CHAPTER II

LITERATURE REVIEW

The literature review is one of the important parts of the study. The theory of community participation in development has been reviewed as a general concept with particular emphasis on health care. There have been numerous studies trying to understand and the use of participation approach in development process but there is no clear answers have been given. The debate on community participation has mainly been going on between anthropologist and epidemiologist, managers and policy makers. Anthropologists are more concerned with conceptual issues like - what the concept means to those involved in planning and implementation processes - while the epidemiologist, managers and policy makers are more concerned about how to implement and operate activities as well as measure levels of participation. After the Alma Ata declaration 1978 advocating the concept of community participation in health care, the debate slowed down. People became more concerned with the complexities involved in practices and operational challenges. Therefore this study tries to investigate the means and ends of the approach, using a framework that has previously been completed by other scholars on how to assess the participation of a community in the study related to the CBHD project.

2.1. Definition of community participation in health care

Community participation was one of the main principles of Primary Health Care (PHC) the strategy proposed in Alma Ata in 1978 by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) and adopted by 150 member states with the meaning of revolutionize the practice of health care and health development, leading to health for all by the year 2000 (WHO, 1978). The definition of Alma Ata was stated as follow:

> *"Community participation is the process by which individuals and families assume responsibility for their own health and welfare and those of the*

community, and develop capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development instead of passive beneficiaries of development aid..."

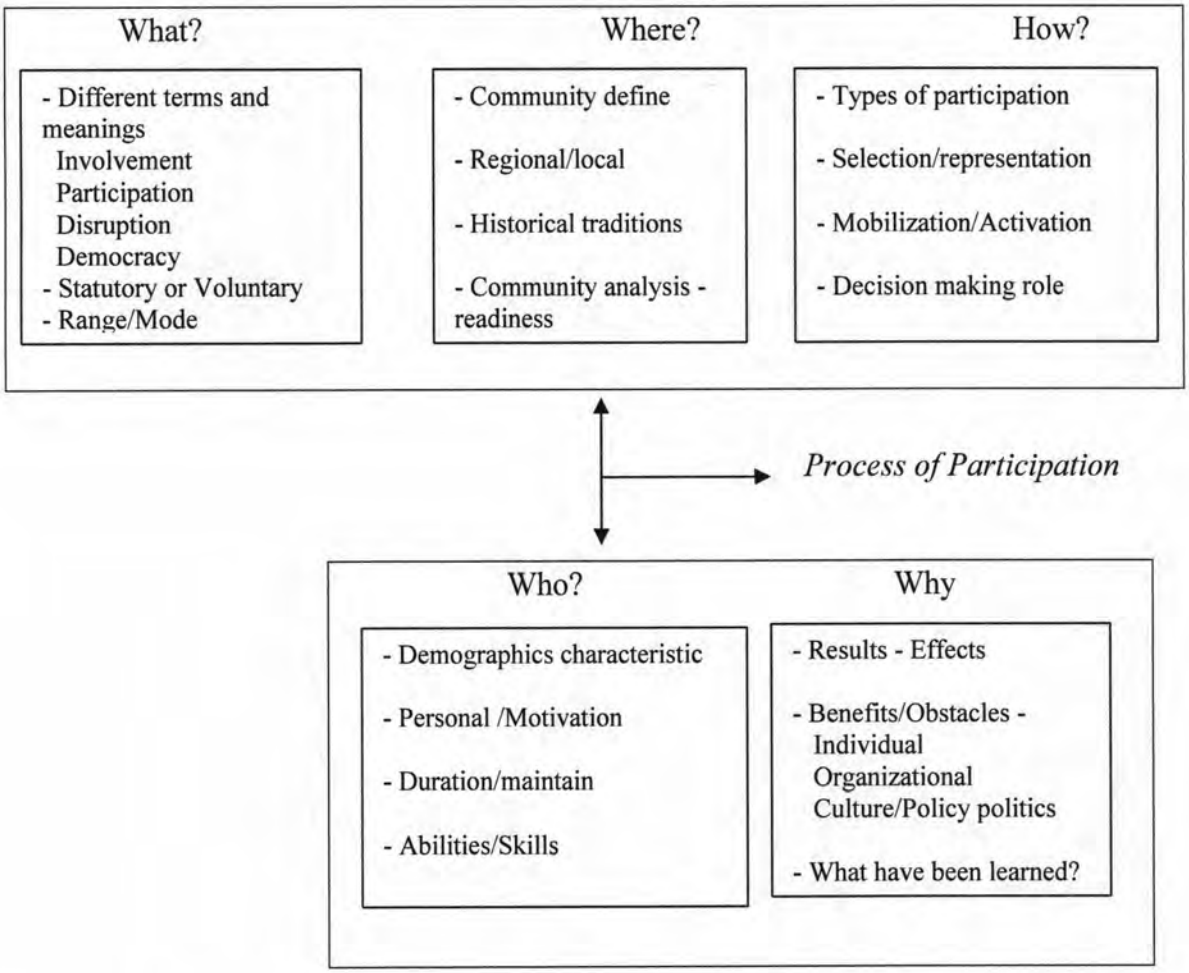
The definition was difficult to clearly understand as the concept is broad. It could not be well managed when applied to community participation in health care development. According to the definition of community participation, question has been raised by others scholars as - Who defines a "community"? Local people or outsiders? - Who will decide in the priority and solve the problem? Local people or professionals?

An effort to define a comprehensive framework of community participation has been made by Cohen and Uphoff (1980) as follows;

- *What kinds of participation – was it participation in decision-making, in implementation, in benefits, in evaluation;*
- *Who participates – local residents, local leaders, governmental personnel, foreign personnel;*
- *How is participation occurring – is it coming from above or below, are there incentives or is it voluntary or cohesive, what are the channels; What is the structure, duration;*
- *Does it give people opportunities for decision-making by building capacities to benefit from the results of their participation?*

To illustrate the theoretical suggestions above the community participation process can be seen in the following figure:

Figure 2: Process of community participation



Source: A framework of community participation (Bracht and Tsouros -1990)

After review 200 cases study for WHO - UNICEF and mainly using the framework of Cohen and Uphoff (1980), Riftkin (1986 to1996) agued that the frame of the Alma Ata declaration purposely left the concept of community participation vague and flexible in recognition of the fact that countries presented diverse contexts. Between theory and reality, the concept became many different things to different people; making it difficult to reach generally agreed definitions, let alone objectives, for developing it in health care. She therefore in her analysis states that health planners used to take three approaches to define community participation based on three similarly differing definitions of health:

- *The medical approach* - which defines health as absence of disease. Community participation is then defined as activities undertaken by community people following the directions of medical professionals in order to reduce individual illness and improve the general environment; e.g. using health services or cleaning the environment. It is based on the notion that health improves as a result of biomedical science and technology or in other word, on the medical professional.
- *The health services approach* – this defines health in the WHO sense of the word: 'physical, social and mental well being of the individual'. It defines community participation as the mobilization of community people to take an active part in the delivery of health services; however, that was not very much apparent in the developing world. For example using community health workers (CHW), recruited from and by the community, trained and supervised by health professionals and 'accountable' to the community to deliver health care;
- *The community development approach* – This defines health as a human condition which is a result of social, economic, and political development. It defines community participation as community members being actively involved in decisions about how to improve that condition; essentially, that health will improve with eradication of poverty brought about by a change in the existing system of power and control relations.

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

The literature review both the medical and the community development approaches in health has been used within the concept of community development as people health has been considered as central part of development. The review is

looking at how these approaches could contribute to create the involvement of community member in health care activities, their contribution in decisions making at local health management, creating empowerment and democracy in the development stage. At the end factors that might have influence on these approaches are looked at in order to see the possibilities improvement in community participation in health care.

2.2 Factors that might have influence to community participation

Theoretical concepts of community participation are rooted in the constructs of social theory. Social theorists are concerned using social theory as a means to understand a changing society. The interpretations of human relations have given rise to a vast literature on the subject. It was argued that the study of human behavior should follow the type of analysis used for the study of natural sciences. Some scholars were critical of examining human behavior in these terms. They saw behavior as actions determined by reason, intention and meaning. The constructs in the context of community development, people's participation and empowerment has to be seen in the views of sociology aspects before transferring the theoretical into practices. And to evaluate/assess the possibility of community participate in health the factors that can strong influence the participation has to be looked into. Below some of literature referred to could perhaps help us to understand more about these factors.

Woelk (1992) has studied cultural and structural factors that have a facilitating influence on community participation in health program in the developing countries. Three aspects were highlighted;

- First, a culture that is not highly stratified.
- Secondly, a communities where there is both a supportive environment and political framework.
- A third factor was a situation where there has been a history of common struggle.
- Another factor is program that interprets health as part of large community empowerment programmed and work inter-sectorally to achieve broad rather than only sector goals.

Experiences from developing countries show that health is rarely a priority except when a person is sick (Rifkin, 1986), Research from small non-government programs investigated how local people perceived participation in their community health programs. It gave evidence that local people wanted the programs to provide drugs and services for their illness needs. They did not want to become involved in the management or the delivery of services even though the planners in the case study in the Philippines argued that involvement in these activities would empower them and build their capacities to change their poor life circumstances. Programs more directed to immediate needs are more likely to gain participation than those which do not.

Community participation is widely agreed to contribute to good governance. It is most advocated for providing a mechanism for potential beneficiaries of health services to be involved in the design, implementation and evaluation of activities. The overall aim is to increase the responsiveness, sustainability and efficiency of health services or programs. Early reviews found that community participation is widely accepted as a fundamental right of the population and is also a principal factor in the success of development programs. Furthermore, when the community is involved in health planning and service delivery, it is made more explicit who currently benefits from services, and therefore starts the process of considering who should be targeted. Then the needs of people health can be better defined (See in Godfrey M. Mubyazi and Guy Hutton, 2003). The advocacy of political regimes on enhancing democracy in grassroots level could contribute to the good governance and strengthening the system. That can create the accountability and transparency in state management. Community participation can not be seen as a tool for the politicians. If doing so, the nature and value of the right of people in participation in health can lead to other results.

The health system is one of the main actors in community involvement in health care. To make people concern about health care, the health system needs to be more systematic and transparent in how evidence. This could be used in decision making if more stakeholders are to be involved. In some developing countries, community based approaches and community participation have strengthened the use

and the legitimacy of health systems (disease burden, cost effectiveness of available interventions), thus enabling the health system to take on community preferences and priorities in a more transparent manner (Reid and Kasale 2000). Public opinion can be included in health planning through opinion surveys, anonymous postal surveys, focus groups, Participatory Rapid Appraisal (PRA) tools and citizens juries. These methods have often been used as a parallel process to the budgeting or decision making, as a tool to ensure that decisions could be in line with public values. By doing so, the citizens and medical professional will have a "common language", that can make it more easy getting and transferring information on health care and health status of the community. Community participation could create better accountability in health managements and the health professional can learn more from the community.

In the article *Revisiting Community Participation* (L. Zakus and Lysack, 1998) critical issues of program implementation have been stated. They summarized the views related to the value of community participation. Then they looked at problems in conceptualizations and evaluation. The authors reviewed a number of projects and assessed what leads to success and failures. One useful contribution made was checklists to look for conditions that made it more likely for better community participation. In their analysis they put forward that the meanings placed on the terminologies of "community"," participation" and "empowerment" could create barriers to meet planners' expectations. They examined the relationship of community participation to health promotion and empowerment. May be the latter two concepts is not easy in line with the idea of "community". They argued that community, as previously defined, puts forward a notion of co-operation while health promotion and empowerment stressed ideas of advocacy and social activism based on autonomy and conflict.

2.3 Lessons learned from other community based projects around the world.

Rene Loewenson (1998) has noted that participation of communities has been widely argued as an important factor in improving health outcomes and the performance of health systems. She has reviewed the Zimbabwe's health system on community participation in health related to two dimensions. The first related to

creating realistic expectations between communities and health services in their contributions towards health. The second related to the governance of the health systems. Examples are shown focusing on the relationship between social participation and control and health outcomes. She has outlined the features of and factors in building participation in governance of health systems. The findings indicates the need for a wider inclusion of social groups from civil society, elected leadership and health systems in structures and processes that set and audit health policies and priorities. The studies discuss issues to be addressed in enhancing participation, including the information, processes, capacities and resources required. The author has ended the argument:

> *"...participation must be seen to affect outcomes and produce visible results; participation should enhance the possibilities for meaningful public input, including from the poorest groups, rather than provide one more bureaucratic structure that distances systems from knowing, understanding and addressing pressing health issues".*

Godfrey M. Mubyazi and Guy Hutton (2003) in the article "*Understanding mechanisms for integrating community priorities in health planning, resource allocation and service delivery*", has given a similar statement related to resources re-allocation. According to the authors most programs and projects were and will just only be a pilot and results can not be use to disseminate in a large sphere of influence. According to the authors most programs and projects were and will just only be pilots and results can not be use to be disseminated in a large sphere.

> *"...in terms of public mobilization and the contribution of labor or monetary resources to run various health activities, some of the most successful community-based health initiatives were those that received financial support from external agencies within limited pilot timeframes, which does not give much hope for scaling successful projects up to national level"(pp26).*

Babken V. Babajanian (2005) conducted a project' evaluation supported by World Bank in Armenia called Armenia Social Investment Fund (ASIF). They looked for the impact of project on the existing forms of local social organization with local

participation in the process. One of the objectives was to promote the participation of local communities. However, at the end, the research found out that the project did not change the existing patterns of local social organization. The project had not any significant impact on the nature of participation in the beneficiary communities. Bottom-up, capacity building interventions were focus mainly on changing patterns of interpersonal social relations. They can not be effective in fostering sustainable civic institutions without changes in the nature of a country's governance. There is a need for increasing the role of central governments and improving national governance to support local development. Institutionalization should take place if the country wants to apply the approach of community participation.

Frank K. Nyonator et al, (2003) have reviewed a community-based model to strengthen health care system at local level in Ghana. The Ghana Community-based Health Planning and Services (CHPS) initiative is a program designed to translate innovations from an experimental study of the Navrongo Health Research Centre (NHRC) into a national program. The intention is to improve the accessibility, efficiency, and quality of health and family planning services changing from a clinical facility-focused approach to a community-based approach. The Navrongo project was regarded by many observers as an undertaking outside the usual administrative operation of the Ghana Health Services, and its lessons were perceived to be alien to the system into which they were to be absorbed.

2.4 **Case study of community based approach in Viet Nam**[1]

The Mountain Rural Development Program (MRDP) supported by the Swedish Government in 1997-2000 was implementing in Phu Tho Province in the north of Viet Nam. This program was carrying out an village-based approach using a "The Village Development Budget Scheme" (VDB). The Village Development Funds can be seen as one attempt to decentralize the local government structure in the north of Viet Nam by the end of the 1990s. Within the scheme, villagers made plans based

[1] The study conducted by Bent D. Jorgensen, Cecilia Bergstedt, Nguyen Quang Dung, Do Thi Phuong Thao (2001), *An Uphill Voyage The Village Development Budget and Decentralization in Phu Tho Province, Northern Viet Nam,* Vietnam Sweden Mountain Rural Development Programme (MRDP), Ministry of Agriculture and Rural Development

on their needs and desires and the funds were directly transferred to the villages to implement these plans. The scheme was based on guidelines set up by the MRDP' project at central level, which regulates how funds were used, how villagers should participate in decision-making and the implementation was to be monitored. The guidelines also outlined the roles of institutions at different levels in the hierarchy.

> *In order to alleviate poverty amongst poor households "the program should contribute to the re-establishment of green productive uplands that are managed in a sustainable way by healthy farmers having secure land tenure, maintaining the ecological, economical, social and cultural diversity of the area".*[2]

However, the involved stakeholders, as leaders of communes, representatives of mass-organizations, did not understand the main ideas of the project. The community was not well prepared and did not gain any knowledge about this scheme. The village plan was not very well known. When asking the villagers, only some of groups who joint the program knew the procedures. (Bent D. Jorgensen et al, 2001, pp 19).

During that time the top-down approach was still applied in both the Communist Party and the administrative system (Judith L. Ladinsky et al 2000). People accepted plans and did not protest. They might attend planning meetings but were not contributing opinions. According to the guidelines, the plans had to be made by the Village Management Group in close consultation with the Commune Management Group as well as district or provincial extension staff. That explained the similarity between the plans from the different villages of the study' sites. This showed that there was not a real participation of the villagers. Each village has great differences in needs and the plan could not be the same. There might also be a strong influence of the elite of communes, districts and even from the province level interfering in the process of village planning.

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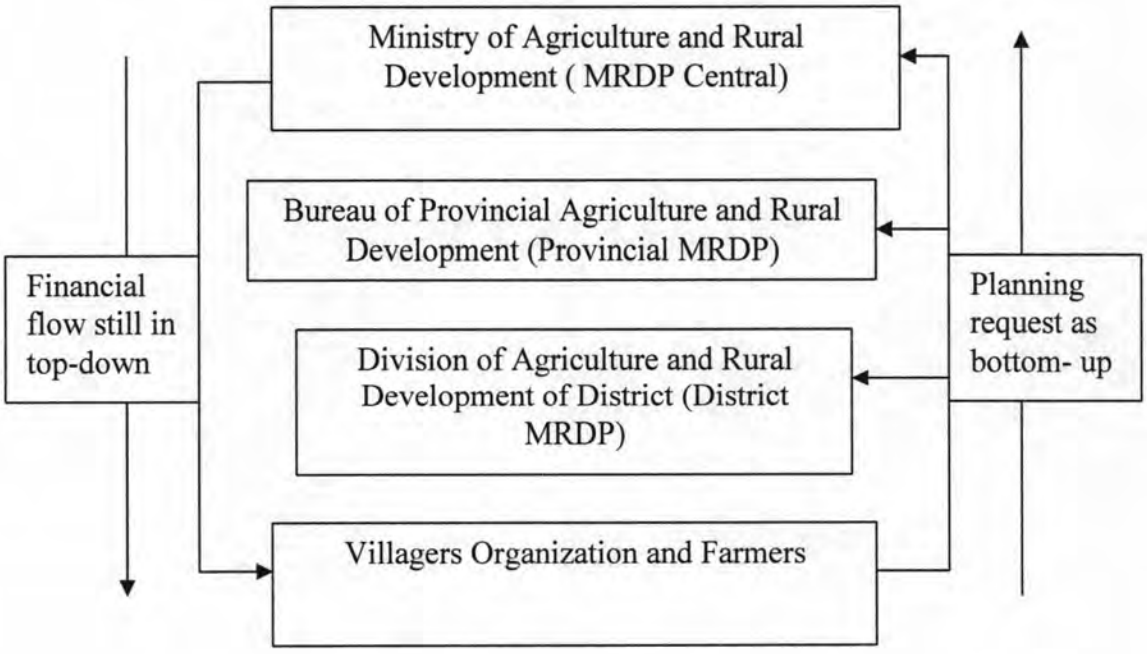
[2] MRDP (1999) *Commune and Village Development Funds, A Model for Direct Funding*, Ministry of Agricultural and Rural Development, Hanoi.

The project has shown that the subsidies were crucial in the implement process of the village action plan. The financial flow of this project was so complicated that the villages have to wait for the funds some time 7 or 8 months after submitting their budget proposals.[3] The commune, district, and province staff had to find unconventional solutions in order to implement the plan. In that situation individuals and institutions was under pressure both from the people and from project knowing that the project team would soon return and monitor the process of implementation. The capacity of institutions should be analysis and suitable for planned interventions. Moreover, the financial and planning should go better together.

Figure 3 The managerial flow of MRDP project



For the monitoring of program: The Village Management Group had little knowledge about who should actually evaluate the activities. The response was often that the commune or district levels should do this but actually in the guideline, the village level should do that job. That means the guideline states was not clear. The

[3] Bent D. Jorgensen, Cecilia Bergstedt, Nguyen Quang Dung, Do Thi Phuong Thao (2001),

special committees formed for that purpose had not been activated since the monitoring and evaluation of variety projects is remain a problem in this program.

Some conclusions were made related to the management, the policy formulation and the capacity of the project stake holders. The flow of information from upper to lower level in the administration structure should be regulated clearly to make the scheme more accountability. The crucial intention of the program has been to increase the level of transparency and participation in decision-making in a process of planning and implementation. The villagers should know about the guidelines in which there rights are stated and higher levels in the MRDP management structure should follow the villagers' decisions.

The effectiveness of this program was important to raise production and give the scheme the necessary legitimacy. The success of any step towards decentralization was related to the strength to force higher levels to formulate and reinforce existing and new legislation and policies.

The local authority and project' staff needed more training when it comes to their attitudes towards ethnic minorities. Pedagogical methods that fit the special circumstances in the mountains needed to be developed and applied. The involved institutions in a Village Development Budget concept also needed to understand the basic ideas about downward accountability, participation, transparency, and good governance as a whole. Therefore, the understanding of the people about the aims of the project and how it would be executing was a big constrains to the success of this project.