Community involvement in health development

An examination of the critical issues

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Foreword

In the past decade, enormous efforts, both intellectual and practical, have been made to devise strategies to improve the lives of the many millions of disadvantaged people in the world. In these efforts, an important concept is the central importance of the people themselves participating in the decisions, and in the implementation and management of development programmes and projects. Participation has been widely recognized as both a basic right of people and of central importance to the success of development efforts.

Naturally, therefore, the link has been made between participation and programmes designed to improve people's health. Many people in the world do not have ready access to health services, and must rely on local knowledge and traditional practices for health care. There is, therefore, a fund of local experience and resources in many parts of the world which could be mobilized to support health programmes. Most countries have at least the elements of a national health structure and in many cases its effectiveness would be increased if local people could contribute to and play a part in its functioning. Community involvement in health development (CIH) has emerged as an imaginative new approach which seeks to bring together the formal, professional health structure and local people with their knowledge and resources.

WHO has played an important role in the promotion of CIH. Since the late 1970s it has actively supported a range of activities which have begun to examine CIH in different fields of health practice to try to define a clearer strategy. Studies have been conducted in over twenty countries and work is continuing in thirteen others. CIH is central to WHO's strategy for health for all, and needs to be considered by all health professionals and administrators in devising programmes for health promotion.

The basic purpose of this book is to bring together the wide-ranging thinking on and interpretations of CIH. It is an attempt to distil an increasing amount of material and present in a clear and

concise form the essential elements of CIH. It is intended to serve as a guide for the health professionals who support the idea of CIH and seek to put it into practice, but do not have the time to review a vast amount of material.

This publication is a milestone in the work of WHO on CIH, signifying the move from talk to action that is taking place in many countries. But action is being hindered by lack of skills, by structural and organizational obstacles, and by lack of tried and tested methods for setting criteria and measuring progress in CIH. WHO is intensifying its efforts in these areas in particular through focusing on district health systems based on primary health care, where national health policies and strategies can be harmonized with local needs, initiatives and resources, resulting in participatory development and better health for all people.

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Preface

The notion of community involvement in health care has a long tradition, but it is only in the past ten years or so that community involvement in health development (CIH) has emerged as a systematic approach to the subject. CIH is widely acknowledged to be essential to the development of health services, particularly in developing countries, where the process of involving the community in other aspects of development, such as agriculture, has already begun. A number of publications are now available which seek to explain the concept of CIH and it has begun to influence the health sector through, for example, primary health care (PHC), tropical disease control and clean water supply. The proceedings of seminars, workshops and meetings held to discuss and analyse CIH have added to the volume of published material.

In June 1985, a WHO inter-regional meeting on CIH was held on the island of Brioni in Yugoslavia, which in addition to reviewing regional and country experience singled out a number of issues critical to the understanding and practice of CIH. The present review is based on the report of the Brioni meeting and seeks essentially to deal in more depth with the issues discussed in it, particularly by analysing the pertinent literature and expanding the conclusions drawn. It is thus an attempt to explain the reasoning underlying the report of the inter-regional meeting and to develop the arguments set forth therein.[a] The facts that most of the literature on CIH has been published in the last ten years and that the concept has been applied in a very wide range of contexts have underlined the need for a single text discussing CIH theory and practice and the main issues involved. This publication seeks to meet that need. It makes no claims to be a definitive text on the subject.

[a] *Community involvement for health development: report of the inter-regional meeting, Brioni, Yugoslavia, 9–14 June 1985*. Unpublished WHO document, SHS/85.8.

At present, knowledge of how CIH is applied in practice is quite limited since in general its implementation has not been on a wide scale and has not therefore been described in widely accessible sources. This book does contain, however, a number of direct references to CIH practice in the belief that a more systematic understanding of that practice will promote wider adoption of CIH as an approach to health development.

Another purpose of this book is to serve as an introduction and source of information for health professionals who are already, or expect to become, involved in CIH as a health strategy. By considering material drawn from a wide range of texts, it pinpoints the critical issues that health professionals will have to consider in implementing CIH. It is neither a training manual nor a detailed review of national policy options. It should, however, be of use to health professionals and to the staff and students of health and training institutions who have to determine how the CIH concept can best be translated into practical measures. As more information accumulates the essential aspects of CIH will need to be studied in greater detail. The book should, therefore, be seen as an initial step towards clarifying conceptual and practical issues in order to broaden understanding of the potential of CIH as an effective health strategy.

The first two chapters examine community participation and community involvement in health development and describe the variety of interpretations that have been given to the two concepts. The longest chapter is Chapter 3, which examines a number of the essential issues involved. Each of these is considered in some detail and suggestions are made on how best to deal with them. The final chapter sums up the current position with regard to CIH and suggests a number of steps that could be taken to use it more effectively as a strategy for health development.

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Contents

Chapter 1

The basis of CIH

Introduction

Any discussion of the concept and practice of CIH must begin by examining what is commonly called the 'development process'. Health development is an important element in the development process in general and is therefore influenced in practice by different perceptions of what constitutes development and what causes underdevelopment. Until the early 1970s the development process was largely dominated by attempts on the part of development planners and workers to modernize and improve the technical performance of the physical assets of a particular country or area. In the health field this approach led to an emphasis on building up the health infrastructure at different levels and introducing health practices based on 'western' concepts of health care. Since the early 1970s, however, a fundamental reappraisal of the nature and content of the development process has been under way and has inevitably influenced thinking on health practice and development (*1*, *2*).

The essential feature of this reappraisal has been the concept of 'participation', i.e. the idea that, whatever material form the development process may take, the active participation of the people in any activities proposed or undertaken must be encouraged. This concept has given rise to a flood of publications and the idea of participation is now part and parcel of most forms of developmental activity. This is not the place, however, to examine this vast corpus of literature on participation, except to say that two main schools of thought seem to have emerged:

(i) One school makes the assumption that there is little generally wrong with the direction of the development process and that past failures have largely occurred because the human element has been neglected and people have not wanted to involve themselves in projects about which they had little information or of whose value they were not convinced. This assumption

has been the basis of measures to fill the gap, to provide more information and to increase the knowledge of the local people concerned. It is believed that this information and knowledge will persuade people to become involved, to commit themselves, and thus help ensure the success of the project or programme.

(ii) The other school argues that the direction of the development process is fundamentally misconceived. It is not the failure to take the human factor into account that is at fault, but rather the unreflecting way in which people have been left out of the development equation and treated as passive recipients rather than active participants. The new approach, therefore, is to seek innovative and flexible procedures, taking into account the knowledge already possessed by local people. Participation in this sense is concerned with the production of knowledge, new directions and new modes of organization, rather than with the wider dissemination of the procedures adopted hitherto.

Clearly these two interpretations of participation are very different; it could indeed be argued that they are diametrically opposed to each other. What matters is to recognize that they exist and may result in equally different forms of practice. There is no single universally valid interpretation of participation. It must be stated, however, that the analysis of the content, trends and practice of CIH in this study is based on the second of the two concepts outlined above.

Whatever the underlying assumptions, however, all ideas of participation agree that people must be given a voice in development decisions, access to the resources and knowledge required for development and a share in the benefits achieved. Participation in development is a multidimensional process which varies from area to area, depending on local circumstances. There are many ways of looking at it and its interpretation very much depends on the approach to development adopted (*3*).

Participation and health

In view of what has been outlined above, there has been an increasing tendency to give favourable consideration to the notion of local participation in health policy and services. There is overwhelming evidence that the majority of the world's people have no regular access to organized health services. Most people in the world in fact confront the diseases and illnesses that plague them with

little, if any, formal support and under conditions of scarce food and financial resources. In most developing countries the formal health services are able to provide coverage for only a small proportion of the people they are supposed to look after (*4*). In coping with the problems of how to stay alive and healthy, millions of poor people have little to support them but their own knowledge and efforts (*5*).

In response to this situation, the aim of achieving health for all by the year 2000 has been adopted as a basic tenet of health policy and development. In the first instance it could be argued that its achievement depends largely on the eradication of poverty and that the actions required are therefore largely outside the realm of medicine and public health proper. Health for all, therefore, is not exclusively an issue of health policy and development. The obstacles in the way of achieving it are daunting. These obstacles are not primarily due to a lack of medical knowledge; indeed it might be argued that, given the appropriate mechanisms and support, the scientific knowledge needed to radically improve the health of the majority of the world's population already exists and that what is mainly required is knowledge of how to achieve the massive, widespread involvement of people themselves, not just in supporting the health services and enabling them to function, but what is more important, in determining health priorities and how to allocate scarce health resources. Community participation has therefore, come to be seen as a way of rapidly improving the health services available for the majority of the world's people. Indeed it is argued that even if the structural changes required are carried out, health for all will be unachievable by the year 2000 unless radically different forms of health care are instituted that tap local manpower and resources and are essentially people's services and not services designed and maintained by external government health representatives. This argument, however, must be considered in relation to the current distribution of health resources within a particular country and should not be interpreted as throwing the onus of providing the resources for health care entirely upon local communities (*6*, *7*).

The arguments for CIH

Inevitably, fresh thinking on development practices has led in the different sectors to critical reviews of previous practices and arguments in favour of change. In the past eight years or so the emergence of the CIH concept has led to widespread reconsideration of previous practices, determination of where they went wrong

and proposals for the changes that are needed. The formal concept of CIH seems to date from the mid-1970s and since then a wide range of publications have argued its merits and suggested the kinds of change it would bring about. It would appear from the literature that CIH has been enthusiastically welcomed as the fundamental change in direction required to promote effective health development.

Advantages of a community participation approach

(i) A community participation approach is a cost-effective way of extending a health care system to the geographical and social periphery of a country – although it is far from cost-free.

(ii) Communities that begin to understand their health status objectively rather than fatalistically may be moved to take a series of preventive measures.

(iii) Communities that invest labour, time, money and materials in health-promoting activities are more committed to the use and maintenance of the things they produce, such as water supplies.

(iv) Health education is most effective as part and parcel of village activities.

(v) Community health workers, if they are well chosen, have the people's confidence. They may know the most effective techniques for achieving commitment from their neighbours and, at the very least, are not likely to exploit them. They come under strong social pressure to help the community carry out its health-promoting activities. However, they must also have dependable supplies and support from the higher levels of the health service.

MacCormack, C. P. Community participation in primary health care. *Tropical doctor*, **13** (2): 51–54 (1983)

The arguments in favour of CIH are not only convincing but also fairly uniform throughout the literature and are frequently based on an analysis of past errors. Health development is not a recent phenomenon but, like the development of other sectors such as agriculture, has long been an important aspect of both national and regional development plans. Criticisms of previous health development strategies, particularly those linked to the notion of

community involvement, suggest four main reasons for their lack of success (*8*):

(i) They failed to encourage people to think or act for themselves in attempting to solve their health problems, impelling them to rely upon external sources for action and solutions.

(ii) Failure to provide adequate training led to local people being unable to maintain the services that had been set up. Those services could not, therefore, be sustained by local resources and knowledge.

(iii) In the past there have been cases of communities contributing resources and manpower to health projects and programmes, but there has been little active community involvement in their design and implementation.

(iv) The conflict between health-directed needs, as determined by the health service and medical profession, and health-related needs, such as housing, water and sanitation, as determined by local people themselves. This conflict often results in an incompatibility between the two sets of needs and a lack of community interest in externally promoted health programmes.

CIH has, therefore, emerged as the antidote to the deficiencies outlined above and the arguments in favour of it have been extensively discussed in the literature. Each of the rather similar reasons for failure listed above underlines the critical importance of local involvement if health programmes and projects are to succeed. Several studies set forth arguments for adopting CIH as a strategy for health development and the following is a composite list of those arguments taken from several sources (*8–10*):

(i) CIH is a basic right, which all people should be able to enjoy. Involvement in the decisions and actions that affect people's health builds self-esteem and also encourages a sense of responsibility. CIH as a principle is of intrinsic value in the development of communities in a wider sense and should be promoted as the basic approach to health development.

(ii) Many health services, particularly in developing countries, function on the basis of limited resources. CIH can be a means of making more resources available by drawing upon local knowledge and resources to complement what is provided by the formal health services. Furthermore, it can help to extend the coverage of health services and to lower their overall cost.

CIH can also make health services more cost-effective and lead in the long term to an adequate return on funds invested in the health sector. It is not, however, a substitute for formal health services or a mechanism of double taxation.

(iii) CIH increases the possibility that health programmes and projects will be appropriate and successful in meeting health needs as defined by local people, as opposed to medical needs as defined by the health authorities. When health services take into account local perceptions of health needs and are managed with the support of local people, there will be a better chance of their programmes being successful.

(iv) CIH breaks the knot of dependence that characterizes much health development work and, on a wider front, makes local people aware that they could become usefully involved in development in general. Ultimately CIH can help to make people politically conscious and eager to make their voice heard in regard to development processes in their country or area.

Comment

In theory at least, health professionals seem to support CIH as a basic principle to be followed in health development. CIH has become a widely accepted concept and doubts about its need or appropriateness are rarely formally expressed. The literature reflects this commitment to CIH, which it supports with persuasive arguments. Among the guiding principles agreed at Alma-Ata and embodied in the health-for-all strategy, for example, is the participation of people in health development. If judgements were based solely on the professional literature it might well be concluded that CIH as a strategy for health development was now firmly entrenched in the minds of those who are responsible for formulating health policy and managing its implementation.

It has to be acknowledged, however, that because of its relative newness as a strategy of health development, the theory of CIH is probably somewhat ahead of its practice. Although there are an increasing number of examples of CIH being applied in a variety of different contexts, as a fundamental principle of formal health service practice it is still largely underdeveloped. It was in view of this that a WHO inter-regional meeting on CIH was held in Brioni in Yugoslavia in June 1985 to examine various aspects of CIH practice. That meeting singled out a number of problems that needed further consideration, and which form the basis of this book.

References and notes

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2. Galjart, B. Counterdevelopment: a position paper. *Community development journal*, 16: 88–96 (1981).

3. The literature on the concept and practice of participation in different fields of development has grown enormously in recent years. A few examples include: Uphoff, N. T. & Cohen, J. *Feasibility and application of rural development participation: a state-of-the-art paper*, Ithaca, NY, Cornell University, 1979; Oakley, P. & Marsden, D. *Approaches to participation in rural development*, Geneva, International Labour Office, 1985; and Galjart, B. & Buijs, D., ed. *Participation of the poor in development*, Leiden, University of Leiden, 1982.

4. Extension of health service coverage using primary care and community participation strategies. *Bulletin of the Pan American Health Organization*, XI: 345–369 (1977).

5. Newell, K. W. Helping people help themselves. *World health*, April 1975, pp. 3–7.

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8. Fonaroff, A. *Community involvement in health systems for primary health care*. Unpublished WHO document SHS/83.6.

9. *Community participation and tropical disease control–an exercise in participatory research*. Unpublished WHO document, TDR/SER/SWG, 1983.

10. *Global Strategy for Health For All by the Year 2000*. Geneva, World Health Organization, 1981 ("Health for All" Series, No. 3).

Chapter 2

Understanding CIH

Introduction

The concept of CIH emerged as a result of concern to encourage local participation in all aspects of development, including health development. CIH means local participation in the design and delivery of health care services, which is needed for the reasons examined in Chapter 1. Health literature, however, seems in doubt as to whether to use the term 'community involvement' or 'community participation'. In most areas of development preference seems to be given to the term 'community participation' but the health sector seems to have opted for 'community involvement' because of its deeper implications. In primary health care the distinction between the two terms can be seen from the following statement (*1*):

> To be successful [primary health care] needs individual and community self-reliance and the maximum community involvement or participation, that is to say, the active involvement of people living together in some form of social organization and cohesion in the planning, operation and control of primary health care using local, national and other resources. The term 'involvement' is preferable to 'participation' because it implies a deeper and more personal identification of members of the community with primary health care.

Such has been the impact in the past few years of the concept of participation in health development that it has begun to influence thinking in a whole range of related health fields. Since the late 1970s there has been a flood of literature analysing the concept of involvement in various aspects of health development. In the great majority of cases the literature acknowledges the importance of such involvement but, as was to be expected, there is a wide range of interpretations and it is frequently necessary first and foremost to define the terms used. Because it is a fundamental principle of

design and implementation, community involvement in health development is open to a variety of interpretations.

Community participation

The concept of CIH cannot be divorced from the broader aim of encouraging the active participation of local people in the development process as a whole. Any understanding of CIH must therefore begin by attempting to understand the concept of participation. And that is where the problem begins. There is no single working interpretation of the concept of participation that has been universally accepted in development work. Indeed there are a variety of different interpretations, each giving rise to a different form of practice. It is important to be aware of this variety of interpretations, since each, in its own way, has profound implications for development practice.

Although there would appear to be widespread agreement on the importance of community participation for bringing about the desired redistribution of the benefits of development, there is less of a consensus on the nature and content of the participation process. A wide range of equivocal terms such as 'self-help', 'self-reliance', 'cooperation' and 'local autonomy' add to the confusion. The following are, for example, three interpretations of participation which reflect quite different concepts of development:

(i) 'Participation means . . . in its broadest sense to sensitize people and thus to increase the receptivity and ability of people to respond to development programmes, as well as to encourage local initiatives' (*2*).

(ii) 'With regard to development . . . participation includes people's involvement in decision-making processes, in implementing programmes . . . their sharing in the benefits of development programmes and their involvement in efforts to evaluate such programmes' (*3*).

(iii) 'Participation involves . . . organized efforts to increase control over resources and regulative institutions in given social situations on the part of groups or movements of those hitherto excluded from such control' (*4*).

These statements bear witness to widely divergent views on the nature of participation in rural development. It is important, however, to reduce these different views to some sort of order if participation is to be subjected to rational analysis. This can be done by