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Igniting the Fires of Hope

A CASE STUDY OF THE SERVOL INTEGRATED EDUCATIONAL PROGRAMME IN TRINIDAD AND TOBAGO

By Sister Ruth Montrichard, Father Gerard Pantin

Introduction

Three months after the founder of SERVOL, Father Gerard Pantin, walked into the ghetto area called Laventille in 1970 he confessed to one of the residents called Chaca that he was getting nowhere and was thinking of giving up and returning to his teaching post at St. Mary's College. Chaca was vehement in his protest: "You cannot do that! It is true that you have done nothing more than get jobs for a few dozen kids; but what you have really done is to bring HOPE to the area. Every morning you walk up the hill, those watching you think: maybe tomorrow it will be my turn to get a job. And once people have hope they will continue the struggle."

These words made a lasting impression on SERVOL's founder to the extent that they have been officially incorporated into the SERVOL Mission Statement which reads as follows:

SERVOL is an organisation of weak, frail, ordinary, imperfect yet hope-filled and committed people, seeking to help weak, frail, ordinary, imperfect, hope-drained people become agents of attitudinal and social change in a journey which leads to total human development.

Today SERVOL still "walks up the hill" every day, but the original two hill climbers have been replaced by thousands of adolescents who bear the emblem of SERVOL on their shirts, hundreds of early childhood educators who journey to their pre-schools, scores of parent outreach workers who visit parents: this little army of trainees, instructors and even pre-school children proclaim silently to people all over Trinidad and Tobago "we are SERVOL and we bring with us a message of hope."

In the ghetto, Fr. Pantin was immediately confronted by the social problems of the area: unemployment, poverty, low self esteem; but he quickly realised that a main cause of these problems was a total breakdown of family relationships in the area, coupled with poor parenting skills. The only problem was that he did not have a clue how to deal with the situation so he decided to begin by listening to the people and helping them to start their own tiny projects.

Setting up of early childhood programmes

He discovered that communities had set up child-minding centres in community centres in which working parents placed their children. The people were asked: "would you like us to help you transform these centres into high quality Early Childhood Centres by training the members and supplying educational materials?" They said "Yes". The result is that today
SERVOL administers 154 Early Childhood Centres, which are managed by a community board of education and staffed by teachers who have received two years of intensive training culminating in their being awarded a certificate validated by the prestigious Oxford University.

AMANDA (parent): At first I thought that all this SERVOL talk about small children learning through play was a lot of nonsense. But when I saw how my child fitted so well into primary school I realised that they were right not to insist on bookwork.

By now the SERVOL staff had grown from one man to a group of 28 people, 16 of whom were middle class women who had volunteered to help with the clerical work while the others were 12 soldiers and sailors who had been "loaned" to SERVOL by the Government which continued to pay their salaries and who SERVOL trained to be a special type of social worker whose job it was to LISTEN to the various community groups and who were destined to work with SERVOL for eight years.

Apart from this, only token help was given by the public sector for the first seventeen years of the initiative; financial help was obtained from the private sector and from overseas foundations in the U.S.A., Germany, Switzerland and Canada and in a very special way Bernard Van Leer Foundation of Holland. Without this financial help and the opportunity that these foundations gave of visiting other projects and sharing ideas and experiences with others, one wonders if our fledgling organisation would ever have grown to what it is today.

**Helping adolescents**

Listening to the wisdom of the grassroots communities, SERVOL shifted its focus from dialoguing with 25-35 year olds to offering skills earlier in life, namely training programmes for 16-19 year olds.

The majority of them had not benefited from the education system and all demonstrated an interest in acquiring a vocational skill. Since neither the public nor the public sector were offering help to this particular group, SERVOL responded by setting up training programmes in carpentry, tailoring, practical nursing, plumbing, electrical installation, food preparation and other allied skills which prepared the trainees to enter the job market.

Evaluation of the outcome of these programmes revealed that only fifty per cent of the trainees sought or found jobs and SERVOL, always attentive to the outcome of its programmes, realised that the self-esteem of many of its trainees was so low that it effectively prevented them from becoming employable, even though they had the necessary skills.

The result was that SERVOL built into its adolescent programme, a human development course which was intended to boost self-esteem and to make the trainees aware of the causes of their problems. The result of all this is that today, everyone who enrolls in the SERVOL adolescent training programme begins with a 14 week human development programme which involves courses in self-awareness, spirituality, the role that the subconscious plays in our lives, an understanding of FEELINGS, particularly that of repressed anger, how complexes and prejudices are born and how to boost self-esteem.
AMELIA (a former trainee): "If the ADP were not there, I don't know how I would be looking at life today. The ADP made me aware of who I am. Every youth in the educational system should be exposed to the ADP."

How much of this stays with them? We do not know for sure, but subsequent evaluations have indicated that the basics are remembered.

Training adolescents in parenting skills

Despite all of this, SERVOL continued to be haunted by the breakdown of family relationships and poor parenting skills.

SERVOL had always had a passion for integration, for pulling things together rather than keeping them apart. That is why we call all our Adolescent centres, LIFE CENTRES, because they are all about life and life is an integrated process. That explains why SERVOL built its largest Life Centre in 1978 and under the same roof included the following: training in welding, practical nursing, plumbing, sewing, auto-mechanics, food preparation, electrical installation, tailoring, woodwork, a day care centre for children from three months to two years and an Early childhood Programme for three to five year old children.

We noticed with increasing interest, the tendency of the male trainees to drift over to these children's units and to gaze curiously at the antics of the babies and toddlers.

We capitalised on this phenomenon by introducing into our adolescent programme a parenting programme taught by trained instructors, in effect an ADOLESCENT PARENTING PROGRAMME. This was especially relevant as most first pregnancies occur between the ages of 17 and 20. Perhaps the vicious cycle of child abuse and neglect could be halted by focusing on adolescents. In this program adolescents study child development. They learn the importance of how poor nutrition, emotional traumas and alcohol and drug abuse by a woman during pregnancy can cause serious physical and psychological damage to the child.

Regarding the practical aspects of parenting, each trainee, boys as well as girls, spend time in the day nursery learning how to interact with and care for babies and toddlers, as well as three to five year olds. And, surprise, they love it; especially the male trainees. Accordingly, attention is given to the male image in the home and the father's role in bringing up children.

As a result of introducing this human development programme into the adolescent training programme, the drop-out rate has fallen from 47% to 4%.

CHARLIE (former trainee): "The ADP made me aware of particular areas in my life. It made me realise that a person has the power to instil knowledge in another person's life. I consider parenting to be an honour and a privilege."

The evolution of POP: Parent Outreach Programme
Based on the educational and psychological research stressing the importance of early child development, SERVOL realized that we cannot wait for children to come to school to begin our assault on the cycle of poverty and deprivation; this must begin with the pregnant mother.

We have found that a significant number of these mothers are single parents who are under enormous financial and psychological stress which often leads to neglect or battering of children. For SERVOL, to think is to act. The result was that we selected our most gifted teachers, gave them additional training in how to dialogue with adults and initiated our POP programme.

To reach out to these under-served people, twenty five (25) trained POP facilitators go into the remote villages and ghettos of Trinidad and Tobago each day, going from house to house, making friends with the parents and helping them to deal with the problems they are having with their small children and life in general. In these encounters the parents are praised for what they have accomplished and advice given on the importance of proper nutrition, vaccinations, sanitation, and suggestions for alternatives to physical punishment.

Subsequent to these one-to-one encounters, parents and the POP facilitators meet in small groups in which they share common problems and possible solutions, and learn how to produce marketable items which enables them to earn an income while staying at home with their children.

*MARVA (parent): "My life has completely changed since my POP facilitator began to visit me. I have now doubled my income by the handicraft and clothes I produce and best of all I can look after my children while working."

To say that POP has been enthusiastically received by thousands of parents is an understatement. What is particularly heart warming is to witness the growth in self confidence of so many parents and how many of them have become successful entrepreneurs in handicraft and other products while remaining at home to care for their children.

*YVONNE (single parent): "I was beaten as a child and so naturally I beat my children. It was only when my POP facilitator taught me the harm this could do and showed me other ways of discipline that I stopped beating."

Expansion, funding and sustainability

For the period 1970-1986, SERVOL was a relatively small organisation administering a total of eleven (11) Early Childhood Centres (ECCE), two Adolescent Life Centres and a school for mentally challenged children.

In 1987, a newly elected Government appointed SERVOL as its agent for ECCE and Adolescent Programmes and asked the organisation to expand its programmes all over Trinidad and Tobago. In response to this challenge, SERVOL initiated a drive to establish an endowment fund fuelled by generous contributions from the local community and the Bernard Van Lear Foundation which has now reached a total of U.S. $3.8 million. Currently, the Trinidad Government gives an annual subvention to pay the salaries of all teachers and
administrative staff of the ECCE and Adolescent programmes, with SERVOL continuing to bear the cost of infrastructure development through the interest obtained from the endowment fund. SERVOL presently serves over 4,000 adolescents and 5000 young children in these two programmes and has expanded its programmes to practically every island in the Eastern Caribbean as well as South Africa and Ireland.

It should be emphasised that all of SERVOL's programmes are COMMUNITY BASED AND PARENT ORIENTED. Every one of the SERVOL based centres is managed by a Community Board of Education which is the official employer of teachers and instructors. These Boards of Education are responsible for paying teachers' salaries as well as National Insurance and Health Surcharge contributions from the funds that are transferred to their account by SERVOL each month. In addition, they monitor attendance, punctuality and performance of teachers and in a number of instances have dismissed delinquent teachers after consultation with SERVOL.

The importance of the community-based nature of the programme was vividly demonstrated in 1992 when another Government was elected and one of their first acts in cost cutting was to slash the SERVOL subvention by forty percent (40%). Since the subvention covered the salaries of teachers, this would have resulted in the closure of many of our centres. The government backed down as a result of community mobilization, which included demonstrating in front of parliament. It is clear that once SERVOL continues to elicit this type of support from Government that the programme will be sustainable.

Sustainability was further ensured in 1997 when the government of Trinidad and Tobago through the Ministry of Education appointed SERVOL as its agent for non-formal education and took over the payment of salaries of teachers and instructors who were formerly paid by grants from overseas foundations.

The SERVOL programmes are now recognised as a life-line to children at risk by the public sector and to quote the words of a Prime Minister: "It would be impossible to think of educational programmes in Trinidad and Tobago without SERVOL."

In 1995, SERVOL felt that it was fully involved in the national educational thrust by training over 4,000 adolescents every year and providing early care and education for more than 6,000 children and their parents on an annual basis.

However, the communities were not finished with us and they challenged us to build one final bridge between the ghetto and the world of high technology. They told us, in effect, that while they were more than grateful for the efforts of SERVOL through which more than 50,000 adolescents had been trained, the majority of whom had secured employment, there was a whole world of high technology sweeping over Trinidad and Tobago to which our graduates had no access. Were the adolescents who come from poverty areas condemned forever to be "hewers of wood and drawers of water" or could we raise our hope for them a notch higher and open up this world to them?

The Inter-American Development Bank, after careful examination, agreed to fund the project; the result is that today we have three (3) Hi-Tech Centres in North, Central and South Trinidad in which our craftsmen follow post graduate courses in Computer Technology, Digital Electronics and Computer Control Electronics and which turn out 400 graduates a year, many of whom are snapped up by local industry.
There is a tracking system in place to chart the outcome of all HI-TECH graduates; the statistics for the 1998/99 class reads as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placed in jobs</td>
<td>53.0%</td>
</tr>
<tr>
<td>Opting for further education</td>
<td>20.7%</td>
</tr>
<tr>
<td>Not placed (inappropriate, dropouts, migration, etc.)</td>
<td>11.2%</td>
</tr>
<tr>
<td>Could not be contacted</td>
<td>15.1%</td>
</tr>
</tbody>
</table>

**Reasons for the success of SERVOL**

It is quite difficult to dissect a living organism and to come up with a clear picture of what makes this specific life form survive in the struggle for existence which surrounds every NGO. However, it may be useful to pinpoint some of the more obvious characteristics which have helped in the struggle.

First and foremost is the IDEALISM that permeates the organisation. It has been said many times that SERVOL is one of the few places in this world where one can witness miracles on a daily basis, the miracle of the transformation of human lives. When you are in contact with small children, adolescents, the mentally challenged, parents, communities and you see them CHANGE and you realise that you are one of the instruments in this change, then you go home each evening exhausted but electrified. The reason is that in helping others to change, you yourself are transformed and there is nothing more satisfying in this world. The SERVOL staff often refer to SERVOL as a virus: once you are infected there is no cure, you are there for life.

Second, SERVOL is a very decentralised organisation in which each player has enough room to do their own thing within limits and everything is done to cut down a creeping bureaucracy as the organisation expands.

Third, there is the constant training and retraining of staff. It is doubtful that there is another NGO that invests so much time and money in the on-going training of staff and this means we can promote our own staff without having recourse to "outsiders". Staff have risen from the rank of instructors, to co-ordinators and even to the highest echelons of administration and some twenty five percent (25%) of SERVOL staff were once trainees in the adolescent or early childhood programmes.

Fourth, SERVOL exercises tight fiscal control of all its finances and vouchers and receipts are demanded for even minor financial transactions.

Yet, in final analysis, it must be admitted that in all the above we have not touched the soul of SERVOL and it could well be that it consists of rekindling the virtue of hope in a world that is beginning to despair.

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ACKNOWLEDGEMENT

In 1998, helped by a grant from the Bernard Van Leer Foundation, SERVOL engaged a company called Supreme Consulting Services to conduct an in-depth assessment of the ADP by interviewing a cross section of trainees who had graduated ten (10) years previously and comparing them with an equal number of individuals from a comparable group who had not attended SERVOL.

Most of the quotes used in this paper are drawn from this evaluation study which is now in its final stages.
1. Introduction

The historic peace accord signed by Israel and the Palestinian Liberation Organisation in 1993 was seen as the foundation for sustainable development in the Middle East. The Gaza Strip and West Bank desperately needed to build the infrastructure and institutions of a modern economy, to provide employment and raise living standards.

Gaza was left in a mess. CNN showed footage of children playing in piles of garbage, empty garbage containers used as barricades, and smoke from burning waste heaps on road shoulders. Newsweek wrote as headline in the May 16th 1994 edition on the Israeli troop withdrawal: “The garbage of Gaza: All yours, Yasser”. An appalling sight – the people of Gaza were very unhappy that their City was depicted all over the world as little more than a garbage dump.

On July 1st 1994, when Chairman Arafat stepped into the Gaza Strip for the first time in 27 years, Gaza faced the immense task of building up its services and infrastructure. The Gaza City Municipality sought donor support and obtained US$ 9 million from the European Union for a solid waste management project.

The overall development objective of the Gaza City Solid Waste Management Project was to improve the health, environment and living conditions of Gaza City’s population. But the aim was not just to achieve regular and affordable waste collection and disposal – the project sought to involve citizens and municipal staff in a wider dialogue on “how to improve living conditions in our city – how to make our city a healthy one”, and to engage the entire Palestinian community in the battle to improve their environmental health conditions, and thus their quality of life.

2. The context

In 1994, the environmental health problems plaguing Gaza City were huge. Years of military conflict and civil unrest had severely degraded the natural and human environment. People threw waste in the streets and set fire to containers as acts of civil disobedience. The high population density of the city (aided by the large influx of refugees) exacerbated the problems.

Non-co-operation with the Israeli Civil Administration resulted in very limited and basic provision of waste management services by the municipalities. The institutional structure of Gaza City was very weak: no revenue recovery, poor planning and organisation, shortage of vehicles and equipment, etc.
There was also a widespread lack of concern for the environment and insufficient knowledge on the hazards of poor solid waste management practices. The public appeared resigned to living in these conditions.

3. **Health and Garbage**

It is assumed that inadequate solid waste management accounted for a huge disease and injury burden although “unfortunately, no comprehensive data is available on morbidity”, as stated in the first National Health Plan for the Palestinian People, published in April 1994.

**Transmission of disease**

An important health risk associated with living near piles of solid waste is transmission of faecal-oral diseases from direct contact with uncollected waste. Solid waste provides a perfect breeding ground and continuous habitat for rodents and mosquitoes – vectors for dengue fever, leptospirosis, even plague. Flies breeding on uncovered piles of rotting refuse play a role in transmitting diarrhoeal disease and typhoid. Waste is also scattered by sheep and dogs.

Uncollected waste blocks drains, leading to stagnant water and sewer overflow. This offers an additional route for transmission of faecally contaminated matter, and uncontrolled disposal of waste resulted in the danger of contaminating surface water and groundwater supplies.

Healthcare and pathological waste left near hospitals and clinics causes injuries to local children from needles, tins and broken glass and exposes them to disease.

Burning waste near dwellings produces noxious fumes and contributes to air pollution – a hazard associated with respiratory illnesses.

Improper garbage management also affects transmission of disease in homes: uncovered waste bins give houseflies a chance to spread faecal matter to food; nappies and other garbage – when disposed of in toilets – block sewers, which in turn can flood streets.

**Wellbeing**

Exposure to an unhealthy physical environment was not the only issue. The constant smell of refuse and the continuous sight of heaps of putrid garbage was very offensive and seriously impaired Gaza citizens’ quality of life.

4. **The Project**
The Gaza Municipality sought donor support and obtained US$ 9million from the European Union to implement an integrated solid waste management project in Gaza City. A Dutch Consultants Consortium was asked to provide the technical support needed by the Municipality to improve its solid waste management services.

The project approach involved purchase of “hardware”: refuse collection vehicles, waste containers, landfill equipment, a garage; and implementation of “software”: environmental health promotion, training, cost-recovery systems, restructuring of municipal departments, and liaison with (environmental) health organisations and projects.

**Improved waste collection and controlled landfill management**

A total of 17 bright orange refuse collection vehicles now cruise the streets daily. 1400 communal containers and 250 litter bins are strategically placed all over the City. The solid waste management workforce increased from 260 to 420 in the period 1994-1999. A controlled landfill is the core of solid waste management: clandestine dumpsites in the City were closed and a central dump site outside the City was upgraded to receive all of Gaza City’s waste. Heavy landfill equipment takes care of waste coverage at the end of the day – there are no more fires and birds, flies and rats have disappeared.

**Restructuring of municipal departments**

The Municipality’s Environmental Health Department, the Workshop/Garage, and the Finance/Accounting Department were restructured. After a functional analysis and needs assessment had been conducted, job descriptions were formulated for all staff in the Environmental Health Department and Garage. A waste collection and disposal monitoring Unit and an Environmental Health Promotion Unit were created within the Environmental Health Department.

In order to determine the real solid waste management (SWM) costs, an accrual accounting/administrative system for SWM services was established, including accounts such as assets, depreciation, debtors, and liabilities. The improved financial information system enabled the Municipality to make cost-price calculations for the SWM service and thus to determine the required service charge.

**Cost recovery**

The project put in place an adequate, cost-effective and reliable daily waste collection and disposal system. Subsequently, and after the introduction of the more transparent cost-accounting system, the project introduced a cost recovery scheme adding a flat surcharge to the electricity bill. Cost-recovery for Operations & Maintenance was 100% by May 1998. However the electricity supply was then privatised and the new utility company stopped billing of SWM fees. The deficit in revenues from SWM fees is currently financed by other
municipal budget lines. By 2002, all SWM costs, including replacement of equipment, will have to be covered by SWM revenue collection.

**Training**

Over 40 training courses in environmental management, finance and administration, health promotion, parliamentary elections, composting, English language, and many other subjects were attended by over 150 staff from the municipal Environmental Health Department, Workshop, and Finance/Accounting Department.

Groups of 10 residents (women and men separately) were trained to engage in a dialogue with municipal cleansing staff and their supervisors on “the mutual rights and responsibilities of citizens and municipal staff in keeping the neighbourhood clean”. Municipal Cleansing staff were trained in “effective co-operation with Gaza citizens” so that community representatives could become actual partners in the development of their localities, rather than beneficiaries only.

**Environmental Health Promotion**

Health Promotion was imperative to guarantee successful re-building of municipal waste management services and to improve Gaza citizens’ capacity to improve and protect their health.

Upon installation of the Municipal Council in August 1994, increased efforts were made by project, political and technical municipal staff to address the wishes and needs of citizens and municipal cleansing staff – this was achieved through the design of a comprehensive Solid Waste Management and Environmental Health Promotion programme, which used a participatory planning process.

As a result, the Environmental Health Promotion & Community Participation (EHP/CP) Section was set up by the Municipality and 13 Gazan women were trained as health promoters. Their main tasks were to raise public awareness on environmental health issues, to encourage citizens to comply with waste collection procedures, and to empower both municipal staff and citizens to act jointly. The aim was not only to establish adequate and sustainable solid waste management practices, but also to engage citizens and the Municipality in a dialogue on how to re-build other municipal services such as electricity, sewerage and drainage, and street paving.

The young women talked with municipal Cleansing Staff and Gaza citizens about their own specific needs and waste management problems, and discussed practical solutions. They paid home-visits, attended neighbourhood meetings and visited health clinics, restaurants, shops and mosques. Young people were reached through schools, youth clubs and summer camps. The subject was also widely discussed on television.
People were encouraged to think and talk about – and act on – garbage disposal, water, health, recycling, cleanliness, the environment. The nuisance that they saw as beyond their control soon became a problem with accessible solutions, and a duty to themselves and their City. “Why should we have to walk down streets lined with garbage and breathe foul air?” people asked. They started to co-operate with the Municipality by using the containers, sweeping in front of their doors, and participating actively in neighbourhood committees to discuss the neighbourhood’s development needs – beyond garbage.

**Liaison with organisations and projects relevant to municipal solid waste management**

Functional relations are considered of special importance in the Gaza Strip, as no central SWM legislation exists in Palestine. The solid waste management projects in the Gaza Strip still serve as pilot schemes – they have and will provide essential information for the formulation of national legislation. Intensive exchange of information between the projects and environmental research institutes was conducted, and will continue in the future.

In 1994, all organisations working in the field of (environmental) health in the Gaza Strip were listed as potential partners for the Health Promotion programme. The approach of the programme created excellent alliances with other health & environment related organisations: among them UNDP, Palestinian Water Authority, World Food Programme, Ministry of Health, and the USAID-funded Gaza Waste Water Project.

Within the Municipality itself, the programme collaborated with tree planting and rodent control campaigns, waste water and drainage awareness and a payment-of-electricity-bills campaign. Many of these activities were implemented using the community level experience and contacts built up by the Environmental Health Promotion Programme.

5. **Impact and sustainability**

Three years later, the visible impact was tremendous. The problem of accumulated garbage in streets and around containers was virtually over, thanks to the efforts of the *Gaza City Solid Waste Management Project*.

Ongoing monitoring and evaluation of performance were an intrinsic part of the project – performance indicators were selected for solid waste collection and for disposal. For the Health Promotion programme, process evaluation was conducted. The data obtained was used mainly for programme management, to adjust planning and implementation.

**Key Environmental Impacts**

Analysis of environmental monitoring data, such as groundwater and surface water contamination in the vicinity of the landfill, showed that the upgraded central disposal site
does not cause contamination. Waste quantities transported to the dumpsite increased from 380 m$^3$ to 1000 m$^3$ per day.

**Health Impacts**

Since no morbidity data were available for Gaza at the start of the project, no baseline yardstick was available by which to measure health impact of solid waste management interventions. Even if such a yardstick had been available and a health impact study undertaken, it would have been very difficult to unambiguously attribute a reduction in, for example, diarrhoeal diseases to improved solid waste management, since many interventions in the water and sewerage sector were taking place simultaneously with the solid waste management project.

**Social and economic impacts**

Social and economic impacts were assessed using routinely collected data on audit of attendance at health promotion meetings (whether the different programmes reached the target population, and types of responses); surveys of citizens’ perceptions of the project; affordability studies; focus groups with cleansing staff; interviews with municipal political staff on policy changes; a pilot survey of hygiene behaviour as a measure of health promotion programme effectiveness; and observations of co-operation and co-ordination between municipal staff and with other environmental (health) related organisations.

The impacts included:

- Citizens’ complaints about untimely waste collection, accumulated litter in the streets, and non-compliant behaviour of neighbours, were dealt with within 24 hours. The number of those complaints per 100,000 declined from 33 to 1.6 per month over the 1994 to 1997 period.
- A 1997 socio-economic study indicated that approximately 90% of households had a very positive attitude to the SWM efforts with only 5% saying there had been no improvement.
- By 1998, Gaza City households and establishments paid 100% of operational, maintenance and indirect costs; recovery of replacement costs will be introduced over a 3 year period.
- Strengthened capacity of the municipal departments to deal with the required level of sophistication in terms of equipment, information flow, community participation, cost-recovery, organisational behaviour, monitoring, professional skills and discipline.
- Neighbourhood committees and individual citizens are consulted by municipal political and technical staff on issues beyond SWM.
- Excellent working relations are established between the Municipality and Governmental Organisations, NGOs, academic institutions, and international donors in the health and environment field.
- 420 people are permanently employed by the Municipality to sustain all SWM activities.
- In June 1998, the project's Unit for Environmental Health Promotion was incorporated into the municipal organisation. All 13 environmental health promoters received a
contract offer from the Municipality for an unlimited period, while at the same time an advertisement for five more women health promoters appeared in the newspaper.

It has not yet been established to what extent these impacts can be attributed to the “integrated solid waste management initiative” as a whole or to specific health promotion interventions.

**Health Promotion impacts**

A systematic evaluation of health promotion outcomes has not been part of the project, mainly because of the complexity of figuring out the “right” evaluation methodology – i.e. both scientifically sound and appropriate to the Palestinian circumstances. The Municipality and donor were keen to work on getting and keeping the City clean rather than conduct sophisticated health promotion research.

Without scientific measurements, however, it is possible to say that the citizens are happy that if they have problems with garbage in their neighbourhood, their concerns are dealt with immediately, and that they can actively participate in meetings with municipal, political and technical staff to discuss city priorities. The Municipality is also very satisfied that it successfully brought together municipal cleansing staff and citizens and facilitated a positive dialogue to solve solid waste management problems.

**Conclusions**

Through the Solid Waste Management Project, the Gaza Municipality and its citizens benefited from improved environment and health conditions. They also highly valued the partnership and participation processes that were initiated – these partnerships are now a permanent feature of the ways in which the Municipality and citizens continue to build their infrastructure, services provision, and their City.

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Enterprise for Health
A case study from Lower Saxony, Germany

Introduction

“When I first heard that the Sickness Fund was going to introduce a health promotion programme at our plant, I thought it would mean another person telling us to drink less,” says Mrs L, employee of an ‘enterprise for health’. “But, then they asked what really bothered us, and I told them I was anxious about losing my job, and that this anxiety gives me stress and often keeps me up at night.”

Health is not determined solely by our individual genetic composition, or our lifestyle and personal choices. Economic and social factors, education and social support are also strong influences on health, as are the conditions in which we work. Today’s businesses increasingly operate under conditions of global competition, flexibility, automation, mergers and downsizing. These conditions have important implications for health and work in today’s society.

Recognising the link between work environments, health and productivity, the WHO Regional Office for Europe launched a pilot project to promote worker health. It knew it had to do more than target individual behaviours like drinking, smoking and eating habits; it needed to influence the deeper causes of ill-health. WHO partnered with the regional association of Local Sickness Funds (Allgemeine Ortskrankenkasße) of Lower Saxony (AOK), Germany, to create an incentive for private enterprises to invest in health. AOK granted “bonuses” in the amount of one month’s payment to the government’s social security health insurance (for both employee and employer payments), for those companies willing to commit to comprehensive workplace health promotion.

“It is about time we identify healthy policy options. I can learn from this project, because, within our decision-making mechanisms, we do not always consider health. To follow a pragmatic approach to see that business becomes business for health is exciting.”

- Ms Merck, Minister of Social Affairs, Labour and Women, Lower Saxony

Working closely with the Ministry of Labour, Social Affairs and Women, the AOK/WHO “Bonus Project” aims to create change within and beyond the pool of enterprises with which it works directly. The project tries to connect the different policy levels and sectors that influence workplace health, and ultimately to demonstrate how health promotion can address not only behaviours but conditions that place peoples’ health at risk.

A tailored approach

AOK initiated the project by recruiting 37 leading companies with strong records of organisational development, organisational culture, project management, know-how and quality management. They only selected organisations with some certainty that further
improvements to workers’ health could be made. To be selected, companies had to demonstrate a commitment to position health as a main goal within their business strategies, expertise in promoting health in their company and a willingness to learn.

Over the past five years, the Bonus Project has established a sound infrastructure to support each company. With a budget of US$28 million (50 million Deutsch-Marks), the project provides:

- An AOK project manager to support and advise each participating enterprise as they work to improve health
- Ongoing support and an external perspective during the self-assessment and evaluation process
- Assistance in creating an action plan to tackle areas of weakness and to identify specific health improvement programmes.

AOK/WHO helps each company set its own priorities, according to where health gains can best be achieved. Thus, the specific programmes in each company vary considerably. In general, the Bonus Project aims to go well beyond those health and safety measures mandated under law. Indeed, the emphasis is to shift the focus away from “sickness” and toward “health.”

Below are examples of what two companies have done to improve employee health, as a result of their collaboration with AOK.

**Company A** began as a small family-run food production business, but is now part of a large holding company. It has extended its definition of health to include physical and mental wellbeing. Management has analysed health hazards at work, arranged feedback of the findings to employees, and established “health circles” to define and tackle work-related health problems.

Company A also conducts regular employee opinion surveys, and the management aims to implement at least two thirds of the employee recommendations. Thus far, the company has allowed workers to select their own shifts, organized work to accommodate family arrangements and social interaction between employees, ensured work rotation, and made regular appraisals and training plans. Workers have access to company-supported recreational facilities outside the workplace.

During the course of the project, company A has seen sickness rates fall, a decline in overall health complaints of 0.2 percent, and a 3.2 percent drop in absenteeism. Staff morale has improved.

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**Company B** is a large, award-winning manufacturer of complex engineering products. It is already recognised for its high quality working environment, but the WHO/AOK project allowed the company to go further in tackling broader management issues with clear links to health. For instance, manufacturing processes were completely redesigned, so that self-managing teams now take responsibility for different stages of the production process. Flexible work systems have been introduced so that individuals and teams can decide the hours they wish
to work. Special efforts are being made to increase the number of female and disabled employees; traditionally Company B has employed few women.

The new working systems have decreased the feelings of isolation reported by workers, while improving worker communication and job satisfaction. Today, half of all apprenticeships are offered to women. The number of accidents per year dropped by more than four percent between 1992 to 1998; days missed from work due to sickness or accidents fell by nearly 80 percent during the same time period.

Though actions such as these could have been implemented without the involvement of AOK and WHO, the personnel officer of Kraft notes, “I don’t believe that we would have applied the various elements in a consistent way. The good thing about this project is that it views the different levels of intervention together.” Mr F, Chief Executive of an ice cream factory agrees, adding, “It is not as if we didn’t have organisational development methods at our plant before. But we now apply these consistently and with a specific health perspective.”

It was found during the initial stages of the project that, while many companies could identify health problems, actually solving them was not as simple. WHO is creating a data bank to provide suggestions and example cases to help companies devise their strategies.

Company Solidarity

An important characteristic of the project is inter-organisational learning. Companies share many of the same issues when attempting to improve worker health. For this reason, a “Companies’ Working Group” was established and meets on a regular basis to discuss what they have learned and to identify problems that can be addressed in more than one enterprise. The working group aims to increase individual and institutional capacity as well as company commitment, as the partnerships that are built over time are able to support individual companies during difficult times of change.

“Looking at productivity rates and quality management, I am convinced that a healthy workplace is good for business. But, this means more than complying with government safety standards or providing employees with health insurance coverage. Often, the investment plans of policy-makers do not encourage us to invest in health.”

Mr A, Chief Executive of a medium sized business

Another innovative aspect is to link the operational aspect of the project with policy development. An “Umbrella Group” was established comprising all relevant political stakeholders who may be instrumental in reducing identified “barriers” to the project’s implementation. The Umbrella Group’s mandate is to influence the political context to support the positive change in company practices. The group also brings together other potential stakeholders, such as the business partners, sickness fund managers and researchers. The benefit of this partnership is that different perspectives are applied to workers’ health. This process clearly improves understanding and communication between the different players.

Auditing Health
AOK helps each participating company assess their progress in a consistent and comprehensive way. The Department of Work Sciences at the University of Kaiserslautern coordinates, monitors and analyzes this aspect of the project. Using an adapted version of the European Quality Model, each company annually assesses their health-promoting capacity, and progress toward the goals they prioritized.

The assessment investigates each of the elements in Figure 1. A baseline assessment of “prerequisite” components covers: level of commitment shown by management and whether managers serve as role models; amount of resources attributed to the project; degree to which health is taken into account in the development of overall plans and strategies; and degree to which staff development programmes are in place (for example, do employees actively participate in the process to put health high on the company’s agenda?). It also measures the company’s emphasis on health promotion in the broader community within which the company is located.

Criteria used to assess the “results” include: the effectiveness of company health promotion in relation to customers and suppliers; employee satisfaction; objective indicators for corporate health status; and the impact of company health promotion on the national economy. The self-assessment exercise is conducted every year, and provides the basis for companies to re-apply to the project and receive the annual financial incentives.

An external process evaluation of the project was carried out by a WHO expert appraisal team, which, in addition to company assessments, looked at changes in the political (regional and national) environment and the potential to reduce larger structural barriers to implementation. The appraisal included a wide variety of techniques, such as interviews, surveys, analyses, site visits and analytical review. The Investment for Health appraisal system can be described as an interactive decision-making process. The auditors obtain information, examine it for its completeness and appropriateness and determine if it is sufficient to assess performance according to the criteria. As a result of the appraisal, action plans were developed with all stakeholders to help the project meet its goals.
Health Benefits Package

The beneficiaries of the WHO/AOK project are numerous. WHO’s expert appraisal showed that workplace innovation had a ripple effect on various government agencies that provide health services – whether for actual illnesses or social functions such as family care – and whose functions overlap. For example, in Lower Saxony, health care and sickness issues were dispersed among the ministries responsible for health, women and labour. They felt few incentives to work together, until the AOK/WHO project provided an example and helped to streamline bureaucratic and redundant systems.

In addition, insurance agencies can benefit from the AOK/WHO project by reviewing the criteria on which treatment is based. People’s involvement in their own health influences their demands on insurance coverage. Indeed, the real savings in health care expenditures will come from improving health, rather than minimizing the cost of transactions for treating illness.

The investment has especially paid off for AOK. The Bonus Project has been welcomed by employers and employees alike. AOK has shown a leadership role in health, demonstrating how the focus of a sickness fund can move from financing health care to promoting health.

The benefits for companies have come in the form of increased productivity, fewer absences and decreased expenditures on health care. Notes one Chief Executive: “I trust that people will work hard to show the positive effects of this project, and show hard evidence that they will put into figures, tables and graphs... However, I would be impressed even without such graphs, and just looking at my productivity rates. Certainly, there are other factors that contributed to the success we had in the last years, but, the project heavily contributed to it. People are more concerned about quality, and we have learned to be more sensitive to the needs of our staff. We took away people’s feeling of insecurity, because we have learned not to ‘hire and fire’. Health promotion has helped us build a level of human capital that gives us an edge over other enterprises in our field of production. And that is what counts, after all.”

In sum, the project’s top outcomes include:

- Clear evidence of improvements in workers’ health and well-being. There have been gains in easily measured and quantifiable indicators, such as reductions in sick-days, as well as qualitative developments such as improved manager-staff relationships and increased morale and motivation.
- Health promotion at work is also a means to increase social capital, as companies are asked to have policies and practices which decrease social exclusion and promote equity.
- Enhanced economic security, as the promotion of health, well-being and work satisfaction can be moved to the heart of the company’s core values.

Despite the project’s success, lingering questions remain: How can the immediate findings turn into long-term benefits? How can workplace health measures become standard business practice? Can lower health-related costs in the workplace be translated into tax reductions or lower insurance premiums? Will workplace health incentives be as appealing without a financial bonus?
By pioneering this new approach to workplace health promotion, WHO and AOK have opened a new debate. There are many lessons yet to be learned.

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My Health: My Asset and My Right
A Case Study of the Self Employed Women’s Association in Gujarat, India

By Mirai Chatterjee

Introduction: Getting Organised

The Self Employed Women’s Association (SEWA) is a union of 220,000 women workers of the unorganised sector in India. “Self-employed” workers constitute 93 percent of the Indian workforce. They do not have regular salaried employment with welfare benefits: no weekly day off, sick leave, pension, nor any maternity benefits. They are the poorest of workers, and yet, they are economically active, accounting for 63 percent of gross domestic product in India. Among these workers, women are the poorest and most vulnerable. They are engaged in the most hazardous and low-paid work in the unorganised sector. These women are:
• Home-based workers – garment workers, incense stick rollers, artisans
• Hawkers and vendors – vegetable, fruit, flower, fish and household item vendors
• Manual labourers and service providers – agricultural labourers, construction workers, head-loaders, waste paper pickers and cleaners.

SEWA was founded by Ela R. Bhatt, a labour organiser and lawyer, in 1972. Ms Bhatt was head of the Women’s Wing of India’s first trade union, the Textile Labour Association (TLA), when she realised the need to organise self-employed workers, particularly women. This proved to be no easy task. From the start, policymakers and even the labour movement questioned the idea of organising these workers. Moreover, organising women in a culturally diverse and male-oriented society was a slow process. It involved uniting very poor women by encouraging them to come out of their homes and lead their own groups and union.

The tremendous courage, insight and creativity shown by these poor, hard-working, resourceful women with little or no education, demonstrated in those early days that SEWA’s greatest resource is its members. Twenty-five years ago, 4000 such women each contributed a day’s worth of their earnings as capital for a SEWA bank. Today, the SEWA Bank has 125,000 depositors and a working capital of over Rs 300 million (over US$7 million).

**SEWA’s Goals and Strategies**

SEWA organises women workers for full employment and self-reliance. Full employment means employment at the household level which ensures work security, income security, food security and social security. At SEWA, social security means health care, child care, insurance and shelter. Self-reliance means that women should be autonomous and self-sufficient, individually and collectively, and both economically and in terms of their ability to make decisions. Today, SEWA has promoted more than 1500 small self-help groups, cooperatives and district level associations of women in India and abroad. This is the SEWA movement. It incorporates the women’s movement and the labour and co-operative movements. Ghandian thinking is the guiding force at SEWA.

**Health Security of Women Workers**

*Testimonies of women workers in Gujarat, India*

“For the last 18 years, I have been sewing garments. I have many health problems. I cannot see clearly and I have chronic backache, but, I have no access to medicines nor treatment.”

“I am a salt loader. We have no equipment. I work deep down to my knees in mounds of salt. My feet and legs keep on bleeding.”

“Even if I wash my hands properly, some dye always remains. I know that I am going to fall sick, but what can I do? I have to work to satisfy my hunger.”

Health security of women workers in the informal sector has been a key concern of the Self Employed Women’s Association since its inception as a union in 1972. It was evident that unless the health of women and their families significantly improved, they would never achieve their goals of full employment and self-reliance. SEWA members, all poor, self-employed women in India, repeatedly emphasise that “health is their only wealth.” Poor health status affects their productivity, and their hard-earned money is spent on expensive health care. On the other hand, good health status enhances a woman’s productivity, and hence, her ability to work and feed herself and her family. In a recent SEWA study, health
was found to be the major stress factor in poor women’s lives, leading them into the vicious cycle of falling productivity and income, indebtedness, deteriorating health and increasing poverty. Hence access to security services like health care is a must for poor women.

SEWA’s health approach is firmly grounded in its philosophy of addressing the needs of women holistically. Economic empowerment, organising and health promotion are addressed in an integrated manner. SEWA believes that women themselves must take care of their own health and that of their families.

The key elements of SEWA’s approach to health security include:

- Linking health security to work security. This means that all economic activities at SEWA have a health component, and all health action, in turn, is linked to the economic activities of the producers’ groups, workers’ trade committees and self-help groups;
- Capacity building of local women, especially traditional midwives, so that they become the “barefoot doctors” of their communities and villages;
- Women-centred health care led by local women;
- Addressing common health problems among poor families, like tuberculosis;
- Promotion of health and well-being by providing access to information and education;
- Linking health services to insurance, provision of basic amenities like sanitation, literacy and other developmental programmes; and,
- Emphasising self-reliance both in economic terms and in terms of women owning, controlling and managing their own health activities.

SEWA puts those principles into practice by organising the following health activities:

- Promoting health and preventing illness through health education, immunisations, micronutrient supplementation, involvement in water and sanitation activities and family planning;
- Curative care through rational drug therapy and referrals, especially tuberculosis care;
- Occupational health care, including the provision of protective equipment, such as sickles for agricultural workers to reduce body sprain;
- Promotion of low-cost traditional medicines and remedies, like local herbs and massage; and
- Sale of low-cost rationed drugs, through three shops and 60 health centres.

“I was a mere agricultural labourer. My mother was a midwife and taught me how to do deliveries. SEWA gave me many more health trainings. I am now a community health worker for SEWA.” - SEWA member

SEWA’s health activities are carried out in a decentralised way, by district-level health teams. These teams are either midwives co-operatives or part of their own district-level associations. With intensive training and support, SEWA’s team of 200 midwives and health workers serve as health educators-cum-barefoot doctors for 75,000 women workers. Ten years ago, they formed their own health co-operative. The first of its kind in Gujarat State, the health co-operative has an annual turn-over of 10 million Indian rupees. It is run by elected representatives of the shareholders, who are midwives and health workers themselves and who earn their living from the co-operative.

“We give training to our sisters in the villages, to create awareness among them. Many of our members are weak and undernourished. When we see pale, anaemic women, we
advise them to take iron tablets and eat green, leafy vegetables. If a woman is pregnant, I weigh her, give her iron tablets and take her to the local health centre for vaccinations. If a woman tells me that she does not want a child for some time, I advise her of birth control options. I suggest birth control pills to her, or take her to a mid-wife for insertion of a copper-T.” - SEWA member

SEWA is not working alone. Effective linkages between local women, SEWA, the health co-operative, and the government and private health systems have been forged. One example is a joint collaboration between the government (central, state and municipality), the World Health Organisation and SEWA for tuberculosis through the Directly Observed Treatment Short-course (DOTS) method. Another is the regular diagnosis and screening for reproductive health problems of women in remote, inaccessible villages — organised by SEWA with the help of both private and government doctors. SEWA also collaborates with local government in programmes to upgrade slums, bringing water, sanitation, toilets and other basic amenities to the poorest of urban and rural communities. SEWA has also initiated mobile health care dispensaries with government, for workers in remote village, especially salt workers in the rural, desert areas.

Occupational health has always been an issue raised by SEWA members. In 1998, SEWA Health Team collaborated with the National Institute of Occupational Health (NIOH) for action-oriented research and health education for workers. Hand-gloves and protective clothing were given to tobacco workers handling the green crop. Patchwork quilt workers, head-loaders and garment workers participated in health training.

SEWA is also working toward health policy changes at district, state and international levels. Below are some ways in which SEWA has promoted health policy changes:

- Worked actively with government, other women’s groups and health organisations to bring in a new “target free” approach to family planning;
- Founding member of “Health Watch”, an Indian organisation committed to the Cairo Conference Platform of Action;
- Member of the Global Commission for Women’s Health of the World Health Organisation, pressing for a comprehensive approach to women’s health;
- Active member of the National Commission on Self Employed Women Workers, including a member of the health task force; and, Member of the national advisory group on Reproductive and Child Health.

Another example of a policy-action measure initiated by SEWA is its campaign for greater recognition and involvement of dais (traditional birth attendants) in reproductive and child health. With the new Reproductive and Child Health Approach (RCH), the issue of quality services being provided at women’s doorsteps has come to the fore. SEWA has been suggesting that dais be the focal point for all RCH activities. Specifically, SEWA supports the recommendations of dais that:

1. Identity cards should be issued for all midwives;
2. Dais should be central in the RCH programme;
3. Training should be ongoing and equip midwives with knowledge and skills in midwifery and primary health care;
4. Dais and their organisations (cooperatives, associations) should run the government’s maternity scheme;
5. The honorarium currently given to dais (Rs. 10) should be increased to Rs. 25 and this entire fund should be given to dais organisations for implementation. Dais who refer complicated cases to higher levels of care should obtain Rs 50; and,
6. A complete kit with regular replenishment should be made available to dais.

In October 1998, identity cards for dais was accepted as official policy by the state along with provision of dai kits and enhanced remuneration. Gujarat is the first state in India to give such recognition to dais.

**Process and Impact Evaluation**

In order to utilise bottom-up planning of all health activities, workers themselves helped to conduct a baseline survey which provides district-wide data, and has helped women plan their own health promotion strategies. The same team of village-based women that plans, also monitors all health activities each month, to determine the extent and impact of SEWA’s efforts. Sixty health workers and 140 midwives, working in 100 villages and nine districts of Gujarat State have been able to deliver the following in 1999:
<table>
<thead>
<tr>
<th>Service Delivered</th>
<th># of Women</th>
<th># of Men</th>
<th># of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education</td>
<td>10,749</td>
<td>1,010</td>
<td></td>
</tr>
<tr>
<td>Curative care in Health Centers</td>
<td>49,569</td>
<td>40,213</td>
<td>27,130</td>
</tr>
<tr>
<td>Curative care through diagnostic camps</td>
<td>5,219</td>
<td>1,074</td>
<td>3,977</td>
</tr>
<tr>
<td>Sale of low cost rationed drugs</td>
<td>5,787,614</td>
<td>40,213</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis treatment (curativa)</td>
<td>871</td>
<td>704</td>
<td>231</td>
</tr>
<tr>
<td>Immunisation (in collaboration with government)</td>
<td>3,357</td>
<td></td>
<td>29,400</td>
</tr>
<tr>
<td>Family Planning</td>
<td>7,000</td>
<td>2,500</td>
<td></td>
</tr>
</tbody>
</table>

In 1997, SEWA conducted an impact survey among members selected randomly from the membership list. The following are some of the positive outcomes evident from that survey:

- No maternal deaths reported
- No measles deaths in children
- 92% of women in districts reported satisfaction with SEWA’s health services
- 65% reported savings due to the low cost drug distribution system
- An increase in health awareness among women and their families including alcohol and “gutkha” (a tobacco product), and several men and women have successfully completed detoxification programmes

An important, though difficult to measure, impact of SEWA’s health work is that it has served to knit together various castes and communities, hitherto divided by age-old traditions. Most of the health workers and midwives are from the most disadvantaged communities, especially the Harijan (“Untouchable”) community. Their health activities have given them a new status in their villages, and despite initial resistance, today all castes and communities seek care from them. They have become leaders, not only as health workers but also of other economic activities like savings groups and as elected representatives in their village councils.

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Street Food Project in Calcutta

Introduction

Street foods have become increasingly popular all over the world and India is no exception. Defined as “ready-to-eat food and beverages prepared or sold in the street or in other similar public places,” street foods have grown both in volume as well as variety to cater to growing demand and varied tastes. The rise in urban population through migration of rural job seekers to urban centres, generally poor economic conditions, including low wages and high unemployment, commuting or travel requirements for workers away from their homes to distance job locations, are some of the reasons for the demand for convenient and low price food suppliers. Lack of resources and absence of regulations and controls has allowed the continued growth and development of this informal food industry.

It is well recognised that this sector has a significant and positive impact on the socio-economic situation of a city. The street food industry provides a source of employment for millions, especially migrants to urban areas, since setting up a food stall is a low-cost investment, requiring little training. The equivalent of millions of United States Dollars exchanges hands every day through street food vending, not only on the street, but also for the production of raw materials in rural areas. The street food trade in the urban economy of Calcutta, India, has become well-entrenched. Including all types of stalls (fixed and ambulatory), street food vending in Calcutta sees a turnover of about Rs 3250 million (US$ 92.85 million) per year.

Street food vendors could be called the nutritionists of the poor. An individual’s daily nutritional needs can be met with just a few rupees. However, street food can pose a significant health risk for consumers. Often ignored or tolerated by food control and public health officials, street food in many cities has become a critical concern from the point of view of food safety. Vendors often work near sewers and garbage dumps, with no place to dispose garbage and no supply of safe water. Unsanitary conditions and poor food handling practices lead to exceedingly high rates of food contamination and outbreaks of food-borne diseases. In addition, outdoor food vending contributes to littering, build-up of garbage and traffic congestion.

Such concerns for health and hygiene, in addition to street safety and traffic control, led authorities in the city of Calcutta to develop a plan of action to improve street food management.

Project Inception

With technical and financial support from the Food and Agriculture Organisation (FAO) of the United Nations, the All India Institute of Hygiene and Public Health (AIITHPH) conducted a study to assess the situation and quality of street foods in the city of Calcutta in 1992. Baseline information from the study indicated that the city has an estimated 130,000 street vending stalls selling more than 50 varieties of food. Approximately half of the stalls are stationary stalls and half are ambulatory. The vast majority (90%) of the stalls surveyed are owned by men. An average of 2.6 persons are employed per kiosk (ambulatory stall).

Stalls were usually open between 10 AM and 9 PM, although the hours of operation were adapted to the characteristics of the market and consumers in different areas. All of the
consumers interviewed reported a long usage of street foods (from 10 months to 15 years). The majority also indicated that they consumed the foods on the spot, though may not always buy from the same vendor.

Consumers spent on average from Rs 40 to 400 a month, according to their income and taste. A balanced street food meal containing approximately 1000 calories cost around Rs 5 (US$0.14). This indicates that street food is possibly the cheapest method of getting balanced nutrition outside the home.

Physical analyses of food sold in Calcutta streets revealed that the foods did not contain excessive amounts filth, dirt or dust, however, the microbiological quality of food and water samples was far from satisfactory. This was evident from the presence of coliform and *E. coli*, yeast, mould, *Salmonella shigella*, *Vibrio cholerae*, *Klebsiella pneumoniae*, *Streptococcus faecalis*, etc. *E. coli*, which indicates fecal contamination, was detected in 55 percent of the samples tested. Forty seven percent of the samples of water used for drinking, cooking, and washing of fruits, vegetables, dishes and hands, was found to be contaminated with coliform and Faecal coliform. Unpermitted and unsafe food colours were also detected.

Thus, the study revealed that while street foods were a way of life in Calcutta, with important socio-economic implications for the city, repeated handling, prolonged storage under unsanitary conditions and use of unclean water were causing unacceptably high rates of contamination.

**Collaborating for Food Safety**

The compelling results of this initial study caused AIHHPH to shift its attention from diagnosing the problem to identifying solutions. The goal was to reduce health hazards for consumers while avoiding a negative impact on the positive socio-economic aspects of the industry.

AIHHPH recognised that this was a matter beyond the control of health specialists and scientists. The most effective and sustainable way to attain their goal was through a co-ordinated holistic approach addressing not only health but traffic, environment and safety. As the National Project Coordinator, Professor Indira Chakravarty, Dean and Director of the Department of Biochemistry and Nutrition, suggested the formation of an Advisory Committee, chaired by the Chief Secretary (chief of administration) to Government of West Bengal, and also co-opted the following as co-investigators: the Honourable Mayor-in-Council in Health; Calcutta Municipal Corporation; Commissioner of Calcutta Police; Joint Secretary and Secretary to the Department of Health and Family Welfare, Government of West Bengal; Secretary to Ministry of Agriculture, Government of India; FAO Representative in India and Bhutan.

Other important stakeholders invited to play a role included consumers and consumer forums, vendors and vendors’ unions, the Calcutta Metropolitan Development Authority, (which works in co-ordination with the Calcutta Police in certain areas), and representatives of non-governmental organisations.

To develop a co-ordinated approach among the various authorities and players, and to share ideas and information, a series of meetings were held, including:
Discussions with the food inspectors of the Calcutta Municipal Corporation, the Honourable Mayor-in-Council (Health), and the Chief Medical Officer of the Calcutta Municipal Corporation;

Meetings with the Police Chiefs of each region, in the presence of the Commissioner of Police;

Meetings with the vendors’ unions and representative vendors;

Consumers’ opinions about street food vending and quality were noted.

From Talk to Action

From those discussions, it was concluded that specific measures were needed to control the number of street food vendors, to improve the safety of street foods, and to provide vendors with an acceptable water supply, kiosks, garbage disposal, improved vending sites and other supportive services. A Calcutta “master plan” on street foods was prepared by representatives of the project’s advisory and technical committees. The Plan of Action contained the following recommendations:

- Preparation of a list of vendors;
- Issuance of identity cards or licenses to vendors;
- Monetary assistance for obtaining kiosks (rolling funds);
- Vending places to be fixed by Calcutta Police (e.g., identification of streets where hawking can be permitted and prohibition of hawking in certain roads);
- Awareness generation among regulatory bodies, vendors and consumers at all levels through training, education, communication and motivation;
- Preparation of education and communication materials;
- Provision of easy access to potable water;
- Garbage and waste disposal facilities by the CMC;
- Regular analysis of food and water samples in the laboratory to ensure microbiological and chemical quality;
- Proper food laws and their implementation;
- Promotion of footpaths;
- Proper co-ordination between CMC, Calcutta Police and the Government of West Bengal for overall improvement.

The AIIHPH prepared a number of innovative training programmes for food inspectors and street vendors. These courses were carried out in May and June 1993, and continued after the project concluded. The training programmes included open air lectures, exhibitions, posters, street plays, video presentations and discussions. In addition, Calcutta police personnel involved in street food inspection and control were trained to increase awareness of their role and responsibilities in street food control. A prototype food preparation and vending cart, using local materials, was produced by a local small-scale enterprise and is available to vendors at a reasonable price. Project activities also increased consumer awareness about the quality and safety requirements of street foods.

The two main agencies supporting the AIIHPH were the Calcutta Police and the Calcutta Municipal Corporation (CMC). The Calcutta Police looked after the legal affairs of street food vending, placement of vendors, designing of kiosks, etc. CMC provided infrastructural help for quality maintenance of street foods, and other basic amenities required for street food vending. In every step, vendors were working alongside the authorities so that decisions
were mutually acceptable. Financial support from FAO provided the opportunity for Calcutta to try this new and innovative approach to improving street food safety.

**Results**

The project tested the proposed improvements for street foods in four test areas of Calcutta. The training and education efforts have raised the awareness of police officers, street food vendors, handlers, food inspectors and police officers of the hygienic requirements in street food preparation and sale. The partnership that was developed with vendors and vendors’ unions, authorities and consumer forums generated motivation and understanding that led to an improved management system; the re-organisation of vendors and rehabilitation of street conditions has produced a significant improvement in hawking and environmental conditions. There has not been a reassessment of the quality of street food, however, with funding from the Government of India, AIHHPH is expecting to initiate a second phase of Interventions and Assessment.

Today, training activities for street food vendors continue, and the coalition partners continue to play their part to implement the street food strategy formulated by the project. The project is being expanded to other areas within Calcutta. The positive results have also convinced authorities of the Government of India to replicate the activities of this project, starting with an assessment of the situation, in other major cities of India. The National Director has participated in several regional fora to present the experience of the project and has encouraged similar actions in other Asian countries seeking solutions to their street food situation.

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Latrine Revolution in Rural Henan, China

Introduction

Situated in the heart of China, with 92.43 million residents (by the end of 1997), Henan is the most populous province in China. The average annual income of the rural residents in 1997 was 1,734 RMB yuan (US$210).

In past decades, unhygienic conditions and behaviours caused diarrhea and intestinal parasitic infections to run rampant in the rural towns and villages. In many districts and even some cities, one could not find a latrine. There was no safe water supply and most rural residents drank polluted pond water or small stream water, also used by cattle.

An agricultural nation for centuries, the use of human nightsoil as fertilizer for farming is a fundamental aspect of Chinese culture. Traditional latrines are simply a dug hole with two stones, from which excreta are scooped out and stored for direct use in fields. Also common are ditch latrines located above ponds. The exposed excreta emit offensive smells and serve as a favourable habitat for flies. Pigs, dogs and chickens can easily come into contact with the excreta and further contaminate food, water and the living environment.

Prior to the 1970s, the Department of Agriculture and Husbandry and the Department of Public Health in Henan sought a way to improve water and sanitation, while also maintaining the cultural tradition of using excreta as fertilizer. Together, they explored the feasibility of reforming the traditional latrines in rural areas. They advocated different types of latrines, but with little success for various reasons: community leaders were not very involved; few benefits for farmers were evident; and people were not ready for change.

From 1977 to 1981, professional health and agricultural workers invented the double-urn, funnel-shaped latrine through collaborative field research. The new design allows human excreta to become non-hazardous fertilizer. It is easy and affordable for rural families and communities to construct. It consists of two parts: a funnel-shaped, removable, but tight fitting pan; and, a front urn and back urn, joined with a pipe. The parts can be made from local materials, like cement, mortar, bricks or plastic. Early studies showed that intestinal helminth eggs and pathogens could be sedimented and eliminated with this design. After being stored in the front urn, manure that reaches the back urn is relatively non-hazardous and can be used as fertilizer any time. The studies also showed that the fertilising effect of the nightsoil stored is well preserved – twice that of the traditional latrine. For example, in a 3 months storage period, 75-95 percent of the nitrogen content is retained.

In 1982, the new latrine won the third prize in a provincial government content for important scientific and technological achievements. From then on, officers of the provincial Patriotic Health Campaign Committee (PHCC) took advantage of every opportunity to meet government leaders at every level and gain their commitment to latrine reform. The Vice Governor at the time became an important supporter, and the media, including various newspapers and radio programmes, also advocated for reform. With the support of government (from the local bureaus of health and agriculture to the State Councillor and Minister of Health), professional workers and farmers, the “latrine revolution” formally began in 1989.
Planning and Implementation

Organisation and Co-ordination

Responsible for coordination of health and sanitation issues, the Patriotic Health Campaign Committee plays an important role in planning the latrine reform programme, organising activities and coordinating with other agencies. The PHCC is a multi-sectoral agency formed by the Ministries of Health, Agriculture, Education, Water Resources, Environment Protection, Transportation, Urban Construction and others. At the national level, a Vice-Premier or member of the State Council is appointed as the director (presently Vice-Premier Mr Li Lanqing) and the administrative office is housed in the Ministry of Health. To implement latrine reform in Henan, the provincial PHCC created technical assistance teams in counties and townships. Specialists and professional workers including PHCC officers at all levels, some epidemic prevention station staff, and one health education staff at county level comprised the technical teams.

Policy Development

Latrine reform is consistent with and supported by a number of policies and existing campaigns at the national and provincial level. For example, China is committed to Health for All by 2000 and the national PHCC established ‘improved sanitation coverage’ as one of the important indicators of this goal. Latrine improvement is included in the 18 indicators of “Model Villages” and one of the 10 indicators to assess the performance of local officials for promotion. In the Healthy City campaign, the coverage rate of sanitary latrines should be above 80 percent for rural suburban areas.

Improvement of latrines is one of the responsibilities of PHCC offices at all levels, stipulated by the “Regulation on Health Campaign” issued by the Provincial People’s Congress. PHCC offices began by convening advocacy meetings to gain the political support of authorities and the commitment of communities. These meetings and mass media spread the message that latrine reform would:

- Substantially improve the environment;
- Decrease the incidence of intestinal communicable diseases;
- Help increase agriculture production;
- Require little investment for high benefits.

Political commitment was formalised when the Vice-Governor signed a contract with mayors, stipulating goals and targets in a given duration. Mayors in turn signed contracts with counties.

Financing

The provincial PHCC office has an annual budget of 300,000 RMB yuan as seed money for latrine promotion. The beneficiaries (families) pay most of the costs involved in constructing and maintaining the new latrines. Both national and provincial PHCC have stressed that most of the costs paid by farmers for building/improving latrines can be earned within a year or two because of the agricultural benefits of the improved manure.
The local government provides subsidies, especially to help poor villagers build latrines. In economically better developed villages, private or village-owned enterprises also make contributions to the villagers for establishing/improving latrines, either by funding or by producing cheaper materials and parts. Many counties have set up special starting funds for latrine improvement, or provide low-interest or interest-free loans to the poor villages and families. Other townships and village committees use part of the public welfare fund and collective enterprise profit on rural area latrine improvement.

**Demonstrations and Technical Training**

Setting up demonstration sites has been a very important strategy to promote latrine improvement, as it allows people to see with their own eyes the effectiveness of the new model. The project established a policy regarding demonstrations: there should be a demonstration township in every county; a demonstration village in every township; and a demonstration household at every village.

The technical teams created by PHCC visit villages and train masons and technicians in sanitary latrine construction. At the village level, village leaders, doctors and women leaders were trained as promoters of the reform program.

**Outcomes and Evaluation**

**Increase in Sanitary Latrine Coverage**

Over the past decade, the coverage rate of sanitary latrines in Henan Province has increased from almost zero to 49.8 percent of households. At the end of 1994, 4.96 million sanitary latrines had been built or improved for a rate of 29.3 percent of the total households and at the end of 1997, 7.8 million sanitary latrines were built or improved. That number has now increased to 8.6 million new latrines.

**Construction Quality Inspection**

A reporting system for the construction of latrines has been established whereby county PHCC offices collect information from their county and report to higher levels, which then report to the province. The local technician group has a mandate to check the quality of latrines once construction is complete.

**Positive Impact of the Latrine Reform**

In 1994 and 1997, the Provincial PHCC Office formed four technician groups to conduct spot check monitoring on latrine improvement in prefectures of one country, one township and one village. The study showed that well-maintained double-urn latrines reduced bad smells from ammonia and sulphide, reduced fly density in the latrine by 96 percent in courtyards and kitchens by 51-72 percent, compared to the control villages where no actions were taken to reform latrines. The average sedimentation rate of ascaris eggs was 95 percent and the average reduction of *E. Coli* in fecal material was 87.8 percent.

In five monitoring spots in 1988 (the preparatory phase), soil contamination of helminth eggs in the courtyards and vegetable fields, where the treated manure were applied, was considerably reduced: roundworm eggs decreased by 70.2 percent and hookworm larvae by 89 percent. Egg or larvae presence on vegetables was also reduced. As a result of the improvement in latrines and the living environment and the development of safe water supply...
from wells, the *E. Coli* content in water from hand-pumped wells in project villages was reduced by 98 percent.

The pilot project in a village in Changge County saw the annual incidence of diarrhea drop from 28 percent to 11 percent in two years. Puyang County compared the incidence of intestinal diseases of diarrhea in 4-year-old children in 1989 and 1992 in 18 townships which reached 70 percent coverage of sanitary latrines, and found a decrease from 428 per 1000 children in 1989 to 92 per 1000 in 1992.

**Recommendations for Further Development**

*Sustaining the Project*

The provincial PHCC office continually assesses the latrine reform program, making modifications when necessary. An important challenge to the project’s success is the human behaviour needed to support the new latrines. Hygienic behaviours, such as effective maintenance of the latrine, keeping the pan clean and handwashing are critical to the new latrine’s effectiveness. Though proper maintenance and usage of the latrines is increasing among users, further improvements are needed. According to one investigation of 226 households in 25 villages in 1991, 62.4 percent cannot water and brush the pan every day; 37.4 percent of pans contained feces; 24.9 percent of the urns contained flies or worms; and 32.3 percent of the latrines had offensive smells. Seven years later, a study of 310 households in Dengfeng City showed that 61.2 percent of the visited households watered and brushed their latrines every day; 10.5 percent of latrine pans contained feces; and five percent of the latrine urns had flies or worms.

Some ways in which further improvements in behaviours will be encouraged include:

- A community problem-solving monitoring system should be developed;
- The PHCC officers at different levels should be further trained on maintenance, hygienic use and relevant behaviours in terms of water and sanitation activities, so that in their communication with the villagers they can further convince them of the importance of these issues;
- Schools and health centres need to be more focused on water and sanitation improvement, and serve as models to promote the program in their communities;
- Women’s groups in villages should be more involved in the program through training and education, and to help monitor the effective use of the facilities; and
- The villages with improved latrine system should be revisited at least once a year to document proper maintenance and effective use of the latrines.

**Expanding the Effort to Other Areas**

The rest of China can learn from Henan’s experience with latrine reform. Valuable lessons learned include:

- Gain political commitment to improve water and sanitation. For example, sign agreements with concrete targets for sanitation coverage between the Vice Governor and mayors, between mayors and county magistrates, between county magistrates and township leaders, between township leaders and village leaders;
- Spread key messages on sanitary latrines to the masses by using a mix of mass media and interpersonal communication;
• Use successful demonstration sites in villages to convince community leaders, village doctors, masons and schools to act as role models so that villagers can see the benefits with their own eyes;
• Develop a reasonable approach for fundraising and resource allocation. Beneficiaries contribute the main part of the costs, but townships, communities and counties should also play a role in the financing;
• Use incentives such as rewarding for successfully reaching targets;
• Provide training to technicians and construction workers such as masons and education to women for maintenance;
• Control the quality of construction;
• Involve finance, agriculture and water resources to make the program a collaboration and to develop a “build now, pay later” approach.

Integration into Other Programs

The latrine reform, in addition to improvements in safe water supply, has been an important step for improving family and community living environments and for preventing common communicable diseases. However, to further promote the health of rural communities, and build infrastructure in rural China, latrine reform must be integrated within other existing efforts. For example:

• Since 1995, a national project on health education for 900 million farmers has been initiated through a joint effort of the national PHCC, the Ministries of Health, Agriculture, and Broadcasting and Television. The National Health Education Institute is responsible for developing education materials, especially video programs on important health-related problems and risks, and distributing them to every province and municipality. Henan Province has been actively participating in the project. The major items within the program include communicable and non-communicable disease prevention, maternal and child health, oral health, tobacco control, water/sanitation and environment, diet and nutrition, and so on.

• Inspired by the improvements in water and sanitation, and the health education project for farmers, a Healthy Village project was started in 1999, with the support by WHO. Coordinated by the provincial PHCC office, the project promotes multi-sectoral cooperation for the development of health policies and regulations, environmental improvement, health communication among villagers, and securing an infrastructure for health in the pilot villages.

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Building linkages with democracy and health: a Nigeria democracy & governance case study

By Susan Krenn, Stella Babalola, Rebecca Holmes, and Bola Kusemiju

Background

Nigerian women carry a huge burden of responsibility for the welfare of their families, but traditionally receive little support. Empowering women to participate in community, regional, and national governance will enhance their ability to gain more support and to make decisions for themselves, their children, and families. This was the intent of a unique Democracy and Governance (D&G) Project in Nigeria, implemented by Johns Hopkins University / Population Communication Services (JHU/PCS). By building a strong and inclusive society, Nigeria will be better able to meet the critical health and economic needs of its people.

The democracy and governance project began in 1997, a period characterized by an unstable and difficult socio-political climate in Nigeria. Under the military dictatorship of General Sani Abacha, Nigerians (particularly women) were politically oppressed. However, Nigerian women have a history of strong community involvement and coalition building and have created a wide array of non-governmental organizations (NGOs) and community-based organizations (CBOs). The United States Agency for International Development (USAID) recognized both the need to give women a voice and the opportunity presented by the existing grassroots organizations in Nigeria. JHU/PCS gave micro-grants to 16 mainly women’s NGOs who developed and implemented their own D&G projects. These established Nigerian NGOs provided a ready base from which to launch the D&G project. This project was designed to be non-partisan, non-confrontational, and grassroots oriented. JHU/PCS followed the P Process implementation framework for the design, development, and evaluation of the D&G project.

This was the first initiative aimed at strengthening the role of women in the civil and political process in Nigeria. Promoting the active involvement of women in public decision-making processes helps to ensure that practical gender interests are adequately addressed through appropriate policies and programs. The issues important to Nigerian women include reproductive and child health, literacy, access to clean water and sanitation, food supplies and prices, increased opportunities for income generation, early marriage, rights to inheritance and property, access to quality health services, and many more. By participating in the democratic process, women achieve more equitable representation in government, and are better able to advocate their causes.

Under the democracy and governance project, JHU/PCS worked in partnership with NGOs known for their existing networks, infrastructure, and strengths to address three main issues: women’s political empowerment, fundamental human rights, and democratic participation. Each NGO’s mini-grant includes one of these issues but is based on the specific needs and priorities identified by the members. Thus activities range in focus from fighting for women’s civil rights, to lobbying for a better market environment, to coverage of women’s issues in

1 A list of the NGOs is provided in the Annex.
2 The five steps of the P-Process can be found in the Annex.
the mass media. While many of the issues addressed may not have health as their origin, they have direct and indirect consequences on health. This paper briefly describes the D&G Project and examines its impact on the health of women in the participating NGOs.

**Project Objectives**

Strategically, the D&G Project sought to:

1. Inform and educate Nigerian women about the concepts, values and practices of democratic participation including the need to identify, campaign for, and vote for candidates of one’s choice;
2. Increase women’s political empowerment and political participation at the local, state and national levels;
3. Inform and educate Nigerian women about the concepts, values and practices of fundamental human rights (including the right to life and property, right of human dignity, freedom of speech and expression, freedom of association, and freedom of movement) and their civic responsibilities; and,
4. Increase women’s advocacy for their fundamental human rights to ensure that these rights are respected.

**Communication strategies**

To accomplish project objectives, JHU/PCS awarded grants to predominately women’s NGOs in sixteen of the 37 states in Nigeria. Among these groups were women lawyers, women journalists, market women, women’s religious organizations, youth advocates, and theater troupes. The groups ranged in size from 30 to over 50,000 members. The broad communication strategies were:

- **Democratic forums:** Implementing carefully-designed Information, Education, and Communication (IEC) initiatives that are likely to have tangible impact and move the democratic agenda forward. Providing democratic forums as opportunities for people to better learn about and exercise their rights and responsibilities as citizens;
- **Media advocacy:** Ensuring that women’s groups have both access to and the skills to partner with the media in order to advocate effectively for women’s health and other issues;
- **Networks:** Coalition-building within the established and nascent D&G NGO community, and between D&G NGOs and other women’s and community mobilization organizations to facilitate information sharing and joint implementation of project activities for greater impact; and
- **Capacity building:** Ensuring that a core of women’s groups, as members of civil society organizations, have the democratic and advocacy skills and organizational capacity to play a constructive role in the country’s reform.

The strategies were pursued through a series of activities that included the development and distribution of standardized IEC resource kits, which served to train the NGO membership in democracy and improve their advocacy and consciousness-raising skills. A variety of other activities were implemented including community education through mass media, leadership capacity building workshops, drama performances, cultural activities with D&G themes, lobbying and advocacy initiatives, and the promotion of women in the media. In addition, many of the NGOs developed posters and flyers, produced radio and television programs, and
created educational dramas on civic responsibility and rule of law. Some of the messages include: “Make a difference, join a political party now”; “Exercise your right, vote and make a difference”; or “Choose to be a leader”.

The media strategy was based on a partnership with the Nigeria Association of Women Journalists (NAWOJ). JHU/PCS worked with NAWOJ in six states (Enugu, Kano, Katsina, Kebbi, Lagos, and Oyo) to promote women’s democratic activities such as the participation of women in the electoral process as candidates and voters, and to advocate on behalf of women. Working with NAWOJ, JHU/PCS trained NGO leaders and female politicians to work with the media to ensure adequate coverage and visibility. Women’s journalist organizations used mass media interventions, such as radio and television broadcasts, newspaper articles, posters and other promotional material, as the primary activity to synergize the NGO efforts.

**Evaluation methodology**

The development community has been slow to evolve workable models for evaluating D&G initiatives. JHU/PCS faced two challenges in the design: (1) applying the Steps to Behavior Change Model traditionally used for health interventions to promote D&G-related behavior change; and (2) constructing a framework to evaluate D&G behavior change. However, from years of experience, JHU/PCS was convinced of the efficacy of their communication strategies which are based on a scientific understanding of behavior change. The Nigeria D&G project was carefully and successfully crafted based on the Steps to Behavior Change Model. The Nigeria D&G Project also designed innovative D&G research methods to assess impact at three different levels: the NGO institutional level, the NGO membership level, and the community level. Relevant indicators pertaining to the cognitive, emotional and social interactions of the major project themes were measured before and after project interventions, at each level in intervals of nine months.

Membership data were collected through baseline (sample size 729) and follow-up surveys (sample size 764) that sought to elicit information on respondents’ perceptions and behaviors relative to the main themes of the project. The follow-up questionnaire also contained questions designed to measure exposure to project activities. In all, six of the sixteen NGOs participated in the baseline and follow-up surveys. The membership surveys were initially designed to yield a panel study. This idea had to be abandoned however, as many of the baseline respondents were lost to follow-up due to the itinerant nature of their job. This was particularly true for members of the Market Women Association of Oyo State who had no fixed shops within the markets.

The aim of the institutional analysis was to examine progress related to the NGO’s infrastructure and determine how participation in the D&G project had enhanced the capabilities of the organization. The analysis set out to collect data that would allow an assessment of the following issues: NGO coverage areas, membership size, networking,

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3 NAWOJ served as a link and outlet among the D&G NGOs by writing about their activities. This gave the NGOs publicity and information about what their counterparts were doing.

4 The five steps to Behavior Change include: knowledge; approval; intention; practice; and advocacy.

involvement in the electoral process, decision-making within the NGO, and behavioral change communication activities implemented. Information relevant to these issues was collected from the participating NGOs through structured interviews with three or more members of the NGO management team.

Community data were collected through the bimonthly omnibus (Nigerbus) survey implemented by a Nigerian research firm - Research and Marketing Services. The aim was to see if there was any impact from the project on the community at large, and the questions asked were similar to the ones used for the membership surveys. Data were collected twice: in October 1997, midway through the project, and in February 1998, at the end of the project. A total of 4,017 community members participated in the 1997 survey while 5,016 were interviewed in 1998.

*Project reach and impact*

The reach of project activities was enormous. Millions of radio listeners and television viewers tuned in to political forums and talk shows. Over 35,000 people attended workshops, seminars and community rallies while more than 800 leaders received advocates in private meetings. About 80% of NGO members were exposed to the D&G activities.

There is ample empirical and anecdotal evidence to show that the JHU/PCS Democracy and Governance Project had an extraordinary impact. The project successfully increased the participation of women in the civil and political process in Nigeria. This project also revealed that working with the strengths of existing grassroots NGOs can be a potent means of channeling information and stimulating change. There have been significant changes in civic awareness, improvements in democratic practices, expansion of women’s networks, nullification of several repressive laws, and the election of a record number of women into political office. NGOs have increased the quantity and quality of their networks. Women’s active role in the democratization process has induced significant political, legal and social changes in their favor.

It is evident women play prominent roles in democratizing their societies. The impact of women’s political participation on their health and the health of their families is logical. If women are active in political decision-making, they are likely to influence decisions regarding utilization of community resources, including allocations towards health. Highlights of the D&G Project’s achievements with regard to health include:

1. **Women in leadership positions.**

One notable achievement of the project has been its instrumental role in supporting women candidates in campaigns for public office and educating potential candidates. The D&G Project has led to the establishment of new women’s political organizations as well as expansion of existing ones. Several NGOs have established women’s political action groups that are providing key information, networking opportunities, and advocacy outreach for women candidates. In elections conducted in April 1998, twenty women were elected to the House of Representatives, seven women were elected as senators in April 1998, several have been appointed local councilors, some have been appointed to the judiciary as High Court Judges or magistrates, while others have been appointed to traditional village councils. While the D&G Project cannot claim credit for all these women in leadership positions, evidence suggests that it has played a positive and crucial role. In this new capacity, women leaders are
in a position to pry open avenues to address their concerns, such as their health and that of their families.

2. **Giving women a voice.**

As a result of coverage of D&G activities by the Nigeria Association of Women Journalists (NAWOJ), several women have become prominent in their communities and are now resource contacts for other NGOs. State newspapers are starting to recognize the work of women journalists and the importance of including articles by women in the newspapers. Through advocacy, NAWOJ has succeeded in convincing a Kaduna-based newspaper to include two full pages devoted to women’s issues twice a week. The Katsina State Broadcasting Service has also established a Women’s Affairs Desk as a result of NAWOJ’s influence. The inclusion of health issues in the newspapers and radio broadcasts has resulted in increased awareness and knowledge of healthy practices.

3. **Expanding women’s health networks.**

The JHU/PCS D&G Project has included a strategic networking component, providing opportunities for women to meet and exchange ideas. This has borne interesting results – for example, during the second year of the D&G project OMWA joined BRECAN, a breast cancer awareness group. The NAWOJ chapter in Kaduna has been working with UNICEF on the girl-child issue; while in Anambra, the Anambra Women’s Awareness Committee (AWAC) has been networking with the Red Cross. The OMWA also has been approached by a local organization to market oral rehydration salts. As vendors, the market women will likely learn about ORS, gaining useful knowledge for themselves as well as their families.

4. **Mobilizing women around health issues.**

Women have been mobilized to participate in various activities that are likely to affect their health. For example, the National Council of Women’s Societies’ (NCWS) Women’s Summit, held in December 1998, forged the political agenda for women during the transition to civilian government. Among the issues discussed were traditional beliefs that hinder women’s progress. To the extent that some of these beliefs also hinder women’s health mean that they can be debated, influenced and publicized in summits such as this. The D&G partners have also become an entry point for information about health, for example, during the National Immunization Days, World AIDS Day, and International Women’s Day. The grassroots women are able to spread health information quickly through their networks to other members of their community, and advocate for improved health behaviors.

5. **Cleaning the environment**

A direct consequence of the D&G Project has been the clean market competitions held by the Oyo Market Women’s Association (OMWA). The first market competition, held in September 1998, was attended by 1500 people. The OMWA has also been holding forums with local health officials to demand water and sanitary facilities. Although they are gender-neutral issues, they particularly benefit women – having a clean environment helps reduce infections, and can therefore reduce the time women spend taking care of sick children. In Oyo state secondary schools, the Women’s Political Empowerment clubs formed as part of the D&G Project have led to a change in the housekeeping assignments – while in the past only girls cleaned the compound, the boys are now required to sweep the compound as well. In changing gender roles, boys are starting to share some of the responsibility for clean, healthy environments. Roles and responsibilities that boys will hopefully keep as adults to ensure the health of their families.
6. Fighting against harmful traditional practices.
The D&G groups have taken on sensitive traditional practices such as early marriage, female genital mutilation, inheritance rights and humiliating widowhood practices. For example, the Abakaliki Women’s Association raised these issues and gained high-level support from local church leaders. In Abia, the local International Federation of Women Lawyers (FIDA) chapter has been addressing the issue of battered and abandoned women – besides providing legal support for women whose civil rights have been violated, FIDA has also established a Rescue Center for women in need. The Enugu chapter of the Nigeria Association of Women Journalists (NAWOJ) has been criticizing dehumanizing widowhood practices and domestic violence against women in the local newspapers. In Anambra State, a judge ruled that the son could not evict his deceased father’s wife from their house. Through the work of FIDA, Abia, a Federal High Court of Appeal issued a landmark pronouncement stating that women should not be discriminated against in inheritance practices and ruled that a widow should inherit her husband’s property. When women are able to stand up against harmful traditional practices, they are more empowered to stand up for other matters that can affect their health. They are better able to advocate for their needs, which can translate into improved health behaviors such as talking to their spouse about family planning or demanding access to quality health services.

Conclusion

Health and D&G issues intersect naturally in the social, economic and political context of women’s lives. The JHU/PCS democracy and governance project provides a compelling opportunity to address women’s issues, including health. Specifically this project linked D&G and health by:

- fighting against harmful traditional practices;
- placing women in leadership positions;
- cleaning the environment;
- providing media coverage and publicity of health concerns;
- expanding networks for health initiatives; and
- mobilizing women on health issues.

In short, the democracy and governance project has been successful in motivating and empowering women to participate in the democratic process and advocate for issues that affect their well being. Placing women in positions of power is a crucial way to foster development, overcome discrimination, and construct more equitable societies. This project has afforded an opportunity for numerous women to improve their knowledge about fundamental human rights, democratic participation, civic responsibilities, and to enhance their advocacy and political lobbying skills. Political empowerment of women and increased participation in the policy decision-making process are not ends in themselves but avenues for ensuring that issues of interest to women, such as reproductive health, domestic violence and low literacy, are adequately addressed.

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Endnotes

1. The participating NGOs from the three USAID clusters in Nigeria are the following:

   **Northern Cluster**: Federation of Muslim Women of Nigeria (FOMWAN), Jigawa State; FOMWAN, Katsina State; Gumel Youth Movement (GYM), Jigawa State; Jagora Cultural Troupe (JCT), Jigawa; Jamiyyar Matan Arewa (JMA), Kano State; Nigerian Association of Women Journalists (NAWOJ), Katsina State; NAWOJ, Kano State, and NAWOJ, Kebbi State.

   **Southwestern Cluster**: Community Women and Development (COWAD), Oyo State; Market Women Association (OMWA), Oyo State; NAWOJ, Lagos State; NAWOJ, Oyo State; and Women, Law and Development Center (WLDCN), Lagos State.

   **Southeastern Cluster**: Anambra State Women’s Awareness Committee (AWAC); International Federation of Women Lawyers (FIDA), Abia State; and NAWOJ, Enugu State.
1. JHU/PCS P Process:

2. The NGOs in the study include OMWA, NAWOJ- Oyo, GYM, JCT, FOMWAN-Jigawa, and FIDA-Abia.
The Healthy Municipality Experience: Versalles- Valle De Cauca, Colombia

By G.S. Millán

Introduction

To ensure the health and well-being of the population of Versalles, local development occurs within a health promotion framework and involves the active participation of community members in determining priorities for action as well as the appropriate strategies for addressing the identified needs. This process has resulted in consensus building and the coordination of work between sectors and non-governmental entities. Using a methodology that combines analysis, action, and reflection, diverse sectors work jointly for education, community participation, equity, and sustainability.

Many individuals and institutions have been involved in the healthy development of Versalles over the last 11 years. Included among these are the medical director at the health service provider, various mayors, the promotion and prevention team of the health department, and local leaders and community members in both urban and rural areas. The following local institutions have provided financial and/or logistical support: San Nicolás Hospital, the Municipal Administration, the parish, the tourist hotel, Corpoversalles, the Lions Club, volunteers at San Nicolás Hospital, community drugstores, the Solidarity Health Company (Empresa Solidaria en Salud), community adolescent and children committees, the Día Seniors Center, schools, the fire department, and community action boards.

Though the health sector has led the Healthy Versalles process, success would not be possible without the active participation and commitment of diverse sectors such as education, agriculture, highways, infrastructure and public services, as well as the local and international contributions of financial resources, training, and equipment. External support institutions include the Pan American Health Organization (PAHO), the Ministry of Health, the Departmental Health Secretariat, SENA CLEM, FES, Fundación Carvajal, the Consortium of Organizations for Community Development, SUNA-HISCA, the Colombian Institute of Family Welfare (ICBF).

Background

In 1989 four crucial events occurred with respect to the process of community participation and development of Versalles: the enactment of Ministry of Health Decree 1216, formation of the Primary Care Team at San Nicolás Hospital, realization of a mental health workshop, and general consensus on development goals among local stakeholders. Decree 1216, which regulates Community Participation Committees (CPCs) for monitoring the delivery of community-level health services, was the starting point of a new community organizational strategy in Versalles. Based on newly formed institutional consensus, implementation of the decree in Versalles was substantially different from that carried out elsewhere in the country.

Instead of limiting its scope to monitoring activities, the Community Participation Committee of Versalles started out with two important philosophical assumptions: first, that the concept of health not only includes treatment of patients, but also the prevention of the causes of ill health; and second, that the solutions for most local problems are in the hands of the community. These two points were used to create an opportunity for consensus building.
between institutions and members of the community, as well as provide a broader approach to CPC activities.

Simultaneously, San Nicolás Hospital managed to secure resources for forming a primary care team and preparing a participatory health survey. As a result, the need for additional services was identified in the areas of health, the environment, basic sanitation, education, culture, recreation, nutrition, housing, public services, and the local production of goods. The survey underlined the seriousness and the extent of these problems in Versalles and corroborated the previously defined need for combining efforts and resources.

Another important input regarding community participation was the Health Department’s presentation of several mental health workshops to promote values such as tolerance, solidarity, and respect within the community. Through their methodology and content, the workshops contributed toward strengthening community participation. In a municipality that has both high levels of violence and strong communal processes, the opportunity to reflect on the aforementioned values was important. Moreover, the use of a participatory methodology, whereby the community developed or reaffirmed its own knowledge had significant positive impact. In short, the mental health workshops created an important opportunity through which the community of Versalles and its institutions could discuss violence and decide jointly on values for peaceful coexistence.

The final part of the process stemmed from a strong collective concern about the problems in Versalles. At the beginning of 1989, Father Vélez, a parish priest at the time, used his office to initiate meetings among institutional stakeholders aimed at forging a different future for Versalles. Initially, the meetings organized by Father Vélez did not result in a solid working team, but as the year progressed, together with the aforementioned events, a group of institutional actors committed to Versalles began to emerge. These meetings produced three specific results: an expanded knowledge of activities at each institution, including strengths, weaknesses, and scope; an analysis regarding possible areas of coordination and collaboration between sectors; and a mutual vision and commitment to work for the well-being of Versalles. These actions made it possible to circumvent personal, institutional, and sectoral jealousies that are typically present in the development process. In June 1990, eighteen months after initiating the process, a solid working team and consensus on what needed to be done were in place.

**Difficulties**

*Lack of mayoral commitment.*

The lack of commitment on the part of some mayors is gradually waning as the healthy municipality process begins to show positive impacts on local quality of life and as the local politicians begin to see the community as an effective leader in transforming its own reality.

*Lack of economic resources*

Little by little the community of Versalles is working to overcome the lack of economic resources to implement development activities. An effective strategy has been sharing the responsibilities for projects through formal and informal alliances among business institutions, the public sector, and the community.

*Disparities in Health*
An important component of the development of a healthy Versalles is ensuring that all residents have access to basic health services. To this end, comprehensive care is provided at every stage of life, through programs and projects such as maternal and child care, care for preschool primary school children, adolescents, young adults, and care for older adults.

Each project is framed within the Municipal Health Plan and its programs. With respect to basic services, 95% of the population has access to water supply, sewage, and comprehensive solid waste management services.

A full 100% of the population has access to health promotion and disease prevention programs, and 100% of the population has access to essential drugs. At present, 80% of the low-income population of Versalles has access to health services through a subsidized system, while the remaining 20% access services through a contributory system. Vaccination coverage is 100%.

Project Financing
The project is being financed through strategic alliances between institutions and sectors, and by the current state revenue allocated to the municipality for the health, education, agriculture, and recreation and sports sectors. Moreover, the project is supported by NGO donations, community contributions in the form of human resources, and technical support given by organizations such as PAHO.

With regard to the sustainability of the Versalles development initiatives in terms other than financial, the community has been encouraging the participation and increased self-esteem of children and young people, with the goal of instilling a culture of participation. Accordingly, this prepares the youth to actively participate in the future development of their community with the goal of achieving a better quality of life.

Achievements
The most important achievements in the social area include community organization, institutionalization of intersectoral teamwork, peaceful coexistence, job creation, greater equity in gender relationships, and increased quality of life for the population.

The development of community organizations in Versalles grew at a rapid pace as a result of the CPC process. In 1991 the CPC had 14 groups, but today includes some 85 groups and more than 7,000 individuals. Beyond these figures, however, what is most important are the qualitative changes occurring in these important groups during recent years. Another important achievement is the institutionalization of intersectoral teamwork. At present, teams and intersectoral alliances are responsible for implementing almost all CPC programs. The community organization process has managed to promote peaceful coexistence in Versalles. The number of violent deaths has declined from 28 cases in 1993 to only 5 in 1999, and the level of non-fatal violence is also lower. Peaceful coexistence was never a specific objective of the process in Versalles. However, the construction of a viable social fabric has facilitated a different lifestyle.

“I believe that through this whole process peace has come to the municipality. And with peace, it has been possible to coordinate future development. The experience has been extremely rewarding, because all the leaders took it very seriously. For me, that’s what I most admired, because the leaders I worked with—and have always worked with—assumed
responsibility for everything with utter seriousness, and I believe that the decisions were not decided on the basis of that particular moment, but on future considerations such as what’s this about and where are we going with this?…I think that the experience has a great deal of validity and that’s the beauty of it—that it has great importance that can be evaluated in an historical context, producing some highly positive results…although there are some shortcomings, but really, the positive aspects are very important.” Rogelio Giraldo, community leader

In terms of employment, the CPC went from a volunteer-based process to an organization that generates employment possibilities to the point that today, the CPC is the third largest provider of jobs in the municipality.

Personal growth within the process of community organization has been remarkable. What is most visible and impressive, taking into account the local culture, is the change in relationships between women and men. As a result of organizing, training and strengthening groups of women, they now have great opportunities for community leadership. Total death rates, maternal and infant mortality, and perinatal morbidity have all decreased. Not a single child has been hospitalized during the last three years with severe malnutrition, whereas previously there had always been between one and four children with severe protein malnutrition (kwashior kor) or marasmus.

“For me this experience has been relevant because I had not seen any community group working for the community. Groups worked for their own interests, thinking only of their individual well-being. Now all we think about helping our neighbors; we think that working together is the way to get things done. We also see that other things have arisen from this perspective that make us think to ourselves, “this is really worthwhile,” and we have to continue down this path, because other organizations have come to visit us, we’ve had more support, we’ve had the freedom to make decisions, discuss them and request support, we’ve seen that we are taken into account…that for me has been a big foundation for community work.” Nancy Arcila, community leader

Eighty percent of the population has insurance coverage for health services, while immunization coverage is 95% and nontraditional vaccines have been successfully introduced, such as hepatitis, meningococcus and *Haemophilus Influenzae*.

The municipal economy has improved through income-generating projects such as floriculture, family businesses and microenterprises in agriculture. Accordingly, families have improved their incomes. We do not have problems of violence associated with common crime, although we cannot escape our current problems due to unemployment. However, we are exploring and studying projects that would reduce these problems in the municipality. Finally the local community has a system of functional community participation in place to propose ideas and share opinions and develop strategies.

“I believe that today, power is not in the hands of any particular person, but in the hands of all members of the Versalles community….Formerly, power was in the hands of those who held the belief that a man was more powerful with a weapon in his hands....Now that’s not the case. I can sit down and talk with the mayor, the doctor, with somebody that works at the municipal dump, with a campesino, with a girl that prepares meals in the home of a given family, with adolescents, with children, with grandparents. Consequently, since we all have the power to speak our minds and express what we want, to share what we feel, I believe that the power is not in the hands of any one person anymore, but in the hands of all.” Ligia Molina, community leader.
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Walterton And Elgin Community Homes

By Jonathan Rosenberg

Introduction

The Walterton and Elgin Estate is situated 4 kilometres Northwest of central London. It is owned by Walterton and Elgin Community Homes (WECH), a resident-controlled housing association. WECH arose out of a community campaign to prevent the local authority, Westminster Council, from redeveloping the area as private housing for sale at prices beyond the reach of local people.

Living conditions

In the early 1980s the Walterton Estate consisted of 350 19th Century houses lacking basic amenities, suffering from damp, water penetration and lack of heating. The houses were multi-occupied and many people shared toilets and bathrooms. At that stage the backlog of repairs was calculated to be in excess of £30 million. These poor living conditions contributed to asthma among young people and bronchitis and pneumonia in older people. The worry of not being able to afford repairs and uncertainty concerning the area’s future also caused a considerable amount of stress amongst residents, particularly the elderly.

The two tower blocks Hermes and Chantry Points were built on the Elgin Estate in the 1960s out of steel, concrete and fibre glass. The lifts regularly broke down, the rubbish chutes blocked, and residents suffered flooding and water penetration.

The worst problem was the wide range of asbestos products used as fire protection. Asbestos is a well known carcinogen, the use of which has been increasingly restricted in the developed world. However, due to the 10 to 40 year incubation period, the effects of exposure are not immediately apparent. In the United Kingdom, asbestos-related deaths are now running at record levels, second only to tobacco and ahead of deaths on the road.

A 1985 study stated that Hermes and Chantry had the greatest potential for asbestos fibre release amongst residential blocks in the United Kingdom. The amosite, or sprayed asbestos, presented the most serious danger: it had been applied to the steel columns and beams and was extremely friable. Disturbed by air currents and vibrations, asbestos fibres became airborne and entered the flats via gaps and the fan assisted heating system. Once asbestos fibres are airborne there is a high risk that they will be inhaled by residents and become lodged in the lining of their lungs.

It was estimated that solving all the problems in the tower blocks would cost £25 million. However, in the immediate term, the living conditions presented serious public health
problems. The landlord, Westminster Council, was in breach of environmental health laws on a large scale on both estates. But since the landlord was also the enforcing authority, nothing was done.

**Social and political context**

Some areas of Westminster, particularly in the South, are very wealthy, but much of the Northern part, where Walterton and Elgin is located, is very poor. Walterton and Elgin was very run down. The community, about one third immigrant Irish and West Indian, was getting older. People had low expectations. On the Walterton Estate most of them did not even know they were part of one landholding. Amongst the 1200 households, only a handful of people had been through higher education.

During the 1980s the Council severely reduced their expenditure on housing, social and cultural services. They also adopted a policy of selling off social rented stock into the private owner occupied sector.

**Resident campaign**

In 1985 residents discovered that the Council was about to engage with a property developer for a £72 million redevelopment of the Walterton Estate and sell off half of the Elgin Estate. A group of residents organised the attendance of 200 people at the council meeting to oppose the plans. So began the Walterton and Elgin campaign.

In the first three years, residents devoted their energies to resisting various schemes and publicising their cause. Attendance at the Council’s Housing Committee meetings was between 80 and 150. Once a month some 20 residents came together to discuss progress and make plans. They made contact with tenants under similar threat in other parts of the country and with organisations involved in housing and politics. Up to 40 residents at a time went on tours to visit the offices of developers and other companies involved to make the views of residents known. The campaign secured a large amount of media coverage in the specialist press, the local and regional media and the national newspapers and broadcast outlets. Aspects of the campaign entered national cultural life through the posters and images generated and references in popular TV drama.

**Taking control**

By 1988, one third of the Walterton estate was empty and Hermes and Chantry Points were heavily squatted and out of control. The future for the estates looked bleak. Unexpectedly, residents found what they needed in a law introduced by the Government. The ‘Tenants’ Choice’ provision in the 1988 Housing Act was intended to encourage the sale of council housing to private landlords. Prospective buyers had to seek approval from the Housing Corporation (a Government agency) and then win a ballot of the residents.
Having approached locally-based Paddington Churches Housing Association (PCHA) for advice, the residents formed Walterton and Elgin Community Homes as a potential landlord. PCHA agreed to act as WECH’s agent in running the estate, should WECH succeed. A resident-controlled committee was elected which included professionals in housing finance and management.

WECH signed up three quarters of the residents as members and, in March 1989, became the first landlord to be approved under the new law and the first to apply to take over council property.

*Winning the battle*

A political battle followed between the Council and WECH. Residents saw this as their last chance to save their homes. The Council realised they could lose ownership of the estates and have to hand over a large sum of money. The battle reached its height when the Council housed homeless families into the asbestos ridden tower blocks in a bid to block the take-over. WECH eventually got the families re-housed.

Protracted arguments occurred over the valuation of the properties. WECH asked for £60 million and the Council offered nothing. Eventually, the District Valuer ruled that the Council should pay WECH £22 million. A further £3.5 million was then obtained from the Housing Corporation in exchange for WECH housing 70 families nominated by Westminster.

Once it was known how much money could be obtained to repair the estates, the decision on whether WECH should take over went to a ballot of residents. WECH’s core support was substantial and most residents had long since decided to make the break with the Council. Nonetheless, WECH provided as much information as possible to residents to enable them to make an informed choice. The ballot was held in 1991. 82% of residents voted, 72% in favour and 28% against the take-over. The transfer of 921 homes proceeded in April 1992.

*Transformation of living conditions*

Following transfer of the properties, WECH embarked on a major programme of repairs and improvements. Resident participation was central and people made a series of choices about their new homes. Residents attended meetings at which the architect explained the plans and tenants made general choices affecting all the homes including external colours, window types and central heating systems. Residents were able to customise their own home, particularly in relation to bathrooms and kitchens, to suit their individual needs and wishes within a controlled budget.

On the Walterton Estate WECH had to devise a very complicated programme of moving people around. The main considerations were to free up whole houses for repair whilst
maintaining the often fragile social and familial ties between residents living in houses or near each other in the same street. This often meant accommodating requests to move to a particular address or floor.

WECH gutted the 19th Century houses and refitted them with full modern specifications, producing self-contained flats with central heating and double-glazing. This work eradicated the main sources of ill health: water penetration, fungus growth from damp and cold rooms, pest infestations, dangerous appliances and electric wiring.

Despite the extensive nature of the works, WECH’s conservation of the historic character of the 120-year-old houses within cost guidelines was praised by English Heritage, the Government body responsible for protecting historic buildings. The Chief Executive wrote; “The fact that none of your mid-late Victorian properties are either listed or within a conservation area makes the results all the more admirable”.

By the time WECH inherited the tower blocks they were completely empty of residents. After careful consideration, WECH concluded that the only sensible future for them was demolition. The future cost and headache of management and maintenance in addition to the very high refurbishment cost meant it was not viable for WECH to keep the blocks going. The asbestos was removed under controlled conditions and the blocks were dismantled piece by piece. Two of the fibre glass panels made it to the Science Museum – all that remains of the 1960s construction experiment Steel Frame 1.

In place of the 202 homes in the tower blocks, WECH built 55 low-rise homes in 2-4 storey brick blocks. The low-rise blocks were improved and the estate re-landscaped.

Community empowerment

The residents’ campaign involved large numbers of people of all ages and sections of the community. As the campaign progressed, an increasing proportion of residents became involved. Three quarters of residents are currently members of WECH, owning a £1 share which gives them the right to vote at the Annual General Meetings. Membership of the organisation does not affect tenancy rights. When WECH conducts major consultation exercises it communicates with all residents.

Two thirds of the WECH Board are residents. The remaining third are professionals in housing and related fields such as finance, law, personnel management, property development etc. The Board meets monthly to manage WECH’s affairs and holds away-days to plan future strategy and receive training from consultants. WECH holds meetings for residents to discuss issues which directly affect them. The Board are elected at the annual meeting. The dozen or so staff ensure that candidates are representative of different cultural and geographical elements in the population. All resident involvement is voluntary.
WECH runs a community centre which is in great demand from local faith and community groups. WECH has taken the lead in supporting other community groups to develop a wider network in the area. Its success has inspired the local community to set up a Development Trust. This Trust has just won more than £13 million from the Government and WECH is helping the community to build its capacity to regenerate a much wider area.

There is no better time or place to maximise accountability to residents than at the Annual General Meeting (AGM) of WECH, when the Board presents its annual report and audited accounts. Each year, WECH staff visit residents to encourage their attendance, making contact with up to two thirds of all households. They listen to people’s concerns and take up any problems.

WECH has steadily built up the turnout of residents at the AGM. In 1997 WECH broke all previous records by attracting 161 households to the meeting out of a total of 501 – over 32% of all residents.

Sustaining resident control into the future

WECH is self-supporting from its rents and has a business plan which will see the organisation debt free in 25 years. WECH operates an equal opportunities policy.

WECH distributes its annual report, regular newsletter and periodic write-ups of the project to residents and more widely. Residents are periodically surveyed to assess involvement and satisfaction levels.

In 1996 residents voted by ballot for WECH to manage their homes and finances without an agent. WECH now effectively stands alone as an organisation, although it still retains PCHA as its development agent handling major refurbishment work.

Health study shows low incidence of disease and stress related symptoms

In 1996, Professor Peter Ambrose from the University of Sussex undertook a health and housing study on two estates in the East End of London. To compare his findings, he carried out the same study on a sample of tenants on the Walterton Estate who had moved to the new homes.

The study showed that residents on Walterton displayed a much lower incidence of disease, particularly stress-related symptoms, resulting in lower health costs. The difference in long term medical conditions, such as diabetes and heart disease, could not be attributable to

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5 Original report by Professor Ambrose "Housing and health on the Limehouse Fields and Ocean Estates in Stepney". Centre for Urban and Regional Research University of Sussex, November 1996.
housing conditions. But of the other ill health episodes (overwhelmingly coughs and colds, aches and pains, respiratory tract, digestive and mental health problems), it was the collective view of the respondents that the housing and environmental conditions were important explanatory factors in up to 75% of cases.

Professor Ambrose commented: “Many residents had been living in the area when it was in an extremely poor and overcrowded state or had been housed in equally health-damaging conditions in the notorious asbestos-ridden tower blocks. Close attention was paid to the quality of the conversions. The overall result has produced warm, dry, safe accommodation. Most crucially, there has been continuous and active involvement by the residents and this has obviated a very important source of stress. The key issue is involvement and thus empowerment.”

The researchers noted that one resident stressed the effects on social cohesion. The study concluded that “the low incidence of physical and mental ill health is evidently saving considerable National Health Service expenditure”.

Statements by residents - health

Seamus Clark, 71, used to work as a labourer. “My old flat made me ill. It was terrible - disgusting. It was very draughty. One time in the bathroom the ceiling came in. It hit me on the head and cracked the bath. I couldn’t use it after that and the Council never repaired it. My new home is wonderful and comfortable. I love going to the annual meetings. People say their piece and we get to talk to each other. It gives me a feeling of content and a sense of balance.”

Samantha is a single parent with two children. She had housing and relationship problems before she moved to a new WECH home. “I feel a lot more settled. Before, I had lots of stress. Kids can pick up on your emotions. My son had very bad eczema. Now I feel positive. My son’s skin problems are clearing up. I can try and sort myself out as I want to.”

Gillian Clarke is married with two children. “We saw no way out of our old flat unless we had money. It was damp, cold and miserable and I was on anti-depressants. Since we moved into our new flat our lives have been transformed with truly positive effects. […] We’ve been able to move on in our lives and do other things. There is no way I could even have thought of trying to set up my own business if I had still been living in my old flat.”

Statements by residents – empowerment

Josie Matthews was an invoice clerk. She contracted multiple sclerosis in 1983. “I’ll always remain 100% loyal to the residents’ group. It saved our sanity and gave us hope. We were nothing before. Now we feel like solid citizens and can hold our heads up. I’ve made some
wonderful friends. We are the community because we have that one thing in common - WECH!”

Rhoda Rhemington is an Elgin Estate resident of 30 years. “WECH spent a lot of money on the community centre and it is a lovely place to meet. I run the club. We meet weekly and organise raffles and outings. I was 83 this week. Keeping me active is keeping me going!”

WECH helped Sam Antoine to use one of its empty shops to open up his own restaurant. “By WECH giving me this opportunity I have been able to provide five other people in the neighbourhood with jobs. People are concerned about their health. I try not to use butter in my sauces. I want to give back to the community by teaching local people how to cook.”

Statements by professionals who were involved

Dr Anne Power, MBE, is a Reader in Social Policy at the London School of Economics and a member of the Housing Minister’s Sounding Board. She has championed the cause of tenant involvement and control and travelled throughout Europe examining run-down estates. “The efforts of ordinary people to gain control of their lives are the watershed in making cities and communities work. This community endeavour is a unique bottom-up model of change. As the Government seeks holistic and sustainable solutions to the challenges of urban decline and alienation, it can look to Walterton and Elgin’s residents as flag bearers of the new approach.”

Architect Hilary Chambers’ involvement goes back 15 years. “When I first surveyed Walterton I was appalled by the scale of the bad conditions. I have dealt with every resident who was re-housed. There is no doubt that people’s involvement has been a major incentive in looking after their property. They are paying rent to their own association and they feel they own it.”

Chris Holmes is the Director of Shelter, the national campaign for the homeless and the UNITED KINGDOM’s biggest housing charity. “WECH was all about the fundamental importance of retaining and increasing decent quality, secure, affordable housing for people in the communities. Walterton and Elgin stands out as one of the most remarkable and successful campaigns of the last fifteen years.”

Jill Selbourne has been active in the community for 25 years and played a key role in the campaign. “WECH has been a force for change. WECH now has a huge asset base and speaks with money and power. People can see that taking action gets results. They think differently now.”

Margaret Beckett is a Member of Parliament and now occupies a senior position in the current Government. She visited the Walterton and Elgin Estate in 1996 and said; “WECH
has been a shining example to others. You have given hope to all those struggling against overwhelming odds and demonstrated that it’s possible for the ‘little people’ to succeed.”

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Towards a Global Movement for Active Ageing

Background

The number of people reaching older ages is increasing globally. Today there are approximately 590 million people over the age of 60, but in just 25 years that number will double to 1.2 billion. In recent decades, life expectancy has increased everywhere, especially in developing countries, where about 60% of all older persons aged 60 and over currently live. Sharp falls in birth rates in recent years have also contributed to the rapid increase in the proportion of older people in the total population.

The fact that people are living longer is one of mankind’s greatest achievements as we enter the 21st century. The majority of older people are far from being frail and continue to be a resource to their families and communities. However, unless vigorous measures are taken to prevent non-communicable diseases commonly associated with the ageing process and to promote health at older ages, the ageing of the population will place new and increased demands on health care systems. By 2020, over 70% of the global burden of disease will be caused by non-communicable diseases, including mental health disorders and injuries. For that reason, policies aimed at ensuring that people maintain the highest possible level of physical, social and mental functioning as they age are of critical importance. Health promotion and primary prevention of disease must go hand in hand with the development of policies that promote social inclusion, provide economic protection, and eliminate social inequities. Together, such policies and strategies will promote health and an active life for older people. This in turn is essential for ensuring their continued contribution to the family, the community and the economy.

The Challenge: Building a Global Movement for Active Ageing

The former Ageing and Health Programme of WHO, now an integral part of the Health Promotion and Non-Communicable Disease Prevention and Surveillance Department (WHO/HPS), has launched new and innovative activities that promote a comprehensive approach to healthy and active ageing through a new network, entitled the Global Movement for Active Ageing. The objectives of the Global Movement are to:

- Identify and advocate for comprehensive policy approaches that aim to maintain the highest level of functional capacity and quality of life at older ages
- Identify models of best practice that promote health and well-being at older ages
- Demonstrate and raise awareness about the causes and effects of risky behaviours and lifestyles throughout the life course and their impact on health at older ages
- Build new partnerships (among various levels of government, civil society and the research community) for effective advocacy for healthy and active ageing
Provide information and new directions for the development of sound policies and project development in the area of healthy and active ageing.

To celebrate the UN International Year of Older Persons and to promote the Global Movement for Active Ageing, WHO launched a campaign on World Health Day 1999 with the slogan "Active Ageing makes the difference". Utilising the definition of health as laid down in the WHO Constitution, Active Ageing refers to the process of seizing and maximising opportunities for mental, physical and social well-being throughout the entire life course to increase healthy life expectancy and quality of life at older ages. Such a life course approach to Active Ageing goes far beyond “age-specific” i.e., limited to the category of those of certain age (over 60 or 65) commonly referred to as “the elderly”.

A thorough life course perspective on Active Ageing requires the development of a new conceptual approach and framework for action as illustrated in Figure 1 below.

**Figure 1.** A theoretical model on how to maintain the highest possible level of functional capacity at older ages.

The functional capacity of most of our biological systems (e.g. muscle strength, cardiovascular performance, respiratory capacity, etc.) increases during the first years of life, reaches its peak during early adulthood and declines thereafter. However, the slope of decline throughout the life course is largely determined by external factors. It can be accelerated by life style factors, such as smoking, poor nutrition, lack of physical activity, as well external and environmental factors, such as pollution or poverty. While the individual may have little
or no influence over many external or environmental factors, these can be influenced through targeted policies and interventions. Based on this concept, the Global Movement for Active Ageing will develop advocacy strategies to raise awareness and disseminate information about the life course approach to Active Ageing.

**Developing advocacy events for Active Ageing**

The vast majority of people in any given country, as they age, continue to live within their local communities. Grass-roots and community-based activities are therefore a natural focus to promote healthy and active ageing. Within the context of simple health-promoting activities at the community level, walking is not only an excellent form of physical exercise but also enhances social integration as it is a good way to meet people or enjoy the companionship of friends and family. Moreover, the ability to walk is a key factor in maintaining independence at older ages as loss of walking ability may result in confinement, isolation and depression. The importance of maintaining the capacity to walk as a predictor of disability is illustrated in Figure 2.

![New disability](image)

**Figure 2.** Customary walking speed as a predictor of new disability.
The proportions of those who developed new disability over four years in groups based on quartiles of customary walking speed in 1122 subjects with no disability at baseline (Guralnik et al. 1995, New Engl J Med 332:556-61).

Building on this approach, the idea of a highly visible advocacy event, the “Global Embrace”, was conceived. Building on the World Health Day slogan of “Active Ageing makes the difference”, the Global Embrace, a walk event and celebration that encircled the globe on 2 October 1999 (the International Year of Older Persons), celebrated healthy and active ageing in a visible, creative way that was attractive to both older and younger people. The event
provided the opportunity for health care workers, activists, and policy-makers to initiate a dialogue on healthy ageing with the general population. It created partnerships among governmental authorities and non-governmental organisations and stimulated voluntary action by and on behalf of older people. Ultimately, this collective walk event delivered a strong health message that found substantial resonance in the media, thus reaching a much larger public.

**The Global Embrace for Active Ageing 1999**

The concept of the walk event was first put into practice in 1997 when Rio de Janeiro and Geneva held "dress rehearsals" for the walk event. Using a variety of channels, WHO subsequently sent out information to cities and communities both large and small in North and South, inviting them to organise similar walk events for the "Global Embrace" in 1999. WHO was able to run the project through contacts at all levels from government ministries to small local NGOs. The guidelines “How to organise a walk event” were disseminated to all participants, including detailed practical advice on setting up an organising committee, choosing date, time, duration, length, registration process, promotion, media, sponsorships, budget advice and evaluation. Participants also received posters, stickers and a logo of the walks from WHO. The Internet site and a generic e-mail address was set up in the from the beginning for faster and easier communication. In addition, just before the event, WHO provided downloadable radio interviews on the Internet and video news releases on Active Ageing.

As the idea spread around the world, a multitude of 'local organisers' confirmed their participation. Each walk was eventually implemented locally with the help of volunteers and with funding from local sources. The preferred method of communication was through electronic networking and by sending updates and information by mail. Local organisers, were urged to look for financial support from local government, NGOs and the private sector.

Everybody, both young and old, was encouraged to participate in the walk. There was no competitive aspect to the event. It was emphasised that the concept of active ageing relates to all people, regardless of where they live, their economic status, or whether they already experienced some functional impairments. In summary, the event stressed the fact that we are all ageing! The event was open and accessible to everyone. For example, most walks required no prior registration and the organisers were asked to ensure that the walk and celebrations were accessible to people in wheelchairs. The walk aimed to reduce inequalities in health and promote the quality of life at older ages.

It is estimated that over 1 million people in 96 countries participated in about 3,000 walks all over the globe on 2 October 1999. They walked on every continent, in cities and villages, along beaches and country roads, in parks and shopping malls. Families, friends as well as community organisers and representatives of local authorities and civil society organisations all joined in.
A brief sampling of the activities includes:

- Following the rising sun, the world-wide walk event started in the Pacific (Fiji, New Zealand, and Papua New Guinea) and continued to Australia and Japan where people participated in walks in 80 different locations.

- Continuing across India, walkers were joined by primary care physicians and medical students stressing the need to improve access to primary health care. In the Middle East (Bahrain, Sultanate of Oman) both men and women walked together and participated in health promotion fairs.

- In Africa, countries from East to West participated: Tanzania, Mozambique, Zimbabwe, Chad, Nigeria, Ghana, Guinea-Bissau, Tunisia. Walks served as a reminder of the important roles older people continue to play in traditional societies while also emphasising the many needs of older persons in resource-poor areas. Community organisers arranged for free examinations at eye and dental clinics as well as screening for hypertension and diabetes. Thanks to funding from local community clubs, free pairs of eyeglasses were made available to older persons. Preventive screening activities for older people, begun on the occasion of the Global Embrace, continue regularly.

- In Europe, many events took place involving creative artists, exercise enthusiasts, and health promotion specialists as well as local government. In Finland for example, a Walking Festival focused on different ways in which one can walk: walking on a tightrope, on one’s hands or power walking with ski-poles. Functional capacity was measured and free physical examinations offered to all participants.

- Several thousand different walk events followed by celebrations took place throughout North and South America. In Brazil alone, about 1600 walks and celebrations took place and in Mexico about 400 municipalities participated in all parts of the country. In one single event in Bogotá, Colombia, about 10 000 participants celebrated the walk in the main park of the city. In New York City, the slogan of the walk through Central Park, “Ageing Out Loud”, asserted that ageing is something to be proud of.

It is significant to note that the message of active ageing was well received by organisations and individuals in developed as well as in developing countries. Organisers in developing countries in particular responded with great enthusiasm as little attention had previously been given to health promotion activities in the context of ageing. WHO provided background documentation for the organisers to mount their own media campaign and the media served as a successful multiplier for the message of how to achieve a healthy old age.

Among the organisers at the national level were: Ministries, Committees of the International Year of Older Persons, international NGOs and the academic sector. At the local level,
municipal authorities, institutions serving older people and organisations of older people, as well as the private sector worked together. Through these partnerships, capacity was built to raise awareness and to address the needs and concerns of older people. As many of the older people themselves participated in the organisation of the event, they acquired new organisational and social skills and their self-esteem and awareness of what contributes to Active Ageing were enhanced.

Yet another outcome of the Global Embrace was the establishment of a broad-based coalition of international NGOs (including HelpAge International, Rotary International, International Sports for All Association, International Council of Nurses, International Osteoporosis Foundation, International Federation of Medical Students' Associations and others) with global outreach and the capability to disseminate active ageing messages to all of their national affiliates.

**Evaluation of the Global Embrace**

Results of a survey evaluation of the Global Embrace were promising. Almost 90% of the responding organisers were satisfied or very satisfied with the outcome of their own local event. Around half of the events had as many participants as expected, while one fifth had more than expected. The media strategy for the Global Embrace was very successful: over 80% of the walks had local media coverage through radio and TV, both local and national newspapers and on the Internet. The broad media coverage also contributed to the overall satisfaction of the organisers. It reflected the impact they made not just locally, but also for a broader audience. Nine out of ten organisations which responded to the survey incorporated active ageing activities within the scope of their organisation or plan to include them in future events. The most usual type of activities were exercise groups, social events, workshops or seminars.

The quotes received through the interactive Web site immediately after the walks included cheerful messages:

- "The Global Embrace 1999 was an event Trivandrum will never forget." Jothydev K., Trivandrum, India;
- "Let us take steps forward into the next century, towards a happy and healthy ageing society" 1999 Global Embrace participants, Nagano, Japan;
- "It was very stormy and rainy in the Netherlands but over 10,000 walkers participated in the Global Embrace" Dutch Committee International Year of Older Persons, Netherlands;
- "We inspired people of all ages" Heini Parkkunen, Turku, Finland;
- "We stretched, we walked and we talked. All are eager to repeat the event in 2000" Barbara Forbes & Jacqueline Goffaux, Nashville, USA;
- "Older people are a human treasure and a precious capital for our countries and our cultures" Ministry of Health, Chad
Tens of thousands of people participated in some locations with media appeal and high visibility. Local and national politicians and celebrities walked in many locations; the Director General of WHO in Geneva, Olympic Medallists and Mayors in many other cities. The Director General of WHO addressed a message of Active Ageing to participants around the world and His Royal Highness The Prince of Wales released a video clip to all walkers in the United Kingdom. Regardless of levels of development or access to services and care, all events conveyed the spirit that it was beneficial for the participants to be part of a global community of old and young people walking together and celebrating the fact that people are getting older everywhere.

However, organisers also encountered obstacles, with funding topping the list. Other obstacles included: difficulties with the distribution of information, lack of interest or problems with human resources/volunteers. In some instances, practical reasons, such as bad weather, had a negative impact on attendance. A few organisers felt that big events were too demanding to organise with the limited local level resources. Despite the obstacles faced, the vast majority of all participants are interested in organising another walk event this year. As a result, WHO/HPS plans to make the walk an annual event. In 2000, the Global Embrace will take place on 1 October 2000 to coincide once again with the International Day of Older Persons.

Almost all participating organisations chose to remain part of the database of the "Global Movement for Active Ageing". Most of them are willing to contribute to the new network and database in different ways, such as providing information on policies and programmes, doing research and linking with other organisations and building partnerships with other sectors.

Continuing the successful collaboration in 1999, WHO/HPS invited several Global Embrace contact persons at the country level to join a meeting in March 2000, to brainstorm and plan the activities for this year’s Global Embrace event. Contact persons will be an essential link between WHO and the grass-root level for better coordination of the activities and also to support walk event organisers at the regional level. Furthermore, through coordination at the national level, WHO/HPS will be able to ensure an improved evaluation process of the walk outcomes.

**The way forward and lessons learned**

The Global Embrace walk events will continue to be a major advocacy and outreach activity of the Global Movement for Active Ageing. It is an effective way for WHO to:

- Build partnerships at the local level for better health across the life-span, especially at older ages;
- Disseminate Active Ageing messages through media strategies;
• Raise awareness about the overall benefits of exercise and an active life style throughout the life-span;
• Build global awareness about the benefits of Active Ageing for national governments;
• Create global partnerships among international NGOs and other partners.

At the same time, the Global Movement for Active Ageing will include a sharper focus on policy interventions, health promotion, prevention strategies and their measurable outcomes to provide more comprehensive policy approaches for an ageing planet.

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**Equity Gauge—A Tool for Monitoring Equity in Health and Health Care in South Africa**  
*By Antoinette Ntuli*

**Introduction**

The Equity Gauge is a national project established to help South Africans know if their health is improving. It also helps to measure progress toward equity in health care provision. The project is a partnership between South African Legislators and the Health Systems Trust, a non-governmental organisation established in 1992 to support the transformation of the health system. The project is funded by the Henry J. Kaiser Family Foundation (USA) and the Rockefeller Foundation.

**Background**

South Africa is one of the most inequitable societies in the world. There are huge differences between the rich and the poor; a first world tertiary hospital stands side-by-side with clinics that lack basic infrastructure, running water and a regular supply of drugs.

Since 1994 there has been some progress in provision of basic determinants of health to the most needy sections of society (access to water and electricity has increased, and provision of free primary health care to all, as well as free care at all levels for children under six has been introduced). However, the picture of inequity is still bleak. Whilst the homelands no longer exist in any formal sense, their legacy remains, impacting harshly upon the lives of those who live in these areas. Whether equity in health and health care is measured by health status, by province, by race, or according to the urban/rural divide, it is almost exclusively poor, African people, whose lives are most impoverished by inequity in South Africa.

South Africa does however have one of the most progressive constitutions of any country in the world. The South African government seeks to promote equity. To that end, the Constitution and policies of government commit the country to a national goal of “equity”. The Reconstruction and Development Programme, which is still regarded as the blueprint for social re-organisation in South Africa, highlighted equity as one of the fundamental principles upon which the new unified health system should be based. The White Paper on Transformation of the Health System released by the Department of Health further expanded on this principle with a number of equity-based core objectives.

National and provincial legislators have a dual function that couples the development and ratification of policy with an oversight function to monitor policy implementation. It is generally acknowledged in South Africa that many of the necessary policies are now in place to ensure the promotion of equity, and that attention needs to be focussed on implementation. However, the legislative arm of government has very little access to technical support to enable it to undertake its oversight function. The National Assembly Health Portfolio Committee has one researcher;
none of the nine provincial health committees have any formal research support.

**Project Development**

The Equity Gauge Project was developed by the Health Systems Trust (HST), a non-governmental organisation established to support transformation of the health service, in conjunction with national and provincial parliamentarians. During 1998, consultations were held with the national Health and Finance Portfolio Committees. These meetings highlighted legislators’ commitment to monitoring equity as well as their concern as to whether they had the capacity to do so. Subsequently, a national meeting brought together legislators and technical experts and laid the groundwork for the project. The meeting identified indicators about which legislators required information, namely: resource allocation and the budgeting process; primary health care provision; promotion of inter-sectoral collaboration and interdepartmental cooperation in health care provision; and promotion of healthy environments. The meeting also enabled legislators to articulate their need for support in using information.

A smaller meeting held after this fleshed out project priorities and a project outline was developed. The project now represents a formal partnership between the legislators and the HST and the chairperson of the Health Portfolio committee chairs the project steering committee.

**Aims and Objectives**

The aim of the “Equity Gauge” is to establish a set of benchmarks by which progress towards equity in health and health care can be monitored over time, and to facilitate its use and application. Specifically, the Gauge seeks to achieve the following objectives:

- To define, measure and monitor a core set of indicators for assessing progress towards equity in health and health care provision;
- To facilitate the use of information provided in the “Equity Gauge” by national and provincial legislators, and local government representatives, to monitor equity;
- To instil the notion of monitoring equity as a key strategy for the promotion of equity among the media and the general population of South Africa;
- To support legislators with information on how the health system functions and the processes followed within government for budgeting and resource allocation;
- A subsidiary aim of the Gauge is to strengthen the accessibility and quality of health data.

**Equity Gauge Contents**

Key indicators for the determinants of health, health status, resource allocation (financial, human, drugs) and quality of health care provision are included in the Gauge. Wherever adequate information exists, indicators are measured in such a way that they can be used to monitor differences and trends between the public/private sector divide, geographical areas (provinces and districts and rural/urban areas), race, gender and disability.

**Sources of Information**

The Equity Gauge draws from both primary and secondary data sources. Wherever relevant, up-to-date information is available, this is used. Research is commissioned in areas where no reliable or up-to-date information exists. For example, following the introduction of the District Health System, little information was available regarding infrastructure and quality of
care in public sector clinics. A health facilities survey covering 10% percent of the country’s clinics and a large proportion of district hospitals was commissioned by HST to address this gap.

Secondary sources include: census data (using 1996 census data as a baseline); government information systems, including birth and death registers, budgets and police reports; national surveys; and records and reports from non-governmental organisations and professional associations.

**Facilitating the Use of the Equity Gauge**

A number of strategies have been identified to encourage effective use of information contained in the equity gauge:

- In general, legislators, particularly those within provinces, have few resources for research. To strengthen information and research support to provincial health committees, two information officers help identify specific information and research needs of legislators and develop appropriate corrective measures that will enable legislators to deal with information provided to them. Careful attention is given to ensuring that all information produced for legislators is presented in an accessible and inviting format. Material is pre-tested before it is published to ensure its relevance and comprehensibility.
- Support is provided to legislators to help them use information from the Equity Gauge and other relevant research. This support comprises workshops and seminars as well as written material on issues of concern to legislators.
- In order to increase legislators’ understanding and knowledge of the reality of health care at a District level, visits are arranged for legislators to go to districts to gain a first hand impression of implementation at the primary care level.
- Research results are publicised to encourage debate about the issues and promote action where inequity persists. The Equity Gauge works with journalists from TV, radio and newspapers.

**Activities of the Project to Date**

The whole-hearted involvement on the part of national and provincial legislators indicates that the project has identified a real need and is contributing to meeting that need. Although a formal evaluation of the project is only due to commence at the beginning of 2000 the range of activities undertaken by the project demonstrate that some objectives are already being met.

**Project Development**

During the development phase of the project there was active participation on the part of members of key national and provincial legislative committees. This enabled the project to prioritise areas about which legislators needed more information and get clear guidance as to the areas in which legislators required support.

**Project Management**

The chairpersons of four key national committees and three of the nine provincial health committees are represented on the project steering committee. A technical advisory group supports the project in its work of measuring and monitoring equity.
Project Launch
A formal launch of the project took place in January 1999 when the findings from two HST publications focussing on Equity in Health and Health Care, the 1998 South African Health Review and the Facilities Survey, were published. There was coverage of the launch in eight newspapers, six regional radio stations and an item on the main news bulletin of the national radio and TV stations.

The June 1999 elections meant that interaction with legislators was constrained from the period between February and early September 1999.

Building the relationship between the project and legislative committees
Since September 1999, presentations about the project were made to two national committees and most of the nine provincial committees. The purpose of these visits was to meet with the committees, introduce the project to them and explore areas in which the project could be of assistance.

Workshops
During the developmental phase of the project, an issue that was continually highlighted by legislators was their need for support to enable them to participate effectively in the budget process. One of the first tasks of the project was to develop the curriculum and materials for a workshop to meet this need. To date workshops on the budget process have been organised and run for five of the provincial committees.

Site Visits
A key strategy of the project in empowering legislators to understand the realities of service provision is arranging visits for legislators to health districts. Two site visits have already taken place in which national and provincial legislators have been exposed to the impact of inequity on health care provision. Visits are accompanied by a workshop in which legislators have the opportunity to explore possible solutions to problems encountered as well as address policy implications of the findings from the visit. Feedback from participants has indicated that they have made use of the information gleaned on site visits during Parliamentary and Committee discussions.

General Support
The National Portfolio Committee on Health holds hearings for the national and provincial departments of health. The Equity Gauge project assisted in these hearings by working with the committee to develop questions to put to the department of health. This was to ensure that issues of equity are prioritised. The committee and the project are writing the report of the hearings jointly. At provincial level, the project is assisting committees by reviewing provincial department of health budgets and making submissions to the hearings.

Project Materials
The Equity Gauge and a booklet on the Budget Process have been developed and were launched at the beginning of December 1999. The launch was attended by the chairpersons of three national and seven provincial committees, two mayors along with committees members and media representatives. The 1999 South African Health Review, an annual publication of the HST with equity as one of its prime foci, was launched in Parliament in February this year. Chapters of the Review of particular import for legislators were summarised in short
“Briefing Summaries”. The Deputy Minister of Finance, committee chairs, and representatives from academic institutions and the media attended the launch, which was covered on national and local TV and radio and in many newspapers.

Project Evaluation

A formative evaluation is planned to commence in 2000. The purpose of the evaluation is threefold: firstly, to record the activities and impact of the project; secondly, to ensure that lessons learnt are documented; and finally to highlight possible ways forward for the project.

The evaluation will aim to document:

- How legislators use the materials developed by the project including the equity gauge itself; and a booklet on the budget process as well as other material which may subsequently be developed;
- The impact of interventions made by legislators on the quality and equity of health care delivery;
- Any progress towards equity with regard to the determinants of health, and what might be attributed to the project;
- Problems experienced by legislators in attempting to fulfill their oversight function;
- Participation by, and role of media in the project;
- The design, management and implementation of the project.

An interim report will be available in 2001.

Reflections on the Project to Date

Legislators are extremely busy. Many provincial legislators sit on more than one committee, and most committees cover more than one area. For example, most provincial standing committees on health also have welfare as part of their remit. In addition, the legislative agenda has been extremely full until recently. These factors limit the time available to legislators to participate in training and site visits.

South Africa still has limited data available with which to measure and monitor equity. For example the first ever South African demographic health survey was undertaken in 1998. Much of the data that is available does not enable analysis of equity according to different racial groups or according to gender. While some data allows for comparisons between rural and urban areas, rarely is there information to analyse the situation in peri-urban areas. Additionally the slow process of establishing health districts is inhibiting the development of effective monitoring of resources at the district level.

A major challenge for the project is to develop tools and indicators for monitoring equity in the context of the HIV/AIDS epidemic in South Africa. Many health status indicators will worsen over the next few years. For example, life expectancy dropped from 65 to 55 years between 1995 and 1999. The project is participating in discussions to seek reliable indicators that are sensitive to improvements in equity in this environment.

The underlying aim of the project is to provide legislators with information that can assist them in policy formulation. It is not yet clear as to whether legislators will be able to
influence the executive branch of government should information from the equity gauge point to the need for policy in conflict with that being pursued by the executive.

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Integration of the Consensus-Action Group: A Network of Academic and Social Institutions For Community Health Promotion and Education

FUNSALUD–SMITHKLINE BEECHAM ALLIANCE
MEXICO

By Dr. Mariano García-Viveros

Introduction

In October 1996, the Mexican Foundation for Health (Fundación Mexicana para la Salud—FUNSALUD) and company SmithKline Beecham (SB) assembled a group of health education specialists in Mexico City. The purpose of the meeting was to analyze various Latin American experiences and identify the most effective health promotion strategies and activities for the population. Investigators, educators, and operational personnel from Argentina, Brazil, Colombia, Costa Rica, Mexico, Puerto Rico, Peru, and Uruguay, as well as representatives of the Pan American Health Organization/World Health Organization (PAHO/WHO), FUNSALUD, and SB participated in the meeting, which produced a series of provisional drafts for addressing health education priorities in Latin America. The recommendations provided by this group of specialists formed the basis for a project to strengthen community capacity, as well as that of various academic, governmental, and nongovernmental institutions, with a view to promoting health in areas where people live, study, work, and play.

As a result of this meeting, the Consensus-Action Group was created to satisfy the need for a network of investigators and educators to provide technical support to those working in health promotion, thus closing the gap between theory and practice. This network includes a variety of institutions with established infrastructure and significant potential for mobilizing strategic sectors to strengthen community capacity in health promotion.

The Consensus-Action Group was conceived within the institutional framework of FUNSALUD, with economic support from SB. Group members consisted of experts in different areas of health promotion and education. In addition to reaching agreements in these areas, members promoted and implemented specific activities targeting the different processes of educational action and health promotion strategies. The Consensus-Action Group helped to incorporate up-to-date knowledge, using innovative means and methodologies to support health education activities and to form a support, monitoring, and strengthening network of experiences carried out by individuals, groups, and institutions.

Activities implemented

Mobilization of Actors

FUNSALUD’s close ties with key public health research groups in Mexico and Latin America, has helped the organization to motivate and bring these groups on board in the process. With respect to its technical and scientific support role for operational groups, FUNSALUD promoted the creation of groups of specialists to define and harmonize criteria on various priority health issues. The project was successful in mobilizing important academic and social sectors around projects presented by various community groups. Invited specialists advised the working groups on topics that were selected by the communities.
These included: accidents, violence, gastrointestinal diseases, sexually transmitted and noncommunicable disease, obesity, dementia, depressive syndromes, and rheumatic diseases.

Information on several topics was prepared into printed as educational support materials for allied health professionals such as nurses, social workers, and health promoters, as well as for teachers, patients, and family members. The impact of these materials was evaluated and suggestions for their improvement incorporated in subsequent publications.

**Consensus-Action Group and Community Health Education**

One of the most successful Consensus-Action Group strategies involved a series of weekly 2-hour teleconferences through the National Autonomous University of Mexico (UNAM) that facilitated the exchange of one or two experiences between various working groups throughout the country. Investigators, educators, and operational personnel participated in these discussions, helping to improve implementation of health promotion strategies and activities in health education. Accordingly, development of experiences was promoted and supported and the results were disseminated throughout our country. These kinds of activities continue to be carried out in order to promote interinstitutional and interdisciplinary actions, thus optimizing economic resources and improving the impacts of educational activities in diverse population groups.

The Consensus-Action Group advises decision-makers in public and private institutions on the results of past experiences, contributes technical guidelines, and suggests the best health promotion practices and educational programs to implement with communities. Moreover, it promotes joint participation projects to identify, together with the population, issues that need to be addressed, as well as strategies to meet them. Others functions of the Consensus-Action Group include:

- To propose and recommend innovative projects, ways in which companies and academic institutions can participate, and strategies for evaluating the processes and outcomes of activities linked with health promotion and education for groups of the population with social, physical, emotional, and labor disadvantages;

- To support the development of effective and appropriate methodologies for improving health education, and to make recommendations on training and development programs needed for personnel who carry out activities linked to health promotion and education, especially in schools, assistance programs, and in the community;

- To promote community involvement at each step of the process, integrating professionals and community representatives in the identification of problems, in decision-making with regard to activities, and in the assessment of the outcomes; and

- To serve as an advisory body of FUNSALUD, as well as to public and private organizations upon request, with respect to health education.

Projects are selected in the interest of sharing experiences, developing innovative strategies, conducting research on health education, and identifying effective strategies for community participation. The Consensus-Action Group only considers projects that can be reproduced in multiple geographic areas and which contain components for evaluating the processes and outcomes. Members of the Consensus-Action Group are also able to propose projects. Moreover, projects from other individuals and institutions are also encouraged. The
Consensus-Action Group informs the Coordinating Committee as to which projects are authorized to receive support and the corresponding amounts.

In 1996, ten projects were funded, while currently 35 projects are supported. Several of the initial projects in the states of Oaxaca, Veracruz, and Jalisco are being expanded in order to benefit new communities and populations. Through the use of various educational strategies and communications media, it was possible to extend training in the conceptual and methodological aspects of health promotion and education to approximately 30 working groups in 18 states throughout the country. The Consensus-Action Group network continues to expand opportunities for the exchange of knowledge and experiences between investigators, technicians, and operational personnel in the communities.

Thanks to the benefits of association coordinated under the auspices of FUNSALUD, economic support from SB, as well as the human, educational, technical, and governmental resources of their members, the Consensus-Action Group has been able to attract more than 30 distinguished members from different disciplines, coordinated in specific health promotion and education projects.

Both short- and medium-term activities were planned, including:

a) Strengthening of the Consensus-Action Group for health promotion and education developed during the first year of the project, which consisted of strengthening activities, including academic mobilization;

b) Collection of materials on priority health issues, as well as health promotion and education, incorporating these materials into different institutions and disciplines;

c) Preparation of model documents (i.e. research, planning, methodology of education process, evaluation, training, production, application of educational support materials, training and communications strategies) with different population groups in various areas of the country, development of innovative educational materials, and projects presented by various community organizations; and

d) Dissemination of scientific and educational materials (i.e. for teachers, community promoters, youth and others) promoting development of health promotion and education in accordance with recommendations of the Consensus-Action Group.

**Interinstitutional Interaction, Interdisciplinary and Community Participation**

6 These members are part of the National Autonomous University of Mexico (School of Medicine, School of Veterinary Medicine, School of Dentistry, TV-UNAM, outreach offices on science and academic computation, open university and distance education), Universidad de Guadalajara (Institute of Economic and Regional Studies, Interdisciplinary Gender Studies Program), Universidad de Colima (Educational Support Materials Production Center), Universidad Veracruzana, Ministry of Health (General Office on Health Promotion), Ministry of Public Education, National Adult Education Institute, Mexican Social Security Institute (Health Promotion Division, Medical Supplies Office), IMSS-Solidarity Program, Ministry of Health of the State of Oaxaca, National Polytechnic Institute, Salvador Zubirán National Nutrition Institute, National Institute of Respiratory Diseases, National Public Health Institute (Regional Center of Health Services Development, Xalapa, Veracruz), Consultoría de Desarrollo Social, the MacArthur Foundation, Vitel-Telscape, Grupo GENE, Yaocihuatl AC.
The results of the network project to strengthen the capacity of local groups for health promotion in places where people live, study, work, and play, demonstrate the potential of this model for optimizing economic, human, technological, and educational resources, as well as community participation. The benefits derived from the network continue to be seen at present, in terms of the daily increases in demand for requests for support to extend activities carried out within each project.

**Schools Promoting Health and a Good Diet**

A concrete example can be seen in the Zapoteca region of Oaxaca, where a program to train teachers about food education was launched in seven primary schools. Subsequently, the program has been extended to train health workers, physicians, nurses, health promoters, teachers, promoters of the National Institute of Indigenous Populations (Instituto Nacional Indigenista) throughout the state of Oaxaca. This program has been incorporated into the “Solidarity System” of the Mexican Social Security System (IMSS), extending these programs to all school districts/units in the country. Through the program, a dentist’s chair was donated for oral-dental health care of girls and boys attending school, as well as their family members. Posters from the “Healthy Diet” poster contest at schools of the Zapoteca region have been exhibited at a local museum. Students and educators at the National Polytechnic Institute, together with primary school students and teachers, prepared a manual on medicinal plants of the region, and an exhibit was organized. An instructional manual on vaccination and worming animals was also produced.

Educational messages in the areas of nutrition and general health were developed with indigenous populations and aired by bilingual radio stations. FUNSALUD-SB, UNAM, the National Polytechnic Institute, the national and state Ministries of Health, the National Institute of Indigenous Populations, the state Ministry of Public Education, but mainly, the community—and the enthusiasm of project coordinator, Mtra. Luz Elena Salas of the UNAM School of Medicine—have made it possible to extend and refine a community-based health promotion and education model. This intersectoral effort combined the activities of different participating organizations, universities and sectors, as well as the educational and communications media, both modern and traditional, to facilitate the necessary knowledge and strengthen activities of working teams in the community.

The Consensus-Action Group funded training for these diverse teams and the program is currently expanding to other states and municipalities. This work model has successfully increased the quality and quantity of the basic infrastructure needed to carry out health promotion and education activities at the community level. Currently, a new proposal has been submitted that would increase the number of projects, making it possible to expand the results obtained from health promotion and education to another 20 localities. One topic of interest for several communities was promotion of healthy relationships within the family, the workplace, and the community. Various projects helped improve family relations and prevent domestic violence. Several training projects for primary and secondary school teachers were also supported.

**What Do We Gain by Changing?**

The Consensus-Action Group-produced video “Men Renouncing Violence” (CORIAC), demonstrates the work of a group where the men analyze the roots of their violent behaviors, put themselves in contact with their feelings and emotions, identify triggers that lead to violent behaviors, and learn new skills for controlling and managing negative emotions. One man commented, “I cannot turn off my emotions, but I can learn to act differently; I can change.” Through this video, with its strong and emotive images and conversations, one can observe the learning process and internalization of new skills for handling anger and changing violent behaviors through tolerance, respect, and dignity.
Various groups of the population benefited from promoter training, including the preparation of educational materials such as manuals, textbooks for work in the classroom, support in the preparation of materials such as pamphlets, posters, videotape production, puppet theater, radio, interactive CD-ROM, and videoconferences. Likewise, the rural communities of the states of Oaxaca, Veracruz, Jalisco, and Tabasco benefited from health education activities. Primary and secondary schoolteachers throughout the entire country received training and materials on education for health and life. Girls and boys in the national education system received free textbooks and had access to the interactive CD-ROM.

With respect to health promotion activities, the participation of parents and the school-age population of the Zapoteca region in Oaxaca, made it possible to make dietary improvements, rescuing traditional foods characteristic of that region, diversifying the diet, and protecting the environment, while simultaneously strengthening cultural values. Medical personnel, nurses, and health promoters throughout the entire state of Oaxaca benefited from training activities, learned about health promotion concepts, and practiced skills in order to carry out health education in the area of mental health, asserting their rights.

**Video-A Hummingbird Told Me**

This is a model of a project to promote the healthy development of family relations and prevent domestic violence. The video depicts different family scenes where violent behaviors of parents are observed toward children. Scenes depicting corporal punishment, as well as verbal and psychological harassment perpetrated by fathers on mothers, and by parents on children. The “School for Parents” project uses this type of material to raise parents’ awareness and to promote changes in attitudes and behaviors. The hummingbird is the messenger of mental health in this story, raising the mother’s awareness of the effects of her behavior, helping her to manage frustration and anger. The educational video shows the family’s changes in behavior and attitudes that help to create a healthy psychosocial environment and emotional support in the family context. The message is clear: that anger can be constructively managed, and children should not suffer the consequences of parental frustrations. It is necessary to protect children from violence and provide a family environment that supports their mental development.

The participation of rural adolescents was strengthened through the IMSS Solidarity Program and, likewise, the number of rural women served also increased. A group of workers in Tlacomulco de Zúñiga, Jalisco, benefited from learning to identify health risks present in their work environments and implemented measures to prevent those risks and promote their health. At the same time, a project was supported for women exposed to domestic violence in neighborhoods of Guadalajara, Jalisco. Moreover, the capacity of several NGOs and social networks was strengthened to support women in violent situations.

Various strategies exist to increase the population’s access to information on health promotion and education. For example, the capacity of UNAM’s UNIVERSIDAD EN LINEA (UNIVERSITY ON LINE) Internet systems was expanded to serve the demand of the users in health promotion and education topics. The Universum Museum, located in UNAM’s Ciudad Universitaria, held the exhibition “Health Corner” (“Rincón de la Salud”) that offered health information to more than 40 thousand museum-goers. Likewise, there were increases in both the quality and quantity of health information available at the official libraries of the Ministry of Public Education (SEP). Increased numbers of listeners to state radio in Oaxaca were reached with health promotion messages. Through support granted to several NGOs working in the area of men for domestic non-violence, various techniques were identified for modifying violent behavior through the adoption of more tolerant attitudes and positive interpersonal practices, respect, and dignity. Several of the projects focused on risk
prevention. For example, a campaign directed at the adolescent population at risk for smoking was carried out to prevent young people from using tobacco.

**Reflections and Recommendations**

Since its inception in 1996, one of the greatest challenges facing the Consensus-Action Group has been its consolidation into a network of health, social sciences, education, communications, and other professionals, for the purpose of identifying, supporting and strengthening the capacity of various groups to design, implement and evaluate health promotion and education activities. The greatest obstacles have been securing the financial, technical, and administrative support needed for projects, especially in terms of monitoring and evaluation. This alliance was created through FUNSALUD’s commitment with support from SB. On the one hand, the success of the alliance becomes evident from the results achieved in the evaluation of each project; and on the other, in terms of its contribution to increasing the number and capacity of individuals, groups, and organizations working in the area of health promotion. At the analysis and reflection meetings of the Consensus-Action Group, we review and monitor increased demand for support in terms of quality projects, as well as increases in the number of requests for expanding activities to other communities and population groups.

More than 35 projects are being funded through the Consensus-Action Group and the FUNSALUD-SB Alliance, which represents a 250% increase in the demand for technical and financial support. Health Promotion activities are being extended through expanded coverage in Oaxaca, Chiapas, Tabasco, and Jalisco.

New institutions are joining the Consensus-Action Group, both to contribute their experience and benefit from the knowledge and experience of other members. For example, the National Institute of Indigenous Peoples has requested that bilingual materials be produced and tested in several languages, and the Ministry of Public Education, unions, and teachers groups continue to request health promotion training. The Consensus-Action Group continues to insist that projects be identified, proposed, and prepared jointly with the community as a condition for funding. Projects with multiple strategies have made the most significant contributions to health promotion in the community, to the promotion of greater social investment by various organizations, and to increasing local capacity to identify and propose health promotion activities in human development. The educational strategy is essential, as is community participation, from the definition of priorities through evaluation. Combined strategies that include educational, communications, and community development components, have met with the most success.

In conclusion, the FUNSALUD-SIB Alliance is an example of how to increase investment in health promotion activities and in human and social development, by advocating social responsibility for health and promoting the participation of other interested sectors. The Consensus-Action Group expanded agreements with more than 35 groups. The training offered by Consensus-Action Group helps increase the infrastructure of promoters and staff trained to implement health promotion efforts in a variety of action areas with the community.
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Association VIVIR: Promoting Daily Health with Community Participation

Introduction

Created as a personal initiative of Dr. Mariana Galarza in 1987, Asociación VIVIR is a non-governmental organization that opened the door to alternative forms of health care in Ecuador. According to Dr. Galarza, the predominant curative approach to health care fails to see the human being in a comprehensive light; ignoring the social, emotional, and environmental causes of illness.

After spending twelve years in private practice, Dr. Galarza decided to dedicate part of her time to working with disadvantaged populations, which led to initiating a social development project. This project- VIVIR- is based on a comprehensive health approach, where health promotion and disease prevention are the foundations for constructing a culture of good health. Moreover, VIVIR has become an institutional approach in response to the predominant model of care, which is utilized once disease is present. The VIVIR model goes beyond service provision to addressing the community's reality--the day-to-day experience lived by individuals and families, but particularly women, who in Ecuadorian culture are those that have assumed responsibility for the health care of their children and family.

Context

Based on a Ministry of Public Health (MPH) study in 1997, the health situation indicators for Ecuador were among the lowest in Latin America, indicating a long-term structural problem. Upon examining socioeconomic levels, the MPH and the Pan American Health Organization (PAHO) estimate that in 1998 the population below the poverty line was 54.7%, with 74.7% in rural areas, and 40% in urban fringe areas. Recent data calculate the living wage to be US$60 per month, and the level of unemployment and underemployment of the economically active population (EAP) at 75%. Upon factoring in that on average some 65% of the population lives below the poverty line, we see some of the underlying reasons for the critical conditions currently faced by Ecuadorian society.

According to available data, the current crisis affecting the country has reduced the number of medical consultations by up to 60% (program: La Televisión, February 2000), which explains the declining quality of life affecting the population. Estimates based on PAHO data from 1998, conclude that maternal mortality during the period 1991-95 was 102.1 per 1,000 live births, while infant mortality was higher than 44 per 1,000 population, and much higher in regions with large indigenous populations. Both indicators are directly linked to poverty, malnutrition, poor nutrition, the level of access to medical services, and education.

The VIVIR Initiative

Association VIVIR stems from the needs and concerns of the population and thus offers a more collective proposal; not only from a services standpoint, but also in terms of active community participation in daily health care. At the local level, the association is part of the Valle de Tumbaco Health Council, jointly with the Municipality of the Quito Metropolitan District (DMQ), Area 14 of the Ministry of Public Health, and other NGOs. VIVIR has entered into partnerships with entities such as: the European Union,
Fundación Esquel, UNICEF, Susila Dharma International, SD Germany, UNPFA, INNFA, the Ministry of Public Health, the Municipality of the DMQ, among other national and international organizations, with which it has managed to successfully promote its Comprehensive Health Model.

VIVIR contributes toward improving health care models and basic education in the area of health promotion. This model can be applied in both the public and private health sectors to improve the quality of services, as well as strengthen community participation in daily care. In practice, VIVIR has been applied through two lines of action:
A comprehensive health care model with a family approach, open to different medical systems, and respectful of culture;
Development of health training and education programs geared towards promotion in daily life, providing the community, the individual, the family, and women in particular, with the tools they need to reclaim the power to provide for their own well-being.

**Comprehensive Health Care**

VIVIR offers low-cost health care for people with limited resources that allow the family to manage simple health problems. Accordingly, health care includes components of prevention and early treatment of health problems before they require hospital care and thus, more expensive treatment. VIVIR offers a service model based on quality and compassion, incorporating different health care approaches without neglecting the use of technical resources.

In the development of the VIVIR model, the most frequent health problems were identified. These data were then compiled into comprehensive clinical histories on physical afflictions, and emotional problems and their social environment. Based on these histories, there was a need to launch training programs to improve nutrition, self-esteem, problems of gender inequity, and address domestic violence. Increases in chronic diseases and social violence reflect a decline in the quality of life and an increase in costs for managing health problems that require long-term specialized treatments (see example below).

<table>
<thead>
<tr>
<th>Prescription</th>
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<tr>
<td>Amoxicillin 500 mg</td>
<td>S/16,000 x 24 = 384,000</td>
</tr>
<tr>
<td>Claritine (antihistamine)</td>
<td>125,000</td>
</tr>
<tr>
<td>Temptra (antipyretic)</td>
<td>25,000</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>534,000 sucre (US$25)</strong></td>
</tr>
</tbody>
</table>

*The current value is of US$1 = 25 thousand sucres. Given the living wage to be $US60 per month, the relative high cost of treatment for chronic problems make this option not readily available to the general population in Ecuador.*

A. **Comprehensive Health Center--Care and Training**

In response to the expensive and inefficient current health care system, VIVIR implemented its “Comprehensive Health Center” care model, 12 km outside of Quito in Valle de Tumbaco. The center incorporates a promotional approach, including health education and training,
applied nutrition (kitchen), playroom for recreation, child psychomotor development, intercultural pharmacy, physician’s offices, as well as the opportunity for alternative treatments (i.e., family medicine, acupuncture, and homeopathy).

Diocelina Cuti (age 34) of Pifo, Ecuador: “... before I had the opportunity to get training at Asociación VIVIR, my diet and lifestyle were pretty bad,... I didn’t understand the importance diet plays with respect to good health... I learned to appreciate my self-worth as a person, and that not only does my health depend on me, but that of my family as well... I learned to appreciate the food produced in our region, such as quinoa, anile, soybeans, etc... The people at Asociación VIVIR are a blessing for our community; they are working to change nutritional habits of so many that there is no shortage of people like me to attest to this fact.” *


The Approach to Comprehensive Health requires a new mentality and the need to work for a vision that is not solely medical in nature. The practical application of our process was based on reality, facilitating the construction of a participatory program. Applying the integrated approach and incorporating the participatory component made it possible to reduce costs. The design of strategies used to introduce, modify, and assess healthy nutritional habits are based on an understanding of cultural contexts and encouraging the potential of each individual to care for his/her health in the home with their own resources, while taking care to ensure that health care services are available to these individuals when needed.

Cecilia Limaico (age 36), Ferroviaria Alta community leader, Quito, Ecuador: “... before I received training it seemed that my family was constantly ill because we were unaware of our day-to-day quality of life needs, especially in terms of nutrition, which has been the basis for restoring health for each member of my family, since when one of them becomes ill, so does our pocketbook... this experience has helped me to continue sharing what I have learned with my family members and friends... Not only have I learned to prevent disease but cure them as well with all our herbs, which are the most beautiful gifts nature provides... my husband and children have learned how to prepare home remedies... For example, about two months ago I was hospitalized along with fifteen other mothers where I gave birth to a premature baby girl. Each of the mothers there were discussing the different diseases their children might develop, but I told them I had no reason to get upset in that regard, and began to teach them how each of these diseases should be treated...while saving money and they began to show interest in how I could help them.” *

* Evaluations: Basic Knowledge of Health and Nutrition Program, 1999

Each quarter, over the period of one week surveys are administered to users of the Comprehensive Care Center to determine their opinion of services. The use of a questionnaire administered to patients during the medical consultation has revealed that the majority of patients are satisfied with medical services. Satisfaction with the type of care and results in terms of improved health of habitual users has generated a chain of new beneficiaries, with the incorporation of family and friends, which can be verified through medical records.

Training and Education Program

VIVIR provides training and advisory services in alternative health programs to health professionals of public and private organizations. VIVIR works with the Ministry of Public
Health to promote an approximation between official western and indigenous medicine, and programs that promote quality improvements in the management of health care services in two pilot areas. VIVIR has held training for indigenous communities, women’s organizations, neighborhood organizations, child development centers, and schools—both in urban and rural areas in 10 of the country’s 21 provinces. Moreover, VIVIR has provided training in 21 of 52 marginal areas (groups 3 and 4) of Quito (Quality of Life and Inequality Measurement, DMQ, 1998), trained more than 44,000 direct and indirect participants, and acquired substantial understanding of the traditional knowledge of Andean culture. Culture plays an important role in VIVIR’s programs: services must take into account knowledge of and respect for culture if they are to positively impact the population’s quality of life.

Moreover, VIVIR has increased our health care volume and also the demand for training through radio programs in which we are regularly invited to participate, as well as through interviews, news articles, and reports in a variety of television programs. VIVIR uses these media to promote natural practices without insisting on a fanatical bent, make known their limitations, and emphasizing the value of scientific medicine with a view to harmonizing visions, and not to create controversy. The communications media are very important for health promotion, provided that messages are designed appropriately in terms of knowing and respecting the target public and providing it with options. The favorable reception and credibility of our media segment have made it possible to attract financing from companies that promote wholesome foods, and organic vegetables.

**Difficulties and Challenges**

The incorporation of alternative medicine systems was met with great resistance by the official system. Today, we have some public sector experiences that have incorporated alternative medicine systems into their medical services as pilot experiences. VIVIR has participated in this process, together with other organizations in two innovative experiences.

Maintaining affordable costs for the provision of health services and training has required a great deal of effort. During the implementation period of programs sponsored by national and international organizations, we have tried to employ creative solutions to financing schemes to ensure continuity without losing quality or compassion, such as:
- Lowering costs of the model through incorporating alternative medicine where appropriate, thereby minimizing one of the highest costs—the use of prescription drugs;
- Implementing programs that facilitate self-sustainability and social participation: Solidarity Families: families and institutions with substantial resources that finance medical care and training for families with limited resources, generating equity; Solidarity Insurance: a corporate group contributes the capital necessary to subsidize cost to low-income families who pay a minimum monthly premium and learn skills in financial budgeting and saving, as well as the benefits of health insurance; Nutrivital: Production of healthy foods and products for the consumer market, a portion of whose profits are donated to the Asociación VIVIR.

**Human Resources.** Another difficulty VIVIR has faced involves the education of health professionals and workers who were trained according to the predominant, vertical curative approach to disease. As a result of the pervasive curative model of education in the health
field, VIVIR invests heavily in re-training their health teams in an integrated, multidisciplinary approach to health care that is open to other medical systems.

**Inequity in Health.** The initiative developed by VIVIR proposes the following actions:
- Diversification of the costs of care and training to increase access to services for those with limited resources;
- Lowering costs of the model based on an alternative approach to health and the incorporation of traditional healing practices, as well as other alternative therapies;
- Community participation and responsibility in their day-to-day health care to decrease excessive dependency on services;
- The promotion of respected and effective collective social participation strategies such as the Solidarity Families Program and Solidarity Insurance.

**Impact**

In order to measure the social impact of our work has had on health since 1987, we defer to the guiding principle of all our activities: “To improve the quality of life of the population by changing the approach to the health proposals that lead us toward comprehensive and lasting health with the active community participation.”

The methodology used for the impact assessment includes variables and indicators stated in the form of questions, such as: what influence did our model of health care and training have on the beneficiary population; what were its benefits; what changes could be seen; what negative aspects were noted; or how many beneficiaries were there; what trend has institutional growth followed in terms of comprehensive health care and training coverage, etc. Our reporting method combines the most relevant aspects of direct and indirect changes occurring over our thirteen years of experience, divided into two central points of analysis: *the comprehensive health care center and health education programs.*

**Comprehensive Health Center**

*Health Care*  
As a result of the experience gained through the exchange of information with other health institutions, changes began to occur in the approach to state health policy proposals. The Constitution, in force since 10 August 1998, states in Article 44: “The State shall formulate national health policy and monitor its application, control the operation of entities of the sector, recognize, respect, and provide advances in traditional and alternative medicines, its exercise shall be regulated by law, and promote scientific-technological advances in the area of health, subject to bio-ethical principles.”

*Efficiency And Quality*  
Health care services cannot be evaluated in terms of the number of patients served per hour, because the program has an educational component designed to change the approach to the health care, and not only to cure disease, which means that it requires more time for each user. Accordingly, the basic clinical history is designed to initiate changes in people and their families, so that the medical consultation itself becomes a therapeutic act.

*Participation*  
True participation in the health care from the standpoint of a medical service is to include prescription drugs, nutritional recommendations, and the use of medicinal plants as elements in the recovery of health, promoting activities that must be carried out in the home and not simply following indications passively, but getting the individual involved in his/her health care.

*Warmth*  
The participation of health workers and the physician during the medical consultation is not only limited to treating disease but to promote a change in user attitudes, encouraging a climate of confidence and cordiality among the participants.

*Economic Impact*  
Health care costs are notably reduced through the use of nutritional elements, medicinal plants, and alternative medical practices (homeopathy, acupuncture) that are low-cost with respect to
Western Medicine. Without these inputs we would not be able to offer a medical consultation, including medication, for US$2.50 for the first visit, and US$2 for subsequent visits. At present, consultation rates and medications in the current system are significantly higher, due to the high costs of prescription drugs.

**Health Education Programs**

**Change Of Approach**

The demand for advisory services and training in the model of education by entities such as the MPH, UNICEF, the municipality of Quito, NGOs (i.e. PLAN International, Young People’s Christian Association (ACJ), Boy Worker Program, Swissaid, church communities, Peace Corps, indigenous communities, women’s groups, Andean University “Simón Bolívar”), and others, attests to the real interest our model has provoked.

**Nutritional Changes**

The incorporation of new elements and criteria, changes in habits, and the revaluation of customs themselves, becomes evident in clinical histories and in workshop evaluations, in addition to verification through household visits carried out by the Fundación ESQUEL as part of its impact assessment methodology in 1995 in neighborhoods and communities trained by Asociación VIVIR.

**Change in Health Care Management**

The project’s emphasis on education and training of the mother are due to our goal to promote early awareness of the risks that lead to the causes of maternal mortality, promoting training programs oriented toward dietary changes, self-esteem building, sexual and reproductive health, with emphasis on the need to seek pre- and postnatal care.

**Managing Simple Problems in the Home**

Participants that have received training are less likely to seek medical consultations for simple health problems since they are able to manage these problems from an integrated approach, with previous knowledge of their limits. The components are explained as follows:

- **Cause (or probable causes)**
- **Nutrition**
- **Medication**
- **Affect**

**Costs**

Training programs emphasize the savings inherent in this methodology for the management of daily health problems, because the use of medicinal plants, diet, and alternative techniques lower costs resulting from patient health complications, and help the physician when the problem is more serious, participating actively to manage diets, fever, and general patient care.

**Conclusions**

The lack of education in more comprehensive approaches to health care, contempt for indigenous health care practices, the high costs involved in the current health care model, in addition to an unjust and exclusionary social order, have left a large portion of Ecuador’s population without education, sanitation, good nutrition, and access to health services. As a result, it was necessary to seek alternative solutions to the crisis (MPH-MODERSA, 1998). Association VIVIR is laying the groundwork for a comprehensive new model, shifting health care from the services area toward its daily promotion, allowing all citizens the opportunity to exercise their rights and take responsibility for their own health. As a result, there has been real change, an idea that previously failed to move beyond theoretical discourse.

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**ASOCIACIÓN VIVIR**  

<table>
<thead>
<tr>
<th>TOPICS</th>
<th>OBJECTIVES</th>
<th>INDICATORS</th>
<th>PERSONAL TESTIMONIES</th>
</tr>
</thead>
</table>
| Comprehensive Health Approach | Structure an approach to health that combines care, prevention and promotion <br>Provide more humane health care services that are accessible to the majority <br>Provide access to alternative medical systems | Qualitative Indicators:  
- 90% of users are satisfied with option to choose among different medical systems  
- 93% of users who opted for alternative medical systems have been successful in their treatment  
- All users express their satisfaction at having training opportunities within health care  
- All users in favor of including a recreational component (playroom) for children and approve of the inclusion of a nutrition and kitchen component in health care  
- All users in favor of including alternative and nutritional inputs in oral health management  
- The vast majority of medical consultations have included components to inform patients and provide them with health care skills  
- All users surveyed felt more secure about the management of their health problems and nutrition, and are content with rates for care and low-cost medication  
- The entire professional team of the medical center is trained in the management of the comprehensive health approach | “I feel as though they see me as a person and are concerned about my emotional well-being”  
“People are very kind and provide information; they are very good with the children;”  
“My child is very happy to come to this center because it has a place to play”  
“This Is a different environment, here people feel good, it’s a very welcoming place” |
- Number of beneficiaries: 44,255 medical consultations  
- Distribution of services: 44% homeopathy, 18% acupuncture; 27% dentistry; 6% psychology and 5% chiropractic therapy  
## ASOCIACIÓN VIVIR

<table>
<thead>
<tr>
<th>TOPICS</th>
<th>OBJECTIVES</th>
<th>INDICATORS</th>
<th>PERSONAL TESTIMONIES</th>
</tr>
</thead>
</table>
| Community participation in comprehensive health care | Form a health structure and training team                                   | Qualitative Indicators:  
- 80% of participants have acquired levels of proficiency that allow them to manage their daily health (food, nutrition, natural therapeutic resources) according to an integrated approach  
- Most participants relate nutrition to the health of their family by incorporating new eating habits in their homes  
- 20% of participants have demonstrated qualitative changes in their couple relationships based on training in beauty, nutrition, and self-esteem  
- 40% of participants have shown a reduction in the incidence of common diseases such as diarrheal diseases, acute respiratory infections, and parasitic diseases through comprehensive and daily health management  
- Reduction of more than 60% in the use of health care services due to recurring health problems of beneficiaries who received training  
- Two participants of each training program have become community leaders in the areas of promotion and development in their communities  
- 100% of NGOs participating in training programs proposed by Asociación VIVIR have changed their approach to health programs  
- The majority of the health professionals at the Ministry of Public Health of Ecuador participating in the training programs have achieved a closer relationship with the community and improved their capacity to manage public medical services  
- 100% of foreign and national observers that have either observed or participated in the training programs endorse the validity of Asociación VIVIR’s new comprehensive health approach  

- Number training teams: 3 from Asociación VIVIR and 5 from other organizations, trained by Asociación VIVIR  
- Number of training programs: 32 (in 10 of the 22 provinces of the country)  
- Urban areas: 19 programs; rural areas: 13 programs  
- Number of workshops: 546 at the national level  
- Number of beneficiaries: 44,218; men 16.7%; women 83.3%  
- Rural areas: 45.7%; urban areas: 54.3%  
(See statisticians tables in annexes) | “We had the opportunity to learn what we need for ourselves, the children and for our marriage”  
“We look forward to Fridays because that’s the day we attend training workshops”  
“We have learned to love ourselves first [as women] in order to love others”  
“Some of us are afraid we won’t be successful in the beginning”  
“Training makes us feel safer”  
“We avoid using dirty words when communicating with our children”  
“We are enthusiastic about practicing treatments at home”  
“It makes me very happy knowing that I am eating healthy at home”  
“I am happier and more at ease”  
“I’m happy to know that I’m a person and not an object”  
“Beauty implies caring for your face, body, hair, diet, and the rest”  
(Personal testimonies collected at the UNFPA Program Workshop UNFPA, municipality of Quito, Asociación VIVIR, 1998) |
Community Care Network Evaluation Case Study: West Texas Community Care Consortium

By Elizabeth Casey, Ann Zukoski, Pat Graham-Casey and Romana Hasnain-Wynia

In 1995, a small community coalition in El Paso, Texas successfully applied for a grant to substantially expand its program from serving one county to a 12 county area. The new partnership, the West Texas Community Care Consortium, initially focused its efforts on improving cancer screening services for the underserved. It has now successfully expanded its service to include more comprehensive efforts to prevent chronic disease and improve all aspects of health care for the residents of west Texas. The following case study describes how the community partnership expanded its programs, mobilized key groups to participate, and developed its infrastructure. This case study provides examples of this partnerships key accomplishments, the difficulties encountered and the issue it now faces in order to sustain its work.

The Community Care Network Program

In 1995, the W.K. Kellogg Foundation, and the Duke Endowment funded the National Community Care Network Demonstration Program. The Community Care Networks (CCN) are comprised of 25 unique partnerships in rural, urban and suburban areas of the United States. The development of CCN arose from leaders at the American Hospital Association who saw a need to address community concerns about hospital and health systems and how communities could effectively address their local health care concerns. This idea was initially developed in response to the Clinton Health plan, which focused on greater local control of health care. The CCN vision consists of four key elements, which include a community health focus, provisions for community accountability, managing within fixed resources and, establishing a seamless continuum of care.

In 1997, the Robert Wood Johnson Foundation, the United States Public Health Service, the California Wellness Foundation and W.K. Kellogg foundation funded the evaluation of the National Demonstration Program. The following case study focuses on one of the 25 CCN partnerships. The CCN Evaluation team collected this information.

The Project: The West Texas Community Care Consortium

The West Texas Community Care Consortium (WTCCC) service area consists of 12 counties located in rural west Texas. The main sources of income are oil and agriculture. The climate is hot and dry and vast bodies of land exist for hundreds of miles between towns, making travel to health services long and difficult. The population is approximately half Latino and half Caucasian. The El Paso consortium focused its services on low-income Latina women, and WTCCC has used the model to expand services to include the adult population between the ages of 21 and 65.

- The majority of Latino people come from Mexico, work in the farms and speak English as a second language if at all.
- As much as 40% of the population is over 40 years of age, which increases the need for chronic health services.
- The average income for the community is $10,000 annually
- Approximately 32% of the population on Medicare and Medicaid, 18% uninsured, and 50% of the population is underinsured due to high deductibles
The overall mission of the WTCCC is to achieve a quality of life where residents are free of needless suffering from chronic disease and are active partners in a prevention-orientated health care system, which is comprehensive and non-discriminatory. The partnership goals are to, within the 12 county catchment area, coordinate a network of wellness and prevention services; educate residents about the importance of lifelong wellness, emphasizing preventative care; provide screening and diagnostic services to residents; provide basic treatment and follow up services; include the local community in developing a comprehensive network of health care services in the region; and secure funding to extend services beyond the 3-year grant period and to evaluate the effectiveness of the network. The WTCC has used a model of one of its partners which focuses services on low income Mexican-American women. Based on this model, the WTCCC has expanded services to include the adult population between the ages of 21 and 65. The partners who provide these services include a medical university, the State Health Department, the Texas Cancer Council and the Cancer Consortium of El Paso.

**Mobilization of groups**

The main groups mobilized to improve access to services include Community Service Advocates (CSA’s) promotoras/consejeras, community volunteers, clinicians, and county hospitals. The WTCCC recognized that one of the largest barriers of indigent care was the boundary defining the 12 county lines. These boundaries prohibited health care providers from seeing indigent patients who did not reside within the defined county borders. In order to address this problem the WTCCC created a memorandum of understanding (MOU). The MOU effectively eliminates county boundaries in regard to receiving health care. The MOU resulted in the following positive developments in the 12 counties: increased continuity of care, patient stability, proper use of local resources, and the development of positive communication among the 12 counties where historically there was competition among providers.

**Infrastructure Development of WTCCC**

The four organization partners involved in WTCCC include 1) the Cancer Consortium of El Paso, 2) Texas Health Department, 3) Texas Cancer Council, the 4) West Texas Coalition for Cancer Prevention/ Texas Technical University Medical School. All partners provide in kind or financial resources to the WTCCC. The Cancer Consortium of El Paso has provided the working model for WTCCC as well as providing administrative services to the consortium. The Texas Health Department provides funding for the partnership and support for tracking data on clients. The Texas Cancer Council helps to reduce duplication of services statewide and also provides a large financial contribution, in addition it provides the mobile mammography van so screening services can be taken to person who otherwise would not have access. The West Texas Coalition for Cancer Prevention was the lead in providing the community needs assessment used to develop the goals for the WTCCC project.

The participating partners established a Steering Committee to bring a balance of power throughout the 12 county region. Its strategy included forming a committee that included one community at large representative, one county government appointee, one health provider three individuals from each county and one representative from each funding partner. Steering Committee meetings are held quarterly and the group as a whole develops agendas. Issues of
access, integration, coordination, reimbursement, and use/sharing of local resources are discussed and solved. The WTCCC has focused on two projects for developing an infrastructure for health promotion: training of lay-case managers (consejeras, promotoras, community service advocates), and training of community physicians and clinicians. These two projects are the focal points for increasing screening and early detection services. In order to insure the stability of this infrastructure, WTCCC established and partially funded lay case manager positions within the hospitals.

**Key Projects of WTCCC**

The WTCCC is comprised of three main structural elements: administrative and coordination of services; training and education of clinicians, lay educators and community; and screening, diagnostic, follow up and treatment services.

**Administrative Services**
The coordination of services is the main focus of the WTCCC while the Cancer Consortium of El Paso provides the administrative support services. This support includes coordinating meetings, training’s and prevention projects, as well as grant writing to sustain funding. Additionally, a bilingual newsletter is distributed to provide out-reach education. The newsletter focuses on an individual community role model telling his/her cancer screening experience story. Also included are healthy recipes and clinic addresses and phone numbers.

**Training, Education and Prevention**
The training and education of lay educators, community members and clinicians are central elements of the WTCCC. Training of peer educators to provide case management and out-reach education in early detection and prevention of chronic disease was adopted from programs in rural Mexico. Health workers have been used in Mexico effectively for years to create community buy-in and trust among the underserved. Using bilingual and culturally competent trainers helped to develop trust, respect and understanding among those receiving the training. The community health workers are responsible for monitoring client outcomes and provide follow-up with referrals for diagnostic and treatment as well as transportation.

Training of clinicians on early detection screening techniques and the implementation of the individual risk assessment and tracking programs is an additional goal of the WTCCC. The training and tracking program entitled *Put Prevention into Practice* focuses on systems change in health care delivery. An individual is tracked through the system, which helps him/her receive better care, and helps the primary care physician provide care more effectively. As a result of this tracking system, physicians want to participate in the steering committee meetings on issues of access, continuity of care and payment.

**Screening Diagnosis, Follow-up and Treatment Services**
As the number of screenings increased and behaviors related to access and client compliance improved, the WTCCC observed the reduction in the use of emergency room use over a two-year period. The benefits early detection and prevention education and control of chronic disease became evident (See Table 1 below). The focus of service delivery was changing from a treatment model to a screening and early detection model. By developing a partnership between clients and clinicians and focusing on prevention, patients began to take an active role in their
care. As a result, compliance increased and communication among health professionals, patients and the community improved.

Table 1

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<tr>
<td>% with cancer</td>
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<td>2</td>
</tr>
<tr>
<td>Of those with cancer, stage of detection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insitu</td>
<td>11 %</td>
<td></td>
</tr>
<tr>
<td>Stage 1</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Stage 2</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Stage 3,4</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Stage 1</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Stage 2</td>
<td>50</td>
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</tr>
</tbody>
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Accomplishments of the WTCCC

The WTCCC has been successful in many ways: the steering committee effectively expanded the project, increased access to care and the utilization of services and made significant positive impacts in the lives of those it serves. The factors that influenced the successful expansion of the program included the split funding of the CSA positions and placing them in local hospitals, the representative structure of the steering committee that included community members, clinicians, politicians, and partners of the project Also the training of CSA’s and clinicians with culturally competent individuals facilitated the trust and respect of the community thus increasing the number of screening services provided and improving the continuity of care. As noted above, the result was more cancers detected and treated at an earlier stage. Finally, the newsletter distribution increased from 3,000 to 7,000 and provided an additional tool for education to support those with chronic disease.

Success Highlights

- Increase in Newsletter distribution from 1996-1998 from 3,000 to 7,000
- Decrease in Emergency Room use in 12 county region 1996-1998 by 5% for adults over 40 years of age
- Increase in Mammography screening in the 12 county region from 1996-1998 from 1,426 to 2,151
- Increase in screening of breast and cervical cancer of 85% in El Paso during 1995
- Decrease in Emergency room use in El Paso county 1996-1998 by 10% for adults over 40 years of age

Difficulties Overcome

Problems began soon after the decision was made to expand the Cancer Consortium of El Paso to west Texas. Originally the WTCCC planned to use the public health department to serve rural
adults. In 1995, due to state re-organization, the decision was made to no longer provide direct services and close all the rural clinics. As a result, the consortium had to brainstorm on how to continue care in this rural area and used this crisis to leverage shared control over services. It was the general consensus of the WTCCC members to provide services with the mammography van for the entire 36 county region. However, the group recognized it needed to start small. They began providing services in a 5 county region to pilot the mobile mammography unit and were later able to expand services to a 12 county region.

WTCCC continues to face two challenges: a lack of bilingual and bicultural providers and lack of long term funding for WTCCC activities. Currently, some progress has been made with case managers working to advocate for the clients’ needs throughout the health system. Ultimately, area clinic and hospitals need to hire health professionals who are bilingual and bicultural, and this has yet to be addressed as a priority for the hospitals.

Short term funding of the next 5 years has been secured for the WTCCC. This has been through local, state and national foundations and grants as well as public health monies at the state and national level. However, the issue of long term funding has not been resolved. The WTCCC has relied on local foundations and grants for funding, but this money is a short-term solution. In addition, the local depressed economic situation does not provide hope for significantly increasing fundraising goals.

<table>
<thead>
<tr>
<th>Stories from the Rural Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imagine the terror of being told you have an abnormal lump in your breast and you have NO insurance or financial support to get the care you need to save your life so you can continue to care for your husband and 4 children.</td>
</tr>
</tbody>
</table>

A 34 year old mono-lingual uninsured mother of 4 began participating in the WTCCC screening activities in 1995 because of the out-reach education provided by the Consejeras/ Community Service Advocates. This Community Care program has changed her screening habits from occasional to annual. This habit saved her life when her Provider found a breast lump during her annual exam and was able to coordinate her services quickly thanks to the West Texas Community Care Consortium. This network helped the patient and get her breast biopsy in her own community by her local Surgeon. The physician, fearing that she may have cancer, made sure she and her family culturally appropriate information so that they could participate in the care decision and on how to proceed with necessary diagnostic tests to further evaluate her abnormal exam. The good news is the woman was found to be cancer free after a special lymph-node biopsy that was done in El Paso. The Network also helped to provide her and her husband with airfare assistance and local support while in El Paso to complete her diagnostic procedures.

<table>
<thead>
<tr>
<th>Sustainability and the Future</th>
</tr>
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<tbody>
<tr>
<td>The West Texas Cancer consortium is in a strong position to continue its activities well into the future. The consortium has a strong steering committee and strong commitment by its members who are proud of its accomplishments. On important consortium effort that will continue in the future is the training of the CSA’s/ promotoras/ conserjeras and health professionals. Training of trainers has taken place along with the creation of manuals. In addition, the people involved in the trainings are hospital employees and are likely to continue serving the community. Their</td>
</tr>
</tbody>
</table>
jobs are secure for at least the next five years, and the value of the CSA’s in providing referrals, culturally competent support, advocacy and outreach in community prevention services has been noticed both locally and nationally.

Another element that will be sustained is the cultural shift in the Latino population in relation to the comfort and ease of using local health services. With this change, professionals working in the health care system need to acknowledge their continued obligation to serve this population. The WTCCC is an example of how a small and effective partnership serving one county successfully expand itself to serve a 12 county region in a rural area of the U.S. This partnership provides an important case of how community partnerships can mobilize key players, capitalize on current efforts and know how to leverage resources and expand their efforts to address a broader range of health care concerns.

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Drug Abuse Prevention with Young People in Peshawar, North West Frontier Province (NWFP) in Pakistan

By Dr. Parveen Azam Khan

The context

Pakistan has an estimated total of about 4.1 million drug addicts, of which 2 million are heroin addicts. Since the early 1980s, political and economic changes within the whole region have facilitated a dramatic increase of poverty and social problems linked to the illegal production, manufacture, marketing and misuse of opiates. Neighbouring Afghanistan is the number one opium-producing country with steadily increasing production. Pakistan itself has succeeded remarkably in supply reduction. Nevertheless, the North West Frontier Province - including the well known tribal border zone with Afghanistan - is seriously affected. Peshawar is located at the gateway of the transit trade route from Afghanistan. Easy availability of drugs (especially heroin, cannabis and opium) at cheap prices are a permanent risk for Peshawar's youngsters and Pakistan's young population as a whole.

The socio-cultural and religious background has additionally facilitated a silent growth of demand among adolescents across all segments of the Pakistani society. 53% of heroin addicts start experimenting with drugs at ages 15 to 25. The main factors contributing to the problem are:

- High levels of illiteracy and lack of social and life skills to deal with the problems of daily life (poverty, unemployment, stress, lack of leisure time activities, etc.).
- Rapid industrialisation, urbanisation, modernisation, and mass media communication resulting in changing socio-cultural values and norms of youth.
- Daily availability of a deadly substance of high psychedelic, analgesic and relaxing properties - a potential source of relief for all kinds of stress, misery and pain.
- Lack of information and communication on the subject of drug use (social taboo).

Many drug addicts living on the streets are young people from dysfunctional families who left their homes and became drug users; they often become involved in petty crime to support themselves. Other street dwellers are drug addicts in the final, chronic stages of drug use - living in extremes of poverty and hopelessness, rejected by their families and society.

The project

In 1992, many treatment centres in Pakistan offered detoxification for drug addicts. However most of them did not offer any additional counselling or social support. This incomplete therapy often resulted in relapse, and successive attempts led to increased hopelessness and helplessness for patients and their families.
The DOST Welfare Foundation, a charitable, non-profit NGO was founded in August 1992 in response to the need for effective rehabilitation based on whole person recovery, i.e. physical, psychological, social and spiritual. The major aim of the organisation was to treat and rehabilitate drug addicts and, in parallel, work for drug abuse prevention in the community, by strengthening young people to resist the lure of drugs and develop healthy alternatives to drug use.

To become self-sufficient, DOST started different fundraising activities which included regular private donations from individuals and members, sponsorship of addicts and activities, and most importantly, training and vocational skills unit of DOST by marketing its products which are made by recovering addicts and women in the prison programme. DOST plans to achieve sustainability through the establishment of a Resource, Training and Vocational skills centre.

DOST started in 1992 with a 12-bed centre in a rented building with only two or three beds occupied. There were 4 to 5 volunteers, i.e. medical doctors and psychologists who worked to establish the residential DOST Therapeutic Community, outpatient programmes and drug prevention activities. The basic furniture and equipment came in the form of donations from friends and family members. After two years, DOST progressed to a 24-bed centre in a rented building. Despite eviction notices, threats and harassment from neighbours it continued to expand its services: street programme in 1995; construction of a 40-bed centre owned by DOST in 1997; and jail programmes in 1998. Prevention programmes for youth and the community have run since 1993.

The Foundation provides high quality treatment and rehabilitation services to drug abusers who are dependent on all kinds of substances. Medical doctors, psychologists, social workers and former clients have generated rich experiences in a variety of programmes on how to successfully create drug-free alternatives, working hand in hand with the drug abusers and their families.

The programme reaches out to varied youth (addicts, workers, smugglers, delinquents, school children) in very different settings: educational institutions, the workplace, streets, parks, neighbourhoods, refugee camps and prisons. The approaches used are therefore necessarily varied, drawing from concepts such as the 12 Steps of Narcotics Anonymous (NA), the Therapeutic Community (TC) of Day Top (excluding any cultural barriers and rigid elements), individual counselling, group counselling and family counselling. Most work revolves around the concept of the Therapeutic Community (TC) which is based on the “self-help approach”. At the core of the functioning of the TC is the idea that, by helping another person, we help ourselves; one person's success empowers the others.
Secondary prevention programmes

a) The outreach street programme

An outreach street programme was started primarily for drug addicts in the last stages of drug abuse. It is carried out daily by teams of social organizers, medical technicians and recovering addicts who work as mobile units to locate street addicts and offer them motivational counselling, social and medical services.

The outreach programme provides counselling according to individual, felt needs on drug-related community and personal issues. Daily street sessions of health education are also on offer, covering HIV/AIDS, hepatitis, personal hygiene, food and nutrition and safer use of drugs (harm minimisation approach). The youngsters respond positively and attend the sessions in large numbers. This has a strong preventive impact, creating awareness of drug use and giving youth the means to resist the temptation to join the "street drug sub culture". The DOST team, which includes recovering addicts, offer positive and healthy role models for young people.

b) The drop-in centre

A drop-in centre was established close to the drug scene. It serves as a refuge for homeless street addicts: a place where they can bathe, wash their clothes, eat, relax and receive counselling and medical care. Lectures and group discussions take place daily on harm minimisation and health education. Out-patient detoxification, family programmes, NA meetings, relapse prevention and aftercare programmes are also on offer. In addition, preventive activities are conducted, consisting of community sensitisation and information campaigns with a special focus on youth, especially in and around the nearby mosque.

The juvenile justice system for young offenders is currently undergoing reform and will hopefully create a legal framework for the police to bring children apprehended on minor charges to the drop-in centre for a "diversion programme", rather than send them to prison.

c) The therapeutic community

Government policies of frequent crackdown on street addicts to disperse or arrest them have proved a failure, resulting in re-location and spreading of the drug threat to new areas.

The DOST approach of harm reduction / harm minimisation through motivational counselling and trust building, is an entry-point for a gradual, flexible rehabilitation programme: rather than using a punitive approach, it builds on the addicts’ potential. In a supportive social environment, the progress of each individual is followed by setting goals for attitude and behaviour change. Every
month, the DOST TC offers free treatment and rehabilitation to up to fifteen patients, admitted only after strict requirements of regular attendance and proof of strong motivation for change have been met.

Client profiles and treatment plans are drawn up according to individual needs assessment and may include:

- **Detoxification**: this first phase of the indoor therapeutic process is based on symptomatic treatment including bath therapy, counselling, peer support and medical care. There is an open door policy.

- The **primary rehabilitation** phase aims at facilitating behaviour change by integration into the TC, which acts as a micro-system for learning social behaviour patterns and life-skills. The daily programmes and duties provide a therapeutic structure and discipline restoring feelings of belonging and solidarity. The recovering addicts run the TC on a self-help basis, by participating in and taking responsibility for all activities. The overall process is facilitated by a professional DOST team.

- The **secondary rehabilitation** phase aims at the further enhancement of social skills and gradual re-entry into the community. Training courses and counselling facilitate vocational rehabilitation and micro-enterprise skill development. Employment support and advice, and credit facilities and saving accounts are offered to youth. The main focus of this phase is to create economically sustainable and attractive futures for young recovering addicts.

- The **aftercare programme** includes relapse prevention, on-going family group counselling and NA self-help group meetings. It is offered on an outpatient basis in different locations and provides continuing support and guidance in recovery for both clients and their family members. Close follow-up in the aftercare programme helps avoid family conflicts and facilitates healthy alternative interests and activities.

**d) Therapeutic communities in jails**

DOST also established therapeutic communities in jails for juvenile offenders, male addict prisoners, women (there are few female drug addicts in jail but a large number of women are charged with drug smuggling) and their children. The daily programmes for the three TCs are designed according to the needs of each group and include spiritual therapy, group work, individual counselling, safe detoxification, medical and legal services, educational classes, vocational skills, recreational activities and family involvement before release. The programmes aim at creating hope and encouraging the prisoners to leave the vicious circle of drugs, crime and imprisonment.
These vulnerable groups in prison are mostly unaware of their rights. DOST provides them with legal counselling and assistance. Children living in prison with their mothers may suffer from social and psychological dysfunction as a result of the experience. DOST arranges for these children to leave the prison daily for school and outside recreational activities to minimise this risk. Youth and children don't belong in prison - DOST advocates for legal reforms including the release of juvenile delinquents and the introduction of “diversion” for minor crimes. While they are still in prison, however, DOST aims to nurture the growth and development of these children and advocates for their rights (CRC).

The primary prevention youth programme

In 1997, DOST decided to offer specific support to the high risk group of young people from 12 to 25 years by gaining access to and addressing them before their first contact with drugs. According to UNDCP statistics, the majority of drug experimentation starts between 12 and 25 years of age.

Since January ’99, DOST has increasingly focused on primary prevention and early intervention. This specific programme receives technical assistance and some financial support from the “Drugs and Development Programme of GTZ (German Technical Development Co-operation).

The overall goal is to improve living conditions of youth at risk and young addicts and to decrease drug abuse and addiction in the project area. Simply bombarding individual youngsters with anti-drug messages is not sufficient, although health education has its useful place. It is important to enable young people to recognize their own needs and priorities, and empower them to address these themselves. Prevention efforts that are initiated, shaped and implemented by self-help youth groups in the community are more likely to thrive, achieve long-term changes and become sustainable. DOST enables young people to organise themselves into self-help and interest groups and carry out measures of prevention and intervention against drug abuse.

The DOST team believes that capacity building and strengthening the social environment is a very valuable investment. The strength of Pakistani social tissue can be a valuable asset – the project uses it positively and builds capacity of religious and educational institutions. It is not in conflict with Pakistani culture – the taboo topic of drugs is addressed using religious and cultural values and codes of behaviour. The family, teachers, religious and other local leaders being the most influential and respected in the social set-up, they are involved in all project activities. Their full support ensures sustainability and progress of the community-based self-help youth groups.

Apart from facilitating these youth groups, DOST prevention activities include reaching out to youth in distress and offering specific help according to their needs. The programme also provides information on drugs and addiction to enable peers, parents, teachers, prison personnel,
religious leaders and other contact persons to take action.

Key partners

DOST has built up a good reputation and indispensable contacts with individuals, NGOs and GOs, private business, volunteers and youth organisations - it has in effect initiated a network of key-players at different levels of society working toward the common goal of drug abuse prevention. The vision is to create a flexible, culturally appropriate social support system with a common understanding of the links between drug abuse and development.

Meetings are regularly conducted with youth, key persons and members of youth-related organisations and institutions in order to create awareness of drug use and drug-related problems and to identify interested persons for the project activities in different settings. Workshops are also held to train people in managerial skills for the formation of self-help groups, intervention and prevention measures.

New youth groups have been formed at university level to carry out activities such as exhibitions and podium discussions about drugs and drug abuse. Schools have invited DOST personnel to give lectures to existing youth groups. Youngsters as well as school officials ask DOST for assistance in organising leisure time activities and integrating drug-related issues into their lessons. Training is offered on request by DOST to teachers, staff of partner NGOs, prison personnel and leaders of youth groups.

Challenges and perspectives

- Access to street children can be a problem, as is the establishment of continuity when working with populations in informal settings. To improve both access and follow-up, DOST applies the experiences of the on-going street programme and co-ordinates with other NGOs who have established access to existing organizational structures among youth (e.g. child labourers and scavengers).

- Sustainability: for the longer-term basis, youth groups will have to manage themselves – the adults involved can then become back-stoppers rather than organizers. Current limited experience does not offer a reliable prognosis as to whether this is possible.

- Drug abuse prevention among young women and girls is a special challenge. The very protective family system of Pakistani culture does not normally allow intervention from outside. DOST plans to open a “crisis centre” for women in distress and for those released from prison - this may help bridge the gender inequity gap which exists in Pakistan and facilitate emergency interventions. DOST personnel includes well-educated and experienced female staff headed by a dynamic woman director, who is a pioneer advocate for human and
gender rights within the moral code of the local community and the guiding principles of Islam.

- The DOST TC model of combining alternative treatment and prevention modules under the umbrella of a systemic, humanistic approach has shown itself to be of great value. Different methodologies of rehabilitation, restoration and social reintegration are used to empower the most vulnerable groups and give them the necessary knowledge and life skills to resist or overcome the trap of drug abuse. The prevention measures are the glue and the recovering addicts the resources for a social support system enabling DOST to understand and work with youth.

- A simple process-oriented monitoring and evaluation (M&E) system was introduced during the first months of operation of the GTZ-sponsored youth project. Result-oriented monitoring of different project activities is carried out using different monitoring tools (i.e. various reporting formats). The project impact will be evaluated upon completion of the project period in December 2000. Impact monitoring of behavioural change as a result of project activities remains a challenge. The gradual involvement of youth in the evaluation process is essential in order to get first hand feed-back and to establish participatory quality management.

- The political situation in Pakistan is a changing scenario. Although DOST has contact with the federal and provincial governments, further clarification of the roles of NGOs, concerned ministries and key-players on task sharing and inter-sectoral co-operation is on the agenda for the year 2000. Since the youth project sponsored by GTZ was a pilot project, replication in larger areas will be discussed and planned with the Government, upon the results of the impact evaluation.

Let us all join hands with our young generation to save precious lives and create a better future!

"If anyone saves a life, it shall be as though he had saved the lives of all mankind."
(AL-Quran: 5:32)

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