Mobilizing resources to achieve Universal Health Coverage: The benefits of working with the communities

Dr Sam Orochi Orach

Executive Secretary, Uganda Catholic Medical Bureau

November 26th 2019

Abstract

This paper speaks to the theme "The Development of Resources and Management of the Resources" for effective delivery of Public Health Services in Africa. The Community itself is a resource that needs to be mobilized and harnessed for its own health. Its resources need to be mobilized, developed and managed for Public Health, especially for achievement of the Universal Health Coverage, and therefore the Sustainable Development agenda. Opportunities as well as challenges of communities in playing the dual roles in health are considered. The slogan "Leave no one behind" in moving towards Universal Health Coverage should consider the community and individuals not only as receivers of Public health services but also as key players in the attraction, planning, and implementing Public Health Services. Therefore they should not only to be effectively reached with services but also be players of various roles including decision making and other processes. For effective contribution to Public Health, especially in the context of UHC, both tangible and non-tangible community resources need to be recognized, mobilized, developed, better managed and leveraged.

Introduction

Public health is the science of protecting and improving the health of people and their communities (CDC Foundation)[1]. Winslow, Charles-Edward Amory (1920)[2] defined it as "the science and art of preventing disease, prolonging life and promoting human health through organized efforts and informed choices of society, organizations, public and private, communities and individuals……". But rather than approach it as a "science and art" it is here preferably looked at as "**Health of the Public**" achieved through the above mentioned channels. The World Health Organization (WHO) defines health as a "State of complete physical, mental, and social well being, and not merely the absence of disease or infirmity". The spiritual life and the physical environment of the community also must be in harmony. The community must also have equitable distribution of resources, have access to education, and respect the environment that in turns creates conditions for good health. From the Alma Ata Declaration of 1978 through the many years since then, one sees changes in the health landscape. But as we move through the Sustainable Development Goal number 3 to "Ensure healthy lives and promote well-being for all at all ages" and the Astana Declaration (2018), the world has largely gone back to the aspiration of "Health for All" of the Alma Ata Declaration which "embraced the principles of social justice, equity, self-reliance, appropriate technology, decentralization, community

[1] CDC Foundation (https://www.cdcfoundation.org/what-public-health) – searched Nov 10th 2019

[2] *Winslow, Charles-Edward Amory (1920). "The Untilled Field of Public Health". Modern Medicine. **2** (1306): 183–191. Bibcode:1920Sci....51...23W. doi:10.1126/science.51.1306.23*

involvement, intersectoral collaboration, and affordable cost" (Wessex Global Health Network).[3].

The community

"We have game changers who have helped us fight ebola and who will also contribute to achieving Universal Health Coverage. The first game changers are the community and community extension workers".

Uganda's Minister of Health, Hon Dr Jane Ruth Aceng - Opening remarks at the country's 25th Annual Joint Review Mission (25th JRM) of the Health Sector Performance - October 2nd 2019,

Mobilizing the community as an asset or resource to protect and improve its health is described in different ways like community participation, community control, community representation, community involvement, community engagement, community consultation etc. These are sometimes used synonymously. It is akin to what one of the oldest political parties in Uganda used to call "Of the people, by the people, for the people". That was political, but we can borrow and add onto it "by the people, with the people, through the people". The important thing is that they add up to having the community as part of the health system that provides for and cares for the health of that community and not only as consumers or users of the system. But who is or are the community?

Recognizing the various ways and extent to which "community" is defined depending on contexts, Cordia Chu (2016)[4] suggests a definition that is widely accommodative, thus broadly being "a network of people linked by common characteristics which distinguish them from others". It looks at a community as "a multi-dimensional concept with different shades of meaning" that "can be viewed as a place/locality (e.g. village, town, neighbourhood, residential unit), a network of interests (e.g. voluntary association, club, self-help group, campaign, professional organisation, union), or a social system (e.g. the education sector, the Regional Health Authority, the city). It can also vary in size ranging from a neighbourhood health centre or a work unit to an entire city (community at large)". In the current age there are also virtual communities. These include whatsapp chat groups and other social media platform users, radio listener groups, group e-mails. Others can be service users for example association of sickle cell children and their parents, diabetic clubs, association of persons living with HIV/AIDS, children of parents living with non-communicable diseases (NCDs), community of journalists biased in health reporting. These can help a lot in advocacy and policy changes as well as initiating action for change.

These are the resources that can be mobilized, strengthened, developed or nurtured for the pursuance of the health agenda.

[3]Wessex Global Health Network-Centre for Global Health at the University of Winchester.

[4] Cordia Chu, Community participation in Public Health: Definitions and Conceptual framework; Ecological Public Health: From Vision to practice, 2016

The burden of ill-health overwhelming both the community and the health system in Africa

There is currently neither equality nor equity in access to and distribution of resources, other influencers of health as well as health care services across the globe, between nations and even between communities and individuals. Africa is also not anymore only experiencing widespread acute and infectious diseases but also fast rising incidences of chronic illnesses such as diabetes mellitus, cardiovascular disease, cerebrovascular disease, cancers, chronic respiratory diseases, mental illnesses, and other non-communicable diseases. The vast majority of these acute or chronic, communicable and non-communicable diseases are preventable and treatable. Where the diseases are active, complications may still be prevented if care is sought early and also provided early.

The burden of disease is not only higher among the poor, but the impact is also economically more catastrophic creating a vicious cycle of poverty and disease. Besides the "intangible costs such as pain, anxiety, suffering, and bereavement", physical disability, etc, all illnesses have heavy toll both on the resource requirement to deal with them as well as subsequent economic impact on the individuals and communities that suffer from them. Paul T Okediji et al (October 2017)[5] studied the economic burden of chronic illness among Nigerian families and noted what may be familiar to many or most African situations. They observed that besides the estimated household's spending on medical care there were on the average, 5.3 work days lost by patients in a month, constituting about 18.9% lost productivity while caregivers lost on average 1.4 work days constituting 5.1% lost productivity. About 15% of subjects lost more than 50% of work days in the preceding month. Also, approximately 12% of caregivers had to seek other ways to make more money to take care of family needs as a result of the burden of the illness. These findings imply that the increase in chronic non-communicable diseases will render poor people and communities poorer.

This burden of disease both drains community resources as well as creating need to the community to stand up to fight or prevent causes of ill-health.

But the health system itself is also overburdened by the situation. The World Health Organization (WHO) in its Africa report of 2014 noted that the health system in Africa was strained due to high burden of life threatening communicable diseases coupled with increasing non-communicable diseases. It also reported that whereas Africa had 11% of the world population, it had 90% of the world's 300-500 million malaria cases, most of which were under 5 years, and that 19 of the 20 countries with the highest maternal mortality ratio were in Africa while over 60% of people living with HIV/AIDS in the world were also in Africa. Fortunately the WHO, from its Global Observatory Data[6], reports a reduction in HIV related mortality in the Africa Region by an estimated 40% between 2010 and 2018 (with an estimated 470 000 [340 000−630 000] deaths in 2018), though this still represented 61% of the global deaths due to HIV related causes.

[5]Paul T Okediji, Adedolapo O Ojo, Akinwumi I Ojo, Ademola S Ojo, Opeyemi E Ojo, and Emmanuel A Abioye-Kuteyi; The Economic Impacts of Chronic Illness on Households of Patients in Ile-Ife, South-Western Nigeria; Cureus. 2017 Oct; 9(10): e1756. Published online 2017 Oct 7. doi: 10.7759/cureus.1756

[6] WHO; Global Health Observatory (GHO) data
https://www.who.int/gho/hiv/epidemic_status/deaths_text/en/

Recognizing the importance of the community in public health – International Declarations and eminent quotes

The importance of community action for health was realized long ago and also supported through various international, national and local commitments, reports, fora and even individual statements.

In Declaration number VII (5) of the International Conference on Primary Health Care of 1978, better known as the Alma Ata Declaration, the world leaders resolved that Primary Health Care "requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate".

Building on the Alma Ata Declaration for "Health for All", the Ottawa Charter for Health Promotion (WHO 1986)[7] identified five important areas for health promotion, among which was Strengthening community action. The others were building healthy public policy, creating supportive environments, developing personal skills and re-orienting health care services toward prevention of illness and promotion of health.

Agenda 21, the United Nations Rio Declaration at the world body's Conference on Environment and Development (June 1992), emphasized ´Focus on the empowerment of local and community groups through the principle of delegating authority, accountability and resources to the most appropriate level" and communities were to play a role in the conception, planning, decision-making, implementation and evaluation of programs. It emphasized supporting "a community-driven approach", promoting or establishing grass-roots mechanisms, giving communities a large measure of participation in the sustainable management ….."

The WHO Africa report (2014) observed that indeed Africa could make big strides in changing the pictures of high burden of diseases and there were already some signs of that. It recommended that for that to happen, strengthening the health system was the way forward. However, it also reported that a community perceptions study had found that regardless of location (urban, semi-urban, rural) community members had a feeling of exclusion from the health systems particularly in terms of decision-making. Lack of interaction with and response to communities was reported as a "major weakness of health systems in the Region". On the other hand it observed that "Partnerships with communities that choose their workers and design interventions and strategies yield effective health care" and that "partnerships capitalize on the strength of tradition that exists within communities (e.g. care for orphans and the elderly); knowledge within the community (e.g. traditional medicine); and community based prepayment schemes for health care".

The World Leaders, in their Declaration of Astana during the Global Conference on Primary Health Care October 2018, envisioned, among others, "Conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being". They further affirmed their "support for the involvement of individuals, families, communities and civil society through their participation in the development and

[7] A global agreement signed at the end of the first international conference on health promotion organized by the WHO in 1986

implementation of policies and plans that have an impact on health". They also declared to "promote health literacy and work to satisfy the expectations of individuals and communities for reliable information about health" and to "support people in acquiring the knowledge, skills and resources needed to maintain their health or the health of those for whom they care, guided by health professionals" . They also declared to "increase community ownership and contribute to the accountability of the public and private sectors for more people to live healthier lives in enabling and health-conducive environments".

In her opening remarks at the country's 25th Annual Joint Review Mission (25th JRM) of the Health Sector Performance on October 2nd 2019, Uganda's Minister of Health, Hon Dr Jane Ruth Aceng noted that "We have game changers who have helped us fight ebola and who will also contribute to achieving Universal Health Coverage. The first game changers are the community and community extension workers".

I love the words of John F. Kennedy at his inaugural speech as President of the United States on January 20, 1961 when he said "Ask not what your country can do for you – ask what you can do for your country". These words, inscribed on his grave, challenged every American to contribute in some way to the public good. But it still remains relevant to all nations today in all spheres of life including public health; but instead of "ask what you can do for your country" we could say "ask what you can do for yourself and your community". Thinking in terms of "doing for your country" often makes people, especially in Africa who believe that the government must do for them because they pay taxes or because donors are giving resources to the government in their names, become even further detached from their responsibilities towards themselves.

The words of the now retired Anglican Archbishop of the Church of Uganda, Most Rev Henry Luke Orombi, in the mid-1990s, then the Bishop for Nebbi (COU) Diocese resonate with well with this subject. At a burial ceremony back then, he said, "If a snake that has a very small head, and no hands can pass in the sand during the dry season and leave a mark and everybody can see that a snake has been here, what about you, me and everybody in the community that have not only big heads but big brains, hands and legs?". Why can't we leave a mark? Why can't we contribute to our community or society by doing?" Communities are surely capable of doing something or contributing something towards their own health.

The need for concerted approach – Why or the what?

Given the WHO definition of health and the SDG3, it is imperative that protecting and improving health requires bringing together multiple resources, multi-dimensional approaches and multiple players that are multi-sectoral with responsibilities at different levels instead of only the health sector.

In 2015 the United Nations General Assembly approved the 17 Sustainable Development Goals of which goal number three (SDG 3) is to "Ensure healthy lives and promote well-being for all at all ages". Among the targets to achieve in contributing to this goal is to "achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all". The public health aspirations are therefore better looked at in the context of the struggle for Universal Health Coverage (UHC), and therefore the Sustainable Development Goals (SDG).

The former World Health Organization's Director General asserted that "Universal health coverage is the single most powerful concept that public health has to offer. (Dr Margaret Chan, DG WHO, 2013[8]). Universal health coverage (UHC) means that all people and communities have adequate access to good quality promotive, preventive, curative, rehabilitative and palliative health services without causing catastrophic financial hardship. A universally healthy population will also in turn be more productive in all other sectors.

The Community assets as resources for achieving Universal Health Coverage

In the multi-dimensional and multi-sectoral approach to protecting and improving health, the community, whichever way it is defined, has a dual role as users of the services as well as resources for the services or interventions for its own health. It and its other assets, both tangible and nontangible, need to be mobilized, developed and managed and leveraged for Public Health. The slogan "Leave no one behind" in moving towards Universal Health Coverage should therefore not consider the community and individuals only as receivers of Public health services who should not fall between the cracks; they should also not be left behind as key players in the attraction, planning, and implementing of Public Health Services, playing various roles including decision making and other processes, hence "Leave no asset behind" or "leave no community resource behind". It is therefore necessary to explore both opportunities as well as challenges of communities.

i. The community itself, in its very existence, as a resource

Reading through the targets for the Sustainable Development Goal number 3 (SDG3), one finds strong verbs like "ensure, end, reduce, support, strengthen, and increase, halve" Such words put the responsibility for the health of the community on other persons. This approach focuses on needs, weaknesses or gaps of the community but not their abilities, strengths or assets.

A proverb among the Alur, one of the Lwo tribes in Uganda, says that "It is the person who has diarrhea that opens the bedroom door when nature calls".

Who knows the pain of a problem or an illness more than the one suffering and who knows the urgency with which intervention is needed better than such a person or community?

The community that has a health problem can actually initiate interventions and work on it if empowered or if not disenabled

Therefore the community resources or assets can be its people or members (human resource), services, organizational units, places etc that can contribute towards its own purpose. Besides

[8] Opening remarks at a WHO/World Bank ministerial-level meeting on universal health coverage
Geneva, Switzerland
18 February 2013

the workplace or places of employment, all people, including public health experts, water and sanitation engineers, religious leaders, cultural leaders, political leaders, teachers etc return with all their knowledge and skills to live in communities to which they are resource persons. Therefore the community resources or assets can be its people or members (human resource), services, organizational units, places etc that can contribute towards its own purpose. They can be mobilized or they can mobilise themselves if able to see the need. When such resources are identified, they can be leveraged or built upon,

ii. Mobilizing or attracting other resources

Communities can mobilise other resources to work in various fields that contribute to health for example, linking to or initiating community health insurance schemes and other community health financing schemes like Save for Health (S4H), Prepayment Schemes etc, improving food production and nutrition, housing, etc. They can also choose members to be trained as trainers to develop individual and community capacities. They can attract and participate in agricultural and nutrition programs, road infrastructure development, and economic empowerment interventions etc.

Benefits of working with the community

i. Gaining ownership and responsibility for their health and sustainability of program outcomes

In these processes the community and individuals therein feel a sense of ownership and are able to draw and bring in their resources in various forms that may include finances, knowledge, skills, materials etc, because they are doing their own thing for their own good and can influence when and how it is done. They also own the outcome, both positive and negative. In this way, they are more committed to sustaining processes as well as outcomes beyond a particular program intervention. Consequently behaviour change achieved during an intervention with the community is more sustainable because it is appreciated, attributable to and owned by them.

ii. Sustainability

By using the "Asset-based approach", the community get to know what strength they have at hand and what they can do with these resources. "Lay experts" can be identified and strengthened. Consequently these resources can be used in the program as well as sustaining the actions and program outcome or building on them. Examples can be using the knowledge and skills in the community to maintain a water source, continue training families in nutrition, reminding members on sanitation and hygiene practices, teaching of healthy leaving, disease control etc.

iii. Generating new ideas

Community members are likely to bring important insights into program priorities and strategies as well as better understanding of the context, sometimes leading to modification of the approaches and priorities.

iv. Better stakeholder engagement and relationship

There is faster outreach to a broader range of stakeholders and building social connectedness or relationship among community members who might have hitherto not been together. This helps to build team work and pulling of resources together for common purposes.

v. Obtaining better program outcomes resulting from increased advocacy for and direct support to services e.g. health promotion, self and peer mobilization

There are many examples of how working with the community as a resource has improved program outcome. Communities can play great rolls in improving their individual as well as collective health seeking behaviours, practicing, innovating and sharing information for prevention of both communicable and non-communicable diseases as well as influencing the social determinants of health like education, water and sanitation, gender disparities, agriculture and food production etc. as sell as health financing. They can significantly help in the fight against disease outbreaks and improving referral. The successful multi-sectoral approach to control and prevention of HIV/AIDS is one to draw lessons from.

Even traditional healers can be turned to be part of the solution. In one personal experience in the mid1990s, there were annual outbreaks of plague (bubonic as well as pneumonic and septicaemic) in Okoro country, what is now Zombo district, in the West Nile region of Uganda. There were a number of cases of patients with plague who presented with stupor, and sometimes semi-comatous but with low temperatures or even hypothermia. It turned out that the patients had earlier on had very high and rapidly rising temperatures that drastically and rapidly dropped after administration of herbs by traditional healers. Some of these herbs seem to have had both antipyretic as well as neurotoxic effects. I had meetings with the group of traditional healers in county and gave them basic information about plague, how to suspect, the dangers of holding onto the patients, importance of immediate referral and how to refer. We also discussed the dangers of the herbs in making diagnosis complicated as well as the apparent neurotoxic effects. After that discussion, referral of suspected plague patients by traditional healers rose quickly and the patients were arriving in better conditions, easier to manage.

We also need to take advantage of other infrastructures in society. The level of education and distribution of educational institutions today is definitely far better than that at the time of Alma Ata, 1978. Somewhere in the first week of November 2019, a seven year old girl told me "When I grow up I will have three or four children only. Having ten children is bad manners". Most likely she heard this in school. It means if we give the right messages about health to children in school, peer to peer as well as child to adult (parents) transfer of knowledge will occur. In addition, such children will grow with better level of knowledge, better attitude and better health seeking behaviours and well as better healthier living practices. Education communities like schools should therefore be supported to become public health auxiliary trainers for better community health.

The community contribution has perhaps been more demonstrated in tuberculosis control programs.

A WHO has coordinated the "Community TB care in Africa" project in 8 districts in 6 countries (Botswana, Kenya, Malawi,South Africa, Uganda and Zambia) that aimed to demonstrate that decentralising the provision of TB care beyond health facilities and into the community can contribute to improving NTP performance in terms of effectiveness, affordability, cost-effectiveness and acceptability of TB care reported that " in a variety of settings, the provision

of community care, including the option of community DOT, was typically well received". It recommended that Community contribution to TB care should be closely linked to, or integrated with, local NTP activity. Community contribution to TB care should be seen as complementing and extending, rather than replacing, NTP activity.

A Global Fund to fight HIV, TB and Malaria reports (October 2018) of a Quality and efficiency case study to increase TB case detection in Tanzania shows that working with the community, including cultural leaders and traditional healers "Demonstrated measurable successes—resulting in significant improvements in case finding indicators" within 18 months.

A partnership of Uganda Catholic Medical Bureau (UCMB) with the German TB and Leprosy Relief Association (GLRA), the Uganda Ministry of Health and the Transcultural Psychosocial Organization (TPO) is (by the time of writing this paper) working with village health teams in the refugee camps in the Rhinocamp area of Arua district, Uganda, to strengthen possible TB case identification, sputum collection and referral for both microscopy and GeneXpert examination. There is a partnership building up between the health facility professionals and the VHTs, seeing them as a team. The fact that the VHT members are not from the host communities, but rather, selected by the refugees from among themselves seems to have been an important success factor. The already existing good relationship between the refugees and the host communities also made it easier for health workers posted to the camp to build relationship and gain trust in working with the refugee VHTs.

There is no other structure that defeats religious institutions and networks in penetrating each corner and point of every community in Africa, down to villages and households. In Uganda the next structures that follow the religious ones are the Local Councils and the Traditional / Cultural institutions. These structures exist, with different names, in most if not all African countries. Politicians try to take advantage of them. Public health experts could still do better in working with them as described earlier. In a project dubbed "Accelerated Community and Civil Society Engagement to End TB (ACE-TB)" launched in October 2019 to cover five districts in the West Nile region of Uganda, again UCMB, GLRA, TPO and MoH, are working with VHTs, religious leaders, cultural leaders, and other community-based structures to reach high-risk populations to increase TB case notification rate as part of a wider objective to for strengthen TB diagnosis, and improve treatment success rate and infection control to end TB. This project is building on the experience of the smaller one in the Rhinocamp refugee camps.

In 2011 a USAID funded program in Sud Kivu province, in the health zone of Nyangezi engageg "community leaders, including religious leaders, local authorities, journalists and the traditional healers, launching a behavior change communications program that encouraged people who were coughing to go to the appropriate health facility". It is reported that in the 18-month period between June 2011 and December 2012, the case detection rate rose from 12% to 86%.[9]

Our experience as the Uganda Catholic Medical Bureau shows that the more health workers combine sharing of information with public accountability through Health Assemblies,

[9] Moïse Barhingigwa; Increasing TB Detection and Treatment in Democratic Republic of the Congo https://www.msh.org/blog/2013/03/28/increasing-tb-detection-and-treatment-in-democratic-republic-of-the-congo

patients' fora, Hospital Open Days etc, the more the communities feel ownership of the services and are willing to advocate for and support in other ways.

The plan by Uganda's Ministry of Health to institutionalize community health workers in what is called Community Health Extension Workers, CHEWs, therefore formally becoming part of the national health system, may appear expensive because of the total number across the country, but would and will create confidence in them and avoid duplication and multiplication of community structures for health services delivery. It is likely, in the long run, to draw more benefits than cost. They will not only work as the usual external persons but will also help build the capacities of individuals, families, groups and other communities**.**

The inclusive approach of the Expanded Program on Immunisation (EPI) is credited for making Bangladesh[10], as an example, have one of the highest immunization coverages in South Asia. Spearheaded by Bangladesh Rural Advancement Committed (BRAC) since after the liberation war in 1971, Bangladesh brings together inputs from Non-governmental Organisations (NGOs), local commercial enterprises, and community volunteers. Besides running massive health programs in the country, BRAC has been doing community empowerment, especially for women, through nationwide education, legal aid services, and micro-credit programs.

Factors that negatively affect mobilization of the community and its resources

So the first role of the individual and the community is to see that they live healthy lives. But then what is going wrong despite all these declarations and statements above?

Let us start with the quote from William James.

"The community stagnates without the impulse of the individual. The impulse of the individual dies away without the sympathy of the community " (William James 2010).[11]

The strength of the community is a build-up of the individual strengths and actions. But the individual strengths if not coordinated and pulled and pooled together, may not be effective. It is also like the fingers and the hand. The hand will only function when the individual fingers are swung into action. But the individual fingers alone will not hold anything, except when they act as a hand.

The role of the community in health can be from different angles and at different levels. But that participation can be discouraged and even destroyed by people in authority or public health professionals who define community participation as simply carrying out or implementing decisions made from the higher or professional levels but not having taken part in the decisions and design of programs. In a study carried out among the community of to establish factors influencing community participation in healthcare in Siaya district, Kenya, Edward Omondi

[10] Taufique Joarder and Malabika Sarker; Achieving Universal Health Coverage Through Community Empowerment: A proposition for Bangladesh; Indian Journal of Community Medicine vol 39(3), Jul-Sep 2014.

[11] William James, Institute of Medicine (US) Committee on Assuring the Health of the Public in the 21st Century.Washington (DC): National Academies Press (US); 2002. ISBN-10: 0-309-08622-1ISBN-10: 0-309-08704-XISBN-10: 0-309-50655-7

(2013)[12] established that "participation was viewed by majority of partners, healthcare workers and even county administrators as a direct link between the community and utilization of healthcare services". In other words, participation simply meant "utilizing services".

Edward Omondi further observed "complex and interrelated" "structural and cultural barriers to community involvement in healthcare programs.
He recommended that to mitigate socio-economic, cultural and attitudinal barriers community sensitization about the benefits of health programs should be prioritized.and emphasized the necessary to engage with a community to build an environment of trust while working with a different cultural and social context,

Whereas the WHO's Africa report of 2014 observed that "Although the community perceptions study found that community members trust their governments to do what is right for the people..", such trust could simply be one of the symptoms of the displaced community awareness of the importance of their own role and responsibility or usurping of such responsibility for their own individual and collective health by public health professionals and other higher authorities. In most, if not all of our African countries, the role of the community is politicized and reduced to irresponsible demanding for services. Politicians, in particular, patronize the community through many promises that may not be fulfilled, instead of making them feel the pride of taking charge of their health. Local politicians, for example, often fear to emphasize or enforce households' role in maintaining sanitation and hygiene for fear of losing the next election.

We must recognise that ultimately, participation is a voluntary activity. People should be able to enter at different points and different levels and should never be coerced. Community disablement owing to professional dominance is cited by a number of writers as one of the chief pitfalls of community participation (e.g. Christian-Ruffman and Stuart, 1977; Sadler, 1977; Wynne, 1987; Edelstein, 1988; Brown, 1990). Community groups slip easily into strategies dependent on experts, largely because: ¬ forums of challenge are fashioned more for the skills of experts than of lay persons ¬ confrontations arise from disparate reactions, and experts are usually called upon to be in the front line, leading to them controlling community input ¬ it fosters a dominant role for the expert within community organisations (Christiansen-Ruffman and Stuart, 1977). The result is that victims become "disabled," suddenly dependent upon professionals to handle various areas of their lives formerly under their control (Edelstein, 1988).

How community resources can be nurtured and developed for public health

i. Individual and community capacity to plan, initiate and implement health interventions

For the community's role to be effective they need to have ownership of their health situation by understanding it and together exploring and appreciating how they can contribute, importance of their contribution or even how their own actions could have led to the existing health situation among them. Therefore community participation in health assessment and sharing with them information early is a very good opportunity for stimulating and mobilizing their individual and collective actions. The community's easy access to national, district, and

[12]Edward Omondi Ochieng; Factors influencing community participation in health care programs: A case of Siaya county, Kenya - A Research Project Report Submitted in Partial Fulfillment of the Requirement for the award of the degree of Master of Arts in Project Planning and Management of the University of Nairobi (2015)

local level data and information as well as policies on health in simple, understandable and locally applicable versions is very important.

Such sharing of data and information stimulate individual actions as well as that of community organizations to initiate interventions. But it is also important to involve them in local, district and national level planning, and access even government funding to support local initiatives.

ii. Capacity to lead and govern health services or interventions

They will definitely want to participate in governance of the local health programs or services. input and leadership in planning and in funding decisions. This is particularly so when they are making their direct input in terms of resources.

Conclusion

The burden of achieving and sustaining universal health coverage is overwhelming for the traditional health system and public health experts alone. Individuals and communities need to know their health situations and be responsible for promoting and protecting their own health. They therefore need to be empowered to be resources to themselves in planning, implementing, monitoring, evaluating, health actions as well as promoting healthy leaving.

The importance of the community, in various definitions or groupings, as a requisite resource in public health has for long been recognized but not utilized appropriately enough. Its relevance is even higher in the multi-sectoral dimension needed to achieve universal health coverage as part of the sustainable development agenda. But at least five things are necessary for the community to play effective role in public health. They include:

- Access to information and health literacy, especially in regard to their local situations.
- Constructive engagement including participation in decision-making forums
- Ability to demand accountability from decision makers
- Capacity (through knowledge and skills acquisition) to work in partnership with public service
- Space to work in partnership with public health experts by being a recognized part of the system in policy and the operational frameworks.

Six Policy Recommendations

1. Countries, various partners in public health need to make and implement deliberate policy decisions that constructively take advantage of community resourcefulness.
2. Aspirations like the one of Uganda's Ministry of Health to make community health extension workers (CHEWs) part of the health system should be encouraged and supported even if it means reviewing the incentive package for the CHEWs.
3. It is important that all programs at their inception take time to identify the community resources or assets to work with.
4. Countries need to not only monitor initiatives or health interventions for their reaching the communities or for their preventive focus. There should be indicators that help monitors participation and action for health at household and community levels, if not at individual levels. Some workplace indicators can monitor actions of individual employees especially with regards to non-communicable diseases predisposition.

5. Program designers should, as a must, consider simplified formats for planning, implementation, monitoring and evaluation of health actions to assure communities meaningful participation
6. Program funders or resource partners should consider meaningful community participation in workplan formulation (as is the case with engendering of programs) and make modifications in the first 3-4 months after winning a grant for a truthful and meaningful participation by communities