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Community involvement in health development: a review of the concept and practice

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Abbreviations

CFA	Communauté financière africaine
CIH	Community involvement in health development
EPI	Expanded Programme on Immunization
GDP	Gross domestic product
MCH	Maternal and child health
MSSPH	Ministry of Social Security and Public Health (Bolivia)
NGO	Nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organization
PHC	Primary health care
SHP	Sub-Health Post (Nepal)
TBA	Traditional birth attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Introduction

In 1978 the Declaration of Alma-Ata sought the commitment of the Member States of the World Health Organization to the target of health for all by the year 2000 (WHO, 1979). This target was to be achieved by a strategy of primary health care (PHC) which was intended to revolutionize the practice of health care and health development. An important element of this strategy was the promotion of greater and more effective community participation in services and structures designed to bring better health care to the millions of people who lacked even basic access to such facilities.

The notion of local communities having a voice in and a view on the diagnosis and the tackling of health problems is not a new concept. In the 1950s and 1960s, urban and rural community development initiatives sought to involve local people in management and decision-making. However, with the increasing technological complexity, relative sophistication and centralization of national health services, more and more of these services became the exclusive responsibility of professional health staff, who increasingly took control of health care delivery systems. The Alma-Ata conference recognized that this trend would need to be halted, or even reversed, if effective health services were to be extended to the majority of people, particularly in developing countries.

Since the Alma-Ata Declaration, WHO has sought to promote wider acceptance and understanding of the notion of community involvement in health care and development. For example, studies in the early 1980s examined community involvement in a range of different health activities (Agudelo, 1983; Fonaroff, 1983). In 1985 WHO convened an interregional meeting on the subject of community involvement in health (WHO, 1985). It was at that meeting that the term CIH — community involvement in health development — was first used explicitly as the term to describe a basic principle of health care and promotion. In 1989 WHO published the first substantive study of the concept of CIH (Oakley, 1989) and in the same year it convened a Study Group both to examine the concept and to review the practice to date (WHO, 1991). These publications have helped to clarify the concept of CIH and describe how it is put into practice in many diverse contexts. Together, they constitute an important resource for health professionals and

practitioners who are beginning, or who have already begun, to apply a participatory approach to development work.

Since the WHO Study Group meeting in 1989, the concept of CIH has matured, and increasingly it is being recognized as an important element in the provision of health care and the promotion of better health. In this age of health sector reform, with its emphasis on such issues as privatization and cost-recovery, the notion of community involvement has gained greater prominence. With its stress on inclusion, CIH runs counter to trends which appear to exacerbate the exclusion of millions from basic health care. In this situation, it was felt appropriate to review both the concept of CIH and its practice, and it is for these reasons that this book has been prepared.

The book essentially seeks to explain where the concept of CIH stands today. It has three main purposes:

- to review and update the concept of CIH in the context of district health services and systems
- to describe the practice of CIH, with particular emphasis upon methodology, assessment and the role of community organizations in promoting health development
- to assess the current situation with respect to CIH and the likely trends of its future development.

The material for this book has come from a variety of sources: current literature on CIH and people's participation more generally, three specially commissioned case studies from Bolivia, Nepal and Senegal, which were researched between 1989 and 1994 (Kahssay, 1991) and the findings of a WHO research project into health development structures (WHO, 1994b).

The book should be seen as an update of the concept and practice of CIH. While not a definitive statement, it provides a guide to what CIH means and how it can be put into practice. We hope that the book will prove useful to health professionals and health auxiliary staff working at the district level and help them to involve local people in tackling health problems.

While the concept of community or "citizen" participation is common in resource-rich economies such as those of the European Union, Australia and the United States of America (Rissel, 1994), the focus in this book is on countries and regions with limited health care resources and where CIH concerns access to and benefit from basic health services. Primary health care is crucial to ensuring such access and benefit, and CIH is a key strategy in achieving them.

Haile Mariam Kahssay
Peter Oakley

CHAPTER 1

Community involvement in health development: an overview

Peter Oakley[1] *and Haile Mariam Kahssay*[2]

Any overview of CIH must begin by locating the concept within the broader areas of development theory and practice. Development is a multisectoral process. The different sectors — agriculture, water, education and health, for example — are all interrelated, and changes in thinking and practice in one sector are likely to affect the others. The concept and practice of development are subject to constant change as researchers and practitioners introduce new forms of analysis and enquiry and learn more about the causes and problems of underdevelopment and poverty. These changes then influence health development.

In the early 1970s there was a reaction against the dominant model of development intervention which stressed external delivery, physical or tangible improvements and the employment of professionals to design and direct development programmes and projects (Hague et al., 1977; Long, 1978). That model of development may have helped to improve the living conditions of some people, but it was argued that it did little to develop the talents, skills and abilities of the mass of urban and rural poor; nor did it provide any role for the poor in the development process. In contrast to that model, it was suggested that development should be more people-centred, with less emphasis on purely physical improvements, and that it should more directly promote people's participation. This new approach to development has variously been called "alternative development", "another development", "people-centred development", "counter-development" and "participatory development". Essentially, it argued two things. The first premise was that poverty is structural and has its roots in the economic and political conditions that influence people's livelihoods. Therefore, in order to tackle this poverty, it is important to develop people's ability to change these conditions. The second premise was that development programmes and projects have largely bypassed the vast majority of people; there is a need, therefore, to rethink development interventions

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in order to give the excluded majority a chance to benefit from development initiatives. Whatever the terms used or the explanations given, this approach to development intervention was seen as the antithesis of what was generally referred to as "top-down" development. A graphic that well illustrates the motivation of community development is shown in Fig. 1.

The concept of community participation gathered renewed strength in the 1990s. In 1990, for example, the United Nations Children's Fund (UNICEF) undertook a formal examination of the usefulness of a participatory approach to its work (UNICEF, 1990); in 1993 the Organisation for Economic Co-operation and Development (OECD) similarly undertook a detailed review of how community participation might improve the effectiveness of the work OECD supported (OECD, 1994); and in 1994 the World Bank issued a major statement on the importance of community participation in its work and took the appropriate decisions to build a participatory approach into its loan operations (World Bank, 1994).

This changing analysis of underdevelopment in the late 1970s and 1980s began to offer different explanations of the causes of poverty and to suggest different forms of project intervention. Poor people were seen as *excluded* and *marginalized* both from broader societal participation and from direct involvement in development initiatives. Simultaneously development policy-makers and planners began to advocate societal political participation and to devise strategies to increase poor people's direct involvement in development efforts. In development terms, recent years have been dominated by efforts to promote people's participation in development. Such participation required a fundamental shift both in attitudes and in methodology, to break decades of top-down, nonparticipatory practice. Since the early 1990s the major donor development agencies have supported and funded the promotion of participatory development (OECD, 1994; World Bank, 1994).

Inevitably the re-examination of development filtered into the health field and began to influence the practice of health care and development. The notion of greater involvement in the benefits of health development was emphasized, for example, in the 1978 Declaration of Alma-Ata. The Declaration has since served as an important guide of health policy and development in many countries. A critical element in the Declaration's emphasis on primary health care (PHC) is the involvement of people, not just in the support and functioning of health services, but more importantly in the definition of health priorities and allocation of scarce health resources at the district level. Indeed, the goals set by the Declaration may be unattainable unless radically different forms of health care are introduced, to develop health services which are for the people rather than services based on the health needs perceived by health professionals. The Declaration of Alma-Ata singled

out PHC as the essential strategy to improve health service delivery to the millions excluded from regular access to adequate health services. The general principles of PHC, which stress accessibility, community involvement, decentralization and equity, as well as health promotion and disease prevention, presuppose a people-centred strategy and a thorough re-examination of existing health care delivery systems.

People's participation in development

The concept of people's participation in development has come to have a major influence upon development thinking and practice. There is already a vast literature on the subject, which has greatly influenced CIH (Burkey, 1993; Cohen & Uphoff, 1977; Midgely, 1986; Oakley, 1991; Rahman, 1985). The concept of participation, however, defies any single attempt at definition or interpretation; in many ways participation has become an umbrella term for a new and more people-centred approach to development intervention. Research has revealed a number of different interpretations of the concept of participation. Inevitably interpretations reflect both the ideological position of those initiating the participation process and its content. The following distinct interpretations of people's participation in development have been identified.

Participation as collaboration

In this interpretation, people in less developed countries voluntarily, or as a result of some persuasion or incentive, agree to collaborate with an externally determined development project, often by contributing their labour and other resources in return for some expected benefit. People's participation is sponsored by an external agency, either the government or some other form of development agency, and in many instances this participation is programmed as a project input. In nationwide health, literacy, resource conservation or agricultural production programmes, for example, people's collaboration will be sought as a means of ensuring the success of the programme. While local people may participate, in that they collaborate with the programme, they have less direct involvement in programme design, control or management. It could be argued that participation as collaboration is the interpretation which dominates much of the practice of current development programmes and projects, and the extent and quality of that collaboration is much debated. Participation as collaboration has also given rise to the concept of the "stakeholder", which in practice involves the identification, and inclusion in the project process, of those individuals or groups who could affect, or be affected by, the outcomes of the project activities (Montgomery, 1995).

Participation as specific targeting of project benefits

Increasingly, one aim of people's participation has been to include previously excluded groups, such as small farmers, landless people or the urban poor, in development activities by targeting *benefits* directly at them — the "*project beneficiaries*". As a reaction, however, to a rather crude "participation = benefits" interpretation, emphasis is often put on direct involvement in different stages of project practice. For example, in the "beneficiary assessment" technique, the views of specifically targeted groups are canvassed and then taken into account in the project process (Salmen, 1990). Paul (1987) summarizes this interpretation when he defines community participation as "an active process whereby beneficiaries influence the direction and execution of development projects rather than merely receiving a share of the project benefits". While, clearly, many development projects seek to put Paul's interpretation into practice, the extent to which beneficiaries effectively influence the direction and execution of development projects varies considerably and may, in some cases, be negligible.

Participation as empowerment

Increasingly, participation as an exercise in *empowering* people has gained widespread public support and the term has entered the development vocabulary. For example, the 1979 World Conference on Agrarian Reform and Rural Development emphasized the transfer of power as implicit in people's participation. Similarly, a major study undertaken by the United Nations Research Institute for Development during the 1980s took, as its working definition of participation, the empowerment of excluded groups in order to increase their access to and control over development resources; and in 1990 a conference on popular participation in Africa, organized by the Economic Commission for Africa, adopted the African Charter for Popular Participation, stressing empowerment and advocating the liberalization of political processes to accommodate freedom of opinion and rural people and their organizations.

However, empowerment is a term which is difficult to define. Some see it as the development of skills and abilities to enable people to manage existing development delivery systems better and have a say in what is done; others see it as more fundamentally political, enabling people to decide upon and to undertake the actions which they believe are essential to their own development. While the term has slipped easily into the vocabulary of development practice, its link with action is not always understood.

The term "empowerment" has come to be used very loosely to describe any development process or activity, such as skills training, man-

agement techniques and capacity-building, which might have some impact upon people's ability to deal with different political and administrative systems and influence decision-making. Many development projects talk of "empowering" specifically as enabling people to cope better with the everyday administrative and bureaucratic demands of a development project. On the other hand, Friedmann's (1992) study examines the notion of "empowerment" in terms of "inclusion" and "exclusion" and the central importance of "power" in a political sense, and not merely limited to a particular development activity.

In summary, two broad and distinct interpretations of participation in development are identifiable. They are neither clear-cut nor mutually exclusive, but they represent two different purposes and approaches to promoting participatory development:

- Participation as a means — participation is seen as a process that ensures local people's cooperation or collaboration with externally introduced development programmes or projects. Participation thus facilitates the effective implementation of such initiatives. People's participation is sponsored by external agencies as a technique to support project progress. The term "participatory development" is more commonly used to describe this approach and it implies externally designed development projects implemented in a participatory manner. This approach seems quite widespread and essentially promotes participation as a means of ensuring the successful outcome of projects undertaken.
- Participation as an end — participation is seen as a goal in itself, that can be expressed as the empowerment of people in terms of their acquisition of the skills, knowledge and experience to take greater responsibility for their development. Poverty is often explained in terms of the exclusion of people and their lack of access to and control of the resources they need to sustain and improve their lives. Participation is an instrument of change and it can help to reverse the exclusion and to provide poor people with the basis for their more direct involvement in development initiatives.

The essence is that people's participation in development concerns two things: structural relationships and the importance of developing people's capacities and skills to negotiate for and to seek the resources and changes they require to improve their lives; and the methods and techniques used to ease local people's involvement in development programmes and projects. Both purposes are of equal importance; the former seeks to secure longer-term, sustainable development for poor people, the latter is crucial in providing immediate access to the benefits of development.

While it is now widely recognized that effective people's participation is essential for empowerment, the means of achieving this are still

being debated. At the macro level, the debate concerns what we might call "participatory societies" and brings notions of governance and democracy to an argument which suggests that people's participation can only flourish in political systems which encourage it. In other words, we cannot merely talk in terms of "participatory projects", we must examine the whole political context of the country. At the project level, the question is whether the promotion of people's participation is an "art" within an ideological framework, or a technocratic function (Dichter, 1992). Whatever the outcome of this debate, the empowerment aspect of participation seems to have been accepted as part of current practice (Wallerstein, 1993; Stiefel & Wolf, 1994).

Community involvement in health development

Ideas concerning people's participation in the development of health services have crystallized around CIH. This concept is not, of course, entirely new; indigenous health practices, traditional methods of community support in times of poor health and positive community action to tackle existing health problems and needs (e.g. mobilizing community efforts for a vaccination campaign or community labour to build a health post) are all manifestations of community participation. Also there has been, and continues to be, a strong relationship between community participation and programmes aimed at disease control. However, CIH is not just a mechanism to lend support to externally led health development programmes. It is a deliberate strategy which systematically promotes community participation and supports and strengthens it in order to provide better health care for the majority of people. CIH involves both a commitment to promote better health *with* people and not merely *for* them, and a strategy radically different from the more conventional approaches to health development.

However, while the concept of people's involvement in health development has long been implicit in many health programmes and projects, it is only recently that it has emerged as an explicit and identifiable strategy. WHO publications in the early 1980s examined the concept of CIH as part of various health programmes, which helped to spread awareness of the concept (Fonaroff, 1983; PAHO, 1984). The publications, however, were exploratory and many lacked a coherent view of people's participation; they did not challenge or question the basis of health care delivery but sought to involve people in this practice, hardly modifying or changing established approaches. People's participation became an additional ingredient in health care delivery instead of the means for an intensified review aimed at increasing the effectiveness and accessibility of health care.

To consolidate the theory of CIH across the spectrum of health care activities into a coherent health development strategy, WHO convened

an interregional meeting on CIH at Brioni (in the former Yugoslavia) in June 1985. The meeting stressed that CIH was not a health programme in itself, but an essential *principle* of health development. The Brioni meeting reviewed the arguments for CIH and suggested that they be summarized as follows:

- Community involvement in health is a basic right of all people. Involvement in the decisions and actions that affect people's health builds self-esteem and encourages a sense of responsibility. As a principle, CIH is of intrinsic value in general community development and should be promoted as the basic approach to health development.
- Many health services, especially in developing countries, depend on limited resources. Community involvement in health can, therefore, help make the available health resources more responsive to the basic needs of the people. Local knowledge and resources can be used to complement those provided by the formal health services. Furthermore, CIH can help to extend the coverage of health services. Similarly, CIH can enhance the cost-effectiveness of health services and ultimately intensify the impact of health sector investments. However, it is important to emphasize that CIH does not imply that the local population has to absorb the costs of health care.
- Community involvement in health increases the possibility that health programmes and projects will be appropriate and successful in meeting the health needs defined by local people, as opposed to those defined by the health service. Health programmes will have a better chance of success when health services are consistent with local perceptions of health needs and managed with the support of local people.
- Community involvement in health breaks the bond of dependence that characterizes much health development work and generally creates an awareness among local people of their potential involvement in development (WHO, 1985).

A decade later, and reflecting on the practice in the intervening period, Rifkin (1996) summarized the benefits which community participation was expected to bring to PHC programmes.

- People would make better use of existing health services and would ensure the sustainability of new services by being involved in decisions about their development.
- People would be able to contribute resources of money, labour and materials to support the scarce resources allocated to health care.
- People would change their poor health behaviour if they had been involved in exploring its consequences.

- People would gain experience and information which would help them to gain control of their own lives and thus challenge the existing social, political and economic system which had deprived them of this control (Rifkin, 1996).

While there appears to be a broad consensus on the arguments for and purposes of CIH, its interpretation presents greater difficulties. A review of relevant health development literature, for example, shows that while there has been considerable discussion of and commitment to CIH, few authors have attempted to define it. However, one definition which has been presented in the context of primary health care runs as follows:

> Community involvement in health development is a process by which partnership is established between the Government and local communities in the planning, implementation and utilization of health activities in order to benefit from increased local self-reliance and social control over the infrastructure and technology of primary health care (Rifkin, 1990).

At its meeting in Geneva in December, 1989, a WHO Study Group on CIH reviewed a range of interpretations and agreed that: "CIH 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. CIH actively promotes people's involvement and encourages them to take an interest in, to contribute to and to take some responsibility for the provision of services to promote health" (WHO, 1991).

Furthermore, CIH implies a partnership among individuals, groups, organizations and health professionals, in which all sides examine the basis of health issues and agree upon approaches to tackle them. At each stage of a process of health development, all actors come together to discuss issues and feasible solutions and to agree upon a course of action. Overall CIH can help to bring about: a better understanding among communities and health workers on health care and development; better health care for people; and the shared management of resources with the objective of achieving efficiency, equity and people's empowerment in health development.

The WHO Study Group's statement is a useful composite of a wide range of ideas, nuances and interpretations of CIH. It was not presented as a definitive statement, but as a broad interpretation to reflect the complexity of the concept of CIH and its wide-ranging implications for health care practice. Community involvement in health is an all-encompassing process which, if effected, cannot be limited to one or two

tiny actions. As an underlying principle of health care, CIH will influence initial analysis, the identification of health problems, the consideration of alternative solutions and the management of available resources. Ultimately, as the Study Group's statement suggested, CIH should empower people to have a role and voice in health care provision and its development.

In the 1990s governments and development agencies working in the health field have come to grips with the need to define the process they are seeking to promote. Programme and project literature in the health field increasingly includes statements on community participation and the ways in which it will be promoted. The following statement from the Five Year Work Plan of the Ministry of Health (1997–2001) of Ghana is illustrative of this tendency:

> Community participation in health is a process. It is the process of initiation and sustaining dialogue with various members of a particular community in a structured manner with the view to genuinely consulting them as equals in a program of activities that aim at building a team between program managers and community members, to jointly understand health problems in the community, to find common solutions to such problems and to act together to solve these problems using as much human and material resources as possible from the community (Ministry of Health, Ghana, 1997).

CIH in context

CIH does not operate in a vacuum. The context in which health care programmes and projects are carried out will necessarily influence both its nature and its potential impact. For example, some countries are relatively resource-rich, while others are resource-poor; capitalist rather than socialist political structures may dominate; the differences in health care in urban and rural areas must be taken into account. The WHO Study Group on CIH identified a number of contextual factors which could influence the implementation of CIH as a basic principle of health development (WHO, 1991):

- *Political commitment* within the country to the concept of people's involvement, and hence the political support that might be required to secure its implementation. This political commitment will be particularly important at the local level where resistance from established interests will have the greatest impact (WHO, 1991). Morgan (1993) called this the "political will" of people's participation and showed, in the context of Costa Rica's rural health programmes, how participation is frustrated by partisan conflicts over implementation. Similarly Walt (1994) compares health sector experiences of

Argentina and Cuba to illustrate how far political systems can affect health policy and people's participation in public policy-making.

- The *reorientation of the formal health and other development organizations* within the country to support the devolution and delegation of bureaucratic authority down to the levels at which CIH will operate. Critical will be the *decentralization* of health services and the corresponding *strengthening of district health services*, which serve as the basic health unit for CIH (WHO, 1991). In this respect, the current preoccupation with the reform of administrative and managerial systems, as part of a more general health sector reform programme, could be crucial in paving the way for effective decentralization within national health services. However, it is still too early to assess how effective these proposed reforms will be (Cassels, 1995).
- The *economic situation* within the country, which will largely dictate the emphasis and resources made available to health development. In many countries, a basic lack of economic resources will make the promotion of health development difficult. In others, health may receive a low priority, ministries of health are often politically weak and, consequently, fewer resources are made available to the health sector. The implementation of CIH requires resources — staff, logistics support and teaching materials — and these may be difficult to obtain in resource-poor countries or where health is not a priority (WHO, 1991). Furthermore, in a climate of structural adjustment and apparent concern to divest the state of its primary responsibility for health care, the potential resource base for a strategy of CIH would appear to be reducing rather than growing. Ironically, CIH has been seen as a means of increasing the resources available for health care and development in national health services — an objective which is difficult to achieve if health care is privatized and the state's role reduced to a minimum (McPake, 1996).
- The level of development of *local structures and organizations*, which can serve as a basis for CIH, as well as the managerial and other skills that may be available in the community to enable the population to play a greater role in health development (WHO, 1991).

Studies by Woelk (1992) in Zimbabwe, Kelly and Van Vlaederen (1996) in South Africa and Tatar (1996) in Turkey have all examined the relation between the promotion of CIH and the context in which it is done and have concluded that a favourable political environment is critical to promoting community participation at the local level. Woelk further suggests that an important factor in promoting community participation is a "common history of struggle" (Woelk, 1992). In countries such as Nicaragua, Peru and Zimbabwe, this common history strengthens community organization, which can greatly facilitate efforts to promote CIH.

CIH is relevant to health in the broadest sense; it is not necessarily limited to health care, but is equally appropriate to health promotion. In this respect, it can be argued that CIH is not only applicable to the treatment of the symptoms of poor health, but also to tackling its causes. Therefore, it potentially poses a challenge to existing health care practice, since it could be argued that most health service structures have been developed on centralized and professionally controlled lines. CIH, however, does not imply any shifting of the burden for health care from existing services to urban and rural communities; more accurately, it implies a sharing of responsibilities between health professionals and communities, in which communities are advocates of their needs and health professionals are responsive to those needs.

CIH and district health systems

Parallel with the emergence of CIH as a fundamental principle of health care practice, there has been an increasing awareness and acceptance of the *district* as the key administrative level in the provision of health services. It is at the district level that people's health problems become most visible. At the national level, communities can often appear abstract and distant; at the district level they are realities, and their health problems can be clearly seen. Crucially, also, it has become apparent that the most pressing problems in the organization of national health systems based on PHC occur at the district level, close to where people live. Traditionally, national health services are divided into regional, provincial, district and local administrative areas or centres. What has been more recently advocated is a particular emphasis upon the district as the intermediate level, in order to give direct support to efforts to implement PHC (Tarimo, 1991). It is felt that the strengthening of the district health system will not only greatly facilitate more effective local participation in the planning and utilization of health services, but will also link up local priorities with national health policy guidelines and resource allocations.

After the World Health Assembly in 1986, the WHO Global Programme Committee defined a district health system as: "a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, nongovernmental, private or traditional . . . Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities" (WHO, 1987).

It has been argued that the district health system is the key to radically improving health care provision for the vast majority of people

(WHO, 1988a). As the most important administrative unit for organizing and implementing PHC, it is at the district level that policies will be put into practice. Weak, inactive and poorly organized district health systems will inevitably mean a lack of basic health care for a country's population. Country experiences have shown that health workers cannot function in a sustained and purposeful manner without effective district-level support and regular supervision from higher levels. A WHO study (1988a) made a distinction between "district health systems" and the "district level". The term "district systems" refers to the entirety of the district, covering all elements and thus all levels; the term "district level" refers to the layer of management, usually located in the district capital, that is hierarchically located between the national and regional/provincial levels and the communities (WHO, 1988a). In terms of the overall district health system, the study identified five main aspects:

- organization, planning and management
- financing and resource allocation
- intersectoral action
- community involvement
- development of human resources (WHO, 1988a).

Major efforts have been initiated to focus PHC services systematically at the district level and to provide the resources and skills, and the backup, required within the district health system to undertake these tasks. But it is not easy for district health systems to function effectively, as a number of essential conditions need to be met. Districts are part of the national health system, and the two are interdependent. District health systems cannot develop fully without commitment and support from the national level, or without some degree of autonomy and authority for planning (WHO, 1988a).

But clearly district health systems could become the focal point for a more sustained and systematic attempt to decentralize health services. Without this, health service resources in most developing countries will continue to be allocated to large, urban, hospital-based services and will continue to be perceived as professionally managed and centrally controlled. District health systems offer a better chance of health for all but, in order to achieve this, a major shift of authority, control and resources within national health systems will be required. The really crucial issue is that of *decentralization* within the national health system in such a way that district systems can function with authority and with resources. There is also a need for a built-in mechanism within the national health system to allow national health strategy to be modified in the light of experience gained at the district level. CIH is a concept which is more readily operational at the district level, and it is at that level that it should be promoted.

CIH and health development structures

A major new focus in the practice of CIH is the potential of local health development structures at the district health system level to facilitate greater community involvement. Such structures include local health committees, health councils or boards, community-based organizations and women's groups, and they are inevitably found at the district level. As we have seen earlier in this chapter, the importance of "organization", as a fundamental element in the development of people's participation, has been widely argued. With the emphasis in national health systems increasingly being placed on the notion of decentralization to the district level, these local structures become potential vehicles for making decentralization work. To date, it would appear that the potential of structures like the above has been largely untapped.

It was with the above in mind that WHO launched a multicountry study of local health development structures in 1992 (WHO, 1994b). The study defined three major components of the district health system, namely:

- *health service structures:* hospitals, health centres or health posts
- *health service management structures and staff*
- *health development structures:* district councils, district development committees, district health committees, village councils, women's, farmers' or labour councils, etc (WHO, 1994b).

The essential purpose of the study was to describe and analyse such health development structures within district health systems in several countries and to assess their contribution to health development. The main conclusions of the study are to be found in Chapter 5.

Community action for health

CIH derives its conceptual strength from the emerging trend towards "people's participation" in the 1970s and 1980s. Yet, it could be argued, CIH has lacked a concrete focus, and in many instances the community's relationship with the health sector becomes biased in favour of a government or public-sector point of view. A more recent evolution of the concept has been termed "community action for health" (CAH). This stresses the notion of "action" and suggests a more proactive and direct involvement of people in health development at a local level. CAH was the subject of the Technical Discussions at the Forty-seventh World Health Assembly (WHO, 1994a), where Member States concluded that not enough had yet been done by governments, health policy-makers and senior health service personnel to promote community involvement.

CAH must be understood as a complete and sustainable process

in which any community — social, geographical or professional — is involved as a full partner at all stages of the health care process; identification of needs, selection of priorities, planning, implementation and evaluation of activities occur in close cooperation with the formal health sector, as well as with other sectors concerned. It is at the same time a basic concept and an essential part of the public health programme. CAH, therefore, implies partnership between health services and communities, a proactive role for the community and, consequently, the "obligation of the formal sector to share power rather than merely to foster cooperation. In the context of community action for health the community is an agent for health and development, rather than a passive beneficiary of health and development programmes" (WHO, 1994a).

CAH consolidates the notion of community involvement in health development and re-emphasizes the importance of community/government partnerships in tackling the problems of health care and development. Given the often ambiguous response of health policy-makers and health care providers to community involvement, and their scepticism about the benefits of the community engaging in health care activities, this re-emphasis is appropriate. CAH invigorates the continuing debate. In this respect CAH can run up against established views and practices and may do nothing to quell any latent conflict. In areas such as the authority to influence resource allocation, the setting of health priorities, the taking of initiatives to promote health development and the delegation of responsibilities within the health sector, the potential for conflict is both real and explicit in CAH. But such conflicts can contribute to the central dynamics of CAH and ensure that the partnership is active and forward-looking.

Thus, CAH is a recent adaptation of a concept which has been debated in WHO over a long period of time. It is inevitably subject to the same kinds of contextual influences seen with CIH, including the following:

- *Commonality of purpose:* between the formal health services and the local population in a health development partnership. In this respect, it is important to consider what measures will be needed to establish this commonality.
- *Sharing of knowledge:* both the community and the formal health structure will have knowledge to contribute to the common purpose of health development, and this knowledge must be shared and respected by both sides.
- *Goals and objectives:* agreeing on common goals and objectives which are intelligible to both sides. They must be realistic and allow the partnership to mark up at least some achievements from an early stage.

- *Training:* the recognition that the training of health workers, particularly at the district level, in the skills necessary to promote partnership and community involvement "will ultimately be as important as preparing staff for other technical and administrative responsibilities" (WHO, 1994a).
- *Political support:* particularly within the health sector and at the district level. Political support is the source of policy and the decisions and resources necessary to support a process of CAH.

Clearly, these are weighty preconditions for the success of CAH, and the support of nongovernmental organizations and that of the other social actors who intervene in health development are needed. Furthermore, there are a number of implicit assumptions underlying the whole concept:

- communities best know their own health needs
- there exists within these same communities the skills and knowledge to play an effective role in health development
- there is a genuine commitment on the part of health service staff to promote this involvement.

Potential problems include the possibility that CAH may be expensive and time-consuming, that it may challenge the fundamental role of health professionals and that it may lead to misunderstanding of the "ownership" of a particular health initiative.

Essentially, all community-based initiatives to promote health development have one or more of the following objectives:

- to increase community participation in decision-making related to the health activity
- to increase the accountability of the health service
- to assist in community education and awareness related to health matters
- to strengthen local action to promote health development.

CAH is a very practical technique for achieving these objectives. Its emphasis upon action recognizes that the concept of community involvement is largely understood and accepted and that what is needed now is a more direct approach to putting the concept into practice.

The value of CIH

As in other sectors, the notion of community involvement in health care and development appears to have been widely accepted and understood and, in many instances, implemented in both developed and developing countries. People's participation is at the heart of PHC, and the latter cannot be implemented on any large scale unless CIH is recognized as

a fundamental operational principle. CIH is not, it must be stressed, a programme or a project by itself; similarly, it should not be seen as merely one component of a PHC approach. CIH is part of the strategic framework within which health development should take place at the district level.

Participation has come to be recognized as a key element in most development programmes or projects, and there is increasing recognition that health for all will not be achieved in resource-poor countries unless the skills, energies and commitment of people at the local level can be made available to support the development of equitable and sustainable national health services. For CIH this is the key issue; it is not just a question of people's participation in health activities or health projects but, more importantly, their *involvement in district-level health services* which is crucial to sustainable health development. It is highly unlikely that the favoured components of certain proposals for health sector reform — for example, privatization, cost-recovery and managed competition — could have any significant impact upon the health of the vast majority of the world's poor people, unless such proposals lead to a stronger national health service. For many countries, a vigorous strategy of CIH is a potentially more productive solution.

The recent appearance of an action-focused strategy for health development — community action for health — takes the whole concept of CIH one stage further. There has yet to be any conclusive breach with the traditional approach of centralized, professional-led health care. Furthermore, partnership between government and the community in the common task of health development has in some cases been renegotiated in the light of economic adjustments, health sector reform and attempts to spread the cost of maintaining health services. Whatever the content and outcome of these changes, the principle of CIH should remain on the agenda. The crucial task is to ensure that calls for greater community participation do not result in governments making decisions about resource allocation which are against the interests of the poor. CIH can never be understood as an excuse for preaching self-help to poorer communities while using health resources in favour of other groups: it is about reorientating the basic principles of health care and development in order to build an effective partnership between district health services and local communities.

Case studies in CIH at the district level

A major part of this book is based upon a detailed examination of the concept of CIH at the level of the district health system. Case studies were undertaken in three countries where it could be argued that CIH was, for the reasons outlined above, a relevant concept; Bolivia, Nepal and Senegal. Each of these countries is essentially "resource-poor", with

few funds available for either the provision or the development of health services. Given the general poverty of the majority of the population, it was unlikely that this situation would be dramatically reversed. For these reasons, it was argued that CIH was a relevant concept in each of the three countries and that its promotion could be fundamental to developing and increasing poor people's access to health services at the district level.

An interesting feature of these three case studies is that the countries in question were "revisited". The original fieldwork was undertaken during 1989 and 1990. The three studies were written up in an internal WHO document (Kahssay, 1991). In 1994, it was decided to revisit each of the original three case-study sites. These visits were completed in relatively short periods of time and did not involve major rewriting or substantial fresh research. Each study was simply updated to reflect developments which had affected CIH in the intervening period.