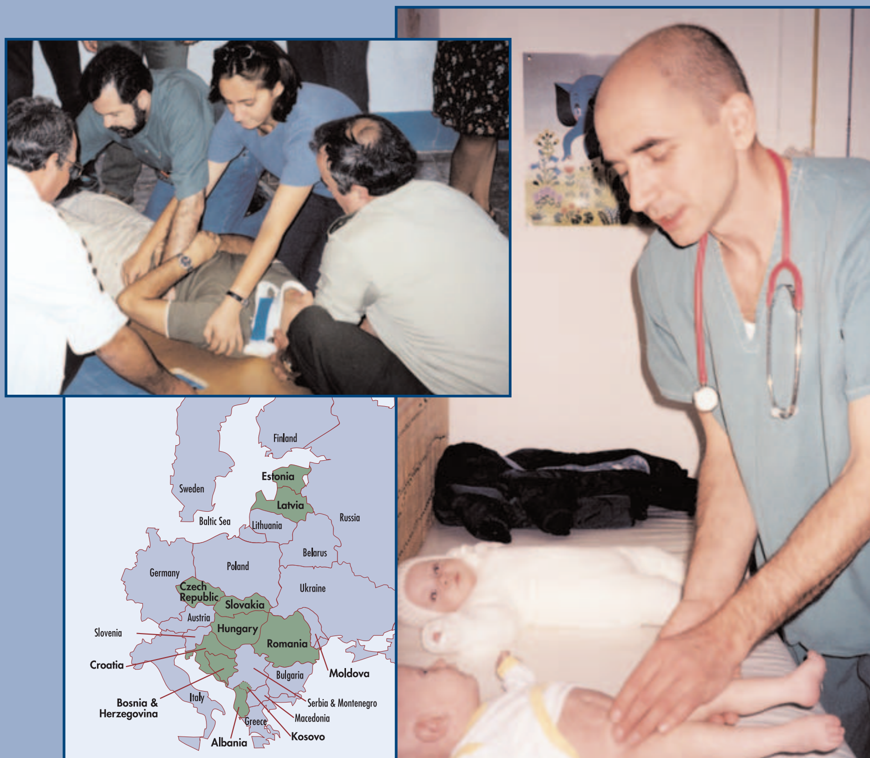
American International Health Alliance

Health Partnership Program Central and Eastern Europe

1994 – 2006

Final Performance Report



III.F. COMMUNITY MOBILIZATION

BACKGROUND

As the countries in CEE began their transformation to democracy and addressed issues of healthcare reform, governments were interested in empowering municipalities and individuals to assume greater responsibility for their health and the health of their communities. The task of maintaining good health could not rely solely on a few decision-makers or healthcare professionals. Health and healthier communities became the collective responsibility of key stakeholders in all segments of the community.

The global movement to engage local governments in health development through a process of political commitment, institutional change, capacity building, partnership-based planning and innovative projects is reflected in what is called the "healthy communities" (HC) movement, popular in North America. healthy communities refers to a strategy and methodology that involves and empowers a community to effect change. WHO embraced this approach through the development of its Healthy Cities program, which promotes comprehensive and systematic policy and planning with a special emphasis on health inequalities and urban poverty, the needs of vulnerable groups, participatory governance, and the social, economic, and environmental determinants of health. It also strives to include health considerations in economic, regeneration, and urban development efforts.

While the recognition existed of the need for communities themselves to be involved in creating health and well-being for their citizens, they generally lacked the leaders, the experience and the tools to engage in this new type of community mobilization and building.

PROGRAM STRATEGY

AIHA, in 1995, adapted the healthy communities methodology to the CEE region and developed a new type of partnership. AIHA's healthy communities partnerships reflected a broad-based, community-to-community initiative that is a unique vehicle for developing skills in community health assessment, planning, and improvement. These partnerships engaged community leaders from CEE and their US counterparts in a systematic six-phase process. The process combined workshops and professional exchanges, typically over an 18- to 24-month period. CEE partners were exposed to strategies and skills for mobilizing their communities to focus on health. They also learned about research and epidemiology including conducting surveys to assess needs. In addition, they used organizational development skills to gain support from key community stakeholders. They succeeded in creating a well-trained cadre of community leaders who were empowered to develop solutions to problems that they identified.

A total of seven healthy communities partnerships were established, with the first two launched in Slovakia in late-1995. Additional HC partnerships were established in Romania (1998), Croatia (2001), Hungary (2001), and other cities in Slovakia (1997). In addition, two of the hospital partnerships (in Vác, Hungary, and Riga, Latvia) incorporated HC projects into their partnerships.

Each partnership focused on different issues, as appropriate to a healthy communities approach which is designed to enable each community to identify and address important obstacles to healthy living in their community. For example, in Slovakia, Martin focused on smoking cessation; Banska Bystrica focused on geriatric, hospice and chronic disease care; Turcianske Teplice (TT) provided community health screenings and improved emergency services; and Petrzalka made support available for drug users and victims of domestic violence. HC partnerships in Romania and two cities in Hungary addressed priority women's health issues. In Constanta, Romania, the main focus was on domestic violence. In the Hungarian city of Győr, which was selected by competition from member cities of the national healthy cities network, partners developed women's reproductive health intervention services and education programs. AIHA also sponsored

a partnership linking the entire Hungarian Network of Healthy Cities with a similar state-wide network in Pennsylvania, to increase the capacity of the Hungarian network to address women's health and other community health issues.

In Croatia, AIHA provided training in mobilizing communities for faculty from the Stampar School of Public Health and the coordinators of the member cities of the Croatian Network of Healthy Cities. AIHA then asked member cities to apply to participate in a healthy communities partnership, which was awarded to the city of Split.

The hospital partnership in Vác, Hungary, decided to expand their focus to address the needs of the greater community and initiated a healthy communities project in the last year of the partnership with Winston-Salem. Similarly, the Riga, Latvia/St. Louis, Missouri partnership reached out to the town of Tukums and worked with them to mobilize around priority issues identified by the community.

KEY RESULTS

➢ *Mobilization of Diverse Community Stakeholders*

As a first step, the HC partnerships worked to mobilize their local communities to plan and implement health interventions. They identified stakeholders, who ranged from health professionals to police and teachers and politicians, who could help provide a diverse view of what steps needed to be taken to improve the health of the community. In many cases, the communities created boards to formally convene the stakeholders.

- In Slovakia, the Turcianske Teplice healthy community project assembled a multi-faceted task force comprised of the town's mayor, town deputies, the town's environmental engineer, a teacher, a priest, a coach, a social worker, and interested community residents. Group leaders engaged residents in an open dialogue on their perspectives of community problems. Together with their American partners, they systematically compiled a list of priority health issues and the resources available to the community to address the problems.
- In Hungary, the Vác/Winston-Salem partnership created the Vác Healthy Community Task Force to coordinate the partnership's healthy community activities. Regular meetings of the task force helped to bring together the community and the municipal policymakers and stakeholders, and convinced them that they were doing significant work for the benefit of the community. These meetings demonstrated to the mayor and local policymakers that everyone must share the responsibility for the community's health and well-being.
- In Tukums, the Riga, Latvia/St. Louis, Missouri partners helped local leaders to establish a community coalition (or council) comprised of representatives of the municipal government, schools, child development center, churches, social workers, healthcare professionals, and the general community.
- The Hungarian partners in Győr established a multi-disciplinary Community Advisory Board to organize and implement the healthy communities process and subsequent interventions.

➢ *Community Needs Assessment*

An essential element of the healthy communities process is a community health assessment. The assessment is critical not only for planning and optimizing the use of community resources, but also to generate a genuine sense of collective ownership, individual responsibility, and shared accountability for creating a healthier community.

It provides an opportunity to establish baseline measures of health status, health practice and health-related perceptions of a population. The assessment draws on both quantitative and qualitative data on health status and use of health services. Factors that are examined include: the political, social, and economic determinants that impact on health; lifestyle factors such as smoking, exercise behavior, nutritional and dietary habits;

environmental factors including, for example, exposure to carcinogenic agents in the air, water and workplace; and relevant hereditary and physiological factors.

- Leaders in Turcianske Teplice conducted community surveys and analyzed data to determine community needs. The initial survey was administered to 1620 school-age children to assess the impact that the economic transformations was having on the family and to provide baseline data with which to assess and monitor the health of school-aged children and their parents in the district. A behavioral epidemiologist from Case Western Reserve University held workshops and discussed the methodology with the TT team in order to assist them in the development of a Family Stress Survey. A survey questionnaire was administered to over 1,600 school-aged children and 500 parents. Results were then used to design interventions.
- Partners in Petrzalka, with the help of a local research firm, administered a survey to over 800 students, addressing the lifestyle and risk of children and youth of that community. The results revealed rising rates of drug abuse among teenagers. An unexpected finding of the survey was that domestic violence was also an issue in Petrzalka where the unemployment rate was extremely high following the collapse of the old regime – 816 children and youth between the ages of 12 to 18 participated in the survey.
- In Romania, the Constanta partners also conducted a community health assessment to identify health needs. Twelve hundred local women were surveyed to identify perceptions and concerns related to women's health. The top three health concerns listed by those surveyed were STI's, domestic violence, and lack of health education.
- The partners in Győr, Hungary, conducted an initial assessment of women’s health needs in the community through the use of focus groups representing the target populations. After receiving training from a research fellow at the Hungarian National Drug Prevention Institute and AIHA, the partners conducted eight focus groups with a total of 46 women. After analyzing the focus group interviews, the partners identified the priority women’s health needs in the community and the target groups on which to focus intervention activities.
- Split/New Jersey partners conducted an initial needs assessment and identified high-risk behaviors among adolescents as the focus of the partnership. To determine the prevalence of risk-taking behaviors among adolescents, the Youth Risk Behavior Survey (YRBS, a data collection tool developed by the US Centers for Disease Control and Prevention) was conducted after the instrument was adapted culturally and translated. The survey was conducted in a sample of primary and secondary schools in Split, and approximately 987 students ages 12-17 completed the survey. Analysis of the YRBS results showed that alcohol abuse was an emerging issue among adolescents in Split. Overall the findings from the YRBS indicated that early onset of alcohol use, in conjunction with high-risk behaviors, was an emerging problem in Croatia. Based on the needs assessment and the findings of the Split/YRBS, the partnership focused on both the problem of alcohol abuse among adolescents and the need to strengthen primary and secondary prevention to empower adolescents and counteract negative societal change.

➢ ***Successful Community-Based Interventions***

The HC partnerships implemented a wide variety of projects and programs based on the needs identified in the community assessments. US and CEE partners worked together to leverage funding for continued projects, create sustainable community organizations, and adapt various interventions to meet local needs.

- The Turcianske Teplice community recognized the need to provide reliable emergency transportation and chose to initiate a voluntary community fundraising drive to purchase an ambulance. A Citroen ambulance was purchased and equipped, which now serves a wide catchment area (12-20 km). Within 10 minutes everyone within that area can get emergency services. Through the process of raising funds, the community learned the importance of approaching new donors, establishing a system to recognize contributors, and changed the tax laws to encourage charitable contributions.
- Petrzalka’s Citizen’s Association of Aid to Children at Risk (CAACR), with the help of Truman Medical Center in Kansas City, worked to prevent drug abuse among teenagers and domestic violence. It designed and implemented an extensive drug awareness campaign for teenagers and trained teachers to recognize

signs of drug or child abuse. Approximately 30 to 50 community residents participate in the monthly anti-drug forums. The CAACR has also opened a crisis hotline and the Hope Center for battered women to provide counseling and self-help activities for women and children fleeing domestic violence or confronted with drug abuse crises. The Center provides services to approximately 500-600 clients each year. In addition to the services provided to clients who visit the center, over 40 volunteers were trained to respond to calls to the Crisis Hot Line. Approximately 1,600 calls are received per year for consultation, counseling and referral. In 2004 the Crisis Hotline received 1,850 calls, a drastic increase over 2001, when they only had 60 calls.

- The Constanta community developed an integrated approach to responding to the problem of domestic violence. In 2000, the Constanta-Louisville Healthy Communities Partnership founded the Constanta Community Foundation and immediately opened an Office for Women which has served over 1,200 victims of domestic violence. Since the Office for Women was opened in December 2000 and the first case of domestic violence was recorded, more than 1,200 victims sought serves from the center.
- In April 1998, the Hungarian partners established the Association for the Health of the Citizens of Vác, a task force consisting of local government officials, educators, public health officials, and leading businessmen. The Association was created in order to develop and implement a community health program in Vác municipality. The association continues to remain active after the end of USAID/AIHA funding, with support of the Vác municipal government. In December 1998, the partners celebrated the opening of the Healthy Community Center in Vác. The Center serves as a venue for community education programs and as a resource center and meeting place for the Healthy Community Task Force.
- Győr/Pittsburgh partners celebrated the grand opening of For Women's Health, the women's health information and resource center in Győr. The center provides women in the community with access to important information about issues such as family planning, healthy childbirth, healthy lifestyles, and mental health. The partners report that in its first six months of operation, For Women's Health held 54 health classes attended by 1,146 people. Over 150 additional individual visitors visited the center. Center staff loaned resource materials to 183 people and distributed 10,900 leaflets on a variety of topics.
- In Martin a Promotion of Non-Smoking Center was established and since then there has been a 6% decline in daily smoking. In the US they were introduced to the concept of using mass media to communicate about public health and learned how to do it. These skills enabled them to reach the entire Slovak population with their messages in newspapers, radio shows, and press conferences. There is a stop smoking day every year and semi-annual press conference on the smoking cessation program. They have established a Web site which has information about tobacco control and they have a Web site and a "Quick Line" for people to call who want advice on how to quit. They also have published evidence-based guidelines for smoking cessation in the Slovak language.
- In Banska Bystrica, a new city department for health care was established, the regional hospital designated a 20-bed ward as a geriatric care unit, and a municipal 18-bed unit was established for pensioner care. The city also began a program that encouraged self-management of chronic disease that included the initiation of the area's first ambulance service, a family stress reduction program and a city clean-up campaign.

➢ *Sustainability*

By building capacity within the local communities for mobilizing resources, the healthy communities partnerships placed great emphasis on the sustainability of initiatives started under the partnerships. AIHA and US partners helped the CEE partners connect with other organizations with which they could collaborate and provided training and tools for fundraising and, in the case where new NGOs were created, for applying for legal status within their countries.

- The Slovakian partners were able to develop a viable ongoing marketing/promotional plan to increase the awareness of Citizen's Association of Aid to Children at Risk's efforts, and to create methods for fundraising activities to sustain the viability and continuation of CAACR with the assistance of a US Peace Corps volunteer. The CAACR received a 600,000 Sk grant ($17,200 approx.) from EUPHARE and

the City of Petrzalka in the Fall of 1998. The grant enabled the foundation to hire four full-time employees to work on Domestic Violence issues and the Hope Center's Fundraising and Public Awareness campaign.

- Since 1995 the Petrzalka partners have initiated numerous promotional activities/media campaigns to inform the Bratislava/Petrzalka community about the seriousness of drug abuse and mental health problems/issues of Petrzalka teenagers and adolescents (e.g., newspapers, radio, television, and drug forums). The founder of CAACR conducts a special radio talk show two to four times per month, and a special television show on an average of once a month, both on local Petrzalka stations. She discusses topics such as social issues, domestic violence, and drug abuse and gives listeners an opportunity to call in and ask questions.
- Hungary's partnership which linked networks of cities embracing the healthy communities approach, provided guidance on women's reproductive health services HAHC's 23 member cities and improved the networking capabilities among the member cities in addressing women's reproductive health and other issues. The partners identified current and potential opportunities for addressing women's health in Hungary, including US models that might be applicable to the Hungarian situation. IHC shared a range of resources to help communities build capacity and collaborative partnerships, including materials related to assessing and improving health status, implementing community health improvement programs, engaging the business community, developing community health policy, and a variety of brochures and newsletters.
- In Croatia, partners implemented a translated version of the American program, Project Northland in 13 local schools. Project Northland is a school-based curriculum designed as a multilevel, multiyear program proven to delay the age at which young people begin drinking, reduce alcohol use among those who have already tried drinking, and limit the number of alcohol-related problems of young drinkers. Designed for sixth, seventh, and eighth grade students (10 to 14 years old), PN uses an ecological framework to address both individual behavioral change and environmental change. PN also strives to change how parents communicate with their children, how peers influence each other, and how communities respond to young adolescent alcohol use. The program includes: active parental involvement and educational programs, behavioral based curricula, peer participation activities, and comprehensive involvement of the community.

➢ *National Impact*

Many of the communities involved in the HC partnerships also had an impact beyond their individual communities by lobbying their governments to pass laws or by demonstrating successful models for replication. Examples include:

- As a result of lobbying by Martin, the haemophillus influenza is now fully reimbursed by insurance, and in 2004 Martin was successful in getting legislation that had been pending for seven years passed which prohibited smoking in public buildings. And as a direct result of the advocacy of the Petrzalka partners, there is now national legislation to protect victims of domestic violence.
- The Constanta experience is being used as a model in six different counties in Romania and for the ministry of health's National Strategy to monitor, prevent and combat domestic violence. In April 2002, the national strategy on fighting domestic violence was approved. It includes provisions for all levels of government to be active. The law created an inter-ministerial committee of the Departments of Health, Justice, Youth, Police, Education, and Sports, etc. with responsibility for improving the laws to protect victims. It also calls for a National Commission for monitoring and preventing domestic violence and it requires counties to establish an Office for Women and a shelter for victims.
- The Hungarian Association of Healthy Communities worked on a national level to 1) better engage business leaders in the Hungarian communities in garnering their support for programs addressing women's health and other issues, and 2) increase the capacity and effectiveness of HAHC coordinators in organizing and implementing community-based programs. To meet these needs, the partners held two meetings in Budapest in February 2004. The Business Leaders Summit engaged Hungarian business

leaders in critical dialogue with executives from leading Pennsylvania businesses regarding their corporate responsibility for improving health and quality of life in their own communities.

CHALLENGES

- The healthy communities partnerships were generally funded for too short a duration to be able to fully support the community interventions being implemented by the partnerships. Healthy communities partnerships were ending just as they were at the point of being able to effectively administer programs. While some activities could not be implemented, AIHA and the partners focused on issues of sustainability during the partnerships, providing the local CEE partner communities with the ability to secure their own future funding. For example, community foundations and other NGOs were established by CEE partners which were able to apply for grants and conduct other fundraising activities.
- In some cases, funding agencies and other entities were expecting immediate results from the healthy communities process. The healthy communities process is most effective when allowed to work over a period of time. Expecting communities to be galvanized and addressing health issues in the first three to six months of a partnership was unrealistic, and created strains on the partners who were trying to navigate through the process. To address this issue, AIHA instituted the idea of "early wins," suggesting that partnerships plan some sort of activities early on in the process which addresses health needs in the community while at the same time galvanizing the public about the healthy communities project.