

Tilburg University

Appreciative principles and appreciative inquiry in the Community Action for Health Programme in Kyrgyzstan

Schüth, T.

Publication date:
2011

[Link to publication in Tilburg University Research Portal](#)

Citation for published version (APA):
Schüth, T. (2011). *Appreciative principles and appreciative inquiry in the Community Action for Health Programme in Kyrgyzstan*. [s.n.].

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Appreciative Principles and Appreciative Inquiry in the Community Action for Health Programme in Kyrgyzstan

Proefschrift

ter verkrijging van de graad van doctor aan Tilburg University
op gezag van de rector magnificus, prof. dr. Ph. Eijlander,
in het openbaar te verdedigen ten overstaan van een
door het college voor promoties aangewezen commissie
in zaal AZ 17 van de Universiteit op
maandag 7 november 2011 om 10.15 uur

door

Tobias Raphael Schüth

geboren op 6 augustus 1958 te Herne, Duitsland

Promotor: Prof. dr. J.B. Rijsman

Promotiecommissie: Prof. dr. H. Martens
Prof. dr. A. de Ruijter
Dr. A.W.M. Keune
Dr. V. Vermeulen

Appreciative Principles and Appreciative Inquiry
in the Community Action for Health Programme in Kyrgyzstan

PhD Thesis
By
Tobias Schüth

Taos/Tilburg PhD Programme

Table of contents

Acknowledgements.....	6
Summary	7
Part I.....	8
Chapter 1: Purpose and outline of this study	8
Chapter 2: The importance of respectful behaviour in the work with communities	10
2.1. <i>A personal note</i>	10
2.2. <i>Why is respectful, non-dominant behaviour so important in working with communities?</i>	14
2.3. <i>Beyond behaviour: meaningful relationship</i>	17
2.4. <i>Little practiced</i>	17
Chapter 3: Description of the Community Action for Health program in Kyrgyzstan	18
3.1. Overview of Community Action for Health in Kyrgyzstan	20
3.2. Short information about Kyrgyzstan	22
3.3. The Development of CAH in Kyrgyzstan	23
3.4. Structure of CAH in Kyrgyzstan.....	27
3.5. Building blocks and results of CAH in Kyrgyzstan.....	31
3.5.1. <i>People's analysis of health</i>	31
3.5.2. <i>Formation of VHCs</i>	34
3.5.3. <i>Health actions</i>	35
3.5.4. <i>Organisational capacity building of VHCs</i>	43
3.5.5. <i>Capacity Building of the Health System</i>	47
3.6. Enabling factors, lessons learnt, challenges	51
3.6.1. <i>Enabling circumstances</i>	51
3.6.2. <i>Enabling design factors</i>	53
3.6.3. <i>Challenges</i>	55
Chapter 4: Theoretical foundations of the CAH program in Kyrgyzstan.....	57
4.1. <i>Overview of concepts that influence CAH in Kyrgyzstan</i>	57
4.2. <i>The socio-environmental public health model</i>	61
4.3. <i>Healthy lifestyle/health education model</i>	62
4.4. <i>Health Literacy</i>	63
4.5. <i>Engagement with communities to promote health</i>	66

4.6. <i>Synthesizing the different streams of health promotion</i>	86
4.7. <i>Summary of Theoretical Foundations of CAH</i>	86
Part II.....	88
Chapter 5: Social Constructionism	88
5.1. <i>A simple proposition</i>	88
5.2. <i>Consequences</i>	90
Chapter 6: Methodology of the two investigations of this study.....	93
6.1. <i>Introductory note</i>	93
6.2. <i>Data producing processes – The presence of appreciative principles in CAH</i>	95
6.3. <i>Data producing processes - Introducing AI into CAH</i>	96
Chapter 7: The presence of appreciative principles in the CAH program before the introduction of AI	98
7.1. <i>Reflection on PRA trainings with HPU staff</i>	98
7.2. <i>Discovery with HPU staff</i>	100
7.3. <i>Discovery with trainers</i>	101
7.4. <i>Interviews with trainers and HPUs on appreciative principles in CAH in Kyrgyzstan</i>	102
7.5. <i>Guest contributions</i>	108
Chapter 8: Appreciative Inquiry in CAH in Kyrgyzstan.....	117
8.1. <i>Appreciative Inquiry</i>	117
8.2. <i>Introduction of AI in CAH</i>	119
8.3. <i>Open Interviews with trainers/oblast HPU staff</i>	130
8.4. <i>Monitoring the number of own initiatives of VHCs</i>	133
8.5. <i>Generation of new ideas from below</i>	134
8.6. <i>Guest contributions</i>	135
Chapter 9. Conclusions.....	140
References.....	144

Acknowledgements

This thesis revolves around the Community Action for Health programme in Kyrgyzstan and I want to acknowledge first those who have contributed to making it possible¹. First of all the three trainers who started with me this adventure and who formed the first village health committees (VHCs): Tolkun Jamangulova, Shaken Janykeeva, and Temir Tologonov. We are indebted to the countless members of the VHCs who responded enthusiastically to our propositions and carried them further than we had ever dared to imagine. On the side of the health system we are deeply grateful for the commitment of the staff of the Health Promotion Units, the prime partners of the VHCs; without their smiles and stamina the VHCs would not exist. We are grateful also to the staff of the Republican Centre for Health Promotion, under its director Gulmira Aitmurzaeva, for supporting the CAH programme and taking over its steering. We recognise the importance of the understanding and support that CAH found with all Ministers of health and with key staff in the ministry ever since its inception. Last not least, we are grateful for the donor organisations that had trust in the process: Swiss Agency for Development and Cooperation (SDC), the Swedish International Development Agency (Sida), the United States Agency for International Development (USAID), and the Liechtenstein Development Service (LED).

I am grateful to John Rijsman for support throughout the writing of the thesis, to the colleagues who contributed their essays, to the staff who contributed their thoughts in numerous meetings and workshops, if not specifically for this thesis but in dedication to their work, and last not least I am very grateful for the Swiss Red Cross, my employer, who financed the tuition fees for this study.

I dedicate the thesis to my parents, in gratitude for all they have given to me.

¹ Community Action for Health in Kyrgyzstan is supported by the Ministry of Health of the Kyrgyz Republic and the Swiss Agency for Development and Cooperation (SDC), as well as, at different times, by the Swedish International Development Agency (Sida), the United States Agency for International Development (USAID) and the Liechtenstein Development Service (LED). The technical assistance has been provided by the Swiss Red Cross under different project names, presently (2011) under the name Community Action for Health Project.

Summary

The thesis has three purposes. One is to document the Community Action for Health Programme (CAH) in Kyrgyzstan that I have initiated in 2001 and have developed since then with colleagues into a nationwide programme and to discuss its theoretical foundations. This is done in part I of the thesis (chapters 3 and 4). The description of the programme introduces the context and the structures of the programme and includes examples of results that were achieved. The chapter on theoretical foundations of CAH in Kyrgyzstan reviews the literature on health promotion and community empowerment and tries to locate CAH in Kyrgyzstan in the different health promotion models as well as in various continuums, scales and coordinate systems that have been proposed in the literature to assess programmes aiming for community empowerment. I will propose a new instrument to assess community capacity building programmes that in my view closes a gap in assessing such programmes.

The second and third purposes of the thesis, covered in part II (chapters 5-8), are to investigate two questions: One is to what degree appreciative principles are present in CAH in Kyrgyzstan (I will define what I mean with appreciative principles), and the second one is to document the lessons learnt and the effects of introducing Appreciative Inquiry (AI) into CAH in Kyrgyzstan. Regarding the first investigation, I had always an interest in the importance of non-dominant, respectful behaviour of staff working with people in community development programmes and put a special emphasis on it while developing CAH. Chapter 7 presents the findings as to how far this emphasis has led to a presence of appreciative principles throughout the system of CAH. Regarding the introduction of AI into CAH, it has built on this earlier emphasis on appreciative principles but opened new dimensions and possibilities. Chapter 8 documents them and the effects they had on CAH.

Part I

Chapter 1: Purpose and outline of this study

Purpose of the study

In autumn 2008 I became acquainted with Appreciative Inquiry (AI in the following) and immediately felt the potential it could have for Community Action for Health in Kyrgyzstan (CAH), the programme I had initiated there. As I will recount in the personal note of the next chapter I had long felt that what really counts in work with communities is less the methods than the behaviour, less the ‘what’ than the ‘how’ and I had sought to give a shape and a place to that conviction in CAH in Kyrgyzstan. And I believed that therein lied a big part of its success. It was difficult, however, to talk about that. People asking for reasons for the success of CAH usually would expect to hear things like the kind of methods used, the kind of political and financial support received, alliances forged, conditions created or luckily found, design issues, its linkage with the primary health care structure of the health system, the remoteness of rural Kyrgyzstan favouring community cohesion, etc. All these are true. But all would have not been sufficient I believe. The glue that binds them together to become effective is non-dominant, respectful behaviour of programme workers with community members. At that intersection everything is decided: metaphorically speaking, the fate of all programmes that aim at community participation and empowerment depend on the smile of the program worker much more than on the method he/she brings.

And AI seemed to have a language for that. Appreciation. Energy. Relationships. The heliotropic principle. The poetic principle. Simultaneity. Positivity. The foundation on social constructionism. There was a language that could give a richer voice to what we had – in the PRA² tradition - always described as non-dominant, respectful behaviour. And a language that could possibly help to communicate to “serious” people what I thought was part of the essence of CAH in Kyrgyzstan.

So after my first course on AI (September 2008 with Jane Magruder Watkins and Mette Jakobsgaard) I was sure that I would want to introduce AI into CAH in Kyrgyzstan and had started to work on ideas during that course. Jane incited me at the end of the course to look into the Taos/Tilburg PhD programme by saying I should document the introduction of AI into CAH. From this the following three ideas for the PhD thesis emerged.

The first purpose is to document CAH in Kyrgyzstan in a comprehensive manner. For this I describe the program in all its aspects and I give examples of its effects. I then discuss extensively its theoretical foundations in relation to the relevant literature on health promotion and community development and empowerment. This is part I of the thesis and it provides at the same time the necessary context for part II.

² PRA: originally Participatory Rural Appraisal, later, and preferred by me: Participatory Reflection and Action

Part II contains the second and third purpose of the thesis. The second purpose is to investigate how far appreciative principles were present in CAH in Kyrgyzstan prior to the introduction of AI. As we gave so much emphasis on non-dominant, respectful behaviour I thought it would be interesting to see to what degree appreciative principles would be indeed present in the system of CAH. “Appreciative principles” I call those factors in one’s behaviour that help to build relationships of mutual liking, trust, respect, encouragement and that are *constructive* (i.e. conducive to human growth and liberation from psycho-social limitations, to opening and widening of possibilities; in sum conducive to hope) as opposed to *destructive* (i.e. undermining growth, trust and respect, closing and narrowing of possibilities, increasing barriers and limitations; in sum conducive to cynicism). Gergen (2009) has called these two opposing forms of relational flow *generative* and *degenerative*; the former being catalytic, injecting relations with vitality, the latter being corrosive, bringing co-action to an end. The appreciative principles then, in Gergen’s terms, would be those factors in one’s behaviour that bring about generative relational flows, or processes. In a broader sense the appreciative principles can also be present in the design and structure of a programme i.e. in those factors that are conducive to generative or constructive relational flow.

The third purpose is to document the lessons learnt and the effects of introducing AI into CAH in Kyrgyzstan.

Outline of the study

I begin with a chapter (chapter 2) that explains first in a personal note why the issue of respectful behaviour in the work with communities has become so important for me and then reflects on that from a theoretical point of view.

Then follows the documentation of CAH in Kyrgyzstan with description of the programme (chapter 3) and a thorough discussion of the theoretical foundations of the programme (chapter 4).

I then summarise in chapter 5 the main propositions of social constructionism and their consequences to lay the ground for the discussions in the following chapters.

In chapter 6 follows the methodology of the two investigations of this study, first the investigation into the presence of appreciative principles in CAH before the introduction of AI and second the documentation of the introduction of AI and its results.

Chapter 7 then describes the findings of the investigation into the presence of appreciative principles in CAH before the introduction of AI.

And chapter 8 describes the introduction of AI into CAH in Kyrgyzstan and the lessons learnt and the results of this introduction.

Chapter 9 finally summarises some conclusions from this thesis.

Chapter 2: The importance of respectful behaviour in the work with communities

In this chapter I will describe in a personal note why the issue of respectful behaviour has been so important in my work before I reflect on it from a theoretical point of view.

Outline of chapter 2

2.1. A personal note

2.1.1. Kolkata

2.1.2. Bangladesh

2.2. Why is respectful, non-dominant behaviour so important in working with communities?

2.3. Beyond behaviour: meaningful relationship

2.4. Little practiced

2.1. A personal note

2.1.1. Kolkata

The first thing I did after graduation from Medical School and after finishing my conscription as physician in the army was to go to Kolkata/India (formerly Calcutta). I had hired with the German Doctors for Developing Countries to be sent as an unpaid doctor to one of their overseas dispensaries in a slum of one of the Third World's megacities. By chance, the German Doctors had chosen Kolkata for me. There I had the great fortune to be able to work together with Brother Gaston, a Swiss born naturalised Indian who shared his life with the poor in an exemplary way. I remember struggling with my rough attitude and behaviour with staff if things didn't quite work out as they were supposed to. Here I was, a young physician from another country, dictating - on the basis of what ? - to these people who were mostly older than me in their own country... I remember that after some weeks I asked forgiveness from my translator, an older man, for my inappropriate and disrespectful behaviour towards him. I struggled with my impatient behaviour towards patients, under stress from too many of them per day. And here was Br. Gaston. He was a nurse and had set up many dispensaries and trained staff in villages around Kolkata. We not only arranged patient flow in our dispensary so that stress would be less. He taught me much more profound lessons. Hearing him training staff one day to treat a child with impetigo, a bacterial skin disease that covers the skin with numerous superficial wounds, he said something that I remember to this day. For treatment, gentian-violet solution is being applied to the wounds. Usually this is quickly shown to the mothers on one or two wounds, then the solution is given to her and she is sent home to do it herself. But Br. Gaston said that staff should apply the GV-solution themselves to all wounds "so that she sees that we love her child." Important for him therefore was not only the application of an effective chemical substance but a relationship. Which relationship? Several probably. At first sight that between staff and child. But I am sure he also

wanted to strengthen the relationship between the mother and her child by reminding the mother what a lovable child she has (despite all the trouble that it is giving her). And a third relationship: that between mother and the staff. For that must improve if the mother sees a caring staff member. I think this relationship was Br. Gaston's last aim.

Over time I must have done something right also with my behaviour because Br. Gaston invited me to dispensaries and projects that he had set up in villages around Kolkata where foreigners had never been seen. On one occasion on such a trip - we must have been talking about behaviour as foreigners - he said "We must behave in such a way that they forget the colour of our skin." It became my guideline for my behaviour for a long time. Robert Chambers (1994) formulated this later less poetically as the necessity to turn off the North-South orientation of development work.

2.1.2. Bangladesh

After half a year in Kolkata I returned to Germany and began a postgraduate education in internal medicine. However, the bond with South Asia remained strong. I travelled each year to work with one of the NGOs outside Kolkata that Br. Gaston had introduced me to, collecting money for them with round letters among acquaintances, spending my holidays with them to help them with their tuberculosis programme. I co-founded the organisation NETZ that to this day supports organisations in Bangladesh and reflected in its eponymous magazine about my experiences in Kolkata. It was but a question of time when I would return. Finally, after five years I realised that I would never want to practice internal medicine. Kolkata had taught me that I also did not want to be engaged in treating patients in developing countries; I had seen too many patients return because the reasons causing their conditions had not changed. So I wanted to be engaged in health promotion, in helping people preventing illnesses, in liberating themselves from causes of diseases, from unnecessary burden. And I had no idea how to do that. But I broke off my internal medicine education and went to Bangladesh to work with one of the partners of NETZ on a remote island in the bay of Bengal.

When I arrived in Bangladesh, in order to learn what others did I observed how health education was done by most organisations active in the field. Later I summarised what I saw (Schüth 2001:5):

If one asks health education workers why people do not do what they teach them one of the answers most often heard is "because they are illiterate", implying that they are not educated enough (or simply too stupid) to be able to understand what workers tell them. The answer sums up the state of affairs of much of the health education in Bangladesh. First, it acknowledges the fact that people often do not do what they are taught even if it is repeated a hundred times. It also shows the helplessness on the part of the workers who are faced with this experience. Beyond that, it betrays the widespread attitude of blaming the people for the failure of health education. And lastly it is witness of the underlying concept of health education, which obviously is seen as a transfer of knowledge from the wise to the ignorant.

The instrument most often used with this kind of approach was the flip chart, a series of pictures bound like a calendar so that they could be flipped and shown in sequence to the audience. Some flip charts had text printed on the backside of the pictures so that the educator would exactly know what to say to each picture. Obviously, such flip charts fitted perfectly the educational concept. It fixes the worker in a teaching role. At the time I analysed the results and the psychological implications of this practice (Schüth 2001:6):

The following experiences seem to be widely shared. The workers start with good hope to teach people what they themselves have learned in the training. They proudly spread their messages and make sure people have understood them. After some rounds people indeed have understood and know the messages by heart. And then the trouble starts. People start to complain about boring sessions and demand to be taught something new. Workers start to feel uncomfortable because they do not have anything new to say. Also, their status depends largely on knowing more than the people and on keeping up the flow of knowledge "downwards". In addition workers begin to notice that many people do not do what they have learned. They start to put pressure on people to overcome their perceived laziness or stubbornness. Typical is asking the people to promise to do what was taught, or making them feel guilty in relation to the worker ("Have you not promised?) or to their loved ones ("Do you want to be a bad mother?"). Creating pressure also comes in handy to regain the authority endangered by the diminishing knowledge gap.

I also noted, importantly, the typical behaviour corresponding with such teaching. This behaviour mostly was not rough, but seemingly good mannered. But it was the kind of good manners adults display vis-à-vis small children. Things were repeated often, questions are formulated in a way that left the answers obvious, and so on.

I analysed that workers in such contexts have, unconsciously, a paradoxical interest to keep people ignorant. For if people grew and gained knowledge the privileged status of knowing more than they would be lost. So the transfer of knowledge combined with the belittling attitude resulted in a kind of double message: on the one hand messages are disseminated and on the other the feeling is conveyed to the people that they are - and probably always will remain - ignorant.

And I concluded that the combination of what clearly was bad communication technique with an attitude and behaviour that served various psychological needs of the worker greatly amplified Freire's mechanism of keeping people dependent through teaching.

Everything in me revolted against such practice. The flipchart became for me the metaphor for everything I wanted to avoid in terms of behaviour and in terms of development strategy, which my friends and I in NETZ were still seeking to define for us. We had long struggled with what we meant with "support" and "help". We were sceptical about traditional forms of developmental aid, its paternalistic connotations, without participation, where people were objects... and problems, not part of the solutions, not partners, where the complexities of issues were brushed over... We saw all that, and knew what we did not want and yet had difficulties to formulate exactly what we wanted. Something more personal. Closer. More humane.

Getting more involved into the complexities of the real issues, on the side of those affected most... - Everything but teaching with a flipchart.

Searching for alternatives I was one day again sitting in a session where a health worker tried to convince a group of women to build latrines. There had been previous sessions about latrines with this group but nobody had yet installed one. The discussion faltered: “But I explained to you... dangerous... microbes.... diarrhea.” Silence. Bowed heads. I had an idea. I tore some pieces of paper from my notebook and gave them to the women and then asked each of them individually to explain what hindered her to install a latrine and to draw a picture of that hindrance. None of them had ever held a pen in their hands and it took a lot of persuasion and patience to make them accept the unusual assignment but finally eight or ten drawings had been produced that showed typical problems the women faced: no money, the husband does not want to make a latrine, a widow had nobody to dig the hole, etc. Then I asked the whole group to each of these problems how it could be overcome. To my great joy the group came forward with practical, realistic solutions to many of the problems: a woman offered that her son could dig the hole for the widow, another said her husband could talk with the stubborn husband, the woman who had said she had no money was reprimanded by the group who clarified that she was pretty well off, etc.

What had happened? Instead of teaching the women what is good for them I asked them to explain me their situation. Instead of making notes myself I handed over the pen and they documented themselves what they said: no extraction of information from the group by an outsider who then owns it but open display of information for all to own and discuss. Instead of being presented flip charts with ready-made pictures the women drew their own pictures. Instead of blaming the women for not installing latrines I had inquired and learned about what hindered them to install them. The women themselves had then made proposals how to overcome these barriers and these proposals therefore fitted their reality. Excuses were unmasked by the group. Moreover, the atmosphere of the session had completely changed. Instead of silent women around a frustrated and insecure worker a lively discussion had ensued that had a direct relation to the life circumstances of these women. Instead of being locked in a fruitless quarrel of “you have to” and “we can’t” the common energy of facilitator and women was directed into finding solutions to problems.

We took these core elements and developed a systematic method around them. We called it Participatory Action Learning and Planning (PALP). At the centre remained the identification of barriers and the discussion about how to overcome them. We used the metaphor of the “fog of hindrances” to refer to the diffuse amalgam of barriers that keep people from transferring knowledge into action. The focus of sessions therefore was not anymore knowledge transfer but development of solutions – not monologue but recreation of reality in dialogue.

A tool for latrine promotion that we developed helped women to analyse the barriers in the described way, facilitated a discussion about solutions and then added an element of planning and documentation of progress: Women announced which latrines they planned to install and subsequent sessions would monitor the progress with renewed discussions around new barriers.

Another tool was developed to address the issue of emergency obstetric care. The setting was an island with the next hospital for emergency care two hours by boat away on the mainland. The mortality rate of mothers and children during delivery was very high because it took up to 24 hours before a woman with a complicated delivery would reach the hospital owing to multiple delays in the numerous decisions that had to be taken to transport a woman in labour to the mainland. Women drew pictures for the steps that typically were taken between the occurrence of a complication and the decision to transport the woman to the hospital. They arranged the pictures in form of a winding street between the house and the hospital. They showed a mixture of several inefficient medical procedures, cultural and religious rituals and practical organisational steps. The women assigned to each of these steps the average time that it required and summed up the total time. This made the reasons for the deadly delays transparent – and actionable. The discussion then revolved around ways to minimise the delays. Certain rituals could be done at the beginning of labour, not at a time of complication. Most importantly, the time-consuming process of convincing mother-in-laws and husbands of the necessity to take a woman with a complicated delivery to the hospital can be prepared with talks during the pregnancy. The money for the transport and the hospital could also be saved during pregnancy instead of being collected from neighbours in the middle of the night. Concrete planning then even assigned tasks to who would talk with whom to bring these changes about because in the Bangladeshi context the pregnant women have the least influence in their social context.

And where was the issue of attitude and behaviour in these new methods? It did not vanish. But because people played such an important role in the process, because their local knowledge had to be asked at each step and they had to discuss among themselves solutions to each obstacle while staff had to listen and because the group produced the results that it owned at the end this changed dynamics and created a more equal relationship of partners working together on a problem. It helped change the attitude and behaviour of staff as they experienced people and themselves in a different way.

These learnings, the methods and the behaviours, found their way into my work in Kyrgyzstan, i.e. into the development of CAH. Before I describe this programme in detail in the next chapter I will first reflect more thoroughly on why respectful, non-dominant behaviour is of so great importance in development work.

2.2. Why is respectful, non-dominant behaviour so important in working with communities?

In a paper reflecting on the early days of PRA Robert Chambers (1994) wrote that while in the beginning the groups experimenting with it thought the most important things were the tools that were being developed it soon dawned on them that in fact the behaviour of the facilitators, i.e. outsiders, towards the community members, mattered more for a successful outcome of sessions. Ever since Chambers has underlined the focus on behaviour as an innovation of PRA vs. its predecessors (1994b) and has argued for attitude and behaviour to be seen as one of the pillars of PRA (e.g. 1994a, 1994b, 1994c, 1997). He describes what typically happens in

respectful, non-dominant behaviour as simple things like sitting down (on the same level, in Africa and Asia typically on the ground, not on a chair, higher than the others), listening (so easily said, so difficult to do: not to interrupt, not to correct), to learn, to ask something one does not know in order to put oneself in the learner's position, "handing over the stick" (the symbol of control of the session, the symbol of confidence that "you can do it"), embracing errors, relaxing, not rushing, and simply "being nice to people" (1994). My own list includes humour, especially about myself if the occasion arises (use of local language while pointing out one's mistakes offers usually plenty occasions). In general Chambers writes about the need of a constant self-critical awareness to counterbalance the given difference in power and dominance between outsiders and locals.

2.2.1. Giving space

Why is this needed? A first answer is coming again from the early days of PRA, reported by Chambers (1994). During a PRA session in Karnataka/India of 45 minutes locals spoke 11 minutes and were interrupted 45 times. "The most difficult lesson for outsiders in PRA training became learning to shut up" (1994). Therefore, non-dominant behaviour was simply needed to *give space* to locals to express themselves. Later in Kyrgyzstan I half-jokingly formulated for a lecture the First Law of Tobias for working with communities: Shut up and listen! Interestingly, Hosking (2004) writes "The 'point', so to speak, is to give space to Other rather than doing something to or making use of Other", when she sums up approaches that use questioning and listening as formative of relations and realities.

Excursus on 'giving space'

I was asked to do a consultancy for an NGO in Tajikistan that was involved with local communities in building water infrastructure projects and in conflict mediation. They wanted help on how to involve better the communities in what they were doing because the communities seemed somewhat passive and unresponsive. To explore this issue I gave participants the task to draw each a picture depicting the relation between the project and the communities. Hanging them on the wall the plenary was asked to summarise the images of the project and of the communities in these pictures. (One image particularly struck me. It showed a manly figure, taking up most of the paper, holding a tiny baby in its arms and feeding it with a bottle.) The participants characterised the project in these pictures as giver, influencing the situation in communities, having a clear goal, dominating, being attractive/complex, educating, etc.; and the communities as receiver, passive, vulnerable, small, dependent, not educated, not prepared for the project, not developed, diverse. Not in the least irritated by these two lists the participants confirmed on my questioning that these lists reflected reality, and they even seemed proud of it. Then I asked them whether they could imagine a possible causal relationship between how the project sees itself (taking so much space) and how the community acts (remaining so small). Only then reflection began. A long and painful discussion ensued. They first negated the possibility but slowly admitted it. But clearly there were hurt feelings. On the next day I had them work in groups on Freire's thesis that "Teaching is Oppressing"; they were supposed to come up with reasons why Freire might have thought that way. All groups grasped the key ideas. Further analysis of the role of communities and of that of the facilitator in Freire's approach followed. Sessions on attitude and

behaviour rounded off the workshop. The feedback comments included: “After the first day I understood that the community is not the problem and I the solution”. “Before I saw the community as a child. Now I see that great resources are within the community” “Before we were sure we are the best. After first day I had doubts, I felt offended. But yesterday evening I understood that we can embrace our errors and learn from them. That was a very important process, deep inside something changed.”

2.2.2. Breaking established patterns

A second answer I would like to call *breaking established patterns*. It summarises several issues. For example the need to break the provider-recipient pattern and to overcome what Saha (2009) criticises rightly as the Subject-Object relationship (Hosking 2004) in development work. Chambers points also to another aspect (1994) when he evokes the metaphor of a North-South magnetic field in which we are each upper or lower magnets, “and some are multiple uppers (male, old, white, wealthy...) and some multiple lowers (female, young, junior, black, poor...)” Chambers writes that change requires a change in behaviour and attitude of uppers. All these patterns are carried by the behaviour of the outsiders (who usually hold several of the upper poles in Chambers’ magnetic field) and they present a powerful reason why their behaviour need to change because their persistence are obviously in the way of development of communities.

2.2.3. Fundamental equality

From my own experience I would like to add one more aspect. What happens in an encounter with locals where the contrast between upper and lower, rich and poor, power and powerlessness are especially stark and where I strive to behave respectfully and non-dominantly is as-it-were an inner bow. And this inner bow has the meaning of the following monologue, which of course does not take place but could be looked upon as the summary of many years of reflection about this sort of encounter: “I recognise that it is a mystery why you are there (poorer) and I am here (richer), it could be the other way around (it’s not my laurels and not your fault); having agreed on that let me say to you first that I humbly admire your struggle and your service to life in adverse circumstances; and second, let’s sit down and think how we can fulfil both our karma in trying to better this situation together.” So another reason for non-dominant behaviour is the need to show fundamental respect through the recognition of a *fundamental equality*. This is much more subtle than what was discussed under *giving space* above.

In summary, and using a social constructionist discourse one could formulate that a change towards non-dominant behaviour is needed because it allows to reconstruct first the relationship between outsiders and locals (with Saha (2009): reconstruct it as a non-Subject-Object relationship) and second reconstruct the self-image of the locals. This happens as they occupy space left open by the outsiders, view the outsiders differently as these question and break their own traditional roles and therefore open new roles for the locals, and boost their confidence, self-respect, and hope as they receive affirmation of a fundamental equality.

2.3. Beyond behaviour: meaningful relationship

Beyond this summary I would like to follow through with one additional thought. Social constructionism of course posits that these changes occur *in relationship*. But what kind of relationship? I want to quote a few witnesses on which kind of relationship is required to enable change. Freire is our first witness (1996). Dialogue is for him the only form in which an outsider can be involved in what he calls in the language of the 60ies the process of liberation. And dialogue he defines – already in constructionist terms - as naming the world together as equals. And then he names five conditions on behalf of the outsider for true dialogue: love, humility, faith, hope, and critical thinking. I will not discuss them in detail here but just say that a greater personal involvement than love can hardly be demanded. Of note is also that four of the five conditions are attitudes, only one is a technique.

A more recent writer on health education and empowerment, Wallerstein (1994) reflects that on the role of health educators that it is crucial to “engage in the empowerment process as partners, plunging ourselves equally into the learning process. For this role as a partner, we need to ask, what can we learn about ourselves...?” Here, too, is the requirement to enter the relationship as more than the expert but as a human being.

Saha (2009) in his dissertation, forcefully demands a non-subject-object relationship between outsiders and communities for self-help processes to work. No technique in itself without such a relationship can achieve that.

And finally, I want to quote a source outside of the development field but nonetheless from somebody whose life work was dedicated to the development of human beings, C.G. Jung. He wrote that “If it concerns the important things it is decisive whether the physician sees himself as part of the drama or whether he wraps himself into his authority” (1990:138). Here we see clearly the dichotomy between on the one side a relationship of Subject-Object, or expert-object, where the personality of the outsider is left out of the equation and he (or she) brings in only his expertise and, on the other side, a relationship where she (or he) allows herself to be drawn into it in a way that makes her accessible beyond her complete control, opens her emotionally and makes her possibly vulnerable.

The witnesses tell us that real change is only to be expected when we enter what Jung would call the crucible of a personal relationship. Then the chance is there for change, growth and transformation of both, locals and outsiders. For that to occur, respectful, non-dominant behaviour is a pre-condition.

2.4. Little practiced

But although non-dominant behaviour, and entering meaningful relationships seem so important for development work with communities they are relatively rarely referred to in literature and in practice, it seems. A search attempt via Google yielded few results (see table 2-1). Chambers (1994) writes “that personal behaviour and attitudes have...been neglected in seeing how to do better.” Saha (2009) reflects on his long personal experience in participatory development work and asks himself whether he was ever asked to be emotional. He says no. He always was trained to be rational,

objective and muses that this may divide the change worker from the community and prohibits genuine co-construction. And he adds that in our efforts to learn techniques we forget to sing songs with the communities – with Jung, wrapping ourselves in the cloak of authority instead of entering the drama.

My own experience confirms Saha’s account. I have not met another project where workers undergo systematically a training in non-dominant behaviour, including a self-experience of own dominant behaviour in role plays and consistent supervision of this aspect of performance, as it is done in CAH in Kyrgyzstan. Regarding relational involvement I cannot imagine to propose to a donor an indicator measuring the relationship between staff and communities, e.g. the number of times staff gets invited to family festivities. This will hardly be accepted as performance indicators. When I began working in Bangladesh I wrote a brief proposal to a donor. A friend of mine was acquainted with the person who received the proposal, both were from South America. As my friend was visiting this person one evening he pulled out my proposal and started to criticise its language as too emotional, even ridiculing it by pulling out a book with poems by Pablo Neruda and comparing his lines with lines from my proposal. I learned my lesson quickly. Well-meaning colleagues advised me to avoid by any means what was called “touchy-feely” language in professional context, if I wanted to be taken seriously. It is an example of how an official discourse has marginalised, or “unvoiced” (Shotter 1993) a form of talk.

Table 2-1: Google search results around behaviour and relationship and community development

Google search terms	No. hits	comments
“Community Development” “non-dominant behaviour”	1	The hit is the website of our programme in Kyrgyzstan
“Community Development” “respectful behaviour”	592	No hits referring to relationship of outsiders with communities
"community development" "respectful behaviour by outsiders"	None	
"community development" "appreciative behaviour"	1	On Appreciative Inquiry
"respectful behaviour by outsiders"	None	
"relationship between outsiders and communities"	None	
"development work" "behaviour of outsiders"	4	Meaningful only a reference to Chambers 1995
relationship "outsiders and communities" "community development"	2	One paper by Chmabers (2010) on development paradigms touching peripherally on relationships and behaviour
"respectful behaviour" "community development"	1920	Not reviewed all, but mostly on respectful behaviour promoted within the community, not between outsiders and communities

Chapter 3: Description of the Community Action for Health program in Kyrgyzstan



In this chapter I will describe the Community Action for Health program in Kyrgyzstan, its development and structure, I will describe its main results with examples and will discuss its lessons learnt and present challenges. The chapter describes the status of the program before the introduction of Appreciative Inquiry.

Outline of Chapter 3

- 3.1. Overview of Community Action for Health in Kyrgyzstan*
- 3.2. Short information about Kyrgyzstan*
- 3.3. The Development of CAH in Kyrgyzstan*
- 3.4. Structure of CAH in Kyrgyzstan*
- 3.5. Building blocks and results of CAH in Kyrgyzstan*
 - 3.5.1. People's analysis of health*
 - 3.5.2. Formation of VHCs*
 - 3.5.3. Health actions*
 - 3.5.4. Organisational capacity building of VHCs*
 - 3.5.5. Capacity Building of the Health System*
- 3.6. Enabling factors, lessons learnt, challenges*
 - 3.6.1. Enabling circumstances*
 - 3.6.2. Enabling design factors*
 - 3.6.3. Challenges*

3.1. Overview of Community Action for Health in Kyrgyzstan

“Community Action for Health in Kyrgyzstan” (in the following CAH) is a partnership between communities in rural areas of Kyrgyzstan, represented by voluntary Village Health Committees (VHCs), and the governmental health system of the country. Its goals are (a) to enable rural communities to act on their own for improvement of health in their villages and (b) to enable the governmental health system to work in partnership with village communities for improving health.

CAH is a countrywide program and part of the national health reform program. Presently (2010) there are over 1,400 VHCs in Kyrgyzstan, covering around 70% of all villages and approximately 2.5 million people.

At the core of CAH in Kyrgyzstan are village health committees (VHCs), supported by governmental Health Promotion Unit (HPU) staff and primary health care staff of the Family Group Practices and Feldsher-Accoucher Points (FGP/FAP). VHCs are community-based organisations that engage in voluntary activities aimed at improving the health of the people in their villages. They are not part of the governmental health system, but collaborate with it as independent civil society organisations. They form federations on the rayon (district) level, which are registered as juridical bodies in the form of Non-Governmental Organisations (NGOs). A national association has been formed in 2010.

CAH in Kyrgyzstan can be described using five building blocks: people’s analysis of health, formation of VHCs, health actions by VHCs, organisational capacity building of VHCs, and capacity building of the governmental health system to collaborate as a partner with VHCs.

The process of CAH in Kyrgyzstan starts with an analysis of health priorities by the people in each village, facilitated by primary health care (FGP/FAP) staff. This is done in neighbourhood groups and with tools designed according to principles of Participatory Reflection and Action (PRA³); it involves 50-70% of village households in a given oblast (region). During this analysis the neighbourhood groups elect people from their neighbourhoods to be members of the future VHC. At the end of the analysis process, these members come together to form the VHC and elect members from the group to serve on the board.

The HPU staff then work with these VHCs in two areas. They build their organizational capacity to help them become independent civil society organizations, and they train them to implement “health actions” in their villages to improve health issues prioritized by the communities, as well as other issues of public health importance.

Health actions cover a broad range of about 10 topics, such as promotion of iodised salt, control of brucellosis, promotion of good nutrition, hygiene education, curbing

³ Formerly known as Participatory Rural Appraisal.

alcohol abuse, hypertension control, sexual-reproductive health, and others. VHC members work without any remuneration. They form action groups for each of the health actions to broaden the base of people involved and to distribute the burden. These health actions have well-documented effects on the health of the population. Examples include a decrease in goitre prevalence among school students (Schueth and Sultanalieva, 2008), an increase in exclusive breastfeeding during the first six months of life, and a decrease in alcohol consumption (Schueth 2008).

The organizational capacity building enables VHCs to manage their affairs as independent civil society organisations, and to increasingly define their own agenda and initiatives to tackle determinants of health beyond the suggested health actions. To this end, they learn to mobilise resources, administer their own fund, and network and collaborate with other organisations in the village, the district and beyond. Important partners are the local self-government agencies (Ail Okmotus), with whom VHCs collaborate on many issues. The Rayon-level federations of VHCs (Rayon Health Committees) link with governmental and non-governmental resources at the rayon level and beyond.

CAH in Kyrgyzstan is steered by the Republican Centre for Health Promotion (RCHP) under the MoH, with technical assistance from a project funded by the Swiss government through the Swiss Agency for Development and Cooperation (SDC) and implemented by the Swiss Red Cross⁴. Together they train governmental health staff (from HPU and FGP/FAPs) in building up VHCs and working with them, and they advocate for the issues important to CAH within the MoH. The RCHP further coordinates all collaboration of donors with CAH.

The development of CAH began in 2001. In 2005, the Ministry of Health (MoH) included the country-wide extension of CAH into the plan of the national health reform program (“Manas Taalimi”). Following this official endorsement, the Swedish International Development Agency (Sida) and the United States Agency for International Development (USAID) joined SDC in supporting CAH and its extension throughout the country. The MoH supports CAH through the allocation of staff time for primary health care workers (FGP/FAPs), HPU and the RCHP. In recent years, a number of other projects and donors, beyond the three core-supporting donors, have collaborated with VHCs. These include World Bank, UNICEF, the Global Fund, Asian Development Bank, GAVI, and others.

The current challenges to ensure the sustainability of CAH include shifting transportation costs of the HPU staff to the health system, transferring the steering of CAH entirely to the RCHP, further increasing the collaboration of VHCs with local self-government agencies, helping VHCs to generate some income for their health funds, enabling self-representation of the VHCs by building a national association of VHCs, and developing mechanisms by which collaborating projects can contribute to the sustainability of VHCs and CAH as a whole.

CAH in Kyrgyzstan is grounded in the framework of health promotion as conceptualised in the Ottawa Charter for Health Promotion (WHO 1986), as well as

⁴ This project has been co-financed by the Swedish International Development Agency (Sida) from 2006 to 2010 and is being co-financed from 2011-2014 by Liechtenstein Development Service (LED)

in general principles of community development, Participatory Reflection and Action (PRA⁵), Participatory Action Research, Appreciative Inquiry, the salutogenic model, and social capital.

3.2. Short information about Kyrgyzstan

Kyrgyzstan is a Central Asian country of great beauty and is dominated by the Tien-Shan mountain range. It gained independence from the Soviet Union in 1991. It is about five times the size of Switzerland, but has a population of only about 5.4 Million. About two-thirds of the population live in rural areas, most of the remaining third in two cities, Bishkek (the capital) and Osh. Administratively it is divided into seven oblasts (regions) and Bishkek. It's economy is predominantly agricultural. Kyrgyz people were traditionally nomads, but were settled by the Soviets.



⁵ Formerly known as Participatory Rural Appraisal

3.3. The Development of CAH in Kyrgyzstan

3.3.1. The PRA study on people's perspectives on health care

When the Swiss Red Cross (SRC), on behalf of SDC, planned the Swiss-funded health project in Kyrgyzstan in 1999 the planners focused on reconstruction of hospital facilities in Naryn oblast, following the wishes of the MoH. The first phase of the project (15 months from January 2000 to March 2001) dealt therefore almost exclusively with the renovation of two remote hospitals in Naryn oblast. Such exclusive focus on construction (“hardware” in development jargon), however, is not according to the principles and priorities of SDC and of SRC (SDC 2003; SRC 2006), nor was this in the spirit of the agreement with the MoH, which stipulated that the project should support the health reform as a whole in Naryn. Therefore, SRC sought to broaden the scope of the project when planning for the second phase began in summer 2000. One of the principles of both, SDC and SRC, in their development work is the involvement of target communities as much as possible in the project cycle of planning, implementation, monitoring and evaluation. As an important step for such involvement of communities SRC wanted to get the voice of the people into the planning process and for that purpose planned to do a qualitative, participatory study of people's priorities on health and health reform. They invited me to do that study.

At the time I was working in Bangladesh for the SRC. My main interest in my six years in Bangladesh had been the search for genuinely participatory ways of working with rural communities on improving their health. In the process I had discovered PRA for me, and it had become the basic philosophy and methodology of my work, which combined community development and health promotion.

SRC and I agreed that I would use PRA as a methodology for the study. It took place in July 2000. As it was the first PRA study in the health sector in Kyrgyzstan there were no trained PRA practitioners. Therefore, I trained the assigned team of eight people, all primary care physicians, in an intensive one week workshop in the remote rayons of Naryn oblast where the study was to take place. It was a clash of cultures. Soviet medical mentality, in which these doctors had been educated, propagated very much a patriarchal, authoritarian attitude of doctors to their patients, that assumed to know best what is good for their patients and therefore tended to take decisions on their behalf often without making sure they fully understood the diagnosis and therapy plan. Patients were simply expected to believe doctors and carry out their orders, which indeed were given and perceived as “orders” of an authority rather than as advice of a caretaker. This reflected the attitude of the Soviet health system that regarded the health of the people as the responsibility of the state, rather than of the people themselves. Contrast this with the maxim of PRA – and any qualitative research method – that it is the people who know and it is the investigator who learns from the people. Instead of teaching and telling people what to do my team therefore for the first time had to shut up, listen and learn from the people. Not to interfere and correct people in their discussions of the health issues during the PRA sessions,

accepting people's views without judging them as right or wrong, proved to be, unsurprisingly, the hardest part. But these workshop participants, my study team, also showed several features of Kyrgyz people that would become very important later, first among them an openness to learn, to discover, a readiness to recognise the limitations of one's view and to try something new if supported by convincing arguments; and second, most understood quickly the importance of attitude and behaviour of the investigator in relation to the people. Following role plays during the training that made them aware of their dominant behaviour, most were able to leave their professional authority as doctors behind and adopt a behaviour that allowed to establish a relationship with people on an equal footing.

There were indications that the training and the study had elements of a transformative experience for the team, among them the enthusiasm of the team members in discovering a new survey method, their constant wondering at the richness of knowledge of the people and their struggle to react creatively to that, their joy in observing a group of villagers absorbed in discussing, ranking, drawing, and the gratifying experience of people opening up and allowing to come close if one leaves one's professional authority and its dominant behaviour behind. As one member put it in a reflection during the training (Schueth 2000):

Working with PRA is like coming out of a tunnel. Before in the tunnel it was dark and narrow, alright, but at least you knew exactly where you had to go; there was only one way. Now, stepping out of the tunnel, there is sudden light, you start to see things, your eyes are opened. But at the same time you have to start thinking where you want to go, because the direction is not pre-decided anymore.

In the end the study went very well. The team mastered the PRA tools that I had designed for the purpose, the groups of villagers that we asked to participate used the tools with ease and discussed with interest their health issues and prioritised them. I invited villagers who had participated to Bishkek so they could help present their results to the MoH themselves rather than only the research team, which made a great impression. I remember that the study process was in fact so well received by everybody that I thought that this would be a great country for the participatory community development and health processes that I was trying to implement in Bangladesh. There, it felt like a constant struggle against odds; here, in Kyrgyzstan, the experience of the study seemed to suggest that it would be a smooth ride.

I named the study "If we were the Minister of Health... People's Perspectives on Health Care. PRA study in 2 rayons of Naryn oblast." It took place in four villages and involved over 600 people in around 70 PRA sessions with 13 different tools. People identified high blood pressure, brucellosis⁶, and anemia as the most burdensome diseases. Their highest reform priority was reducing the financial barriers to accessing health care, specifically reducing the costs of outpatient drugs and removing the informal payments ("bribes") to doctors in the hospitals. They perceived a steep decline in access to and quality of hospital care since Soviet times.

⁶ Brucellosis is a disease of sheep, goat and cattle that is often transferred to people tending them; it is rarely lethal but can be chronic and can make a person an invalid. Kyrgyzstan has one of the highest rates of human brucellosis in the world.

Interestingly they demanded higher salaries for health care staff suggesting a high respect for their service to their communities. (Schueth 2000).

In autumn of 2000 I was invited again to Kyrgyzstan to moderate the planning of the second phase of the Swiss-supported health project. SRC's proposal of a large community based health promotion component was initially rejected by the MoH that insisted that almost all allocated resources be used, as in the first phase, for reconstruction of hospitals. Only the readiness of SDC to increase the funding beyond the originally allocated amount could secure the inclusion of community based health promotion into the project.

When SRC asked me at the end of this planning process to move to Kyrgyzstan and lead the project I accepted mainly in memory of the happy days of the PRA study and of my intuition at its end that Kyrgyzstan would be a country where my ideas of community development and health promotion could come to fruition.

3.3.2 First steps – “The Jungal Model”

Beginning of 2001 I arrived in Kyrgyzstan and took over the leadership of the project. Besides managing the hospital reconstructions, much of the first year was spent generating and exploring ideas and possibilities of working with communities through the health system. For this was my premise: whatever we did, I wanted it to be done through the governmental health system, both, to foster a partnership between communities and the health system and to increase the likelihood of the model's sustainability. The idea of forming some sort of village organisation that would engage in voluntary work for the improvement of health in their villages was rejected as impossible in the higher administrative levels of the health system and in the MoH but was thought very possible and warmly welcomed among the PHC staff in the villages. An exception was the then Minister of Health himself who supported our ideas and gave us complete freedom to experiment, including the use of governmental health system staff.

At the end of 2001 I installed three people from the study team as the first team with whom we would start to work with the village communities. We selected Jungal rayon of Naryn oblast to start, a small, remote rayon with only 15 villages. The team, two women and one man, were familiar with my style of working, we had come to trust each other during the study, where they had displayed a thorough understanding and skilful handling of the principles of PRA, which would play a crucial part in our work, especially of the importance of avoiding dominant behaviour. They agreed to leave their families behind and live in this remote rayon for almost a year in order to have daily contact with the communities. This intensive contact with the communities allowed us to test and develop the key elements of the emerging model during the first year. After a few months the first Village Health Committees were formed, and after half a year they had implemented successfully the first health action, the promotion of iodised salt to control goitre. People in the MoH started to take notice of what we did and after a year the Minister baptised what we had developed “The Jungal model”, further sanctioning and encouraging our efforts.

Within two years we had grown sufficiently confident to plan the extension of the model throughout the other four rayons of Naryn oblast. For this we wanted to replace

the team in their role of direct implementers and have governmental health system staff take over that role, while the team would become trainers of this staff (therefore in the following “trainers” for the team). However, such governmental staff did not exist. We developed therefore, together with the Republican Center for Health Promotion (RCHP), the idea of the Health Promotion Units (HPUs). They would be the first governmental health system staff exclusively dedicated to health promotion, and for the time being, exclusively dedicated to working with VHCs. The MoH agreed to this, they installed HPUs in the four rayons of Naryn as a pilot to enable the extension and further development of the model.

Beginning of 2004 around 110 VHCs had been formed in all villages of Naryn oblast. By beginning of 2005 further 95 VHCs had been formed in another oblast, Talas, and five health actions had been developed that VHCs were busy implementing: on iodised salt promotion, brucellosis control, high blood pressure screening, vegetable gardening (nutrition/anemia), and alcohol consumption. First results from these efforts started to be documented.

3.3.3. Endorsement and extension throughout the country

During 2005 the MoH developed its second phase of the health reform programme, called Manas Taalimi (Taalimi = lessons learnt from the past) and included in it the extension of the “Jungal model” (or Community Action for Health, CAH, as it was now called) throughout the country, asking donors to support this and offering to install HPUs wherever the programme would be financed. Two donors heeded this call. USAID adopted two oblasts, Issyk-kul and Jalalabat, where they intended to implement CAH through an existing USAID funded project (“ZdravPlus”), with technical assistance from the Swiss-funded project. Sida decided to co-finance the existing Swiss-financed project, which led to it being renamed as the Kyrgyz-Swiss-Swedish Health Project. This co-financing would allow the extension of CAH through the three remaining oblasts, Batken, Osh and Chui.

Since then almost every year an entire oblast or half an oblast has been added to the programme. (Figure 3-1). Table 3-1 summarises the main events of the development of CAH in Kyrgyzstan. As of 2010, there are around 1400 Village Health Committees in over 70% of the villages of the country.

Figure 3-1: Extension of CAH throughout the country with population covered

years	2002	2003	2004	2005	2006	2007	2008	2009	2010
Jungal rayon (Naryn)	25000								
Naryn other 4 rayons			135000						
Talas				114000					
Issyk-kul					255000				
Jalalabat 1						249000			
Batken						321000			
Chui 1						293000			
Chui 2								303000	
Osh 1								270000	
Osh 2									624200
No. VHCs	15	15	124	219	365	802	802	1125	1400
population covered	25000	25000	160000	274000	529000	1392000	1392000	1965000	2589000

Table 3-1: Chronology of CAH in Kyrgyzstan

Year	Progress
2001	Second phase of the Swiss-funded health project begins, which includes the mandate to develop a community-based health promotion model. Work with communities begins in Jumgal rayon in the end of 2001.
2002	First VHCs formed in Jumgal rayon
2002-2005	Extension of CAH through two oblasts
2005	Inclusion of CAH into the health reform program
2006	Sida and USAID join SDC as core-donors of CAH
2007-2010	Extension of CAH throughout all remaining oblasts

3.4. Structure of CAH in Kyrgyzstan

This chapter describes briefly the main elements of CAH in Kyrgyzstan. Figure 3-2 summarises the structure.

3.4.1. Village Health Committees (VHCs)

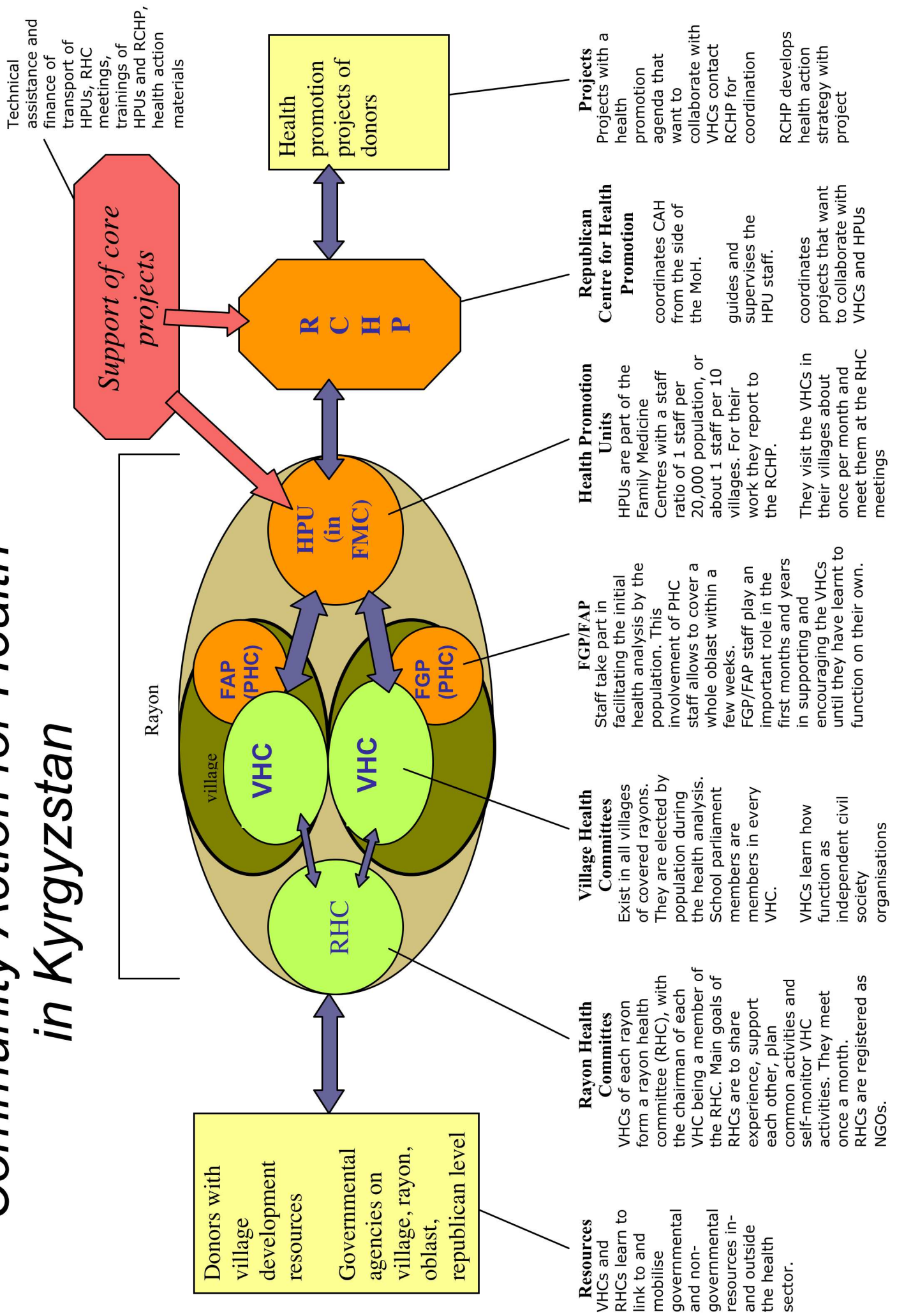
VHCs exist in all villages of all covered rayons (districts), but not in the small towns of the rayon centres. Members are elected by the population during the health analysis. School parliament members (see below) are invited to be members in every VHC. VHCs learn how to function as independent civil society organisations and are encouraged to engage in initiatives addressing local determinants of health. Most VHCs have a meeting room in the FGP/FAP, school, or Ail Okmotu. VHCs are also trained to engage in “health actions”, vertically designed activities geared toward controlling specific diseases. For each health action they form Action Groups so that burden is spread and more people become involved. The work for health actions is entirely without payment.

3.4.2. Rayon Health Committees (RHCs)

All the VHCs in each rayon join to form a Rayon Health Committee (RHC), with the chairperson of each VHC being a member of the RHC. RHCs are registered as NGOs with juridical status. They meet once a month. The main goals of RHCs are to share experiences, support each other, plan common activities, and monitor VHC activities. The RHC meetings are also key occasions for exchanging information between VHCs, HPU, and projects. RHCs link with rayon level governmental resources, inviting representatives to their meetings to discuss requests and suggestions. RHCs also serve as a conduit between VHCs and donor organisations, which usually require juridical entities as partners for grants. The formation of a national federation of VHCs is in progress. Its task will be to engage in dialogue with the MoH and projects, and to formulate and represent VHC interests.

Figure 3-2

Community Action for Health in Kyrgyzstan



3.4.3. School parliaments

A school parliament is a student body which exists in every school in Kyrgyzstan. Mimicking government structures, they are divided into “ministries” that take on extracurricular tasks in the school related to their “portfolio.” The VHCs invite some or all members of the “health ministry” of the school parliament to serve on the board of the VHC. This creates a very close link between VHCs and schools, ensuring that most activities of the VHCs are reflected in the schools, which utilizes the well-known efficacy of children as health messengers at home. The link also capitalises on the vast amount of voluntary human resources the student body can offer.

3.4.4. Health Promotion Units (HPU)

To carry out the implementation of CAH, the MoH has established Health Promotion Units with a staffing ratio of 1 staff per 20,000 population, or about 1 staff per 10 villages. This results in between two and eight staff per HPU and rayon, depending on the size of the rayon. Overall, there are currently about 100 HPU staff engaged in CAH in Kyrgyzstan. From an administrative perspective, they are staff of the Family Medicine Centres in the rayon centres. Most are physicians, nurses, or paramedics (feldshers), but some are also from other professions requiring middle or higher education. They receive guidance from and report to the RCHP on the progress of their work. They visit the VHCs in the villages about once per month and meet them at the RHC meetings. They work with VHCs in two core areas: (1) organisational development to help VHCs become independent civil society organisations, and (2) training on health actions, and the collection of monitoring data from these actions. HPUs are the key link between the governmental health system and the VHCs. HPU staff in an oblast meet once per month for exchanging experiences, planning and monitoring.

3.4.5. Family Group Practices (FGPs) and Feldsher Accoucher Points (FAPs)

FGPs and FAPs are the network of Primary Health Care providers of the governmental health system. One or the other is present in most villages. FGPs have at least one physician and are present in bigger villages. FAPs have paramedics and midwives and are present in smaller villages. For the implementation of CAH, the MoH mandates that all FGP/FAPs take part in facilitating the initial health analysis by the population. It is this extensive network of PHC staff, trained by HPUs, that allows coverage of an entire oblast in a short period, and the involvement of around 30,000-50,000 people per oblast in the PRA analysis (or 50-70% of all households). Additionally, VHCs are formed in all villages within 2-3 months of beginning community engagement in an oblast. It is one of the unique features of CAH in Kyrgyzstan that governmental PHC staff is engaged in facilitating people’s analysis of health and forming community-based organisations.

Beyond their role in establishing VHCs, FGP/FAP staff play an important role in the first months and years by supporting and encouraging the VHCs until they have learned to function on their own. FGP/FAP staff receive trainings on the concept of CAH, modern concepts of health promotion, working with communities, and specifically on their role in supporting VHCs in their early months and years. Many VHCs have a meeting room in the FGP/FAP building.

3.4.6. Republican Centre for Health Promotion (RCHP)

The RCHP is an agency of the governmental health system that reports to the MoH. With technical assistance from the Kyrgyz-Swiss-Swedish Health Project, it coordinates CAH and guides and supervises the HPU staff. It coordinates the collaboration of organizations or projects with VHCs and HPUs and advocates issues of importance to CAH in the MoH. Beyond CAH, the RCHP is responsible for all health promotion in Kyrgyzstan.

3.4.7. Local Self-Government (Ail Okmotus)

Ail Okmotus are the local self-government bodies of the Kyrgyz administrative system. They are appointed by the rayon administration. They administer governmental funds allocated to them from the rayon administration, as well as local taxes generated in the village. Clusters of one to four villages form an Ail Okmotu, with representatives of the Ail Okmotus in each village (Ail Bashy). Ail Okmotus are also head of the Ail Kenesh, the village parliament, which has elected members.

The department of local self-government in the presidential administration has issued a recommendation for the Ail Okmotus to sign memoranda of understanding with the RHCs that recognise VHCs and RHCs as important independent partners of the Ail Okmotus.

3.4.8. Health Promotion projects

There are donors or projects with a health promotion agenda that want to collaborate with VHCs and with the HPUs. They contact the RCHP to coordinate with the CAH program. If the proposal matches people's priorities in the requested region, or is aligned with another public health priority, and if the RHCs concerned agree, the RCHP develops a health action with the project that fits the way VHCs work. Vice versa, the RCHP may look for a suitable donor or project to support a need identified by the population or voiced by the VHCs. Collaborating projects are expected to contribute something to the sustainability of VHCs as organisations, beyond the funding of the implementation costs related to their agenda. Donors that have collaborated so far include the World Bank, UNICEF, the Global Fund, the Global Alliance for Vaccines and Immunization (GAVI), and the Asian Development Bank (ADB).

3.4.9. Non-health sector resources

VHCs and RHCs learn to link to and mobilise governmental and non-governmental resources both within and outside the health sector. Examples include, on a rayon level, the forestry department for tree planting, or the veterinary department for brucellosis control. VHCs write project proposals to donors that offer small grants.

3.4.10. Core-supporting projects

Core-supporting projects include the Kyrgyz-Swiss-Swedish Health Project and the USAID funded project, ZdravPlus. The two core-supporting projects have two to six trainers per oblast, based on the size of the oblast, who train and supervise the HPU staff. The core-supporting projects finance core functions of CAH, such as transport of HPUs to the villages, transport of VHC members for RHC meetings, and trainings and materials for the health actions developed by these projects. Kyrgyz-Swiss-Swedish Health Project also provides technical assistance to RCHP in steering CAH and coordinating collaborating donors. A third donor, Aga Khan Foundation (AKF), is currently adjusting its community-based health project in 50 villages to become in line with CAH. Between these three donors, all villages in Kyrgyzstan are covered, or intended to be covered.

3.5. Building blocks and results of CAH in Kyrgyzstan

It is useful to describe the processes of CAH in five building blocks, as outlined in Table 3-2. This chapter will describe these building blocks and the main results of CAH in Kyrgyzstan.

Table 3-2: Building blocks of CAH in Kyrgyzstan

Building block	Explanation
People's analysis of health	HPU and FGP/FAP staff facilitate this analysis with PRA tools, involving a large proportion of the population
Formation of Village Health Committees	During the health analysis people propose members for the VHCs from those in their neighbourhood. These members elect the boards and thereby establish the VHCs
Health Actions	HPU staff train VHCs to implement actions that address the health issues prioritised
Organisational capacity building of VHCs	HPU staff train VHCs to function as independent civil society organisations. VHCs form Rayon Health Committees that are registered as NGOs.
Capacity building of the governmental health system	RCHP and Kyrgyz-Swiss-Swedish Health Project train HPU staff and guide the MoH to act as a partner for the VHCs. They advocate the issues important to CAH at MoH and donors.

3.5.1. People's analysis of health

The extension of CAH into a new rayon or oblast starts always with a broad based analysis of people's perspectives on health in their villages. The FGP/FAP staff in each village collect neighbourhood groups of about 10 people and facilitate the sessions using tools designed according to principles of PRA. HPU staff train and supervise the FGP/FAP staff in this facilitation task. HPU staff themselves are trained by trainers from the core-supporting projects. The training for facilitating discussions using the PRA tools takes 10 days. One staff member from each

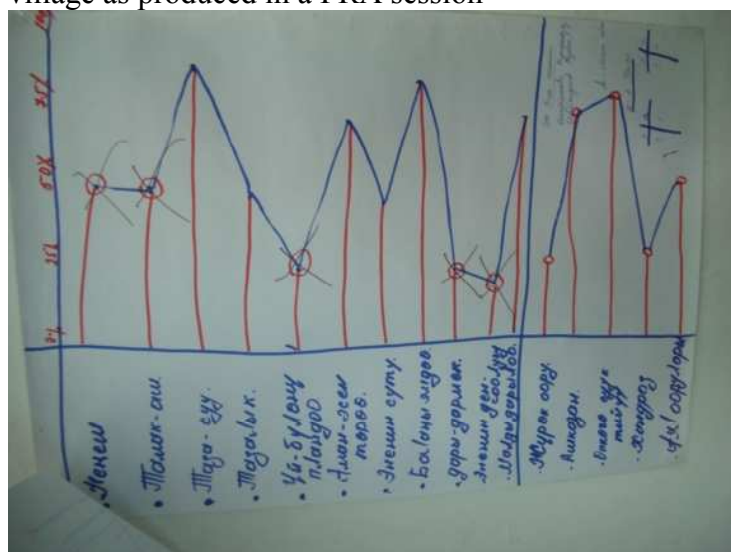
FGP/FAP (more than one in bigger villages) is trained and then engages for about four to six weeks in facilitation of PRA sessions in their villages. This is done simultaneously in all villages of the extension area (part of an oblast or an entire oblast) and results in several thousand sessions, which typically involve 30,000 to 50,000 people (from 50-70% of households in the area). As it is mostly women who participate in the sessions (they are the ones typically at home when the groups are collected), a few sessions are held with men only to make sure their views are heard. The results of the sessions are compiled on village, rayon and oblast level.

Facilitation of people's analysis of health begins by calling a group of five to ten neighbours together for a one to two hour session. The facilitator gives the group pen and paper and begins with the first of two questions: "What do you need to stay healthy in this village?" This question focuses the discussion on determinants of health, rather than on treatment of diseases. People are asked to collect their thoughts on the paper. When they are done, the facilitator shows the list of the main elements of Primary Health Care as outlined in the WHO Declaration of Alma-Ata (WHO 1978). Invariably, the people's list contains most elements of the Alma Ata Declaration, such as access to nutrition, clean water, information, vaccinations, pharmaceuticals and treatment, etc. Often, the people's list contains additional elements, such as clean air, a sport hall, a bathhouse, etc. This comparison with the list of the Alma Ata Declaration helps to encourage and affirm people in their analysis, as the facilitator explains that they have thought about the same things as the world's leading health experts

Figure 3-3: People's analysis of health: group discussion with a PRA tool



Figure 3-4: People's analysis of health: a graph depicting the health situation in a village as produced in a PRA session



during this conference. It also helps to categorise the answers according to a well-known structure. The facilitator now asks the second question: “what are the main diseases in your village?” This investigates the endemic diseases, the control of which is also an element of the Alma Ata Declaration. Again people list their suggestions on a piece of paper. As this list tends to be long, the facilitator asks the group to rank the diseases according to both frequency and burden, and to mark the five most frequent and burdensome. This is done as a typical PRA ranking exercise. As the next step, the facilitator asks the group to draw two lines in the form of a coordination system (a vertical and horizontal axis) on a big piece of paper and to list the determinants of health and the five most frequent diseases along the horizontal axis. On the vertical axis a scale of 0-100% is drawn. The group then assigns to each of the items on the horizontal axis the degree (a “percentage” value) to which it is present in their village. The result is a graph profiling the village's health situation as seen by this group of people, which includes key elements of the Alma-Ata Declaration on Primary Health Care. An example is shown in Figure 3-4. The five worst ranking determinants of health and the five most frequent and most burdensome diseases are used for the compilation of results on village, rayon and oblast level.

The extensive involvement of large parts of the community in analysing the health situation in their village has several purposes and effects. Not only does it fulfil the primary purpose of generating a broad-based consensus on what the perceived health priorities are in a village, rayon, and oblast, but it also serves as a mandate regarding which issues to address. Its second purpose is to start the process of VHC formation (a more in-depth explanation follows). Another purpose is to change the traditional roles, which typically are health care providers being those who know and give information, and people being ignorant and receiving information. When FGP/FAP and HPU staff train for their role as facilitators, there is extensive reflection on how to leave behind the typical dominant posturing of a health professional who instructs people what to do. Listening to people, instead of teaching them, sets the stage for a relationship of equals and partners. Very often we have heard astonishment from the facilitating health care providers about the insights people display; and many times

people have told staff at the end of a session that it is the first time someone asked their opinions and listened to them. Therefore, this analysis is also a first step toward a new relationship of partnership between people and health care providers. Table 3-3 gives an example of the result of people's analysis of health in one oblast.

Table 3-3: Ten highest ranking determinants of health and most frequent and most burdensome diseases. Batken oblast, 2007. (Compilation of 3317 sessions, with 30,338 participants from 56% of households in 167 villages. The points indicate the number of times a given item appeared among the first 5 priorities in a session)

Health determinants			Diseases ranked by frequency			Diseases ranked by burden		
	Points	Rank		Points	Rank		Points	Rank
Clean water	2353	1	Anaemia	2773	1	High blood pressure	15553	1
Access to treatment	2092	2	High blood pressure	2718	2	Anaemia	13691	2
Drugs	2047	3	Influenza	2277	3	Goitre	9503	3
Information	1717	4	Goitre	2104	4	Influenza	6077	4
Bathroom	1424	5	Joint diseases	1465	5	Joint diseases	5503	5
Sanitation	1410	6	Dental diseases	1167	6	Brucellosis	5351	6
Nutrition	1407	7	Women diseases	1155	7	Alcoholism	3086	7
Sport hall	660	8	Brucellosis	1049	8	Women diseases	4499	8
Ambulance car	487	9	Diarrhoea	1041	9	Diarrhoea	2680	9
Pharmacy	334	10	Intestinal worms	870	10	Intestinal Worms	2624	10

3.5.2. Formation of VHCs

At the end of each PRA session, the facilitator asks whether the participants think that some of the issues they identified could be addressed by the community itself if some sort of organisation would coordinate the effort. Invariably, people see such a possibility. The next questions are then what kind of people they would want in such an organisation and, after criteria are established, whether they know people in their neighbourhood who fulfil these criteria and whom they would want as members or leaders of such an organisation. The suggested names are noted. After the analysis is completed in the village, they are invited to a meeting, along with all villagers, where the results of the analysis are presented, and the idea of a Village Health Committee is discussed. The names of the proposed members are listed, and using a secret ballot, the board of the VHC is elected from this list. All other people proposed by the group sessions become members of the VHC. The secret ballot ensures that the people elect those whom they trust to take on the responsibility and work diligently, rather than simply influential people who want control and not responsibility (often in a public vote, no one wants to be seen not voting for influential people). The board elects the

chairperson, secretary and cashier among themselves. The board can later invite other people to join it without election by members. The key data of the newly formed VHC are collected on a “passport” for documentation purposes. Most members and board members of the VHCs are women.

3.5.3. Health actions

A health action is a set of activities carried out by the VHCs, which are geared toward controlling certain diseases. HPUs train VHCs to implement these health actions. Health actions are developed by the RCHP with technical assistance from projects. The topics for health actions are chosen from the priorities that were identified during people’s analysis of health; in some cases, they may correspond to public health priorities that are not among people’s priorities. Most health actions consist of three elements: a baseline survey or action research, activities to promote behaviour or circumstances that lead to better health, and data collection for monitoring or follow-up surveys. We often call the baseline surveys action research because they are done not by outsiders, but are conducted by the VHCs themselves, who also analyse their own data. This results in a deeper understanding of the issue at hand among the people affected by it. It also often contributes to people’s willingness to change behaviour or address an issue. The action research by VHCs, therefore, corresponds to a common definition of Community-Based Participatory Research (Green and Mercer 2001): “a systematic inquiry, with the participation of those affected by the issue being studied, for the purpose of education and taking action or affecting social change.” The examples of health actions described further below should further clarify what is meant.

The activities to promote behaviour change consist mostly of information, communication, and education measures. These activities are mainly in the form of distributing information material, but this is often accompanied by explanations in one-on-one discussions. These activities can also involve more practical actions, such as checking the iodine content of household salt or screening for high blood pressure.

Collection of monitoring data is built into each health action. The data mainly consist of reported behaviour, but in some cases include observed behaviour or objectively measured indicators. Data are collected either as a part of the health promotion work with targeted people, or in sample surveys. VHCs document the results of their work, including baseline and monitoring data, in tables and graphs, and keep a separate file for each health action. HPU staff copy these data, compile the data for their rayon, enter data into computers in specially designed entry forms, and forward the data in an electronic format to the central database of RCHP and the core-supporting projects for compilation on oblast and national level.

One primary health care (FGP/FAP) staff member is invited to each training on a health action. This ensures that primary health care (FGP/FAP) staff are aware of what VHCs are doing, and also enables them to clarify questions if needed, and participate in the implementation of the health action, if they so wish; this is left up to them.

The Kyrgyz-Swiss-Swedish Health Project, together with the RCHP, has developed health actions on the following 13 issues.

Iodised salt consumption	Alcohol consumption
Anemia/nutrition	Brucellosis
<ul style="list-style-type: none"> • Exclusive breastfeeding • Supplementary feeding • Nutrition in pregnancy 	Hygiene and sanitation
Hypertension	Deworming
Acute Respiratory Infections	Sexual Reproductive Health
	Dental hygiene
	Malaria

The following examples of five health actions explain in detail how they function and what results have been produced.

3.5.3.1. Design and results of health actions

Example 1: iodised salt promotion

Iodine deficiency disorders (IDD) are highly prevalent in Kyrgyzstan. During Soviet times, since the 1970s, IDD were well controlled through state-controlled iodisation of salt (Sultanalieva and Mamutova 2001). With the break-up of the Soviet Union, state controls deteriorated and allowed non-iodised salt to flood the market in Kyrgyzstan. This persisted even after the country adopted legislation forbidding the sale of non-iodised salt. The main reason is fraud – declaration of iodisation on the salt packet without the salt actually being iodised. The result was a rapid increase in IDD during the 1990s (Sultanalieva and Mamutova 1998; Housten, Rashid, and Kalanzi 1994).

This was the context in which the health action to promote iodised salt through VHCs was developed. The key tools of the health action are the test kits that are widely used for monitoring salt iodisation. A drop of their solution turns salt blue/violet if iodine is present and leaves it white if not. The test kits are very cheap, and one kit can test hundreds of samples with one small ampulle.

The iodised salt health action begins with VHCs checking salt in all households using these test kits, as well as testing salt samples at retailers in their village. This action research allows VHCs to learn in detail about the consumption and sale of iodised salt in their village. At the same time this action research in itself has a powerful educational effect: seeing one's kitchen salt turn blue or stay white and being explained the significance of that leaves a lasting impression. It also helps identify the brands of salt that are typically not iodized.

In addition to testing salt, the health action consists of (a) explaining to people during the testing the importance of iodised salt and encouraging them to ask for iodised salt at the retailers, (b) giving a test kit to all retailers and asking them to use it at the

whole sale market when buying salt to make sure they bring only iodised salt to the village, (c) checking a few samples of salt every month at the shops of retailers to keep up the pressure to provide only iodised salt (after 2 years, the frequency of this testing is reduced to once every 6 months), and (d) renew the test kits of retailers every 6 months.

Monitoring for the health action consists of: (a) a second round of testing in all households a year after the baseline testing, (b) documenting the test results of salt samples at the retailers, (c) from the third year on, a yearly sample survey among households (no longer testing all households) on the presence of iodine in their salt.

This health action was gradually implemented between the years 2002 and 2008 in all oblasts where CAH was introduced.

Detailed analysis of the data produced by VHCs during the implementation of this health action in Naryn oblast (2002-2003) led to the following observations and conclusions, which have been published (Schueth et. al. 2005).⁷ The first important observation was that VHCs reach a high proportion of households with their testing of kitchen salt. In Naryn they covered about two-thirds of households (65%); in other oblasts there was similar coverage. This broad based testing of salt in households, the action research component of the health action, had a measurable effect on the coverage of households with iodised salt,⁸ which rose from 87% to 97% within half a year. This is probably due to the powerful educational effect of seeing one's salt turning blue or staying white with a simple test and being given an explanation of its significance for one's health. It caused people to ask for iodised salt at retailers. The second component of the health action - testing salt at retailers and providing them with test kits for use at whole sale markets - had an even greater effect. Only test kits for *iodated* salt (which don't react to *iodinated* salt) were distributed to retailers in order to promote this more stable form of iodised salt. In one area, we were able to demonstrate that this produced an effect separate from the effect of the action research, and this area saw an increase (from 71% to 90%) in only six months in the coverage of households with the preferred *iodated* salt. Clearly, retailers did use the test kits when purchasing at the whole sale markets, and this had an effect on the kind of salt people had in their kitchens.

The significance of these results is underlined when the results are compared with a survey of household coverage of iodated salt across Kyrgyzstan, which was conducted at the same time that our intervention in Naryn oblast took place. The survey found almost no increase in coverage from 2002 (69%) to 2003 (72%). However, following the roll-out of the health action throughout 23 of the country's 40

⁷ In Naryn oblast the effect of the action research component could be discerned separately from the effect of the work with retailers because of a phased introduction of these two components of the health action.

⁸There are two forms of iodine that can be added to salt, potassium iodate (*iodated* salt) and potassium iodide (*iodinated* salt). Iodated salt is nowadays the preferred form because of its greater stability. We use "*iodised* salt" when iodine is added in any form. To facilitate reading we add italics throughout the text when referring to *iodated* or *iodinated* salt.

rayons, a survey in 2008 found that 96% of households had iodated salt (Sultanalieva 2008).

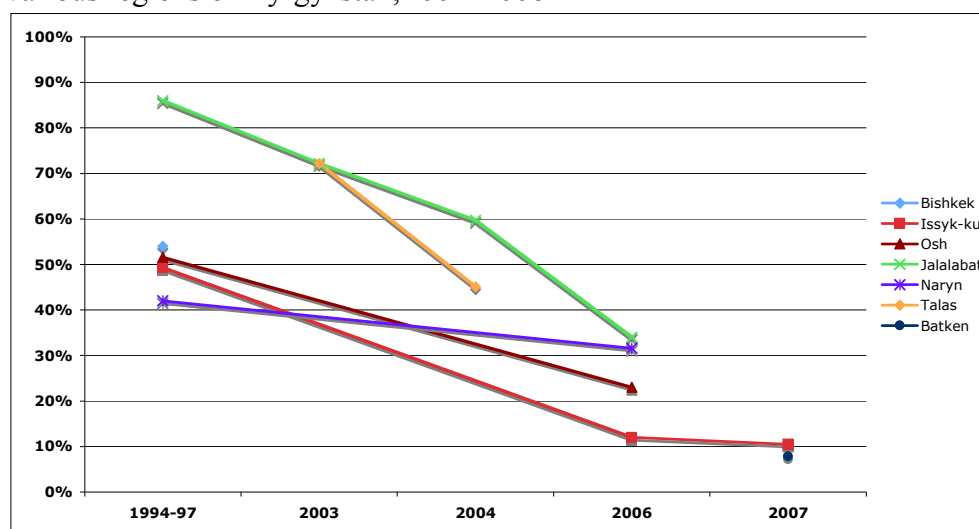
A further indication of the effectiveness of the health action comes from comparing the VHCs' baseline and one-year follow up data on household coverage. As shown in table 3-4, there is a clear increase in all regions where the health action was introduced. Also, VHC data show that 88% of retailers in villages had test kits in 2008; none of the retailers had test kits before the health action.

Finally, there is evidence that all these efforts had an impact on the prevalence of disease. As shown in figure 3-5, the prevalence of goiter in school children has decreased dramatically over a decade starting in the mid-90s. The graph summarizes all palpation studies conducted in various regions of the country that took place during these years. (Sultanalieva, 2006a, 2006b, 2007, 2008; Schueth and Sultanalieva 2006; Asian Development Bank 2006; UNICEF 2007). There are several factors behind this success in disease control, including legislation enacted in the mid-90s banning non-iodised salt, as well as supporting producers in the iodization of salt. However, as the significant increase in coverage of iodated salt occurred only after 2002, it seems reasonable to assume that the VHCs' health action played a crucial role in reducing of the prevalence of goitre.

Table 3-4: Effect of iodised salt health action of VHCs on household coverage with iodated salt (data from VHC surveys)

Oblast	Baseline and follow-up time	Baseline	1 year Follow-up
Naryn oblast	October 2002 – September 2003	76%	90%
Talas	April 2005 – April 2006	91%	97%
Issyk-kul	April 2006 – April 2007	62%	90%
Batken	September 2007 – September 2008	85%	94%
Chui West	September 2007 – September 2008	85%	93%

Figure 3-5: Goiter prevalence in school students (6-11 years). Palpation surveys in various regions of Kyrgyzstan, 1994-2008



Example 2: Curbing alcohol consumption

Alcohol was identified in Naryn oblast as one of the main health priorities during the people's analysis of health. During Soviet times, the Kyrgyz society adopted Russian cultural traditions surrounding alcohol, including vodka as the preferred form of alcohol and exerting considerable social pressure to use numerous occasions of daily life to drink. Not offering vodka or drinking vodka at these occasions – or, for example, not bringing alcohol as a gift during a visit - is considered impolite or even unacceptable. Discussions with people revealed that the concern about alcohol is two-fold: the loss of money due to alcohol in these economically difficult times, and the large number of alcoholics and associated disruption of families and social life.

To address the alcohol issue, we therefore developed two approaches: one was a health action by the VHCs that tackles the traditions around alcohol and is geared toward reducing alcohol consumption by the overall society; the other offers help to alcoholics through the establishment of groups of Anonymous Alcoholics.

The health action to reduce alcohol consumption began in 2004 with VHC members going from house-to-house to calculate an estimate of money spent per year on alcohol for each family. They also asked about the negative effects of drinking in this village, and they asked what families would do with the estimated amount of money if they had it at their disposal. The amount of money lost each year on alcohol was eye-opening for many families. The results of the action research were compiled for the entire village and presented at a village meeting. Seeing the amount of money spent on alcohol by families and by the whole village – the latter often several thousand dollars per year - raised people's willingness to change behaviours related to alcohol. During the village meeting people determined which specific behaviours should be replaced by what we called "new traditions." In the relevant trainings VHCs were discouraged from trying to promote any radical solutions, such as complete abstinence or a forced prohibition, as experience shows that these don't work. Instead, VHCs were encouraged to facilitate a discussion of what seemed possible and realistic steps in the direction of reducing alcohol consumption. Most VHCs settled on measures like "no alcohol at funerals anymore," "no alcohol as a gift when going for a visit," and "no forced drinking at celebrations and parties."

The VHCs then began to promote these new traditions (implementation part of the health action), using self-made posters with the results of their action research: the amount of money spent on alcohol in the village, the main negative consequences identified and the "new traditions" agreed upon. They do so by talking about the new traditions in private interactions at all appropriate occasions and by meeting systematically with all groups and influential people in their village to ask them to join in the promotion of new traditions. In addition, school parliaments made the new traditions known to all children, asking them to propagate them at home.

The VHCs monitor the effect of the health action with yearly surveys that inquire about adherence to the "new traditions." The survey asks about behaviours at the last relevant occasion. Table 3-5 shows the adoption of "new traditions" over three years.

Table 3-5: Naryn oblast: Consumption of alcohol on typical occasions. “The last time at these occasions ...”. Data from VHC monitoring surveys 2006-2008

	2006 (%) n=5505	2007 (%) n=5945	2008 (%) n=5243
Did you bring alcohol as a guest present	43	43	37
Did you receive alcohol as a guest present	51	42	39
Were you offered alcohol at funeral	29	19	15
Were you offered alcohol for a small occasion	40	34	31
Did you celebrate a small occasion with alcohol	35	26	25
Were you forced to drink alcohol at a party	38	30	30
Did you offer alcohol as payment for small works	43	31	33

Unfortunately, this yearly survey was not introduced until 2006, as the monitoring of the health action evolved over time. To account for the time between the beginning of the health action in 2004 and the introduction of the survey in 2006, we attempted to measure the effect during this time period with a survey in 2006 that asked people to retrospectively compare their behaviour before the health action with their present behaviour. Of course, a retrospective assessment such as this is much less reliable than asking concretely about the last relevant time of an occasion in question. Nonetheless, the results of that survey, shown in table 3-6, suggest a positive trend may have started before 2006.

Table 3-6: Consumption of alcohol at typical occasions before beginning of promotion of new traditions and currently. Naryn oblast, 2004-2006

	Most of the time		Sometimes		Rarely	
	2004	2006	2004	2006	2004	2006
Typical occasions for alcohol						
Bringing vodka as guest present	46%	23%	41%	59%	13%	18%
Receiving vodka as guest present	43%	21%	45%	60%	12%	19%
Presence of vodka at funerals	35%	16%	41%	44%	24%	40%
Offered vodka for small typical occasions (e.g. when bought something new)	38%	23%	42%	49%	19%	29%
Received vodka for small typical occasions	37%	19%	44%	49%	19%	32%
Received pressure to drink at typical occasions	39%	28%	39%	45%	22%	27%
Paid for work with vodka	44%	28%	37%	43%	19%	29%

Anecdotal observations illustrate the change in attitude towards alcohol. Whereas before, it was considered rude not to offer vodka as a visitor’s gift, and a festivity without vodka was unthinkable, VHCs now proudly tell stories of recent festivities entirely without alcohol.

To offer help to existing alcoholics, the project invited two alcoholics from each village for a one-month rehabilitation course, designed according to the international 12-Steps Programme of Alcoholics Anonymous (AA). Participants in the program also learn how to set up AA groups in their villages. It is hoped that in this way, they can build the necessary support for themselves to stay dry, and that through forming AA groups in these villages the effect of the rehabilitation courses can spread beyond the people who go through the rehabilitation. They receive regular supporting visits from AA groups that have been set up in the rayon centres. These are the first AA groups in villages in Kyrgyzstan. The rehabilitation courses in Naryn were conducted from 2004 to 2006. By end of 2010, there were over 500 abstinent alcoholics in Naryn villages.

Example 3: hypertension

The main causes of mortality in Kyrgyzstan are heart infarct and stroke, i.e. cardiovascular diseases (CVD). Kyrgyzstan's CVD-related mortality for all ages is the sixth highest in Europe, and the stroke-related mortality is the second highest (WHO 2006). Reasons for this include a high prevalence of risk factors for CVD, the most important being high blood pressure (hypertension), combined with a very low level of control of this condition. The VHCs were the first to establish prevalence figures for hypertension in Kyrgyzstan based on widespread screening. Using automatic wrist-cuff tonometers VHCs screened over 140,000 adults in three oblasts. The high prevalence of hypertension found in this non-representative screening, provided justification for a nationally representative survey, which found an age-standardised prevalence of high blood pressure of 31% in the adult population, one of the highest in Europe (Jakab, Lundeen, and Akkaziya 2007). The study further confirmed the very low degree of control of the disease: Only about a quarter of people with high blood pressure were aware of their condition; only 17% took medicine for it the day before; and only 2% of those with the disease had their blood pressure controlled in the normal range. These figures illustrate the enormous importance of high blood pressure for public health in Kyrgyzstan. People in all oblasts, therefore, rated hypertension among the top health priorities.

This led us to develop a health action that would enable VHCs to improve the control of hypertension. Its action research element consists of measuring blood pressure in the adult population with automatic upper-arm tonometers, and identifying other risk factors for CVD (smoking, diabetes mellitus, hereditary disposition and girth as a proxy for body mass index). With these data, VHC members calculate the risk level for a heart attack or stroke for each person as a means of raising awareness of the risks posed by these factors and promoting life style changes; thus, once again the intervention is already part of the action research. Each household receives a brochure explaining CVD and its causes and consequences. Those found with elevated blood pressure are given a patient sheet on which their blood pressure and risk level are noted, and are also sent to the local FGP or FAP for further diagnosis and treatment. The VHC members follow up with these patients during periodic visits, which helps to control their blood pressure and remind them of the need to take their medication daily.

In September 2010 HPU staff did a survey among hypertensive patients followed by VHCs in 4 oblasts where the health action started in 2009. They found that 27% of them had come to know about their hypertension from the VHCs, and that among these 79% had gone the FGP/FAP to get a proper diagnosis and treatment of their

condition – thus fulfilling the main purpose of the health action. A cohort of 484 of these patients where a minimum two blood pressure measurements were available in the patient leaflet at the time of the survey showed a significant decrease of the average blood pressure from 168/100 to 157/95 mmHg indicating an effect of the follow-up by VHCs.

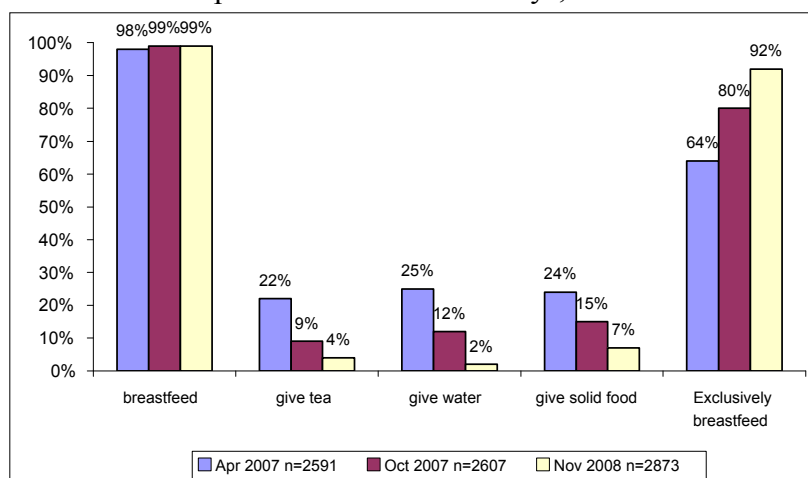
Example 4: Exclusive Breastfeeding

It is recommended that infants be exclusively breastfed during the first 6 months of life; all other foods or drinks should be avoided. In Kyrgyzstan, only 9% to 45% of mothers, depending upon region, breastfeed their infants exclusively during the first 6 months (UNICEF 2006). As blood analysis for anaemia is routinely done in pregnant women and children under 2 years of age in Kyrgyzstan, people are very aware of the widespread diagnosis of anaemia. Therefore, it was not surprising that anemia was identified as one of the top health priorities in all oblasts, especially by women.

To promote exclusive breastfeeding VHC members establish a list of all nursing mothers with babies up to 6 months old, visit them, and explain the benefits of exclusive breastfeeding. They also help with any difficulties mothers may experience with breastfeeding. In Kyrgyzstan, it is also necessary to raise awareness of the harm involved with giving tea to infants, as tea is the most commonly consumed beverage and it is even given to children only a few months old because it is considered beneficial. During their first round of home visits, the VHC members investigate and document current breastfeeding practices (action research) and repeat such documentation at certain intervals for monitoring purposes.

Evidence on the effect of this health action comes from Batken oblast where we developed and first implemented it. Figure 3-6 shows the baseline data from April 2007, and data at 6 months and 19 months after the start of the intervention. As can be seen, practically all mothers breastfeed their children under the age of 6 months. However, only 64% breastfed exclusively at baseline; 36% gave tea, water, solid food or a combination of those. This behaviour decreased drastically within 1.5 years, raising exclusive breastfeeding to over 90%.

Figure 3-6: Feeding patterns of children up to 6 months. Baseline and 6 and 19 months follow-up. Data from VHC surveys, Batken oblast 2007 – 2008.



3.5.4. Organisational capacity building of VHCs

VHCs are meant to be civil society organisations capable of *acting on their own* to improve health in their villages. Health actions only partially fulfil this goal. Although the selection of topics for health actions is based on priorities of the people, health actions are not planned and designed by VHCs, and the primary initiative to engage in the health actions does not come from the VHCs; instead, VHCs are asked to implement them and are uniformly trained to do so. Thus, there is an element of acting on behalf of an outside agency, albeit on issues that people have identified as important to them. To *act on their own* – or to engage in own initiatives, as we call them - a far greater degree of organisational capacity is needed than that required to organise the implementation of a health action. Therefore, engagement in own initiatives - activities initiated by VHCs and not by projects - is an important indicator of organisational capacity.

Organisational capacity building of VHCs begins during the process of forming VHCs. The bottom-up election of VHC members and of the board leaders makes it clear to them that their responsibility and accountability is downward to the people of their village and not upward to some outside agency. This becomes obvious when compared with a quite common process where the outside agency with the help of a few influential people in the village select members of the group they want to establish. Members selected in this way feel mostly accountable to the outside agents, which often results in a demand for payment. In contrast, one of the most common answers from VHC members when asked why they do what they do is that people have entrusted them with a responsibility and they want to live up to that.

HPU staff provide the following trainings to VHCs for organisational capacity building during the first 2-3 years after their formation. Three are described in some detail as examples, the others are listed.

3.5.4.1. VHC as an organisation

This is the first training on organisational development for the VHC boards. It is provided after the first health action has been implemented – usually iodised salt testing in households - because a practical task is well suited to enable VHCs to understand their role in working for health. This training then includes a discussion on their role as an organisation. They are made familiar with the concept of a voluntary, community-based, democratic, civil society organisation, and with VHC rules and regulations, or by-laws, that have been developed with the first VHCs.

3.5.4.2. Holding meetings and networking

The need for regular meetings is discussed with the VHCs, and the VHCs decide for themselves how often to hold meetings. They are encouraged to find a permanent meeting room. Arranging these meetings often requires support in the beginning, and primary health care (FGP/FAP) staff play a crucial role in this. A simple structure for meetings is suggested, which aids in discussing and deciding the issues at hand, including making simple action plans with the questions what, who, and when. The concept of action groups is introduced. An action group is set up for each health

action by inviting new members to participate specifically for this issue. This enlarges the active base of the VHC and distributes the burden. During the training, it is discussed how board members can build interest among new members for joining these action groups. Finally, the board identifies all relevant organisations active in the community, and defines its desired relationship with them. This is the beginning of networking.

3.5.4.3. Yearly self-evaluation

Once a year all members of a VHC evaluate together the progress they achieved during the last year. The results of all components of the review are discussed, and a rough yearly plan is developed that gives focus to issues needing the most attention, according to the review. In addition, every two years an election of all board members takes place and the board members elect a chairperson. Outside of this regular election schedule, members can propose elections during any self-evaluation exercise if they think it necessary. This self-evaluation exercise enhances the ownership of all activities by the VHCs, helps to keep track of progress, gives VHCs a sense of pride in their achievements, and helps them to present their results to those outside their group. In fact, many VHCs present the results to their Ail Okmotu and in village meetings.

Further trainings are held on the following issues pertaining to organisational capacity-building:

- Structure and vision of VHC
- Facilitation of meetings and protocol writing
- Leadership, consensus building, delegation
- Creating a health fund and accounting
- Project proposal writing

3.5.4.4. Federation building and juridical registration

In addition to these trainings, when VHCs are about a year old we suggest to them that they form a federation of VHCs in their rayon, called the Rayon Health Committee (RHC). Most VHCs immediately like the idea because they sense the opportunity for mutual support through sharing and common learning. The chairpersons of all VHCs form the RHC and meet monthly. These meetings of RHCs have proven to be a crucial tool for information exchange and mutual organisational capacity-building. The RHCs are registered as juridical entities (non-profit organisations) in order to increase the sense of official status and to enable them to apply more easily for governmental and non-governmental resources. The meetings are currently still financed by core-supporting projects. A national federation of VHCs has been formed in 2010.

3.5.4.5. Results of organisational capacity building

Data from Naryn oblast are provided as an example to document the impact of CAH on organisational capacity of VHCs, as Naryn has the longest history of data collection.

Assessment by HPU staff

We developed a tool to monitor the organisational capacity of VHCs. HPU staff assess each VHC twice yearly with an instrument that consists of 25 indicators in 10 categories. The categories are: vision, level of organisation, management capacity, leadership, networking, planning-monitoring-evaluation, own initiative, resource mobilisation, level of recognition in village, and poverty orientation. Table 9 lists the 25 indicators. Each indicator is rated on a scale of 1 to 4 (1 = very weak, 2 = weak, 3 = good, 4 = very good). This allows the HPU staff to track the development of their VHCs. The results are also discussed in the RHCs, so that they see the progress made and may take measures to help weak VHCs. The results are further compiled at the oblast level. Figure 3-7 shows a compilation of the data from the year-end assessments from 2005 to 2008, leaving out the mid-year assessments for the sake of clarity in the graph (August 2005 was the first assessment and serves as a baseline). This compilation confirms the steady increase in organisational capacity, as suggested by the self-evaluation and our observation of the VHCs over time. Similar dynamics are visible among VHCs in all the other oblasts. Table 3-7 explains the 25 indicators of figure 3-7.

Figure 3-7: Naryn oblast: organisational capacity of VHCs, % VHCs ranked 3 or 4 (good or very good) on a 4-point scale, 2005 – 2008

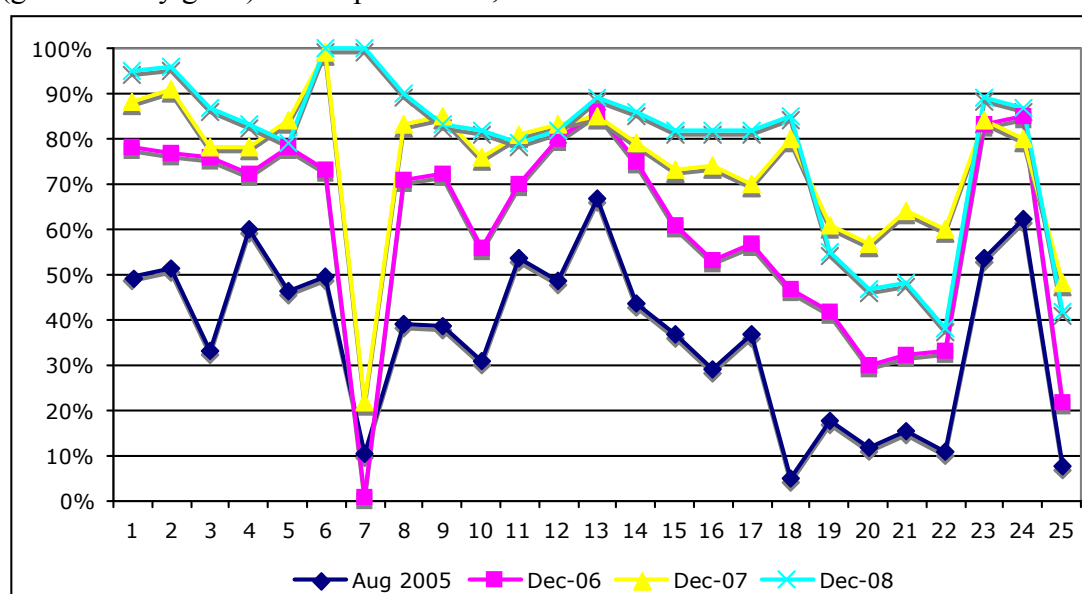


Table 3-7: Categories and indicators of organisational capacity of VHCs used by HPU staff

Organisational Capacities	Code	Indicators
Vision	1	Understanding of the VHC vision by VHC board
Level of organisation	2	Understanding of organisational structure of VHC
	3	Stability of the board
	4	Inclusion of other Community Based Organisations in the board of the VHC
	5	Action groups
	6	Registration as a Community Based Organisation at Ail Okmotu

	7	Own bank account of VHC
Management Capacity	8	Capacity to make decisions
	9	Capacity of consensus building/participatory decision making
	10	Implementation of decisions
	11	Capacity to do simple accounting
	12	Capacity to hold formal meetings with protocol
	13	Capacity to write protocols
Leadership	14	Skills to motivate people for voluntary work
	15	Skills to approach village leaders/other organisations for cooperation
	16	Skills to resolve conflicts
Networking with organisations in the village	17	Link with local self-government body (Ail Okmotu), NGOs, projects, etc.
Planning, monitoring evaluation	18	Yearly planning and evaluation exercise
Own initiative	19	Developing ideas for and implementing own initiatives
Resource mobilisation	20	Periodic resource mobilisation in village
	21	Source of regular income
	22	Resource mobilisation from outside the village (from rayon administration, other organisations, small grants...)
Level of recognition/influence in village	23	Recognition and influence among people in the village
	24	View of other organisations about VHC (Ail Okmotu, elder councils, youth club, mosque committee...)
Poverty orientation	25	Specific attention of the VHC to poor people in the village

Own initiatives

We follow “own initiatives” of VHCs as a means of measuring their organisational growth. Own initiatives are activities that VHCs undertake without being asked to do so by the HPUs. This is an important sign of organisational capacity of VHCs because it requires identifying something they can do, plan relevant activities, find the necessary resources, and implement the actions. VHCs are encouraged to also engage in activities beyond the immediate disease control context. Examples of own initiatives include finding and arranging a meeting room, income generating measures, applying for grants for small projects, organising collective work in their villages for waste disposal or for planting trees, and collecting money to fund an operation for a poor child or helping poor families plant vegetables. During 2007 and 2008, there were 469 own initiatives among 550 VHCs, meaning that about one-third to one-half of VHCs engage in an own initiative in a given year.

Health Funds

The VHCs are encouraged to generate a fund – called a health fund – from which to pay running costs and finance small initiatives. Many VHCs are creative in generating income for their health fund. Currently, health funds contain an average of about 50 USD. VHCs use these funds typically for help in medical emergencies and for minor expenditures like stationary costs.

Civil society building

One can point to several phenomena that seem to indicate that VHCs have an effect on civil society building in their villages. First, voluntary work itself is a new phenomenon that VHCs bring to their communities. In Soviet times, engagement in voluntary work was very unusual. There was mandatory unpaid extra work, in the form of the infamous “subnotniki”, i.e. community work on Saturdays. In a village with a newly established VHC many villagers express persistent doubt that VHC members indeed work without payment. Second, most community organisations, such as women’s clubs or youth clubs – in Soviet times mandatory in each village as well - existed only on paper. An organisation actively engaging in issues relevant to the community, without orders from any official side, is a new phenomenon in most Kyrgyz villages. However, there is evidence that this is gradually being accepted and supported by the communities and local self-government agencies (Ail Okmotus), most of which collaborate with and support the VHCs, allowing civic engagement to unfold. Similarly, on the rayon level, most rayon administrations cooperate with the RHCs. Lastly, there are increasing numbers of VHC members being elected to the village parliament (Ail Kenesh) as a result of their civic engagement.

3.5.5. Capacity Building of the Health System

Work in partnership with communities, let alone formation and capacity building of community-based organisations, is not a traditional task of health systems, and it is not something that health professionals are taught during their professional education. Therefore, one of the goals of CAH is to enable the health system and its professionals to build community-based organisations and work with them as partners. The following paragraphs describe the capacity building of the main players in this endeavour, the Primary Health Care system and the Health Promotion system.

3.5.6. Primary Health Care system (FGP/FAP)

Staff of the Primary Health Care system (i.e. FGP/FAPs in the villages) are the players within the health system who are geographically the closest to the VHCs - being situated in the same village - and who have the most contact with VHCs. Especially in the first two years of a newly formed VHC the local FGP/FAP staff play a crucial role in motivating the VHC and helping it understand its role and get organised. This role is new. Traditionally, prophylactic work among the population has been restricted to dispensing individual health advice during patient calls and mandatory prophylactic house visits to certain defined groups, such as pregnant mothers, mothers with infants, and patients with certain chronic diseases. Work with community-based organisations has never been part of this and was introduced into their task description only with the introduction of CAH.

As part of CAH, the primary health care (FGP/FAP) staff receives a number of formal trainings to aid them in their tasks. The first is the training on facilitating the PRA analysis of people's health priorities. The PRA process is the first time that the FGP/FAP staff goes out into their village not to dispense advice, but to listen to people's opinions. To stop telling people what to do and to listen instead is difficult for most health care providers, and practicing this new behavior is a very crucial part of the PRA training. This starts a process of change in their perception of people, from passive objects of care and recipients of one's instructions (often unwilling recipients), to partners in health. Such change of attitude is a precondition for supporting the growth of community-based organisations, such as VHCs. Difficult at first, it comes natural after the first health actions by the VHCs show very practically the value of such a partner, and most FGP/FAP staff soon appreciate the VHCs and their contribution to health in the village.

FGP/FAP staff also receive a training introducing them to the principles of modern health promotion, structure and vision of VHCs, and the role of FGP/FAP staff in supporting the development of VHCs. Apart from these formal trainings, FGP/FAP staff is invited to take part in all meetings of the HPU staff with the VHCs, which involves them continuously in various aspects of VHC development. Also, one staff member per FGP/FAP is always invited to the trainings of VHCs on health actions, so that they are informed what the VHCs are doing, can assist with questions if necessary, and can take part in the health actions if they so wish.

3.5.7. Health Promotion Units (HPU)

The central element of CAH on the side of the health system are the HPUs. The MoH has specifically installed them for the CAH program. They are the key link between the VHCs and the health system, and as such receive intensive capacity-building provided by staff of the core supporting projects and RCHP. They are selected on the basis of their interest and capability to work with people; people with a "bossy" attitude are avoided. The capacity-building of HPUs is a constant process of on-the-job learning. It starts with training on PRA for people's analysis, with the same emphasis on behaviour as described above for the FGP/FAP staff. They then, under supervision, deliver this training to the FGP/FAP staff and supervise and support them in facilitating the PRA analysis among the village populations. In this sequence HPU staff are trained for all health actions and for organisational capacity building of VHCs. In monthly meetings the HPUs of one oblast – between 8 and 15 people - come together to share experiences, learn from each other, discuss progress and problems, and plan the monthly activities.

3.5.8. Republican Centre for Health Promotion (RCHP)

The RCHP is the main partner of the project on the national level, and engages in policy work and program implementation. Through close daily cooperation with the staff of the Kyrgyz-Swiss-Swedish Health Project the RCHP learns to steer the CAH program. This includes the following functions: development of health actions and inputs for organisational development of VHCs, monitoring, documentation and reporting, coordination of CAH with programs of the MoH, institutionalisation within the health system, coordination with local self-government structures, coordination

with programs of projects/donors, searching for financing for CAH, and continuous development and improvement of CAH on a strategic level.

3.5.9. The Ministry of Health

Lastly, policy-makers within the health system have to develop an understanding of what VHCs are, what their possibilities and limitations are, and what a partnership between VHCs and the health system could look like. This understanding is nurtured by inviting key decision makers, including the ministers themselves, on field visits, by inviting VHC members to conferences and presentations to the ministry, and by regular reporting on progress. Field visits are the most crucial measures among these. No amount of explanation can be as convincing as an hour spent with a VHC. In Kyrgyzstan, in all cases, initial scepticism of a policy-maker was transformed into enthusiastic support after such a visit. Once support of policy-makers is ensured, they have to learn to resist utilising the VHCs to solve problems of the health system, as this would risk overburdening the volunteers. Such utilisation for issues outside their own priorities would quickly result either in weariness of the VHCs or in demands for remuneration, which both threaten the principle of voluntary participation.

3.5.10. Impact of CAH on the health system

Impact on health policy

The most important impact of CAH on the Kyrgyz health system is its inclusion in the second part of the Kyrgyz health reform program, “Manas Taalimi” in 2006. In the first “Manas” health reform programme of 1996, health promotion was mentioned in a short, eight-line paragraph out of a 200-page document, and community involvement was not mentioned at all (Ministry of Health of the Kyrgyz Republic 1996:44). In contrast, the second health reform programme of 2006 (“Manas Taalimi”) featured community involvement as one of its four main components. It cited specifically the experience with VHCs among the lessons learnt and to be built upon, and called for the extension of CAH throughout the country (Ministry of Health of the Kyrgyz Republic 2006). The MoH created the Health Promotion Units specifically to enable this extension, and allocates considerable time of the governmental PHC staff to this programme (see below for more on both these topics). There were a number of rival models for community involvement that were piloted in parallel with CAH. The Republican Health Promotion Centre chose CAH because it offered the broadest approach, allowing numerous health issues to be addressed within one model. Since 2008, the monitoring system of CAH has been integrated into the Medical Information Centre of the MoH.

Impact on donor funding for community involvement

Following the recognition and endorsement by the Ministry of Health, two donors joined SDC as core donors for CAH. USAID, in 2005, agreed to finance the extension of CAH in two oblasts, Issyk-kul and Jalalabat, under technical assistance by Kyrgyz-Swiss-Swedish Health Project. In 2006, Sida began co-financing CAH through a delegated implementation agreement with SDC, which allowed the extension of CAH

into the three remaining oblasts (Batken, Chui, and Osh). In the following years a number of donors have cooperated with the CAH system on implementation in a more limited way, i.e. on defined health issues. These include the World Bank, The Global Fund, GAVI, and UNICEF.

Impact on Primary Health Care Service

In addition to the MoH's endorsement of CAH, the program has influenced health policy in a number of other ways. Involvement of all PHC providers in facilitating the people's health analysis and in supporting and partnering with VHCs in their villages changed the perception of policy-makers on how PHC providers could be engaged in health promotion and in partnership with communities. Such engagement is part of the definition of PHC, but before CAH, it was not done in Kyrgyzstan due to lack of knowledge regarding how to facilitate this. Surveys among PHC staff show that most support their new role. In 2007, a survey in Naryn oblast found that 94% of FGP/FAP staff deemed the formation of VHCs in their village as "useful" (37%) or "very useful" (57%) (4 and 5 on a scale of 5), and 93% rated their own interest to work with VHCs as either "high" (33%) or "very high" (60%) (Turganbaeva, Jamangulova, and Schueth, 2007a, 2007b). The same survey found that FGP/FAP staff spend about 8 hours per month working with VHCs, which was considered a very reasonable workload. A qualitative process monitoring study, conducted in Naryn oblast in 2004 using Focus Group Discussions among FGP/FAP staff, resulted in similar conclusions: 1) FGP/FAP staff appreciate their VHCs' work because it supports their own work, 2) people get much more information about preventive behaviour and often accept advice easier from VHCs than from FGP/FAP staff, and 3) the population started to view health as a matter of their concern rather than the concern of the medical staff (Pfander, Jamangulova, and Schueth, 2004).

Impact on Health Promotion Service

The MoH installs HPUs in all oblasts where CAH is planned to be implemented. This is an important policy decision in that it allocates health system resources to the CAH program and, therefore, shows that the MoH is committed to its extension and sustainability. CAH, therefore, helped bring about a shift of health system resources toward health promotion. Presently, the MoH is also preparing to take on the financing of transport costs of HPU staff necessary for their regular visits to the VHCs in villages.

The Republican Centre for Health Promotion (RCHP) was established in 2001, and its establishment transferred the responsibility for health promotion from the Sanitary-Epidemiological Service (SES). The SES, in Soviet times, was the public health service, combining functions of health protection and health "propaganda." The latter was an apt name for the very limited attempts at health education, which consisted only of top-down delivery of health messages. International advisors for the health reform in Kyrgyzstan advised the government to remove the health promotion function from the SES, arguing that the horizontal, participatory, process-oriented culture of modern health promotion would not be able to take roots and flourish in the vertical, hierarchical, controlling setting of SES (Hagard, personal communication⁹). CAH has enabled the RCHP to understand more fully the concept of community involvement in modern health promotion, turning it from an abstract idea in health

⁹ Spencer Hagard, e-mail message of Nov 9, 2008 to the author.

promotion texts to a concrete experience. This has made the staff of the RCHP avid supporters of, lobbyists for, and, increasingly, independent actors in CAH. The RCHP has been designated to take over the steering of CAH from Kyrgyz-Swiss-Swedish Health Project, once the project ends. With HPUs at the rayon level and RCHP at the national level, two important health system partners of VHCs have been established, and will be crucial elements for the sustainability of CAH. As a link between the two, oblast HPUs have been established in 2010, and most trainers from the Kyrgyz-Swiss-Swedish Health Project have switched to these posts, taking their know-how with them.

3.6. Enabling factors, lessons learnt, challenges

3.6.1. *Enabling circumstances*

3.6.1.1. The Ministry of Health

Support from the Ministry of Health of the Kyrgyz Republic has been crucially important for the success of CAH in Kyrgyzstan. When developing CAH, the Swiss-financed project was presented with the opportunity to involve primary health care staff from one rayon in the formation of VHCs. When these first VHCs showed promising potential, the MoH piloted the HPUs in Naryn oblast, thereby establishing the first staff dedicated to health promotion, which enabled the extension of CAH in Naryn. The MoH called for the formation of VHCs across the country in the second health reform program (Manas Taalimi). It committed resources for this by installing HPU staff in oblasts in which CAH is extended, and by adjusting their salaries to the level of FGP/FAP staff.

3.6.1.2. Health reform

The progressive and comprehensive health reform program that has been implemented since the mid-90s provided an accommodating framework for the development of something radically new like CAH (radical for the former Soviet Union). This is in contrast to the experience described by Restrepo (2000:7) who argued in 2000 that Health Sector Reforms adversely affect community capacity building.

As is often the case, equally important were personalities. Crucial during the beginning was the support of the then minister, Tilek Meimanaliev, who had a keen interest in health promotion due to personal involvement in health education efforts in his academic career. He recognised that strengthening health promotion, and specifically the involvement of communities in health promotion, was congruent with the goals of the health reform, despite the fact that in the first health reform program, there was only a fleeting reference to this. This early support from the minister himself provided the space to experiment and develop a model. When this became successful, it in turn influenced the agenda of the second health reform program, in which community involvement became a central feature.

The health reform program's continuation of the Soviet-inherited network of public primary health care services certainly greatly facilitated the development of CAH. FGP/FAPs are responsible for providing a defined community with public health services, such as vaccination and health education. The role of FGP/FAP staff in CAH fits into this concept of an assigned community. Also, as FGP/FAP staff are public employees, they can be relatively easily directed through ministerial orders to assume new tasks. This would be much more difficult, of course, with a network of private practitioners. The main advantage of involving the public primary health care system in the design of CAH is that we can use this vast network to establish hundreds of VHCs within a time period of only about two months.

3.6.1.3. Coherent village communities

In the beginning, we tried to establish VHCs also in the rayon centres but found it was not possible. Rayon centres are mostly small towns with roughly ten times the population of a typical village. Even when split into parts not bigger than villages, VHCs would not form in these parts. This is in line with the experience in many other contexts that the social cohesion in urban areas tends to be far less than in rural communities. Almost all villages in Kyrgyzstan are geographically well defined, with generally a few (but up to fifty) kilometres distance between villages. This seems to nurture a feeling of togetherness that favours common action, and this is absent from more urban areas.

3.6.1.4. A flexible donor

SDC has been from the very beginning a very flexible, accommodating donor with great understanding for the needs of a participatory process with communities, allowing for great freedom of experimenting and for the allocation of resources according to peoples priorities. Unfortunately, in recent years SDC has become much more prone to believe that tighter control leads to higher quality. Chambers (2007) argues that for participatory processes detailed planning, schedules and targets do not make sense and can even distract and demoralise, especially for projects that are expected to generate new methodologies, e.g. CAH. The obstacles and opportunities on the way are just unknowable. The "virus of logframes" (Chambers 2007) that has gripped donors since the early 90ies tries to fix a complex fluid reality into neat logically related boxes. The danger, again and again observed throughout my professional life in development work, is that these boxes start to "construct" reality: Workers start to see reality through these boxes only, any outside logic, any outside reality fades away. For example, because funding exists only in certain boxes things are not done that are useful but for which exist funding, whether useful or not, etc. I seriously doubt that with today's level of control and bureaucracy in SDC it would be possible to develop the CAH model.

3.6.1.6. Varia

There were numerous supporting factors that are hard to concretely define but were certainly important, including: 1) the high literacy rate (close to 100%), which greatly

facilitates training and documentation of health actions and organisational capacity building; 2) a dedicated and committed team that developed CAH; 3) the interest of most FGP/FAP staff in the villages, under very difficult economic circumstances, to learn something new and to do something good for their communities; 4) the general Kyrgyz trait of being ready to look at reality as it is (without being hampered by the concern for a loss of face), from which flows the openness to try something new; and 5) the imponderable effect of supportive personalities in the health system and trusting relationships between key stakeholders.

3.6.2. Enabling design factors

3.6.2.1 People's priorities

The principle of designing CAH around people's priorities had several consequences that seem to have contributed to its success. First, it necessitated starting with an analysis of people's priorities, which required health care staff for the first time to listen to people instead of teaching them, and thus created the opportunity to change their relationship from that of providers with clients to one of equal partners. The behaviour that such a partnership requires is discussed separately below. On the side of the people, this analysis created an interest in the process and in discussing health issues because they felt valued when asked for their opinion and felt as though their voices were heard; obviously, the participatory, engaging nature of the PRA tools played a role in creating this interest. Second, the primacy of people's priorities necessitated a design that could accommodate work on diverse health issues. This was one of the reasons why the Republican Centre for Health Promotion chose CAH over other competing models of community involvement, which were built around one issue. Third, obviously, starting with and working around people's priorities is standard good practice in community development, because it facilitates the mobilisation of volunteers and increases ownership of the process. When we propose a health action on any of the issues on the list of people's priorities there is no need to explain to people why this is important; they themselves had told us that it is and they are glad that the issue is being addressed.

3.6.2.2. Health actions

The fact that VHCs engaged from the very beginning in concrete health actions for disease control helped them to have a sense of purpose and usefulness from the very beginning; they could identify with concrete actions while organisational capacity building took its time. Health actions also probably played a considerable role in endearing CAH to the health system on all levels. It would have been much more difficult, if not impossible, to convince the health system that CAH is worthy of support if we had engaged only in organisational capacity building. But the usefulness of vertical health actions, covering large parts of the population with a voluntary work force, was immediately evident. From there, it was easy to argue that VHCs needed organisational capacity building if they were to sustain themselves. The capacity building for VHCs in turn enabled their engagement in own initiatives to tackle broader determinants of health.

3.6.2.3. Organisational capacity building

The intensive organisational capacity building for VHCs likely contributes to the success of CAH. First, it enables VHCs to tackle numerous health actions simultaneously. Second, an orientation toward building an organisation (not simply fulfilling voluntary tasks) gives the clear message to the VHCs that their ultimate goal is not participating in the objectives of outside programs, but to develop their own objectives in response to the needs of their communities; the capacity-building provided through CAH enables VHCs to do that. Simultaneously, it reminds program managers of this ultimate goal and avoids using VHCs for program goals. Third, it encourages VHCs to venture beyond immediate disease control measures into tackling broader determinants of health. Lastly it helps them to grow a strong sense of identity and ownership.

3.6.2.4. The primacy of respectful behaviour

The most important principle that is taught to all staff of the CAH system is respectful behaviour with people in the village communities in general, and with the VHCs in particular. All staff undergo training – in the PRA tradition - that makes them aware of dominant aspects of their behaviour with people perceived as being lower in social status. This is especially important because most staff in the CAH system have a medical background, which – especially in the Soviet and post-Soviet context – predisposes them to authoritarian, condescending or otherwise dominant behaviour with people. The selection of staff for working in CAH excludes the most authoritarian people and attracts those that have a natural ability to interact with people on an equal footing. The initial training on behaviour then shows them in playful ways the effect their behaviour has on how people either believe in themselves or not, and how they remain passive or become active. They learn through their own experience how their supportive relationship with people, and valuing people's contribution, is the foundation upon which voluntarism grows. Such behaviour by HPU and FGP/FAP staff with people is only possible if the whole system is characterised by a non-dominant, participatory attitude among the staff. Community development will not work if implemented by a hierarchical, authoritarian system.

3.6.2.5. Collaboration with local self-government agencies

VHCs are encouraged soon after their formation to seek collaboration with their local self-government agency (Ail Okmotu). Most of them support their VHC. Their recognition is important for the self-confidence of VHCs and it adds to the perceived status of VHCs among the village population. Their support can include giving them the floor in a village meeting, granting a piece of land for generating income for the health fund, or helping the VHC mobilise resources for a project. Therefore, a fruitful relationship with the Ail Okmotu is an important factor for organisational development of VHCs.

3.6.3. Challenges

The main challenge/issue at this stage of CAH development is to ensure its sustainability beyond the end of the core-supporting projects in a few years. As mentioned, the two core-supporting projects, supported by SDC, Sida and USAID, finance core functions of CAH, such as transport of HPU staff to the villages, transport of VHC members for RHC meetings, and trainings and material for the health actions developed by these projects. Kyrgyz-Swiss-Swedish Health Project also provides technical assistance to RCHP in steering CAH and coordinating collaborating donors.

A number of measures have been and are being put in place that create conditions to ensure CAH can be sustained beyond the end of the core-supporting projects.

The fact that CAH was designed as a partnership between the health system and the VHCs clearly provides an important pillar for its sustainability, as long as the health system sees an interest in sustaining that partnership. So far, that seems to be the case. In addition to official anchoring of CAH in several MoH documents, there is broad recognition at all levels of the health system of the invaluable contribution of the VHCs to health promotion. Additionally, there is willingness to provide increasing health system resources for this partnership, as evidenced by the installation of HPUs where CAH is implemented, the increased salaries for HPU staff, and the principle willingness (not yet decided) to take over the costs of their transport to the villages.

A major challenge for CAH with regards to the health system is linked to the broader strategic challenge the health system faces with staff retention. Many physicians and nurses emigrate to neighbouring Kazakhstan and to Russia where much higher salaries are offered. As more primary health care posts are abandoned due to lack of personnel, it will be increasingly difficult to keep the HPUs staffed at a level that allows sufficient contact with the VHCs. Allocation of budget for their transport to the villages may turn out to be another challenge, as these expenditures compete with other needs within the tight budget of the Family Medicine Centres. However, as VHCs mature they become more independent from HPU staff, and it may be hoped that this will compensate for decreased contact (for example, quarterly contact instead of the current monthly contact).

Retention of staff is also an issue in the RCHP, and it will be a challenge to secure sufficient funding for staff and working budget for the RCHP to completely take over the steering of CAH. Also, the health promotion structure on the oblast/regional level must be put in place to take over the supervisory function of project trainers.

The most important partners of VHCs outside the health system are the local self-government agencies (Ail Okmotu). Most VHCs have developed a good working relationship with them. The RCHP and the department for local self-government in the presidential administration have developed a recommendation which the department has sent to all Ail Okmotus. It proposes to them that they sign memoranda of understanding with the RHC in their rayon that recognise VHCs and RHCs as important independent partners of the Ail Okmotus. These memoranda establish, in

addition to the connection with the health system, a second official link of the VHCs with government structures. The challenge in this regard is to ensure that both VHCs and Ail Okmotus understand and fulfil their roles in this partnership. For many Ail Okmotus it will be new to deal with a community-based organisation as a partner, supporting it, but refraining from trying to control and dominate it.

Organisational capacity-building prepares the VHCs to function independently from projects and government agencies, and act as civil society organisations. The challenge is to find ways for the VHCs to generate some minimal income that can cover the running costs and help finance small projects. Such income will, however, not be able to cover the costs of the monthly meetings of the Rayon Health Committees and the operating costs of the soon-to-be-formed national federation of VHCs. For these important components of organisational development, separate funding must be sought from donors that are interested in supporting civil society development. The national federation of VHCs is supposed to represent VHCs vis-à-vis the Ministry of Health and the donors, a task currently fulfilled by the RCHP and the core-supporting projects. It will be a challenge to develop effective structures and processes for the national federation of VHCs.

A number of donors and projects besides the core-supporting projects have already collaborated with VHCs, demonstrating that CAH can attract and accommodate projects with a focus on a single health issue. They obviously will finance the health action around the issue of their interest, i.e. production of information material and trainings. The challenge is to have these projects contribute also to the sustainability of the VHCs and CAH as a whole. It has been made a condition for such projects that they allocate some funds to the health funds of the VHCs. This supports the independence of VHCs and allows them the greatest flexibility in using the contribution. However, most projects need to first find ways of accommodating such a contribution within usual procedures of budget allocation and accounting. Other kinds of support can include financing the monthly Rayon Committee Meetings during the time of collaboration or offering a small grant fund to which VHCs can apply.

Chapter 4: Theoretical foundations of the CAH program in Kyrgyzstan

In this chapter I will review the main concepts on which CAH in Kyrgyzstan rests. First, I will give an overview of these concepts, shortly describing each and the influence it had on CAH in Kyrgyzstan. Then I will discuss in depth those concepts that are of central importance for the CAH programme: the different models of health promotion and the concepts of health literacy, community capacity building and community empowerment. Finally, I will discuss where to locate CAH in Kyrgyzstan in these central concepts. While doing so, I will propose a new tool for assessing the community capacity building potential of programmes.

Outline chapter 4

4.1. Overview of concepts that influence CAH in Kyrgyzstan

4.2. The socio-environmental public health model

Healthy lifestyle/health education model

4.3. Health Literacy

4.3.1. Overview of the concept

4.3.2. Health literacy in CAH

4.4. Engagement with communities to promote health

4.4.1. Historical roots

4.4.2. Target- and empowerment-oriented frameworks

4.4.3. Community capacity building and community empowerment in health promotion

4.5. Synthesizing the different streams of health promotion

4.6. Summary of Theoretical Foundations of CAH

4.1. Overview of concepts that influence CAH in Kyrgyzstan

Community Action for Health is defined in the WHO Health Promotion Glossary as "collective efforts by communities which are directed towards increasing community control of the determinants of health, and thereby improving health" (WHO 1998).

The Community Action for Health (CAH) programme in Kyrgyzstan is characterised by such efforts of communities on the one hand, and on the other, by a partnership between communities and the governmental health system.

Engaging communities is a central part of modern health promotion. This consensus is formulated prominently in the Ottawa Charter for Health Promotion (WHO 1986), the founding document of modern health promotion. It calls for strengthening of community actions through community empowerment and for acceptance of "the community as the essential voice in matters of its health". Ever since, key health promotion documents of the WHO have confirmed this view (WHO 1988, 1997, 2005).

Within this principle of engagement with communities, there are two aspects that are characteristic of CAH. One is that it combines both, community capacity building (CCB) and vertical health actions for disease control, which are usually discussed as

separate, if not contradictory, aspects of health promotion (e.g. WHO 2000:12; Raeburn, et. al. 2006). The other is that it is actually the governmental health system that engages in community capacity building. This is in line with the Declaration of Alma-Ata on Primary Health Care (WHO 1978) that considers community development and community participation a part of Primary Health Care (PHC). During the Fifth Global Conference on Health Promotion in Mexico City, Restrepo (2000:16) reiterated that community capacity building should be viewed as a task of the health system. This engagement of the health system in community capacity building also reflects a reorientation of health services in the direction of health promotion, which is demanded by the Ottawa Charter. It provides CAH in Kyrgyzstan, last not least, with the rationale for building the capacity of communities to address social determinants of health through intersectoral approaches.

The program's engagement with communities and VHCs is informed by general principles of community development or community capacity building with the goal of community empowerment. The principles compiled by the Community Development Society International may serve here as a reference. Representation, participation in decisions, engaging in learning, respecting diversity, and developing leadership (Community Development Society International 2009) are the basis for starting with people's health priorities and building the organisational capacity of VHCs.

More specifically, CAH in Kyrgyzstan is guided by three approaches of engaging communities: Participatory Reflection and Action (PRA¹⁰), Participatory Action Research or Community-Based Participatory Research (CBPR), and Appreciative Inquiry. From PRA (Chambers 1994a, 1994b, 1994c), we learnt to design simple, visual instruments that facilitate group discussion around an issue and documentation of the results. Equally important, PRA's great emphasis on non-dominant behaviour of outsiders when working with communities was made a core principle of CAH.

Action Research involving communities is being practiced under many different names, such as Participatory Action Research or Community-Based Participatory Research (CBPR). Their definitions usually involve four basic themes: empowerment of participants, collaboration through participation, acquisition of knowledge, and social change (Masters 1995). To quote a commonly used definition of CBPR, it is "a systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting change" (Green and Mercer 2001). Most health actions implemented by the VHCs contain an inquiry that in itself is effecting change. The results help the VHCs to better understand a certain issue in their village and to monitor change related to that issue. Results are compiled at the regional level.

Appreciative Inquiry (AI) is a strength-based approach to change and development. It assumes that building on strengths is more creative and more effective than focusing on problem-solving. Stories about positive experiences are the main source for identifying strengths on which to build. VHCs have used AI for a strategic planning process. They have identified their core motivations, values and strengths – in AI terminology their "life giving forces" – and based on these, have built a vision for the

¹⁰ formerly known as Participatory Rural Appraisal

future and formulated plans to realise this vision. In addition, VHCs and personnel of CAH use storytelling at multiple occasions to remember and strengthen the life giving forces.

CAH in Kyrgyzstan is also grounded in the salutogenic model proposed by Aaron Antonovsky (1979, 1987, 1996). It assumes that what keeps us healthy is a Sense of Coherence, which is a global orientation that consists of three components: comprehensibility (experiencing the world as predictable and comprehensible), manageability (the confidence that things one encounters are manageable), and meaningfulness (the experience that things in life make sense on an emotional level and therefore are meaningful enough to care about) (Antonovsky 1987). This concept provides another basis for the key assumption of CAH in Kyrgyzstan: that empowering people and communities is conducive to health, not only in the sense that it increases their control over determinants of health but, in a more direct and literal way of promoting health, this empowerment increases people's Sense of Coherence, (i.e. their experience that the world is comprehensible, manageable, and meaningful).

The concept of social capital assigns value to social networks. It claims that social networks have positive effects for both people and society, and also for people's health (Smith 2007). Forming VHCs and their interaction with their communities can be assumed to increase social networks and cohesion, and thus lead to improved health and well-being. Therefore, the social capital concept provides yet another basis for promoting health through community development.

The logic model (figure 1) links these concepts with the key structures and activities of the programme.

Figure 4-1: Logic Model of CAH in Kyrgyzstan

Community Action for Health Logic Model						
Inputs	Outputs			Outcomes		
	Activities	Participation/Reach	Short	Medium	Long	Distal
Physical, informational, and monetary resources to implement health actions and small projects	Training Participatory Reflection and Action (PRA) for people's priority analysis	Communities Village Health Committees (VHCs)	People's Analysis of Health (PRA)	Health literacy of the population	Empowerment of People and Communities	Improved Health
Time of trainers of supporting projects	Training VHCs, FGP/FAPS, and School Parliament members on health actions	School Parliaments FGP/FAP (local Primary Health Care staff)	Formation of VHCs and action groups	Healthy behaviour	Increased Control Over Determinants of Health	Improved Well-being
Time and planning / implementation efforts of Village Health Committees	Organizational capacity building of VHCs	Health Promotion Units (HPUs) – Rayon and Oblast level Republican Centre for Health Promotion (RCHP)	Health implementation by VHCs Own initiatives/ small projects implementation by VHCs	Health infrastructure Organizational Capacity of VHCs (planning, resource mobilization, implementing, monitoring, evaluating)	Increased Sense of Coherence Increased Social Capital	Improved Quality of Life
Time and monetary contribution from communities	Capacity building of Primary Health Care System	Ministry of Health Staff of supporting/ collaborating projects	Capacity of Health Promotion/Primary Health Care System to Work With Communities as Partners	Partnership between health system and communities		
Time training/oversight efforts of HPU, FGP/FAP, and RCHP staff						

4.2. The socio-environmental public health model

In 1848, Rudolf Virchow was sent by the Prussian government to investigate a typhus epidemic in Upper Silesia, a poor province with a Polish majority governed by a German minority. Virchow was 26 years old and would become later the world-famous discoverer of cellular pathology, on which to this day rests the microscopic diagnosis of cancer. However, this 16 day investigative mission and the report he wrote about it would first make him one of the founding fathers of social medicine in Germany and would lead him to be involved with health policy until the end of his life. The report not only discusses all medical aspects of the epidemic but also in detail the sociological, anthropological, cultural and economical dimensions which he sees as the true causes of the epidemic. This leads him to conclude that only far-reaching political and social reforms would be able to prevent such epidemics in future, including "education, with its daughters liberty and welfare" and "free and unlimited democracy"! (Virchow 1849a, in: Brown and Fee, 2006).

In 2008, 160 years later, the Commission on Social Determinants of Health of the WHO opens its report with the words: "Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death." And it defines one of the principles of action as to "tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally" (WHO 2008).

These two documents are examples of the strong stream in the history of public health that views social justice and healthy policies as central to its mission. Virchow later became member of the Berlin City Council and was instrumental in providing the city with central drinking water supply and canalisation – the first in a major European city. For him, the "physician is the natural attorney of the poor" (Brown and Fee, 2006) and "medicine is a social science, and politics is nothing but medicine on a grand scale."

Those advocating such a social model of health promotion looked very critical on the lifestyle/health education model (see below) that took a very prominent role in the health promotion discourse and practice since the 1970ies, with its focus on behavioural change of individuals as the mode to improve health. They argued that the lifestyle model amounted to blaming the victims in that it shifted the responsibility for ill health to the individual and his or her behaviour and away from the socio-economic factors. The social model of health promotion prevailed in the central document of health promotion, the Ottawa Charter of 1986 (WHO 1986). As Raeburn and Rootman (1998) point out, it mentions lifestyles only once – saying that health promotion must go beyond it. Instead, the prerequisites for health in the Ottawa Charter are "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity" (WHO 1986). This list has much similarity with Virchow's recommendations for preventing future epidemics and proves once more health promotion's roots in the public health movement of the 19th century. However, putting these concepts into practice was another matter. The 1980ies and 90ies were dominated by the neo-liberal ideology that led, dictated by World Bank and International Monetary Fund, to drastic reductions in social sector spending in poor countries, with "severe adverse impact on key social determinants of health" (WHO 2008: 166-7). The WHO renewed efforts to focus on social determinants with several

initiatives during the 90ies (WHO 2005). The latest, most comprehensive such initiative is the establishment of the Commission on Social Determinants of Health (CSDH) in 2005. Its report, published in 2008, collects the available evidence of the link between poverty and health. Closely linked with the social-environmental model is the concept of health inequalities that has come into prominence since the 1990ies because analysis of the social determinants showed that the most disadvantaged in a society are most effected by adverse health determinants. Improving their health, therefore, has become a recent focus of health promotion.

In CAH, the socio-environmental model of health promotion is reflected in its engagement with communities, which aims at enabling them to address broader issues influencing their health. Attention to health inequalities is given by the mere fact that CAH works in the disadvantaged rural areas, including in the most remote villages. Within village societies, however, CAH does not seek to work only with the poorest. But VHCs are encouraged to make sure that everything they do includes the poorest of their communities. This is written in their regulations and it is being monitored. CAH's engagement with communities is examined in detail in the discussion on community capacity building and community empowerment below.

4.3. Healthy lifestyle/health education model

Although the socio-environmental view of health rests on the strong tradition described and has been upheld in many central documents of public health (WHO 1948, 1978, 1986, 2008), the enormous advances during the 19th and 20th centuries in understanding the microbiological and biochemical disease aetiologies and their consequent advances in curative medicine have strongly influenced the practice of public health. Especially in the latter half of the 20th century technology based vertical programmes dominated public health (WHO 2005) that were grounded in a biomedical understanding of health.

It was in this context, that health promotion, as a discipline distinct from traditional public health, was first formulated in the 1970ies, most prominently in the "Lalonde Report" in 1974 (Lalonde 1974), a document elaborated under the then Canadian Minister of Health and Welfare, Marc Lalonde. This report analysed the lack of improvement of overall health of Canadians despite growing proportions of the Canadian GDP being spent on health. It demanded a shift of health expenditures away from traditional health services in order to focus on the causes influencing the dominant premature illnesses, such as cardio-vascular diseases, nutrition-related illnesses, alcohol abuse, and others. These were to be addressed by programmes aimed at changing people's lifestyles that – based on the newly gained understanding of the biomedical causes - had influence on these diseases. This report led to the formation of a new institution, the Health Promotion Directorate, that was to set up such programmes. It was the first such institution dedicated to the young discipline. The initial focus of health promotion on individual lifestyles became known as the health education/behavioural model of health promotion and has remained very influential throughout the following decades. It is one of the theoretical grounds for the health actions that are an important part of CAH in Kyrgyzstan.

4.4. Health Literacy

4.4.1. Overview of the concept

The concept of health literacy has been gaining prominence in the health promotion discourse in recent years. I place its discussion here between the healthy lifestyle/health education model and the chapter on engagement with communities with its discussion of empowerment because it contains elements of both and indeed bridges these two concepts. The Health Promotion Glossary of the WHO (WHO 1998) defines health literacy like this: "Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health." In an influential paper Nutbeam (2000) elaborated on the history and implications of the concept. He regrets that the role of health education was too much downplayed with the resurgence of the social model of public health since the late 1980ies. He traces this low regard to the largely disappointing outcomes of health education efforts that did not acknowledge social and environmental influences on lifestyle choices. Reviewing different levels of literacy as elaborated in the literature on general literacy he describes three levels of health literacy: functional health literacy as the factual knowledge of health risks and how to use services and the compliance with health messages or medical instructions; interactive health literacy as the capacity to act on knowledge, and increased motivation and self-confidence to do so; and critical health literacy as the skills to implement effective individual, social and political action. He then calls for a renewed and broadened understanding of health education that aims at all three levels of health literacy, including, importantly, the third level of critical health literacy. He then argues that such a broadened health education would have to widen its contents and methods to include raising the awareness on social-environmental determinants of health with the aim to build the capacity for actions, individually and collectively, that address these determinants, and therefore would have both, individual and collective benefits. The methods of communication of such health education would have to be interactive, participatory and invite critical analysis reminiscent of the "critical consciousness" approach of Paulo Freire. Understood and practiced in this way health education would be critical to empowerment and could be an important, necessary part of comprehensive health promotion interventions.

The central thesis of Brazilian educator Paulo Freire (Freire 1996) is that education is not neutral, it can be a tool for oppression or for liberation, depending on both, its form and its content. While the influence of the content on the effect of education might seem obvious, Freire elaborates especially on the importance of the form of education for its oppressing or liberating effect. An education that takes the form of passing knowledge from teacher to student has oppressive effects as it cements the notions that knowledge is pre-existent to the learning process and that the student lacks knowledge and depends on a teacher to gain it. A liberating education, by contrast, seeks to create processes that enable learners to create knowledge themselves – becoming a subject of learning instead of a passive object of teaching -, mainly through sharing insights and experiences among each other on factors influencing their lives. This newly gained knowledge then needs to be put in practice in order to become true learning. Freire called this interplay of reflection and action

'praxis' and its result 'conscientisation' or 'critical consciousness'. The goal of education, therefore, is not to adapt the learner to a reality but to enable him/her to change it. The process is fuelled by a dialogical attitude of the educator that is open to bidirectional learning and overcomes the teacher-student dichotomy.

The role a Freirian approach could play in health education and therefore the importance it has for the concept of health literacy can be gauged in the work of Wallerstein with various co-authors (Wallerstein and Bernstein 1988, Wallerstein 1992, Wallerstein and Bernstein 1994, Wallerstein and Sanchez-Merki 1994). They tried to build Freire's insights and principles into health education, even before the term health literacy became en vogue in the health promotion discourse. Wallerstein and Bernstein (1988) describe a process of listening (investigating), dialogue and action. The process begins with listening of people not to the educator but to each other, co-investigating an issue through sharing of experiences affecting people's lives. The educator facilitates the dialogue about what was seen and heard while being herself/himself engaged in it and adding information when and where needed. This dialogue is triggered and fuelled by "codifications", emotionally charged symbols of the issue at hand and involves five elements: describing what is felt and seen, defining the various levels of the problem, link it to own experiences, critically analyse its causes, and develop plans how to address it. Finally, actions that address the issue are an integral part of this learning process. Wallerstein and Sanchez-Merki (1994) stress that this process is not linear but iterative and cyclical.

Comparing this process with more traditional participatory health education Wallerstein and Bernstein (1988) note that both work with issues determined by the communities and use active learning methods. But the differences are important: in Freireian health education people are themselves engaged in the investigation of the issue and listen rather to each other than to an outside expert; and it includes actions, and these actions address broader issues than only personal choices and lifestyle. In assessing health education programs through a Freireian lens Wallerstein (1992:204) proposes to ask, whether a program "subtly fosters dependence and powerlessness, or whether it enables participants to be decision makers and assume responsibility for their own program and curriculum." Also, ideally the curriculum should be developed out of the listening process, not prescribed from outside. Wallerstein (1992) acknowledges that this is often not possible due to various program constraints but suggests that as a minimum the process should involve sharing real life issues.

4.4.2. Health literacy in CAH

This review of the concept of health literacy suggests that it can provide a useful theoretical framework for a discussion of the health actions of CAH in Kyrgyzstan.

Most health actions could be located at the first and second health literacy levels, as they provide relevant information but mostly also some skills to overcome certain barriers to changing behaviours. In most cases the elements of the actions (the 'curriculum' in Wallerstein's (1992) terminology), are prescribed from outside, uniform for all VHCs, ie. not, as would be ideal, developed by the VHCs. This seems necessary in a program that deals with hundreds of communities simultaneously. But for all health actions VHCs are encouraged to develop additional accompanying activities, which many do, thus contributing with own, individual elements to the overall health action.

As illustrations, I attempt in the following to locate four health actions in the three levels of health literacy defined by Nutbeam (2000) and described above. I use those health actions that were described in some detail in the description of CAH in Kyrgyzstan. This analysis shows that health actions have elements on different levels and that some reach the level of critical health literacy. This location relates to the members of the public to whom the VHC members address the health action. The VHC members themselves, by contrast, go in most cases through a 'praxis' process (critical health literacy), with analysis (action research), action, and reflection (monitoring surveys and analysis of results). This means that in each village a group of people thoroughly analyses and understands the issues and – in many cases – becomes an initiator of additional actions around the health actions.

4.4.2.1. Exclusive breastfeeding

This health action mostly aims at the first level of health literacy, as it mostly consists of providing mothers with the knowledge about good breastfeeding practices. However, VHC members also explain mothers how to overcome difficulties with breastfeeding and involve mother-in-laws in their talks – who greatly influence the behaviour of the lactating mothers. One could argue therefore that there are elements of interactive health literacy at play, in that to a certain degree of skills to overcome difficulties are learned and the environment (mother-in-laws) is influenced to support the change of behaviour.

4.4.2.2. Iodised salt promotion

The testing of salt in households and the information given there on the need to consume iodised salt aims at the first level, functional health literacy. The testing of salt samples at retailers and the provision of retailers with test kits to be used at whole sale markets is clearly aimed at empowering communities to overcome the barrier of lack of access to iodised salt (a determinant of health) and therefore would fall into the second level, interactive health literacy.

4.4.2.3 Hypertension control

Screening for people with hypertension and providing them the relevant information on the necessity to control their blood pressure and how aims at functional health literacy. Explaining them the difference between branded drugs and generics and encourageing them to claim prescription of the latter, cheaper drugs from their doctors aims at interactive health literacy as it offers skills to overcome the barrier of unaffordable drugs.

4.4.2.4. Reducing alcohol consumption

This is an example of a health action that displays the full range of features of the third level, critical health literacy. It involves most households in the initial action research in that each households calculates for itself the amount of money spent on alcohol per year and the adverse effects of high alcohol consumption on the family and on the village community. The communities then analyse the compiled results of the action research and decide themselves which traditions they want to change in their village. These are then propagated. Relating this to the Freireian process as described by Wallerstein and Bernstein (1988) one recognises the listening stage (action research), the dialogue stage where the amount of money spent on alcohol in the family and in the village as a whole is the most important 'codification', an emotionally charged symbol of the issue that fuels discussions around analysis and action. The action research gives also occasion to share stories in the families, touch different levels of the issue, analyse why the problem exists and at which occasion people mostly drink. The third stage, finally, sees the planning and implementation of

action, which is geared not only towards changing individual behaviour but towards changing the social environment, a determining factor for drinking habits, from being conducive to drinking to being adverse to it.

In summary, the concept of health literacy seems to combine elements of the health education model and the target-oriented and empowerment-oriented frameworks of community engagement, blurring the boundaries between them. This crossing-the-borders of health promotion models is particularly apt at discussing health actions in CAH in Kyrgyzstan as they are closely linked to the organisational capacity building aspect of CAH, ie. the aspect that explicitly is aimed at enabling empowerment. This aspect will be discussed in detail in the following.

4.5. Engagement with communities to promote health

4.4.1. Historical roots

The third important stream of experiences that fed into the emerging field of health promotion was the work with communities on health issues. It emerged in the 1960ies and 70ies out of critique of the Western style health care strategies that failed to address adequately the health needs of the vast majority of people in underdeveloped countries (Werner and Sanders 1997). These community-based health programmes turned "the system upside down, from a top-down system to a bottom-up approach" (Werner and Sanders 1997: 16), in that they were characterised by lay people taking over medical tasks, a focus on low-cost interventions with local resources, emphasis on prevention, putting disease in its social context and, importantly, strong participation and leadership by the community. This experience was reflected in the Declaration of Alma-Ata on Primary Health Care (WHO 1978) that considers community development and community participation a part of Primary Health Care (PHC).

4.4.2. Target- and empowerment-oriented frameworks

However, as Rifkin (1985) has analysed in an extensive review of community involvement in health programmes, these programmes displayed two different frames of reference, the target-oriented and the empowerment-oriented frame of reference. For the target-oriented frame the aim of community participation is to improve the health status of people. It is rooted in the biomedical model of health and illness and is characterised by a top-down approach where programme specialists define the goals and strategies of the programme and try to convince communities to take part in them. The empowerment frame of reference has its roots in the Marxist influenced struggle for justice and equity in the post World-War II and ex-colonial period. People are rather subjects than objects of change. Its aim is to assist people, especially the poor, to gain access to information, resources, and eventually increase control over their lives.

This empowerment frame of reference would later be reflected as an important aspect of health promotion in the Ottawa Charter: "Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process

is the empowerment of communities - their ownership and control of their own endeavours and destinies" (WHO 1986). It is this stream of empowerment that seems to have most obviously influenced the definition of health promotion in the Ottawa Charter: "Health promotion is the process of enabling people to increase control over, and to improve, their health" (WHO 1986).

This dichotomy between target-oriented and empowerment-oriented frames was later slightly reframed by John Raeburn with varying co-authors (Raeburn and Rootman 1998, Raeburn and Corbett 2001, Raeburn and MacFarlane 2003) as the difference between conventional epidemiological approach and a "people-centred" approach. Health promotion in this view is "above all... an intensely personal and human area" (Raeburn and Rootman 1998:1) and while traditional public health, based on biomedical sciences, is concerned with preventing diseases – a negative concept –, the people-centred approach promotes the positive concepts of health, well-being, quality of life, which demands a more holistic view and calls for a broader, interdisciplinary science base.

However, Raeburn and Corbett (2001:7) find in their literature review that, despite its importance for the concept of health promotion, the community engagement with an empowerment-oriented frame, i.e. the people-centred health promotion, is comparatively little practiced. They write: "Most community health promotion does not have a good handle on 'community', and tends to ignore the very heart of what is implied in the term 'community development' - that is, that the building of community as such is a goal, and is beneficial to health - and instead, uses community as a tool or instrument for outsiders' agendas, with little regard for the people or community-building dimension, or for issues beyond the health problem being addressed."

In CAH in Kyrgyzstan, the empowerment-oriented frame of reference of community participation is obviously of central importance and reflected in the formation and organisational capacity building of VHCs. Because of its central importance to CAH I will examine related theoretical concepts and their reflection in CAH in greater detail below (see sub-chapter 4.4.3. "Community Capacity Building and Community Empowerment").

The target-oriented frame of reference is present in the health actions of CAH, as they are designed according to biomedical knowledge, even though the issues are identified by the communities. Health actions also, obviously, are related to the health education/healthy lifestyle model of health promotion, as they aim at behavioural change. But they even are related to the concepts of community capacity building and empowerment, as some of them go far beyond providing information and involve people's analysis, actions aimed at overcoming barriers, and monitoring. Health actions, therefore, seem to correspond rather well to the concept of health literacy, that, as discussed above, combines elements of the health education model, and the target-oriented and empowerment-oriented frameworks of community engagement, blurring the boundaries between them.

4.4.3. Community capacity building and community empowerment in health promotion

In the following I will first clarify the terminology, distinguishing community empowerment from community capacity building. I will then explore the rationale for community capacity building and community empowerment in health promotion, followed by an in-depth examination of these two concepts. I will then try to locate CAH in Kyrgyzstan in various frameworks of empowerment and this attempt will lead me to describe a new tool to measure the inputs of a programme in terms of capacity building.

4.4.3.1. Clarification of terms

The work with communities is referred to under a number of different names, such as community-based work, community capacity building, community participation, community empowerment, community development, community organisation, and others. There is no generally agreed nomenclature in the literature that defines how these different terms should be used. There is, however, agreement that there are radically different ways to work with communities and that there is a need to use different terms to refer to them.

As mentioned above, Rifkin (1985) distinguishes between two major approaches of working with communities and uses the terms 'target-oriented frames' and 'empowerment-oriented frames' for them. For those programmes operating in a target-oriented frame of reference, ie. where participation is token or limited to complying with outsiders' agendas, Raeburn and Corbett (2001) more recently propose to use the term "community-based". For those programmes operating in an empowerment-oriented frame of reference more recent reviews use the terms community capacity building and community empowerment (Goodman et al 1998, Restrepo 2000, Laverack 2004, Wallerstein 2006, and Raeburn, et. al. 2006). Raeburn et. al. (2006) formulated key aspects that characterise this category of empowerment-oriented programmes: "(i) the concepts of capacity and empowerment (versus disease and deficiency), (ii) bottom-up, community-determined processes and agendas (versus top-down/externally determined) and (iii) processes for developing community competence." Within this category, the terms community capacity building and community empowerment are sometimes used interchangeably, sometimes distinctions are made. I will make a distinction and call community capacity building the engagement by the outside programme with the communities (if it fulfils the above criteria) and community empowerment the process and the outcome that occur – hopefully - within communities as a result of such engagement. This view is supported for example by Laverack (2009:109). It seems to me that this distinction reflects the fact that all we can do as outside agents is try to build capacity and that it is the community that can empower itself, even if facilitated from outside.

4.4.3.2. Why community capacity building and community empowerment to promote health?

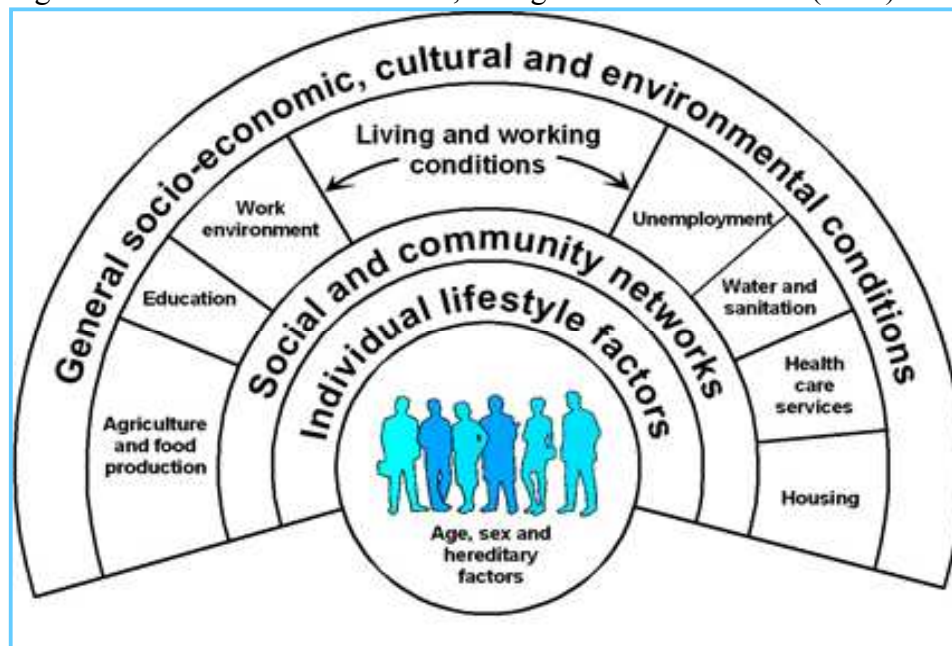
In the review of the history and concept of health promotion I mentioned that community empowerment is an important aspect of health promotion. But a thorough explanation why that should be so was not given. To engage with communities for health promotion has been demanded for many years in proclamations of WHO and other relevant bodies. On the one hand it is dictated by common sense because the

community is one of the major settings where health is produced or hindered. Virchow had an early insight into this aspect as well: "The real care for the health of an individual must always be rooted in the small circle of personal friends, of the family or of the community..." (Virchow 1849b, in: Morabia 2009). On the other, involving communities offers insights into local determinants of health and increases the likelihood that these can be addressed. Involvement further offers the possibility to mobilise resources the communities might have to improve health, for example volunteer time. But in the following I like to put forth two more arguments in some detail that are less obvious but that are important to CAH in Kyrgyzstan.

Influencing social determinants of health

The social model of health promotion argues that health to a large degree depends on socio-environmental determinants. Dahlgren and Whitehead (1991) have summarised this concept in a well-known diagram (Figure 4-1). If health promotion is the "process of enabling people to increase control over, and to improve, their health" (WHO 1986) then it is obvious that work with individuals will enable them to increase control over a very limited range of health determinants, mostly the ones closest to the people in the diagram, i.e. personal lifestyle factors. And even with these, control can only be limited, as it is naïve to assume that individuals are free to choose their

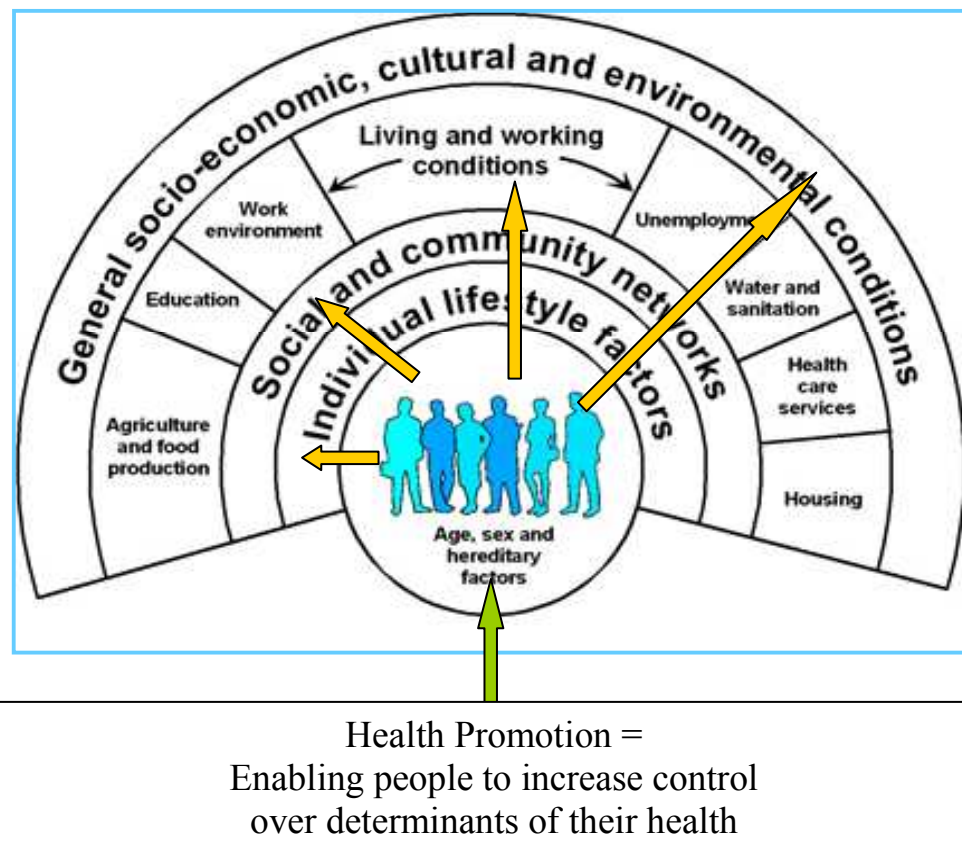
Figure 4-1: Determinants of health, Dahlgren and Whitehead (1991)



lifestyle independently from their social environment. If, however, people are organised in groups, they can attempt to influence and control a broader range of health determinants. As groups grow larger, their networks wider, their vision bolder, their clout greater they reach to broader determinants and one day may even reach towards the outermost layer of determinants through democratic processes or civil disobedience. This is the process of strengthening civil society, and its potential effect on health is a powerful reason for health promoters to engage in community capacity

building. Figure 4-2 summarises this reasoning in a diagram adapted from Dahlgren and Whitehead.

Figure 4-2: Health promotion and the determinants of health, adapted from Dahlgren and Whitehead (1991)



The salutogenic model of health

The other argument is provided by the salutogenic model, developed by Aaron Antonovsky (1979, 1987, 1996). To repeat, it assumes that what keeps us healthy is a Sense of Coherence, which is a global orientation that consists of three components: comprehensibility (experiencing the world as predictable and comprehensible), manageability (the confidence that things one encounters are manageable), and meaningfulness (the experience that things in life make sense on an emotional level and therefore are meaningful enough to care about) (Antonovsky 1987).

If this is the case, then enabling people to control determinants of health increases health not only because this makes the environment healthier. Rather, the fact that people have more control in itself is conducive to health. This is supported by the evidence linking powerlessness to ill health, summarised for example by Wallerstein

(1992). This means that it does not matter on what issues people engage, whether these have an obvious, immediate health connection or not; the fact that they engage and increase their control over their environment in itself is healthy, because their world becomes more predictable, manageable and meaningful. This is the main reason why CAH in Kyrgyzstan - although denominated as a health promotion project and although it uses health as an entry point to community capacity building – supports VHCs if they venture beyond the immediate health realm into broader issues, be it tree plantation or establishment of a Kindergarten. Such ventures, of course, have a – distant - health impact by themselves as well, but what is of interest here is the more immediate impact through the increased Sense of Coherence. It seems appropriate to quote one last time Rudolf Virchow in this context. In the said report on the Typhus epidemic in Upper Silesia (Virchow 1848) he laments one of the reasons for the devastating effect of the combined famine and Typhus epidemic, namely that the people "had lost all energy and all self-determination and exchanged for them indolence, even indifference to the point of death." This is a description of total loss of Sense of Coherence. And when reflecting on possible measures to turn things around Virchow writes: "A population will never achieve full education, freedom and prosperity in the form of a gift from outside. The people must acquire what they need by their own efforts." Besides expressing the political insight that people have to fight for their rights this quote might also be read as an intuition about the health promoting effect of increasing the Sense of Coherence through social engagement and its empowering effects.

4.4.3.3. Empowerment

One can find various frameworks in the literature that are used to describe and analyse the concept of empowerment. I will shortly review the concept of empowerment with the help of three such frameworks: the intrapersonal vs. the interpersonal/structural empowerment, the relationship between communities and outside agencies in empowerment processes, and the domain approach to measure and operationalise empowerment. I will then attempt to locate CAH in Kyrgyzstan in these frameworks. With regard to the relationship between communities and outside agencies, I will argue that the existing tools for assessing and characterising this relationship lack a crucial dimension, namely an assessment of the quality of the capacity building inputs of the outside agency, i.e. an assessment how appropriate and likely these inputs are to induce a process of empowerment in the community. I will propose a new tool to measure this dimension and will apply it to CAH in Kyrgyzstan. Finally, I will propose a combination of tools that should be able to describe any health promotion programme that engages with communities.

Empowerment is typically defined as a process by which people increase their control over factors influencing their lives. The following three definitions may serve as examples: "Empowerment refers to the process of gaining influence over events and outcomes of importance" (Fawcett et. al, 1995:678). Wallerstein (1992:198) defines it as "a social-action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice." And Laverack (2007:29) offers: "Community empowerment is... a process by which communities gain more control over the decisions and resources that influence their lives, including the determinants of health". Although these definitions describe

empowerment as a process, it is generally seen as both, a process and a goal, as asserted for example by Wallerstein (1992), Laverack (2004) and discussed in detail by Tengland (2008) in his review of the concept of empowerment. As a process it strives for and results in increased levels of empowerment (goal and outcome), and these in turn likely induce further empowering processes.

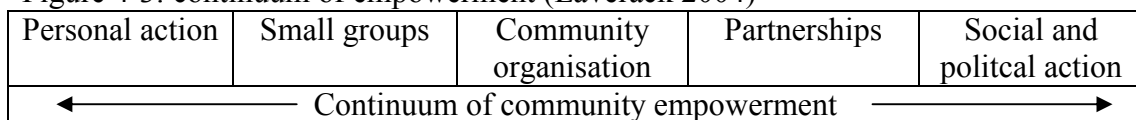
Intrapersonal and structural empowerment

A more important distinction seems to be the one between individual/psychological and community or structural empowerment, as outlined for example by Wallerstein (1992). The individual/psychological empowerment refers to the process in (or goal of) individuals that engage in change processes, either alone or in groups or communities. For this aspect of empowerment Raeburn and Rootman (1998) identify the following psychological elements: control (the sense that one can influence events), competence (the confidence that one is able to do something), self-esteem (believe in oneself, sense of being valued), contribution (the sense that one has to offer something) and participation (the sense to be part of a broader cause). These experiences are obviously closely related to Antonovsky's Sense of Coherence, and Raeburn and Rootman (1998) indeed link these experiences closely to health, as does Antonovsky's salutogenetic concept.

The structural empowerment refers to the process (and goal) of increasing the power of individuals or communities to effect change in their environment, often in the form of sociopolitical changes, in which case a transfer of power from the powerful to the powerless is involved. For Laverack (2004) organisational empowerment is an important link between individual and structural empowerment.

Raeburn and Rootman (1998:47) propose to combine personal and structural views and quote Labonte (1993): "Unless we practice thinking simultaneously in both personal and structural ways, we risk losing sight of the simultaneous reality of both." Laverack (2004:48), based on Jackson, Mitchell, and Wright (1989) and on Labonte (1990) depicts the process of structural empowerment as a continuum along five points between personal action and sociopolitical action of communities (Figure 4-3). He points out that the process can start at any point in the continuum and any point can be seen by itself as an outcome. Laverack (2004) emphasises the community organisation stage as crucial, as it is the one that allows to coordinate individual efforts into community action.

Figure 4-3: continuum of empowerment (Laverack 2004)



Personal action in this continuum must not be mistaken with the intrapersonal, psychological dimension of empowerment. Rather, the latter must be seen as manifesting itself in actors throughout this continuum. Indeed, in contrast to Laverack (2004), Raeburn and Rootman (1998) stress the central importance of this personal empowerment, which they see as a condition for people to take sociopolitical action towards system change. Both point out repeatedly that empowerment is a process that requires time. Freire (Shor and Freire 1987) also sees the necessity of individual empowerment for community empowerment but adds an ethical aspect to this relation

in claiming a moral imperative for those who have gained individual empowerment to use it for the liberation of others and transformation of society.

Relationship between communities and outside agents

In case an outside agency engages with a community the power relationship between the two is an important dimension of the empowerment process. To describe this power relationship Arnstein (1969) has proposed a 'ladder of participation' with eight rungs that indicate the range between total control of the process by the outside agency and complete control by the community. The lowest rung is manipulation where the outside agency manipulates communities into going along with what it wants. The second lowest is called therapy and stands for the intention by the outside agency to solve the problems for the community. Both rungs lack any intention of participation. The next three rungs Arnstein (1969) sees as varying levels of tokenism, namely a relationship characterised by involvement of the community through information about the intended intervention (rung 3), consultation in the decision making process (rung 4), and placation of power sharing (rung 5) where community members sit in decision making bodies but without real possibility to influence decisions. Rungs six to eight indicate increasing levels of power sharing and handing over of power. Rung 6 is called participation and stands for an equal relationship as partners in decision making. Rung 7, called delegated power, describes a situation where the community has the majority in decision making bodies, and rung 8, citizen control, means total control of decisions by the community. The ladder has been very influential in the discourse about participation and empowerment as it makes transparent where a program stands regarding its proclaimed empowering goals and the actual degree to which it shares power with communities.

Domains of Empowerment

Another way to frame the concept of empowerment is to identify the key domains that characterise it. In an extensive review of the literature on this approach and of case studies, Laverack (2001) identified the following nine domains: participation, leadership, organisational structures, problem assessment, resource mobilisation, asking why, links with other organisations, the role of the outside agent, and programme management. Table 4-1 gives short descriptions of these domains. Laverack describes these domains as means to measure the status of empowerment of a community. And in this sense CAH in Kyrgyzstan uses them in the regular assessments of VHCs by the HPU staff, as described in chapter 3.

But further down I will propose that one can use these domains also to measure the inputs that a programme provides in terms of community capacity building. I will show that CAH in Kyrgyzstan engages in all of these domains through its organisational capacity building for VHCs.

Table 4-1: Domains of Empowerment (Laverack 2001)

Participation	Working with, not for people. Involving people in all decision-making mechanisms. Representativeness of community partners. This is the most fundamental principle that runs through all others.
Leadership	Participation gives rise to leadership and vice-versa. All community initiatives depend on local leadership. Programmes must engage in developing the skills of leadership.

Organisational structures	Community groups – preexisting or formed by the outside programme – are the mechanism through which participation happens, bodies of decision making and of action, and they are the partners for outside programmes.
Problem assessment	It is the people who have to decide the issues on which a programme engages, not the outside agents of the programme. The skills to do that may have to be built up by the programme.
Resource mobilization	In order to become independent from an outside programme communities must build the capacity to mobilise resources on their own, internally and externally.
Asking why	the capacity to critically reflect on underlying causes of dis-empowerment in order to bring about, on the basis of heightened awareness, social and political change (Laverack 2004)
Links with other people and organisations	Communities' agendas can be strengthened through partnerships or networks with like-minded communities or organisations in the sense of coalition building. This can also be an aspect of resource mobilisation. Verhagen (1987) adds to this the aspect of movement building by which he means building a multi-tier structure in order to address broader and more complex issues.
The role of outside agents	Laverack (2004) says that this and the last domain apply specifically to programme settings. He explains that outside agents often have a crucial role to play, especially in the beginning, triggering a process and building the capacity to sustain it and can lend credibility to a process to the outside. However, the relationship must be guided by an empowering attitude.
Programme management	Closely linked to the previous point is the necessity to increasingly share the control of the programme and its resources with the communities, supporting an increasing sense of ownership of the programme by communities (Laverack 2004).

4.4.3.4. Location of CAH in the empowerment frameworks

Intrapersonal and structural dimensions

CAH can be located in these frameworks in the following way. The intrapersonal dimension of empowerment is very much present in CAH, as evident in countless stories told by VHC members. The feature of CAH most relevant for this dimension is the importance that CAH assigns to the appreciative, non-dominant behaviour with community members. But the intrapersonal empowerment process is of course fuelled by complex influences other than outside encouragement, the strongest of which is possibly the experience of success and achievement with its strong effect on the confidence that things can be changed.

With regard to the structural dimension of empowerment the process in CAH starts in the middle of the described continuum (figure 1), by forming community organisations (ie. VHCs) and building their capacity to analyse and to act. Starting from there, VHCs expand with their activities to the right side of the continuum, engaging in partnerships on certain issues and some even in social/political action.

Relationship between communities and outside agency

Regarding the relationship between communities and outside agency the placement of CAH on Arnstein's ladder of participation is more complex, as different components of CAH correspond to different rungs. The health action component begins with the analysis of people's health priorities and from these the projects choose those on which to develop health actions. Therefore, health actions correspond to the consultation rung. Likewise, the organisational capacity building of VHCs is controlled by the projects. The VHCs are partly informed about and partly consulted on its contents so that it can be placed on both, the information and consultation rungs. So the main inputs of projects within CAH are on the information/consultation rung. Of course, these programme inputs of CAH are meant to induce empowerment outcomes and these are most visible in the form of own initiatives of VHCs, which must also be regarded as part of CAH. As they are largely controlled by VHCs their place is on the higher rungs of the ladder.

Coordinate system 1: Level of participation and continuum of empowerment

In figure 4-4 I have joined two dimensions of the empowerment process, the continuum of empowerment and the ladder of participation, into a coordinate system. (At first sight, using these two dimensions as coordinates of a system may not make sense. It implies that there must be programmes or initiatives conceivable for each location in the system. This may seem questionable especially for the right-lower corner of the system where the higher levels of empowerment on the continuum meet the lower rungs on the ladder of participation. But one can conceive of scenarios that would be located there, if for example an outside agency manipulates a community into sociopolitical action, exposing the people to the risks such action entails without them really having made an informed decision about it. The other locations in the system pose no difficulty to imagine corresponding programmes or initiatives.)

I have placed elements of CAH into this coordinate system. The capacity building and health action inputs (in bold) are placed on the information/consultation rungs of the ladder and on the organisation building stage of the empowerment continuum. The empowerment outcomes in the form of own initiatives of VHCs I have placed (in italics) at various locations in the coordinate system, reflecting their varied nature (see explanations below the figure). I have indicated the link between inputs and outcomes with arrows.

Figure 4-4: Location of CAH in the coordinate system of community empowerment

Ladder of participation	Citizen control			OI	OI	OI
	Delegated power					
	Partnership				OI	
	Placation					
	Consultation			HA		
	Informing				OCB	
	Therapy					
	Manipulation					
		Individual	Small group	Organisation	Partnership	Sociopolitical action
		Continuum of empowerment				

Explanations to Figure 5

HA: health actions (inputs). Almost all are based on people's priorities (therefore on the consultation rung) and implemented either by VHCs alone or in partnership with other organisations (organisation/partnership level on the continuum).

OCB: Organisational capacity building (inputs). These are mostly decided by the projects, therefore on the information rung.

OI: Own initiatives of VHCs (outcomes). On the partnership rung are those that are funded by an outside agency, i.e. small grant projects, and planned and implemented by the VHCs alone or with local partner organisations. On the citizen control rung are those that are planned and implemented by the VHCs with own resources, either alone (organisation level on the continuum) or in partnership with other organisations (partnership level), or those that amount to sociopolitical action.

But the placement of CAH elements into this coordinate system reveals important limitations of Arnstein's ladder in the context of community capacity building programmes. The ladder was developed for programmes of civil society – government cooperation, where the power relations between the two sides is of crucial importance, i.e. the degree to which civil society representatives can participate in decision making. This scenario presupposes civil society organisations that have already the capacity to act as partners and to handle decision making power. But in many community capacity building programmes organisational structures and their capacity must first be built before decision making power can be handed over. In such settings, where capacity must first be built, these inputs necessarily take place on the rungs of information/consultation/placation and it is then misleading to label them as tokenism (as Arnstein does). For they do not pretend to be something that they are not, i.e. high levels of participation or power sharing. Instead, they intend to create conditions where empowerment processes can take place. There seems to be broad support for this view. Tritter and McCallum (2006), for example, criticize Arnstein's ladder for not considering the need for inputs intended to create the capacity to get effectively involved. Raeburn and McFarlane (2003), while acknowledging the pivotal role of community control, stress nonetheless the importance of the enabling dimension in the relationship between outside agencies holding the power and resources and the communities. Tengland (2008) in his extensive analysis of the

concept of empowerment also defends the inputs of a facilitator as compatible with being empowering – as long as these inputs create an environment that encourages the desired change.

This means that, even if the outside agency holds final control over the agenda and resources, a programme can have empowerment potential if it provides inputs that are conducive to empowerment. But this raises the obvious question how to assess to what degree a programme's inputs are indeed conducive to empowerment, and I will discuss this further below.

Very big capacity building programmes, like CAH in Kyrgyzstan, are faced with an additional difficulty. CAH deals with hundreds of communities simultaneously and therefore has to give organisational capacity inputs perforce in a unified way, which requires control to be with the outside agency – at least in the beginning and maybe longer than in small programmes. Tritter and McCallum (2006) formulate this point as the dilemma between involving few people intensively and many people in a limited way.

Despite these limitations I have chosen to locate CAH on Arnstein's ladder because it is such a well-known point of reference and because once organisational structures are built gradual handing over of decision making power is indeed necessary in order to further promote the empowerment process. For this, Arnstein's ladder provides a constant reminder and useful challenge also for community capacity building programmes. In CAH, the formation of the National Association of VHCs has opened the opportunity of shifting the power relationship between projects and communities more towards decision making in partnership because with this association outside agencies have a single partner to negotiate with instead of hundreds of communities.

Coordinate system 2: Level of participation and level of health intervention

Another coordinate system for characterising the relationship between programmes and communities was proposed by Raeburn and Corbett (2001) in their review of the effectiveness of community development in health promotion. One dimension describes the relationship between the outside agency and the community, the level of participation and power sharing, analogue to Arnstein's ladder of participation. But because their system is meant specifically for programmes working on health issues, i.e. health promotion programmes, they add as a second dimension the aim of the health intervention that the programme predominantly pursues: treatment or recovery, prevention of specific diseases, or wellbeing based on a global concept of health.

In Raeburn and Corbett's system the dimension that describes the relationship between communities and outside agency has three categories of participation and power sharing:

1. Community-based: This level is farthest away from inducing an empowerment process. Programmes in this category take place in the community, but hardly involve it. It is analogous to Arnstein's lowest two rungs of the ladder of participation.
2. Community action: This level is divided into four sub-levels with increasing degrees of community participation.

- a. The lowest sub-level, ("indirect involvement" in Figure 4-5), is characterised by assessing the needs indirectly through interacting with services present in the community, relying on their knowledge about the community based on their work in it (e.g. social workers or voluntary agency representatives)
 - b. The second sub-level is characterised by a needs assessment and by interventions involving the community directly (called "direct involvement" in Figure 4-5)
 - c. On the third sub-level communities have a degree of control over the agenda and the intervention activities
 - d. On the fourth sub-level, communities and outside agencies share control to an equal degree
3. Community development: This highest level is characterised by the presence of three criteria: a) community control over agenda and interventions, b) community building, ie. a process of enhancing social cohesion and other criteria of a functioning community, and c) community capacity building.

In Figure 4-5 I have located CAH in Kyrgyzstan into this coordinate system. Here, too, the programme inputs (in bold) are on a mid-level of community control. I have added again the outcomes (own initiatives, in italics), which take place on higher levels of control (see also explanations below the figure), and have linked inputs and outcomes with arrows.

This coordinate system shares the same important limitation with the previous one: it cannot express the strength and quality of the community capacity building inputs.

Figure 4-5: Location of CAH in Kyrgyzstan in the coordinate system of community health promotion programmes (adapted from Raeburn and Corbett 2001)

		Categories of community health promotion				
		Community-based (no involvement)	Community action			Community development (full control)
			Indirect involvement	Direct involvement	Degree of control	
Type	Treatment					
	Prevention		PAH	HA	▼ OI	OI
	Wellbeing			OCB	► OI	► OI

Explanations to Figure 4-5:

PAH: People's analysis of health. The participatory analysis of people's health priorities

HA: Health actions. Concerned with disease prevention and implemented with a large degree of control by the VHCs.

OCB: Organisational capacity building. Concerned with global health and wellbeing through enabling communities to address determinants of health and through increasing their Sense of Coherence.

OI: Own initiatives. Take place regarding prevention or wellbeing, and in shared or full control by communities

In summary, I have placed CAH in two coordinate systems that have a power relationship scale as one dimension. On these scales CAH capacity building inputs are localised in mid-levels that are characterised by a high degree of control by the programme. This reflects the fact that the control of the resources for and of the decision about these inputs squarely lie with the outside agencies and not with the communities (even if based on their priorities). I have argued that assessing community capacity building programmes in this dimension of power relationship has important limitations, because it does not capture the capacity building inputs that are meant to create conditions for empowering processes to take place. This, then, raises the question of how to measure the design or quality of these inputs, and I will discuss this in the following. This discussion will also lead to localising CAH in the third framework of empowerment mentioned, ie. the domains approach to analyse empowerment.

4.4.3.4. A new tool for assessing community capacity building inputs

How can one discern between programmes that indeed have the intention and appropriate design to build community capacity and therefore are likely to induce a process of empowerment, from those that do not have or only claim to have that intention or are not designed appropriately and therefore have a low likelihood to promote empowerment? Raeburn and Corbett's (2001:7) lament brings the necessity of this distinction into focus: "Most community health promotion...tends to ignore the very heart of what is implied in the term 'community development'...and instead, uses community as a tool or instrument for outsiders' agendas..." We have seen that assessing the power relationship, as Arnstein (1969) and Raeburn and Corbett (2001) propose, does not reliably distinguish between such programmes. Of course, at some stage in the programme the presence or absence of community-owned processes – the outcomes - will prove or disprove the intention or the appropriateness of the design. But long before one can assess outcomes, how would one see the difference in the *design* of programmes? How would one see whether a programme has a high likelihood to promote community capacity building and empowerment?

One would have to measure the presence or absence and the quality of capacity building *inputs* of a programme. I propose an instrument that uses the nine domains of community capacity building to do that with the aim of assessing the likelihood of programmes to induce processes of empowerment.

Laverack (2004, 2005, 2007) has proposed a tool for measurement of community empowerment based on the nine domains. It is a rating scale where the five levels of ratings for each domain have a description. The tool is applied by choosing for each domain the description that comes closest to the current state of a given programme. However, this tool is designed to measure outcome, i.e. the degree to which a community has achieved progress in the nine domains (or it measures the baseline status of a community), and is therefore not applicable here, as we look for a tool to measure inputs. In CAH, outcome assessment is done in regular intervals by the VHCs themselves and by the HPU staff, and examples of such assessments have been given in chapter 3. Furthermore, in Laverack's tool the description of each level of the scale of each domain is problematic, as such detailed descriptions are hardly applicable to widely diverse community capacity building contexts and programmes.

Several descriptions of distinct levels did not make sense when I tried to apply the tool to CAH.

Therefore, I propose here another tool to assess the inputs that a programme offers for community capacity building. I call it the Scale of Capacity Building Inputs (SCBI). In it I have defined only the least desirable (lowest score) and the optimal situations (highest score) for each domain in the broadest terms possible. The assessment for each domain is done by assigning scores between 1 and 10 to the inputs according to their approximate ("felt") position between these two extremes. For this, all inputs of the programme relevant for a given domain should be reviewed. However, more important than these subjective scores are the justifications for each score which are given in the two columns "Strengths (why is the score so high?)" and "Limitations (why is the score not higher?)" next to the score. These justification can and should be very programme specific. Therefore, owing to the general descriptions of the extremes, the tool should be applicable to a wide range of programmes and contexts, but at the same time, it can be expected to provide programme-specific descriptions on each domain, which can be used to inform strategic decisions on the future direction of the programme. The SCBI could lend itself to participatory evaluations, with participants of the programme filling it out in group work. The validation of the tool in various programmes is beyond the scope of this dissertation.

I applied the SCBI to CAH in Kyrgyzstan. Tables 4-2 to 4-4 and Figure 4-6 show the results. They show fairly strong assessments on seven of the nine domains, while weak ones on two domains. The justifications describe the reasons for the scores in programme-specific terms. In general, the strong domains reflect the fairly intensive inputs into organisational capacity building for the VHCs described in chapter 3. The weak programme management domain reflects the necessity for a unified approach in a programme that deals with hundreds of communities. The weak "asking why" domain reflects a conscious decision not to push communities into confrontations that in the political context of Kyrgyzstan can have severe consequences.

The fairly high scores in most domains of this third dimension say that the capacity building inputs are strong – despite being located only on a middle rung of the scales that measure sharing of power. And these strong capacity building inputs explain the existence of empowerment outcomes in the form of own initiatives and in form of testimonies of intrapersonal empowerment.

Table 4-2: Scale of Capacity Building Inputs (SCBI): definitions of lowest and highest scores, on a scale of 1 -10

Domains of Community Capacity Building	Lowest score (1)	Highest score (10)
Participation	Community organisation leaders selected by outsiders or community leaders. Those most affected are not represented. No input to encourage increased membership, diversity (gender, ethnicity, economic status), and participatory leadership style and decision making	Community organisation leaders elected by community. Those most affected are most represented. Major inputs to encourage increased membership, diversity (gender, ethnicity, economic status), and participatory leadership style and decision making
Leadership	No input in leadership development	Major input in leadership development
Organisational structure	Community organisation were formed only to fulfil tasks of outside agency. No organisational capacity inputs	Community organisation were formed to enable communities to address issues identified by the communities. Major inputs in organisational capacity building.
Problem assessment (and management capacity)	Content of the programme based on outsiders' assessment. Community organisation are not meant to assess problems and initiate actions on their own. No capacity building or encouragement to engage in issues beyond the one of interest to the outside agency. No input in management capacity building.	Content of the programme based on people's own assessment.. Community organisation are meant to assess problems and initiate actions on their own. Major encouragement and capacity building by the outside agency to engage in issues of own choosing and to manage coordinated action
Resource mobilisation	Community organisation are not encouraged to generate own resources. No capacity building input in this regard.	Community organisation are encouraged to generate own resources and to use them fairly, including for the poorest. Major capacity building inputs in this regard.
Asking why	Community organisation are not supported nor encouraged to critically analyse issues for underlying causes and to reflect on possible actions addressing the causes.	Community organisation are supported and encouraged to critically analyse issues for underlying causes and to reflect on possible actions addressing the causes. However, outside agency is careful to follow the communities' own pace and avoids pushing them into addressing issues without their full understanding of the risks involved.

Networking	Community organisation are not provided the opportunity to build federations and to network and cooperate with other organisations to address issues together. No inputs are provided for this.	Community organisation are provided the opportunity to build federations and to network and cooperate with other organisations to address issues together. There are major inputs provided for this.
Relation with outside agent	Staff of outside agent relate with community organisation as teachers, older brothers/sisters, bosses, leaders	Staff of outside agent relate with community organisation as equal partners, consultants on request only, common
Programme management	Decisions on content and finances of programme fully in hand of outside agency	Decisions on content and finances of programme fully in hand of community organisations

Table 4-3: Applying the Scale of Capacity Building Inputs (SCBI) to CAH in Kyrgyzstan: Scores, on a scale of 1 – 10, and justifications

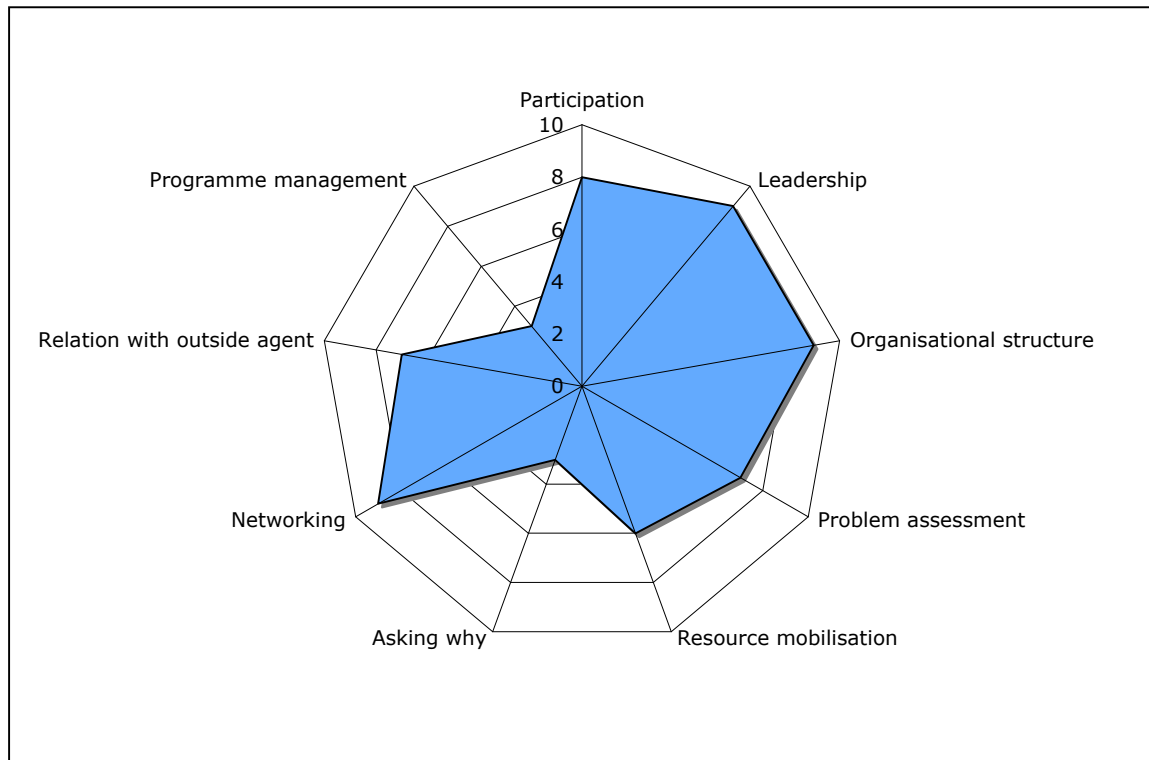
Domains of Community Capacity Building	Scores on scale 1-10	Justifications of scores	
		Strengths (why scores so high?)	Limitations (why scores not higher?)
Participation	8	Considerable inputs to encourage VHCs to have elected boards, diversity in boards (men, women, ethnic groups), regular elections, and to use participatory decision making	Few men in VHC boards, number of women decreases with higher leadership levels, number of members per VHC relatively small
Leadership	9	Considerable input in leadership development through trainings, federation building, cross visits, exposure	Leadership development not everywhere of equal quality
Organisational structure	9	Formation of VHCs. They work on people's health priorities (through unified health actions) and coordinate independent community action on health determinants. Major, continuous organisational capacity building input for VHCs. Federation building with legal status of rayon federations of VHCs (Rayon Health Committees) and of national Association of VHCs.	Much of organisational capacity building in the beginning went into enabling health actions, focus on own initiatives later.

Problem assessment (and management capacity)	7	People identify the health priorities for the health actions. Considerable capacity building of VHCs to engage in own initiatives, i.e. to identify problems and manage coordinated actions.	Much of management capacity building in the beginning went into enabling health actions, focus on own initiatives later. Management capacity building most intensive only where VHCs are supported with small grant projects
Resource mobilisation	6	VHCs are encouraged to generate own resources, through informal microcredit schemes, stimulation grant for income generation activities. Partner projects are required to contribute to resource generation.	Microcredit scheme informal and limited due to legal barriers. Not all VHCs receive stimulation grant for income generation.
Asking why	3	Encouragement and support of VHCs that engage by their own initiative in analysing and addressing causes of issues. Capacity building in the other domains contributes indirectly to the capacity for critical analysis.	No direct stimulation of critical analysis, in order to avoid pushing VHCs into something of which they do not fully understand the risks
Networking	9	Strong encouragement of VHCs to collaborate with other governmental and non-governmental organisations in the village, in health actions and own initiatives, in and outside of village. Strong federation building. Movement building.	Not everywhere enough encouragement to collaborate with youth clubs
Relation with outside agent	7	Much emphasis on non-dominant, respectful behaviour in training of staff who engage with VHCs.	Early emphasis on health actions as the necessary trainings induces more a teacher-student relationship. More continuous and consequent monitoring of the relationship would be needed.
Programme management	3	Encouragement of VHCs to seek their own funding for own initiatives. Evolving programme content is being discussed with RHCs and national Association of VHCs. RHCs and national Association of VHCs are encouraged to seek their own funding. National Association of VHCs sits in coordination committee of CAH.	Decision power of support of VHCs, and its content lie fully with outside agencies

Table 4-4: Summary table of scores of CAH in the SCBI

domains	1	2	3	4	5	6	7	8	9	10
participation								X		
Leadership									X	
Organisational structure									X	
Problem assessment							X			
Resource mobilisation						X				
Asking why			X							
Networking									X	
Relation with outside agent							X			
Programme management			X							

Figure 4-6: Spiderweb diagram of the scores of CAH in SCBI



Finally, as a by-product of this attempt to locate CAH in the discourse of community capacity building and empowerment I would like to present the insight that a combination of instruments should be used to describe and assess any health promotion programme engaging with communities. Best suited for this purpose seems a combination of the following three tools: the continuum of empowerment because it describes the complexity of organisational structures involved; the coordination system of Raeburn and Corbett (2001) because it includes the important dimension describing the degree of participation or power sharing between outside agency and communities and because it indicates in its other dimension the level of the health intervention between treatment and well-being; and finally the newly proposed Scale of Capacity Building Inputs because it adds the necessary dimension of the quality of capacity building inputs.

4.4.3.5. Summary of sub-chapter on community capacity building and empowerment

In this sub-chapter on community capacity building and empowerment I have reviewed these concepts and discussed how they are reflected in CAH. I have reviewed tools that help locate the design of health promotion programmes in dimensions that are relevant in the discourse on health promotion and empowerment. I have used these tools, partly adapted, to locate CAH in Kyrgyzstan in these dimensions. In the empowerment continuum CAH in Kyrgyzstan can be located at the level of organisational structures (figure 4-4) because VHCs are its main feature. On Arnstein's ladder of participation (also figure 4-4), i.e. in the dimension of the power relationship between outside agency and communities, its inputs can be placed on the information and consultation rungs because decision power on inputs is clearly with the outside agencies, while many outcomes can be placed on the higher rungs of partnership and civil control. The same applies for the placement in the power relationship dimension in the coordinate system proposed by Raeburn and Corbett (2001) (figure 4-5), i.e. in the range between community-based programmes and community development. In the other dimension in the latter coordinate system CAH in Kyrgyzstan is best placed in the prevention and well-being categories.

I have then argued that these existing tools miss an important dimension necessary to describe a health promotion programme that engages with communities, namely a dimension that assesses the quality of the capacity building inputs. I have therefore proposed a new tool, the Scale of Capacity Building Inputs, SCBI, that assesses the quality of these inputs, based on the broadly accepted nine domains of community capacity building or empowerment.

I have applied this tool to CAH in Kyrgyzstan and found that it shows a fairly high level of capacity building inputs, which can explain the numerous outcomes that are indicative of empowerment.

4.6. Synthesizing the different streams of health promotion

In more recent years the view gains support that the different models of health promotion need to be pragmatically combined in order to have the greatest effect. Thus, Raeburn and Rootman (1998) propose to move beyond the debate between the lifestyle and social models, in order to focus on the essence of health promotion, which in their view is its concern with people. Laverack (2004:7) argues also for a pragmatic combination of the various streams of health promotion, saying "that distinctions between the medical/behavioural and the social approaches to health promotion are helpful for analysis, but are much more blurred in practice." He sees another important ideological fault-line in health promotion between top-down and bottom up approaches and, although community empowerment (ie. a bottom-up approach) is the path favoured by him, he argues that the "challenge is to work in both directions: from top-down to bottom-up, and from bottom-up to top-down approaches" (Laverack 2004:70). This view is shared by various authors, e.g. Rütters et. al. (2000), Chappel et. al. (2005), and the Commission on Social Determinants of Health (2008).

This combination of various health promotion models and dimensions of empowerment is a characteristic feature of CAH. To repeat and summarise, the health actions in CAH represent mostly a health literacy model, with elements of health education/healthy lifestyle and target-oriented and empowerment-oriented frameworks of community engagement, while the organisational capacity building of VHCs represents the bottom-up model, inspired by the social model and community stream of health promotion. It is very much our observation that the aspects of CAH that correspond to different models of health promotion strengthen each other mutually. The guidance of VHCs towards concrete, useful actions and the experience of tangible results, as well as the action research elements in health actions, have strong implications on the self-confidence of its members and on their leadership and other organisational skills. In fact, all nine domains of empowerment are being strengthened by health actions. Vice versa, the inputs in organisational development help VHCs plan and implement complex health actions.

4.7. Summary of Theoretical Foundations of CAH

In this chapter on theoretical foundations of CAH I have shortly presented concepts that have influenced the design of CAH. I have then reviewed in more depth the history and key concepts of health promotion - the social-environmental model, the life-style model, the healthy literacy model, and the engagement with communities – because CAH is conceived as a health promotion programme. Within this review I have given most space to a discussion of community capacity building and empowerment because of their central importance to CAH.

I have shown how these concepts and their desired integration and mutual complementation are reflected in CAH. Health actions have their roots in the life-style model of health promotion and in the concept of health literacy. The formation and organisational capacity building of VHCs are founded on the socio-environmental

model of health promotion and the latter's strong tradition of empowerment-oriented engagement with communities. The latter includes an understanding of an intra-personal dimension of empowerment whose complexities we find best captured in the concept of salutogenesis of Antonovsky.

While analysing the roots of CAH in the tradition of empowerment-oriented engagements with communities I have used tools described in the literature to locate CAH in the discourse of community capacity building and empowerment. Doing so I have discussed the limitations of these tools in assessing community capacity building programmes. During this discussion it became evident that a tool to assess the quality of capacity building *inputs* of programmes is missing, and I have presented a new tool for that, the Scale of Capacity Building Inputs and used it to assess the capacity building inputs of CAH, which were found to be fairly strong. Finally, as a by-product of this comparison of CAH with the discourse on empowerment-oriented health promotion programmes I mentioned the insight that a combination of the empowerment continuum, Raeburn and Rootman's coordination system, and the newly proposed SCBI could be useful in fairly comprehensively describing the design of most health promotion programmes engaging with communities.

Part II

Chapter 5: Social Constructionism

In this chapter I will review the main propositions of social constructionism and its consequences.

Outline of chapter 5

5.1. A simple proposition

5.1.1 From where comes this proposition

5.1.2. Language games, confluences

5.1.3. Power

5.2. Consequences

5.2.1. From bounded to relational being

5.2.2. The ethics of agency

5.2.3. Knowledge and Truth

5.2.4. Research, ethics

5.1. A simple proposition

Social constructionism makes a simple central proposition: meaning is created through collaborative activities (Gergen and Gergen 2004). This proposition is being formulated in many variations in social constructionist literature, some of the more popular ones are that there is no meaning without social interaction, that we create/construct the world we live in through our social interaction, or that reality is created through social interaction. The latter two formulations seem to imply an ontological statement, as if negating the existence of “reality” or the “world” in the absence of social interaction. This, however, is usually not meant by most social constructionist writers, as for example Gergen and Gergen (2004) point out. To say that the “world” or “reality” is created through social interaction therefore is meant to mean that whatever exists “out there” and whatever happens has no meaning in itself but its meaning can only be created in the interaction between social agents. Social constructionism, therefore, is not concerned with statements about Kant’s thing-in-itself, nor even with investigating what we can know about it, but rather how meaning is created in social interaction.

5.1.1 From where comes this proposition

The reason for this proposition for most writers seems to be the observations that a) a word or utterance can have multiple meanings depending on the context it is spoken in, and b) that the meaning of an utterance depends in large part on the reaction of the person to whom this utterance has been directed, in that the reaction signifies to the speaker that he has been understood in a certain way. If the speaker in turn confirms the meaning implied by this reaction a meaning has been locally established, a “reality constructed”. This observation, it seems, can be made in regard to all human interactions, not only in regard to speech: any action gains a meaning only through a

counteraction: a man kicking a ball in itself is an act open to many meanings; it becomes a game of football if the person he kicked the ball to starts kicking it back; if not, it gains the meaning of a declined invitation. In this sense Gergen (2009:xv) can say that “virtually all intelligible action is born, sustained, and/or extinguished within the ongoing process of relationship.” He calls this process co-action.

Another observation is often elaborated on that lends further weight to the primary proposition and extend its meaning. A person is not completely free in making the first utterance in an interaction. She is rather part of a tradition, established in countless similar situations before (by her society at large and by herself) that guides her in choosing among endless possible acts those that fit the situation according to the tradition and are therefore likely to be understood. The choice of response, likewise, is guided by this tradition. Social constructionist writers refer often to Foucault’s concept of “discourse” and to Wittgenstein’s concept of “language games” to support this notion of a tradition that guides the interactions of people. In both concepts language plays an essential role in constituting our social world.

5.1.2. Language games, confluences

Thus, in acting within their tradition, people’s co-actions are an expression of this tradition or of their “discourse” or “language game”. But in following it, they also confirm it: every time people act according to their tradition they strengthen it further, confirming its guiding power for future interactions. Therefore, “dialogues both express and constitute social reality. In other words, our conversations both express and help to create our particular world in which we and others live” (Sampson 2008:108).

Gergen (2009) takes a closer look at the situation of the people in interaction and introduces the concept of confluence, by which he means the sum of those things and happenings in a given situation that make up its meaning. Confluences, like traditions, influence the spectrum of possible actions. He gives the example of a baseball game in a park. A man throwing a ball is only playing baseball if there is also a man with a bat and some things on the lawn indicating a border of the playing field, etc. In regard to the question of innovation and creativity under these circumstances Gergen (2009) proposes that this happens through cross-fertilisation from other frames, conversations, contexts.

5.1.3. Power

If we create meaning, and indeed reality, in interaction the aspect of power immediately comes to mind. Rarely will the two interacting sides be equally powerful. One will mostly be more dominant than the other and will therefore contribute more to the construction of the meaning and reality. Sampson (2008) mentions examples from socio-cultural history, such as men-women and white-blacks in Western societies. Said (1994) has extensively analysed the construction of the dominant discourse of the colonialists over the colonised. A further example is the history of Jews in Christian Europe. Sampson (2008) analyses that these examples have in common that the dominant, more powerful side can and does construct a disadvantageous role for the other and helps - through that - construct an

advantageous kind of self for themselves. And he examines various forms of suppression of true dialogism by the dominant part. These have in common that the dominant parts refuse the chance to be transformed through a true encounter.

5.2. Consequences

The simple proposition of social constructionism has a number of interesting consequences.

5.2.1. From bounded to relational being

The most profound consequence is that, as there is no meaning without the other, I am not without the other.

The simple central proposition of social constructionism denies intrapersonal, intrapsychic processes the paramount importance that they have received in centuries of Western culture and thought (Sampson 2008), because it questions the primacy of an individual self-contained being that is acting out of intrapsychic impulses or conditions, and is interested rather in the social interaction as the originator of norms, emotions, and behaviour. It posits that there is no self without the other, no reason and emotion as the possession of an individual mind but only of relation (Gergen 2009). As Sampson (2008:142,155,107,108,) puts it: “We are essential aspects of each others very being.” “Self needs the other to be self at all.” “The mind and all its attributes, as well as personality and personal identity (i.e. “self”), are emergents of a dialogic, conversational process and remain socially rooted as an ongoing accomplishment of that process.” “First of all we learn that we are fundamentally and irretrievably dialogic, conversational creatures, whose lives are created in and through conversations and sustained or transformed in and through conversations.” Gergen attempts (2009:62) to “recast the discourse of the mind in such a way that human connection replaces human separation as the fundamental human reality”.

5.2.2. The ethics of agency

The observation that our actions are influenced by traditions, “discourse”, “language games” and confluence brings up the question of determinism vs. volunteerism of our actions. Social constructionist writers do not deny the individual the possibility to decide on his acts, to have individual agency. Traditions are a mere frame that guide these acts, they provide a likelihood for certain acts over others (out of necessity to be understood, to create meaning). But rather than discussing the theoretical question of determinism vs. volunteerism most social constructionist writers are more interested in the ethics of agency, that is in the more practical question of how we can shift our interactions to a mode that is more aware of the mutual creation of meaning and therefore more open-ended, self-critical, and tolerant. (Side remark: by the very nature of this question social constructionists must presume that humans have at least to some extent the free will to act one way or the other). They are concerned with how to shift the mutual, relational construction of reality in our private lives as well as in professional contexts to a more constructive, less confrontational mode.

This is not surprising. If indeed we shape reality through language and actions in our immediate relationships and if these in turn shape further relationships in a theoretically infinite network then we indeed have an immense responsibility. Such demands are formulated like a challenge to “celebrate the other” (Sampson 2008) or more straightforward as “The future is ours – together – to create” (Gergen and Gergen 2004). Shotter calls for viewing psychology not as a natural but as a moral science, that should study “how we actually do *treat* each other as being in everyday life” (1993:23). And even he writes about the “major corporate responsibility” we all have in maintaining and developing the “communicative ‘currency’” in our daily social lives. Gergen (2009) analyses relational processes as being either degenerative or corrosive on the one side or generative or catalytic on the other. And he claims that “we stand each moment at a precious juncture, gathering our pasts, thrusting them forward, and in the juncture creating the future. As we speak together now, so do we give shape to the future world. We may sustain tradition; but we are also free to innovate and transform” (2009:49).

5.2.3. Knowledge and Truth

The central proposition of social constructionism has also profound consequences on the perception of knowledge. If meaning is produced locally in relationships and in traditions then words are not unchangeably representative of a certain reality. Rather, whether their representation is regarded as true will depend on the local context or tradition. Therefore knowledge is not absolute but valid only within a system of rules and conventions Wittgenstein called language games. As Gergen and Gergen (2004:71) put it “Knowledge is the product of particular communities, guided by particular assumptions, beliefs and values.”

Gergen (2009) approaches the issue from another perspective. A quick overview of epistemology in the history of philosophy seems to show to him that the intractable problems of what is knowable to the mind are linked to the concept of a bounded being looking upon an independent world. The concept of a relational being he had introduced earlier (see above) dissolves this question: “If the idea of the bounded being is a construction that we have invented, then the philosophical problems of how mind and world are related are for the most part problems in discourse. They are not fundamental problems of human existence, but sophisticated games of language.” (2009:203).

Shotter (1993) returns our attention to the observation by Foucault that the discourse of Enlightenment has marginalised or even excluded other discourses and he mourns that, in analogy, in the socio-psychological debate a special kind of knowledge has been “unvoiced” as he writes: a “knowledge – to do with how *to be* a person of this or that particular kind according to the culture into which one develops as a child.” (Shotter 1993:19) He calls it knowledge from within (‘knowing-from’), as opposed to theoretical knowledge (‘knowing-that’) and practical knowledge (‘knowing-how’).

When social constructionist writers thus look critically at claims of absolute truths they are careful at not proposing their own position as such a truth but rather as an invitation to consider their view as a point of view among others and to move forward

in a dialogue among view points, each being aware of its own language game and relative truths.

5.2.4. Research, ethics

If truth is a construct from a constructionist perspective then the pursuit of truth in separate disciplines within their language games has limitations and, as Shotter (1993:26) warns, is dangerous, because "...experts can become trapped within systems of thought of their own making." For social constructionist the area of interest of research rather shifts to how knowledge and meaning is created in relational activity between human beings. As Shotter (1993:7) observes: "...until recently, this third sphere of diffuse, sensuous or feelingful activity, this unordered hurly-burly or bustle of everyday social life, has remained in the background, awaiting elucidation in terms of yet to be discovered, ahistorical principles of either mind or world."

Further, if knowledge is created mutually then the strict boundary between researcher and object that is observed in traditional sciences and the ideal of unattached observer that is upheld there is first not possible to fulfil, second not necessary or even not desirable. Not possible, because any interaction (experiment setting) has an influence on its outcome (Gergen 2009) and not necessary and not desirable because useful meaning is created in the interaction that, if accounted for its mode of creation, can contribute to the understanding of the matter at hand. The construction psychologist is for Shotter (1993:34) not the "Olympian scientist looking down upon the society they are studying with no part to play within it themselves...They are taking part in a contested (or at least contestable) process, a struggle to do with the constitution of our own mental make-up."

Gergen and Gergen (2004) list four challenges of constructionist research. First, the challenge to break or blur the disciplinary boundaries comes from the constructionist impetus to relativise truths. Second, the challenge to evaluate societal functions of research comes from the insight that the utility of research is lastly a value question and that it therefore should be decided by the community. Further, the challenge to encourage multiple methods comes from the constructionist view that methods tend to reflect assumptions of the researcher about nature rather than find 'the truth' about it. Using multiple methods then is a way around this trap. An important method that fits very well this constructionist challenge is action research where the barrier between researcher and researched is purposefully broken down so that both collaborate on the matter at hand with the goal to both, produce research insights and change reality at the same time.

In contrast, in traditional socio-psychological research the study objects are not given the right to express their views, they are not seen as subjects with something to say, but instead discredited as biased, subjective and not detached (Gergen 2009).

And finally, social constructionism poses the challenges to sciences to expand forms of expression beyond the writing of books and papers in a style that must aim to sound detached, objective, not passionate, and God beware emotional. This challenge

stems from the desire of constructionist writers to also come into communion with a broader audience than only with a narrow scientifically trained one and create meaning in this communion. Gergen and Gergen (2004) name for example narrative forms of writing that experiment with a less observing, more experiencing mode of expression, and writing in multiple voices that tries to make clear that there is no one objective outcome of the research but there remain multiple perspectives. Shotter provides an example of how constructionist views can be expressed. He describes what he does as offering instructive statements that “provide an *account* of a number of what I feel are crucial aspects in the nature of conversational exchanges. Their function is not to represent a state of affairs, but to direct people’s attention to crucial features of the context, features that ‘show’ connections between things that otherwise would go unnoticed. They have the form: ‘*attend to X* if you want to grasp the crucial feature that gives you insight into the issue in question here” (1993:34).

I would like to end this summary of social constructionist thought with a quote from Gergen and Gergen (2004:96) who formulate that “the hope is simply to generate a consciousness of possibility, an orientation to meaning and to knowledge, and not the “new truth””.

Chapter 6: Methodology of the two investigations of this study

In this chapter I will first reflect on principle issues of methodology and of presentation of findings under a social constructionist point of view. I will then describe the processes that produced data for the two investigations of this study, the investigation on the presence of appreciative principles in CAH before the introduction of AI and the documentation of the effects of the introduction of AI into CAH. I do not use the term “methods” but “data producing processes” because these processes were part of the implementation process of CAH, not separate research methods applied specifically to produce research data.

Outline of chapter 6

6.1. Introductory note

6.2. Data producing processes – Appreciative principles in CAH

6.3. Data producing processes - Introducing AI into CAH

6.1. Introductory note

As social constructionism doubts the existence of ‘One Truth out there’, or at least our capability to grasp it, research under the aegis of social constructionism seeks to construct local meaning and knowledge among those involved in the research process and then present findings in such a way that invites readers to construct their own meaning from it.

Concerning those involved in the research the process must by necessity be participatory in order to allow an interaction in which meaning can be co-constructed. But this also means that the researcher is part of the process! The ideal of the unattached observer is discarded because it is anyway not possible (any experimental setting has an influence on the outcome) and not desirable because local meaning is created in the interaction between researcher and researched. The researcher's role should therefore be acknowledged, not denied.

Concerning the construction of meaning among the readers social constructionist researchers experiment with various forms of writing (Gergen 2009). They have in common to avoid a monologic presentation, the speaking with one voice that gives the impression of representing the truth. Van der Haar and Hosking (2004) for example, give an exemplary overview of such practices in their review of responsive evaluation in the version of Tineka Abma. Her premises are social constructionist in that they are a) "propagating polyphony, appreciating differences and *preserving this diversity* instead of trying to reduce it" (italics in original). Also, b) the researcher gives up the role of the distant, seemingly objective observer and "subject-object relationship with Other". A program should further c) be evaluated in its own context. Further, d) story telling should be an important part of an investigation and the report should include thick descriptions and stories. Further, e) it is important in this process that participants reflect upon the common co-construction of meaning that is taking place as this raises awareness and opens possibilities. And lastly, f) an evaluation or investigation process is specific to a particular inquiry and they are indeed closely interwoven so as to be really no longer separate processes.

I will therefore try to follow these principles. Regarding a personal note, acknowledging the biographical perspective and outlining the personal reasons why I am interested in the research subject, I refer back to chapter 2. Most data producing processes that I have used have been highly participatory processes where either the participants produced the outcomes entirely on their own or in interaction with me. I do not call these processes research methods as this would imply that they were separate processes from the ongoing implementation of the CAH programme, designed only to collect data for research. But all (except one, which I will point out) of these processes have been part of the ongoing implementation of the CAH intervention so that research and intervention were not separate but one, and while these processes were ongoing anyway I have been collecting their data for this investigation - hence "data producing processes", not methods. Of course it will be me who will be presenting these findings here, inevitably through my own filter of concepts, biases, interests, blind spots, etc. However, in presenting the findings I will quote numerous stories relevant to the context in order to give colour and background to the text and provide the reader with a means to have her/his own associations. To further enrich the polyphonic structure I have asked colleagues to provide short independent essays on the two key questions of this investigation: a) the presence of the appreciative principle in CAH before the introduction of AI (in order to use familiar terminology for my colleagues the question was formulated for them as: what role does the non-dominant, respectful behaviour play in CAH?), and b) on the role of AI in CAH. I place these contributions unedited in the text in a different font and colour to enable the reader to construct a meaning out of different voices. In summary, the objective of presenting my findings is not to demonstrate factual truths

but to lay out the local meanings that we constructed during the intervention and research processes and by producing the data, stories and foreign contributions to invite the reader to construct her or his own meaning as to what role appreciative principles might have played in the success of CAH.

6.2. Data producing processes – The presence of appreciative principles in CAH

The data producing processes that I used to investigate how far the appreciative principles were present in CAH before the introduction of AI were the following.

6.2.1. Reflections on PRA trainings with HPU staff

There were two trainings on PRA taking place in two regions (Osh 1, Chui 2) during the introduction of AI in CAH, in October 2008. In both cases I took the occasion and asked participants on the last day of the 10-day training – that as outlined in chapter 3 contains an extensive part on non-dominant behaviour - to tell stories about their best experiences. A third training took place one year later in a third region (Osh 2) and again I took the occasion to talk with staff about their experience, however this time two months after the training. Analysing stories and experiences together with staff led to insights into changes that had occurred in regard to appreciative principles through the PRA training.

6.2.2. AI Discovery with HPU staff

Between end of January and end of February 2009 HPU staff in six regions (Chui 2, Chui 1, Talas, Naryn, Issyk-kul, Batken) came together in their regions and went through a discovery process with individual interviews and identification of themes or life giving forces. These seminars were part of introducing AI into CAH and familiarised HPU staff with the discovery process which they were later to facilitate with the VHCs. I was present in all six seminars and noted the themes that were identified. Reviewing these themes can help us see to which degree appreciative principles were present in CAH before the introduction of AI.

6.2.3. AI Discovery with trainers

In January 2009 a two day seminar was held to introduce AI to the around 20 trainers of CAH, collected from all over the country, as well as to the key staff of our partners in the Republican Health Promotion Centre. During this seminar participants went through a discovery process with interviewing each other and identifying themes or life giving forces. These will show us the presence of appreciative principles in the minds of key stakeholders of CAH before the introduction of AI. During the seminar we also did an exercise in which the participants identified where the principles of AI (constructionist, anticipatory, simultaneity, poetic, positive) had been in use in CAH already before the introduction of AI.

6.2.4. Survey on appreciative principles in CAH among trainers and HPU staff

This is the only instrument that was designed and applied specifically for this investigation and that was not part of the implementation of CAH, although its content fitted well within the culture of reflection within CAH. It consisted of a written questionnaire with the following 6 questions:

1. What are the three to five most important things about CAH for you?
2. If you should rank the success of CAH on a scale between 1 and 10, how would you rank it? (a scale allowed to tick boxes)
3. Why do you think CAH was and is successful to this degree? What are the most important features for its success?
4. In your opinion, how much emphasis is given in CAH on non-dominant, respectful behaviour? Try to give a score on a scale between 1 and 10. (a scale allowed to tick boxes)
5. Assess your own level of non-dominant, respectful behaviour before and after joining CAH on scales between 1 and 10. (a double-scale allowed to tick boxes for before and after)
6. Do you think that the emphasis on non-dominant, respectful behaviour was important for the success of CAH? Please explain your opinion.

These were sent to trainers and HPU staff and they were asked to fill it out and send it back. I received the interviews back from all 20 trainers and from 62 HPU staff (52%). I analysed them separately for trainers and HPU staff. For questions 1 and 3 I scanned the answers for items that expressed appreciative principles and listed them in a table and counted them and calculated their proportion out of all answers. This was meant to see whether and to what extent staff would think of non-dominant, respectful behaviour as an answer to these open ended questions. Answers to questions 2, 4, and 5 were entered into an excel sheet and averages calculated. The answers to question 6 are not summarised, but quoted in full in order to provide thick text as these answers provide insights into the level of reflection and understanding of staff.

6.3. Data producing processes - Introducing AI into CAH

The data producing processes that I used to investigate the effects of introducing AI into CAH were the following.

6.3.1. Sessions with HPU staff

These were numerous sessions between October 2008 and spring 2010 in all regions, of about 2-3 hours duration during their monthly staff meetings. I began these meetings with the introduction of AI into CAH as a mechanism of training, feed-back, and reflection. I would typically start by asking for stories about an issue and then have a plenary discussion about it. The learnings from these sessions I documented in my AI diary.

6.3.2. Analysis of discovery themes of VHCs

Because the discovery themes, i.e. the life giving forces of VHCs, were entered into computers in the periphery by HPU staff it was possible to analyse them partly for this thesis. I had data from 356 VHCs of 12 rayons to analyse. They were first translated from Kyrgyz to English. In order to keep the volume of this analysis limited I chose to analyse only the themes identified from two sections of the discovery interview, from the stories and from the question on *What do you like about being in the VHC?*, as these two sections are the ones closest to the question at hand – the motivation of the VHCs and the motivational boost they had received from the discovery. For this analysis I initially scanned the words of several rayons. This made five word fields come apparent, one around an altruistic attitude, one around a sense of being active and the joy of that, one around self interest, one around connectedness and relationships, and one around human qualities that again most closely resembled appreciative principles. I proceeded to assign all themes of the stories and of the question *What do you like about being with the VHC?* to one of these five groups, using a sixth group to collect all that did not fit in one of the five. The sorting and counting was done in excel files.

6.3.3. National HPU forum

In December 2009, about a year after the beginning of the introduction of AI into CAH, a national HPU forum was held. During this event there was occasion to discuss also the effects of the introduction of AI into CAH. HPU staff looked in group work at the effect of AI in CAH in regard to four different aspects: story telling in HPU meetings, discovery seminars, strategic planning seminars, and informal use of AI. I present the results of these group works in the narrative about these aspects.

6.3.4. Reflections with trainers/oblast HPU staff¹¹

In December 2010, about 2 years after introduction of AI into CAH, I held discussions with the trainers/oblast HPU staff in charge of 7 regions, separated by regions. With each team of 2 or 3 people we reflected upon two questions in the frame of about two hours. The questions were: 1) To what degree is AI today being implemented in CAH, on the level of VHCs, RHCs, HPU staff, and yourself? 2) What effect had the implementation of AI on VHC/RHC, HPU staff, yourself?

6.3.5. Monitoring the number of own initiatives of VHCs

The number of own initiatives of VHCs is an indicator within CAH that measures the overall organisational development of VHCs. Its dynamic over the time of the introduction of AI into CAH may give an indication of the influence of AI on organisational development.

¹¹ Oblast HPU staff are previous trainers who recently, earlier in 2010, left the project in order to continue the same function of supervising rayon level HPU staff from within the governmental health system. This was offered to them in view of the limited time frame of the project and the need to create conditions for sustainability of the system of CAH. To our great joy almost all trainers agreed to continue to work under greatly reduced salaries in the governmental system

6.3.6. Generation of new ideas from below

One effect that we hoped for from the introduction of AI into CAH is the generation and spreading of new ideas from below, i.e. from one VHC to others. We view this as a function of the regular story telling. We document the generation and spread of new ideas among VHCs.

Chapter 7: The presence of appreciative principles in the CAH program before the introduction of AI

This chapter investigates in how far the appreciative principle was present in CAH before the introduction of Appreciative Inquiry (AI).

Outline of chapter 7

7.1. Reflection on PRA trainings with HPU staff

7.2. Discovery with HPU staff

7.3. Discovery with trainers

7.4. Interviews with trainers and HPUs on appreciative principles in CAH in Kyrgyzstan

7.5. Guest contributions:

7.1. Reflection on PRA trainings with HPU staff

In the two sessions with HPU staff who had just undergone the PRA training (Osh 1, Chui 2) there were many stories that clearly showed the staff's awareness about appreciative principles. They became aware of one's own dominant behaviour and the need for a behaviour change, even at home in families during the short period of training. In one meeting (Chui 2) we analysed which human qualities and strengths are present in these stories and they came up with the following list of things that remind us of appreciative principles: readiness to change, courage to admit mistakes, self-confidence to talk to and invite people, humility, respect, humour, capability to laugh about oneself, believe that 'people can do'. In the meeting in Osh 2 in November 2009 staff that had been working for 2 months with PRA analysed the difference between their previous work and their present work. Table 7-1 shows their results. Again, appreciative principles seemed to be expressed like listening, learning together, letting people taking over the talking and analysing, acknowledging people's gratefulness for their coming and people's reaction to their own changed behaviour. I quote a few stories from these meetings to illustrate these findings.

Table 7-1: What is different in the work with PRA? (HPU staff, Osh 2 after 2 months of work with PRA)

- We listen to people's opinion, about their problems

- We don't teach, we learn together
- Before we took diseases from statistics, gave lectures according to plan, now people help us to analyse, they analyse themselves
- Before only medical personnel talked, they told people what to do, now people talk
- We learnt that people can talk openly about their problems, understood that it's their problems, that they can and should talk
- people like it because
 - o before nobody came and asked about our problems
 - o all were happy, grateful that we came, wished us all the best
 - o they liked especially that we collected people in groups to discuss
 - o they understood that they can do something by themselves
 - o people feel your behaviour and they feel more free to open
 - o they commented about us being nice people

During the training I wanted to change a window in my house and called a carpenter. When he arrived and took measures I saw my husband was not happy at all and realised that I had not asked him. Thinking of PRA I asked him about his ideas and wishes and I agreed that it could be done also in that way and everybody was happy. (HPU staff, Chui East oblast)

Asel, one of our trainers in Chui oblast, had asked the HPU staff she worked with how they liked the new method (PRA) they worked with. Their answers: We are allowed to make mistakes, there is no fear, no threat of punishment. Our opinion counts. We contribute. There are no orders from above exactly how to do something with us only fulfilling what we are told (contrasting with typical Soviet/post-Soviet style working environment).

During training of PRA we had theory and practice about behaviour, my family noticed that I changed to the good side. I have a choleric character, am quickly angry. My wife told me I changed, that I say nice words. I learnt about dominant behaviour, decided to try it with my family. Before when my wife did something small wrong I shouted, now I ask her or suggest gently another way, for example: what do you think if you do this in this way. (HPU staff, Osh 2)

In one session during PRA training a dominant lady came in and said to participants don't believe them (project), they will lie to you. We could change her attitude with nice behaviour and at the end of the session she asked forgiveness and said she will take part in the VHC. I feel that it was our behaviour that caused this change. (HPU staff, Osh 2)

I am teacher (50), I think I can find common understanding with all people. I liked that our trainers were young. But their behaviour was so nice, that I always liked to come here. I always knew that they would always have nice words, that was important for me. In school they ask me where I like it better, I say here, because here I feel easier, free, in good relationships. I never had something like that and it is important for me. (HPU staff, Osh 2)

I am medical statistician, department leader, my opinion was always the most important, I am very outgoing, strong person. After PRA I learned to listen to the opinion of others, that their opinion is also important. My co-workers told me that I changed very much to the better. They even didn't believe it is me - so patient, so respectful: "Before you never listened to us, now you ask us." My daughter (15) told me as well: before you shouted at me. Now she became more like a friend, tells me her secrets. After first PRA session in training I tried it at home with daughter and daughter remarked: Mama, is this you? So patient? So calm? (HPU staff, Osh 2)

Some can tell nice stories, but not all are like that. To me nobody has said that I changed. The norms of PRA are normal human norms, nothing special. Probably I changed a little bit, but not much. It confirmed my view about how to behave with people. (HPU staff, Osh 2)

I am very shy, closed. PRA has helped me to open, to relate to people. (HPU staff, Osh 2)

The last two comments are indicative of an interesting phenomenon that we observed throughout many training sessions with PRA. It is the most dominant personalities that change the most dramatically in the confrontation with PRA, possibly it most starkly confronts them with their own mirror image. But it changes more subtle characters as well, as is testified by Tolkun Jamangulova in this chapter (7.5).

7.2. Discovery with HPU staff

The analysis of the discovery sessions with HPU staff in six regions showed the results presented in table 7-2. These are the themes identified from the one-on-one interviews when stories and key insights from these interviews were shared in plenary. Besides the part asking for best experiences/stories the interview had the following sections: what are your personal values/strengths; what do you value in your work?; what personal changes did you experience through being involved with CAH?; what is the importance of CAH for Kyrgyzstan?; what are the core values of CAH? In order to focus the search on the most likely areas to find appreciative principles I present themes only from three areas: from the stories, from the sections on core values of CAH and from the section on personal changes through involvement in CAH. I brought the themes from all six seminars together. To save space I present in this documentation only those themes that are appreciative principles or at least have an obvious affiliation with them. Numbers behind themes indicate multiple mentioning. The themes in the table give a convincing impression of the breadth of appreciative principles HPU staff experience and live through their involvement with CAH.

Table 7-2: Themes from HPU staff discoveries that are related to appreciative principles

Themes from Stories

Closeness to people, value people's opinion, capacity to listen, trust/belief (2), respect for each other, responsibility (2), able to build relationships, simplicity, honesty, not being shy, gratefulness, able to attract people, humour, pride
Themes from Core values of CAH Belief in people, belief in others (2), ability to build relationships (2), one level with people, partnership, importance of people's opinion, all people equally valued, democratic process, population can solve problems independently, collaboration, humanity (2), partnership, honesty, forgiveness
Themes from Personal changes through CAH Changed dominant behaviours (5), learned to listen to people (2), can better understand people, lost shyness, ability to talk (2), to behave on one level with people, embrace one's errors, building of relationships (2), increased number of acquaintances, being optimistic, won trust of people, restraint, able to solve problems without conflict, learnt to see good side of people and work

7.3. Discovery with trainers

The discovery with trainers in the introductory seminar in January 2009 yielded the themes as grouped in table 7-3. I rendered those bold that have an obvious affiliation with appreciative principles. The numbers indicate points in the scattergram where participants could distribute 5 points each on these themes. One sees that appreciative principles played a great role in trainers' consciousness before the introduction of AI.

Table 7-3: Themes from trainers' and RCHP staff discovery interviews

Readiness for self-improvement	Readiness to improve (oneself) 13 Being self-critical 5 Ready for own growth 2 Growth of one's ideas and knowledge 1	21
Importance of behaviour	Respect others' values 5 Respect for oneself and for others 4 Capability to listen 1 Words can give life 4 Human relationship 3	17
Responsibility	Responsibility 12	12
Determination	Determination 11	11
Competence	Being competent 1 Confidence in one's work, possibilities and strengths 3 Capability to take decisions 5 Confidence 2	11
Believe in people	Believe in people 6	6
Initiative	Initiative	5
Communication	Communication 3	3

In the exercise in which the participants identified where the principles of AI (constructionist, anticipatory, simultaneity, poetic, positive) had been used in CAH

already before the introduction of AI the participants were quick to identify several obvious areas, as given in table 7-4.

Table 7-4: Presence of AI principles in CAH before introduction of AI, results from trainers' seminar

AI principle	Where it was used in CAH before introduction of AI
Constructionist	PRA through asking people's opinion Emphasis on respectful, simple behaviour because it values others
Simultaneity	PRA through observing that people already start to behave differently because we behave differently, they start to think differently because of our questions
Anticipatory	Our believe in people's capacity is the foundation of our work
Positive	Present in many ways, mainly in our believe in people and in the continuous encouragement we provide to VHCs

7.4. Interviews with trainers and HPUs on appreciative principles in CAH in Kyrgyzstan

7.4.1. What are the most important things about CAH for you?

When trainers answered the question *what are the most important things about CAH for you* 16 out of 71 of the answers (or 23%) could be regarded as appreciative principles. They are listed in table 7-5.

Table 7-5: Appreciative principles among "Most important things about CAH for you" (in brackets multiple mentioning), trainers

People defined their priorities (2), Relation with people as equal partners, Using the conversation of AI, PRA, Partnership (3), Self-analysis, self-assessment, Relations between people (4), A person can come to work here and change here a lot, Every person counts, even if quieter than others, Mutual understanding

To give an impression of what else was mentioned as most important things table 7-6 lists a selection of items.

Table 7-6: Selection of other items mentioned as "most important things about CAH for you"

Reorientation of health services to health promotion, Formation of VHCs, Own initiatives, Relation with local self-government, Working on determinants of health, Based on voluntary work, Leadership, Health related information, People taking care of own health, VHC sustainability, VHCs' understanding of their identity as community organisation, HPU network supporting VHCs

When HPU staff answered the question about the “most important things about CAH for you” they came up with 16 out of 146 items (or 11%) that could be regarded as appreciative principles. They are listed in table 7-7.

Table 7-7: Appreciative principles among “Most important things about CAH for you” (in brackets multiple mentioning), HPU staff

VHC members are very friendly, Open and good relations, It teaches to look at different situations from the positive side, Respect, Politeness, Simplicity (2), Non-dominant behaviour (3), Respectful attitude (2), Good attitude and behaviour (4)

The fact that trainers and HPU staff mention appreciative principles in a substantial proportion among the most important things for them about CAH as an answer to an open ended question seems to support the notion that indeed appreciative principles have been present in CAH and that the emphasis on non-dominant respectful behaviour has had its effects in the system. The fact that among the answer of HPU staff is a much lower proportion of appreciative principles than among the answers of trainers can be explained by the fact that trainers are in average much longer involved in CAH and have a deeper understanding of the principles. There is quite a high turn-over among HPU staff.

7.4.2. Why do you think CAH is successful?

To provide a base for this question the questionnaire asked in a previous question to rank the success of CAH on a scale between 1 and 10. Trainers ranked it an average of 7.6, HPU staff an average of 7.5.

When trainers gave reasons for this perceived success they mentioned 17 times appreciative principles (or 23%) out of a total of 66 reasons. HPU staff mentioned 17 times appreciative principles out of 104 reasons (or 16%). Tables 7-8 and 7-9 give the appreciative principles provided.

Table 7-8: Appreciative principles provided by trainers on the question “why was CAH in Kyrgyzstan successful?” (brackets: multiple mentioning)

Democratic principles of working, Working with priorities of people, Relation with people as equal partners, Attitude of HPU staff to VHCs, Participation of population, Respect for one another, Mutual understanding within team (2) , Good communication skills of HPU trainers and specialists, All people can participate Relations (3), Because people work with pleasure and willingness, Because good people attract good people (2), Positive thinking, PRA

Table 7-9 Appreciative principles provided by HPU staff on the question “why was CAH in Kyrgyzstan successful?” (brackets: multiple mentioning)

Patience, The trainers are friendly, Respect and support of HPU and people, Special approach to people, I have learnt how to be more patient, To see positive moments in everything that surrounds you and look for the best stories and memories because nowadays life is difficult, CAH explains the meaning and necessity of working closely with people, Treating others equally, Appreciating others more than yourself, Unity, Friendship (2), HPU/FAP express good attitude, Respectful attitude, our behaviours and values (2), Mutual understanding, VHCs work thanks to good words, We treat people as equals, Because of respectful, non-dominant behaviour

Again, trainers and HPU mention appreciative principles in an open ended question in a substantial proportion as a reason for the success of CAH in Kyrgyzstan, supporting the presence of appreciative principles in CAH. And again we find a lower proportion of appreciative principles among the answer of HPU staff than of trainers, and the reason is the same as discussed above.

7.4.3. Self-assessment of non-dominant, respectful behaviour

After the open ended questions the questionnaire then asked directly about how much emphasis is given in CAH on non-dominant, respectful behaviour (to be answered on a scale between 1 and 10). Trainers gave an average of 9.6, HPU staff an average of 9.4. This indicates a very high awareness of our efforts on this issue.

The assessment on one's own level of non-dominant, respectful behaviour before and after joining the CAH program on a scale between 1 and 10 resulted in an average for trainers of 4.9 before and 8.5 after. For HPU staff the averages were 4.9 and 8.3. These clear differences give another testimony to the transforming experiences about change of behaviour that are captured in many stories throughout this thesis.

7.4.4. Was the emphasis on non-dominant, respectful behaviour important for the success of CAH in Kyrgyzstan?

This last question directly asked for an opinion on the link between non-dominant, respectful behaviour and the success of CAH, to be expressed freely. Two trainers did not provide an answer to this question and 10 HPU staff did not. All of the remaining trainers and HPU staff answered the question in the affirmative and most included reasons for this. In order to provide thick text tables 7-10 and 7-11 provide all answers to this question. I have counted the different reasons given in these answers and found that trainers most often argued that improved relations (7 times) and increased confidence of VHCs (4 times) were the reasons why respectful behaviour contributed to the success of CAH. Among the HPU staff the most common reason given was that respectful behaviour helped them to communicate more easily with VHCs and win them over/attract them to this new endeavor (19 times). This was followed by personal changes (7), improved relations (4), confidence of VHCs (4), and listening/understanding (4). Further reasons mentioned were improved management relations, motivation, appreciation, belief in others, and patience. 20 answers (4 trainers, 16 HPU staff) did not contain a reason. Combined for trainers and HPU staff therefore four reasons stand out: communicate more easily/attract people

(19), improved relations (11), confidence of VHCs (8), and internal changes (8). All, of course, are different aspects of improved relations, and this shows that staff have experienced the importance of relationship for work with communities. This supports a fundamental value underlying the CAH programme and lends credit to their affirmative answer to this question.

Table 7-10: Importance of non-dominant, respectful behaviour for the success of CAH, answers of trainers

Such behaviour preserves relation between independent people
VHCs say: because of it we are more confident, motivated, proud
I think it's the most important thing, because there is dominance in all other bodies. Even in a family, if someone dominates it diminishes the balance, equilibrium and being equal. In such behaviour everyone feels comfortable and tries to discover own abilities and qualities. Also people become more responsible, because they want others to believe they are good, although the former have some disadvantages. Some people with a high self-estimation are selfish and don't understand that they behave as spoiled children
It's easy to talk for people, freely, as partners; we are welcome
Employees and employers have good relations
CAH calls for tenderness and changes
Because VHCs feel themselves confident and independent organisation
Helpful for volunteers of VHCs otherwise they can't work
In terms of non-dominant behaviour people don't feel the barriers between one another. This leads to spiritually close relations, patriotism
People treat one another as equal. Improves relations
In CAH success is not based on shouting and punishing
This behaviour makes you want to stay in VHC
Almost everything depends on the way we behave, on our relations to one another
Yes. I think that respectful behaviour, but not dominance plays a great role. Medical workers and other people used to pay less attention on their behaviour before. I think that the preventive work demands more respectful behaviour
Yes. During last 20 years the associations like VHC have been organized just for the first time. That's why people's vision was very different at the inception. Relations must be in the centre of our activity
Yes, I think that dominating is the first problem you meet, if you want to work in VHC. If you behave in a negative way and show your dominance, no one will listen to you. No one will come to meetings organized by you. If you behave well, people will remember you for a long time. You are treated the way you treat others. While talking to people, you have to express your ideas openly
we think that the key role to success was absence of domination and respectful attitude of people to one another
I think its role is very great

Table 7-11 Importance of non-dominant, respectful behaviour for the success of CAH, answers of HPU staff

Yes, it has a great role, because you can reach many things thanks to respectful behaviour.
Yes, there are great changes. If you have a respectful behaviour, you'll have good relations with people. Relation with VHC

Yes, non-dominance and forgiveness are important for CAH success
You are treated the way you treat people. You are understood the way you understand others. I know how to appreciate people's work and praise it. It leads to success
Respectful behaviour is necessary for CAH success
It has a great meaning. For it let people express their opinion completely
Yes, it was great. If you treat people respectfully it will be beneficial for yourself.
Internal relations are confidential. We know how to listen to others
The role of the respectful behaviour is great. A good word helps to understand one another.
The meaning of the respectful behaviour is great. Relations. Patience. Belief in one another.
I understood that we have to behave respectfully not only in the framework of the CAH, but everywhere and anytime
The role of respectful attitude is great. Patience
Good coordination of working process and communication. Well-organized and coordinated work of project coordinators and RCHP. Special approach to people, CAH workers, VHC. Real plans. Transparency. Cooperation. Good motivation: moral and financial incentive, encouragement and awards
It is very important. Otherwise, people won't work with us
You have to treat others equally. You can't dominate over others people
Yes, it has a great role. There are fewer problems among the workers. Their characters have changed
Yes. Respectful behaviour helps to deal easily with people and leads to good results
Before being involved to CAH I was a dominant. Now I listen others more, I work harder
Of course, it's very important
A non-dominating behaviour is important for CAH success, because now people listen to each other and take decisions together
Yes, because a good word helps to communicate with people easily. They trust us
I apply AI everywhere
Yes, person opens himself and is ready to act if he is treated as an equal interlocutor, if he feels respect to his point of view
The meaning of respectful behaviour is very important. Only this way you can attract people.
I think its role is great. Reasons: now we try to analyze all the problems that were made and to avoid them next time
Purposefulness. Working in team. Knowledge. Unity.
When a person is treated as an equal one, he can express his opinion freely. He feels free
Yes, because the model of relations "equal-to-equal" leads to trust and respect in relations
A good word helps to succeed
Yes. With a good word you can succeed in everything
Yes. Respectful behaviour is really necessary for VHC to stay sustainable. A good word is a magic word
My behaviour has changed, because we have to interest people that don't have any medical education and work as volunteers
The role of respectful attitude was great because now people know more. People know more about each other

In order to work in CAH you have to have a non-dominant behaviour, because we attract people and succeed thanks to our behaviour and attitude to people
You are respected if you respect. Respect both old and young people. A good word helps to succeed
Before I started working here I was a housewife. I didn't know many things. Now I am happy that I can communicate with people and be a volunteer. I love my job very much.
Of course, respectful behaviour demonstrates your attitude to others. I think that the success of our work depends on our non-dominant behaviour. We have to cooperate and be partners. Every one has a right to express his point of view and it must be included into discussion
Respectful behaviour's meaning is very important. Thus we found a common language with VHC; we treated them as good people. I understood that health is very important for every one. They managed to carry out RHC meetings on their own.
Yes, because I deal with many people at the seminars, meetings. When you express respectful attitude to people, they listen to you and treat you well
Yes, the role of the respectful behaviour was great. I could easily find a common language with people. We communicate much better
Yes, I agree that "respectful behaviour" played a great role. I know how to find a common language with people. We witness progress in our activity
Yes. I saw that the work is not done when we are quarrelling because VHC members are working for free. The committees are sustainable thanks to respectful behaviour of people. People are expressing own initiative, asking "When will we have another campaign?"
Of course, CAH success is provided by non-dominating, respectful behaviour. When a person behaves in a good way, the person next to him can express own ideas freely. If our behaviour will be as a sample of "a teacher and a schoolchild", we won't reach success.
If a person I don't like is asking me some question, I'll help him with the smile on my face. And his interest to work will rise even more. If I fail to do this, then the person will accept it negatively and won't continue working as a volunteer
I think that the key feature of CAH success is non-dominating respectful behaviour. You can make people listen to you and follow your advice only this way
It seemed that my dominating behaviour was diminishing my role in a VHC. Thanks to respectful behaviour VHC members contribute to society with their initiative
Non-dominating behaviour led to CAH success, we don't treat one another as teacher and schoolchild. I became friends with VHC members thanks to respectful attitude
I think that non-dominant behaviour is one of the reasons of CAH success. Only with the help of a good word and friendly attitude we can work with people.
You are treated the way you treat others. After the AI trainings people started seeing positive things. It leads to mutual understanding, good relations and respect to one another. It got people's belief
No one says "No". Equality
Yes, respectful behaviour is important for CAH success. Working with different classes of society demands patience. You have to listen to people's opinion
I think that great changes took place in my private life. My relations with people have changed. I love my job. I've met many new people. I've seen many things. I've understood many things
Yes, the role of respectful behaviour was great

I think that its role is great. Working with people demands respectful behaviour
No one says “No”. Working, respectful relations among each other and diligence lead to success. VHC is an independent organization
Yes, close cooperation with people
CAH success is in non-dominant and equal relations; in respectful behaviour of people

7.5. Guest contributions

I split the essays of the colleagues whom I had asked to reflect on the two main investigations of this thesis. In this chapter I copy their thoughts on the role of non-dominant, respectful behaviour in CAH; in chapter 8 I will produce their thoughts on the role of AI in CAH.

Shaken Janykeeva

Shaken was a pioneer of CAH. She was among the three first trainers that formed the first VHCs in 2001 and helped developed the model of CAH. On my request to reflect on the role of non-dominant, respectful behaviour in CAH and on the role of AI in CAH she submitted a short essay. Here I copy the part that answers the first question (role of behaviour in CAH). The part of the essay answering the second question (role of AI in CAH) is copied in chapter 8.

The role of non-dominant and respectful behavior in CAH is very important.

As medical workers (personally during 24 years of working) we used to do a lot of health education work. For example:

- carrying out meetings, delivering lectures for different institutions, organizations, for people;
- dictations written by schoolchildren;
- visiting people’s houses in order to give information about preventing different diseases;

80% of the work done was formal. Medical workers didn’t manage to cope with the work. We saw no real results and impact. We used to treat people as if we were their teachers. We were arrogant. We had no time to listen to their opinions. Our lectures were boring and monotonous. People weren’t interested in what we were doing at all. People were paying little attention to their own health, thinking that it depends on medical workers; that others must take care of their health.

New working principles were introduced with the Swiss project that started in 2001. PRA trainings were carried out and Village Health Committees formed. Non-dominant and respectful behaviour plays a great role in PRA principles of CAH. We have learnt more about the significance of non-dominant and respectful behavior and apply them in practice. Now I want to highlight the importance of respectful behavior. They are as following:

- respecting people;
- being simple, merciful, truthful and impartial (objective) to people;

- treating others as equal ones;
- not showing off, being patient;
- being strong but well-mannered at the same time;
- listening to others with real interest;
- let others speak without interrupting or correcting them;
- respecting others points of view, supporting others;
- asking people for help if you don't know anything;
- no suppression, blaming;
- no imposing own ideas, just showing directions;
- being a partner;
- let others manage;
- helping them to feel necessary and significant;
- realizing own drawbacks and disadvantages;

The role of non-dominant and respectful behavior is great in CAH. After FGP/FAP workers received PRA trainings, they collected groups of 10-14 people and started applying their skills. Because of the respectful behaviour people feel free in these groups, they can express own ideas freely, and they listen to one another, give and take advice and after discussions come to one solution. They define the factors and problems influencing health and define those that are to be solved immediately. When discussing criteria for choosing people for the VHCs it seemed they were taking the behaviour of FGP/FAP and HPU workers as examples, as they mostly included respecting people, and ability to listen to others, besides being reliable, working for people, being truthful, objective, patriot, responsible, active and smart.

Story...

2003, Jungal region, Dyikan village. A medical worker remembers: "We have chosen one house and invited people to the meeting. We were asking them to spend 1,5 hours to talk about health issues. But they found many excuses not to come like "I have no time", "I have to leave", "My children will cry", "I have much housework" and so on. What's more interesting, some replied: "I don't care. You have to ask our medical workers. They have to know". But we managed to carry out the meeting thanks to our non-dominant and respectful behavior. We have applied PRA principles. We succeeded, women even forgot about time. The meeting took 2 hours while we could discuss many things. Women got so interested that they didn't want to leave, striving to start working as soon as possible."

We, trainers, HPU, FGP/FAP workers understood the necessity and significance of non-dominant and respectful behaviour, and people's attention to their health has changed. They understood that they can solve all the problems affecting their health negatively if they come together.

We are respected by people. We are equal, we are partners. We've learnt many new things, we realize our drawbacks and try to correct and change them. We know people's problems and help them. We support them, accept their points of view. If we make mistakes, we admit it. Friendship, belief. People are open, they ask for advice, share own secrets. We have reached success both in families and work. Former HPU workers became trainers (Ryspek, Venera, Fatima).

Stories...

Tonia Toktonazarova - HPU worker, Jungal region.

"I understood the significance of respectful behavior. There's an ease, respect in my work. I became closer to ordinary people; I understand the way they live. I was touched by interest of VHC members, they devote themselves for people. I found out that there are many patriots taking care of people's lives. During the meetings we talk, exchange our opinions, I feel free. I was glad to see VHC members' openness. No matter whether you are old or young, man or woman, you are respected. You feel comfortable and it helps VHC to succeed."

Meerim Bekchoro kyzy, School Parliament, Kok Jar village, Naryn region. (VHC gazeta February 2007)

"VHC members started carrying out the explanatory work at a higher level. Despite working as volunteers their interest is becoming even stronger. 7-8 students from our School Parliament started working with VHC.

I started working with them when I was an 8th grade student. Now I am a 10th grade student. The number of schoolchildren that wants to join us is big. We like the way HPU members behave, speak, teach, their respectful and merciful attitude to people very much. They always want to know our opinions, thank us for all the work done and express their contentment. We can express our points of view freely without hesitating. That's why VHC work is very interesting, useful and clear for us. VHC members are very interested in their work. I believe that VHC can become sustainable and independent organization. It's our aim to continue the work done by VHC."

Jiide Mambetova - FAP worker (paramedic), Ak-Moiun village, At-Bashy region. (VHC gazeta, September 2007)

"In 2004 there was one week PRA training carried out in Family Medicine Center by the Swiss Red Cross trainers and HPU workers. It concerned non-dominant and respectful behavior mostly, because we are doctors and we think we are better than others. After the trainings we started working with people. I felt some changes that took place in my life. Despite I have been working with people for a long time, I couldn't understand them fully. I felt that I wasn't able to explain everything well enough. With the help of the PRA method my behavior has changed. I feel free, I talk to people in a respectful way; I can find a common language with people easily. I listen to people. If there's anything I don't know, I'll ask for help. I appreciate people's opinions. I think I became much closer to people. I know that they respect me. I had to speak before a huge number of people at the meeting. It was my first experience of such a performance. I think I could explain people what I meant."

Non-dominant and respectful behavior helps to succeed. "You are treated the way, you treat people".

Non-dominant and respectful behavior are key factors that lead to founding of VHCs, increase of VHC membership, ever-growing interest of VHC members, gaining people's support, giving people the information, being well-known by Regional Administration Bodies and defining the problems. This is a great achievement for CAH. They are looking for the factors that might effect people's health and try to solve the problems. For example, "Village cleanliness", "The best house", "The best street", "Green village" campaigns, gyms, baths were repaired, drinking water was provided and so on.

Thanks to respectful behavior the relations between VHC and RHC, between VHC and HPU workers have changed for the better. There is friendship, mutual respect, cooperation, mutual support and success as a result.

Experience exchange, friendship, sustainability, striving to solve health problems, giving people information about health, people's interest, increase of VHC membership, communicating with state bodies (through written statements, letters, notices etc.) are vivid examples of the significance of non-dominant and respectful behavior promoted by CAH.

Iskender Mirzaahmedov

Iskender was a trainer of the CAH program from 2006 to 2010. In our last meeting he started to reflect by himself on what he had learned from the program in terms of behaviour and I asked him to write it down for my thesis which he agreed to do.

When I was working as a stomatologist, people used to turn to me only with health problems. They used to come to me. I knew a little about people, about their lives, problems and the way they solve these problems. Probably, the majority of doctors do the same as I do. When a patient comes, a doctor writes down a prescription and medicates a person. I would stay such a doctor if there was no Swiss Red Cross and the CAH project. Now we visit people. In the inception it was quite difficult to wear form own habits and system. The core was in different approach, attitude to people. Before everything was clear: you are a doctor or FGP/FAP manager. You get instructions then you send it forward; then you just demand and control the work. It was a system. It was difficult to change the system, yourself (your attitude, behaviour, decisions etc.).

I used to think that my opinion is the most important. Others must just follow me and agree with me. I didn't take into account others' points of view. This used to happen even in my family.

But when I started to work in the project people working in the project became examples for me. Because they don't demand strictly results, they never say you to do something, they just prompt and then let people work at their own discretion. If there is a problem, we gather and discuss it trying to make a correct decision. Everyone's opinion is taken into account, even those that are not quite correct. We've learnt to deal with each other as equal ones, we are sincere, and we try to understand others' problems and help to find solutions together. We give people the opportunity to think, to look for answers, because they know situation and conditions of an area better. Thanks to the project, I've learnt to see advantages of a person, his values that are not always seen to others. I give a few examples.

In 2008 the VHC Chairperson of the Tamasha village declined to work and all the members lost interest in working. Zamira was elected as a new Chairperson. She is very energetic, sociable and has good organizational skills. She hesitated. After the RHC meeting I told her: "Your VHC became weak. We must raise its level. Our last hope is you. Because you are energetic and sociable, you have good organizational skills. You'll manage to do this." After a month the number of VHC members rose, the

campaigns were carried out by own strength. Every meeting she used to share her ideas, proposals and experience.

Gulduromo Urinsa, the VHC Chairperson, used to check one old man's blood pressure. He had a hypertension. She used to support him saying him good words. One day that old man asked about her job. She explained that she was a volunteer and working for the good of society. Then he replied that his daughter didn't work. He wanted his daughter to join VHC.

Akturpak area is the most remote one. The medical workers from the region visit it rarely. After a VHC was founded the HPU members started visiting it twice a month for conducting seminars for locals (elderly people, schoolchildren and local self-government members). A great work has been done. As the result great changes took place in those people's lives. Cleanouts of channels and streets, road repayments are carried out frequently.

The Chairperson of the Kyrgyzkyshtak VHC Kamalova Mukadas said: "While working in a VHC we've changed. While talking to people we try to find something good in them. And we say about their advantages. We always ask whether they need any help. We praise a person, even if he has done just some part of work. If there are any problems, we try to solve them ourselves. We don't wait until someone will help us. This happens not only at work, but at home too. All this we have understood during the seminars. Our trainers, HPU members were examples for us."

Altynai, manager of HPU in a region, always used to fulfill the instructions and got used to it. It was difficult for her to take decisions on her own, especially about the reports. That's why we had some problems with her. But she has good organizational skills. Once I asked her to sit with me and help to fill the reports because she was responsible for it. When there were any uncertainties in reports I asked her opinion. Thus we have good relations. Now she became more confident. She tries to solve problems independently and succeeds in this.

During the PRA sessions I also invited people in my house and conducted a session there. I was surprised that my daughter Zulaika and sons know much about problems and diseases in villages. Then I understood how little I knew about my family members. Because I was interested, I rarely talked with them. I was closed for them. I rarely conversed in an open and frank manner with them. Now while taking any decision we come together, discuss it, ask for everyone's opinion. We even listen to the youngest one and just then take a final decision. When I want them something to do, I never speak in the form of an order; instead I say "would you mind doing this..." It gives a person confidence. He feels that his opinion is important and he is respected. Even if the work isn't done till the end, I try praise a person. All these skills I try to apply in communicating with my relatives, friends etc. To tell the truth I don't always manage to do it. All these skills I gained thanks to my work in the project, experience of working with people is becoming a part of my everyday life and is forwarded to others. This way of working with people is forwarded in the project to trainers, HPU members, VHC members and all the residents. This is happening because our work, principles and methods fit people's needs. We always have problems, but now people are learning how to solve them on their own. People realize that all the health problems can be solved if we come together. Our health is in our hands.

Tolkun Jamangulova

Tolkun is presently the deputy director of the project (Community Action for Health Project). She was, like Shaken, a pioneer of CAH, one of the three first trainers that formed the first VHCs in 2001 and helped to develop the model of CAH. On my request she submitted her thoughts on the role of non-dominant behaviour in CAH, which I copy here, and on AI in CAH, which I copy in chapter 8.

What does non-dominant behavior in CAH mean?

I've been working in the project where everything is based on the principle of non-dominant behavior for 10 years. When I faced a dominant behavior for the first time, I understood that unintentionally I was using it at my work. During one of the seminars for medical workers that took place in Kazakhstan, the organizers were displaying a dominant attitude to others as if saying "We came from the capital... and who are you?" Only then I understood the role of non-dominant behavior. I remembered that I myself had behaved like that after graduation and felt ashamed. I am grateful to Tobias, because he taught me to treat everyone as an equal person.

Non-dominant behavior is a central and basic element of our work. Since we implemented CAH we are working on this theme with all those who are to work in CAH. Non-dominant behavior was the basic element of our first training on PRA for the HPU staff. Further they were to teach FGP/FAP staff and work closely with VHCs. The majority of the training's participants found it difficult to understand and accept that such a behavior is possible and effective, especially with village residents they had to work with. To the participants' surprise, after the first PRA session they understood that non-dominant behavior helps to create reliable, friendly relations. People were taking an active part in discussions expressing great enthusiasm.

In my opinion, the best way to make a person aware of his behavior is to reflect it to himself from aside. I have never used such a method before. The one that impressed me so much is taking a video of a person while facilitating the PRA session. Later you show this video to all the participants and the person can look at himself from aside, especially the way he treats other people. A person starts analyzing himself and all others start thinking about themselves. I went myself through this process. I started thinking about everything in detail, what was very good, what I was proud of, and about the things to be changed for the next time. And really, it works after 2 or 3 times of such a feedback video. A person tries to change own behavior and attitude to everything.

After the PRA training, FGP/FAP staff leave for own villages and start carrying out the PRA sessions with HPU staff and project trainer observing them. It is a very important step, because this is the very beginning for creating VHCs. People lost faith after the collapse of the Soviet Union. They found it difficult to believe that local doctors or nurses would begin such a work, that people would be asked for their opinions and problems and treated as equal ones.

In the course of this work the changes in HPU and FGP/FAP staff were becoming more and more apparent. They believed in people and started treating them respectfully. "People know everything; we thought that the health problems were known just for us, medical workers", were typical comments. Of course, not all the medical workers have undergone such changes. In treating others as equal ones, the great role belongs to your feelings and sincerity. While these qualities are born with a person; one can gain these qualities, but one has to work very hard and feel it. Falseness is always noticeable and it pushes people away from you.

One HPU staff has been working in the program for 2 years before having to leave. She said that she wouldn't turn back to her previous place of work in the health care system because after working in such an atmosphere she couldn't turn back there.

The main effect of non-dominant behavior is a respectful attitude. It provides everybody with a feeling of self-confidence, it raises your interest to work, you start working with a great pleasure etc. In other healthcare systems doctors feel themselves more important than nurses, just because they have a higher medical education. This is not so among HPU staff where the relations between doctors and nurses are equal.

I think that our project has succeeded and gained support of people mainly thanks to such behaviour and attitude to one another.

Rahat Aidaraliev

Rahat is presently the coordinator of the CAH programme in the Community Action for Health Project. Prior to this post he has been a trainer in CAH programme for 3 years. On my request he submitted his thoughts on the role of non-dominant behaviour in CAH, which I copy here, and on AI in CAH, which I copy in chapter 8.

The role of non-dominant behavior in CAH

I'd like to speak about this through the prism of my personal feelings and experiences. I can say that before joining the project I was a typical representative of a worker in the medical sphere with traditional views of a person wearing a doctor's coat. I mean that I had a feeling of superiority, of patronage over the "ordinary mortals" that were my patients. I was trying to display to them that I was better than they; that my advice should be accepted as the only truth. I felt indignation when somebody doubted my words. But not everybody followed my instructions. Even in the department I was managing, the staff wasn't accepting all the methods I wanted to implement. I couldn't understand why, because although I explained them everything in detail they couldn't manage to do it. And I wasn't expecting any initiative from them. I thought that a strict hierarchy must be kept and that everyone had to know their duties. No democracy.

But after I started working in the project my thoughts and views have undergone great changes. At the beginning though I looked at everything with scepticism. I remember the first seminar when we were told that in working with communities only 20% of success depends on the tools and instruments we use, while 80% depends

on our behaviour. My internal reaction was not quite positive. I thought these were just empty words, just bla bla bla. How could it be: we are going to work with people on the health issues and our behaviour turns out to be the most significant theme of our trainings?! But in course of working in the project I understood that the relations are the very corner stone of CAH.

All our efforts for creating VHCs, promoting health issues would be nothing if we had failed to create good relations between us. The harmonious work of the chains of RCHP, HPU, FGP/FAP, VHCs, project members depends on the relation among the chain links. For example, in order to get a real picture whether the model works or not, or whether there are problems to be solved we need to get real reports (something we always had problems with in our country, where people write reports with figures invented from nowhere etc.). Thus creating relations based on mutual trust, respect without any fear would solve this important problem.

Or let's take the example of implementing CAH in Batken oblast. There we faced the problem that anyone from the centre (from Bishkek) is treated as a chief, a higher rank person. You can't contradict him or tell him bad news. Our trainers working there told us that it is normal and that a manager should support and even cultivate such an attitude toward himself. They said that if you base your relations on the principles of non-dominant behaviour, it won't work with HPU staff or VHCs. I was told not once that I don't behave like a representative that comes from the capital. I was told that if I let them treat me equally they would just become impudent, especially HPU staff. But it wasn't so. The principle that 80% depends on behaviour worked there too. Nowadays Batken VHCs are among the best ones. HPU staff have so much initiative, that sometimes I can't catch up with them.

In my opinion, the common standard of interrelations among medical workers and common rank people, chiefs and workers accepted in our society was broken in CAH. While coming to a meeting with a VHC, you feel that you are expected to behave in the accepted manner, i.e. in a dominant way; but when you start speaking with them as with equal ones, when you ask their advice you see their feeling in their eyes. It is as if they would say "How can I fail to do something, when I am treated in such a way, when I am sitting at one table with them. I can't fail to fulfil the expectations!" And again I see that the 80% principle works; that the main reason of CAH success is in an absolutely different principle of conduct.

While training medical workers on PRA I've heard from them ask: "What information are you giving us? These things (on behaviour) are so obvious. Do you have anything more serious?" because the first days we spend our trainings on behaviour issues. They were skeptical about involving community members into the health promotion activities. They were joking: "Sure, we'll start using the principles you are implementing and all the local residents will leave everything and come to us". However, when we went to meetings with locals within the practical part of the training, the medical workers were amazed and surprised. People behaved very differently from what they had expected. As medical workers have admitted, they were afraid that people would abuse them, accusing them for example of stealing the medicine sent within

humanitarian aid programs. Instead they were thanked for coming and talking to them. They said that this kind of meeting was new for people, when doctors were coming and talking to people in such a manner, moreover asking for opinions. Of course, not everything went well. Many medical workers admitted that these principles seem simple, but sometimes they found it difficult to follow them. It turned out to be much more difficult than it was expected. When you do it just mechanically, it doesn't work. Everything must come from your heart, you must be sincere. Only thus you become reliable and then these "simple" principles wonderfully start working.

At last I want to recollect my recent business trip to the Batken oblast. There I've met my former colleague that used to work as a trainer from our project in Kadamjai rayon, Batken oblast. While we were talking, he told me that the experience he gained through working in CAH helps him a lot. When I told him that actually he hadn't received any specific knowledge in CAH, he replied: "The experience of interpersonal communication was the best knowledge I have received during working in the project".

Chapter 8: Appreciative Inquiry in CAH in Kyrgyzstan

This chapter will describe the introduction of appreciative inquiry into CAH in Kyrgyzstan and the lessons learnt and effects we could see from that. I will explain the introduction of AI in CAH chronologically and with each step present the related evidence from my sessions with HPU staff, from the HPU forum and from the analysis of the discovery themes of VHCs. The findings from the open interviews, the own initiatives, and generation of new ideas I will present separately. At the end of the chapter I will offer again three guest contributions on this question. I begin with a short overview of appreciative inquiry.

Outline of chapter 8

- 8.1. Appreciative Inquiry*
- 8.2. Introduction of AI in CAH*
 - 8.2.1. Introduction of story telling
 - 8.2.2. Discovery seminars with VHCs
 - 8.2.3. Dream/Design (Strategic Planning) seminars
 - 8.2.4. VHC National Forum (AI Summit)
 - 8.2.5. Introducing informal use of AI
- 8.3. Open Interviews with trainers/oblast HPU staff*
- 8.4. Monitoring the number of own initiatives of VHCs*
- 8.5. Generation of new ideas from below*
- 8.6. Guest contributions*

8.1. Appreciative Inquiry

This short overview does certainly not capture the many different views and varieties of AI that exist and are practiced today. As van der Haar and Hosking (2004) point out there are many definitions of AI in the literature and that what AI 'is' must be answered according to each case. This is very much the case for AI in CAH. It does not follow much standard procedures. Van den Haar and Hosking point to the "thought style" of the narrator as a key identifying feature. As reflected upon in the methodology chapter, although the data producing processes that I used to try to document the effects of AI on CAH were highly participative there is no way around me being their narrator for this text and to a large extent their summariser. To counterpoint that I juxtapose my narration with direct quotations wherever feasible and helpful in order to bring in a multi-voice tone into the text. Again, this is further enhanced by the short independent essays by colleagues, as in chapter 7.

This short overview of appreciative inquiry (AI) follows Watkin's and Mohr's book (2001) and Watkin's AI Workshop Resource Book (2008). AI began as a positive approach to organisation change in the 1980ies. David Cooperrider developed its foundations in his PhD work at Case Western University under Suresh Srivastva. In the meantime it has developed into other areas beyond organisation change such as education, research, therapy and developmental work. Ludema et. al. (2003:9) define AI in the following straightforward way: "At its core, appreciative inquiry is the study and exploration of what gives life to human systems when they function at their best. It is based on the assumption that every living system has a hidden and underutilized

core of strengths – its positive core – which, when revealed and tapped, provides a sustainable source of positive energy for both personal and organisational transformation.”

AI is based on social constructionist thought as it assumes that the meaning of a system is co-created through the discourse of its participants. This constructionist principle is the first of the five principles of AI. This gives rise to the possibility to change systems, and AI posits that systems tend to follow our imagination: that is the anticipatory principle of AI, often illustrated by the Pygmalion effect. AI further says that this change starts with the first contact with the system, with the first question: the inquiry into a system itself already changes it, which is why AI calls the first question fateful as it may determine the direction of change according to the anticipatory principle. This simultaneity of inquiry and change is aptly called the simultaneity principle. The inquiry happens typically with the help of stories about best experiences as it is believed that these contain the hidden positive core, the life giving forces that one is looking for. The reason AI treasures stories is that they transport not only facts but also emotions, a holistic experience that is, and are therefore well suited to mobilise energy. “AI is a treasure hunt for energy” is a bonmot that can be heard often in AI seminars, and it is true. The source of energy is on the one hand the What of what is being discovered, positive experiences, but on the other the How, that is the stories. This valuing of stories is called the poetic principle of AI. Lastly, overarching all is the positive principle, the principle to seek the positive, the choice, so to speak, that guides the anticipatory principle towards the positive image instead of the negative.

AI is typically applied in five phases, the so-called 5-D cycle, shortly outlined in the following table 8-1

Table 8-1: 5-D cycle of AI

Definition	Define what to inquire into, the issue, and outline the process
Discovery	conduct the inquiry and identify the key ideas. This is typically done with one-on-one interviews using a so-called generic interview protocol. It consists in general about a section of story telling about best experiences regarding the topic under investigation, then a section about personal and organisational values, and lastly a question on wishes, where negatives can be formulated as positive images of the future. From these interviews then themes are identified in group work that are the life-giving forces
Dreaming	Based on the life-giving forces a vision for the future is developed. The strength of that vision is said to be that it is based on experiences as expressed in the stories and therefore grounded in reality
Design	The vision is broken down into strategic fields of activity and responsibilities are assigned
Delivery/ Destiny	The design is implemented, less in the sense of following a rigid plan than in the sense of a continuous process of decentral innovation and inquiries according to the design outlines

8.2. Introduction of AI in CAH

8.2.1. Introduction of story telling

We began the introduction of AI into CAH in autumn 2008 with several months of exploration (October 2008 – January 2009) during which ideas took shape, the first of which was the introduction of story telling in meetings. HPU staff have regular monthly meetings and the first thing we did was to join such meetings and experiment with asking the staff for good stories. The purpose was to learn to ask questions for good stories, to hear what kind of stories were being told, and to develop ideas of what could be done with these stories.

In these sessions we learnt that some staff needed to learn the difference between report and story. It was new to them that we wanted to hear the story beyond the mere summary of facts, especially if asked to tell stories in plenary. We needed to learn how to ask so that not only big stories are expected but small ones are felt acceptable as well.

When we asked after these sessions of story telling “How do you feel now?”, the reactions were always similar: they said they felt lighter, happy, energised, ready to work further, etc. “Because we feel with people, their own success”, “We feel closer to each other”, were typical quotes after such sessions.

An idea came up: We suggested to staff to start each meeting with story telling: We suggested to just ask if anybody has a good story, if not, not, but if yes, allow time for it. The first justification for this was this increased energy level that we had noted and that would hopefully spill over into the business-of-the-day session.

At one point the idea came up to analyse the stories according to the questions *What does it tell us about the ideal VHC?* or *What does it tell us about the ideal HPU staff?* For a time it was tried to identify a specific learning from each story and note it in a folder with the idea of generating and renewing over time the image of ideal VHCs and HPU staff out of their own experience. But later this procedure was dropped again as too formalistic and bureaucratic. Instead, we trusted that learning would take place simply through sharing the stories, telling and listening. In other words, we trusted the power of images of ideal VHCs and HPUs that would form through these stories in the minds of the HPU staff even if these images were not captured in words and concepts. This then became the second justification for story telling in each meeting.

Another idea came up: write down and collect the best stories and we will publish them periodically for CAH stakeholders, especially all VHCs. In this way story telling would serve as a way of sharing across all of CAH.

One last idea came up: filter all stories for new ideas that can enrich and improve CAH overall. Share and discuss these new ideas with HPU staff in your region. When they approve a new idea then it is being recommended for extending in the whole region and it is being made known to all regions for discussion. This is meant as a process of generating and capturing innovation from below.

At the end of this exploratory stage and learning process (October 2008-February 2009) in which we introduced story telling for HPU staff meetings we had understood three reasons why it seemed a good idea to do so. First, because it would raise the energy level and the emotional bonding among each other, renewing motivation for the following working session and for their work in general; second, the stories renew continuously the image of an ideal VHC and an ideal HPU staff, adjusting the inner compass of self-improvement – in AI language probably: we were counting on the anticipatory and heliotropic principles; and third, the story telling could be a way of capturing innovations for the good of all of CAH.

An early feed-back on the effect of these informal sessions with HPUs on AI I received from Tolkunai, a trainer in Batken oblast, in February 2009, just a few months after we started these sessions (there had been two sessions with HPU staff in Batken).

From my AI diary: Over dinner Tolkunai told me that she had noticed some marked changes since beginning of AI. She said that before HPU staff had typically asked VHCs about problems when meeting them and then trying, often in vain, to solve them, leaving frustrated. HPU meetings were full of such problems being discussed. Now it is much easier. Their relationship with VHCs has changed. They first ask for the positive. This changes the atmosphere, takes away the pressure from the VHCs, HPU staff now look forward to meetings with VHCs. Now HPU staff also don't push to finish their staff meeting soon, don't look at their watches constantly, their relationship among each other has become closer, stronger.

In the HPU forum HPU staff discussed the question what the effect of telling good stories at the beginning of each HPU meeting was. In table 8-2 I summarised the results of the working groups. They confirm the evidence collected in my AI diary from talks with HPU staff that story sharing in the meetings were indeed broadly beneficial.

Table 8-2: The effect of story sharing in HPU meetings, HPU forum results

- | |
|---|
| <ul style="list-style-type: none"> - Ideas and initiative appeared, our interest to work rose - We started working in a positive way, an inquisitive desire appeared - We have learnt how to deal with one another, we became more patient - Exchange of experience, learning from the best stories, getting energy, we have more strength, there is also an element of competition |
|---|

Early on we had experimented also with asking for good stories in the monthly RHC meetings. The reaction was very positive. RHCs liked it so much that many proposed themselves to do it in every meeting. Ever since this has been a fixed feature of every monthly RHC meeting all over CAH. This story telling has been an immensely useful feature, as numerous encounters with VHCs and HPU staff have testified. It changed the atmosphere of the meetings from a place of whining about problems into a place of celebrating small and big progresses and small and big human qualities. The issues of the day are dealt with in a more creative, energetic, positive spirit. There is more of a spirit of unity. And last not least, ideas are shared on a regular basis and in the most accessible way, free for everybody to imitate, and creating the wish to imitate or even

do better! This contributed to the tremendous increase of the amount of own initiatives that will be discussed further down. The stories in these RHC meetings are one of the source of the stories that HPU staff recount in their monthly meeting to one another.

AI diary 9th December 2008: After a reflection on the first 2 months of exploration with AI Tolkun (deputy Team Leader of CAH project) says “This is a totally new philosophy for me”. I say, “For me, too, there is much new – and yet, much we already practiced. I believe that our focus on respectful attitude and behaviour and even more our belief in the capabilities of people triggered the self-confidence in people (we can do it!) in a similar way (non-verbally) as asking for good stories. The attitude is the same, an attitude that instils hope and confidence. I believe that is the secret of the success of CAH.” Tolkun: “Stories help to remember and to explain the essence of our work and of CAH...It will be a second bomb! – CAH was the first bomb, and introduction of AI in CAH will be the second bomb.”(referring the effect of astonishment that the VHCs have brought about in the health sector in Kyrgyzstan)

8.2.2. Discovery seminars with VHCs

During the exploratory phase we did an introductory seminar with about 25 leading staff of the CAH programme. They experienced the discovery phase through story telling and identification of their life giving forces and we discussed the principles of AI. The staff was convinced that the approach would work with VHCs and that it held great promise for the CAH programme. As one participant put it: “I understood that to make CAH sustainable we need not only guidelines, rules, orders, agreements in place but also an inner source of energy that VHCs and staff can tap into.”

During the exploratory phase I struggled with the question how to introduce the 5-D-cycle of AI at the VHCs. The design of the facilitation module had to be easy enough in order to be replicable by over 100 HPU staff in sufficient quality with over 1100 VHCs without giving up on the principles of AI discovery and the other phases. An additional difficulty was time. VHCs can't meet much longer than 2 hours, then members get restive, household chores wait, etc. In the end I decided to split the cycle into two parts, discovery and dream/design. The first we called the discovery seminar, the second the strategic planning seminar. I designed a facilitation module, we tested it first with one HPU group, then with two VHCs. The generic interview questionnaire is given in the annex to this chapter. It contains a first question on best experiences while working in the VHC, then several questions on values, personal and VHC related, and a last question on wishes for the future of the VHC.

We then trained HPU staff to facilitate these seminars. These trainings served at the same time as the discovery seminars for HPU staff with generic interviews and identification of their own life giving forces. I reported on the results of these discoveries of HPU staff in chapter 7. In February and March 2009 then HPU staff facilitated the discovery seminars for over 1100 VHCs in 6 regions (Naryn, Talas, Chui West, Issyk-kul, Batken, Jalalabat 1). In spring 2009 I had meetings with HPU

staff and could ask them about the first results of these sessions. According to my AI diary these can be summarised as follows.

- Many VHCs looked with astonishment at the amount of work they have already done. They felt happy remembering good things. They said it is important to remember how much they had done and achieved. This was mentioned in all HPU meetings. (Remembering achievements was not an explicit part of the seminar but probably came automatically with telling stories about VHCs activities). This remembering led to the realisation that VHCs are an important factor in their villages. VHCs realised why people come to them for advise, with questions: because they have earned their trust. So also in a literal sense the VHCs did discover something in these seminars.
- There is a new energy in most VHCs
- Almost all VHCs recognised the importance of responsibility as a life giving force
 - Many VHCs were waiting on time at the next meeting who before had to be collected (HPU staff suspected an effect of the reflection on the theme of “responsibility”).
 - Many weaker VHCs started to become more active, in various ways, looking for new members, putting their documents in order, create new ideas to improve health actions, etc. Some VHCs already began to do new own initiatives.
- In one oblast, where VHCs had always talked about getting paid for their work, this kind of talk stopped after the discovery workshop.
- Many VHCs said that they had had no words for why they were working but that the life-giving forces gave them these words and that they felt happy about that. As one VHC said that everybody always had asked them why they worked without payment and now they knew what to answer.

2 weeks after a discovery seminar one HPU staff member met the chairperson of a VHC who told her that during the seminar her mind was somewhere else, she didn't understand anything. In the evening she looked through her notes and suddenly she got it, and understood how important this was. She called another meeting and repeated the seminar by herself. (HPU staff Batken)

All the changes so immediately after the discovery seminars of course can be taken as a confirmation of the simultaneity principle of AI: the inquiry itself already starts to reconstruct the reality.

Because HPU staff and trainers mentioned so often that VHCs were enthused and energised in the discovery phase among others by the fact that through the themes identified from their interviews – the life giving forces - for the first time they were able to express in words what they had felt all along why they were doing what they were doing I decided to analyse the themes in order to see what words the VHCs had come up with that captured their motivations. It would – as a side effect – also help answer the question that many a visitor has asked me and them – why are they (you) doing it (so much work free of charge?) What drives them (you)?

I repeat shortly the method of analysis. I initially scanned the words of several rayons. This made five word fields come apparent, one around an altruistic attitude, one around a sense of being active and the joy of that, one around self interest, one around

connectedness and relationships, and one around human qualities that again most closely resemble appreciative principles. I proceeded to assign all themes of the stories and of the question *What do you like about being with the VHC?* to one of these five groups, using a sixth group to collect all that did not fit in one of the five. The sorting and counting was done in excel files. I had data from 356 VHCs of 12 rayons to analyse in this way. Table 8-3 shows the results. It also shows the most often occurring words in the five groups and contains therefore the answer to the question which words – which Life Giving Forces - so enthused and motivated VHC members in the discovery sessions – and by the way to the question why VHC members do what they do. The results do coincide with observations in the field. VHC members typically use words from these word fields when answering the question why they do what they do.

The phenomenon that finding these words had such an effect on VHCs begs an explanation that social constructionism may provide. It can easily describe what happened as dialogical, relational process (the one-on-one interviews) through which meaning was co-created (the themes, life-giving forces). This created a new reality for VHC members: a new *shared* identity as who they were and especially why they were it. The discovery that they all shared these feelings, these meanings, this reality, that they had unexpressed felt inside, presumably contributed considerably to the exhilaration of the moment. But it was not a fleeting moment. A new reality had been constructed on which to build future.

Table 8-3: Life Given Forces of VHCs: Themes from Discovery of 356 VHCs

Most common themes in the 5 word groups identified in the stories and under the question <i>What do you like about being in the VHC?</i>	Frequency of occurrence in 356 VHCs (%)
1 Altruism patriotism, responsibility, sharing information, take care of people's health	1120 (33%)
2 Sense/joy of being active active, interest in work, striving forward, diligent	486 (14%)
3 Self interest learning something new, recognition, fulfilment, gratitude, pride, increased authority	756 (22%)
4 Connectedness/relationship work with people, close relationship with people, friendship, exchange of experience, find common language, cooperate with other organisations	439 (13%)
5 Appreciative principles patience, tolerance, respect, trust, simplicity, forgiveness	185 (5%)
6 Others	409 (12%)

In the HPU forum HPU staff discussed the question what the effect of the discovery sessions on the VHCs was. I summarised the results of the working groups in table 8-4. The results confirm not surprisingly what HPU staff had told me earlier in their meetings with me (see above).

Table 8-4: Effect of discovery on VHCs, HPU forum results

- | |
|---|
| <ul style="list-style-type: none">- Gave strength to advance the work, to enjoy working.- Increased determination and responsibility, leadership, unity, initiative, future outlook.- A team has been build that strives forward- Relations have changed, there is understanding, patience- There is faith, an awareness of own importance- A sense of happiness, having found a common language |
|---|

8.2.3. Dream/Design (Strategic Planning) seminars

The dream/design (in the following: strategic planning) seminars were facilitated for the VHCs in May and June 2009, again with the same over 1100 VHCs in 6 regions (Naryn, Talas, Chui West, Issyk-kul, Batken, Jalalabat 1). During this seminar they first reviewed the life giving forces from the discovery seminar. They then did a valuation exercise where the group named 2-3 characteristics of each member that they valued and collected them on a list. And finally, they listed the major achievements of their VHC so far. These three lists – life giving forces, strengths of members and achievements so far – were then presented as the assets that VHCs already possessed and on which they would now plan and build their future. A tree was drawn on a flipchart pad with these three assets as roots. They were then asked to write their dreams into the crown of the tree, envisioning what kind of VHCs they would dream of becoming based on these strengths in 5 years time.

Once the crown was filled with dreams the VHCs were asked to consider what would be the consequences if these dreams came true. Things like gratitude, confidence, etc were named and written into leaves or fruits falling from the tree onto the ground. A Kyrgyz proverb was helpful in explaining what was meant here: “All good deeds come back to you.” Discussion guided them to recognise that these leaves and fruits ultimately nourished again the life giving forces, the roots of the tree. Thus, the idea of a cycle was put forth where their life giving forces would bear fruits but these fruits in turn would nourish their life giving forces. Finally, VHCs were asked to think what else these roots would need in order not to dry out and to stay alive and grow. Raindrops were drawn and filled with outside resources but also with ideas like humour, parties, joy, etc.

As for designing, the dreams were then one by one put into a table and analysed as to which resources would be needed for their realisation and in which of the next three years they should be implemented. Furthermore, those dreams were identified that needed no outside resources and could be started immediately. Detailed planning of measures was to be done in later sessions.

As the reader notices, we did not use dream statements or provocative propositions. We felt it not needed for the process and that it would have been a difficult endeavour to come to meaningful statements in each VHC. We thought therefore to leave that better to the summit that we planned for a later stage.

In sessions with HPU staff shortly after the strategic planning seminars I could gather impressions about these seminars. From my AI diary I summarise the following.

- Most VHCs found the process very interesting, were happy about their future plans and found them stimulating. They believed that they can do what they dreamed.
- It was important to know their roots, values and present situation
- The process opened their eyes to the fact that they have a future beyond the end of the project, now they see that they can continue without project, that it depends on them. They started to think about sustainability.
- VHCs said that they learnt how to implement dreams: by putting them into concrete order (like in the table). Some said that they understood that they can do certain things by themselves without outside resources. In a more general sense, many VHCs understood that they can do something by themselves without waiting to be told from outside to do something. Some local self-government bodies have already promised money for some issues planned by the VHCs.
- Some VHCs only now understood that they should not only fulfil health actions proposed by projects through HPU staff but that their deeper *raison d'être* is to initiate by themselves activities that address issues affecting health in their villages.

In this strategic planning process, in a very direct sense, VHCs co-constructed their future and with that created meaning for their common work; as some even expressly experienced, they created meaning in finding a new *raison d'être*.

In the HPU forum HPU staff discussed the question what the effect of the strategic planning sessions on the VHCs was. The results of the working groups I summarised in table 8-5. They are in accordance with what I reported above from the sessions with HPU staff.

Table 8-5: Effect of strategic planning seminars on VHCs, HPU forum results

- | |
|---|
| <ul style="list-style-type: none"> - Ability to envision the future, faith in the future - Planning skills, ability to decide reality based, optimal variants - Striving to aim for a goal with responsibility, interest to work increased - Organisational matters were raised, faith in sustainability and in being an independent organisation, trying to increase the fund, better planning and maintaining records, creating detailed working plans, quality of work improved. |
|---|

8.2.4. VHC National Forum (AI Summit)

In order to capture and focus the energy generated in the discovery and strategic planning processes in the periphery we organised a VHC National Forum in form of an AI summit with 160 representatives from (at that point) about 1100 VHCs from six regions about half a year after the beginning of the discovery process (September 2009). They convened for three days. They were seated at 16 tables with 10 delegates each. The summit itself again started with a discovery process, in that participants interviewed each other and reviewed stories that had been collected before from the discovery process in the VHCs. Life Giving Forces were identified from these stories. Here then dream statements were creatively enacted and formulated. The enactments were truly amazing, taking us into TV shows far into the future and onto plane

journeys to other countries. A team reconciled the many dream statements into one which was accepted by the plenary: "We dream to see VHCs in Kyrgyzstan in the future as sustainable, independent, self-financed, and strong organisations, closely cooperating with government and non-governmental organisation, and reaching an international level." The design foresaw the formation of a national Association of VHCs in Kyrgyzstan, a task which was completed a half a year later. A meeting with the Minister of Health and various donors where the VHCs presented the results of the summit and where the minister and the donors pledged continued cooperation completed the summit. A 3-hour DVD was made from the summit and sent to all VHCs. Kyrgyz people love to write poems and songs. During the summit participants used every occasion to present their productions. Here is a small selection of poems/songs from the summit.

*VHC is like a small child who awakens the warm feelings
It will be healthy in 5 years and will increase its authority
At a state level from a nongovernmental organization
It will turn into an association whose members we will be- then Kyrgyz people
will develop
Chui region, Alamedin district, Kara-Jygach village, Asylbekova Kanykei*

*VHC will get the blessing for its deeds
People having a strong health
Will always remember VHC
Naryn oblast, Naryn rayon, Ornok village
VHC leader: Mambetova Nurzat*

*Let VHC be the organization of a high level
Let it fight against each disease
Let it have the bright future and success
And let it have its own needed strength
Let it have thousands of offices
Let's support each other
Materially and morally as well
Let VHC organize forum each year
And never let the donors go
And let Tobias be always around us
Manas rayon, Talas oblast, Kok-Dobo village,
VHC leader Abakirova Kulsun*

*You take care of poor people
You share your opinion with them
Without strong health there is no interest in life
Thank you very much for your work
Jayil district, Chui region, RHC leader Ajimuratova Asylkul*

*Let the VHC be all united
Let it know its responsibility
And let it achieve all the due respect*

And be respected by the people

Then it will have all the success

Valakym village, Bakirova Raziya, Batken region, Kadamjai district

VHC strives for cleanness

VHC escapes from bad things

VHC decreases the deceases

And increases people's lives

I wish long life for VHC

I wish it success in everything it does

Let the VHC grow towards a bright future

Osh region, Aravan district, Otomoun village

VHC cares about people's health

It gives advice to us

It gives light to us

It gives assistance to the ones in need

And does not even sleep

The ones who got assistance from VHC are grateful to it

Bumaira Malidinova, Osh region, Nookat district, Jiide village

VHC works for the people

It goes from house to house

And gives all the needed information

We sit in the rooms

And go online

And do not get tired of searching for donors

Since we work for the well being of our people

VHC has achieved its own respected status now

It does not let any decease to appear in our village

And saves people's lives

From Arslan bob village, Shamshiddinova M. VHC leader

Being away I miss it

If it closes I will feel sad

This is VHC for me

Let VHC live forever

Let it grow towards a prospective future

I wish to have an office

Wish to have a computer in it

I wish all my plans to get implemented

*And my dream will come true
Osh region, Nookat district, Isanov village, VHC leader M. Sakaba*

The dream phase of the national forum consequently brought the idea to form a national association of VHCs. The design phase included that task to share with all VHCs the atmosphere and results of the national forum. A meeting with the Minister of Health and various donors where the VHCs presented the results of the forum and where the minister and the donors pledged continued cooperation completed the forum. A 3-hour DVD was made from the forum and sent to all VHCs.

The co-creation of a new identity during the national forum was palpable throughout the days. The feeling and understanding was borne that all VHCs are part of a national movement. From my AI diary I can summarise that the effect of the national forum was felt throughout the system of CAH, virtually in all VHCs. The reports of the emissaries of the festive, energetic atmosphere, the feeling of being part of a national movement – theoretically known before but not experienced – together with the images of the DVD video in all VHCs, the appearance of the Minister of Health, all that sent a wave of enthusiasm, motivation, and energy throughout the system and captured most VHCs. New meaning and a new reality was co-created on a broad scale. The consciousness of a national unity was created.

8.2.5. Introducing informal use of AI

Early on, already in the exploration phase, we had encouraged trainers and HPU staff to experiment with this „method of good stories“ in situation where it seemed appropriate. The idea was to keep an open mind and try to ask for a good story when it may seem useful in their work with VHCs. Very soon, however, we enlarged this idea to mean not only asking for good stories but experimenting with what we called the appreciative view: seeing what was positive in a situation and trying to use it, to make it visible, to enlarge it, in order to solve a situation to everybody's advantage. The idea was that if all staff does that then the system of CAH changes and improves from inside, independent from any training delivered from above. We talked about this in a series of meetings with HPU staff mainly in the first half of 2009. Staff got used to it rather slowly, had to be reminded often and patiently. But then a good number of them did seem to get into the habit of applying the appreciative view where it seemed feasible, both at work and in private life. The attempt to ask them to write diaries about these incidences failed, however. The following selection of stories from my AI diary bears witness of the range of situations where staff attempted to apply the appreciative view.

*Some HPU staff mention that now, when few members come for a VHC meeting, they do not show their displeasure but appreciate those who came.
(Batken, May 2009)*

Iskender, trainer (May 2009): when wife and children do something not right he tries to see what is still positive in that, instead of shouting at the negative. They are surprised and change. Example: recently his son didn't look well

after the sheep. Instead of shouting at him as usual he said, it's good that you look after the sheep, but next time do it in this way.

Alior, HPU staff, Batken (May 2009): lives with parents. His wife always complains because he is always away, doesn't help her with her chores, among them taking care of his ill father. Before he argued with her about that, now he finds words of support.

One HPU staff member did not like mother-in-law, now she tries to see positive sides of her and it helps to like her. And she changes! They can now talk about things, before not. (Naryn, June 2009)

Another HPU staff member asked a woman who complained heavily about another VHC member to tell something good about her, in her account she immediately changed into another person. Now they are friends and work together. (Naryn, June 2009)

A VHC leader and the leader of the self-government agency (Ail Okmotu, AO) were always at loggerheads. VHC leader was about to write a letter of complaint because the AO never gave what he promised. At one meeting they were again at each other. One HPU staff was present and asked the AO to say in front of everybody all the good that the VHC leader had done for the village. That did it. Since then they were at peace and the AO is the biggest supporter of the VHC.

During strategic planning a VHC leader complained about work: no effect, many difficulties... HPU staff asked about what VHC has achieved. Non-members were present, they started to list all good things. Then the list of strengths of members really changed the perception: all that is us... Then members started to plan and the leader finally changed his outlook and energy. (Chui East, June 2009).

Powerful VHC leader, didn't want to leave. We always were angry with her, but she didn't leave. The HPU staff decided to change strategy and start to value her, told her that she feels sorry for her high blood pressure, offered support... suggested to let others work. In the end she agreed. (Batken, November 2009)

In the HPU forum HPU staff discussed the question what the effect of the informal use of AI – the use of the appreciative view - was. The results of the working groups I summarised in table 8-6.

Table 8-6: Effect of informal use of AI, HPU forum results

- | |
|--|
| <ul style="list-style-type: none">- Our behaviour has changed, it has improved- We learnt to see the positive in everything, to praise, to seek consent and understanding, to be patient- Our relations have improved, it helps to see own weaknesses, helps to deal with one another, to find a common language, looking for the best side of one another |
|--|

- A good word can cure a person, a bad word can maim a person (Kyrgyz proverb)
- Family life has improved

8.3. Open Interviews with trainers/oblast HPU staff

To what degree is AI being practiced in CAH today?

Regarding the VHCs most trainers/oblast HPU staff said that they only tell stories when HPU staff come to their meetings and ask for stories. Only from Naryn and Chui-1 there were accounts of a few VHCs that start their meetings with story telling and even collecting good stories in folders. As for informal use of AI (appreciative view) there is anecdotal evidence that some VHC leaders use it for motivational purposes with their members, others to soothe husbands.

Regarding RHCs all interview groups said that all RHC meetings start with asking for good stories and that story telling happens in a very free, relaxed atmosphere without any pressure or any sense of a formal exercise. Sometimes there are more stories, sometimes less. People come prepared, they think about it on the way to the meeting what they could tell. RHCs select the best stories and have them written down and HPU staff collect them. But most interview groups also said that in the beginning the exercise was often dry, had a formal character, people often didn't know what to tell, or told only funny things. This is confirmed in the interview from the youngest region, Chui 2, where staff reported that their RHC meetings still had elements of these difficulties. Among them is especially the notion that only successes or reports count as stories and not the kind of sharing that takes place over lunch. It seems then, that story telling in RHC meetings needs some time to come into its own, or needs at least careful facilitation in the beginning to get into the right tracks.

Regarding the HPU staff all interview groups report that all staff meetings begin with asking for good stories and that the best ones are written and collected. In all but the newer ones the atmosphere is lively, free, not as a formal exercise but as something the staff engages in full of interest. Again there were some hints that the beginning was a bit awkward, and from the newer regions (Chui 2, Osh 1) the interview group reported that the story telling was more like a formal exercise, not yet free. As for the informal use of AI (appreciative view) most interview groups reported that HPU staff apply it amply, both with VHCs and among each other, with less critical, sharp language, more humour, leading to better, more respectful relationships among each other. One group said that all have used it even before AI because CAH was built on it. After clarification and differentiation they confirmed that HPU staff did use the specific appreciative view as well since the introduction of AI. Again, interview groups of the newer regions, Osh 1 and Chui 2, do not report that HPU staff apply informal AI.

HPU staff often say let's remember AI, especially in moments of conflict, in families, among each other, or with authorities. They also are used to critique not directly but only after a positive introduction. (Anara, oblast HPU staff, Issyk-kul oblast)

Regarding the trainers/oblast HPU staff themselves most rated their own use of informal AI (appreciative view) fairly high but in their explanations often referred to either a pre-existing disposition of their character to such behaviour or to the previous experience with PRA as part of the reason for this behaviour, in addition to reference to AI.

In summary, it becomes clear that these interview groups see the use of AI by VHCs lowest, by RHCs higher through regular story telling, and by HPU staff also higher through regular story telling in meetings and the occasional application of informal AI. Their own use of AI or of appreciative principles they rate quite high.

Which effect did the introduction of AI have on CAH?

Regarding the VHCs/RHCs (for this question these two were considered together) the conversation of the open interviews revolved mostly around two broad clusters, the effect of story telling in RHC meetings and of the discovery/strategic planning process, as these had clearly the most impact. As for story telling in RHC meetings the interviewees agreed that the atmosphere of the meetings has changed to become more stimulating, with work then proceeding more easily, creatively, effectively, with more interest, more focused, with more energy. But some mentioned also a change in relationship to the effect that people listened more carefully to each other in dialogue, don't interrupt as easily, have a closer relationship to each other. Finally, story telling is reported to have a great effect on own initiatives, as ideas are shared and imitated, and the interest to do something is infectious.

Now all prepare on the way to the RHC what good story to tell. So the atmosphere is automatically a different one. Problems pull down. Good stories lift up. (Erkin, oblast HPU staff, Issyk-kul)

As for the discovery/strategic planning process three themes emerged from the interviews. One is a boost in self-confidence and self-awareness as community based organisations with a future independent from outside projects and with agenda on its own. The identification of the life-giving forces played a great role in that and vision and planning of an own agenda. Second, more interest to work could be felt, a greater enthusiasm, more energy, a greater responsibility and motivation to fulfil tasks, and as an effect a great increase in own initiatives. Thirdly, there was also mentioning of a greater unity and relationship building through this process.

Regarding HPU staff three themes emerged from the open interviews. One is an increase in motivation, energy, responsibility, stimulation and interest in work that is coupled with an increased self-confidence and that mostly seem to stem from the story telling at the monthly meetings. A second theme is an increase in skills to find solutions to situations, diplomatic ways with authorities, to grow through sharing of experience, to become wiser, calmer, more confident. The third theme is about their relationship among each other, which has become better, there is less tension, a greater unity, better team work, they comment on each other with humour about their change

The relationship among HPU staff has improved, they comment on each other with humour about their change, especially after the training on discovery. The biggest change in their behaviour came of course after PRA training, but even then we saw mostly the bad sides of situations and people, but after AI training we try to see the good sides. Even if we talk now about a person we say no no he also has good things. We think: if we didn't know AI we would not talk like this. (Bigzat, oblast HPU staff, Osh 1)

Regarding the trainers/oblast HPU staff their accounts about the effect of AI on themselves talk about changed relationships at work and in their families, better skills to analyse situations and to be quieter and more patient. Rather than trying to extract more abstract content from their accounts it seems more appropriate in this case to let some of their very varied personal accounts speak for themselves.

AI was very important for me. I don't talk much, people think of me as thinking of myself as above them. Wife also says I don't give enough attention. I started thinking how to change. Slowly I started talking more with family members instead of watching TV, and through that they also started to talk more with me. A circle of talk started. Before I was more authoritarian patriarch, now follow more a participatory method. Basis for this was laid with PRA but this latest attempt was done after AI. There is a feeling of gratitude to you [note: for having introduced him to PRA and AI] for the chance to change: I wanted to change but didn't know how. On the professional side: try to control my voice, without angry emotion, appropriate to the situation, respectful. – Tobias: But this is all what we learnt from PRA, what is there new from AI? - Now I try to look at things from several sides. Before when something was not done I was angry, now I ask for reasons (e.g. when the reports are not done in time). I notice that reaction is different, no defensive position but cooperation, explanation. Relationship are more open as a consequence. Sometimes I compare this with the authoritarian method. This also leads to a result but with much nervous stress on both sides, with negative relationship, negative talk and atmosphere, with questionable quality, without interest. (Aibek, trainer, Chui 1)

Before often I felt hurt when someone made a remark, now I don't. I find it easier to find a common language with everybody, also with authorities. When I see somebody does something not right I do not feel helpless like before but can find a way to get involved and solve the situation. There are many such situations now, in work and in private life. (Halima, Batken)

In all situations I know that there is not only one truth, only me. Now there are many sides. Before I reacted angrily when something was not like I expected, saying WHY SO? Now there are different ways to look at things, solve them, different ways to understand a person. Through PRA I changed behaviour, through AI I change the way I think, the analysis, the understanding why. (Anara, Issky-kul)

Before I was often angry with my son, now I praise him more, use different language, the relationship has changed, it is closer now. At work I do the same, it has a good effect. (Cholpon, Naryn)

I got married recently, by the decision of my parents who selected my wife. In the first time I was angry with my wife. Now I use AI, try to see her good side, and indeed the relationship improves. I also use AI in relation with colleagues and in guiding HPU staff. (Bigsat, Osh 1)

We changed, because we saw many good examples of the good that AI does. Interesting to observe how people change if you behave differently with them, government people for example, when you use AI with them they start to behave normally, simple, not rough anymore, on one level with you. (Melis, Talas)

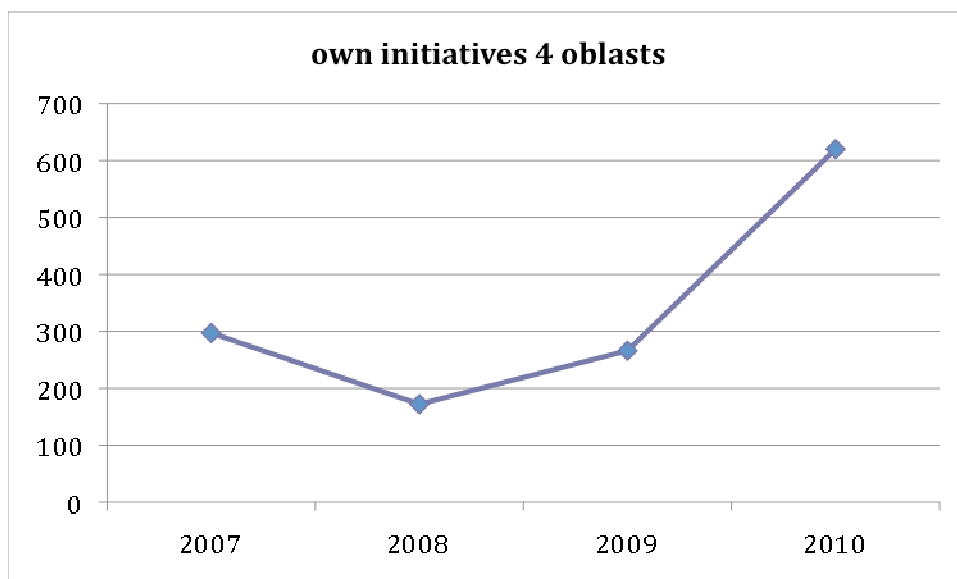
I am now quieter than water under the grass. When I am angry I count now until 10. – Tobias: Why is that due to AI? - Because I understood that more important than reports is the relationship with HPU staff. If I shout I don't get the report now anyway, so I say, ok then bring it in the morning. (Asel, Chui 2)

In summary, according to these interviews, AI seem to have resulted in energised VHCs, higher motivated HPU staff, better relationships among staff, and accounts of personal change.

8.4. Monitoring the number of own initiatives of VHCs

As described in the methodology chapter we see own initiatives as an indicator of organisational capacity and empowerment of VHCs and monitor their number. In 2010, the year following the introduction of AI in CAH (2009), we saw a doubling of the amount of own initiatives by the VHCs of the four oblasts Naryn, Talas, Chui-1 and Batken where we follow the data for four years (see figure 8-1). We believe that this is largely due to the introduction of AI into CAH, with the discovery and dream/design (strategic planning process) in 2009, the regular story telling with sharing of new ideas in RHC meetings, and with the national forum in form of an AI summit in September 2009. This corresponds to the numerous reports of field staff of increased activities of VHCs mentioned at various places in this chapter.

Figure 8-1: Number of own initiatives of VHCs in 4 oblasts



8.5. Generation of new ideas from below

One idea linked to the story telling is that new ideas can generate from VCHs and can spread among VHCs without being proposed from a project or the Republican Health Promotion Centre. In a way, many own initiatives are examples of that, as they are generated by one VHC, told in the RHC meeting as a good story and copied by other VHCs, which certainly is one reason for the great increase in the number of own initiatives shown above.

But we have introduced a filter with the intention to capture new ideas among these countless own initiatives that are worth spreading further. HPU staff are asked to tell those ideas that have been picked up by several VHCs in one rayon in the monthly meeting at oblast level where it is discussed. If it seems worth to distribute it to other rayons in the oblast then HPU staff tell the idea to the RHCs in these other rayons as well as at the half-yearly meeting of oblast HPUs at national level. In this way a worthy idea can be distributed from below.

There is one example so far where this is happening. In 2009 one VHC in Kadamjay rayon in Batken oblast in the South of the country decided to tackle the horrendous and impoverishing costs that traditional rites around funerals and weddings impose on households. Talking to influential people in the village they achieved a general agreement that the host family would in future be expected to buy only 2000 breads instead of 4000 (these breads are taken home by guests), that guests would bring 50-100 Som (1-2 USD) in cash instead of food contribution to the occasion; for weddings the car procession would be only 3 cars instead of 10, and dowry would be reduced by two-thirds to about 630 USD. They told about it at the RHC meeting and some other VHCs took it up and copied it. HPU staff present in the RHC meeting reported it in their monthly meeting to their colleagues from other rayons and as it was not long before the national forum of September 2009 the chairman of the VHC that had come up with the idea reported it at the forum as well. This led to spreading the idea through four oblasts with presently 89 VHCs having taking the initiative to change the traditions in their village around very high costs for funerals and weddings. Of course,

they have introduced variations to the way how expenditures are reduced. In the North it is mainly about reducing the amount of animals slaughtered, either a sheep instead of horse or a cow in richer families only one horse instead of several, or by offering meat only to guests from outside of the village to take home (being traditional nomads offering meat for the way home is a time-honoured tradition of Kyrgyz people). Another variant is to not offer anymore a piece of ornamental textile to each female guest and a handkerchief to each male guest, as had been the tradition. These variations and ideas are shared locally in the RHCs and taken up among the VHCs. We hope that this mechanism can capture and distribute more valuable ideas. One very difficult one that is being discussed at the moment by a few VHCs is the issue of bride kid-napping. This is a Kyrgyz tradition that has been on the rise in recent years again. We are eagerly waiting to see whether some VHCs find a creative way to address this contentious issue in their village and then use the story telling to spread the idea.

8.6. Guest contributions

Here I produce the thoughts of three colleagues on the role of AI in CAH.

Shaken Janykeeva

As presented in chapter 7, Shaken was a pioneer of CAH. She was among the three first trainers that formed the first VHCs in 2001 and helped developed the model of CAH. Here I copy the part of her essay that answers the second question (role of AI in CAH).

The role of AI in CAH

VHC development and sustainability are very important for CAH program. AI plays a great role in VHC development. VHC members share interesting stories during seminars and meetings. When people hear such stories they feel more energy and willingness to act, interest and strength to strive forward and hope for the better. VHC members feel that with sharing their positive experience they are changing. They have found "life giving forces" thanks to using AI. AI process is applied by VHC, HPU members, trainers not only at work, but in their private lives as well.

Story...

VHC coordinator, Ornok village, Jungal region. (VHC gazeta May 2010)

One day when I was at home, a small boy ran into my house. He said: "My mom has a stomachache. She needs medical examination. Please, you must help her because you are a VHC member". I followed him, and we came to his house. The woman bore a baby. She was crying: "I had no money to go to the doctor; I have nothing to cover my baby". I ran to the shop and bought clothes for a baby from the VHC Fund's money. We took the woman to the doctor of the region with the car given to the VHC. I felt happy that day. The next day I was thanked by the paramedic and the village self-government leader.

During a meeting Nurjan- another HPU worker from the Naryn oblast - told this story. She didn't like her mother-in-law. Their relations were bad, but after AI, Nurjan said she wanted

to try something. She tried to remember and keep in mind all the good things done by her mother-in-law. She saw that her attitude was changing. What was more interesting, the mother-in-law started changing too. She became more merciful and closer. Now they easily deal with one another, despite before they had nothing common to discuss.

Fatima- the trainer from the Naryn oblast - also told the following story during a meeting. She noticed the emerging problem between 2 VHC members. One of them wrote a statement against the other one to the VHC. An HPU staff decided to find a different approach to the problem. She asked the one who wrote the statement to say anything good about the other person. Then the first woman started praising the second one for all her activities in VHC. Both of them have changed opinions about one another. They became close friends and now work together.

As a result of applying AI VHC members think about the future and they have already written plans for 2-3 years ahead. Their plans, their aspiration help to believe that VHCs will become sustainable organizations.

Transforming of VHCs to sustainable, strong and independent organizations and solving priority health problems will become a great award for CAH activities.

Tolkun Jamangulova

Tolkun, as presented in chapter 7, is presently the deputy director of the project (Community Action for Health Project). She was, like Shaken, a pioneer of CAH, one of the three first trainers that formed the first VHCs in 2001 and helped to develop the model of CAH. Her thoughts on the role of non-dominant behaviour in CAH I copied in chapter 7. Here I bring her thoughts on AI in CAH.

AI in CAH

AI was implemented in CAH in order to charge it with energy. In order to prove that there is something alive in CAH, besides simple figures as the number of villages covered. It's not just simple data of monitoring the VHC activities provided to donors, Ministry of Health. AI helped to initiate positive changes. When you think of the positive results, you want to make more and more of them.

Of course we apply AI in our everyday life, even though we don't realize it. We apply it toward our close people, especially children without noticing its effect. For example, you have praised your child for a good grade or good deed. You did it automatically. The next day your child will do something even better.

AI training was carried out for the main CAH members as HPU, VHC and project staff. In course of the trainings they have discovered the "life giving forces" in their work and organization from the experience of past success stories. Retelling good stories is the main AI element that charges people with energy and good mood. So people don't get stuck in problems.

I saw the AI effect for the first time, when we came to the last PRA session for the HPU in Osh oblast. I thought that as it always happens everybody would start telling us: "It was difficult to collect/ gather people, to ask correct questions, that people were not speaking to the point and it was difficult to work in villages, that FGP/FAP members can't do this and this and etc." However, to my great surprise, Tobias asked another question: "Tell us *everything good* that happened during the last 10 days". Of course there was a great pause; but then the participants started telling all the good things tha had happened, among them many funny stories. Everybody emphasized the significance of non-dominant behavior. They were full of energy and started discussing and underlying good moments although they had faced many difficulties and had been away from their families for 10 days.

We proposed HPU staff to use AI in two ways: The first- informal (individual), it lacks defined rules. You just have to remember and use it when you can. You have to try to see something positive, what we call the "positive view". It can be used everywhere: at work, in family, among friends etc. The second-formal, nowadays all the HPU and VHC meetings are started by sharing good stories, if there are any. Thus people get energy to continue to work. Many people (HPU, VHC) that used AI say that it gives "life". You feel interested and you want to improve everything you do. I have also found for myself and have defined my "life giving forces" that provide me with energy and I am happy for it.

Rahat Aidaraliev

As presented in chapter 7, Rahat is presently the coordinator of the CAH programme in the Community Action for Health Project. Prior to this post he has been a trainer in CAH programme for 3 years. His thoughts on the role of non-dominant behaviour in CAH were presented in chapter 7. Here are his reflections on AI in CAH.

The role of AI in CAH

AI is a method that lets organizations develop in a well-organized way. If to speak about our VHCs, this method is very useful because it helped VHC members to realize the life giving forces on which their motivations is based. It let their dreams take distinct forms and turn into real plans. I remember when I faced the practical usage of the AI method for the first time. This took place in Osh city. The process of implementing CAH was taking place there. I was carrying out trainings for HPU staff together with the trainers from the Osh oblast. By the end of the training Tobias and the representative of Switzerland-Monika came. We all were very tired and exhausted. We had many

problems. I thought it was the right moment to show and tell them about all the difficulties we have to overcome while working. So I was ready to start complaining.

Tobias, however, opened the discussion in a very different way, he asked us to tell some good things or funny moments that took place during the trainings. Everybody hesitated at first, and then the process began. A bit later all of us were laughing, eyes were shining, we were even interrupting one another to share our stories. I forgot that I was just to complain about all the difficulties and was trying to recollect more good stories that happened during the trainings. As the result, we got just a great amount of positive energy. We had a feeling that we would manage to fulfill any task.

Now all the meetings at the level of HPU, RHC and VHC begin by sharing "good stories". These "good stories" often happen to become not just energy charge but new ideas generator as well. Because the stories are collected from all the levels (VHC, RHC and HPU meeting). Once I participated at the HPU staff meeting in the Batken oblast. That day's agenda included an issue concerning stimulating grants for profitable activities. There were some problems because a few people didn't manage to realize own projects because they had not thought through the profitability of their business schemes. While discussing we decided to talk about successful projects rather than this kind of problems. Thus we heard the success story of a VHC in the Leilek rayon that was heard by an HPU staff member at an RHC meeting. That VHC bought kitchen utensils, made tables and chairs and then started renting all these things for different festivities and feasts. This business turned out to be demanded for there are no cafes and restaurants in villages. Also these feasts are carried out at home, but hosts don't have all the necessary stuff. Moreover, VHC members could involve new members by renting all the equipments to needy people for free, provided that those people would work in VHC in return of the service. All the meeting participants liked this business and they decided to propose the experience in own rayons during the RHC meetings. As the result, some VHC members have changed their businesses and their incomes started increasing.

We often use AI in our everyday life even though we don't notice it. For example, I noticed one interesting thing. Sometimes at the seminars I lacked a contact/link with some people (VHC and HPU staff). Sometimes it was vice versa, there was an energy explosion, the feeling of unification and mutual understanding. Both cases happen with the same people. Now when I analyze those meetings, I think, I know what happened. Probably my spirit and the image I have depend on the atmosphere. If I thought that the meeting would be difficult because the agenda to be discussed was difficult then and it would indeed turn out to be difficult. My energy was transmitted to the participants turning back to me two- or threefold. My fears used to be materialized. And if I was going to the meeting in high spirits and keep a positive image in my head I was getting good results. And in this case the positive image has materialized. I guess, we can create our own future at the stage of planning. This effect was used with VHCs as well. Many VHC members understood who they are and what they are working for through dreaming and imagining themselves in the next 5-10 years. For example, HPU staff said that after AI seminars VHC members said that they realised that they have

possibilities beyond waiting for what HPU staff asks them to do; that they now look into the future for what they themselves can do.

Chapter 9. Conclusions

1. The discussion of the theoretical foundations of the CAH programme (chapter 4) showed that it has elements of all main public health models and one can conclude that the pragmatic combination of these frameworks, which are often ideologically pitched against each other, is a reason for the effectiveness of CAH in promoting health. Healthy lifestyle programmes, top-down administered and focusing on delivering information (education), forego the possibility (and negate the necessity) of changing broader determinants of health. Also, they can mobilise voluntary partners in communities only in a very limited way, as the motivation of volunteers is directly correlated to their involvement in decision processes; both features limit the effectiveness of healthy lifestyle programmes. On the other side, programmes informed by the socio-environmental model of public health often underestimate the usefulness of information; and those among them that focus on engagement with communities, often take a very long time to be able to show concrete health gains and they usually demand a level of facilitation and engagement by outsiders that can in most cases only be provided in a limited number of communities. Viewing the experience of the CAH programme in the light of these models supports the growing view in the literature that a combination of top-down and bottom-up approaches is possible and has advantages over single approaches. In particular the following insights may be gained from CAH in Kyrgyzstan:
 - Programmes can partner with voluntary community based organisations (CBOs) on top-down health education campaigns for extended periods of time if they invest at the same time in the organisational development of these CBOs. Many programmes build voluntary groups in communities for a specific disease control campaign. These groups often work for a short while and then loose interest or demand payment because the programmes do not invest in organisational development of these groups. Investing in their organisational development will convince the CBOs that the programme's last interest in them is not the cheap labour they provide for its disease control campaigns but that it has their independent growth in mind, ie. their ability to do what *they* think is important. That can be the basis of a partnership.
 - The combination of a community development approach with centrally designed health education campaigns renders health campaigns also more effective, as the CBOs have greater motivation and resilience and often add activities to the campaigns on their own initiative.
 - This combination allows a greater involvement of the people in some health campaigns. In other words they can take place on a higher level of health literacy, including critical health literacy.
 - In this combination vertical health campaigns can have a positive effect on the organisational capacity of CBOs.
 - This combination is very useful to quickly gain and sustain support from policy makers. In the case of CAH this was primarily the Ministry of Health whose staff the CAH programme engaged in the unusual task of forming and developing community based organisations (not something a

Ministry of Health typically wants its doctors and nurses to deal with). This was possible because early results of the centralised campaigns convinced policy makers of the usefulness of the approach. The same applies to funders of such programmes.

- While engaging in organisational capacity building of such CBOs in large scale programmes it is possible, useful and may even be necessary to choose a level of participation that leaves major decision power in the hands of the programme, at least in the beginning (i.e. at a level of participation that would correspond to a middle rung on a power-sharing scale such as Arnstein's ladder of participation or similar tool). This allows organisational capacity building inputs in large scale programmes and does not contradict the possibility of initiating empowerment processes. On the other side, there is always a danger for programme managers in such settings to get too absorbed by the centralised health campaigns – and get carried away by their possibilities and successes – and lose sight of the necessity to invest with equal measure into organisational capacity building, as well as of the need to always strive towards a higher level of power sharing.
2. Viewing the CAH programme through the lense of social constructionism gave an additional theoretical frame for one of its fundamental premises: the importance, even the primacy, of non-dominant, respectful behaviour in the work with communities. If meaning and reality are created in the process of relating to each other then the quality of that relationship is obviously of utmost importance – and not only on a level of exchanging information (on a content level), but – if we indeed *are* relational beings – also and especially on a personal level. A more specific social constructionist argument for the importance of the respectful behaviour can be derived if we apply this distinction between a content level and a personal level of relationship to the relational dance between the community member and the programme worker. On a content level the programme worker will be dominant in regard to certain knowledge she brings with her while the local knowledge of the community member will be subdued. This is due to the relationship on the personal level where the programme worker is tempted to dominate initially due to the resources she brings, or to the educational status, or to the fact that she represents an official authority (or due to sex in case it is a man). In this situation the community member will only dare to bring his local knowledge to bear if the programme worker offers to create a new reality on the *personal* level - by intentionally refusing to lead the dance (not acting dominantly). Into this void the community member can step, thus accepting and co-creating the proposed new reality of a partnership of equals. With each step that claims the space offered by the worker he learns to dance a new dance and learns to lead it, until his confidence eventually may lead him to venture off seeking other dance partners. Hence the primacy of non-dominant, respectful behaviour, which determines relationships on a personal level, over programme content and models and approaches in programmes seeking to enable empowerment processes. The findings reported in this thesis support the view that the principle of non-dominant, respectful behaviour is largely recognised by staff throughout the CAH programme and that this principle is an important factor in explaining the success of the CAH in Kyrgyzstan.

3. Our experience with Appreciative Inquiry supports this social constructionist reading of the importance of respectful behaviour and of the relationship between worker and community member. By far the most powerful feature of AI in the context of CAH is telling of good stories. Time and again staff reported two main effects of story telling: raising of the energy level in the meetings leading to a more positive, constructive atmosphere, and improved relationships between members of the group sharing stories. Social constructionist theory can explain the latter by pointing out that telling a story not only transports content (information) but also emotions. Emotions influence the *personal* level of the relationship between story teller and listener and, if the story conveys appreciative principles, represent an invitation to create a new meaning of the relationship between them, one that is “conducive to human growth and liberation, to opening and widening of possibilities, to hope”, as I defined appreciative principles in chapter 1. If the story finds an appreciative listener the relationship cannot but improve. This in turn can explain the raised energy level, together of course with the uplifting effect of the *good* in good stories.

The findings reported in this thesis support the view that the introduction of AI into CAH in Kyrgyzstan has strengthened the underlying principle of non-dominant, respectful behaviour and substantially increased the motivation of staff and VHC members and the organisational capacity of VHCs.

Annex: Generic interview format for VHCs

The first question asks for your best experiences with the VHC.

Questions 2-5 are about values

Question 6 is about your wishes.

Stories

1. Tell a story about the best time you have had with the VHC. Look back at your experiences and remember a time when you felt most actively involved, most happy to be a member of the VHC.

What made this such a good experience? Describe in detail what happened, who was involved, when, how.

Values

2. Without being modest, which qualities do you value in yourself as a person?

3. What do you like about being a member of the VHC?

4. Did your life change since you are in the VHC? How?

5. What is the most important impact of the VHC for your village?

6. In your opinion, from which values does the VHC live?

Wishes

7. Which three wishes would you have for increasing the vitality and sustainability of the VHCs?

References

- Antonovsky, Aaron. 1979. "Health, Stress and Coping". San Francisco, Washington, London: Jossey-Bass
- , 1987. "Unraveling the Mystery of Health. How People Manage Stress and Stay Well". San Francisco, Washington, London: Jossey-Bass
- , 1996. "The Salutogenic model as a theory to guide health promotion". *Health Promotion International*, 11 (1), 11-18
- Arnstein, Sherry R. 1969. "A Ladder of Citizen Participation." *Journal of the American Planning Association*, 35 (4), 216-224
- Asian Development Bank. 2006. "Prevalence of endemic goitre in school students age 6-8 of various regions of Kyrgyzstan (by palpation method)". (Original in Russian: Rasprostranennost endemicheskogo zoba u shkolnikov raslichnih regionov Kyrgyzstana po dannym palpazii). Early Childhood Development Project. Project Document.
- Beaglehole Robert, Ruth Bonita, Richard Horton, Orvill Adams, Martin McKee. 2004. Public health in the new era: improving health through collective Action. *Lancet*, 363, 2084-86
- Brown, Theodore, Elizabeth Fee. 2006. Rudolf Carl Virchow, Medical Scientist, Social Reformer, Role Model. *American Journal of Public Health*, 96 (12), 2102-05
- Burr, Vivien. 2003. *Social Constructionism*. Second Edition. Routledge, East Sussex.
- Chambers, Robert. 1994. *NGOs and Development: The Primacy of the Personal*. Draft. Paper for the Workshop on NGOs and Development Performance and Accountability Institute of Development Policy and Management, University of Manchester, 27-29 June 1994. IDS working paper 14.
- , 1994a. "The Origins and Practice of Participatory Rural Appraisal". *World Development*, 22 (7), 953-69
- , 1994b. "Participatory Rural Appraisal (PRA): Analysis of Experience." *World Development*, 22 (9), 1253-63
- , 1994c. "Participatory Rural Appraisal (PRA): Analysis of Challenges, Potentials and Paradigms." *World Development*, 22 (10), 1437-54
- , 1997. "Whose reality counts? Putting the first last, London: Intermediate Technology Publications.
- , 2007. "Creating, evolving and supporting participatory methodologies: lessons for funders and innovators." 177-89 in *Springs of Participation*, eds., K. Brock

- and J. Pettit. Institute of Development Studies. Practical Action Publishing, Warwickshire.
- Chappell Neena, Laura Funk, Arlene Carson, Patricia MacKenzie and Richard Stanwick. 2005. Multilevel community health promotion: How can we make it work? *Community Development Journal*, 4, 332-66
- Community Development Society International. 2009. Principles of Good Practice. <http://www.comm-dev.org/inside/>. Accessed September 27, 2009
- Dahlgren Göran, Margaret Whitehead. 1991. Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies
- Fawcett, Steven, Adrienne Paine-Andrews, Vincent T. Francisco, Jerry A. Schulz, Kimber P. Richter, Rhonda K. Lewis, Ella L. Williams, Kari J. Harris, Janette Y. Berkley, Jacqueline L. Fisher, Christine M. Lopez. 1995. Using Empowerment Theory in Collaborative Partnerships for Community Health and Development. *Am J Comm Psych*, Vol 23, (5), 677-95, 1995
- Freire, Paulo. 1996. *Pedagogy of the Oppressed*. Penguin Books, London
- Gergen, Kenneth, Mary Gergen. 2004. *Social Constructionism: Entering the Dialogue*. Taos Institute Publications. Chagrin Falls, Ohio.
- Gergen, Kenneth J. 2009. *Relational Being. Beyond Self and Community*. Oxford University Press.
- Green LW, SL Mercer. 2001. "Participatory research: can public health agencies reconcile the push from funding bodies and the pull from communities?" *Am J Public Health* 2001;91:1926-29.
- Hosking, Dian Marie. 2004. Change works: A critical construction Ch 12 in Jaap Boonstra (ed). *Dynamics of Organizational Change and Learning*. Chichester: Wiley
- Housten R, B. Rashid, H. Kalanzi. 1994. Rapid assessment of iodine deficiency in Kyrgyzstan: Report of consultative visit. Bishkek, Kyrgyzstan: UNICEF, 1994.
- Jackson, T., S. Mitchell, M. Wright. 1989. The community development continuum. *Community Health Studies*, 8 (1): 66-73. Quoted in Glenn Laverack. 2004. *Health Promotion Practice. Power and Empowerment*. SAGE Publications Ltd.
- Jakab, Melitta, Elizabeth Lundeen, Baktygul Akkazieva. 2007. "Health System Effectiveness in Hypertension Control in Kyrgyzstan". Health Research Paper No. 44. Health Policy Analysis Unit, Center for Health System Development, Kyrgyz Republic.
- Jung, Carl Gustav. 1990. *Erinnerungen, Träume, Gedanken von C.G. Jung. Aufgezeichnet und herausgegeben von Aniela Jaffé*. Walter Verlag Olten und Freiburg im Breisgau. (Translation of the quotation by author of the dissertation)

- Labonte, Ron. 1990. Empowerment: Notes on Professional and Community Dimensions. *Canadian Review of Social Policy*, 26, 64-75. Quoted in Glenn Laverack. 2004. *Health Promotion Practice. Power and Empowerment*. SAGE Publications Ltd.
- Lalonde, Marc. 1974. *A new perspective on the health of Canadians*. Ottawa: Ministry of Health and Welfare
- Lundeen, Elizabeth, Tobias Schueth, Nurjan Toktobaev. 2008. "Prospective Cohort Study Of Young Children And Pregnant And Breastfeeding Women To Test The Efficacy Of Sprinkles In Controlling Anemia In Kyrgyzstan." Technical Report of the study. Kyrgyz-Swiss-Swedish Health Project Document.
- Laverack, Glenn. 2001. An identification and interpretation of the organizational aspects of community empowerment. *Community Development Journal*, 36 (2), 40-52.
- . 2004. *Health Promotion Practice. Power and Empowerment*. SAGE Publications Ltd.
- . 2007. *Health Promotion Practice. Building Empowered Communities*. Open University Press. McGraw-Hill Education, Berkshire.
- . 2009. *Public Health. Power, Empowerment and Professional Practice*. Second Edition. PALGRAVE MACMILLAN.
- Ludema, James D., Diana Whitney, Bernhard J. Mohr, Thomas J. Griffin. 2001. *The Appreciative Inquiry Summit. A practitioner's guide for leading large group change*. Barrett-Koehler Publishers, Inc. San Francisco.
- Masters, Janet. 1995. "The History of Action Research." In: Hughes I, ed. "Action Research Electronic Reader." The University of Sydney, on-line. Accessed on September 25, 2009. (<http://www.scu.edu.au/schools/gcm/ar/arr/arrow/rmasters.html>).
- Ministry of Health of the Kyrgyz Republic. 1996. "Manas National Programme on Health Care Reforms 1996-2006"
- . 2006. "Kyrgyz Republic National Health Care Reform Program, 'Manas Taalimi', 2006-2010".
- Pfander, Babette, Tolkun Jamangulova, Tobias Schueth. 2004. "Process Monitoring of Extension throughout Naryn Oblast of Community Action for Health (Jungal Model), August 2004". Project Document. Kyrgyz-Swiss Health Reform Support Project.
- Raeburn, John, Marco Akerman, Komatra Chuengsatiansup, Fanny Mejia, Oladimeji Oladepo. 2006. Community capacity building and health promotion in a globalized world. *Health Promotion International* 21 (S1): 84-90.

- Raeburn, John, Irving Rootman. 1998. *People-Centred Health Promotion*. John Wiley & Sons, Chichester.
- Raeburn, John, Sarah Macfarlane. 2003. Putting the public into public health: towards a more people-centred approach. In Beaglehole R, ed. *Global public health: a new era*. Oxford: Oxford University Press.
- Raeburn, John, Tim Corbett. 2001. Community Development: How effective is it as an approach in health promotion? Paper prepared for the Second International Symposium on the Effectiveness of Health Promotion. University of Toronto, Centre for Health Promotion <http://www.utoronto.ca/chp/Symposium.htm>. Accessed on January 6, 2010.
- Restrepo, Helena. 2000. "Increasing Community Capacity and Empowering Communities for Promoting Health." Draft Technical Report, Fifth Global Conference on Health Promotion, Mexico City, June 5-9, 2000.
- Rifkin, Susan B. 1985. *Health Planning and Community Participation: Case Studies in Southeast Asia*. Croo Helm. London. Quoted in: Rifkin, Susan B. 1996. *Paradigms Lost: Toward a new understanding of community participation in health programmes*. *Acta Tropica*, 61, 79-92.
- Rütten Alfred, Thomas Von Lengerke, Thomas Abel, Lasse Kannas, Günther Lüschen, Josep A. Rodríguez Diaz, Jan Vinck, Jouke van der Zee. 2000. Policy, Competence And Participation: Empirical Evidence for a Multilevel Health Promotion Model. *Health Promot. Int.* 2000 15(1): 35-47
- Saha, Shayamal Kumar. 2009. *Promotion of Self-help in Development & Social Change Constructing Non Subject-Object Processes*. Doctoral Dissertation. Taos/Tilburg.
- Said, Edward W. 1994. *Culture and Imperialism*. Great Britain. Surray.
- Sampson, Edward E. 2008. *Celebrating The Other. A Dialogic Account of Human Nature*. Taos Institute Publication. Chagrin Falls, Ohio.
- Schüth, Tobias. 2001. *Participatory Action Learning and Planning (PALP). A Facilitation Strategy and Tools for Learning and Action in Community Based Health Promotion*. DASCOH Dorpo.
- Schueth, Tobias, Elizabeth Lundeen 2007. *Action Research on Hypertension by Village Health Committees in Naryn, Talas and Issyk-kul Oblasts*. Kyrgyz-Swiss-Swedish Health Project Document
- Schueth, Tobias, Tolkun Jumanaliev, Shaken Janikeeva, and Temir Tologonov. 2005. "Power from below: Enabling communities to ensure provision of iodated salt in Kyrgyzstan." *Food and Nutrition Bulletin* 26 (4): 366-75

- Schueth, Tobias, Ziauddin Hyder, Melody Tondeur, 2007. "Technical Report on a Study with Weekly Dosage of Sprinkles for 6 Months in Kyrgyzstan." Kyrgyz-Swiss- Health Reform Support Project Document
- Schueth, Tobias, Rosa Sultanalieva. 2006. "The effect of test kits in the hands of communities and retailers on urinary iodine excretion. Prospective study among 1800 school students in Jalal-abad and Talas oblasts". Kyrgyz-Swiss Health Reform Support Project. Project Document.
- . 2008. "Power from below – test kits in the hands of Kyrgyzstan retailers pressure producers to iodize salt." IDD newsletter 29, August 2008: 16-17
- Schueth, Tobias. 2008. "Kyrgyz-Swiss-Swedish Health Project, Annual Report 2008." Kyrgyz-Swiss-Swedish Health Project Document
- SDC 2003. "SDC HEALTH POLICY/2003–2010." Accessed May 3, 2009 (http://www.deza.admin.ch/ressources/resource_en_24123.pdf)
- Shor Ira, Paulo Freire. 1987. *A Pedagogy for Liberation: Dialogues on Transforming Education*. South Hadley, MA, Begin and Garvey.
- Shotter, John. 1993. *Conversational Realities. Constructing Life through Language*. Sage Publication. London
- Smith, Mark K. 2007. Social capital', the encyclopedia of informal education, www.infed.org/biblio/social_capital.htm. Accessed on September 26, 2009.
- SRC 2006. "International Cooperation, Health Policy." Accessed May 3, 2009. (http://redcross.ch/data/info/pubs/pdf/redcross_338_en.pdf)
- Sultanalieva RB, S. Mamutova. 1998. Endemic goitre in Kyrgyzstan. Materials of International Symposium on Iodine Deficiency Conditions: results of study of iodine deficiency disorders in the Republic of Uzbekistan, Tashkent 1998 (original in Russian: Endemicheski Zob v Kyrgyzstane, Materiali Meshdunarodnogo Simposiuma Iododeficitnye sostoyaniya: Itogi isledovaniya iododefizita v Respublike Usbekistan, Tashkent 1998).
- . 2001. Control and prevention of iodine deficiency among people of mountainous Kyrgyzstan. *Central Asian Medical Journal* 2001;Vol 7, No 2 (original in Russian: Kontrol i profilaktika deficita ioda u zhitelei gornogo Kyrgyzstana. *Centralna-asiatskij medicinskij zhurnal* 2001,7/2).
- Sultanalieva, Rosa. 2006a. "Iodine Deficiency Diseases in Kyrgyzstan". Dissertation. Kyrgyz-Russian-Slavian University Bishkek. (original Russian title: Ioddefitsitnye zabolovaniya v Kyrgyzstane)
- . 2006b. "Prevalence of goitre among school students in Issyk-kul, 2006". Kyrgyz-Swiss-Swedish Health Project. Project Document.

- , 2007. "Prevalence of goitre among school students in Issyk-kul, 2007". Kyrgyz-Swiss-Swedish Health Project. Project Document.
- , 2008. Report on provision of iodine to children and pregnant women in Kyrgyzstan. UNICEF Kyrgyzstan Project Document.
- Tengland, Per-Anders. 2008. Empowerment: A Conceptual Discussion. *Health Care Anal* (2008) 16:77–96
- Tones, Keith. 2002. Health literacy: new wine in old bottles? *Health Education Research*, 17 (3), 287-290
- Tritter, Jonathan Quetzal, Alison McCallum. 2006. The snakes and ladders of user involvement: Moving beyond Arnstein. *Health Policy* 76. 156-168
- Turgunbaeva, Alia, Tolkun Jamangulova, Tobias Schueth. 2007a. "How do FGP/FAP staff assess their work with Village Health Committees? Assessment of relationship with and interest of VHCs in Naryn oblast, April 2006". Project Document Kyrgyz-Swiss-Swedish Health Project.
- , 2007b. "How do FGP/FAP staff assess their work with Village Health Committees? Assessment of relationship with and interest of VHCs in Talas oblast, April 2006". Project Document Kyrgyzs-Swiss-Swedish Health Project.
- UNICEF. 2006. "Findings from the Multiple Indicator Cluster Survey, implemented in the Kyrgyz Republic, 2006 (MICS3)" Preliminary Report.
- , 2007. "Prevalence of endemic goitre among school students age 9-10 in Batken oblast by palpation method". UNICEF Kyrgyzstan. Project Document.
- Van der Haar, Dorieke, Dian Marie Hosking. 2004. Evaluating Appreciative Inquiry: a relational constructionist perspective. *Human Relations*, 57, 8, 1017-36.
- Verhagen, Koenraad. 1987. Self-Help Promotion, a challenge to the NGO community. Royal Tropical Institute, Amsterdam/Cebemo, Oegstgeest.
- Virchow, Rudolf. 1849a. Mittheilungen über die in Oberschlesien herrschende Typhus- Epidemie. *Archiv für pathologische Anatomie und Physiologie und für klinische Medizin* 2 (1849) 143-322. Quoted from: Brown Theodore, Elizabeth Fee. 2006. Rudolf Carl Virchow, Medical Scientist, Social Reformer, Role Model. *American Journal of Public Health*, December 2006, Vol 96, No. 12, 2102-2105
- Virchow, Rudolf. 1849b. The diseases of the people, *Medicinische Reform*, No. 51, June 2, 1849. In: Rather LJ, ed. *Collected essays by Rudolph Virchow on public health and epidemiology*. Canton, Massachusetts: Science History Publications, 1985. 15. Quoted from: Morabia, Alfredo. 2009. Is epidemiology nothing but politics on a different level? *J Epidemiol Community Health*. March 2009 Vol 63, 3, 188-90.

- Wallerstein, Nina, Edward Bernstein. 1988. Empowerment Education: Freire's Ideas Adapted to Health Education. *Health Education and Behavior*, 15 (4), 379-94.
- . 1994. Introduction to Community Empowerment, Participatory Education, and Health. *Health Education and Behavior*, 21, 141 (2), 141-148
- Wallerstein, Nina. 1992. Powerlessness, Empowerment, and Health: Implications for Health Promotion Programs. *American Journal of Health Promotion*, 6 (3), 197-205).
- Werner, David, David Sanders. 1997. The Historical Failures and Accomplishments of the Western Medical Model in the Third World. In: *Questioning the solution: the politics of primary health care and child survival*. HealthWrights, Palo Alto.
- Wallerstein, Nina, Victoria Sanchez-Merki. 1994. Freirian praxis in health education: research results from an adolescent prevention program. *Health Education Research*, 9 (1), 105-18.
- Watson, Jane Magruder. 2008. *Appreciative Inquiry. Theory and Practice*. Workshop Resource Book for the AI Foundation Course in Lincoln, UK 2008.
- Watson, Jane Magruder, Bernhard J. Mohr. 2001. *Change at the speed of imagination*. Jossey-Bass/Pfeiffer. San Francisco
- WHO. 1978. Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978
- . 1986. Ottawa Charter for Health Promotion. First International Conference of Health Promotion, Ottawa. WHO/HPR/HEP/95.1
- . 1988. Adelaide Recommendations on Healthy Public Policy. Second International Conference on Health Promotion, Adelaide, South Australia, 5-9 April 1988
- . 1994. Community Action for Health. Background Document. Technical Discussion, Forty-Seventh World Health Assembly. WHO, Geneva.
- . 1997. Jakarta Declaration on Leading Health Promotion into the 21st Century The Fourth International Conference on Health Promotion: New Players for a New Era - Leading Health Promotion into the 21st Century, meeting in Jakarta from 21 to 25 July 1997
- . 1998. Health Promotion Glossary. WHO/HPR/HEP/98.1
- . 2000. Fifth Global Conference on Health Promotion, Mexico City, June 5-9, 2000. Conference Report on the Technical Programme. P 12
- . 2005. The Bangkok Charter for Health Promotion in a Globalized World (11 August 2005).

- , 2005. Action on the Social Determinants of Health: Learnig from Previous Experiences. A background paper prepared for the Commission on Social
- , 2006. "European Health for All database." Accessed May 9, 2009. (<http://data.euro.who.int/hfadb/>)
- , 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.
- , Determinants of Health. WHO. Secretariat of the Commission on Social Determinants of Health.