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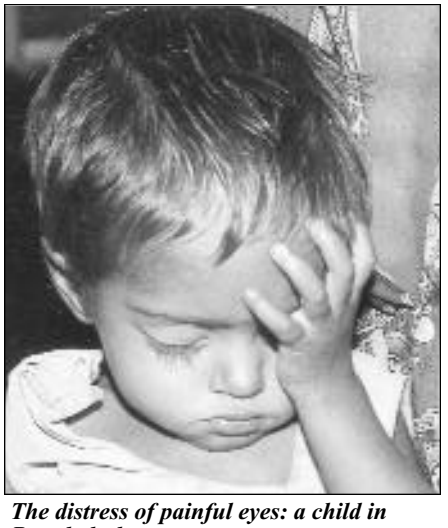
Review Article

Mobilising Resources Within the Community: 'Mobilising the Unmobilised'

Muhammod Abdus Sabur
MBBS MCommH
Health Adviser
Save the Children (UK)
House 28, Road 16 (New)
Dhanmondi R/A, Dhaka
Bangladesh

Introduction

Every community has evolved ways of preventing and managing disease throughitsownunderstandingofthecauses of illness. Health care is provided at many levels by many different groups of people. These include mothers and family members, traditional practitioners and private and public health workers. The contact betweenpeopleandhealthworkersthrough an equitable health system can lead to better understanding of the choices available to the people in addressing their health needs. It also offers an opportunity to improve people's health. At every level the capacity of people can be enhanced and the range of choices they have to protect their health problems can be increased.



The distress of painful eyes: a child in Bangladesh

Photo: Murray McGavin

Access to Health Care

Many people lack access to health care and also lack the basic health-related knowledge which would allow them to control their environment and/or their behaviour in the interests of their health. As a result, preventable and curative health conditions frequently lead to death or disability and, even when they do not, are a common reason for poor families becoming even poorer and without hope. Women and children face considerable additional difficulties in receiving health care, compared with men, and also are frequently allowed only limited participation in decisions concerning their own or their family's health. This has a significant adverse effect upon their health and upon their health-seeking behaviour. The problem is not that solutions are unavailable, but rather providing these solutions to individuals and communities who require them.

- ***Using existing community resources***

Health issues are social needs which cannot be fully met through exclusively medical approaches. Mobilisation and better use of existing resources (human, social and financial) can lead to a significant improvement in health. The aim should be to empower communities with basic health knowledge (preventive and basic curative), so that they can make better decisions with regard to their environment and their health. Empowering communities may be done by working directly with all sections of the community or through the existing groups/institutions or through selected volunteers. In Bangladesh, Save the Children (UK) worked with and through men, women and children of the project area (see below). The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), through its Chakoria project, worked through existing self-help groups (mosque committee, school committee,

Communities should be empowered with basic health knowledge

Photo: Murray McGavin

market committee, local youth clubs). Several government health care projects (Primary Health Care Intensification Project, Thana Functional Improvement Pilot Project) had experience of working through selected volunteers. The National DiarrhoeaControlProgrammeusesschools and scouts. The National Immunization Programme uses mosques and schools.

- ***Traditional practitioners***

Every community has traditional practitioners. They are available, accessible, affordable and enjoy the confidence of the community. Some of their practices, however, may be harmful. When the health system recognises their strengths, works with them without ignoring them, their efforts will then support the health system. Thus, improving the existing indigenous resources of the community results in optimal use of resources for sustainable improvement of quality, equity, relevance and cost-effectiveness in health care. In Bangladesh, Save the Children (UK) working with the popularly known 'Village Doctors', demonstrated effective results. Also, the National Diarrhoea Control Programme and the Acute Respiratory Tract Infections Programme are working with them.

- ***Material resources***

Material resources may also be mobilised within the community for health care. In Bangladesh, through philanthropic contributions (giving donations), several health facilities have been developed. If communities feel the need of health, they are willing and capable of arranging the resources required to deliver health care. The ICDDR,B's Chakoria project has demon-

strated that in Bangladesh. Several studies in Bangladesh have shown that even the poor people are capable and willing to pay for services, if these are perceived to be useful. A number of methods of mobilising finance for health care programmes have been successfully used in Bangladesh. These include lotteries, cultural shows, putting a levy on transport, cinema tickets, renewal of trade licences or fire-arms. Also, community medical funds, where each member contributes at a fixed rate on a regular basis and draws an interest free loan for medical expenses in the case of need, such as hospitalisation, has been made available in Bangladesh. 'Zakat' (where Muslims contribute at a fixed rate from their wealth due to religious obligation) is also not an uncommon source of funds in Bangladesh, to run health programmes or support individuals in case of their medical need.

Health Care and Medicine

Health issues need to get out of the narrow field of medical intervention alone. For social effectiveness, these need to be addressed by the broader society in all its interventions. Other development programmes need to integrate into health issues (preventive and basic curative) with appropriate back-up support from the medical programme. In Bangladesh, several micro-credit programmes (provision of low-cost loans) have successfully integrated the health component within their programmes.

Mobilising existing resources within the community - human, social, financial - and using these strategically will clearly lead to better health.

Community Selection of Ivermectin Distributors

Uche Amazigo PhD DTM&P

African Programme for Onchocerciasis Control WHO/APOC Ouagadougou 01 Burkina Faso

Background

Onchocerciasis (river blindness) ranks among the leading causes of visual impairment and blindness in Africa. The infection is caused by the filarial nematode, *Onchocerca volvulus*, transmitted from man to man by the man-biting simuliid or black-flies which breed in fast-flowing water.

An estimated 123 million people are exposed and about 18 million in the world suffer a grave burden imposed by the disease.[1]

With the availability of ivermectin (MECTIZAN®), a safe and effective micro-filaricide, suitable for large-scale treatment, active community participation in ivermectin delivery became crucial. The microfilaricide needs to be given at least once per year to affected populations, and continued for more than fifteen years.

The Onchocerciasis Control Programme (OCP) and the African Programme for Onchocerciasis Control (APOC) sought for a community-based mechanism which could be integrated into and sustained by national health systems.

The CDTI Approach

Following the findings of a multi-country study,[2] APOC adopted the Community-Directed Treatment with Ivermectin (CDTI) approach with sustainable features as its principal control strategy.

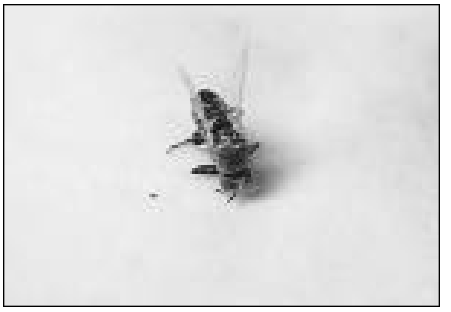
This approach is an evolution from community-based delivery strategies. It promotes active community participation as an integral part of ivermectin distribution, to improve access to the drug and a sense of community ownership of the project. The communities plan their own distribution systems. They make decisions on who should distribute the drug, the method (house-to-house, central location) and place (chief's compound, school, church) of distribution. Communities collect ivermectin from a collection point if not located far from them and decide when to distribute ivermectin.

Ivermectin Distributors

Ivermectin distributors are members of the community chosen by the community through a democratic process and trained to distribute ivermectin - which is considered safe enough for trained non-health personnel to handle. By 1998, 26,821 community-directed distributors (CDDs) had distributed ivermectin to their communities in 16 countries in the OCP and APOC areas.

During health education sessions, communities are informed about the detailed tasks of a distributor. However, they are left to decide on selection and provision of incentives (if agreed) to distributors.

Different communities have varying criteria for the selection of CDDs. Generally, cultural, structural and political influences and the tasks given to the distributor, provided by the programme facilitation team during health education of the community, affect community criteria for the selection of CDDs. For example, it has been shown that including females in the facilitation team when approaching community leaders can influence community decisions to select females as distributors. Whilst community criteria may vary, available data suggest that some attributes are common to distributors. These attributes include honesty, good conduct, integrity, literacy and trustworthiness.[2, 3]



The black biting fly

Photo: Ian Murdoch

Tasks of Ivermectin Distributors

The tasks include:

- conducting a census to determine the number of ivermectin tablets required for the next distribution.
- distribution of the correct dosage of drugs to eligible members based on height measurement with measuring sticks (photograph) and exclusion of those not eligible.
- record-keeping.
- keeping an inventory of ivermectin used, lost and unused.
- referring cases of severe adverse reactions to the nearest health facilities.

To be able to carry out these tasks CDDs are trained and re-trained every year, or every two years, by members of the National Onchocerciasis Task Force (NOTF). The NOTF is a partnership between Non-Governmental Development Organisations (NGDOs) and the Ministry of Health responsible for installation of sustainable ivermectin delivery systems.