COMMUNITY PARTICIPATION IN MATERNAL AND CHILD HEALTH / FAMILY PLANNING PROGRAMMES

SUSAN B. RIFKIN

WORLD HEALTH ORGANIZATION

Community participation in maternal and child health/family planning programmes

An analysis based on case study materials

Susan B. Rifkin
London School of Hygiene
and Tropical Medicine
England

World Health Organization
Geneva
1990

WHO Library Cataloguing in Publication Data

Rifkin, Susan B.
Community participation in maternal and child health family planning programmes: an analysis based on case study materials.

1.Community health services – organization & administration 2.Consumer participation 3.Maternal health services – organization & administration 4.Child health services – organization & administration 5.Primary health care I.Title

ISBN 92 4 156135 1 (NLM Classification: WA 310)

TYPESET IN INDIA
PRINTED IN ENGLAND

89 8096—Macmillan Glass 6500

Preface

This review, which was prepared at the request of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), is based on case studies sponsored by both governmental and nongovernmental organizations in many developing countries. The material has been collected from publications and from the files of the following agencies: WHO, UNICEF, the International Planned Parenthood Federation (IPPF), the United States Agency for International Development (USAID), the American Public Health Association (APHA), the Pan American Health Organization (PAHO), the Population Council, the International Development Research Centre (IDRC), the Canadian International Development Agency (CIDA), the International Council of Adult Education (ICAE) and the Oxford Committee for Famine Relief (Oxfam). Discussions were held with various members of those agencies to ascertain their views on community participation in programmes with which they were familiar. The author has also drawn on field experiences gained while she was working and doing research in Asia.

Acknowledgements

The author acknowledges a debt of gratitude to the many people who spent time and effort to obtain materials and discuss their own views, in particular the following: Dr Manuel Carballo (WHO), Dr Mark Belsey (WHO), Dr Karin Edström (WHO), Mr Ralph Diaz (UNICEF), Ms Beth Preble (UNICEF), Dr Maria MacDonald (IPPF), Dr Antonio Solis (PAHO), Ms Marilyn Rice (PAHO), Dr Gerald Bailey (USAID), Dr Susi Kessler (APHA), Dr Wayne Stinson (APHA), Dr Mike Favin (APHA), Dr Margaret McEvoy (Population Council), Dr Karl Smith (IDRC), Ms Nancy Gerein (CIDA), Ms Joyce Frieson (CIDA), Mr Brian Pratt (Oxfam)

and Ms Jo Boyden. Special thanks are due to Mr Phillip Payne and the Department of Human Nutrition at the London School of Hygiene and Tropical Medicine who provided logistic support for the study.

Introduction

In the past decade, since the adoption of the Declaration of Alma-Ata on primary health care, community participation has become increasingly recognized as an important element in improving health, particularly among poor and underserved populations in developing countries. The development of this concept and the various attempts by planners to incorporate it into new or existing health care programmes have been extensively documented; these records vary in both length and quality but nevertheless offer many valuable lessons for those concerned with this topic.

The purpose of this book is to review a wide range of experience in maternal and child health/family planning (MCH/FP) programmes, with the aim of determining whether it is possible to single out the factors and conditions that encourage effective community participation.

The text is divided into four chapters. The first, a brief history of community participation in health care, concentrates on the changes in attitude since the Second World War, the influence of community development ideas on community participation in health care and, in particular, MCH/FP activities in primary health care. In the second chapter the various interpretations of community participation are discussed, with emphasis on those that are most relevant to the delivery of MCH/FP services. It is suggested that, by determining who participates, why and how, it is possible to arrive at a functional definition of the term that will also allow clear programme objectives to be set.

The analytical framework for the study is developed in Chapter 3, which describes programmes on the basis of their objectives and the ways in which those objectives are pursued. Two sets of factors are suggested, which determine how much progress a programme has made at a given time and to what extent it has been successful. The first set consists of "descriptive factors", which are mainly environmental and/or structural, such as national culture, history

and type of government. The second set consists of "action factors", i.e. those that will influence planners and agencies; they include assessment of needs, community organization, programme management, resource mobilization, leadership, and concentration on the needs of the poor. The final chapter is concerned with the application of the framework to case studies, the possibility of determining the conditions that make community participation effective, and the limitations of this approach.

To determine what is meant by community participation, three questions were formulated:

Why participation?

Who participates?

How do people participate?

These questions not only provide a multidimensional answer but also make it possible to obtain a clear statement of programme objectives. On this basis, the types of programmes reported in the literature were classified and the factors determined that influenced the ways in which community participation developed in those programmes.

To illustrate several of the points in the sections defining community participation and describing one such set of factors, a number of programmes are briefly outlined. As several of the descriptions are taken from file studies rather than publications and as they are used to provide examples rather than to analyse or criticize any specific programme, the projects are not identified by name, only by country.

This study is not intended to be a comprehensive review of health programmes that include MCH FP services and community participation, nor is it a definitive analysis of the dynamics and development of community interaction in the use and delivery of health services. Rather, it is a basis to enable planners who are interested in community participation to recognize some of the more important management and behavioural issues that may affect the development of their programmes. By suggesting a range of programme objectives and indicating factors that may determine the extent to which these objectives are achieved, modified or abandoned, the study draws attention to some of the more important problems and potentials of community-based health service programmes. The aim is to provide a framework for the management and human aspects of such programmes and an analytical tool to enable planners to begin to discuss the goals and direction of their

programmes, both among themselves and with a variety of people in the community.

Of the several hundred case study files reviewed by the author, only about 15 contained any thorough analysis of community participation, either in health service programmes in general or in programmes with an MCH/FP component. The document *Community involvement in primary health care: a study of the process of community motivation and continued participation* (UNICEF/WHO, 1977) was among the first to single out and describe some of the factors that influence effective community involvement. Studies by the American Public Health Association (APHA, 1977, 1983) and the World Federation of Public Health Associations (WFPHA, 1984) classify the various approaches to community participation adopted by different programmes but do not discuss the ways in which participation develops. The WFPHA publication, on the training of community health workers, began to deal with the deeper issues involved. One of the best analytical studies on the topic is *Meeting the basic needs of the rural poor* (Coombs, 1980); it reviews the problems and possibilities of community participation over a period and discusses programme adjustments in response to the failure of previous approaches and assumptions. A more recent study (Carino et al., 1982) covers five programmes in the Philippines sponsored by the government or by nongovernmental organizations, and suggests ways of measuring the effectiveness of health programmes with community participation. Of the studies reviewed here, this is the only one that deals directly with the topic.

An excellent analysis has been carried out by the Pan American Health Organization (PAHO, 1984). Based on studies of eight countries in the PAHO region, it derives valuable lessons for planners within both governments and nongovernmental organizations. From the analytical point of view the various evaluations by Oxfam of its own field programmes, which investigate the broad issue of community participation in health care, are also valuable. Those evaluations, however, were carried out in response to requests from headquarters, rather than as systematic studies of community participation in health care. Additionally, there are a few reports—two evaluations from IDRC, a field report from an APHA researcher, and three or four papers in the book *Practising health for all* (Morley el al., 1983) — which give some insight into specific cases. Overall, considering how much has been written about the subject, remarkably few studies have made any attempt to analyse the concept and its implications for programmes.

Contents

Chapter 1

Community participation in health care: a brief history

The growth of primary health care

Interest in community participation in health care is not new; there was community support for healers in past centuries and it is still a feature of traditional cultures today. It was recognized in the nineteenth century as a fundamental factor in the public health movements that swept Europe—particularly the United Kingdom—and North America during that period. Today, many international organizations and agencies, including UNICEF and WHO, emphasize the importance of community involvement in health care as a basis for improving health throughout the world.

The stress now laid on community participation has resulted from two trends that emerged after the Second World War. The first was increasing disillusionment with the ability of the "Western" medical system to improve the health of the majority of the world's people. That system, which had developed in the industrial countries, stressed curative, hospital-based treatment and one-to-one doctor/patient relationships, and was transferred to their colonies by those same countries. With the advent of decolonization, the inadequacies of the system were dramatically exposed. New nations had neither a suitable infrastructure to sustain it nor the money to support its high costs. Moreover, since it was based mainly in the urban areas and available principally to those with the money to pay for its services, it denied care to the majority of the people, who lived in rural areas where they had little access to any type of health care.

To deal with the health crisis that began to develop as a consequence, it was proposed that a logical step would be to shift the emphasis away from this type of medical service and new technologies towards preventive, decentralized, community care based on epidemiological priorities. Health service delivery was seen in terms of social policy rather than technological development. Planners believed that providing people with knowledge, through health

education, would greatly improve health. However, the policy gradually degenerated into the mere provision of knowledge, generally handed down from experts to lay people and resulting in only limited improvements in health. As a result, new approaches to health care delivery were adopted which rejected health policies handed down from "the top" and health education concerned merely with the provision of knowledge. It began to be apparent to many that it was necessary to involve in the planning of health services those who most needed them.

Put succinctly, it was increasingly recognized that the differences that exist between urban and rural societies, ethnic and regional groups, and people with different lifestyles and values, make it essential that the consumer—the community — influences the nature of the health service available to it. Thus, if any noticeable improvement in health status is to be effected, communities must be involved in decisions concerning health services.

The second trend to emerge in the post-war period was the recognition that public health policy was not only concerned with curing disease but formed an integral part of a country's general development policies. In line with the arguments of the Swedish economist Myrdal, health was increasingly recognized as an "investment in man" (Myrdal & King, 1972). As a result, health services were no longer the preserve of the medical profession but became an integral part of all economic development planning. Thus the debates about "basic needs", "social justice", and "people's participation" began to involve health care.

The development of these two trends resulted in the concept of primary health care. As defined in Alma-Ata in 1978 by WHO and UNICEF, primary health care is "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford" (WHO, 1978). Among the most important aspects of primary health care are the following:

(1) Health is not the responsibility of the health sector alone, but is also affected by development activities in other sectors such as education, housing, agriculture. Hence a need exists to integrate all such development activities.

(2) The development of self-reliance and social awareness through continuing community participation is a key factor in improving health.

(3) If health care is to be improved it is essential that the community should define its needs and suggest ways of meeting them.

(4) Decentralization is necessary if community needs are to be met and problems solved.

(5) Community resources, financial and human, can make an important contribution to health and development activities.

Community participation is seen as the key to primary health care, which is concerned not with advanced medical technology but rather with applying tried and tested health care procedures to the health problems of the poor and underprivileged, most of whom live in rural areas of the developing countries. It is believed that only if those who most need health care participate in its delivery will there be any impact on the diseases afflicting them, and that only community involvement can ensure that culturally acceptable care is available to those who are at present underserved.

WHO and UNICEF have not confined themseleves to mere advocacy of primary health care based on community participation but have also pursued activities designed to promote its practical application. In developing a strategy for "health for all by the year 2000", WHO has focused on examining the role of members of the community in the delivery of health services. For example, it has promoted exchange of experience among countries in which community health workers have been utilized and has supported research to assess the extent to which community participation in health services has led to an improvement in health status. It has also sought to integrate community participation into several specialized health care activities. Those concerned with the control of communicable diseases have examined methods of involving members of the community in their efforts and have incorporated community participation components in their training modules.

UNICEF has adopted a more integrated approach, in which community participation is developed through a number of community development activities (discussed in the next section) in addition to health services, including food production, nutrition, water and sanitation, education, and income generation. UNICEF's experience of this approach to community participation has contributed much to an understanding of how people in the community can be motivated and involved in improving their own health. It has also helped give a broader meaning to "health" in primary health care, expanding the definition beyond health service activities alone.

Primary health care and community development

In approaching the integration of health into development planning by promoting primary health care, the history of community participation in development programmes in general is relevant. The interest in community participation in development programmes in the Third World is not new, nor did it begin with development of the primary health care concept. In the 1950s, the United Nations was instrumental in promoting what has been called the community development movement, which advocated that people in the community should play a major role in their own development programmes. Used originally in various parts of Africa as a mass education activity for the rural poor, it gradually gained wide acceptance throughout the world. It was defined at the 1948 Cambridge Summer Conference on African Administration, called to discuss the social policies of colonial administrations; in part, the definition read "Community development . . . . embraces all forms of betterment. It includes the whole range of activities in the district, whether they are undertaken by government or unofficial bodies" (quoted in Brokensha & Hodge, 1969). The definition was later expanded by the United Nations Department of Social and Economic Affairs to stress the *processes* in which communities and government joined together to improve the economic, social and cultural conditions of the community (UN Department of Social and Economic Affairs, 1971).

Community development, it has been suggested, can be seen as a method, as a movement, as a programme and as a concept (Sanders, 1970). As a method, it is very similar, but on a community scale, to the techniques used by social workers with individual clients, such as gaining the trust of the client, using that trust to find out the client's view of the problem (felt needs) and its causes (real needs), encouraging the client to discover what he or she can do to help improve the situation, and supporting any efforts to find and use the resources necessary for such improvement (self-help). When programmes are implemented, this method develops the following characteristics (Mezirow, 1963):

— concern for ensuring the integrated development of the whole of community life, involving the integration or coordination of technical specialities;

— planning based on the "felt needs" of the people;

— emphasis on self-help;

— concentration on singling out, enouraging and training local leaders;

— provision of technical assistance in the form of personnel, equipment, materials and/or money.

Foster (1982) has compared the conceptual similarities between community development and primary health care. He notes that both concepts:

— emphasize multipurpose activities;

— presuppose that the provision of basic services and material gains are essential to development;

— recognize to a greater (community development) or lesser (primary health care) degree that the processes by which the goals are achieved (local initiatives, self-confidence, self-reliance and cooperation) are more important than the goals themselves (achievement of concrete objectives).

In addition, both concepts stress the need for planners to base their plans on a community's felt needs and to utilize community resources, including its people, to carry out programme tasks.

Foster also discusses a number of false assumptions that plagued the community development movement and that, in his view, had to be corrected if primary health care was to be successfully developed. They include the following:

(1) "Communities are homogeneous." In fact, communities are mostly not homogeneous, nor do they usually see reasons for always cooperating "for the common good". Experience shows that individual concerns often override community goals, particularly in areas of poverty. Only when people rise above the level of extreme poverty and lack of resources does cooperation become feasible.

(2) "Knowledge will automatically create desired changes in behaviour." In reality, communities do not change their types of behaviour because new practices are taught by community development workers. Time and experience have proved not only that new knowledge does not automatically induce change but also that traditional practices often have some value. Behavioural change — for better or worse — takes a long time.

(3) "Community leaders act in the best interests of their people." The actions of community leaders do not always benefit the entire community. People singled out by community workers

as having influence often use the opportunity to enrich themselves and their families. Thus, a programme designed for the poor has often benefited only those who were already better off.

(4) "Government and community workers share the same goals for community development." This is often not the case. Government workers want to mobilize local resources in order to free capital for other national programmes; community workers want to inculcate confidence and self-reliance in the members of the community. This conflict of interest has sometimes inhibited community development programmes.

(5) "Community development activities do not create conflicts for planners." In fact, the management of community programmes may pose several problems for planners. For example, the need to show results may conflict with the need to allow members of the community sufficient time to become active in programmes with new orientations; professionals may define the community's needs on the basis of their own training and their capacity to provide for those needs, whereas the community may wish to give priority to other needs which its own experience shows to be more important; the wish of personnel to "serve the people" may conflict with their own career goals; and personnel may wish to promote their own sector's interests rather than cooperate with other ministries.

These problems have actually been encountered in many programmes but tended to be forgotten or ignored when planners in both health and development programmes were searching for a definition of community participation that could be used as a basis for implementation.

Community participation and MCH/FP activities

While literature analysing the necessity for community participation in primary health care has proliferated over the past decade, few case study reports have dealt specifically with the relationship of community participation to MCH/FP activities. Rather, the reports tended to explore the role for members of the community in a whole range of health activities, of which MCH/FP programmes are usually considered a part. For the purposes of this publication, however, it seems useful to review briefly the reason for concentrating on those sections of the community — mothers and children — that derive direct and immediate benefit from MCH/FP activities

and on the potential and limitations of their involvement in improving health conditions and health care.

The factors that either constrain or favour the involvement of women in community health activities were treated at length in a recent WHO book *Women as providers of health care* (Pizurki et al., 1987). The book points out the following factors, *inter alia*, as reasons for involving women in health activities, particularly those designed to improve the health care they themselves receive.

First, women have a traditional and natural role in providing health care. They are the principal providers of health care both within the family and in communities. Moreover, as role-models for children and younger people, they can do much to encourage health-sustaining attitudes and behaviour. Women also provide the greater part of care delivered by formal health systems, within which they work as doctors, nurses, modern and traditional midwives, and paramedical and voluntary workers.

Second, the opportunities provided for communicating with other women during the course of normal domestic tasks—water-collecting, shopping, etc.—ensure that much valuable information is passed on. Communication and mutual support within this informal "network" often supplements the work of formal health providers.

Third, women frequently have stronger community roots, especially in developing societies where men may migrate to urban areas in search of better-paid work. In volunteering to become village or community health workers, or becoming active in other areas of community life, they provide a continuity that is essential in rural development and health programmes.

Many of the traditional activities of women, such as the collection of water, the provision and preparation of food, the rearing of children, reflect aspects of the intersectoral approach to improving health. Where they strive for basic levels of sanitation, clean water supplies, improved food safety, etc., women can have a positive influence on health status; the promotion of health will then come to be seen as a community activity rather than solely a task for the health services.

Finally, the women's organizations that already exist in many communities provide a ready-made structure for the participation of women in health-promoting activities. Such organizations include child-care groups, community centres and, to an extent, schools, where the majority of teachers are usually women; they are experienced in mobilizing resources for the common good and are therefore able to put their experience to good use in promoting the improvement of health.

The book also discusses the constraints that limit the participation of women in community activities in general and health in particular. Perhaps the most significant of these is the relatively low social and economic status of women in many rural and developing societies, combined with the frequent lack of educational opportunities, as a result of which their personal and material contributions to their traditional role as health providers are rarely understood by planners. Government policy-makers in particular give little credit or support to women or women's organizations in this area, with the result that women are rarely consulted on health issues and frequently lack training opportunities and funding.

Women are also hampered by cultural traditions that relegate them to menial tasks in the community. In a male-dominated society there is likely to be entrenched opposition to any radical change in the status or role of women that is seen as giving them greater authority.

In many developing countries, women in poor rural areas are often overburdened with domestic responsibilities and prone to ill health, which leaves them little time or energy for activities outside the home. When they are able to participate in other work this is likely to be in an undertaking that will bring immediate economic benefit rather than long-term advantage; health or sanitation programmes may well be seen as the responsibility of the government rather than the community.

These factors apply to the involvement of women in community development generally and in health activities specifically and must be taken into account in analysing community participation in MCH/FP programmes.