CHAPTER II

EASSAY ON COMMUNITY HEALTH PARTNERSHIPS: THE POWER OF COLLABORATION

2.1 Introduction

As a renewed emphasis on public health efforts, and the outgrowth of the social movements, more recently re-emerging dominant notion of disease prevention and health promotion have expanded their efforts through creating positive environments, strong community action, and using public policy in new ways that support community collaboration (WHO et al., 1986; and Hanson, 1988-89). In recent years, a number of programs, such as Planned Approach to Community Health or PATCH (Sutherland et al., 1992), the Assessment Protocol for Excellence in Public Health or APEX/PH (Centra and McDonald, 1997), and Healthy Cities (Campfens, 1997), have guided community mobilization activities.

In Thailand, the decentralization of health sector and development of district health systems, are part of the broader process of political decentralization, which has the aim of strengthening local government and the critical relationship between local government and local health systems to create considerable potential for health promotion and community action (Wibulpolprasert, 1998; Hasroh, Mhankham, and Khamsirirak, 1999; and Wongkhomthong, 2001), have been introduced on political, managerial and ethical grounds providing the opportunity for people to participate individually or collectively by exercise their voice and exit options. That is, at the very least, local communities need to be encouraged to collaborate and influence health

activities by forming co-management and shared responsibility as partnership, involving staff and community representatives to work together on community health issues. However, their actual work is still fragmented and not comprised overall community collaboration. Furthermore, there remains a need to broaden the understanding of the key principles that underlies successful community collaboration in public health. This is because in practice, it resulted in what Ugalde (cited in Mosquera et al, 2001) defined as '*symbolic participation*' whereby community involvement was largely confined to collaboration with the existing system and hence 'the legitimization of low quality care for the poor'.

According to the foundation that health services exist to benefit the community in which community has the right to participate in the determination of health priorities, selection of strategies, implementation, and evaluation of programs. However, in practice and from initiative's analysis and other various studies of public health have made it clear that the missing element is the direct community involvement in health (Braithwaite, Bianchi, and Taylor, 1994; Florin, Mitchell and Stevenson, 1990; Glans, Lewis and Rimer, 1997; and Hatcher and McDonald, 1993). In other words, community is limited to the participation in the planning, decision-making and management of health care as well as an active community collaboration is still uncommon and is not free of problems (Nilson and Kraft, 1997; Wibulpolprasert, 1998; Hasroh, Mhankham, and Khamsirirak, 1999). Therefore, to address health issues in bringing both professional and consumer perspectives together in a community to plan a comprehensive set of health improving activities, health partnerships is critically considered.

Therefore this essay is primarily intended to provide the basic community development, opportunities and challenges of partnerships as the power of community collaboration, the problems or barriers underlying collaboration among health partnerships and how it could be improved.

2.2 The concept of community

It is considered to be a good idea to take a first step in considering the meaning and concept of community. Fundamentally, community is a fluid concept. This means that what one person calls a community may not match another person's definition. However, those interested in working with a community must first have a clear picture of the entity they are trying to address. Understanding the dimensions of the concept of community will enable those initiating partnership processes to better target their efforts and work with community leaders and members in developing appropriate participation strategies (Chavis and Newbrough 1986).

How, then, can communities be defined? This question can be answered from two viewpoints. First, a broader sociological or systems perspective as well as a more personal, individual perspective. In either case, central to the definition of a community is a sense of "who is included and who is excluded from membership" (Campfens, 1997). A person may be a member of a community by choice, as with voluntary associations, or by virtue of their innate personal characteristics, such as age, gender, race, or ethnicity (Campfens, 1997; Fawcett et al., 1995). As a result, individuals may belong to multiple communities at any one time. Therefore, when initiating community

participation efforts, one must be aware of these complex associations in deciding which individuals to work with in the targeted community.

From a sociological perspective, the notion of community refers to a group of people united by at least one common characteristic. Such characteristics could include geography, shared interests, values, experiences, or traditions (Florin and Wandersman, 1990). John McKnight, a sociologist, once said that if one were to go to a sociology department in search of a single, simple definition of the word community, one would "...never leave. To some people it's a feeling, to some people it's relationships, to some people it's a place, to some people it's an institution" (CBC, 1994).

Communities may be viewed as systems composed of individual members and sectors that have a variety of distinct characteristics and interrelationships (Thompson et al., 1990). These sectors are populated by groups of individuals who represent specialized functions, activities, or interests within a community system. Each sector operates within specific boundaries to meet the needs of its members and those the sector is designed to benefit. For example, schools focus on student education, the transportation sector focuses on moving people and products, economic entities focus on enterprise and employment, faith organizations focus on the spiritual and physical well-being of people, and health care agencies focus on prevention and treatment of diseases and injuries. In reality, these sectors are a few of the many elements that comprise the overall community system.

Furthermore, a community can be viewed as a living organism or well-oiled machine (Florin and Wandersman, 1990; Chavis and Wandersman, 1990; and Fawcett et al, 1995; and Kendrick, 2001). That is, for the community to be successful, each sector has its role and failure to perform that role in relationship to the whole organism or machine will diminish success. In a systems' view healthy communities are those that have well-integrated, interdependent sectors that share responsibility to resolve problems and enhance the well-being of the community (Kretzmann and McKnight, 1990). Thus, it is increasingly recognized that to successfully address a community's complex problems and quality of life issues, it is necessary to promote better *integration*, *collaboration*, and *coordination* of resources from these multiple community sectors (Israel et al, 1994; Mattessich and Monsey, 1992; Kroutil and Eng, 1989; and Wibulpolprasert, 2000).

2.3 Community development

Community development has evolved from a very different perspective. The term *community development* has been in use a long time and has taken on many meanings. Other labels are in use that can be confused with community development, such as community mobilization, community empowerment, community action, community organization, and community-based programming. However, what is common to almost all community initiatives is a philosophy and process that:

- emphasizes the participation of people in their own development (as opposed to "client" state),
- recognizes and uses people's assets (as opposed to attending mainly to their problems and limitations),

- encourages the participation of people in the generation of information about community needs and assets (as opposed to the research controlled by professionals),
- empowers people to make choices (as opposed to the management of people by institutions of power), and
- involves people in the political processes that affect their lives (as opposed to nonparticipation) (Brown, 1991; Campfens, 1997; Dluphy and Kravitz, 1990, Fawcett et al., 1995; Green, George, et al., 1995; Kretzmann and mcKnight, 1997; Perskins and Zimmerman, 1995).

2.4 When does community development happen?

Community development stems from the belief that community itself has or is able to develop solutions to the issues and opportunities within the community. Rather than waiting for someone else, community members believe in their own ability to take action. However, some people may need to be convinced that they do in fact the have the power to act and that the contribution they could make is of value (Frank, and Smith, 1999). Therefore, it can be said that the foundation requirement for successful community development is empowerment (Bracht, 1999).

2.5 Community empowerment

Empowerment is a central construct for community health promotion. For example, the World Health Organization (1986) defined *health promotion* in a document known as the Ottawa Charter as "the process of enabling people to increase control over, and to improve, their health" (p. 17). This definition suggests a picture of health promotion as a dynamic process or series of events and strategies that must

necessarily involve consumers and consumer ownership of the process. In addition, empowerment is defined as a sharing of power and the result of a good agreement developed by the community (Lyttleton, 1996). That is, each participant feels that their needs are being met and that their credibility is increasing.

According to Butterfoss, Goodman and Wandersman, (1993), and Florin and Wandersman (1990) empowerment has been defined in many ways.

Psychological empowerment can be defined as a subjective feeling of greater control over one's own life that an individual experiences following active membership in groups or organizations. Psychological empowerment may occur without participation in collective political action and is assessed with the individual as the unit of analysis.

Community empowerment is a state that communities or community subgroups may attain. It can be considered as defined by participation in collective political action that results in a raised level of psychological empowerment and the achievement of some redistribution of resources or decision-making sought by a community or subgroup.

Lasker and the Committee on Medicine and Public Health (1997) points out that in current environment, working in traditional ways on health issues is no longer a viable option, a proactive approach to deal with this challenge is that the health professionals and community-based organizations should participate in the collaborations. The language and practice of health and human services since the 1990's are dominated by two catch phrases: coalition building and empowerment. Both Chavis and Florin (cited in Wolff, 1992) and Himmelman (1992) point out that the

empowerment-community development approach leads to increase both in community ownership and in individual and community control over their own destiny.

Empowerment also has an extensive literature regarding definition. In its simplest form, defined by Minkler (1989) as "the process by which individuals and communities gain mastery over their lives". The Cornell Empowerment (1989) states that "Empowerment is an international, ongoing process centered in the local community, involving mutual respect, critical reflection, caring and group participation through which people lacking an equal share of valued resources gain greater access to and control over those resources". Wallerstien (1992) states that "Empowerment is a social action process that promotes participation of people, organizations and communities toward the goals of increased individual and community control, political efficacy, improved quality of community life and social justice".

Labonte (1989) explores the political aspects of empowerment and offers some cautions regarding its universal use in the 1990's that "Empowerment is a noble word, but the reality of political and economic distribution of power does not yield win-win scenarios. That is, socially disadvantaged communities empower themselves, in part, by reducing the constraints imposed upon them by wealthier and more powerful interests". This is because, the empowerment involves a process of working *with* people rather than doing *for* people. Therefore, to create the community empowerment, participation by the population is also needed. This is because the failure of many conventional development projects and programs, people are identified as the missing element in development efforts (Oakley, 1991). The limited success of many development

initiatives was attributed to failure to involve people in the design and implementation of projects and programs (Cernea, 1991; FAO, 1990; Hincheliffe et al., 1995; Kottak, 1991; Oakley, 1991; Uphoff, 1991; and World Bank, 1998).

2.6 Community participation

Definitions and concepts of participation in community development have evolved over time. Their roots can be traced back to community and popular participation, promoted mainly by non-governmental organizations (NGOs) in the 1950s and 1960s (Oakley et al, 1991; Karl, 2000). In the late 1970s and early 1980s, multilateral agencies, such as Food and Agriculture Organization of the United Nations (FAO), International Labour Organization (ILO) and the United Nations Development Program (UNDP), also began to promote popular participation in development projects and programs (Rudqvist and Woodford-Berger, 1996: http://www.fao.org/sd/PPdirect/Ppre0074.htm; Unisa, 2000 http://www.unisa.ac.za/commcul/policy.html).

The main emphasis in the 1980s was, therefore, on popular or people's participation and on ways to involve the rural poor in development projects and programs. One of the early initiatives to involve people in development was FAO's People's Participation Program (PPP) with a focus on the rural poor, women in development and promotion of small groups in development projects and programs (FAO, 1990; Warren, 1998). This program viewed participation as enabling the rural poor to pool their efforts and resources in pursuit of objectives set by themselves (FAO, 1990).

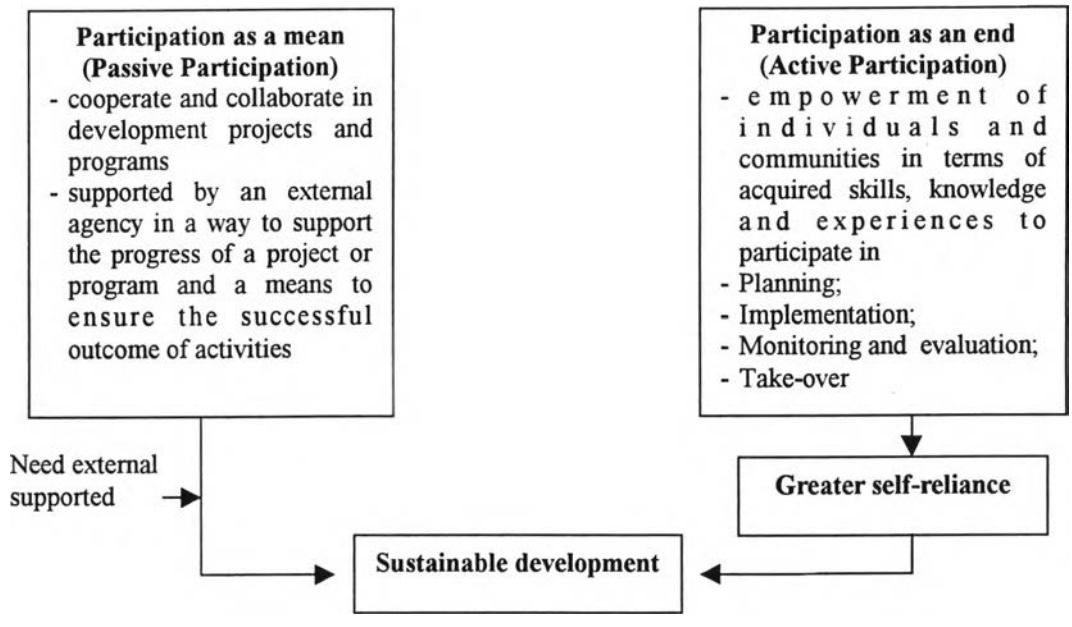
The Popular Participation Program in the early 1980s defined participation as "the organized effort to increase control over resources and regulative institutions in a given situation on the part of groups or movements hitherto excluded from such control" (cited in Rudqvist and Woodford, 1996, p. 11). Additionally, according to Oakley (1991) popular participation can be interpreted along three broad lines:

- Participation as contribution, such as voluntary or other forms of input by rural people to predetermined programs and projects.
- Participation as organization, either externally conceived or emerging as a result of the process of participation.
- Participation as empowerment, enabling people to develop skills and abilities to become more self-reliant, and to make decisions and take actions essential to their development.

Rudqvist and Woodford-Berger, (1996), suggested that participation in most of development projects and programs is widely seen as both a means and an end. While many development agencies give equal to both, some emphasize one or the other aspect of participation.

As a means, participation project in which people and communities cooperate and collaborate in development projects and programs (Bracht, 1999; IDB, Clayton et al, 1998). In this view, participation, sponsored by an external agency, is a way to support the progress of a project or program and a means to ensure the successful outcome of activities. The term "participatory development" is commonly used to describe this approach (Warren, 1998; Clayton et al., 1998; and Wolff, 1992 http://www.ahecpartners.org).

Figure 2.1: Participation model in community development



As an end, participation is a process as the empowerment of individuals and communities in terms of acquiring skills, knowledge, and experiences, leading to greater self-reliance (Mosquera et al, 2001; Ramiro et al, 2001; and IDB, Clayton et al., 1998). Participation is an instrument to break poor people's exclusion and lack of access to and control over resources needed to sustain and improve their lives. It is intended to empower them to take more control over their lives (Bracht, 1999 and Clayton et al., 1998). Participation is also viewed as an end to help ensure sustainable development (Rudqvist and Woodford-Berger, 1996; and Uphoff, 1992).

Concepts of participation have widened to include not only the rural poor but also other sectors of civil society (Hasroh, Mhankham, and Khamsirirak, 1999; and Rudqvist and Woodford-Berger, 1996). This is reflected in a charge of terminology from "the rural poor", "beneficiaries" or "users" to "stakeholders" and "partners" (Rudqvist and Woodford-Berger, 1996; World Bank, 1998). The World Bank's

Learning Group on Participatory Development defines participation as "a process through which stakeholders influence and share control over development initiatives and the decisions and resources which affect them" (World Bank, 1998, p. 11).

Several factors have influenced this notion of participation as involving a wider range of stakeholders. One is the trend towards decentralization and transfer to responsibilities from government to people. Another is the conclusion that small-scale community participation and empowerment are not sufficient to ensure the sustainability of development efforts (Oakley, 1988; Rudqvist and Woodford-Berger, 1996; Warren, 1998).

With this has come an emphasis on partnership and dialogue among the various stakeholders (Rudqvist and Woodford-Berger, 1996). In complex socio-political environments, the concept of participation has increasingly come to include "involvement of local institutions and civil society in a power-sharing scheme, based on negotiation and conflict management" (Warren, 1998 p. 122). Four broad types of participation can be distinguished in popular participation projects and programs (Oakley, 1988).

- Involvement: the community gets involved in and benefit from the activities of rural development projects.
- Community development: the community participation in specific tasks.
- Organization: the community participates through a formal organization.
- Empowerment: the community actively participates in development projects and gain access to, and share in the resources required for rural development.

Looking at the perspective of any of the community participation in the projects, participation can include a range of possibilities (DFID, 1995; Chuchati, Suwanphong, and Goykaewprink, 1995).

- Being in control and only consulting, information or manipulating other stakeholders.
- Partnership such as equal powers of decision-making with one or more of the other community-based organizations.
- Being informed by other community-based organizations who have more control.
- Being manipulated by other stakeholders such as to contribute labour or money to an activity in which one has no interest or perceived benefit.

A continuum of participation can be ranged from minimal participation to intense participation. The following table outlines several different views of this continuum.

Table 2.1: Different views of participation continuum

Development projects and programs (Clayton et al., 1998)	World Bank supported projects (World Bank, 1996)	Participatory research (McAlliter, 1999)	World Bank Poverty Reduction Strategy (Edgerton et al., 2000, McGee and Norton, 2000)
Manipulation: participation is contrived as the opportunity to indoctrinate.		**Cooperation:** token participation, with no real input or power. Compliance: community is assigned tasks.	
Information: stakeholders are informed about their rights, responsibilities and options.	**Information sharing:** projects' designers and managers share information with beneficiaries.		**Information sharing:** one way flows of information to the public.
Consultation: stakeholders may express suggestions and concerns but have no assurance that their input will be used.	**Consultation:** people are given the opportunity to interact and provide feedback to the development agency.	**Consultation:** local opinion is sought, but analysis and decisions are made by outsiders.	**Consultation:** two-way flow of information between the coordinators of the consultation and the public.
Consensus-building: stakeholders negotiate positions.		**Cooperation:** local people help determine priorities, but the process is directed by outsiders.	

Development projects and programs (Clayton et al., 1998)	World Bank supported projects (World Bank, 1996)	Participatory research (McAlliter, 1999)	World Bank Poverty Reduction Strategy (Edgerton et al., 2000, McGee and Norton, 2000)
Decision-making: stakeholders take collective decisions.	**Decision-making:** people have a role in making decisions on policy, project design and implementation.		**Collaboration:** shared control over decision-making.
Risk sharing: community makes decisions together and share in the risks.			
Partnership: community-based organizations work together as equals towards mutual goals.		**Co-learning:** local people and outsiders share knowledge and work together to firm action plans.	
Self-management: community interacts in a learning process which optimizes the well-being of all concerned.	**Initiating action:** people are able to take initiative in terms of actions and decisions pertaining to operations.	**Collective action:** people act their own agenda and carry it out in the absence of external initiators.	**Empowerment:** transfer of control over decision-making and resources to all community-based organizations.

Therefore, since every organization in the health field has customers, clients, or constituents who influence how the work is accomplished and received. Community participation has expanded to include many additional techniques since the 1970s as advocates, politicians, and professionals have come to realize that project benefits form community participation at numerous points in the planning process, not simply at the end (Mattessich and Monsey, 1992; McMillan, et al., 1995; and Bracht, 1999).

Community participation is defined as the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being through constituents to achieve common goals (Mosquera et al., 2001; and Bracht, 1999). The process demands that those implementing the participation effort communicate with community leaders and members who have diverse backgrounds, values, priorities, and concerns. It is at this point that the principles and organizing concepts underlying community participation come together with real-world activities. That is, people in the community should participate not just for some romantic notion about their involvement but because they have a particularly locale, specifically situated expertise that is different than, but equally important to, that of professional designers. This can be said that only they will know during the planning stage which features likely will be respected and nurtured, which neglected, and which abused, leading to better plans and designs. Hence, conducting and managing community participation activities are ongoing and critical responsibilities of every organizational leader involved in health-related decision-making.

During the past two decades, researchers have provided evidences to support the notion that the social environment in which people live, as well as their lifestyles and behaviors, can influence the incidence of illness within a population (IOM, 1988). They have also demonstrated that a population can achieve long-term health improvements when people become involved in their community and work together to effect change (Hanson, 1988-89). For example, many communities are already involved in coalitions and partnerships around specific issues such as HIV/AIDS (Chai-ngummuang, 1999), substance abuse prevention, and community and economic development (AED, 1994).

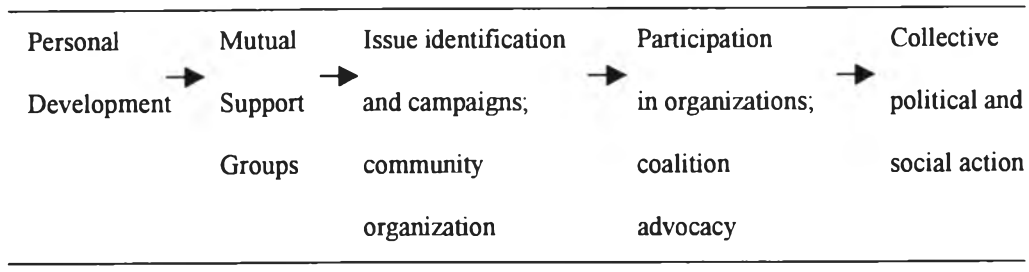
2.7 The process of empowerment and participation

It can be said that community participation has been directly linked to empowerment as the principal mechanism by which individuals and groups become empowered and as a means of promoting healthier individuals, communities, and environments (WHO, 1991). Participation facilitates psychological empowerment by developing personal efficacy, developing a sense of group action, developing a critical understanding of social power relationships, and developing a willingness to participate in collective action (Bracht, 1999; Florin and Wandersman, 1993). Psychological empowerment and community empowerment are linked through the logical expectation that there ought to be empowered individuals within an empowered community. Hence, it is possible that an empowered community facilitates the psychologically empowered individuals can lead to an empowered community. Alternatively, psychological empowerment and community empowerment may be two independent constructs that do not overlap.

Community empowerment is linked with community by definition. That is, to be empowered community, "community" must exist. Psychological empowerment is linked to community because "sense of community" has been found to enhance citizen participation in groups and organizations and in social actions, as well as sense of personal power to influence people and events (Chavis and Wandersman, 1990). By enhancing participation in collective action, a raised sense of community within a community contributes to the likelihood that the community is empowered. It might be expected that groups with actual control over resources have a high level of reported psychological empowerment.

As community development or organization is the means by which communities or groups might become empowered (Bracht, 1999; Chavis and Wandersman, 1990; and Frank and Smith, 1999), the community health development continuum is a useful schema for representing the psychological empowerment and community empowerment process. The potential for community empowerment is maximized as the focus shifts from the individual to collective social action (Chavis and Wandersman, 1990; Florin and Wandersman, 1990; Bracht, 1999), although the process need not be simply linear, with one stage automatically following the other. For instance, personal development might follow participation in an organization, or support groups might emerge following issue identification activities.

Figure 2.2: Community development stages for maximizing community empowerment potential.



Source: Adapted from Jackson et al., 1989, in Bracht, (1999) Health Promotion at the Community Level 2: New Advances, Sage Publications: New Delphi.

The process of community empowerment begins with an assumption that a power deficit or an unattended social problem exists, despite the presence of some competencies. By contrast, an empowered community logically should include groups of individuals who have a raised sense of empowerment. Joining mutual support, self-help, or action groups (whether formal or informal) builds and expands social networks and provides an opportunity for a personal mentor (Hatcher, and Mcdonald, 1993). Or groups to support personal development process. At the same time, individuals may become more critically aware of how political structures operate and affect them and their subgroup or this critical consciousness or awareness may develop through participation in a group or other mediating social structure. Participation in and influence of a group or organization is an important stage of both psychological and community empowerment (Green et al., 1986; Perskins and Zimmerman, 1995; and Campfens, 1997). It is often the means by which people learn skills that may be able to transfer to other situations (Glanz, 1997) and how communities develop their problem-solving capacity (Fawcett et al., 1995).

Participation in collective actions is also fundamental to the successful redistribution of resources, which is necessary before a community or community subgroup can be said to be empowered (Bracht, 1999; and Perskins and Zimmerman, 1995). The emphasis on community actions as a core component of community empowerment (Brown, 1991) is also consistent with the principles of community health *partnership* (Boelen, 2000; and Fawcett et al., 1995) Issues being addressed by the group or community should be or have identified by the group. Ideally, the outcome of the community empowerment process is a greater degree of psychological empowerment among community members than before the process, as well as an actual increase in control over resource.

2.8 Organizational model for integration

Making the best of the available expertise and resources, a common agreed-upon mechanism among the main health partners or stakeholders, which entails coordination or integration. Coordination or integration may not necessarily be viewed in the same was by all the health partners, who may argue that they are only means to an end and that a sense of responsibility can be enhanced only by a certain degree of autonomy.

Table 2.2: Compares the concepts of autonomy, coordination, and integration with a number of issues in order to help clarify the position of partners in each case.

	Autonomy	Coordination	Integration
Health information	Circulates mainly within a group of the same partners	Circulates actively among groups of different partners	Orients different partners' work to meet agreed upon needs
Vision of the system	Influenced by each partner's perception and possibly self-interest	Based on a shared commitment to improve the overall performance of the system	A common reference value, making every partner feel more socially accountable
Use of resources	Essentially to meet self-determined objectives	Often to ensure complementary and mutual reinforcement	Used according to a common framework for planning, organization and assessing activities
Decision making	Independent coexistence of decision-making modes	Consultative process in decision making	Partners delegate some authority to a unique decision node
Nature of partnership	Each group has its rules and may occasionally seek partnership	Cooperative ventures exist for time-limited projected	Institutionalized partnership is supported by mission statements and/or legislation

Source: *Boelen, C. (2000)* ***Towards Unity for Health: Challenges and Opportunities for Partnership in Health Development****, Geneva: World Health Organization.*

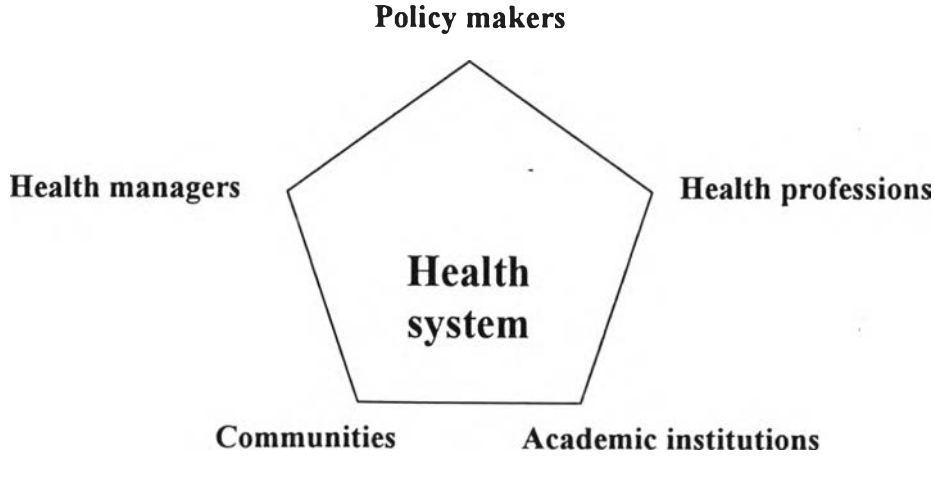
Autonomy is a stage in which each partner works mainly independently and relates to other in specific situations. Coordination is a stage in which partners with different backgrounds function in an agreed-upon working relationship with a view to reducing unnecessary duplication and optimizing everyone's outputs.

2.9 What is partnership?

Partnerships are a good vehicle for building effective community development processes and structures. A partnership is defined as a relationship where two or more parties with compatible goals form an agreement to share the work, risk, and results or proceeds (Boelen, 2000, and Espeut, 1998 http://www.ahecpartners.org).

According to the study of "Toward Unity for Health" or TUFH (Boelen, 2000), although there may be others, five principal partners have been identified; policy-makers, health managers, health professionals, academic institutions and communities. All have their own features and references, strengths and constraints, expectations and agendas. However, this heterogeneity can be mitigated if the partners share a common set of values as well as a certain vision for future health development. "The partnership pentagon" (Figure 2.3) illustrates the richness of possible permutations in establishing working relationships among partners with the common aim of creating a health development based on people's needs.

Figure 2.3: The component of partnership pentagon (Boelen, 2000)



A productive and mutually rewarding partnership can be anticipated if the stakes for creating unity for health are well known and documented (Boelen, 2000; Bracht, 1999; Idechong, 1998 http://www.ahecpartners.org). Partners or stakeholders must be aware of their individual potential and interests should prevail over sectoral interests. However, for a better appreciation of the value of synergy created through partnership, it is useful to review some of the facilitating and restraining factors (Boelen, 2000; Wiess, Miller and Lasker, 2001) for a collaborative process, as controlled by each of the five partners/stakeholders (see Table 2.3).

Table 2.3: Facilitating and restraining partnership from five stakeholders

	Facilitating factors	**Restraining factors**
Policy makers	- Capacity to articulate a long-term vision of a health services delivery system. - Potential to highlight on priority health concerns and people's needs in unbiased way and provide evidence for it - Capacity to set conditions for resources allocation by regularity mechanisms and legal action.	- Risk of being politically biased and not neutral enough to equally inspire trust among some stakeholders to get involved in partnership ventures. - Difficulty in translating policy orientation into range of organizational models conducive to synergistic action. - Lack of consistency and continuity in advocacy and support for institutional changes by failing to monitor and evaluate progress.
Health managers	- Potential to add credibility to partnership projects by a critical appraisal of their economic feasibility. - Capacity to stress on concrete implications for the (re)allocation of responsibilities among partners - Provision of resources to support collaborative work if evidence of benefits is given.	- Tendency to focus on specific subgroups (i.e. enrollees in health plans, patients, people at high risk) rather than a general population. - Risk of restricting attention to vertical rather than horizontal and intersectoral approaches. - Inclination to be self-sufficient in fulfilling their mandate by essentially referring to economic and administrative criteria.

Health professionals	- Direct and constant contact with people as principal providers of health services and compliance with a code of ethics in service delivery. - Concrete implementation of policy decisions and operational procedures with capacity to provide on-going feedback. - Permanent source of information regarding health concerns and priorities of individuals and society at large.	- Organized in strong associations to protect sets of values and corporate interests. - Autonomous minds and scepticism regarding usefulness of wide partnership except with their like-minded service providers. - Competition among the health professions, sometimes at the expense of equity and cost-effectiveness in health services.
Academic institutions	- Capacity to induce the acquisition of desired skills and behaviours for the implementation of a health agenda. - Inquiring mind and application of research methodologies o design and assess innovative models of health services delivery. - Role model for practitioners and reference regarding quality of care and health technology advancement.	- Relative isolation from the social content leading to misalignment of education and research programs with priority concerns and evolution of health systems. - Sanctuary of specialties and subspecialties at the expense of holistic vision, largely responsible for fragmentation in health services. - Lack of leadership for practical guidance in implementing multidisciplinary approaches in health and social development.
Communities	- Expression of needs and expectations with a problem-oriented approach. - Increasing awareness of rights and obligations, as well as opportunities for influencing the health agenda. - Voluntary force, readily avaiiable for collaboration and easily mobilized for alturistic causes.	- Tendency to excessive demands and relative reluctance to share risks and responsibilities - Volatile and unstable partnership, particularly for long-term action and institutional changes. - Influence by media and fasion. Passion of the moment sometimes prevails over rationality of facts.

Source: Bracht (1999) *Health Promotion at the Community Level : New Advances*, Sage Publication: New Delpi.

2.10 Opportunities and challenges of partnerships

According to Bracht and Kingsbury (1990) among the opportunities created by partnerships are assigned as following areas.

Pooled resources: It is clear that no one organization or sector acting alone has the necessary resources to significantly affect the changes needed to improve health of a community. Those who share interest in health improvement must come together to pursue their common goals (Boelen, 2000, Bracht, 1999). Effecting change in the determinants of health will require active participation and contributions from a wide range of stakeholders, including public health and managed care professionals, community-based organizations, health care providers, academic institutions, purchasers, and consumers (Bracht, 1999; Espeut, 1998 http://www.ahecpartners.org).

Similar goals and missions: In order to achieve the goals and objectives relating to population health orientation, partnerships serve a larger shared responsibility maintaining optimal health for every member of every community (Baker, et al., 1994). According to the mission of public health that has been long to improve, protect, and promote the health of all the citizens of a community, working as a partnership seemed to be covering.

Eliminate overlap and duplication of effort: It has recently been estimated that when people and organizations are recognizing the importance of collaboration in transforming and strengthening the health care infrastructure, and share an interest and responsibility, brings about solid and long-lasting changes and improvements in the health of the whole population (Levinve, 1996).

Incorporates community values into strategies plans: "Community partnerships has inherent value because of its positive effects on social relationships and community solidarity (Bryan, et al. 1994). The success can be found in community mental health program such as the one in the Venezuelan Andes where "the existence of a strong committed leadership with ties to local communities and to the power structure, the availability of clinic staff open to training and direction, and the isolation and dense, extended family ties to these Andean communities all contributes to success in the efforts of change the mental health system" (Levinve, 1996, p.32).

Allows people to develop new skills such as negotiations, collaboration and consensus building: The National Breast Cancer Coalition (NBCC, 1996) offers a model of partnerships in which members of the community become their own advocates to mobilize resources on behalf of a public health issue. At NBCC's foundation are a number of community-based support groups, which reflects the desire to establish relationships within the community. The coalition, very much in line with the concept of community self-determination, crafted new roles for women with the breast cancer and also took steps to provide members of their community with the capacity-the skills and knowledge-to participate in and contribute to the public health and policy process.

Builds bridge between various governmental and non-governmental organizations as well as between people of different socio-economic levels: For instance, a community-based/community-wide information system for data and computer application to track childhood immunizations in Peninsula Health District. This immunization tracking system was one of the first community-wide, immunization data base efforts in Peninsula to connect public and private immunization records.

By developing effective and enduring alliances with the community, and by empowering a community and its leaders, the rate of missed immunization opportunities have decreased and increased in the percentage of children adequately immunized by age of two (Williams, 1990).

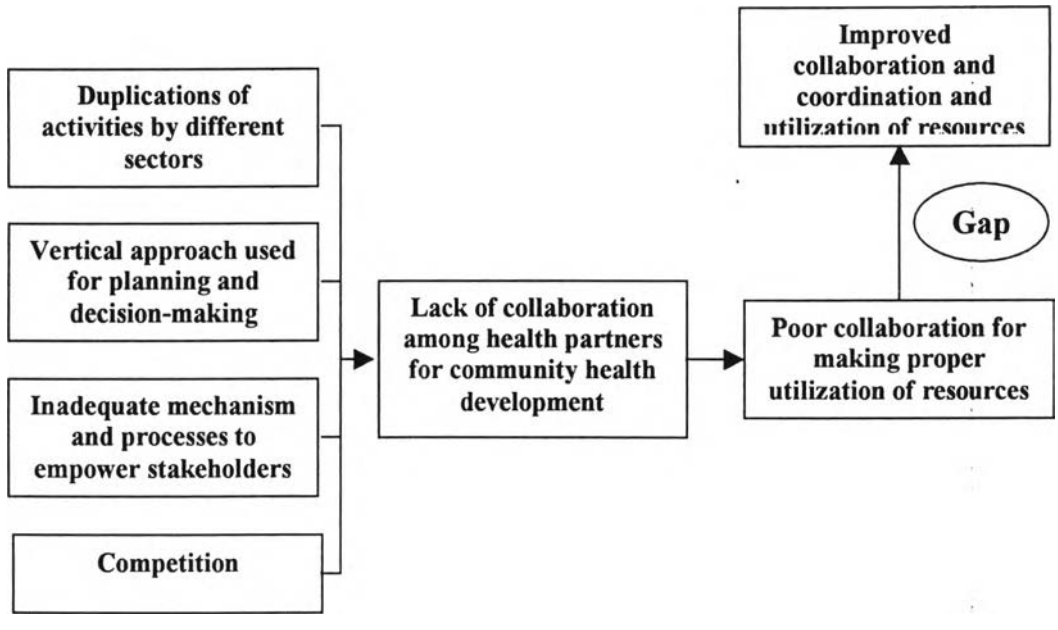
Creates a sense of local ownership in community activities and projects: This can be seen in the Milwaukee's community partnership program (NACCHO, 1996) that are being applied to violence prevention in Milwaukee, Wisconsin, a city that experienced a more than 300 percent increase in violent death and injury from 1983 to 1993. The city's health department responded to this alarming trend with SAFE NIGHT, an award-winning model program that helps communities develop the capacity to reduce violence in their neighborhoods and homes. The program incorporates which stresses capacity building for achieving community health goals, which emphasizes long-term commitment (National Association of County and City Health Officials (NACCHO), 1996).

2.11 Potential barriers facing partnerships

Competition between large systems of care can complicate the work of a coalition whose partners are competing with one another. In addition, health plans focus on cost saving to remain competitive. Purchasers and customers alike are interested in lower costs of care (Boelen, 2000; Espeut, 1998; and Idechong, 1998 http://www.ahecpartners.org). Even with compelling reasons for health development, in real incentives for doing so, it is difficult to put collaboration into practice without linkages of community organizations that can bring together the perspectives,

resources, and skills of diverse health professionals, people and organizations. Therefore, there is a risk of further fragmentation, turf protection, duplication of work and waste of resources.

Figure 2.4: Factors contributing to poor community health development system in Muang district, Maha Sarakham



Within a pluralistic system and even in the absence of a formal coordinating or regulatory body, many projects have failed to have lasting influence on the behaviours of stakeholders, in the absence of timely introduction of a strategy for long-lasting institutional change. In other words, there is no connecting thread or a catalyst for long-lasting health partnership (Frank and Smith, 1999). In general, harmonization of a wide range of activities of different professional groups, even when genuinely moved by the same will to serve people's health needs, does not happen easily or naturally. It must be organized.

Furthermore, there are significant challenges and potential barriers to sharing data. In a highly competitive market, managed care providers have concerns about revealing the content of their proprietary data system. There are issues of turf and concerns about relinquishing control of data (Al-Kodmany, 1999).

The professionals are the key and central decision-makers rather than being as resources to the community's problem solving. Under this excessive professionalism, the efforts of the program will lead to the betterment rather than empowerment, and also lead to even more misunderstanding and potentially misdirected programming (Himmelman, 1992; and McKinght, 1989). Himmelman (1992) distinguishes between collaborative betterment and collaborative empowerment. Both are forms of multi-sector collaboration. He also notes that "the ownership of any social change process is among the most, if not the most important of its characteristics. Ownership is a reflection of a community's capacity for self-determination and can be enhanced or limited depending upon how collaboration is designed and implemented". The series of differentials between collaboration betterment and collaboration empowerment initiatives are described as follows:

- The community development commencement: if it started outside the community, it is a collaborative betterment process whereas, if it started from inside the community, it is collaborative empowerment process.

- In the collaborative betterment process, the *role of the community* is to be invited in; while in a collaborative empowerment process the community is the central to the effort and is the starter.

- Decision control: In collaborative betterment efforts large institutions are in control, on the other hand, with collaborative empowerment it is the community.

- The outcomes: the outcomes of the collaborative betterment process are policy changes and improved program delivery and services. In contrast, the outcomes of the collaborative empowerment process include both those things accomplished in collaborative betterment plus long-term ownership and enhanced community capacity for self-determination.

Additionally, the power of combining resources to achieve a shared objective has been appreciated for a long time. The current environment provides compelling reasons for professionals and organizations in the community to give serious consideration to establishing closer working relationships. Yet, a concrete, practical framework for moving forward with cross-organization seems to be lacking (Allen and Allen, 1987; and Altman et al., 1994).

In brief, it can be said that collaboration is difficult work, however, it is challenging. The problems that mentioned above was based on the review of the literatures which are seen as same as the problems experienced by the researcher when working with the community. That is, overwhelmed by the changes that are occurring, and with little experiences working with the others, they do not look to community participation as an obvious strategy for dealing with current challenges. Therefore, in the current environment with the emergence of new incentive pressures they face, it should be more feasible for them to establish cross-sectoral relationships than it has been in the past.

2.12 Steps to be successful partnerships

Regardless of what traditionally caused the separation between the public health and other stakeholders, there is now a chance to advance alliances to last through collaborative actions. There are; however, lessons to be learned and applied in future collaborative work through health partnerships, which are summarized below (Ulstad, 1997 cited in Bracht, 1999).

1. Develop a clear purpose: Collaboration between health agencies and health plans is more successful when a clear purpose is defined and agreed upon between the partners. For example, in the case of Minnesota experiences, the partners shared a deep and clear commitment to high-quality, cost-appropriate patient care for all citizens of their region. This was the foundation of their work and the touchstone to orient the partners in their work together.

2. Encourage a shared belief in and place high value on working for the common good. Acknowledgement by all stakeholders that there is real value in addressing the health of all citizens in the community is important. There should be a widely shared belief that working together is a wise investment in the future. This shared vision and value on working for the common good seems to allow many members with diverse organizational structures and missions to come together even when the community issues or state or national political issues may be working to drive them apart (Boelen, 2000; Hospitl Research and Educational Trust, 1996).

3. Place a high priority on developing relationships between the members. Change is required if diverse stakeholders are really to work together to improve the health of whole communities (Boelen, 2000, Bracht, 1999, Lasker, 2001). This change may occur in the roles and responsibilities of various organizations, as well as in

funding streams and measures of accountability. Placing a high priority on developing relationships between the members can result in the development of higher levels of trust and more respectful treatment of members toward each other.

4. Use consensus decision making whenever possible. The process of decision making chosen by groups is important to the overall commitment of its members (Lasker, 2001, Rich et al., 1995). That is when the decisions have been made by consensus and members believe this process significantly contributed to their success, thereby rewarding those who participated with a voice in the decisions.

5. Conduct productive meetings. Particular notable features of meetings in successful partnerships have been the regular attendance of most members, detailed accurate meeting minutes that are distributed in timely manner, adherence to agendas, and meetings that are detail oriented with most decisions being made at the meetings.

6. Recruitment of talented and committed members with reliable capacity to follow through with tasks for which they are responsible. That is need forward thinkers who are generally not risk averse and who support each other in answering to their constituencies.

7. Ability to stay on focus. The collaborative group must develop an ability to recognize distractions or work avoidance that are not fundamentally the concern of the group (Singer, 1995).

8. Shared leadership. When new partners, such as managed care and public health, accept shared responsibility for the health of the community, shared leadership of a coalition can provide a check and balance system. It not only builds trust but also can help develop understanding among members with different perspectives.

9. Celebrate and recognize group success. When the short-term objectives are achieved, recognition of the participants and celebration of the accomplishments will help greater pride and 'buy-in' (Lasker, 2001, Bracht, 1999).

10. Willing to work hard in the hope and expectation of eventual success. Collaboration is said to be hard work that take time and care to develop. Therefore, a sense of hope of eventual success will be held people together.

2.13 Why partnerships?

With an intention to "re-connect" the community to become more responsive, and collaborative to their local needs based on an *integrated* response to the primary health care needs, formal, accountable linkages among providers of health and human services, health planners, and educational system to allow for coordinated case finding and service delivery across the continuum (Fagence, 1977; Sanoff, 1978; and Milen, 2001). This approach reflects the diverse range of health concerns in the community. Therefore, health partnerships among university, local school district, health center, hospital, charitable health organizations, local government unit, and local-based organization is needed.

In addition, according to the broad understanding of a fundamental component of the community health development, a local health department and community public/private health care partnerships is the *catalysts* for change in community health development (Kretzmann and McKnight, 1990; Wolff, 1992 http://www.ahecpartners.org). The challenge is what is gained by members enhancing each other's capacity, by sharing risks, responsibilities, and work collaboratively in planning, supporting interventions, and decision-making in health promotion, health

protection, and disease prevention rather than relying solely on a law enforcement approach, is a newer strategy gaining widespread acceptance (Fawcett et al., 1995).

Over time, the 'new public health' defined as an interdisciplinary pursuit using collaborative strategies and building on public participation, can act as a strong force for community health development. Others acknowledge the local health partnerships' role of community health in advancing for broad participation (WHO, 1993; Wattanasiri, 2001; Labonte, 1994). In addition, partnership rather than a matter of pooling academic, service agency, and community-based resources, it is one of allowing an interorganizational networks to set collaborative agendas and make collective decisions (Leoprapai, 1996; and Karch, 2001) as well as responsibility continue to grow as more and more respect and equity enter the agreement (Frankish, 1996 http://www.ihpr.ubc.ca; UNED Forum, 2002 http://www.oarthsummit2002.org). Therefore, it may be appropriate for an organization to move away from a position as lead agency to a position as one of many partners in a broader effort. In addition, it might be the time to broaden community participation and engage new communities on new issues while nurturing existing collaborations.

Finally, the semantics around "integration" have been problematic. Ambiguities and misunderstandings have been numerous, particularly when dealing with organizational issues. Integration has often been taken to mean loss of freedom or individuality, discouragement of initiative, imposed uniformity and top-down planning. Alternatively, integration may be understood as reduction of undue overlap,

control of waste, synergy for more efficient response in solving health problems, and people-centred service meeting clients' expectations (Aja, 2001; Dolye, 2001; and Bracht, 1999).

2.14 Health partnerships versus community health development

Due to the forces that are driving consolidation are establishing an incentive for professionals and institutions to come together to facilitate new relationships among a broad range of organizational and personnel. Also, it can be clear that without a compelling need to work together, and without supportive incentives, the critical conditions for collaboration will never be met. That is, they will evolve along separate and virtually independent tracks which will then result in increasing the possibility of future interactions less and less likely. Through the Health of the Public and other programs, the public health sector is reexamining its role, emphasizing the need for broad-based community participation (McKinght, 1989). New community alliances are being established through Community Care Networks and the Healthy Cities and Healthy Communities movements, for example (Boelen, 2000). In these cases, partnerships call for the formation of such interaction. Such partnerships are required to undertake community needs assessments and wellness-promotion programs, and to develop health education materials on topic such as nutrition, well-child care, childhood screening, injury prevention, and smoking cessation. For example, in Minnesota (Bracht, 1999), managed care organizations are required to produce action and collaboration plans that demonstrate how they intend to work with local public health agencies to improve community health.

It can be said that the underlying premise of health, individual is inseparable from the health of the larger community (WHO, 1993). Therefore, there is a need to develop intervention that is economically feasible and culturally acceptable to encourage people to participate in community health development. However, ensuring meaningful community participation is essential to the success of community partnerships (Bracht, 1999; Boelen, 2000; and Kretzmann and McKnight, 1990). The partnership was started as part of the Martha Jefferson Hospital's mission statement - to serve the community and to provide resources to improve health (Voluntary Hospitals of America, Inc., 1993). The program provides direct resources, evaluation, access improvements, coordination, and public/professional education. They followed an action oriented service delivery approach which focused on community health issues. In coordination process, technical workshops, coursework, and presentations to citizen advisory group members on risk analysis will fosters an active learning process between the members of local health partnership and community members. While affected community members work to become more educated about the scientific process - and thus empowered to participate more fully in decisions concerning their own health (Doyle, 2001; Hann and Olmstead, 2001 http://www.health.state.ok.us/partners/part2.html).

The practice shows that the separation between vertical programs (characterized primarily by external aid focused on specific disease-oriented objectives) and horizontal programs (aimed to support the health services infrastructure) is not clear-cut. Some vertical programs, such as polio eradication and tuberculosis control, have a horizontal component when they strengthen routine immunization and surveillance (CDC, 1995). This point has important implications for not only various actors who

have different approaches in both vertical and horizontal programs, but also of the possibility for *integration*, since vertical programs can be used as an entry point to strengthen basic services.

Generally, the health organizations and community organizations were already linked, but they did not routinely work together and do not have ongoing collaborations. Therefore, community health partnership is needed as an *action network* or *systemic network*, to strengthen and responsive to the community's needs on an ongoing basis. By doing so, groups should collaborate on all tasks rather than have each organization assigns to accomplish a task alone is needed. This is because decision-making power resides with the network. It was clear that the coalition has the capacity to maintain a long-term presence and undertake complex projects. For example, it can be seen in the work of the UNI universities (cited in Bracht, 1999) has become increasingly relevant in social terms due, in part, to the experience of interaction with the environment beyond their walls. As a result, some university decision-making bodies are proposing an "UNI approach" to other career areas, including service learning opportunities and broader efforts by universities to build alliances with their communities. Therefore, community partnership efforts will integrate this vision of community participation into their organization's daily efforts. Moreover, the health professional, community organizer, or volunteer who sees promise in addressing the social environment as a means of promoting health may find it necessary to convince others of the usefulness of a particular community-level approach (Bracht, 1999).

In addition, Himmelman (1992) defines collaboration as a "voluntary, strategic alliance of public, private, and non-profit organizations to enhance each other's capacity to achieve a common purpose by sharing risks, resources, and rewards". Thus at its heart, the degree of intensity of the partnership can range from networking, to coordination, to cooperation, to collaboration with an increase in complexity of purpose, intensity of linkages and formality of agreements (Himmelman, 1992; and Bracht, 1999). Therefore, a key strategy to making many collaborations work is the involvement of a community participation. For example, Albany County's "Healthy Partnerships" have gone forward because partners contribute complementary resources, skills and expertise to the endeavor by bringing diverse "building blocks' together, the group as a whole is able to achieve results that no single partner could achieve alone (McKinght, 1989). Wolff (1992) also suggested that partnership building is one of important path to empowered communities to hold great hope for building healthy communities that have both competent and responsive helping systems and an empowered and mobilized citizenry.

Community health development through community participation which emphasis on holistic people-centred and community is not new process in Thailand. For example, Deesuwan (1997) studied on Strategies for Malnutrition in Children under 5 Year olds in Prae from 1st October 1995 to 30th June 1996 in 34 villages in 4 districts which the rate of malnutrition degree 1 was greatly high (23.23%). The objective of the study was to find out the relationships between factors related to malnutrition using both qualitative and quantitative approaches. The strategies used was community participation in problem analysis, solutions planning and evaluation according to the six months plan. The findings showed the establishment of community activities was seen

as (1) establishment of community committees to support the program (2) Mother's group to make soya bean for children (3) Nutrition education by the community after the 6 months period of the program. As a result, the malnutrition rate decreased from 23.23% to 15.33%. It can be seen from this study that when the community have been involved in problem identification, planning to solve their own problems can lead to the several community activities establishment resulting in decreasing the problems and lead to continuous development.

Furthermore, Sornlump, et al., (1997) studied on the process of community capacity for AIDS prevention and control in Pisanulok, 1989-1996. The qualitative approach was used based on secondary data, observation, in-depth interview on AIDS situations, perspectives, community capacity development, roles of community organizations, and impacts of AIDS prevention and control. The study suggested that the model proposed in Pisanulok focused on people as a center of community development through health education by creating community leader at all levels in governmental official, community, school as well as entertainment places. AIDS groups center to support village group capacity development. It can be said that community participation in the program as health partnership is the crucial approach in health development. For example, Chai-ngammuang (1999) studied on health partnerships between community and school by creating team building to identify problems, learning seminar improvement using PRA. The study showed (1) the members perceived on health problem and actively participated to solve problems such as drug abuse and AIDS (2) the perception that the coordination from all organizations can help in solve problems so that their attitudes towards health seminar was changed.

Sangsurin (2000) studied on the development of civil society: Case study in Donwan sub-district, Muang, Mahasakham using Appreciate Influence Control (AIC) to strengthen the community capacity through community participation. The results of the studied can be summarized as follow:

1. The development of civil society can bring several stakeholders and community to work together for community development.

2. The learning process through civil society is two-ways communication with good supportive environment, respect and acceptance others which lead to a great collaboration in community development.

3. The effort of Tambon development plans created by the community were useful because it covered all areas that community knows it is needed to be improved rather than external people assigned for them.

4. The information system was developed. Therefore, people can access to available information sources and more accuracy in gained information.

Above all, the health problems are decreased, increased quality of life. However, according to the recommendations of Panya (2000) on "The capacity of people around the Tambon Administrative Organization (TAO) is the community capacity" that the appropriate systemic interactive learning techniques and strategies will lead to community capacity development can be considered into 2 aspects as follow:

1. It must be the tools or strategies that community can be able to understand the linkage of their own problems or their community and the external structure. Furthermore, it needs to build trust for the community whether it can be able to solve their personal problems, family problems and the community problems as a whole.

2. Interactive learning strategies should provide time and space for people to be able to participate or carry out the task through the process.

It can be clearly seen that "health" is a broad and complex issue that needs the movements of all sectors both within and outside the community. Therefore, creating health process must build based on community capacity in which community is an internal force in collaboration in defining problems, planning, implementing, and sharing risks and benefits, as well as the needs of external supports to serves community needs, this will lead to sustainable development.

According to the study on Health Team Problem Solving (HPTS) that applied District Team Problem Solving (DTPS) (WHO, 1997), Nan Provincial Public Health Office (2000) shows that HTPS is a new approach of health development that leads to interactive learning through action which can be summarized as follow:

1. Team learning: This is the process that enables people to learn about one self capacity, learning and accepting others as well as learning to deal with problems for self development, team work development and community health development. However, health managers should change their role to be health facilitators upon health partnership for organizational and community development.

2. Communication skill is another crucial technique to support and advocate health team and community to work collaboratively, systemic problem solving. Information exchanges between health team and community is needed for motivate people to concern about their health and community problems towards community development.

3. Problem solving based on area based learning in which stakeholders and community are collaboratively planning and decision-making through holistic approach. This will lead to self-reliance forward community capacity.

4. Learning-based-social capital is a technique that integrates traditional community value ad culture that are said to be social capital with new techniques that appropriate for their community development. This will lead to new thinking about community health that in turn will lead to collective leadership, and community forums to exchange and share knowledge and experiences.

5. Interactive learning through action will establish owing to team working that will lead to new social movement at grassroots level to create public space for community development. However, this continuum of this program is not existed since there is only health sections involved in the program. Therefore, the collaboration among related organizations both public and private as well as other community-based organizations to address health problems is needed.

Figure 2.5: Interactive learning through action in HTPS process

Source: *Nan Provincial Public Health Office, 2000*

2.15 Conclusion

Originally conceived as a strategy, partnership has gradually become a major goal in itself to maximize creativity, dialogue, and the implementation of innovations. The most successful projects – those that show the highest degree of sustainability and the greatest impact – are the ones that developed a multi-institutional partnership (CDC, 1995; Brown, 1991; and Butterfoss, Goodman, and Wandersman, 1993). Moreover, the empowerment of community organizations, using health as an entry point, has significantly increased the sense of citizenship, commitment and shared responsibility, and helped build better relationships among communities, universities, and government-operated services (Butterfoss, Goodman, and Wandersman, 1993; and Bracht, 1999). In other words, effective community health development requires communication, coordination, and collaboration between those persons who provide and those persons who receive services, as well as among those individuals who plan for service delivery (Dignan and Carr, 1992). Under this situation, it may include education, environmental change to support improved health, legislation, or shifts in societal norms which members of target populations is urged to become involved on as many levels as possible in planning health programs that are intended to influence them. People are; thus, more eager to adopt changes when they play a role in determining what the changes will be and how they will be affected. Additionally, no single profession has a corner on the delivery of health programs. Therefore, to implement partnerships within the time and situational constraints of complex emergencies is a challenge that can be only met when the partnerships have already developed and strengthened in "normal" circumstances.

However, to facilitate the active involvement of individuals and organizations interested in planning, conducting, reporting and following research related to health effects is not always easy as well as it cannot happen by itself, however, requires skills, resources, planning, action and monitoring. Therefore, a desirable framework such as collaborative health partnership through HTPS is desirable to be the critical locus for this practice community empowerment and development. This is because it may apply not only to the health sector but also to health-related sectors and community-based organizations, as well as the people to jointly develop a close working relationship.

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