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MOBILIZATION OF THE COMMUNITY IN SUPPORT OF HEALTH FOR ALL

CONTENTS

EXECUTIVE SUMMARY

Community mobilization, a continuum of organization, mobilization and involvement of the community in determining the extent to which the health services are in harmony with overall development, is a most important principle of health for all based on primary health care. Political and socioeconomic circumstances may support community mobilization or limit it, as well as shape the characteristics, process and dynamics of community mobilization. Community mobilization advances health as part of development, helps people to help themselves, contributes to the development of primary health care infrastructure in its broadest sense, encourages its sustainability through sound financing schemes, promotes integration of health care in accordance with community priorities and helps to bridge the gap between community and health services.

The implementation of community mobilization requires a conducive political environment and commitment to make it thrive. It is also important to the implementation of community mobilization that health professionals seek to understand the community, and to be understood by it. In the Eastern Mediterranean Region communities have been mobilized through different approaches, such as the basic development needs approach and other, similar developmental approaches including *el-touiza* in Morocco and *el-ta'awin* in the Republic of Yemen. The use of community health workers, such as the "Friends of Health Centres" in Saudi Arabia, the community support groups in Oman and the health volunteers in the Islamic Republic of Iran, is an appropriate strategy for mobilizing the community, while schools and nongovernmental organizations are important community assets which can be used as entry points to launch community mobilization. The potential already available for mobilization of the community in the Region needs to be studied and made use of. This may include, for example, using existing traditional systems such as the *shura* system, focusing on spiritual and social dimensions, using the techniques and methods of quality health care, or reviewing investment policies.

Assessment of community mobilization is an important and complex exercise. Indicators of the process of community mobilization need to be developed in order to enable all partners to assess progress. Models for assessment by the local community should be researched, developed and used.

It is recommended that clear policies be formulated in support of community mobilization, and inventories compiled of development institutions in countries. Community health workers and local leaders should be involved in mobilizing the community. It is necessary to train health staff to communicate with the community, and to encourage research in community mobilization.

1. INTRODUCTION

The health for all movement based on primary health care as the main vehicle of delivery stresses the principles of equity, intersectoral coordination, appropriate technology, political commitment and community involvement, which is at the heart of the health for all movement. Community mobilization concerns the "all" of health for all; in other words, health for all can only be achieved by involving everyone. Indeed, it is sometimes claimed that the outstanding evolution in the thinking as promoted by health for all was the notion of community involvement as the outcome of community mobilization and organization.

When Member States of the Eastern Mediterranean Region endorsed the concept of health for all based on primary health care they accepted its principles, strategies and priorities, which are based on community involvement. Since the Declaration of Alma-Ata on primary health care in 1978 the world has changed; developments have taken place which affect primary health care and health for all and which highlight the importance of community mobilization. Such changes include an increase in overall life expectancy, a shift in epidemiological patterns, with more and more chronic diseases that require long-term care and follow-up, increases in the costs of health care, aging populations, and rapid urbanization with a shift towards nuclear families. Such changes have effects on health delivery and health care, inviting more home health care and consequently greater community involvement. Health indicators have undergone a shift, from measurement of disability, morbidity and mortality towards measurement of quality of life. Such a measurement is broader than a measurement of health status; community mobilization and involvement are vital to making this measurement work and to achieving a better quality of life.

All these changes and challenges illustrate the overall environment which influences the relation between the health care system and the community at large. This means that the context in which the health services function is predominantly determined by the community and, therefore, community mobilization can contribute to creating a conducive environment for health for all to be achieved.

2. CONTENT OF COMMUNITY MOBILIZATION

The components of community mobilization are determined by the national and local social, political and economic circumstances, and by the expectations, needs and abilities prevailing in the locality. It is essential to see the components as a continuum of community organization, mobilization and involvement.

Community organization is about creating self-awareness as an active entity. Although communities have implicit systems which have always existed and survived, from the point of view of health services at least, a community should have a representative body to liaise and communicate with. This will give the community an explicit and functional structure.

Community mobilization is more than simply motivation to participate in a particular health activity. Its components relate to the process that allows the creativity of

the community to influence health care delivery, through its physical, social, economic, and spiritual potential. This has tremendous effect on health systems and therefore it is clear that with such potential the community should be involved in all aspects of health care.

Community involvement is the expression and outcome of commitment and ownership by the community. It shows how the community is empowered to take decisions about its affairs. The components of community involvement comprise all the achievements made in the decision-making with regard to management, organization, resources, economics and delivery of health-for-all programmes.

It is worth noting that the three terms—organization, mobilization and involvement—are generally used interchangeably to mean the whole continuum. This is because each one affects the other two in many intricate ways within the community.

3. CHARACTERISTICS OF COMMUNITY MOBILIZATION

3.1 Community mobilization—a means or an end?

Community mobilization is sometimes regarded as a way to achieve the pre-set targets of health projects or services. In this way of thinking community mobilization is a temporary activity linked to available resources, time and locality. The role of the community in the setting of targets, strategies, operational aspects, resources and assessment is absent. It is a passive role, one which does not involve taking part in the operational aspects of predetermined functions. This is an example of the use of community mobilization as a means and, as such, community mobilization is ad hoc and short-lived.

In contrast, community mobilization may be thought of as a process of empowerment of the community and of building up its capacity to decide and experience its full rights in overseeing the formulation of policies, planning, development, implementation, achievements and progress in all activities that concern and affect the quality of its life. This latter example is in line with the concept of civil service, where all employees are supposed to be accountable to the public they serve. In the Eastern Mediterranean Region, both types of mobilization are encountered. However, in practice community mobilization is most often a means rather than an end. A promising example of community mobilization as an end is the basic development needs (BDN) approach.

3.2 Community mobilization—a "learning-by-doing" process

Through community mobilization, individuals, communities and sectors such as the health sector learn how to appraise real life situations together. The different partners learn how to identify their individual needs and problems, and then they work together to solve them. The process brings confidence in tackling further problems, whether acute or chronic. Sectors learn how to work closely with communities and "people", to take part in true dialogue which then translates into sustainable action. The process can be seen as "democratizing", since it allows people to practise their rights in health and development through mutual understanding, sharing of information and responsibility and working together.

3.3 Community—a dynamic entity

Communities work differently from hierarchies and government administrations. With time they develop their own implicit and explicit systems. These systems reflect the different interests, conflicts and priorities which change with time and with generations. Accordingly, the skills, knowledge, values and practice of the community also change with time. The pace at which the community develops differs from that at which health services evolve. Thus, matching community development with health services development is complex, and the more so with each new generation. This shows that community mobilization as a relationship between formal (static) authority and (dynamic) community should be understood as an ever changing process.

Understanding these characteristics will reduce areas of conflict between community and government and enable priorities to be more easily matched. It will also enable control over programmes and plans, and lines of authority to be harmonized between the two. Community mobilization should thus encourage and foster the partnership between people and governments.

3.4 Sustained support from all levels

Community mobilization is a long-term investment which is of mutual benefit to health providers and planners on the one hand and to the community on the other. Government can support community mobilization by developing policies which enable people to change their lifestyles and achieve better health through their own action. All forces will thus be mobilized to address the health problems which are common to all society and enhance the achievement of health for all. Influencing the stakeholders who shape public policies, such as policy-makers, legislators, influential groups, syndicates, media, and religious and community leaders, is a prerequisite to community mobilization. It is evident that community mobilization needs sustained support from all levels.

4. MAIN AGENDA OF COMMUNITY MOBILIZATION FOR HEALTH FOR ALL

It is important to clarify the purpose of community mobilization. Indeed, the purpose will differ from one setting to another, in accordance with the socioeconomic pattern of the country or locale in question as well as with time. The main agenda of community mobilization for health for all includes: development and health; helping people help themselves (centering on people); the development of primary health care infrastructure; integration; bridging the gap between community and health services; and sustainability of health care and sound financing.

a) *Development and health*

It is now more evident than ever before that improving health status starts in domains that lie largely outside the hierarchical set-up of the health services. Improvement in public health is affected by many partners, but especially by the community. Poverty, the most important factor affecting health, has to be addressed through long-term and medium-

term development approaches. The experience gained and methodologies developed so far in community development show the strong links between health and development.

b) *Helping people help themselves (centering on people)*

Health is one of the most important parameters in determining quality of life. People are the most important assets in the fight to attain better health for themselves. Major achievements in health status were brought about when simple and appropriate technologies, such as oral dehydration therapy, were introduced because people were themselves the main actors concerned. The role of communities in the health sector needs to be reviewed in order to further improve community management of health programmes. Community mobilization is basically about helping people to help themselves.

c) *The development of primary health care infrastructure*

By this is meant not only the physical infrastructure but also the human, organizational and managerial structure, together with the norms, knowledge and practice of the system. The scope of primary health care development is wide and complex and extends beyond the mere medical arena to involve many other partners whose potential should be tapped prudently to achieve sustainable health for all. Primary health care addresses a wide range of health determinants, such as poverty, illiteracy (especially among women), increased population growth, unemployment, migration from rural to urban areas, drug addiction, environmental issues and epidemics. Existing primary health care systems do not take these health determinants into account and therefore require reorientation. Community mobilization can play an important role in this and in making the primary health care system effective in tackling the determinants. Once community mobilization is well established the primary health care infrastructure will be equitable, sustainable, adequate, continuous and transparent.

d) *Integration*

A community has a comprehensive view of itself and its needs. The priorities of the community usually extend over several levels of bureaucracy and several sectors. There is now more awareness of the importance of integrating health into overall development. The forms of integration are various and may concern organizational or technical aspects, or operational delivery of services. An example of where community involvement can support integration is in addressing the integration of the notion of cure into that of overall well-being, which includes health promotion and protection as well as improvement of the quality of life of individuals and communities.

e) *Bridging the gap between community and health services*

There is a distinct differential between the interests and concerns of a community on one hand and those of the health services on the other. There is also a distinct differential between the health actions and health concerns of the health services and those of the community. The complexity and dynamics of the community warrant the effort and time spent in social preparation and laying the foundation for a lasting social contract between the community and its health services. The contract should be based on interdependence

between health service and community. The era of independence of health care from the community is gone. Now, health care is striving to attain user (community) satisfaction; this is a step in the right direction. The community usually has multiple individual interests as well as a common one. Through community involvement it is possible to reach a balance between the interests of individuals and of the community.

f) *Sustainability of health care and sound financing*

It is increasingly being recognized by the countries in the Region that health care is an expensive service that warrants serious consideration, analysis and review with regard to the current policies of health care financing. The need to reduce the cost of health services has never been greater than at present. The role of government as the sole provider responsible for health care is now shifting more towards that of a coordinator, evaluator and broker. Health financing is shifting from the public sector as the main provider of health services to involving the private sector, through mixed financing schemes.

Various approaches are being explored to provide alternative forms of health care financing, covering all its aspects—preventive, promotive and curative—but, which are at the same time affordable. Community mobilization can provide for a sustainable financing system such as income-generating schemes, revolving funds and schemes centred on religious foundations. Indeed, the primary health care concept was evolved in response to the need for an affordable health care system based on community collaboration and participation which enhances self-reliance.

g) *Health promotion and protection*

Health is a human right and a responsibility to which the community should contribute. In view of current demographic and epidemiological changes it is now essential that people are involved in health promotion and protection and are encouraged to lead a healthy lifestyle. The experience of mobilizing the community gained in disease prevention programmes should be extended to address the emerging burden of noncommunicable diseases, drug trafficking and addiction, alcoholism, sexual promiscuity, violence and accidents. All of these have a strong social etiology which calls for a strategy to mobilize all the potential of communities in order to take action against the increasing threat posed by these new epidemics.

5. EXAMPLES OF COMMUNITY MOBILIZATION INITIATIVES IN THE REGION

The second evaluation on implementation of the Global Strategy for Health for All showed that there is an acquired attitude of considering the State as responsible for providing the totality of health services. The evaluation also showed that:

a) diverse organizations such as women's organizations are more and more involved in health affairs;
b) ad hoc mobilization in support of some programmes, such as immunization and training of traditional birth attendants, have been instrumental in making health care accessible;

c) some countries have experience of information sharing and of involving communities through area development committees and boards, which are examples of community organizations supporting health action in the locality.

These findings indicate that experience in community mobilization exists in the Region and this can be built on to attain health for all with the full involvement of people. Clearly it is important to guide countries on how to promote and launch community participation so that communities become full partners in health action.

Health professionals involved in mobilization of the community should start with a clear vision and policy regarding the role of community, and this should be followed by a seeking to understand the community and its subtle processes. Based on this understanding, the next move is to be understood by the community through respect, humility, and candidness. It is possible then to synthesize initiatives for the change in a way that ensures community involvement.

The following is not an exhaustive list of community mobilization initiatives. It is based on the actual and potential initiatives in the Region which are in line with the spirit of seeking to understand the community and be understood by it. These examples are meant to illustrate the variety of ways in which community mobilization can be effected, with special reference to real experiences in the Eastern Mediterranean Region. The ideas contained in these examples may be adapted to the socioeconomic circumstances of individual countries.

a) *Basic development needs and similar development approaches*

The basic development needs (BDN) approach, which has been adopted by 12 countries of different social and economic circumstances in the Region so far, aims at improving quality of life for communities and individuals through a comprehensive development process planned and managed by the community itself.

Basic development needs is based on a triad: organization of the community; building up its capacity; and mobilizing its potential and resources to ensure self-reliance and self-management. Basic development needs shifts the focus on to community leadership and sustainability and away from short-lived interventions. With BDN programmes and initiatives the accessibility of and coverage with health care services increases, and morbidity and mortality decrease. It has also accommodated concepts such as poverty alleviation and "healthy villages" and enriched them with a community methodology which puts harmony and balance into social and economic development. This is what is sometimes called "development with a human face".

People are the key element in this change process. They decide upon the change, design it, manage it and carry it out. In turn, this increases each individual's perception of "self", and each individual's perception of the community's own identity.

The organization of the community may take a variety of forms. An important and standard form is a village or area development committee which is a body selected or elected by the community representatives. The committee is responsible for liaison between government sectors and nongovernmental organizations on the one hand and the community on the other hand. It should have some control over all development inputs and channel

them towards the identified priority areas. The committee, as an organized body, ensures that local activities are sustained. Mobilization of the community becomes easy and is built into local activities. Community mobilization is sustained from within the local committee structures and by leaders in the community.

The Eastern Mediterranean Region has witnessed other community-based initiatives similar to the basic development needs approach, such as *el-touiza* (community solidarity) in Morocco and *el-ta'awin* (cooperation) in the Republic of Yemen. In both of these the community is at the centre of the initiative.

b) *Community health workers*

The term "community health workers" covers a long list of local terms used for community-based health care providers in the Region. The range of activities carried out by these workers depends on the social and cultural circumstances of the community and the links between the community and the health system. Experience with community health workers in the Eastern Mediterranean Region has been evolving since long before the Alma-Ata conference on primary health care in 1978. Some countries have embarked on training community health workers as extension agents to increase accessibility and coverage by health care. Other countries have focused on traditional health workers, such as traditional birth attendants, *hakeem* and local healers. Tapping such traditional resources means that use is made of community-based workers who are already accepted by the community and have long been familiar with it. One of the main functions of community health workers is to motivate and mobilize the community. The proper orientation, continuing training and support of these community health workers are essential to ensuring that they are able to carry out their functions in this regard. Four regional examples exist which are relevant.

In Saudi Arabia groups of "Friends of Health Centres" comprise devoted people who are interested in supporting and promoting health. They come from different walks of life and usually have no training in health care delivery. Rather, the "Friends" promote and support healthy lifestyles and also promote health as an important issue on the agenda of politicians and decision-makers. Their contact with health services is usually at several levels of care and it is interesting to note their participation in the managerial processes of the health centres.

Other countries have sought to mobilize the community through volunteers, mainly part-time workers who are traditional or trained health workers, and sometimes activists, often women, who are members of unions or nongovernmental and other philanthropic organizations. Volunteers may come from a variety of backgrounds and interests but they are basically prime movers in their communities. The primary health care centres usually provide technical support to the volunteers, as is the case in the Islamic Republic of Iran. In Oman the community is mobilized in various health programmes through community support groups. In Pakistan thousands of community health workers are being trained at first-level health facilities to provide care and to liaise with their communities so as to ensure their involvement in health matters. This is a national initiative which focuses on deprived rural and slum areas.

These and other similar community health workers form a base from which to initiate community mobilization.

c) *Action-oriented school health curriculum approach*

In this approach to community mobilization, the school is as an asset and can be used as an agent for change. The schoolchildren are taught by trained school teachers in how to address health and health-related issues at home, in the community and at school. Schoolchildren are also taught how to advocate better and healthier lifestyles through, for example, campaigns against tobacco and drugs. The experiences in Bahrain, Pakistan and the Syrian Arab Republic are excellent examples. The interface between the health system and the community through the school has the dual advantage of both involving the new generation and fostering long-term commitment from it. The widespread presence of schools, their leadership role (in the present and in the future) and their access to all families are all opportunities for the school to mobilize and involve the community.

d) *Nongovernmental organizations*

Nongovernmental organizations are well equipped to work in close contact with communities. There are many national nongovernmental organizations working in the Region. In Egypt, for example, there are about 15 000 registered nongovernmental organizations. The work of many of these includes the delivery of primary health care services to the urban poor and periurban dwellers. However most of their work is dependent on the individual motivation of community members. Nongovernmental organizations usually have strong relations with women's unions, youth federations, etc. Their widespread presence at the grass roots level, their experience and their commitment allow them to play an important role in community mobilization. A striking example of the potential of nongovernmental organizations is contained in the experience during the conflict in Lebanon. The community took over full responsibility for health care provision with the result that health indicators in Lebanon remained among the best in the Region. A similar experience was witnessed in the basic development needs areas in Somalia.

6. TAPPING POTENTIAL IN THE REGION

Examples of community mobilization exist which show the opportunities which can be seized in our Region. Successful approaches should build on what communities already accept as a belief, tradition or culture.

a) *Religious tradition*

There is much precedent for community mobilization in the Eastern Mediterranean Region—historically, socially and religiously. One example is the *shura* system. *Shura* is a basic Islamic principle to ensure that the views of the community are taken into consideration in all affairs pertaining to the life of the society. *Shura* ensures transparency and accountability of leadership to people. The applications of the *shura* can be immense, covering all aspects of present day democracy and, according to Islamic scholars, go far beyond. The argument in favour of *shura* is that it does not end at voting for representatives but goes further in following up on their activities and in the continuing involvement of the public. Entry points to launch and strengthen community mobilization can be sought through *shura*. Needless to say, this system covers all walks of life in a society, whether social, economic, political or otherwise. The *shura* system also allows for *al-takaful*, i.e. mutual community solidarity and support.

Other entry points are the economic principles in Islam, such as *zakat*, *waqf* and *sadaqat*. The Church has similar entry points and a rich tradition in providing community support within its constituency. There is a wealth of historical experience in the Region which can be used.

b) *Focus on the conceptual, social and spiritual dimensions of primary health care*

Primary health care should not be restricted to or equated with medical care only. This is a severe hindrance to primary health care and health for all, the more so in our Region which is very rich in values and principles that favour solidarity, equity, social justice, community partnership and human integrity and dignity. The fact that the primary health care approach is endorsed by all Member States and that it has now been operating for some nineteen years should give us an opportunity to maximize the primary health care principle of community mobilization. Home health care as an example of community mobilization can support the movement of health for all based on primary health care. Professional associations, individuals and charitable societies can also be partners in mobilization of the community.

c) *Quality health care techniques, methods and tools*

Quality health care is an important attribute of any public health action. The quality health care approach recognizes that client or customer satisfaction is a vital aspect of the health care system and the most important indicator of quality. Now we have an opportunity to make use of the present interest in quality by both health professionals and community members to highlight elements of community involvement which are built into quality health care. Raising public awareness of the importance of quality of care will lead to the forming of public opinion on the subject and, in the long run, will ensure the involvement of the community in health issues.

d) *Investment policies*

A variety of options are currently being debated as possible ways and feasible mechanisms of introducing a cost-recovery system and other means of generating funds for the health sector. Options include the involvement of the private sector, health insurance policies, out-of-pocket, cost-sharing and co-payment systems which directly involve communities. Community mobilization can be promoted as a strategy to ensure the cost–effectiveness of health for all. This can be achieved through greater transparency of health administrations and participation of the community in health decisions, which will result in more appropriate and acceptable health services thereby avoiding waste. There is a consensus among development planners that investment in the social sector, including health care, is as productive as the industrial sector when regarded over a longer perspective, and that the products, in the form of human development and a healthy population, can be projected as being marketable just as can industrial products. The best investment is in people. The introduction of health financing policies requires well studied and well designed norms and rules which regulate the application of procedures for payment for health care. Through community mobilization such norms and rules can be refined, agreed upon and applied. It is important that the State and community both have a role in monitoring the quality of health for all.

TABLE 1. Ranking scale for assessing the progress of community mobilization

Major issues for assessment	Ranks				
	1. Narrow	**2. Restricted**	**3. Mean**	**4. Open**	**5. Wide**
Community needs assessment	Imposed from outside with a medical, professional point of view (e.g. by CHL, village health worker, health post staff); or a programme imposed on the community e.g. latrine building	Medical point of view dominated by an 'educational' approach. Community interests are also considered	CHL is active representative of community views and assesses the needs	VHC actively represents community views and assesses the needs	Community members in general are involved in needs assessments
Leadership	One-sided, e.g. by a wealthy minority, an imposing ward chairman, health staff assuming leadership; or VHC is not heterogeneous	VHC does not function, but CHL works independently of social interest groups	VHC functions under the leadership of an independent CHL	VHC is active and takes initiative	VHC fully represents variety of interests in community and controls CHL activities
Organization	VHC imposed by health services and inactive	VHC imposed by health services, but has developed some activities	VHC imposed by health services, but is fully active	VHC actively cooperates with other community organizations	Existing community organizations have been involved in creating VHC
Resource mobilization	Small amount of resources raised by community. No fees for services. VHC does not decide on any resource allocation	Fees for services. VHC has no control over use of money collected	Community fund-raising periodically, but community is not involved in control of expenditure	Community fund-raising periodically and VHC controls use of funds	Considerable amount of resources raised by fees or otherwise. VHC allocates the money collected
Management	Imposed by health services. CHL supervised by health staff only	CHL manages independently with some involvement of VHC. Supervision by health staff only	VHC is self-managed but has no control of CHL's activities	VHC is self-managed and involved in supervision of CHL	CHL responsible to VHC and actively supervised by VHC

CHL = Community health leader
VHC = Village health committee

7. ASSESSMENT OF COMMUNITY MOBILIZATION

Assessing community mobilization can be a complex and tedious undertaking but it is a capability that countries need to be familiar with.It is essential in order to build up the confidence of those involved in mobilizing the community and encourage them to identify the strengths to build on, the weaknesses to correct, the entry points to use and the opportunities to seize. The methodology of assessment may use a combination of different tools. The findings of the assessment should be disseminated to and used by all partners involved in evaluation. It is anticipated that the evaluators will be a group that represents all interested parties, namely the community, the providers, and other stakeholders such as planners. The presentation of the assessment should be designed so that it can be easily understood.

Different formats can be developed to measure community mobilization descriptively. The range and scope of community mobilization can be assessed through the consideration of certain issues, such as the leadership role of the community, community organization, resource mobilization, community needs assessment and managerial processes in support of community mobilization. In order to assess these major issues a ranking scale has been developed. The ranking starts with a score of 1 or "narrow" when the performance of the issue or its implementation is very limited or poor. A score of 5 or "wide" is given when performance or implementation is at its highest. This implies that the greater the number, the better the achievement. There are three ranks in between the two extremes—"open" (4) has a higher score than "mean" (3) which in turn is a better performance than "restricted" (2). This ranking is descriptive and thus should be developed within the context of the specific locality. To be more meaningful evaluators should study the trend of the performance of each major issue over time and see whether progress has been achieved and to what extent. This trend analysis will allow strengths, weaknesses, opportunities and risks to be identified. Correction and improvement can then be initiated. The ranking system and its trend analysis provides for graphic and pictorial representation of the data to the different target audiences, which will provide better scope for brainstorming, debate and discussions involving interested partners. Table 1 is an example of how issues of community mobilization can be ranked. The table should first be reviewed, adapted and tailored to the specific conditions prevailing in the country or locality. The important thing is that we accept the idea of assessing the progress of community partnership based on agreed upon, ranked criteria. We do the assessment, learn from it and act on it.

8. RECOMMENDATIONS

1. Member States should formulate a clear policy regarding community mobilization in support of health for all, especially its role in health and overall development. It is of paramount importance to orient influential decision-makers who shape public policies to recognizing the role and contribution the community can make in attaining health for all and to ensure their commitment to supporting and encouraging initiatives in this regard.

2. Community resources should be identified and studied. An inventory of nongovernmental development structures, agencies and organizations in each country of the Region should be conducted, documented and used. The proforma of the inventory

and its guidelines should be prepared by a group of experts. Countries may wish to plan for the design, conduct, documentation and dissemination of the inventory in the 1998–1999 budgets.

3. Religious scholars should be encouraged to study the potential economic resources that might be used in support of community mobilization, such as *zakat* and *waqf* and those that are available in the catchment areas of mosques and churches.

4. Red Crescent and Red Cross societies, nongovernmental organizations, pensioners, active community leaders and local bodies should be briefed and involved in health activities in their catchment areas.

5. Governments should develop and encourage different forms of community health workers and "friends of health" in support of health care services and ensure appropriate training and evaluation of their contribution.

6. Ministries of Health are advised to develop and impart training programmes for health personnel, especially executives and managers at district level to strengthen their capabilities in communicating with communities and developing partnership with them.

7. Social scientists should be involved in developing effective methodologies and approaches for promoting community mobilization that will change the perceptions of communities and lead to their taking greater responsibility in promoting health. Social scientists should be members of the health teams responsible for planning, programming and assessment of health services, particularly in relation to community involvement.

8. Member States should encourage research on the different aspects of community mobilization, including the impact of the different regional initiatives (basic development needs, community health workers, etc.) in mobilizing community in support of health for all.

9. WHO should support intercountry activities and consultations to develop guidelines and strategies to enhance community mobilization in support for health for all.

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