences in managing HIV/AIDS as well as from other health conditions. The lessons learned cover:

- health structures and programmes;
- approaches to building partnering capacity; and
- key actors for bridging between the health services and the communities.

Health structures and programmes

Health centres and community health workers. Health centres and community health workers have demonstrated their ability to reduce barriers to access and to increase access to care generally. Community health workers have succeeded in reaching people at community level with their services and have influenced the acceptability of the existing services. As a result, they have increased the utilization of these services (Kahssay, 1998; Swider, 2002). The employment of community health workers has also been successfully applied in community care for patients with tuberculosis (Hadley and Maher, 2000; WHO, 2003c) and in home care for patients with HIV/AIDS (Uys, 2002).

District hospitals. District hospitals have demonstrated their ability to organize outreach services for HIV/AIDS and to build community capacity through partnerships. The Chikankata hospital in Zambia pioneered the work in this area and provides one of the classic examples of what can be accomplished through working in collaboration with the communities (Malama, 2001). This hospital has served as a model for a range of other community care programmes in Southern Africa (UNAIDS & SANNAM, 2003).

Tuberculosis community care. Tuberculosis community care programmes have demonstrated that volunteers from the community are able to supervise treatment in an appropriate manner if there is a close interaction with the national tuberculosis programme and with the general local health services (WHO, 2003c).

Home care programmes. Home care programmes for patients with HIV/AIDS perform well when supported and supervised by professional health workers. It has been demonstrated that community members can be trained to assist families with care at home within a period as short as 3 months, but supervision and support by professionals are of the utmost importance (Uys, 2002). Effective partnerships between the government health facilities and the home care programmes of NGOs and missionaries have been identified as a way of expanding successful home care programmes (Nsutebu et al, 2001).

Responsive health services. Responsive health services have an empowering effect on people and on community capacity. Personal services directed towards individuals can be empowering to individuals and communities if delivered in an empathic and supportive way (Labonte, 1994) or as a right to people (Pilisuk & Minkler, 1986). Similarly, access to health services is essential in maintaining the supportive capacity of families, networks and communities (Pilisuk & Minkler, 1986). Access to essential services (including health services) has also been proved to enable women to engage in other empowering activities (Kar et al, 1999). In the case of HIV/AIDS, responsive and knowledgeable health providers have an empowering effect on patients and are identified as being critical components of the infrastructure required for care and treatment of PLWA (ICASO, 2002).

Approaches

Academic institutions — the use of participatory action research. Academic institutions have been effective in facilitating local partnerships and in building community capacity as well as capacity for partner roles between health workers and non-professionals. Schools of public health are increasingly engaging in partnerships with the health services and communities and are able to facilitate collaborative action (Schensul, 1999; Galea et al, 2001; Lantz et al, 2001). Nurse researchers have also successfully employed PAR to build community capacity for action and change in health generally (Lindsey & McGuinness, 1998) as well as specifically for HIV/AIDS (Lindsey et al, 1999). Similarly, community-oriented medical schools with innovative programmes have reduced the social distance between health services and communities (Blumenthal & Boelen, 2000).

Participatory and learner-centred approaches. Participatory and learner-centred approaches to the education and training of health professionals have been shown to be effective for teaching a range of non-clinical skills that are required at community level. Various methods that differ from those used in conventional training have been used,
including supportive supervision (Wishik & Bertrand, 1990; Butcher et al., 2000), role-modelling of partnership skills (McIntosh, 2001), creative team-building (Butcher et al., 2000) and methods that use transformation theory and adult education (Haaland & Vlassoff, 2001).

**Gender-based interventions.** Gender-based interventions initiated by health services, often in association with women’s groups, provide opportunities to address a range of factors that determine vulnerability to HIV infection. Examples of such interventions include the development of skills for negotiating safe sex and the use of the female condom (Raphan et al., 2001; Pulerwitz et al., 2002).

**Key actors**

**Capacity, skills and knowledge of PLWA.** The capacity, skills and knowledge of PLWA can be raised to high levels. Peer education supported by NGO efforts has been found to lead to a good understanding of the disease and its care, including a significant level of knowledge among lay people. The building of capacity, skills and knowledge is not restricted to individuals in developed countries with high-level education, but has also been reported in less well educated individuals (ICASO, 2002).

**Committed nurses can play vital roles.** Committed nurses can play an important role in care of patients with HIV/AIDS in the community and in the home. Such a role involves empowering PLWA and their communities and challenging the attitudes to the stigma attached to HIV/AIDS among nurses and within communities. Individual nurses in southern Africa who have taken the initiative to work with communities on care and support for patients with HIV/AIDS have managed to set up community and home care programmes while under considerable stress from working on low salaries, lacking the most basic needs and being surrounded by professional peers who were sceptical about the efforts that they were making (UNAIDS and SANNAM, 2003).

**Civil society organizations.** Civil society organizations (CSOs) play a critical role in addressing the problems of HIV/AIDS and are key to the fostering and implementation of change. They have challenged the control of health professionals over health programmes and have taken on roles that were conventionally performed only by professionals. For example, grass-roots groups have organized community-based drug testing trials and have taken on roles that were normally reserved for trained academic researchers (Indyk & Rier, 1993). In addition to providing a variety of services themselves, CSOs have influenced the existing mainstream health services and the global and national policies (UNRISD, 2000).

**A final word: the interface — complex but feasible**

Some promising opportunities for HIV/AIDS prevention and care lie in the interface between health services and communities. However, the dynamics of the interface are complex and the nature of the interface is affected by various factors.

The constraints identified are strongly interrelated. Addressing the lack of partnership skills in health workers without addressing their attitudes towards communities will not lead to improvements. Changes in attitude are difficult to bring about without changes in the culture of the health institutions. Once changed, the attitudes and the related practices are difficult to sustain unless there is an enabling environment. If the gap in professional education is not addressed, academic institutions will continue to produce health workers who are ill-equipped for working at the interface with communities. If community capacity does not include individual as well as collective empowerment, structural barriers in HIV/AIDS will not be addressed and the success of the HIV/AIDS programmes will be limited. If the potential achievements of enhanced community capacity are not made evident and strengthened where necessary, the conventional attitudes towards communities are reinforced and the difficulties related to the attitudes of health workers will be difficult to overcome.

Despite the complexity of the interface there has been a wealth of experience and important lessons learnt over the past two decades demonstrating the feasibility and effectiveness of positive and effective interactions between health services and communities.

**References**


Goodman RM et al. 1998. Identifying and defining the dimensions of community capacity to provide a basis for measurement. Health Education & Behavior, 25:258–278.


Labonte R. 1994. Health promotion and empowerment:
Structural and operational underpinnings of partnership work


Structural and operational underpinnings of partnership work


he presentation of the cases-studies at the WHO Consultation on the Enhancement of the Health Services–Community Interface was an important way to share lessons of good practice. The case-studies represented a range of positive approaches to collaborative interactions between health services and communities. They also demonstrated a variety of ways of responding to the many challenges that arise. The important lessons to be learned from the case-studies are summarized below.

1. Any gaps between the communities and the service providers will require bridging. The experiences from the Local Response Initiative in Uganda suggested that partnerships between a variety of stakeholders result in wide coverage of, and targeted tailoring for, marginalized groups. The experience also highlighted the appropriate entry points into the villages and communities, as well as the importance of functional coordinating mechanisms and structures that link the districts to the local health committees to the hospitals and to the communities. However, for success to be achieved, the support of facilitators is needed to bridge the gap between communities and service providers.

2. Within the formal health care system, national frameworks and innovative models of care can be developed that facilitate partnerships aimed at increasing the involvement of PLWA in HIV/AIDS care. In the WHO Western Pacific Region, national frameworks and plans for HIV/AIDS care have been drafted, and several approaches aimed at constructive dialogues and discussions between the community and the health services are being promoted. However, there are certain prerequisites for success, namely, political commitment to comprehensive care and the provision of opportunities for the involvement of PLWA.

3. There are lessons for efforts in HIV/AIDS prevention and care to be learned from the TB programmes that are based on community contributions to treatment. Decentralized community approaches from sub-Saharan Africa and Asia are reported to be more cost-effective and to have a better rate of treatment success than the conventional TB programmes. However, there are certain prerequisites for success: good links between health professionals and the community members involved in TB treatment are essential for quality care.

4. Nursing institutions have the potential to facilitate partnerships between nursing institutions and other health service providers on the one hand and communities on the other hand. Experiences from Thailand suggest that family-based nursing care programmes for patients with HIV/AIDS are both feasible and effective when founded on a strong community base. It is possible to prepare communities to live with HIV/AIDS without stigmatizing families and individuals and to enable family caregivers to develop family-based skills for caring for patients with AIDS. However, there are certain prerequisites for success: projects must be based on respect for human dignity, use holistic approaches that address the spiritual, psychosocial, economic and physical needs of the PLWA, and be rooted in the communities through mobilization, empowerment and networking.

5. Collaboration between the mainstream government health services and marginalized groups is both achievable and necessary. Evidence from Bangladesh indicates that partnerships between government health workers and disadvantaged groups such as sex workers are both possible and functional. However, there are certain prerequisites for success: there must be a willingness to address the priorities of each group of stakeholders, unlimited by the boundaries of any single issue. Effective partnerships might need to go beyond HIV/AIDS or even beyond health to a broader focus on societal justice and development. The lessons from Bangladesh also show that non-professionals have the potential to run their own clinics and, after training, to be able to carry out various administrative and clinical tasks traditionally performed by professionals.

6. Community groups can implement their own HIV/AIDS care and treatment programmes in association with the health professionals. Experiences from Burkina Faso and the Philippines show that PLWA community groups are able to organize and implement comprehensive care and treatment programmes. However,
Partnerships for HIV/AIDS: case presentations

there are certain prerequisites for success: health workers who are open, encouraging and sympathetic to community-driven initiatives and committed to linking with and supporting the community movement are essential for effective treatment programmes. In communities where many people are affected by HIV/AIDS, community groups are an important source of support for the efforts of health workers who have heavy workloads and are constrained by limited resources.
Section 3
Conclusions and recommendations

OUTCOMES OF THE MEETING

The meeting was chaired by Mr Tesfamicael Ghebrehiwet, Nursing and Health Policy Consultant of the International Council of Nurses (ICN) and Mr Stuart Flavell, International Coordinator of the Global Network of People Living with HIV/AIDS (GNP+). Through the meeting’s plenary sessions and discussions, presentations and small-group work, the participants of the meeting were collectively able to formulate several outcomes. These outcomes were related to identifying strategies and mechanisms for the enhancement of the health services–community interface, identifying ways in which WHO could contribute to strengthening the collaboration between health services and communities, and providing suggestions of avenues that WHO could explore.

The meeting’s participants were in consensus regarding several issues:

❖ The potential of the concept of the interface offers a great opportunity to move forward with the prevention, care and treatment of HIV/AIDS.
❖ There were serious constraints on working in partnership with the communities. Most of these constraints were at the level of the health care system, and needed to be addressed.
❖ There were strategies (based on various successful experiences in the field) that could enhance the interaction between the health services and the community.
❖ There was a leading role for WHO in putting the strategies into action.
❖ The next important step is developing a plan of action.

STRATEGIES AND MECHANISMS

Strengthening the capacity of health care systems to interact with the communities

The participants at the Consultation identified several strategies for strengthening the capacity of the health systems to interact with the communities. They considered that further progress would require the triad of reducing the interpersonal barriers between the health workers and the community members, changing the attitudes of the health workers towards the communities, and building capacity to work in partnership with the communities and families. The participants presented several mechanisms that would contribute towards accomplishing these goals. The means of applying the proposed mechanisms would require the development of a true understanding of the community by health workers and application of the concept of “we” rather than “them and us”. Hence “people-centred” approaches will be needed to facilitate mutual and joint learning and to emphasize the necessity for listening to and learning from the local responses of communities and PLWA. The recruitment of PLWA with the necessary skills for all levels of service provision (planning, implementation and evaluation) is also necessary.

The participants also perceived a need for creating enabling environments in which the health services can interface with the communities. Such work would have to involve all the stakeholders and all the levels of the health system in the process of building an enabling environment and bringing about change (towards collective vision, shared values, respect, trust and dignity). The accomplishment of such goals would require a review of the existing human resource frameworks in health to explore how these relate to the interface and how they can provide a foundation for developing human resources for collaborative interaction.

Another direction would entail making effective use of the existing professional bodies and organizations to bring about changes in the practice of professionals in their interactions with communities. These mechanisms will also require improvements to the resources and integration of the local health services, while creating and employing incentive systems for increasing self-esteem, setting a higher value on work done and offering better remuneration to health workers.
Conclusions and recommendations

Strengthening the capacity of the community for interacting with the health services

The participants at the Consultation indicated that the application of a variety of approaches that collectively contribute to community empowerment would be necessary. The mechanisms for these approaches would need to focus on community strengths and assets rather than on weaknesses and deficiencies. They would also build on respect and trust between individuals, while mobilizing the communities and promoting community ownership of projects and programmes. A pertinent point raised was the creation of enabling environments for the community to interface with health services. Such mechanisms would need to alter the balance of power between the health workers and the community by recognizing the expertise and responses of the communities. There is also a necessity to support the work of effective activists, advocates, champions and “boundary-spanners” from the existing community structures. In addition to these mechanisms the creation and employment of incentive systems for increasing self-esteem, setting a higher value on work done, and providing opportunities to increase the financial remuneration for the community is needed. The working groups also called for strengthening of the HIV/AIDS-specific capacity and knowledge within communities where a good understanding of HIV/AIDS prevention, care and treatment issues is required.

Strengthening the processes and methodologies for change

The participants felt that it was essential to acknowledge and mainstream a range of participatory methodologies. The mechanisms for this goal could make use of, and give recognition to, the role and potential of participatory methodologies in the prevention, care and treatment of HIV/AIDS. They could also expose stakeholders at the central and global levels to experiences and lessons from community action initiatives with the aim of influencing policies. There is certainly a place for documenting and analysing the processes and methods that work effectively and produce good results. The working groups also noted that the promotion, exploration and use of participatory methods and tools is essential. Mechanisms to establish participatory methods were suggested such as providing opportunities for PLWA to take leading roles in the participatory processes, the use of bottom-up planning, and the inclusion of civil society members and PLWA. It was also suggested that policies that build on positive community experiences, and methods and channels to feed back knowledge and experiences to the communities should be developed.

WHO ROLES

In general, the role of WHO is seen as being in the area of supporting the institutionalization and replication of the small-scale successes that have been achieved in the health services–community interface. For this to happen, WHO should take a leading role in enhancing the collaborative interaction by reinforcing messages, facilitating the removal of barriers in the health care system and providing global visibility of the achievements possible at the local level.

The participants agreed that WHO should formulate, endorse and advocate a clear policy on the interface. WHO can bring about a process of change in the practice of local health service provision that will move towards collaborative interaction with communities. WHO should network and tap into the resources of a broad variety of organizations and sectors.

Normative role

The participants felt that the normative role of WHO should focus on the development of concepts and frameworks. This would include the development of a viable framework for the concept of the interface and advancement of the interface as a workable public health strategy. The normative role of WHO could also include the facilitation of the development of principles of good practice for the interface and guidelines for countries. Through such activities, WHO will be validating the participatory approaches and partnership building. A further point was the role of WHO in directing the change in policy to make it more conducive to interactions between communities and health services and in expanding the successful but small-scale experiences to a larger scale.

Advocacy role

The participants at the Consultation agreed on the role of WHO as regards advocacy. This would include promoting the concept of the interface and persuading governments to adopt approaches that have been shown to work and to allocate resources for enhancing the concept of the interface between the health services and the communities. WHO will have to advocate partnerships using the evidence on the benefits of partnerships in health, give recognition to the value of civil society and provide visibility of cases in which civil society has been successfully included in health planning and HIV/AIDS service provision.
Research role
The working groups considered the research role of WHO to be a multi-pronged one that embraces three aspects: the building of the evidence base, operational and action research, and monitoring and evaluation.

The evidence base. It was agreed that WHO will need to contribute to building the evidence for the necessity for the interface and local partnerships in health in order to develop evidence-based policies and to justify approaches.

Operational and action research. WHO could document and analyse methodologies that work for partnerships to enable identification of the critical factors that bring about change and lead to success. A further role identified was the demystification of research and the promotion of participatory research methods that will allow NGOs and communities to document the experiences themselves and will maximize the dissemination of lessons learned by the communities.

Monitoring and evaluation. WHO could promote and provide guidelines for the monitoring and evaluation of partnership processes and of the performance of local health services in partnerships with communities.

Capacity-building role
The participants suggested that WHO has a role in capacity building that embraces both the health services and the community. As regards the health services, WHO’s role was seen as facilitating the development of an enabling environment for building capacity and expertise in participatory methods and partnerships, and the development of appropriate guidelines and manuals. Participants considered that WHO will need to provide support to countries in building capacity, in resource allocation and formulation of incentives for forming partnerships with communities. The role would also include networking and making use of the existing professional organizations and training institutions in capacity building and supporting countries to develop strategies for the involvement of the next generation of health workers in partnership work.

In connection with community capacity, the working groups indicated that the role of WHO would be to recognize and build on existing community responses and actions, while networking with NGOs and CBOs that can help with community capacity building. It would also embrace the provision of support to community organizations in building the necessary capacity for the interface and for HIV/AIDS prevention, care and support and develop appropriate manuals.

Role in facilitating and supporting implementation
As regards role-modelling, the working groups felt that the WHO role would be to demonstrate its commitment to enhancing the interface. This would include a position statement or declaration about the interface and the value of partnerships, as well as the implementation of the necessary activities and the allocation of resources to this area of work. A further point was the bringing about of internal institutional changes within WHO that could contribute to the credibility of partnerships (e.g. WHO’s own relationship and partnership dialogue with NGOs, and the position on PLWA who are employed by WHO).

Suggestions to WHO for follow up
The participants made the following suggestions:

- That WHO Headquarters take a leading role in advocating the development and enhancement of the notions of the interface and partnerships. WHO will need to recommend ways of enhancing and promoting the collaborative interactions movement and of facilitating the global exchange of information on collaborative partnerships at the interface between the health services and the community. A centralized role will be required, as this work goes beyond the capacities of the regional offices.
- That WHO bring together an ad hoc group to carry forward the agenda and recommendations arising from this international meeting.
- That there be an exploration into whether donors with related agendas are willing to fund this WHO initiative.
- To pose the interface as a prominent feature of the International Treatment Access Coalition (ITAC).
- That WHO form links with other agencies with similar concerns and explore the possibilities for complementary roles.
Conclusions and recommendations

- That there be joint development with relevant partners of a framework for partnership between health services and communities. Such a framework will need to incorporate the principles of good practice learnt from experiences in various countries that have promising strategies for strengthening the capacity of health systems to interface with communities and, similarly, to strengthen the ability of communities to interact with health systems.

- Different parts/sections of WHO have different relationships with countries based on global, regional or country connections. Such relationships need to be utilized and could contribute to the playing of different and harmonizing roles in taking the agenda forward and making progress.
# Annex

## List of abbreviations

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>CBO(s)</td>
<td>Community based organization(s)</td>
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<td>CHW</td>
<td>Community health workers</td>
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<tr>
<td>CSO(s)</td>
<td>Civil society organization(s)</td>
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<tr>
<td>DRI</td>
<td>District Expanded Response Initiative</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GIPA</td>
<td>Greater involvement of people living with HIV/AIDS</td>
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<td>GTZ</td>
<td>Deutsche Gesellschaft für technische Zusammenarbeit (the German bilateral technical cooperation agency)</td>
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<tr>
<td>HBC</td>
<td>Home-based care</td>
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<td>HCD</td>
<td>Human capacity development</td>
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<td>ICASO</td>
<td>International Council of AIDS Service Organizations</td>
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<td>IEC</td>
<td>Information, education and communication</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<td>LC(s)</td>
<td>Local council(s)</td>
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<td>LR</td>
<td>Local response</td>
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<td>MTCT</td>
<td>Mother-to-child transmission</td>
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<td>NAP(s)</td>
<td>National AIDS programme(s)</td>
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<tr>
<td>NGO(s)</td>
<td>Non governmental organization(s)</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<td>PAR</td>
<td>Participatory action research</td>
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<td>PHC</td>
<td>Primary health care</td>
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<td>PLWA</td>
<td>People living with or affected by HIV/AIDS</td>
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<td>PRA</td>
<td>Participatory rapid appraisal</td>
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<tr>
<td>SEARO</td>
<td>South-East Asia Regional Office</td>
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<tr>
<td>STI(s)</td>
<td>Sexually transmitted infection(s)</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TDR</td>
<td>UNDP/World Bank/WHO Special Programme</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on AIDS</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
</tr>
<tr>
<td>WHA</td>
<td>World Health Assembly</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WPR</td>
<td>Western Pacific Region</td>
</tr>
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</table>
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For example: