



## COMMUNITY PARTICIPATION: AN ABUSED CONCEPT?

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### Abstract

One of the main principles of PHC was community participation. However, the interpretation and practices of community participation are so diverse that it became different things to different people. The lessons from the understanding and application of the community participation concept are that health service is not enough as a rallying point for community participation, it is power laden, it is a process of change and context specific, and it is a slow process. It can be regarded as being an abused concept because of the cosmetic, simplistic and superficial impression it is given by its advocates. But it is well used if it empowers communities to analyse, take decisions, and gain confidence and self-esteem. To release the concept from this moribund state may require a new paradigm.

### Introduction

"The language of development rhetoric and writing changes fast. The reality of development practice lags behind the language. In other cases words persist and prevail, whatever happens to the field of reality. Participation is one such word which is experiencing a renaissance in the 1990s" (Chambers, 2000).

Community participation was one of the main principles of Primary Health Care (PHC), the strategy proposed in Alma Ata in 1978 by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) and adopted by 150 member states of the two organizations. It was meant to revolutionize the practice of health care and health development, leading to health for all by the year 2000 (WHO, 1978). Not that the concept was new; in 1950s and early 1960s, it was used within health programmes and health care; but also broadly in social practice and development. Monopoly and control of health care delivery systems by professional health staff resulting from technological complexity and centralization of national health services however, culminated in the Alma Ata declaration calling for the halting, or even reversal of the trend (Kahsay & Oakley, 1999). So by the time of the Alma Ata declaration, the environment within United Nations agencies was focused on the involvement of people in decisions about development.

### Definition of community participation at Alma Ata

The Alma Ata definition was, as usual, lengthy and went as follows: "community participation is the process by which individuals and families assume responsibility for their own health and welfare and those of the community, and develop capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development instead of passive beneficiaries of development aid....". – One interpretation given of this definition vaguely is: "... that community people would become involved in both delivery of and decisions about health and health services in order to provide the type of care most appropriate to their own defined needs and circumstances" (Rifkin, 1986). However, many questions remained unanswered; for instance: 'Why participate?', 'Who participates and who benefits?', 'How do community people participate?', 'With what?' and, 'How would outcomes be assessed?'

Rifkin, (1996) has argued that the framers of the Alma Ata declaration purposely left the concept of community participation vague and flexible in recognition of the fact that countries presented diverse contexts. (Were the seeds for the abuse of the concept or those of simply more rhetoric than reality planted then? Perhaps) Anyhow, as a result, the concept became many different things to different people; making it difficult to reach generally agreed definitions, let alone objectives, for developing it in health care. A plethora of different interpretations and meanings were given to the concept of community participation and its practice. What follows is illustrative.

Rifkin, (1986) reviewed 200 case studies for WHO and UNICEF, and this is what emerged from her analysis:

Health planners used three approaches to define community participation based on three similarly differing definitions of health:

- the *medical approach* – which defines health as absence of disease. Community participation is then defined as activities undertaken by community people following the directions of medical professionals in order to reduce individual illness and improve the general environment; for example using health services or cleaning the environment. It is based on the notion that health improves as a result of biomedical science and technology.
- the *health services approach* – which defines health in the WHO sense of the word: 'physical, social and mental well being of the individual'. It defines community participation as the mobilization of community people to take an active part in the delivery of health services; for example using community health workers (CHW), recruited from and by the community, trained and supervised by health professionals and 'accountable' to the community to deliver health care
- the *community development approach* – which defines health as a human condition which is a result of social, economic, and political development. It defines community participation as community members being actively involved in decisions about how to improve that condition; essentially, that health will improve with eradication of poverty brought about by a change in the existing system of power and control relations.

The first two came to be known as the 'top-down' and the last and third one as the 'bottom-up' approaches. In the former approach, the health professionals have the predominance in decision-making; in the latter, stress is placed on the importance of community people learning to decide what is best for them and the process of how to achieve the change they desire. In short in the latter approach, the solution is secondary to the process that leads to the change that ensues in community members' attitudes and behavior.

### Lessons from the above analysis

1. Health services alone are neither enough to foster community participation nor solve health problems;
2. Authentic community participation has to be premised on the broad needs and interests of the community; and quoting research findings (Elliott, 1975), health services are usually not a priority to lay people except when sick. ("When lay people were asked what they want most, more income, food, shelter, and clothing rank above health services"). Wide community participation therefore develops as part of a process that addresses a range of community needs;
3. Community participation is interwoven with the issue of power. It is therefore erroneous to assume that communities are homogeneous; that leaders always act in the interest of the communities they lead; and that government and the community share the same development goals. Indeed to illustrate the above, experience showed that in areas of poverty, individual concerns often over-ride community goals; people who have been identified by the community as having influence often use new opportunities to enrich themselves; and governments want to mobilize local resources so as to free capital for other programmes, respectively;
4. Community participation is not and should not be considered as a component of a health programme, or an intervention to improve health services and/or health care, but as a process of change that is context-specific. Motivation among community members seems to be the major ingredient;
5. Community participation is heavily influenced by factors such as culture, history, government policy, social, political and economic structures; it is therefore dynamic rather than static. A common history of struggle seems conducive to community participation in terms of community motivation, organization, and structures;
6. Community participation is time consuming, and therefore needs patience and tact.

Other authors concur with these lessons/findings (Woelk, 1992; Tumwine, 1989; Carino et al, 1982; Coombs, 1980).

### A decade after Alma Ata and up to-date.

A decade later, WHO was seeking to promote wider understanding and acceptance of community participation in health care. In 1985 WHO convened an inter-regional meeting in Brioni (former Yugoslavia); it was at that meeting that the term "community involvement in health development, CIH" was explicitly used as the term to describe a basic principle of health care and promotion. In 1989, WHO published the first substantive study on the concept of CIH (Oakley, 1989) and the same year it convened a Study Group to examine the concept and review its practice (WHO, 1991). These actions were made necessary because health sector reform emphasizing cost recovery and privatization – notions that tend to exacerbate exclusion rather than inclusion of the poor in health care – were being promoted. WHO's work was helped by the fact that people's participation in development was already having major influence upon development thinking and practice. Hence support for community participation came from UNICEF; OECD, 1994; World Bank, 1993 & 1994; Health 21 (the health for all policy for the WHO European Region, 1999); Agenda 21 (United Nations Earth Summit in Rio de Janeiro, Brazil, 1993); and the Ottawa Charter for Health promotion, 1986.

In spite of this broad consensus on arguments for community participation and its purposes, the concept however, continues to defy any single definition or interpretation. Interpretations have inevitably reflected the ideological position of those initiating the participation process and its content. Other differences have been as a result of the different ways in which the terms 'community' and 'participation' have been defined and interpreted by different actors in the field.

The word *community* is used to refer to people grouped together on the basis of geography, common interest, identity or interaction or exposed to a particular health risk, depending on whether a planner or a politician, or social scientist or an epidemiologist is the one defining it, respectively. Similarly the term *participation* is used by various actors to mean: collaboration (e.g. contribute land or labour or other resources, hence some form of stakeholders) or target beneficiaries (just receiving programme benefits) or involvement (active engagement in some activities) or lately empowerment (political process of gaining information, understanding, skills and power necessary to articulate their concerns, ensure that action is taken to address them and, more to broadly, gain control over their lives). Empowerment has drawn inspiration from Freire's theory of *consciousness*, namely that information through education is power; hence participation is both a means and an end (Freire, 1972).

Be that as it may, the WHO Study Group gave the following working definition: "Community involvement in health development is essentially a process whereby people, both individually and in groups, exercise their right to play an active and direct role in the development of appropriate health services, in ensuring the conditions for sustained better health, and in supporting the empowerment of communities for health development" (WHO, 1991).

As the debate on the meaning and practice of community participation continues, it would appear that it has become an umbrella term for a people-centred approach to development. It is a continuum which will depend on the actors, though the tenets of genuine community participation, would include the following: active and genuine involvement by community people in defining problems/issues of concern to them; deciding priorities for action; formulating policies to address them; designing plans, implementing, managing, and monitoring solutions; and evaluating outcomes – all in an empowerment frame.

### So is community participation an abused concept?

The answer is both "yes" and "no". "Yes" first, when it is used as a cosmetic label, to make what is proposed or what is done appear good. Initiators of programmes require participatory approaches and consultants, planners, and managers say that they will be used, or they have been used, while the reality has been top-down in the traditional style. Second, when used as a co-opting practice, to mobilize local labour or materials and reduce costs – meaning 'they' (the local people) participate in 'our' project. "No" when used as an empowering process which enables community people to do their own analysis, to take command in terms of design, planning and action, to gain confidence and self-esteem, and make their own decisions; albeit with the experts acting as facilitators of learning rather than teachers. This latter situation is currently more rhetoric than reality.

In general, the impediments to the promotion and practice of genuine community participation remain formidable for the reasons already advanced. Health sector reforms confound the situation further.

Rifkin, 1996 suggests that to release community participation from its present moribund state, it is advisable to employ a new paradigm of 'both –and' (Uphoff, 1992) rather remain stuck in the 'either – or' paradigm. Whether this is pragmatism *par excellence* or an apologist view to acquiesce to powerful forces just like in the debate between comprehensive and selective primary health care, will remain to be seen.

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