ASSESSING THE LEVEL OF COMMUNITY PARTICIPATION IN HEALTH DEVELOPMENT PROGRAMMES

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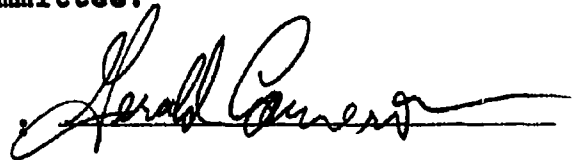
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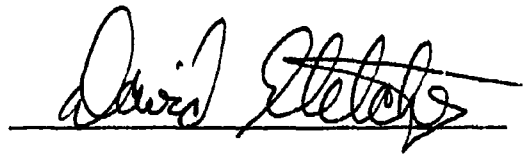

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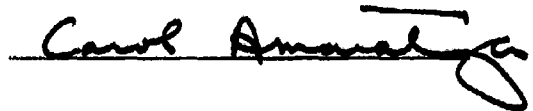   Prof. Gerry Cameron

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IN HEALTH DEVELOPMENT PROGRAMMES

ABSTRACT

It has been recognised that a number of health development projects and programmes have failed as a result of the unreflecting way in which community members have been left out of development processes and treated as mere recipients. These failures have raised much debate about community participation. Despite the controversy about the meaning and means of achieving community participation, it has been widely recognised and accepted that wider participation of community members in planning, implementation, management and evaluation of projects produces better results in health programmes. Community participation can be assessed by first recognising that participation occurs at different levels and by finding ways of measuring participation.

This study examines indicators that have been developed for assessing the level of participation in development projects. Using seven indicators which strongly influence the process of community participation, an analytical framework is presented with which participation is measured. These indicators are; needs assessment, leadership, organization, management, resources mobilization, action orientation and evaluation. An illustration of how the framework might be used is given with two case studies of health projects, one done in Nigeria and the other in Kenya.

The method provides a tool to assist those involved in a project to describe participation in such projects and to base future actions on their assessment. The method is descriptive, giving a visual presentation of the participation process. It is demonstrated that the framework is useful in understanding participation as a process.

Ihedinma Joy Ngadi

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CHAPTER I - INTRODUCTION

1.1 PROBLEM STATEMENT

Development strategies have shifted over the years, from various ways of thinking based on modernisation theory of development towards a systematic search for alternatives. Historically, development programmes especially those related to health, were marked with the assumption that local people have nothing to contribute but would cooperate by utilizing the facilities provided through such programmes. Most of these programmes and projects had government sanction and financial commitments. In these programmes, no significant effort was made to determine the aspirations, values, needs and norms of the communities involved. The result was that most of these facilities remained under-utilized. The realization that development programmes and projects have not only by-passed but marginalised the poor, especially in the rural areas of developing countries, led to the formulation of other strategies such as, Integrated Rural Development, Meeting Basic Needs, and Community Development. In recent years, the concept of participation has emerged. In almost all development programmes initiated by government and non-government agencies an element of community participation is now often built in. However, the procedure of evolving community participation have mostly remained ill-defined or illusive.

The term "community participation" has been used with different meanings
The majority of development programmes have claimed to be participat.·ry for the
mere fact that local people were gradually involved in an activity which was
designed and guided externally. These programmes have been implemented
through "experts" in form of consultants, government and international agencies
going into a locality to diagnose its problem, determine the types of programmes
and services needed, and the strategies that should be used in addressing such
problems (Oakley, 1991). Foster (1987) referred to this as "the silver platter
model" which makes the assumption that rural people (recipient of help) would
immediately appreciate the advantages of the new ways once exposed to them,
and given the opportunity to quickly adopt them. The community usually has no
central role nor any control over the programme or project. Many of these projects
have failed either as a result of unsuccessful completion of objectives or
stagnation of the programme when the external experts depart. Invariably, the
community could not identify themselves with the prescribed project and activities
involved.

1.2 THESIS STATEMENT

Recently, within development circles, there has been a wide support of the view that community members, especially people in the rural communities, should be actively involved in the initiation, implementation, monitoring and evaluation of development programmes (Korten, 1980). Peoples' participation in decision-making processes, the recognition of felt needs, implementation and management of such programmes will ensure the adequate utilization of the services provided through such programmes, and capacity building of the people concerned. In essence communities should not be mere objects of development projects (Wignaraja, 1984).

Rural people when given the opportunity, have contributed much towards planning and management of development programmes that relate to them; much more than just taking part in some of the activities involved, being assigned responsibilities to, or being used as cheap labour. They have more technical expertise than is usually recognised by development agencies. They are able to make decisions and take actions which they believe are essential to their development. According to proponents of participatory action-research, people have the capacity to think and work together in developing skills and abilities for a better life. Knowledge, skills and resources should be shared. The common assumption that the modern scientific knowledge of the professionals from industrialized countries and urban cities is sophisticated, advanced and valid and,

conversely, that whatever rural people may know is unsystematic, imprecise and superficial is incorrect (Chambers, 1983). Development agents can learn from rural people and vice versa.

Outsiders are not likely to understand the needs of a community more than the members of the community. It is important for development agencies to appreciate such rural needs, knowledge and resources and be able to develop better strategies that will support and supplement the indigenous system. Participation implies a greater chance that resources available to development projects will be used more efficiently. It is cost-effective in that fewer costly outside resources will be required and highly paid professional staff will not get tied down in the detail of project administration. Added to this, many of the results are in the local interest. The fact that they are carried out by those who will benefit from them provides a certain guarantee that the work will be well done, and that future operation and maintenance of the installation or services will be taken care of.

Community participation should be seen as a precondition for rural development in most developing countries. The condition in which the rural population find themselves is such that they cannot depend on the state toward the meeting of all their needs. Moreover, most of their problems are too urgent to await external help. Infrastructure is concentrated in the urban areas whereas rural areas are ignored.

The economic situation under the Structural Adjustment Programme (SAP)

has led to a cut back on the budget allocated for social services especially in health. This has worsened the situation in rural communities (Kanji et al, 1991). There is a considerable potential for the mobilization of human resources and the availability of skills and resources in rural areas. However, any programme can be successful only if the people have a genuine felt-need for it, aims were chosen and accepted by the community and, provided their mobilization involve genuine participation. Members of a given community, despite all their problems, traditions and diversities, can be motivated to act together to improve their communal environment through dialogue. Participation which allows a community to have a voice in decision-making, be involved in administration and management, and make available their local knowledge, skills and resources will lead to more effective projects (Oakley, 1991). In essence, not only authentic participation, but also a wider level of participation is essential in making a project effective and beneficial. It is important to device a means of assessing the level of authentic community participation in a project. This would further the operationalization of the measurement of community participation as a process.

1.3 SCOPE AND OBJECTIVES OF THE STUDY

There are questions that arise in discussing community participation. First, what makes a project participatory and what are the criteria to determine the level of community participation towards a project?. Second, who initiates the process of empowerment, and who controls the development process?. Third, how do agencies address the problem of political control when participation challenges the power of the existing elites?. Fourth, as most communities need resources which they are not capable of providing, at least at the initial stage of a project, how can they avoid creating new patterns of dependency?. These questions will be addressed in this study.

This study will highlight an overview of some principles and factors that could determine the level of community participation in health development projects. It does not intend to give a comprehensive review of participatory projects, nor does it give a definite analysis of what authentic participation involves. The objective of this study is to examine the factors that make a project participatory, and to develop indicators which could serve as a framework in assessing the level of community participation. These indicators will be tested using two specific case studies of health development projects.

This paper is divided into seven chapters. The first chapter provides background information, the thesis statement, the scope, objective and limitations of the study. The second chapter is a general introduction of the different

concepts used in community participation in health development. In the third chapter, a review of literature in this topic is given, and it presents a description of the different meanings and levels of community participation that have been identified. Different reports on health related programmes and projects that were claimed to have involved community participation are cited. The fourth chapter gives an outline of the different methodologies that have and are being used in data collection, implementation and evaluation of participatory projects. It also contains a description of the indicators which will be used in this study for the analysis of the level of community participation. These indicators will be used to develop a framework for assessment of participation.

In chapter five, a detailed report of the Michika health development project in Nigeria is given, and the level of community participation in it is analyzed based on the indicators developed. Chapter six is the report and analysis of the Kibwezi Rural Health Scheme in Kenya. Conclusions and recommendations are presented in chapter seven.

CHAPTER II - COMMUNITY PARTICIPATION IN HEALTH DEVELOPMENT

2.1 INTRODUCTION

Development strategies over the years had emphasized economic growth and industrialization with centralised planning and control over the distribution of resources. From the end of the Second World War until the 1970s, the dominant international view of the solution to the problem of underdevelopment has been what was termed "trickle down". This was taken to mean a process in which a growing national product in a poor country would eventually become large enough so that it would trickle down from the rich to the poor, thus bringing and end to underdevelopment (Gish, 1982; Wilber and Jameson, 1975). The objectives and processes were viewed in economic terms and great reliance was placed on economic factors to achieve results. The model assumed that rapid economic growth could take place if there was central planning and control of the economy as a "top-down" process, with emphasis on industrialisation, modernisation and urbanisation (Wignaraja, 1984). Within the modernization theory, the rural poor were not seen as a major resource for furthering the process of development but rather as obstacles, and attention was turned to mobilising them through mass education and community development. It was assumed that the injection of capital inputs from outside would result in a "take-off" and the eventual spread of

benefits throughout the system (Oakley and Marsden, 1984; Bhasin, 1991).

The result of this form of development was that a small section of the society was benefitted, whereas the majority were excluded. Despite major achievements, human progress has proved a far more elusive and complex goal than the early development pioneers ever imagined. In today's age of dazzling technology, over one billion people, or one out of five, live in absolute poverty. Half of these are chronically undernourished. Over 900 million have no education (UNDP, 1990). The failure of this development strategy was attributed to the human factor. The structural crisis witnessed by donor and recipient national governments and even institutions such as the World Bank, showed that development projects had failed to produce the expected results.

Over the years, many developing countries have benefitted from the support extended by external development agencies as well as individual governments. The health sector like others, have been beneficiary of such developmental assistance. However, the result shows that these services have been "top-down", disease-oriented and hospital-based, centred in cities and towns, predominantly curative in nature and accessible to a minute well-to-do strata of the population. In many developing countries, out of the 80% of the total population which live in the rural areas, less than 15% have access to modern health services. The failure of such development programmes to reach and meet the needs of the poor coupled with the world economic recession worsening the situation, has led to the search for alternative ways of meeting the health needs

of the rural poor.

2.2 HISTORICAL BACKGROUND OF PARTICIPATION

The word "participation" appeared for the first time in development jargon during the late 1950s (Rahnema, 1992). Since then, it has connoted different meanings. During this period, the United Nations was instrumental in promoting what was called the "community development movements" which advocated that people in their community should play a major role in their own development programmes (Rifkin, 1990). Community development programmes focused on small and mainly rural communities, seeking to establish democratic decision-making institutions at the local level and to mobilize people to improve their economic and social status through a variety of development projects. However, the decision-making process was generally top-down, benefitting few community elites. Programmes and targets were formulated centrally and were implemented through conventional bureaucratic structures with little regard to the willingness or capacity of the people to respond. The conflict of interest inherent in stratified village social structures were ignored by programme planners while existing power structures were accepted as given (Korten, 1986). The panel on people's participation was established in 1981 by the Inter-Agency Task Force on Rural Development. It came as a result of a growing awareness within the United

Nations System of the importance of participation as a development objective. The International Labour Organisation (ILO) was the conveyor of this panel (Oakley and Marsden, 1984).

It was realised that with active participation of local people in projects, more was achieved with much less, even in sheer financial terms. Adelman and Morris (1973) stated that, participation in political decisions and national planning is often thought to favour the achievement of a more egalitarian distribution of economic and political power. Participation by individuals in participant institutions such as labour unions, political parties and farmer cooperatives is one way to provide a sense of personal worth and identity without which the dislocation of economic development tend to produce alienation and anomie. Different authors like White (1982) and Rifkin (1985), have also given a number of reasons why community participation is needful; however this is beyond the scope of this research.

Community participation is a "new" social development strategy which, departing from conventional models, is based on the desire to satisfy the un-met needs of a vast majority of the population primarily in developing countries. It relies on the massive use of auxiliaries chosen by the community, and on plans of action based on expressed need which is elaborated, implemented and evaluated with the local population (Mandl, 1982). This development strategy is more than the provision of social services and the introduction of new technologies. Rifkin (1988) defined community participation as a social process whereby specific groups with shared needs living in a defined geographic area

actively pursue identification of their needs, take decisions and establish mechanisms to meet such needs.

The literature and documentation about the concept and practice of participation is quite vast. Other concepts that have been introduced and used, apart from the actual notion of community participation in development activities are, participatory research, participatory action-research, participatory field-action and participatory evaluation. Although these other areas are equally important and are somewhat related, the focus of this thesis is on actual participation of local community in health projects. More emphasis is placed on rural communities since the majority of the poor reside there. This does not suggest that communities exists only in rural areas. There has been evidence of the ability of urban people to organize themselves towards the achievement of specific objectives. However, the conceptualisation and discussion of participation is broad-based.

It is necessary to make a distinction between the participation of some local individuals (beneficiaries) and the participation of the organised community. However, White (1982) argues that it may be unrealistic to insist that "true" community participation is only achieved when local people are in full control of the process of making decisions entirely for themselves. A report by Olujumi and Egunjobi (1991) examined the various ways by which the people of Ajowa in the then western region of Nigeria in 1955 participated in the Ajowa Village Regrouping scheme. The initiation of the scheme was by the Ajowa community

leader and the village heads of Ajowa group of villages who traditionally (though maybe not in practical terms) were the representatives of the people. The community was absolutely ignored in the preparation of the plan, and this had its consequences. Nevertheless, they participated actively in the implementation of the scheme by embarking on self-help projects for the provision of their felt-need infrastructures.

2.3 PARTICIPATION

There is no single universally accepted interpretation of participation. The lack of a standard definition has resulted in divergent views or inadequate understanding (Smith, 1991; Rifkin, 1986). However, all ideas of participation agree that people must be given a voice in development decisions, access to resources and knowledge required for development and a share in the benefits achieved (Seeley et al. 1992). Governments and development agencies have realised that active participation will lead to long-term sustainability of projects. Peter Oakley is one of the known scholars that have written a great deal on the concept and practice of community participation (Oakley, 1984, 1989 and 1991). Oakley (1989) identified two main schools of thought in the literature on participation. One school assumes that there is little generally wrong with the direction of the development process and that past failures are linked to the

human element which has been neglected, resulting in the lack of people's involvement in a project about which they had little information or of whose value they were not convinced. Therefore, it was (and still is) believed that providing more information and increasing the knowledge of the local people concerned would persuade them to be more involved and thus help ensure the success of a project or programme.

The other school of thought argues that the direction of the development process is fundamentally misconceived. The failure to take into account the human factor is not the problem but rather, the unreflecting way in which people have been left out of the development process and treated as passive recipients. The new approach therefore, is to seek innovative and flexible procedures taking into account the knowledge already possessed by local people (Oakley, 1989; Oakley and Marsden, 1984).

Successful community programmes tend to be those that maximize community participation; that is, they are oriented to locally identified needs, feaslbie within the community context, locally managed, and are adapted to the existing cultural and social conditions (Underwood, 1983). This has been advocated in both health and health related programming. Rhode and Hendrata (1983) believe that in community nutrition programmes, the community must be involved, not only in a passive way but also in the development of leadership trusted with continued implementation of programme activities.

2.4 COMMUNITY

Community is referred to in this study as comprising of individuals with common concerns forming groups in order to achieve specific goals (Smith et al, 1993). Community is also defined as a group of people with face to face contact, that is, a common geographical location; though comprising of a rich diversity of groups and interests, has a sense of belonging together, a common perception of collective needs and priorities, and can assume collective responsibility for community decisions (Sheng, 1990; Gott and Warren 1991; Ahmed, 1978; Korten, 1986). Christenson and Robinson (1980) gave a summary of four main components involved in defining the concept of community as, people, area or geographical boundaries, social interaction or interdependent on one another, and common attachment or psychological identification. It should however be noted that in whatever way that community is defined, there is the need to take into account economic and social differentiation within the community which may lead to conflict between groups within the community. Again, different communities live in different political environments which will largely determine the features of community participation. However, this alone should not be used to judge the ability of any particular community to become involved in health development.

2.5 PARTICIPATION AND HEALTH

Health, according to the constitution of the World Health Organisation (WHO) is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity (Hansluwka, 1985). Health is a personal state of well-being that enables a person to lead a socially and economically productive life (Mahler, 1981). This definition points out the fact that health is a multi-dimensional phenomenon. It is a social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector (Macdonald, 1993). The measurement of health may be determined by the value system of the society concerned. Therefore, health has a cultural concept, which is closely related to human feelings and sense of identity, to the meaning ascribed to life, disease and death, and to the spirit and the customs of the community in which individuals live (Borrini, 1987). This concept of health is overlooked when the people are mere on-lookers in the process of development with respect to their health. Ram (1989) argues that health is a social and spiritual phenomenon which greatly depends upon the interaction of people, their participation and involvement in all matters that affect their well being. Making people aware of their right and responsibilities helps them to determine their own health priorities and take part in solving their own health problems. This is a very essential step toward empowerment. To bring about a real change in health practices, people have to decide for themselves and take responsibility for their

own health.

Health is a goal of development in its own right, therefore, development should be a process of change promoting health for every member of the society. While health is a pre-requisite for economic well-being, it has to be recognised first as a fundamental human entitlement and a condition of well-being which has to be protected and promoted by the entire development process that is taking place in a country (Gunatilleke, 1988). It should also be noted that while discussing health, other health related factors like, food production, nutrition, housing, water supply, sanitation, education and income generating which directly or indirectly affect health cannot be overlooked. Therefore, it is acceptable to consider any project that addresses such issues as a health project.

2.5.1 PRIMARY HEALTH CARE (PHC) AND PARTICIPATION

Primary Health Care (PHC) was initiated as a result of the dissatisfaction with the medical approach and a search for an alternative strategy (Mahler, 1976; Mahler, 1981; Rifkin, 1985). The medical model sees the health professional, most often the doctor, as the powerful and active partner whereas the client (community) is the passive recipient of health services (Macdonald, 1993; Cohen and Uphoff, 1977). At the International Conference on Primary Health Care (PHC) sponsored by WHO and UNICEF and held at Alma Ata in 1978, it was declared that primary health care is the principal strategy for attaining the goal of Health

for All (HFA) by the year 2000. The concepts that were accepted included: equity - a universal coverage of the population with care provided according to needs; services to be promotive, preventive, curative and rehabilitative; services to be effective, culturally acceptable, affordable and manageable; communities to be involved so as to promote self-reliance in defining health problems and needs, developing solutions, implementing and evaluating programmes; approaches to health to be related to other sectors of development (WHO, 1978a; Bryant, 1988; Mahler, 1988). It is clear that among other things, community participation in health was theoretically identified in this conference as a vital tool in attaining health for all.

Community interest and participation in solving their own problems is not only a clear manifestation of social awareness and self-reliance, but also an important factor in ensuring the success of PHC (Muhondwa, 1986). The World Health Organisation defined PHC as "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community can afford" (WHO, 1978a; Macdonald, 1993). Primary health care should be seen as a means of helping people in their struggle for lasting improvement in the quality of life. The community should have the power to initiate, plan and implement decisions on matters that affect their lives.

The philosophy of PHC had overturned the entire approach to health service development. Instead of starting from a prepacked, overpriced,

inappropriate and irrelevant package of medical technologies and thrusting them on the people, the new approach advocated that health service development start from the people themselves. It implied that health services will be subservient to the needs of the people and that the people will have a major say in the shaping of these services (Mahler, 1981). Community self-reliance, social control over medical technology and intersectoral action for health are the keystones. Health services have to be developed in an integrated form combining curative, preventive, promotive and rehabilitative services. It also offers coverage to the entire population (Banerji 1988). This approach is later referred to as comprehensive primary health care (CPHC), distinguishing it from the selective primary health care (SPHC). The scope of CPHC includes; health education, food supply and nutrition, water and sanitation, maternal and child health, immunization, prevention and control of locally endemic diseases, treatment of common diseases and injuries, and provision of essential drugs (WHO\UNICEF, 1978; Mahler, 1988; Unger and Killingsworth, 1986).

Community participation and community involvement is used interchangeably in this study. However, PHC has made a distinction between the two opting for community involvement because of its deeper implication. In primary health care, the term "involvement" is preferred to "participation" because it implies a deeper and more personal identification of members of the community with PHC (WHO, 1984).

2.5.2 SELECTIVE PRIMARY HEALTH CARE AND IT'S CRITICISMS

Selective primary health care (SPHC) has attracted wide-spread attention as a major alternative to the CPHC concept. The SPHC strategy emphasizes rationality and potential cost-saving. SPHC is supposed to institute health care directed at preventing or treating the few diseases that are responsible for the greatest mortality and morbidity in less developed areas and for which intervention of proved efficacy exists (Unger and Killingsworth, 1986). Walsh and Warren (1980) claims that the goal set at Alma Ata has a large and laudable scope which makes it unattainable in terms of its prohibitive cost and the numbers of trained personnel required. They advocate that until comprehensive primary health care can be made available to all, services targeted to the few most important diseases may be the most effective means of improving the health of the greatest number of people in developing countries.

Selective primary health care has been criticised as a short-term, technocentric approach of health care which threatens to reverse the historic gains made at the Alma-Ata conference. Newell (1988) called SPHC a counter revolution which tries to counteract the key changes proposed in PHC that are linked to qualities such as power, ownership, equity and dignity. Banerji (1988) cited the example of the Universal Child Immunization Programme, UCI-90 as a contradiction of the PHC approach. He argues that UCI-90 inhibits community self-reliance and social control over medical technology by making people once

again dependent on western countries for funds, vaccines and equipment. He believes that through SPHC, a propaganda campaign euphemistically called "social marketing" has been launched to browbeat people into accepting whatever is handed down to them by manipulators from abroad. Unger and Killingsworth (1986) reaffirm that the adoption of SPHC is not determined by health factors, but by political and economic constraints acting upon decision makers. Macdonald (1993) claims that the failure of SPHC to significantly reduce overall mortality rate point to the failure of health services to implement a comprehensive PHC approach along the guidelines laid down in the conference. He referred to SPHC as a medicalization of the original PHC message in that it does not call for any significant shift of resources, nor indeed for any transfer of power. Gish (1982) commenting on a paper written by Walsh and Warner, states that SPHC offers a traditional defense of the vertical health programmes. According to Berman (1982), cost-effectiveness which SPHC claimed to be a useful approach in health planning is an insufficient criterion for PHC programme design.

In response to such criticisms, many other authors have argued that the concept of SPHC was built into the original definition of PHC in the background document for the Alma-Ata conference. Taylor and Jolly (1988) states that it is a mistaken assumption that CPHC services were supposed to try to implement all eight components of PHC equally and at the same time because it is impossible to do all at once in a country with limited resources. Moreover, the economic situation in most developing countries have changed dramatically since the

conference. Per capita income has declined in two-thirds of African and Latin American countries since 1980. This has had its effects on health budgets. Walsh (1988) claims that limited resources calls for priority and the use of technology. Warren (1988) states that the SPHC approach was to be an interim measure which could in no way preclude the use of any other health or intersectoral measures for fostering the well being of people.

The proposal is that selective and comprehensive PHC should not be seen as two contrasting lines of action, but complementary ones. Priority does not mean exclusivity, but flexibility is needed in adapting national priorities to local programmes. With the debate over SPHC and CPHC, UNICEF launched its Child Survival and Development Revolution (CSDR) in 1982, promoting four specific "social and scientific advances" for improving the health and nutrition of the world's children. These were growth monitoring, oral rehydration therapy, breastfeeding and immunization. This is also referred to as GOBI (Warren, 1988). In 1984, three more areas of intervention were added; family spacing, female education and food supplements (FFF). UNICEF in the GOBI-FFF programme agrees that ultimately all decisions about priorities must be made by countries themselves and that international agencies should be careful to limit themselves to roles of advocacy and support (Taylor and Jolly, 1988).

It could be suggested that any programme whether under SPHC or CPHC should give a priority to the essential elements of PHC, namely concern for participation, equity and intersectoral collaboration. However, the medical

professional conservatism, together with its interaction with elite interests and political priorities, remain the obstacles in achieving the objectives of PHC (Green, 1991). Participation challenges the existing power structures and acceptable role models for health professionals (Brownlea, 1987; Madan, 1987). Though PHC is an intervention to replace this model, it should be recognised that those entrusted with the idea of promoting participation have been trained in a system in which thinking and acting is non-participatory. The notion of people's participation in health and sharing of power runs counter to basic medical training. Therefore one critical step toward wider participation is to overcome this bureaucratic power structure.

2.6 NEED FOR COMMUNITY PARTICIPATION IN HEALTH PROJECTS

The importance of community participation in any project, but especially in health projects cannot be overemphasised. Community participation is a basic right which all people should be able to enjoy. Involvement in decisions and actions which affect peoples health builds self-esteem and also encourages a sense of responsibility.

Community participation is a means of making more resources available to health services by drawing upon local knowledge and resources to compliment those provided by the formal health services. This is especially important in

developing countries on the basis of limited resources. It leads to greater cost-effectiveness in health services (Madan, 1987).

The possibility that health programmes and projects will be appropriate and successful in meeting health needs as defined by local people is increased with community participation. Community participation includes, but is not limited to resource provision. More partnership oriented community participation enhances the prospect of Health for All.

Community participation breaks the knot of dependency that characterises much health development work. It further creates an awareness in the local people of their potential involvement in development. Ultimately, it can help create a political consciousness among people that causes them to seek a voice and to be heard in development processes (Oakley, 1991, p.48).

CHAPTER III - LITERATURE REVIEW

There has been a great deal of confusion about the meaning and objectives as well as the approaches to be used for the promotion of community participation within the literature. There is little systemic knowledge to draw on in the social sciences concerning participation, however, there have been various efforts and studies contributing to its understanding (Cohen and Uphoff, 1980). Oakley (1991, p.6) presented four ranges of interpretations in an effort to illustrate the direct relationship between interpretation and development analysis. This implies that in development analysis, participation cannot be used "blindly" without identifying the extent to which the participation is occurring. The next section examines how different authors identified community participation in levels.

3.1 LEVELS OF COMMUNITY PARTICIPATION IN PROJECTS

Development projects can be differentiated into participatory and non participatory or conventional projects. Participatory and non-participatory projects do not differ in the broad dimension of their activities, rather the difference lies in such factors as interpretation, style of intervention, nature of activities and methods of implementation. Mburu (1989) gave an illustration discerning three

typical characteristics in project development. The first group involve projects whose initiators do not take time to prepare objectives and involve the community. The second is were initiators rely on good background planning, community technical know-how, resource inputs and good ideas, without involving the community. The third type of project, though difficult, are known to be long lasting. This process involves mobilization of the community, dialogue and in-depth understanding of the social network. Mburu believes that the sustainability of projects is possible to the extent that the community is involved in the operation of the programmes.

Among the projects that are claimed to be participatory, different levels of participation could be noticed. This level can be identified by uncovering the participatory elements of a project. Arnstein (1969) was among the first to examine participation at different levels. She developed a typology of eight levels of participation arranged in a ladder pattern, with each rung corresponding to the extent of citizens' power in determining the end product. The levels ranged from, utilization of services and facilities, (which is a form of manipulatory or therapeutic intervention) to cooperation with initiatives planned by an outside agency, (which is considered as token forms of participation associated with the extension of information, consultation and collaboration of one sort or another) to involvement in planning and managing activities, (which is a real form of participation associated with partnership, delegated power and citizen control) (Arnstein 1969; PAHO, 1984). Oakley and Marsden (1984) presented a similar continuum of

participation which ranges from voluntary contribution to increased control.

In a farmer's participatory research project, Ashby et ai (1987) identified four modes or levels of farmers participation which differ in objectives and organisational and managerial arrangements required for implementation. These ranged from contract, consultative, collaborative and collegiate. Seeley et al (1992) applied these four modes in their study of community-based HIV/AIDS research in Uganda. They concluded that majority of the community participation in the programme was at the contract level since the nature of the research programmes as a "foreign imposition" with "foreign goals" precluded the involvement of the community in much of the policy development and research planning.

Rifkin (1990) in her book, "Community Participation in Maternal and Child Health/Family Planning Programmes" made an orderly distinction of five levels of community participation. These are:

i. People's participation in the benefit of programmes: This first level is a passive participation where members of the community receive services and education provided by planners and agencies.

ii. People's participation in programme activities: In this level, community members contribute resources like land, labour and money to health programmes in which they will benefit. This cannot be considered as active participation, because those concerned do not participate in the choice of activities to be undertaken or in decisions as to how such activities will be carried out. This

decision remains the prerogative of health planners, agencies or the government. The members of the community simply agree to carry out the activities laid down by the planners.

iii. People's participation in implementation of programmes: In addition to participating in benefits and activities, members of the community may have some managerial responsibilities, since they make decisions about how some activities are to be run. However, the activities to be undertaken and the programme objectives to which they contribute are decided by planners to whom the members of the community have to refer for advice, supervision and approval. It is therefore the planners rather than the community who are the focal point of these activities.

iv. People's participation in monitoring and evaluating programmes: In addition to all that had been mentioned above, community members may be involved in deciding how to measure objectives and systematically monitor activities. They are in a position to modify programme objectives but not to determine those objectives themselves.

v. People participation in planning programmes: This is the level at which community participation is the broadest, in both range and depth. It involves members of the community receiving benefits, joining in activities, implementing projects, evaluating and monitoring programmes and making decisions about, and taking responsibility for programme p .cy and management (Rifkin, 1990 p.11-15). Rifkin believes that this is the ideal towards which many programmes strive. The reality in most health programmes however, is that participation is seen

mainly as receiving benefits, involvement in programme activities or in implementation. In an evaluation of 52 USAID-sponsored programmes of PHC, all proclaiming to promote people participation, Cohen and Uphoff (1977) found little evidence of significant participation in decision-making and evaluation.

Oakley (1991) distinguished projects which are termed "participatory" into two broad groups. The first group sees participation as an element in the overall project objectives and in the other group participation is seen as the fundamental dynamic of the project. Participation in the first group is interpreted as a means of achieving a set of material objectives or goals. It is essentially describing a state or an input into a development programme. The result of participation in the shape of predetermined targets are more important than the act of participation (Oakley, 1989).

Where participation is the fundamental dynamic of the project, increased control by the participants of a project is seen as an end in itself. Emphasis is laid on participation as a process in which confidence and solidarity among rural people are built. It is possible to trace and identify the basis of a strategy in the sort of projects where fairly radical changes of approach have been put into practice. Oakley argues that authentic people's participation in development projects occurs where the participation is central to the projects activities and where the analysis employed by the project sees participation as essential to the empowering of local people (Oakley, 1991, p.159-161, Oakley and Marsden, 1984, p.27).

In this authentic participation, the initial contact and nature of interaction with rural people is seen as the crucial first steps which will determine the nature of the ensuring participation. Participatory projects challenge the normal process of pre-established sequence of stages around which different objectives and inputs are correspondingly organised. It stresses the importance of starting a project by building up peoples confidence and abilities as the basis for their participation. This process requires time which has a cost.

Oakley does not however suggest that all projects must fall into either one of the categories. The level of community participation in any project could fall somewhere in the continuum between these two types.

There is a delicate balance between "process" and "outcomes" in empowerment and health development. It is important that attention must be paid to both. If all the attention/activity revolves around the process of empowerment without any tangible benefits to the participants, the interest of the community may not be sustained if the project falters. If on the other hand, the focus is heavily oriented toward outcomes without meaningful participation of the community, then there is little basis for empowerment, self reliance and sustainability (Purdey et al, 1993). Despite this, it is believed that authentic participation is that in which participants are empowered to define and assume responsibilities for their own lives. It is more than a way of harnessing the existing physical, economic and social resources of rural people in order to achieve the objectives of development programmes and projects. Since empowerment is a

central issue in distinguishing types and levels of participation, the next two sections will examine different projects based on this differentiation.

3.2 THE REALITY OF PARTICIPATION IN VARIOUS DEVELOPMENT PROJECTS

An earlier and widely accepted view considers participation as mobilisation of people to take part in projects designed by people who are not part of the community. Participation is considered a voluntary contribution by the people in one or another of the public programmes supposed to contribute to national development, but the people are not expected to take part in shaping the programme or criticising its contents (Oakley, 1991). This view is based on the assumption that some countries and people are already developed and they know what needs to be done to "take development" to the "underdeveloped" (Bhasin, 1991). in most development programmes, even under PHC, the people have not been actors but recipients. Many of the so called "integrated development programmes" are still popular among many development agencies, but in practice these programmes are more multi-sectoral than truly integrated. Each sector is usually planned by sectoral experts who are primarily interested in seeing the people organise to implement "their" activities (Burkey, 1993). Uphoff (1985) refers to this as "pseudoparticipation".

Within this paradigm, participation is not perceived as a threat since it yields greater productivity at low cost. It has actually been used to manipulate people into accepting the responsibility in solving their own problems rather than depending on the state; abdicating the government from its responsibilities to the rural poor, whereas the power structure remains the same. Participation in this sense can be a manipulation of people by bureaucrats and technocrats, for the purpose which are believed to be for the people's good. Thus participation becomes a social rhetoric, or even just a cliche (Madan, 1987). Participation has become a politically and economically attractive proposition (Rahnema, 1992). It is known that people are more willing to support an administration which gives the impression that it is willing to involve the ordinary persons. Ugalde (1985) discusses the political objectives behind participation in urban and agricultural programmes in Latin America. He stated one of the objectives is the legitimization of low quality care for the poor, also known as primary care. The other is the generation of much needed support from the masses for the liberal democracies and authoritarian regime of the region.

It may appear, looking at projects of this nature that a certain level of success was achieved in meeting the need of the community. However, this form of participation failed to address certain questions. First, how are basic needs defined, and by whom?. Second, where does the power and control lie, and who constitutes the decision making body?. Third, are people participating willingly or do they just comply because they have no alternative choice due to their lack of

resources and technical skills?.

A study was done by Bah (1992) on community participation in rural water supply development in Sierra Leone. The sinking of more improved wells or improving the existing ones was a great economic burden on the rural sector in the northern province of the country. The study surveyed the improved water wells programme of the Plan International Rural Development Project in Makari-Gbanti Chiefdom. The assumption made in this programme was that community self-help in meeting part of the cost of input to be provided is essential in promoting the effective utilization of the services provided. The study revealed that the improved wells were found to be least effective in providing the dry season water supplies to the villagers. The ill-conceived nature of the community self-help development strategy adopted was among the factors responsible for this situation. Villagers were found to meet part of the cost of the improved well, not because of genuine felt need for the system, but because they are interested in the associated benefits of the integrated package, which included, roads, schools, health centres and community centres.

This top-down approach was also used in a programme of immunization of children with diphtheria-pertussis-tetanus and polio-vaccines in a rehabilitated Bombay slum. It was mainly an involvement of local community resources, with the participation of school children, local leaders, voluntary agencies and medical students, in a door to door immunization campaign. According to Kowli et al, (1990), a positive result was that it substantially improved the follow-up of the

diphtheria-pertussis-tetanus and polio-vaccination. However, nothing was reported on the improvement this procedure had in the general well-being of the community.

Bang et al (1990) reported on a community based intervention trial to reduce childhood mortality from pneumonia in Gadchiroli, India. The intervention included mass education about childhood pneumonia and case-management of pneumonia by paramedics, village health workers (VHWs) and traditional birth attendants (TBAs), who were trained to recognise childhood pneumonia and treat it with a specific drug. The whole exercise appeared to be a top-down curative one. Though it was mentioned that the first element of the approach was to generate awareness in the community by extensive health education and community participation, the extent of the participation stopped at the training of VHWs and TBAs.

In 1978 a low level of community participation was identified as one of the weaknesses of the health sector in the United Republic of Tanzania. In order to remedy this situation, a systematic process of training trainers and students was established with full involvement of the villagers. Decisions were made to encourage people to participate in the planning, implementation and evaluation of their own programmes. Though the students were asked to secure community participation, they received little advice on how this might be done. The process and methods used placed students in the position of experts, actors and initiators while the villagers assumed the role of subordinate passive recipients (Shoo,

1991).

The Saradidi Rural Development Project (SRDP) was launched in 1979 specifically for the development of a section of a community in Bondo Division, Siaya District, Kenya. One of the main objectives of the projects was to improve the living conditions of the community through the promotion of community participation and involvement in socio-economic activities, health development and intervention. Kaseje and Sempebwa (1989) claimed that the community was involved in planning, organisation, setting of priorities and objectives, implementation and evaluation of the programme. However, further reports state that the VHC selected by the villagers was very weak by the end of the first year, and the leadership was dominated by men despite the fact that women were often most aware of certain village problems. Mburu (1989) confirmed that the dominant top-down management suppressed grass-root initiative and potentially, participation in decision-making process. Participation was often interpreted to mean "rubber-stamping" of irrevocable decisions already made be a group of elites that forms the executive management board. The expected community contribution was in the form of labour. As a result, the community developed little confidence in the experts (Mburu, 1989; Kaseje et al, 1987).

The report by Ugalde (1985) points out that participation can be used to manipulate people into supporting the government political agenda. The Plan International Rural Development Project in Serria Leone showed that participation in receiving of benefits do not necessarily mean that people are participating

voluntarily. There may be other motives towards the utilization of the services, and thus cannot be regarded as authentic participation. The report by Kowli et al (1990) explained that participation is much more than receiving of benefits and participation in programme activities. Participation should not stop in the involvement of few members of the community in the implementation of a programme, as was the case in the community-based project in Gadchiroli, India (Bang et al, 1990). Community members (both men and women) should be actively involved, as equal partners with development agents in a project. This was lacking in the reports given by Shoo (1991), Mburu (1989) and Kaseje et al (1987). It can be concluded that in the projects just cited, the level of community participation was either manipulatory or mere involvement in project activities. There was little or no empowerment of the people.

3.3 PARTICIPATION AS EMPOWERMENT

Another view of participation is that of empowerment. This has been done through grass-roots movements, a method used mainly by non-government organizations (NGOs). Grass-roots development policies have been embraced by governments, international agencies and NGOs alike as one of the most effective means of improving conditions and fostering growth in rural areas (Rigg, 1991). Other terms used to describe this form of participation are "bottom-up", "people-

oriented" and "people-centred". Participation here is defined as people's involvement in decision-making processes, in implementing programmes, sharing the benefits of development programmes and their involvement in efforts to evaluate such programmes (Oakley, 1991). Mburu (1989) explains that effective participation implies taking an active part on the basis of knowledge and interest. It is the voluntary involvement of people in deciding for themselves about change. Boyd and Williams (1989) made a distinction between participation and contribution. Participation involves control and management by the community while contribution means that outside people create activities and provide resources, encouraging local people to join in, but giving them virtually no control. The community must participate in the dialogue, which implies a protracted process rather than a short, easy-to-fix event. It also implies an in-depth understanding of the social network in the community. Korten (1990) defined people-centred development as a process whereby members of a society increase their personal and institutional capacities to mobilize and manage resources to produce sustainable and justly distributed improvements in their quality of life, which is consistent with their own aspirations.

Lackey and Dershem (1992) explained that sustainable community development involves civic competence and empowerment through community members managing and participating in the development of their own communities. It is a political process whereby community members acquire a say in decision-making (Ebrahim and Ranken 1988). Participation in community

activities requires interaction with people of different knowledge, skills, attitudes, beliefs and values. This interaction results in increased knowledge and skills. Thus, community participation is seen as developing agencies working with people rather than working for them. Participation is an act of partnership which take time and effort to establish and can only succeed and continue to flourish where there is mutual trust (Drucker, 1980). Participation speaks to the need for structural change in the politics of development. It refers to development as essentially educating the powerless to become powerful. As power comes through unity, development means organizing the poor to fight for their rights, to tilt the balance of power in their own favour. Arnstein (1969) believes that participation is the redistribution of power that enables the have-not citizens, who are excluded from the political and economic process, to be deliberately included in future, and to affect the outcome of the process.

Powerlessness has increasingly been viewed as an objective phenomenon, where people with little or no political and economic power lack the means to gain greater control and resources in their lives. Wallerstein (1992) defined empowerment as a social-action process that promotes participation of people, organizations and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life and social justice. The relationship between powerlessness and empowerment toward health development is that, whereas the former emerges as a broad-based risk factor for disease, the latter can be demonstrated as an important promoter of health.

Empowerment reflects an understanding of the perceived and actual component of powerlessness and encompasses the linkages and interaction between change processes on an individual, organizational and community system-wide level. It is an avenue for people to challenge their internalized powerlessness while at the same time developing real opportunity to gain control of their lives and transform their various settings. In practice however, it is the health professionals, health promotion policy advisors and decision-makers who most often control the determinants of health, leading to disempowerment of people (Grace, 1991).

The literature is vast on reports of programmes in which active participation through empowerment is claimed. Gott and Warren,(1991) discussed how people of the North Staffordshire district in the United Kingdom planned and implemented a community service project designed to increase local participation in health matters. Neighbourhood forum met to examine local needs and make decision involving available resources and services. The forum was instigated by the local community health unit, with an idea to give members of the community an opportunity to influence local health service decisions, reorient local health services towards the expressed needs of the community, and increase partnership in local health-related planning, delivery and assessment. Majority of the participants of the forum believed either that community participation in decision-making occurred or that there was potential for it to occur. Few believed that although the forum allowed the community a say in local health-related matters, some of the issues raised were beyond their powers.

In Yirrkala in the northern territory of Australia, there had been a major transformation in education through the use of participatory research approach. There was a change from the European system which did not respect Yolngu knowledge and culture, and contributed to the erosion of Yolngu values and traditions. The process required the participants to set the directions of their endeavour, everyone involved to accept the role of a "learner" and, to involve themselves in acquiring new skills and knowledge so that they could contribute to their community's development through developing their skills as Yolngu educators (Marika et al, 1992).

Children can be regarded as an integral community group and an important part of a community rather than passive recipients of health care services. They can be valuable assets in PHC programmes. Children have needs and aspirations as well as potential and skills (Kowli et al, 1990). The usefulness of children in the success of a programme was shown through a rural community project in the Eastern Nigeria among the Ibo people. Planning with children in the community mobilization was most rewarding, especially after it proved difficult to involve adult participation at the early stage. After the discussions on health matters, the children on their own reinforced "little" laws to ensure their respective compounds were clean. Eventually, group health education were held in compounds between parents and children, and the health education reached all homes simultaneously within the shortest amount of time (Onyejiaku and Rogers, 1989). Drucker (1980) explains that children have an enormous amount of knowledge, whereas adults

have failed to gather and put to use the very careful research undertaken, quite voluntarily with or without guidance, by children using their inherent sense of curiosity.

3.3.1 POPULAR PARTICIPATION

Another form of participation through empowerment comes under what Rahnema (1992) referred to as popular participation. It is defined as the organised efforts to increase control over resources and regulative institutions in given social situations on the part of groups and movements of those hitherto excluded from such control (Oakley, 1991). This grows out of their conscientization or critical awareness of social and economic problems around them. Conscientization helps build their capacity to address and halt the process of domination, manipulation and colonization of the mind (Boyd and Williams, 1989).

Popular participation has been used mainly in education programmes. This method of learning was greatly advocated for by Paulo Freire. According to Freire (1989), learning is a process that could be equated with life itself. Learning allows one to become more knowledgeable, and to adapt by adopting new values, new methodologies which are essential in adjusting to a world of accelerated change and complexity. The learning process approach assumes a system of people interacting over time - generating ideas, trying out and implementing such ideas, identifying problems and correcting errors in a mutually beneficial way. This is

referred to as innovative learning. There is the deficiency in our present day education effort to train minds and bodies in innovative learning processes. The emphasis is almost exclusively placed on maintenance learning. Freire (1989) referred to this process of learning as a "banking system", where learners are cut-off from the real world and are fed programmed information. This process of education is channelled toward the transfer of the prevailing norms and patterns of behaviour to maintain the existing order. Freire (1972) argues that education should be a liberating process and not a domesticating, conforming and restrictive one. He defines education for domestication as nothing but a mere act of transferring knowledge, where educators recognise themselves as those who know and have knowledge, and the learners as those who do not know. On the other hand, education for liberation is an act of knowing. The educator does not only possess the knowledge, but he knows that he does not know in a complete and total way. Therefore, knowledge is not a fact but a process (Freire, 1973). The power of the elites lies partly in their control of information and manipulation of the people through selective dissemination of such information to ensure their hold on power (Mburu, 1989).

Freire emphasizes that liberation takes place through dialogue between two people, as they work together to become aware of the oppressive situations in society and begin to discuss how to take action to change those situations. The concept of conscientization refers to a process of self realization and consciousness-raising that a person or groups of people employ to identify the

social, economic, political and cultural forces that shape their lives and thus find a strategy to counteract those forces. It means the ability and power to perceive critically the way things exist in the world.(Freire, 1989). This solution cannot be achieved in idealistic terms. In order to wage the struggle for their liberation, the oppressed must perceive the reality of oppression not as a closed world from which there is no exit, but as a limiting situation which they can transform. Freire claims that there is a dialectical relationship which involves not only knowing the reality but also having the ability to transform that reality through action and reflection (praxis).

Jones (1993) reported on community health programmes on several South Pacific countries that involved popular participation. He stated that plans of action were decided upon by community members in order to meet local health problems head-on. Needs were priotized by the community with guidelines from the health team. Local materials and resources were identified using participatory techniques. In popular participation, people are expected to jointly identify their common problems, assess their resource potential, conceptualize and formulate a plan, and implement the project. The range of communication strategies used include theatre and other small-scale media, group meetings and workshop types of gatherings (Boeren, 1992).

In 1984, the Union Macional de Agricultorese Ganadc,os (UNAG) developed a popular participation program in El Rama, Nicaragua. It's main objective was to improve the living conditions of the poor peasants through their

participation in productive groups (Blokland et al, 1988). Popular participation has a critical or radical perspective based on socialist principles of equality and justice. It expects the oppressed to define their own development and be able to create the condition that would lead to social organisation and political action. To be liberated, the oppressed should be able to overcome their fears, recognise their potential and mobilize themselves to work together.

There has been some criticism as to the practicability and feasibility of popular participation. Some have looked at participation as a myth which lead people to believe in a utopian vision. Another concern is the possibility of the facilitator imposing his or her own concept of oppression on the participants. The risk of having a counter-revolution following a social transformation also exist. Feminist authors have also criticised this ideology for failing to address gender oppression as a subject.

3.4 THE EMPOWERMENT PROCESS

As has already been pointed out, a meaningful participation involves some direct access to decision-making and some active involvement in the determination of problems and interventions. In the literature however, there is a contradiction on who initiates this process of empowerment (the community or the outside body), and whether authentic participation can be achieved without a

structural transformation. Oakley and Marsden (1984, p 65) considered a strategy which does not depend on bureaucratic decentralisation or legislation to encourage local organisations, but which attempts to achieve participation in the context of existing administrative framework. They claim that it is possible to bring about effective participation without waiting for the structural changes generally indicated as indispensable.

Chambers (1983) argues that the rural poor are already trapped in a situation of powerlessness and poverty, therefore it requires the "outsider" who has power, knowledge and resources to help change the situation of the poor. From Rifkin's (1990) point of view, it is difficult to get the poor to participate in any type of service programme beyond the level of receiving benefits, because of the social and economic structure in most communities giving them virtually no access to resources. The poor have neither the time nor the energy to change their situation. This lack of knowledge and skill confines them to their feeling of helplessness. Freire (1989) believes that despite this powerlessness, it is the oppressed v/ho are faced with the great humanistic and historical task, which is to liberate themselves and their oppressors.

Maguire (1987) cautions against the dichotomy of, "they know, I don't", or "they don't know, I know". She rather suggests a relationship in which both the researcher and the researched are open to personal transformation and conscientization based on the assumption that both have something to contribute. Uphoff (1988) reaffirms this view by describing two fallacies that are sometimes

upheld. In the paternalistic fallacy, it is believed that planners possess all the knowledge and the poor should be responsive and grateful beneficiaries. The populist fallacy on the other hand, assumes that the poor themselves possess all that is needed for their own advancement. Certain other researchers also believe that a harmonious combination of "top-down" institutional component and a "bottom-up" grassroots component is the best way to empower the rural poor. Uphoff (1985) agrees that one of the paradoxes of participation is that promoting bottom-up development often requires top-down effort. He states that a strategy that transcends both "top-down" and "bottom-up" approaches is more promising in community participation. More important than whether the impetus for development work comes from above or below, is the orientation of those who plan and support that work from above. They should not presume that they have, or can have all the answers to the problems of the poor, but that the poor have ideas, intelligence, management skills, technical capacity and leadership qualities to contribute to the processes of development in addition to material resources (Uphoff, 1988).

Asuzu (1990) gave a report on the success of the Elesu community PHC programme in northern Ibadan, in Nigeria, which was developed by the combined effort of the Department of Preventive and Social Medicine, Ibadan College of Medicine and the community involved. The emphasis was on community self-reliance and the possibility of using the opportunity to identify and solve other community problems within a PHC framework. Another report of a successful

community health development programme in two villages in Haiti, involved a close cooperation between a district hospital, a local dispensary and, most importantly, the inhabitants themselves (Nugroho, 1993). The programme was simple, financially realistic, adaptive to local conditions and linked to activities designed to meet basic requirements, such as those of food production and water supply. Resistance to change and reluctance to become involved in the programme were overcome through honest, open discussion and the building of mutual trust between the partners on a basis of equality. Contribution in cash and kind from the people were made possible by community development activities that generated income, produced food and improved the water supplies.

A community development approach was adopted in the outreach component of the work of the Alexandra Health Centre in South Africa. Its success depended on the ability to identify real needs and to link these needs with organizations that can help families and individuals. The importance of local township organizations was recognised. Community participation at the centre involved the creation of stable structures for planning together, and for the regular exchange of information between health workers and community leaders to coordinate and control the implementation of the agreed plan. There was a continuing learning process among health workers and members of the population (Ferrinho et al, 1993).

There has also been criticism toward the combination of "top-down" and "bottom-up" approaches because of structural and administrative obstacles found

In certain societies. Reporting on a Community Based Integrated Rural Development Project (CBIRD) initiated in July 1981 in 60 villages in the north-eastern region of Thailand, Rigg (1991) explains that majority of the problems encountered during the implementation of the project was as a result of the hierarchical nature of Thai society. Other obstacles identified were a centralized and inefficient bureaucracy, and entrenched interest groups. It was argued that grass-root ideologies, based upon conceptualizations of peasant culture, may be no more in-tune with the aspirations of peasant than those orthodox strategies they aim to replace. He concludes therefore, that grass-root development policies may be seen as being incompatible with the planning context, and thus face long-term and deep-seated constraints of effective implementation.

In the 1980s Cuba institutionalised mechanisms of central planning and popular participation under the system of Management and Planning of the Economy (SDPE). This mechanism yielded a number of the expected productive results. However, there were tensions between participation and central planning which limited the effectiveness of the SDPE. These tensions were linked to the specific forms of participation and material incentives used. The limitation on administrative autonomy, largely restricted workers participation to issues of plan implementation, and workers had little decision-making power with respect to plan formation (Meurs, 1992). The suggestion given was that alternative forms of material incentives and broader popular input into planning targets could reduce these tensions and improve agricultural performance.

3.5 WOMEN'S PARTICIPATION

Participation through empowerment has also been advocated for women's groups and movements. Women should have equal if not greater participation in their community programmes since they are among those with greater health risks due to their multiple roles of production and reproduction. Moveover, being the manager and care-takers of the home, the health of the whole family to a greater extent depends on women. Again, poor rural women are the best managers of scarce resources. Once unleashed, the creativity and potential of ordinary men and women is extraordinary. Women have participated effectively both on their own or jointly with men in rural development. Examples of organisations where this has been made evident are Gonoshasthya Kendra, Njera Kori (in Bangladesh), SEWA and the Chipko movement.

With few exceptions, there is a continuing neglect of women's role in society in development planning. Women are still often seen only in their role as consumers of social services. They derive benefit from projects without participation in the planning. An example of this is a report by Pascal (1988) of an Integrated Rural Development Project (IRDP) carried out in the West Indies. The main objective of the project was community participation at all levels. It was reported that the project was used to promote confidence and initiative by building leadership and management training for men and women at the community level; providing skill training and field experience for community agents at the extension

level; and opening up avenues for change at the policy-making level. This project however, reflects a planned project delivered by experts from outside and not an empowering process.

Projects have been designed for women by men, without seeking women's input in the decision-making as to what their priorities are, and the approach to be taken in addressing both their strategic and practical needs (Young, 1988; Moser, 1989). These projects designed by external agencies do not take into account women's views, attitudes, abilities, and the constraints upon them. The findings of the United Nation development system show that less than one in six projects that were deemed to affect women's live and work, took women's interest into account in the design of project activities (UNDP, 1985). As a result, development processes have sometimes marginalised and worsened the conditions and situations of women.

Feminist theories have followed a pattern in ascribing different interpretation to women's participation in development programmes. The liberal feminists look at participation as an increase in number of women, and level of involvement in economic production especially in the public sphere. This strategy fails to address the issue of women position and status in relation to men. The radical feminists advocate for structural transformation and seek for revolutionary ways to break away from the capitalist international economic system. Socialist feminists assert that the structure of capitalist patriarchy must not only be transformed to allow ordinary women and men dignity and control, but

concurrently women and men need to transform the relationship between them. Gender as a social force needs to be analyzed within a historical and cultural specificity (Jaquette, 1982; Brydon and Chant, 1988).

The Bantu Society was formed by the women of Golden Grove, Guyana following a revolt as they fought for their rights in a dominating situation. The formation of this group led to expansion of economic activities through training and actual production of handcrafts, launching of applied nutrition programme and the use of appropriate village technology. The women were on their own able to take initiatives without the intervention of a political figure (Kempadoo, 1977).

Women's participation should be encouraged not by integrating them into development process in an unaltered system of domination, merely making more resources available to them, nor seeking to divide them from men. Rather, there is need for a transformation of the system that integrate capitalist accumulation, patriarchy and relationship based on domination.

3.6 PARTICIPATORY RESEARCH

Community participation has followed the ideology of participatory research. Participatory research or participatory action-research is commonly used in the analysis of community participation. Nichter (1984) believes that participatory research is a first step towards community involvement in primary health care.

Participatory action-research was developed primarily by people of developing countries. It concerns the movement from the present reality to a potential reality in the future. It is an alternative paradigm or world view which has a systematic approach to radical social transformation (Smith et al, 1993; Maguire, 1987). The alternative world view, as opposed to the dominant paradigm, uses a critical-conflict approach with the belief that societies are in conflict rooted in class and group struggles and competition for power and scarce resources (Maguire, 1984). Participatory research calls for radical transformation of systems and relationships based on domination, rather than promoting ordinary and oppressed people's increased participation in an unaltered system of domination. It is based on the assumption that ordinary people who are provided with tools and opportunities, are capable of critical reflection and analysis.

Participatory research is based on the belief that no research is neutral and devoid of a value base, rather knowledge is tied to human interest and norms. It assumes that work has implication for the distribution of power in society, and that control of the production of knowledge is central to the maintenance of power (Smith et al, 1993). The radical concept of knowledge rests on how well the oppressed can use it to question the very processes used to constitute and legitimize knowledge a experience. Participatory research begins with identification of a problem, then thought, understanding, action and transformation follows. The essence of the approach is collective reflection and action which involves three activities namely, investigation, education and action.

On a broader level, participation has been associated with transformative research. Beder (1991) stated that transformative research does not generate knowledge for the sake of knowledge, nor does it seek to uncover laws and scientific principles. It rather produces reflective knowledge which helps people to "name" their world and in doing so, to change it. The critical awareness must be supported with systematic research that enables learners to recover their experience so that they can reflect upon it, understand it and improve it. Transformative research is an orientation toward research which is defined by its intended outcome, humanistic social change directed toward producing a more just and equal society. Participatory research as an exchange of knowledge starts from the realisation that there is the need to avoid unequal exploitative situation in which educated research personnel communicate with the people without putting their knowledge and resources to use for its benefit (Swantz, 1978).

In participatory research, the researcher openly demonstrate solidarity with the oppressed and disempowered people. This methodology has also been widely suggested in feminist research. Mies (1983) advocates against the postulate of value free research, of neutrality and indifference towards the research object, and calls of a conscious partiality which is achieved through partial identification with the research object. Mies argues that spectator knowledge should be replaced by active participation in action, movements and struggles for women emancipation. Feminist women must deliberately and courageously integrate their repressed, unconscious female subjectivity, that is, their own experience of

oppression and discrimination into the research process.

Participatory action-research is based on this same ideology that people have the capacity to think and work together for a better life. It also affirms that knowledge and resources should be shared so as to support fair distribution (Smith, 1993). Participatory research attempts to break down the distinction between the researcher and the researched, the subject and the object of knowledge production, by the participation of the people themselves in the process of gaining and creating knowledge. In the process, research is seen not only as a process of creating knowledge, but simultaneously as education and development of consciousness, and mobilization for action (Gaventa, 1988). Participatory research methodology as a representation of an alternative system of knowledge production explodes the myth of neutrality and objectivity, and emphasizes the principles of subjectivity, involvement, insertion and consensual validation in order to develop its method of data collection and analysis (Tandon, 1988).

3.7 KEY ACTORS IN THE PROCESS OF PARTICIPATION

Oakley (1991) and Uphoff et al (1979) have listed a number of actors that can be involved in the participatory process. Uphoff et al (1979) referred to this as the "who" variables which included local residents, local leaders, government personnel and foreign personnel. External agencies could be government or non-government organisations. Those with local roots are the local residents, local leaders, project groups, and local organisation. In the middle are project agents who could be outsiders or part of the community. Three of these key actors thought to be important in this study would be discussed in details. These are non-government organisations, local organisations and village health workers.

3.7.1 THE ROLE OF NGOs IN PROMOTING COMMUNITY PARTICIPATION

Projects which most often support community participation are usually small, private or non-government projects (Werner, 1976; Uphoff, 1985; Oakley, 1991). Oakley (1991) believes that such projects regard participation as a fundamental dynamic. Participation is more apparent and its outcome often evaluated. The nature of NGOs as voluntary organisations is both a source of strength and of certain limitations. Grassroots organizations are likely to enhance the political power of the poor, which government agencies may not promote given their close ties with the prevailing political structure. NGO's intervention may

also nudge the bureaucracy to be more responsive to the needs of the poor. With their great local knowledge and commitment, they are more likely than government organisations to have interests and skills to adapt development projects and programmes to local conditions. Other advantages of NGOs include, the capacity to reach the rural poor and outreach to remote areas, and to operate at low costs. Their limitations on the other hand include, limited replicability, self sustainability, and lack of broad programme context. Also, they may have limited funds, or may not be able to provide needed technology, research and other infrastructure nationally (Cernea, 1988; Paul, 1988). Midgley et al (1996) argue contrarily that government agencies have a more important role to play than NGOs since they have access to central decision-making and to a greater volume of resources.

Oakley (1991) claims that projects supported by government or larger international donors see participation as an element in the overall project objectives. In these projects, the element of participation is at times difficult to identify or, at least any substantial assessment is rarely taken. There is little or no discernible strategy; much of the approach is ad hoc and an attempt to reform existing approaches in such a way that they become more participatory. Paul (1988) however believes that government and grassroots organisation have differing but complementary strengths. More could be done for the poor if the two sets of institutions would move from antagonism or co-existence to collaboration. Though it is accepted that projects which lay emphasis upon consciously

developing people's participation are generally smaller, it cannot be assumed that all NGO- sponsored projects encourage and practice authentic participation. Though NGO-sponsored projects are known for their flexibility and adaptability, it is fallacious to conclude that bureaucratically organised management structures and the use of a "top-down" approach is a distinctive feature of government bodies. It cannot be generalised that all NGOs are flexible and innovative. Rigg (1991) discussed on the considerable discrepancy found between word and deed in some grass-roots development policies. He explained that it is rare to find grass-roots development policies that are implemented in a coherent fashion.

There are two critical issues which affect an external agency's performance. One is the basic objective which is linked to the agency's understanding of the meaning of participation. The second is the actual role the agency has in the process, which could vary between directing, supporting or facilitating the process of participation (Oakley, 1991). Voluntary organisation (VOs) and NGOs have a variety of strategic orientations; some deliver relief and welfare services to alleviate immediate suffering; some engage in community development interventions to build capacity for self-help action. Others seek to change specific institutions and policies in support of more just, sustainable and inclusive development outcomes, while others may facilitate broadly-based people's movements driven by a social vision. However the pattern of evolution seems to move away from more traditional relief activities towards greater involvement in catalyzing larger institutional and policy changes (Korten, 1990).

3.7.2 LOCAL INSTITUTIONS

Eliciting and sustaining community participation will require some configuration of community organizations that are accountable and responsive to their members. The variety of interest and needs among rural people may require a variety of organizations even in the same area. It may be more effective to work with and through existing local organisation rather than setting up new ones, but there is no systematic evidence to prove the point one way or the other (Uphoff, 1986). Korten (1980) highlighted the advantages of working with established institutions at the local level wherever they exist and are reasonably suited to project purposes. The adjustments required are more easily made and the risks of imposing new methods unsuited to community's needs are greatly reduced. It also reduces the likelihood that programme intervention will "de-skill" the villagers and thus increase their dependence on external experts and suppliers over whom they have no social control.

Primary health care programmes face the issue of what kind of institutional arrangement or accommodation to seek with the existing system. According to Uphoff (1986), a more general strategy is to follow a "learning process" approach, planning and implementing a programme in an incremental, participatory, experimental manner, and adapting it in ways suggested by experience. The particular forms of organization will vary with specific local experience, the task to be performed and the political administrative environment (Esman and Uphoff

1984). In a study on three projects conducted by NGOs in the Iringa region of Tanzania, it was found that there was very little involvement of the villagers in planning the projects. The main reason was that the project leaders wrongfully assumed that the village governments were the people representatives (Mannion and Brehony 1990).

In general, there is a strong link between organisation and participation. To strengthen the process of participation, organisations should be based upon indigenous pattern and should lead toward social action and not mere receiving benefits. The development of infrastructure for the rural poor is a continuous process which takes time and gains strength as it develops and as it extends its contacts and actions into the area where it is located. Most often, there is no clear differentiation between organisations and groups, and in many instances they are used interchangeably (Oakley, 1991). In most cases, a group develops into an organisation, but sometimes an appropriate organisation becomes a critical first step in forming a group.

An important issue in the process of community participation is the degree to which community organisations are linked to the wider political system. In a study done on some Latin American countries, Gilbert (1985) noted that in most cases, the state controls participation through such linkages, resulting in little sign of participation in the sense of growing control by poor people over the resources and institutions that determine their quality of life.

3.7.3 VILLAGE HEALTH WORKERS

Village health workers (VHWs) play a key role in the process of participatory development. Other terms that have been used to describe these set of workers include, "primary health workers" or "community health workers". The general role of VHWs include establishment of links between community and the developing agency. They are to provide and deliver services as well as act as catalysts or "change agents". Thus their work should include both health care and community development (Muhondwa, 1986; Uphoff, 1986). They embark on low-cost activities such as first aid, health education, and environmental sanitation. Two conditions for sustaining the effective performance of VHWs are, effective periodic and continuous supervision from a higher personnel and, accountability to the community (Uphoff, 1986).

Village health workers often have limited formal education. The kind of training they receive depends on the particular project involved, but could vary from few weeks to about a year (Matomora, 1989). Often their training in terms of participation is rudimentary and they do not possess any particular technical skills. Emphasis is more commonly placed on non-technical skills and particular personal qualities which suit them for participatory development (Oakley, 1991).

The selection, roles and training of VHWs are critical factors affecting the level of community participation. Sometimes, VHWs have been selected using development agencies criteria, or through officials making final selections from a

list of community nominees. VHWs should not only be selected by the community concerned, but the mode of selection is also important. Matomora (1989) agues that communities should be allowed to go through the process of identifying their problems, sorting out their priorities, and means of solving identified problems, before the selection of VHWs. He warns that the selection of VHWs before a community has been allowed to go through such a process is an imposition which robs PHC its most fundamental components of community participation, self determination and self reliance.

Where VHWs are imposed, the role shifts from that of serving the community to serving the agency. They become just another worker in the health care system and their responsibilities are to the agency. Also the conventional method used in the training of most VHWs helps to alienate them from the community. This has led to a gross and inherent misunderstanding of the status of VHWs. To the agency, he\she is part of the community whereas the community sees him\her as an imposed fellow. The VHW is thus cut in the middle of conflicting expectations. The task of health professionals is not to instruct villagers to select VHWs, rather villagers should be helped to become more conscious of their own potentials as creative beings. The feasibility and practicability of this however, is another issue that needs to be addressed.

CHAPTER IV - RESEARCH METHODOLOGY

4.1 RESEARCH APPROACH AND METHODOLOGY

A noticeable gap exists between writings on the theory and concept of participation and evidence of its practice. While much had been written about community participation in health programmes, there is little consistency on how community participation is conceptualised and subsequently measured (Eng et al, 1990). There is little specific literature on the practice of participation in development projects, and few examples of any systematic enquiry into the functioning of participation at the project level (Oakley, 1991). The only substantial source of information are project documents. There has been no universal standard model or proven strategies to the practice of participation, nevertheless there is a broad strategy of participation that can be applied in all different sectors of development (Oakley, 1991).

4.1.1 QUALITATIVE VERSUS QUANTITATIVE ANALYSIS

The method of evaluation in any project depends on what records are kept, and are available, the time, interests and motivations, and especially the desired objective. Conventional participatory projects state objectives almost wholly in

quantitative terms and seek to achieve those objectives through various degrees of people's participation whereas participatory projects have more qualitative objectives directly linked to the participatory process. Most advocates for participatory research (Maguire, 1987; Mies, 1983; Kirby and Mckenna, 1989) support the use of a qualitative methodology. Quantitative analysis treats people as units and society as a quantitative sum of the situation of these units. The application of the technique leads to an over simplification of reality and to an abundance of quantitative analysis not related to history or evolving social relationships (Burkey, 1993). Qualitative evaluation on the other hand is naturalistic. The evaluator does not attempt to manipulate the programme or its participants for the purpose of the evaluation. It employs inductive analysis rather than imposing predetermined and expected outcomes. It does not restrict itself to preformulated questions or lines of inquiry. Qualitative evaluation is holistic and sees the programme as a working whole which needs to be both understood and analyzed from many different perspectives. It implies a continuous and close contact with the participants of a programme in their own environment to authentically understand their realities and the details of their everyday life (Oakley 1991, p.245).

The parameters and contents of any evaluation of participation will necessarily be linked to the operational understanding of participation (Oakley, 1991, p. 239-240). If the operational understanding is limited to the notion of economic benefits derived from successful projects, physical attendance at project

activities or extended project coverage, then the evaluation will be largely quantitative. In this regard, participation is seen as a tangible objective which can be measured as an outcome at the time of project evaluation. Participation here is defined in terms of direct contributions to projects, sharing in the economic benefit or physical involvement in project organisation or decision-making procedures.

On the other hand, if this understanding is closely linked to participation as a process with a series of qualitative objects, the evaluation will demand a qualitative form, even in the methods of information and data collection and analysis. The evaluation of this participation will be concerned with the analysis of a dynamic qualitative process and not merely the measuring of a static, physical outcome.

Inspite of the certainty that community participation cannot be measured in quantitative terms, material development of people cannot be overlooked. The poor are not interested in consciousness-raising for its own sake. Rifkin (1990) has explained the difficulty faced in involving the poor in programmes beyond the level of receiving benefits. However, while there is a clear quantitative dimension to participation, there will also be a qualitative one which need to be evaluated. It is therefore possible and actually important to have a good synthesis of evaluating tangibles and intangibles, quantitative and qualitative results (Wallerstein, 1992).

4.2 THESIS METHODOLOGY

In this thesis, specific indicators would be used to develop a framework with which to analyze the level of community participation in specific health projects. The focus would be on indicators which reflect the qualitative aspect of the projects since there has not been much work done on this area. A description of how the framework could be used is given using two health development projects. The first is the Michika Health Development Project, in Nigeria. The other is the Kibwezi Rural Health Scheme, in Kenya. This framework will be explained in more details later.

Data collected for this work is in the form of secondary material. They are mainly project documents written by different individuals who worked at one point or another in the projects' cycles. Time and financial constraints did not permit the investigation and verification of the information available through primary field data. However, primary information were collected through in-depth and informal interviews conducted with two individuals who were extensively involved in the two projects being assessed. It should also be added that the indicators and the framework developed in this study are specific enough to give an objective analysis of the case studies. Given the information available, it is believed that the conclusions drawn in this study are valid.

4.2.1 LIMITATIONS OF APPROACH

There are difficulties and limitations associated with this methodology as is the case with other methodologies used in qualitative evaluation. The main constraint is that qualitative results are difficult to quantify in line of social science methodology since processes are essentially qualitative and not normally amenable to quantification for statistical analysis (Oakley, 1985). Other difficulties include logistic constraints, observational bias, time, and financial resources. Despite these limitations, I believe that it is still possible to assess the level of community participation in a project.

4.3 INDICATORS FOR ASSESSING OF COMMUNITY PARTICIPATION

Indicators give an indication of a given situation or a reflection of the changes which have taken place. They are variables which help to measure changes. They are used as markers of progress towards reaching set objectives and targets, as well they should be able to be identified and monitored or observed. Indicators provide yardsticks whereby countries can compare their own progress with other countries. Programmes or stages of a programme can be compared using indicators. It can be used to monitor the progress of an overall socioeconomic development. Indicators can be used to monitor health

programmes at different levels - national, provincial or district, or community level (WHO, 1981b; Oakley, 1991 p.247). They are scientifically respected provided that they are valid, objective, sensitive and specific. Developing indicators for an issue as complicated as participation is therefore a real challenge. The World Health Organization (WHO, 1981b) suggests that it may be possible to use only qualitative indicators in assessing community involvement. A number of authors over the last ten years (Oakley, 1991; Rifkin, 1985 and 1988; Shrimpton, 1989) have attempted to develop both qualitative and quantitative indicators that can be used in measuring participation in projects. Oakley (1991) states that quantitative indicators provide framework for the evaluation of participation in quantitative terms. These indicators include, economic, organisational, participation in project activities and development momentum. The economic indicators could show the measurable economic benefits of a project. The organisation indicators give, among other things the percentage of rural adults within a project area who are formal members of the project organisation or the frequency of attendance at project organisation meetings. The number of members who are actively involved in project group meetings is reflected in the indicator, "participation in project activities". Development momentum indicates the internal sustainability, or the ability of the project group to maintain its own development momentum.

Oakley explains that qualitative indicators of a process of participation are directly related to the changes which occur in the nature, growth and behaviour of the project "group" as a result of the project activities. Qualitative indicators

include, organisational growth, which may explain the internal structuring of the project group; group behaviour, which could indicate the changing nature of involvement of project group members, and group self-reliance, which could reflect an increasing ability of project group to propose and to consider courses of action. These qualitative indicators are more difficult to monitor. Rifkin (1985) reaffirmed this view and suggested the use of participatory monitoring and evaluation (PME) with qualitative indicators such as community contribution, organisation and attitude change in assessing the outcome of participatory programmes. Shrimpton (1989) also focused more on qualitative indicators. The indicators he discussed are, need assessment, organisation, leadership, training, resource mobilization, management, orientation of actions, and monitoring and evaluation\information exchange.

Cohen and Uphoff (1980) made a distinction between dimension and contexts of participation. Uphoff et al (1979) explains that the process of eliciting and sustaining community participation can be divided into dimensions of what (the kind of participation taking place), who (the sets of actors involved in the participatory process) and how (the specific characteristics of that process). The how variables add the qualitative dimension to the analysis of participation. How participation is occurring is determined by such variables as, whether the initiative for participation comes form above or below; whether the inducement for participation are more voluntary or coercive; the structure and channels of participation over time through formal and informal organisations; and the duration

and scope of participation.

The context of participation focuses on the relationship between a rural development project's characteristics and the patterns of actual participation that emerge. The context also includes the characteristics of the physical setting, history of the region and the social systems which have subtle but powerful effects on participation pattern. Social factors which can facilitate or limit participatory development strategies in a community are, competing opportunities, development experience and local leadership. Participation is more effective in villages that are relatively isolated from competing urban opportunities, have prior positive experience with development efforts and community endeavour, and hold greater confidence in traditional village leaders and local government agents (Useem et al, 1988). Eng et al (1990) used a rural water supply project as an empirical test to ascertain that communities which participate in decision making throughout all phases of a water supply project will display higher rates of participation in other primary health care activities (such as EPI) than communities which have either a non-participatory water supply project or no water supply project at all.

Rifkin (1985; 1990) has written extensively on indicators of participation. In her book "Community Participation in Maternal and Child Health/ Family Planning Programmes", she listed certain factors that influence the effectiveness of community participation which could also indicate the level of community participation in a project. These factors are divided into two distinct groups.

1. Descriptive factors : These may be cultural, economic, social and political or historical. They may also reflect:

- the degree to which national policy respond to local aspirations and needs.

- the degree to which the civi, service has decentralized.

- the degree of organization at local level.

- the degree to which communication takes place between the centre and the periphery at both local and national level.

2. Action factors: These are of special importance in determining to what extent short-term or long-term objectives are being achieved. Unlike the descriptive factor, planners have greater influence on action factors. These factors reflect the following:

- how community need are assessed.

- how community organisation are developed.

- how programmes are managed.

- how financial and human resources are mobilized.

- how leadership is developed.

- how the problems of the poor are dealt with.

In a paper title "Primary Health Care: On Measuring Participation", Rifkin, Muller and Bichmann (1988) presented a methodology of assessing participation in health programmes based on five action factors (mentioned earlier) which could influence community participation. This analytical framework has been used by

Bichmann (1987) in a fieldwork in Nepal; Laleman and Annys (1989) in a community-based health programme (CBHP) in the Philippines; and by Bjaras et al (1991) in a community intervention programme aimed at preventing accidents in Stockholm county. It was concluded that the framework proved to be a practical instrument to structure discussion on the process of community participation. The criteria for scaling the different indicators will most probably vary from programme to programme (Laleman and Annys, 1989). This framework will form the basis of analysis in this study.

4.4 A FRAMEWORK FOR ASSESSING THE LEVEL OF COMMUNITY PARTICIPATION

A slight modification of the framework developed by Rifkin et al (1988) will be used in this study. It is felt that there are some factors which were not included. In addition to the five indicators already mentioned, two more are added from a list of indicators given by Shrimpton (1989). Therefore, a total of seven indicators will be used. These are, needs assessment, organisation, leadership, resource mobilization, management, action orientation and, monitoring and evaluation.

These indicators do not aim at producing an objective and quantitative measurement of a particular situation but rather a subjective and qualitative one.

It does not prove that wider participation is "good" or "bad". They can be used to compare differences in participation; at different times in the same programme, by different assessors of the same programme and by different participants in the same programme. In this study however, the indicators will be used by one assessor at one particular point in the project cycle. The use of these indicators can explain in any specific programme whether participation has become narrower, broader or remained unchanged. In addition, they serve as a departure for discussion about community participation which helps to understand the process better and which can help the people involved in the programmes to achieve better results by allowing for greater involvement (Rifkin et al, 1988).

For each of the factors, a continuum was developed (each radiating from the same point), with wide participation at one extremity and narrow participation where the continua met. Each continuum was divided into a series of points. Some authors (Bjaras et al, 1991; Labonte, 1993) have used three points of ranking. However, a five-point scale following the original framework by Rifkin et al (1988) will be used in this analysis. (Fig 1). A mark is placed on each continuum at a point which most closely describe participation in the programme being assessed. Marks on different continua are then connected in a spoke configuration. The first point at the narrow end of the continuum is not at the point where the continua meet because it is recognised that in any community there already exists some participation which people undertake to meet their health needs (Laleman and Annys, 1989; Rifkin et al, 1988). Again, the point to be
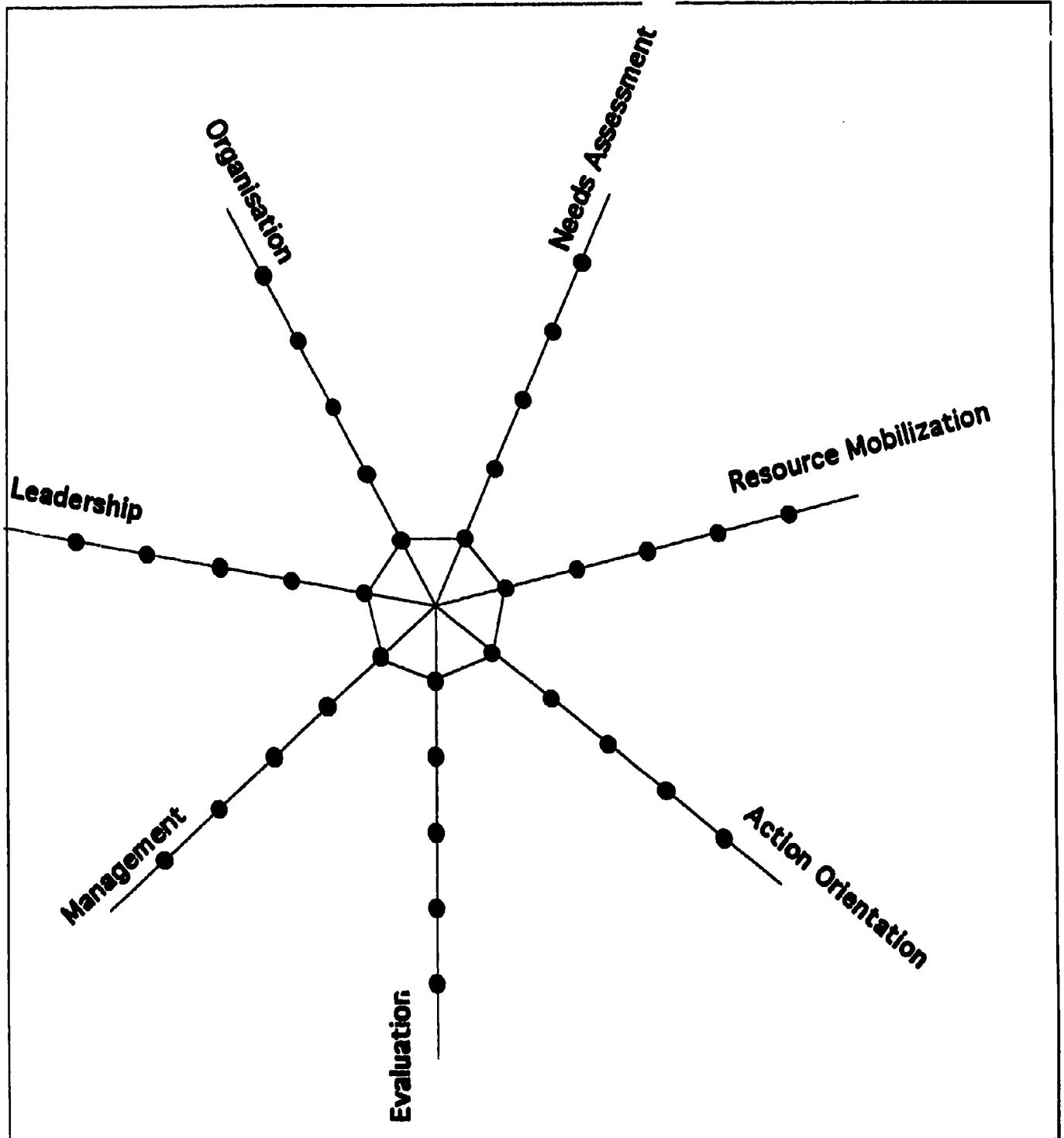
Figure 1:   Illustration of Plotting the Breadth of Community Participation

plotted on the continuum does not have to be precise but rather comparative. The indicators are explained in more detail below.

Needs assessment: This means finding out what members of the community see as their major problems and then working with them to define some possible solutions. The issue is not merely finding out what the people want but gaining their confidence so that they are able to discuss their problems with outsiders. Needs assessment can be made by professionals using their training and past experience either to project possible problems or carry out surveys in order to plan actions. Professional assessment alone places the indicator at the narrow end of the spectrum. It moves toward broader participation with actions that involve community members in research and analysis of needs.

Organisation: Ideally organisation for community participation in general should be created by members of the community. Where no health-related organisation exists, established organisations in other fields can be used to promote health activities. It is also possible to create an organisation from scratch often in the form of a community health committee. However, it is necessary to find ways of ensuring that the community at large is involved in committee decisions. Programmes with community organisations created by planners places the indicator at the narrow end of the continuum. Where community organisations exist, include a broad constituency and incorporate or create their own

mechanisms for introducing health programmes, the mark will fall near the broader end of the continuum.

Leadership: In most communities, leadership patterns are historically and culturally determined. These patterns should not be ignored. The structure of community leadership and the types of people who provide it will also determine, to some extent, whether participation will be narrow and represent only small and wealthy minority, or whether it will continually broaden so that all socioeconomic groups with variety of interests are represented.

Management: This indicates whether a community has a say in decisions or if management is in the hands of professionals from outside the community. A major objective of many programmes is that the community should manage the programme, that is, play a decisive role in its planning, implementation and evaluation. Achievement of this objective would represent the widest degree of participation.

Resource mobilization: Communities can provide resources in terms of labour for building and maintaining facilities, people to serve as community health workers, and funds to pay for minor forms of treatment and medicaments. Attention should however be drawn on who makes the decisions on how to mobilize resources; the outsider, a minority or a majority section of the community. The indicator for

resource mobilization must not only take into account the commitment of community resources but also the flexibility which can be exercised in deciding how these resources can be used. A point at the narrow end of the spectrum therefore, would be one which describes a programme with a small commitment of indigenous resources and/or limited decisions about how local resources are allocated.

Action orientation: This means whether the programme is concerned with improving or extending health services and benefit, or if it leads to wider community development in terms of self reliance and empowerment. It covers issues such as objectives and target of the project. It also gives an indication of whether the project is inclined towards curative or preventive measures and whether it is process or impact-oriented, or both.

Monitoring evaluation/information exchange: There should be a periodic ongoing reflection and changes made accordingly on the processes taking place in a project. Moreover, the assessment of community participation should not stop at the end of the project implementation. Information on the problem dimensioi, or programme progress should be disseminated to the community. This shows participation at the broadest end of the continuum.

Figure 2 shows a matrix which was used to assign relative ranks to each

Figure 2: An Analytical Framework for Assessing Community Participation in Health Projects

Indicator	RANK				
	Narrow, nothing	Restricted, small	Mean, fair	Open,good	Wide, excellent
Needs assessment	None	Done by outsiders with no VHC involvement	Assessment by outsiders and dicussed with VHC whose interests are considered	Community does assessment and outsider helps in analysis and action choice	Community does assessment/ analyses/ action choice
Organisation	VHC imposed with no activity; no community organizational support; or no form of organisation	VHC imposed with little activities	VHC imposed but became very active	Active co-operation with other community organisations	Existing community organisations involved in controlling activities

Leadership	One-sided organisational support dominated by elite or health staff	CW or health staff working independent of social interest groups or commuity support structure	VHC or Organisational support fuctioning under leadership of independent CW	VHC active, taking initiative	Organisational support fully representing variety of interests in community
Management	Induced by health Staff. CW only supervised by health staff	CW manages independently with some involvement of VHC. Supervision by health staff	VHC self-managed without control of CW activities	VHC self-managed and involved in supervision of CW	CW responsible to and actively supervised by VHC
Resource mobilization	Small amount or no resource raised by community. No fees for services. Community has no control over its allocation	Fees for services, no fund raising. VHC has no control over the utilization of money collected	Community fund raising periodically, but no involvement in control of expenditure. CW voluntary	Occasional fund raising, but no fees and VHC controls allocation of money. CW voluntary	VHC raised funds, collects fees and controls allocation of money, pays CW

Action orientation	No clear objectives, no targeting. Curative only	Process-oriented objectives, but no targeting. More curative than preventive	Process and Impact-oriented objectives, but no targeting. More curative than preventive	Process and Impact-oriented objectives. Interventions targeted to at-risk groups. More curative than preventive	Process and Impact-oriented objectives. CW interventions targeted to at-risk groups. Preventive and curative
Monitoring evaluation/ information exchange	No evaluation, nobody aware of problem dimension or programme progress	Information sent to outsiders who are aware of problem dimension and programme progress, but no feed back to VHC	Decision making by CW who is aware of dimension of process and programme progress	VHC recieves information necessary for decision making and is aware of problems, programme progress/ benefits	VHC disseminates information so that community is aware of problems, programme progress/ benefits

VHC = Village health committee (Could also mean team members or villagers involved in project).

CW = Community worker (Could also mean team leader or team members).

(Adapted from: Rifkin et al., 1988; Shrimpton, 1989)

of the seven above-mentioned indicators using a 5-point scale. The five points are scaled in the order of narrow, restricted, mean, open and wide. The explanation under each rank gives a guideline which will enable an assessor to develop questions for a specific programme. In the next two chapters this framework will be applied in two health development projects, one in Nigeria and the other in Kenya.

CHAPTER V - MICHIKA HEALTH DEVELOPMENT PROJECT

5.1 BACKGROUND TO THE PROJECT

Michika Local Government Area is located in the north-eastern part of Nigeria in Adamawa State. The three villages involved in this project belong to the Higgi tribe. The total population of the local government area was estimated at about 300,000 and approximately 50% are under the age of 15 years. Eighty-five percent of the population still live in the rural areas, and are mostly farmers of maize and groundnuts at little more than a subsistence level. Trading is another occupation of the rural people. There are also a few government jobs in health services, education and administration (Fletcher, 1993). A local government health survey in 1988 showed that the major health problems in the area were malaria and diarrhoea, followed by measles, pneumonia, diseases relating to pregnancy and childbirth, and finally malnutrition and worm infestations (Michika Local Government Area Health Department, 1988).

The project was titled "Promoting Community Participation in Health: An action research project in rural Nigeria". It covered a period of 12 weeks from April to June, 1992. The project was funded by a Young Canadian Researcher's Award from the International Development Research Centre (IDRC). The purposes of the study were,

1. to determine opportunities for, and constraints to authentic community participation in health development in three rural communities in north-eastern Nigeria.

2. to produce three case studies which could serve as "snapshots of community groups" perspectives on issues of participation in health development.

The project was conducted in seven chronological phases which are; selection of team members, team building, training workshop, evaluation and planning workshop following the pilot investigation, village investigations and feedback, final evaluation, and writing of case study report (Fletcher, 1992). A participatory action research (PAR) approach was used which incorporated three phases, viz: investigation, education and action. It is therefore assumed that the project was in support of full participation of community members. The project involved three sets of people; the team leader, members of the research team, anJ members of the community. I hope to examine this project in two distinct functional phases.

Phase 1: Team leader working with members of the research team. In this phase, the team members who are native to the area, are taken to be community members.

Phase 2: Team members (including the team leader) working with the community. Here, the team members are regarded as outsiders. Though they are native to the area, they reside in the city which is about 30 kilometres from the community. Their initial contact with the community was through their participation in this

project. Moreover, since they are government workers, their professional background differentiates them from the community members.

Though these two phases are continuous and sometimes even intertwined, I would analyze their process of community participation separately. The reason is due to the nature of this project, in that it's main concern was training community health workers (CHWs) and not strictly embarking on a development programme for the entire community. Therefore, a substantial part of the project covered both phases.

5.2 THE PROJECT : PHASE 1

Arrangements for the project were made by letters and upon the team leader's arrival in the field, with the director of the Health First Development Society (Healthfirst), the chairman and The Head of the Health Department of Michika Local Government Administration (HOH, Michika LGA). It was proposed that four health workers, two men and two women work part-time on the project over the course of three months. The initial selection of the team members was done by the team leader and the Healthfirst Director, through consultation of individuals who had interest in the project. However, as a result of some administrative problems, the health workers were not approved by the HOH. He finally did a new selection of team members.

The second part of the project was a training workshop with the team members. This involved three separate segments; team building and introduction, research strategy workshop, and evaluation and planning workshop following the pilot investigation. The team building session provided an opportunity for members of the research team to get to know one another, to become more aware of the process and goals of the research and to provide needs assessment information to the team leader.

The research strategy workshop held with the team members comprised of the use of incremental learning design whereby a variety of different techniques were used, each building on the other. The techniques included brainstorming, the use of web-charting, and the use of visual aids. The goal was to help participants learn new knowledge and attitudes concerning the multiple factors that i. iuence health and well-being. It was also important for the participants to develop skills of analysis which they would need when facilitating focus groups, and later in the feed back and report writing stages. The workshop was also used for planning the process and logistics of the research, and learning interviewing skills.

There was a pilot investigation in one of the three villages and this was followed by a two-day "Evaluation and planning workshop" organised for the project team. The aim was to reflect on and evaluate the work conducted in the village, and to develop ways to improve it before visiting the other two villages. These visits constitute the second functional phase which will be discussed later.

The first functional phase also included the compilation and review of

materials and information collected from the focus group discussions by the project team in preparation for the feedback session. The agenda was planned and individual team members were assigned specific responsibilities which they prepared for. The large joint tasks, such as the development of health education, and dramas were carried out jointly in the workshop setting, and practised in preparation for returning to the villages.

Comprehensive case study reports were produced at the end of the project. This was achieved through the joint responsibility of all the team members. The final evaluation session consisted of discussions concerning learning and difficulties from the project, and a positive vision for the community in future.

5.2.1 ANALYSIS OF THE PROJECT: PHASE 1

Needs Assessment: The idea of training of CHWs was initiated from outside the community. The initial strategy for selection of team members involved outlining criteria for selection and contacting candidates on an individual basis to establish rapport and determine their interest in the project. However, there were changes and the final selection of team members was done by the HOH. It appeared that the CHWs had little or no say in this selection. The assessment of the needs to train CHWs and who to train was "top-down". It was reported however, that the

introductory session provided needs assessment information to the team leader. This needs assessment was conducted with the team members. Thus, the kind and pattern of training was jointly decided upon by the team leader and team members. Therefore, the needs assessment was described as "restricted to mean".

Organisation: The organisation here is made up of the project team which was formed by the HOH. The team building and introduction provided an opportunity for members of the team to know one another and to become more aware of the process and goal of the research. Throughout the project, there were indepth discussions with the research team concerning a number of issues and decisions were often made by a consensus facilitated by the team leader. Though the organisation was formed by the HOH, the team became very active. The mark on the organisation continuum was therefore put at "mean".

Leadership: It could be said that the leadership was shared between the team leader and the other team members. There were individual discussions and interviews between the two prior to the commencement of the training workshops and in all the other stages of the project. Excessive concentration of power was avoided by task sharing between the team leader and team members. Thus the indicator for leadership was assessed as "open".

<u>Management</u>: As already mentioned, the team members (including the team leader) shared responsibility for much of the work. Their (both men and women) views were accepted or considered. The team leader acted like a facilitator, guide and modeller. Facilitating discussion groups was something that the team members did for the first time. It enhanced their managerial experience. All members of the team shared joint responsibility for the completion of the report writings. However, it appeared that there were certain responsibilities that the leader assumed, which could have been delegated to other members of the team. The team members were more responsible to the team leader than to the community. The indicator for management was therefore described as moving from "restricted" towards "mean".

<u>Resource mobilization</u>: Financial resources were solely provided from outside by the project sponsor. However, it should be noted that the project was more of a training exercise which required very little finance. The Department of health provided the human resource in terms of releasing the team members to work in the project on a part-time basis. The team members provided their skills and talents voluntarily based on there interest in the project. However, they had very little control over the resource mobilization or utilization. The level of resource mobilization was thus described as "mean".

<u>Action orientation:</u> The concept of participation was initially expressed by the team members as being an issue of cash or in-kind contribution that community members could make. This limited idea led to discussions to articulate different views of participation and describe different "community experiences" which showed the wide range of ways community could become involved in their own development. This is an impact-oriented objective, though with no specific target. The ability to write and produce jointly the report document was an empowering experience for the team members. Again this is an impact-oriented objective. The action orientation was thus described as "mean" with a slight tendency towards "open".

<u>Evaluation:</u> There was a periodic evaluation at the end of each of the phases of the project. The team members with the leader had a final evaluation session, discussing their learning and difficulties. Though the entire community was not involved in this stage, the level of participation tended towards the broader end of the continuum. Therefore the mark was put as almost "wide".

Figure 3 illustrates the breadth of participation in the first phase of the project.
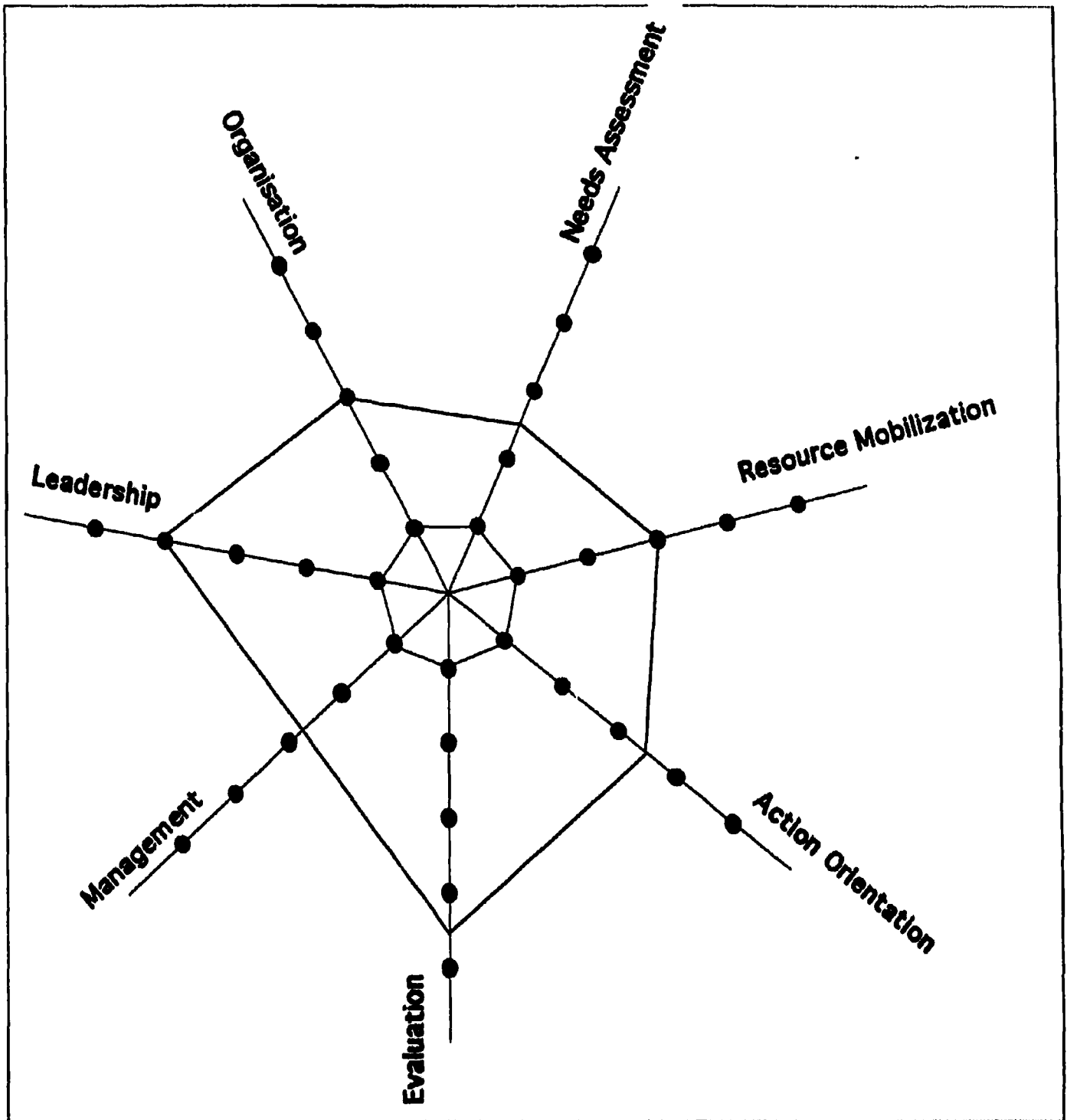
Figure 3: The Breadth of Community Participation in the Michika Health Project: Phase 1

5.3 THE PROJECT: PHASE 2

The second phase of the project consisted of village investigations in the form of focus groups discussions, meetings, and feedback session. Contact was made with the community through consultation with the District head (traditional ruler of Michika) a few days before the arrival of the research team. Investigations began with a general village meeting where men, women and youths were informed of the project and how the team intended to conduct their work. The investigation was conducted through discussions with groups of about ten men, women or children in different wards of the village. The purpose of the project was to learn about the general well-being of the people in the community, to discuss possibilities for improving the situation and to produce a report which could be forwarded to the local government administration.

An initial discussion was held with the village elders or some other key informants in the community to get a better sense of the layout and dynamics of the community, to identify groups and leaders within the community, to plan logistics for meeting with some of these groups, and to discuss issues of health and well-being. Focus groups were held to investigate villager's perceptions of health and well-being, to learn what issues are of primary importance to people, and to discuss ways in which these issues might be dealt with.

Feedback sessions were scheduled usually four days after the focus group discussions were concluded. Apart from the community members, representatives

of the Local Government Administration attended the sessions. The session began with a description of the work that was done and what was learned generally. Each session was designed not only for feedback both ways, but also to serve as a mobilization tool for future work by the community members themselves. One of the components of the feedback session was the presentation of a honorarium to each of the three communities for participating in the research process.

5.3.1 ANALYSIS OF THE PROJECT: PHASE 2

Needs assessment: Focus group discussions were held to investigate villagers perceptions of health and well-being, to learn what issues were of primary importance to people, and to discuss ways in which these issues might be dealt with. Questions were asked to generate discussions, priorities were set by the villagers concerning these issues, and there were more discussions on how they might go about solving the issues, and what resources they might need. It could be accepted that the community's needs were assessed correctly, therefore the indicator for needs assessment was described as "wide".

Organisation: The team recognised and worked with local authorities, i.e leaders, village elders and key informants. It appears there was no structured organisation in the village. There was no specific investigation done on community decision-

making processes, therefore it is difficult to conclude whether the leaders and elders represented the community well or not. It should also be noted that the leaders and elders are adult males. The effort made by the team to include women and youths in the focus group discussions gave these groups an opportunity to express their opinion which may not have been done otherwise. It also seem to suggest that some of the traditional, consultative processes of decision-making and leadership in the village has been lost and replaced with a highly structured, hierarchial structure where a few men make decisions for the community (Fletcher, 1994). The level of organisation was thus described as "restricted".

Leadership: Though the community members participated in the activities, the leadership was controlled by the team. There were a lot of "the people were told" and "this forced the participants to". Thus the leadership was dominated by the health staff, and for this reason it was decided to describe the leadership as "narrow".

Management: Management includes not only the management of the organisations responsible for the project but also the management of the project itself. The main responsibility the villagers had was to participate in the focus groups discussions and aativities and also in the feedback session. The selection of the CHWs, the line of activities for the focus groups sessions and the number

of people participating were decided by the team. However the nature of the sessions was non-structural and flexible to allow any changes that came up in the line of discussions. The level of management was thus described as "restricted".

Resource mobilization: Like the four members of the project team, the villagers saw participation as primarily a contribution in cash or in-kind to the predetermined, planned activities of outsiders. Time was taken to reorient them on this attitude. Financial resource was mainly provided by the project sponsor in form of honorarium presentations which was given to support initiatives from the villagers to deal with issues affecting their general well-being. Villagers voted on what and how to invest the money and who would take custody of the fund. As mentioned earlier, community members were very much involved in the activities carried out during the focus group discussions and the feedback sessions. Though the community made no financial contribution, there were in-kind contributions in form of provision of food and accommodation for the team members during their visits. Moreover, they had control over the allocation of money and made plans on how to raise funds in future. Therefore, the mark on the resource mobilization continuum was placed at "open".

Action orientation: Participation of the villagers in the focus groups were expressed to be a process towards a long-term goal of solving many of their health problems and not just taking care of an immediate need. The feedback

sessions served as a mobilization tool for future work by the villagers themselves. This should have had both a process and impact-oriented objectives. However, it seemed that the villagers were more interested in discussing about and expressing their health problems, and lack of assistance and material support from the government than they were in discussing their potential which they can utilize. This is a process-oriented objective which is also more curative oriented than preventive. Although, the team leader hoped to develop this project exercise to an empowerment process, it appeared that the villagers were not yet ready for it. Thus the indicator for action orientation was described as "restricted".

Evaluation: The feedback sessions gave opportunities to show what the research team had learned from the villagers. It also gave those who had participated in the focus groups and those who had not an opportunity for further discussions, clarifications or additions. The attendance of members of the local government was useful in that it brought together different sectors of the population which have influence over the resulting outcomes. The level of monitoring, evaluation and information exchange was thus described as "wide".

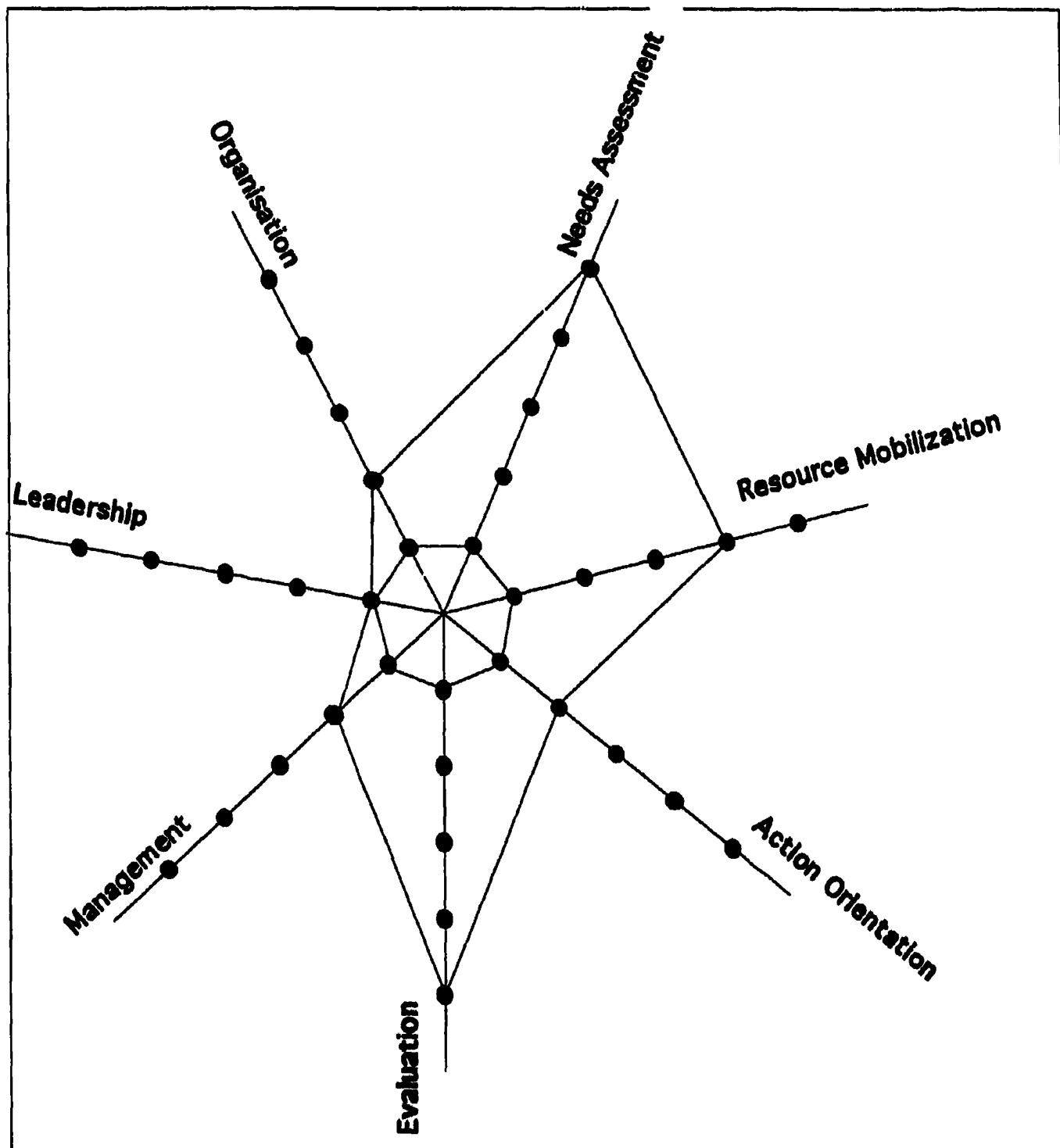The breadth of participation in the second phase of the project is shown in Figure 4.

Figure 4:   The Breadth of Community Participation in the Michika Health Project: Phase 2

5.4 CONCLUSION

There may be other factors (some of which Rifkin defined as descriptive factors) which could have influenced the overall level of community participation in this project. The political system and cultural values of the area and the bureaucratic nature of the health care system may have contributed to the narrow level of participation ascribed to needs assessment in the first phase of the project. The top-down decision making procedure (of selection of individuals to be trained in the project) is a norm (Fletcher, 1994). This factor could have also affected the management, since the team members were previously used to a didactic teacher-centred style of learning. In the second phase, the low degree of organisation at the local level was another descriptive factor which may have affected the level of community participation. It could have been difficult to overlook this in developing a community organisation for the project.

One lesson that could be learnt in this analysis is that participation which extends to consciousness raising and awareness is a process which requires long term commitment. It should start and proceed at a pace a community is willing to take. It is also necessary not to ignore any section of the community, like women and youths, and other government bodies whose decisions affects the community. In this study, the conclusion that could be drawn from using this framework of process indicators is that a wider level of participation was achieved especially in evaluation, leadership and management in the first phase, and in evaluation,

needs assessment and resource mobilization in the second phase.

CHAPTER VI: KIBWEZI RURAL HEALTH SCHEME

6.1 BACKGROUND TO THE PROJECT

The Kibwezi division in the Makueni district is found in the eastern part of Kenya and is within two hours drive from Nairobi. It covers an area of approximately 3400km square of semi-arid land of Kenya and have a widely scattered population of about 150,000 (Johnson, et al 1989). The area is known for its high migration rate. Majority of the people are from the Akamba tribe, with the same language and culture. The tribe has a reputation for community cooperation and the population was relatively young and educated, and potentially more receptive to new ideas. All these factors contributed to the appeal of the Kibwezi area for this model rural health scheme.

A baseline survey carried out in 1978-79 found that 90% of the people were farmers while the remainder were involved in government parastatals as well as services centred around the major road and rail lines from Nairobi to Mombasa. There was uneven distribution of wealth even among the farmers. Sheep and goats were commonly kept. Livestock was seen by the Akamba as a symbol of wealth and as insurance against financial hard times. Many of the households were headed by women with husbands and sons employed in the cities.

Health hazards in Kibwezi may be seen to take two general forms. First, the scattered population, harsh terrain and poor communication makes access to health services extremely difficult. At the time the project began, there were seven static health facilities in the area. All the facilities offered predominantly curative services, and were inadequate to meet the needs of the population. Most were located on the main route, thus inaccessible to the more remote population of the area, and had the common problems of lack of buildings, space, equipment and trained personnel. The disease pattern ranged from respiratory infections, malaria, gastro-enteritis, malnutrition, childhood infections, tuberculosis, bilharzia and leprosy (Ferguson, 1983). Second, the ecological conditions, particularly the lack of water, lead to the widespread prevalence of diseases like trachoma, scabies and intermittent outbreak of cholera (Johnson, et al 1989).

Rainfall is erratic, both temporally and spatially. Subsistence crops include maize, beans, millet, cassava and cowpeas with yearly yield being directly proportional to the timing and amount of rainfall. Some irregular commercial growing of fruits and vegetables exists along the river. Water related fluctuations in available food supply lead to pockets of malnutrition. The 1984 drought led to a famine in the area which affected mostly mothers and children under 5 year. Another drought and famine affected the area in October, 1992 (Johnson, et al 1989; AMREF Annual Report, 1992).

6.2 THE PROJECT

The Kibwezi Rural Health Scheme was developed in 1978 by the African Medical and Research Foundation (AMREF) at the request of, and in collaboration with the Ministry of Health, Kenya. Funding was from various donor agencies. This project was in response to the interest of the Kenyan Government in community-based health care since conventional curative facilities were inadequate and not easily accessible. The health scheme was founded based on two underlying philosophical concepts. The first was a grass-root approach of maximum local participation with the organisation and functions related to local needs and conditions, and dependent on the idea of voluntarism to a large extent. The second was emphasis on preventive and promotive health care.

The component of the scheme included, a community health centre, a CHW programme, a family planning and nutrition service, a mobile outreach service, a water project and complementary research and evaluation activities. Numerous community change agents were identified to support the implementation of the scheme. These included, the mobile health unit team, CHWs, TBAs, rural shop keepers, women's groups, school nutrition clubs, primary school teachers, adult literacy teachers, and self-help groups. From these groups of people, a village health committee was formed. These individuals were seen as vital links between the project and the community, as valuable resources for input into the project, and for providing feedback from the community.

The project started with the sensitization of the community to the project, and a baseline survey designed to provide important information necessary to the implementation of the project. The health centre was one of the first components of the project to be initiated. Plans for the centre were approved by the Ministry of Health. The facility in the centre included a 15-bed in-patient unity with a maternity unit. It provided maternal, child health and family planning services as well as other out-patient services. In addition to its regular health centre activities, the centre provided mobile outreach services and training for CHWs.

The selection and training of CHWs was the most innovative component of the project. The original proposal that CHWs would be paid by AMREF was later changed. However, individuals selected as CHWs were to have at least a standard 7 (Grade 7) education level and were expected to work part-time in the communities. Some of their duties included, maintenance of contact with community members and their leaders and other community development workers; initiation and participation in community projects; and advisement to the community in health promotion measures. Others were, referral of all complicated cases to a higher authority; liaise with the TBAs on maternal and child health care; and performance of selected health activities. The health promotive activities included water supplies, refuse disposal, nutrition and health education.

The first group of CHWs were selected by the community self-help groups, and experience showed that these groups were not always representative of the entire population in the community. Future selections were made by more

representative Village Health/Village Development Committees. There was also an initial trend towards selections of male CHWs of at least 22 years of age because of the rugged terrain. Later on, when the training and programmes were moved to the villages, more females were selected for training. Villages chiefs and members of the VHCs were also invited to training sessions which greatly enhanced their support for the CHWs. The training started in 1980 with practical problem-based approaches and using traditional methods of communication. The curricula were developed jointly by the CHWs and the trainers. Basic training for CHWs were conducted by the trained nurses with the backing of AMREF and the health centre staff. The training period took six to twelve weeks with follow-ups sessions. Supervision was by the VHC with technical support from the community nurse. As at December 1990, 400 CHWs and 198 TBAs have been trained.

Trained CHWs were recognised as family planning advocates. In addition, TBAs who were already recognised in the community and had participated in the delivery of over 70% of the children born in Kibwezi were incorporated as advocates as well. Rural shopkeepers were also selected and trained to offer free family planning supplies to the community. Due to the prevalence of malnutrition in children from 12 to 60 months and coupled with the famine in late 1984 and early 1985, a famine relief programme was formed. After the famine, the programme was replaced with a more comprehensive applied nutrition programme.

Since lack of adequate supply of uncontaminated water was a major health

problem in Kibwezi, a water project was initiated in September of 1983. The aim was to assist self-help groups with the construction of wells and rain water catchments using low cost methods socially and technically appropriate to the communities. The structure of the project required that the community take initiatives in contacting the water project staff. If the proposal was accepted by the project staff, the community then selects a water committee who manages the project. AMREF's water project staff facilitate the organisation of the committee and provide technical supervision and support.

The Mobile Outreach Unit started in 1981. One of the most important roles of this unit was the integration of health centre services with the community through CHWs and TBAs.

6.2.1 ANALYSIS OF THE PROJECT

Needs assessment

There were baseline surveys carried out at the beginning of the project by outside professionals to find out the health needs and prevailing health problems in the com nunities. It was also used to evaluate the curative, preventive and promotive health-care needs of the communities. This included the people's perception of health and disease, beliefs, taboos and customs. It appears however, that the community was not very much involved in this exercise. Moreover, it was reported that because of the extra time taken to sensitize the

community to the purpose of the survey and the project as a whole, less time was available for data analysis and little analysis was done. The result was that social issues were not addressed in the project. Needs assessment also involves gaining communities confidence to express their need. This seems not to have happened. Therefore, the indicator for needs assessment was described as "restricted".

Organisation The scheme incorporated existing organisations like women's groups, community leaders, self-help groups and TBAs. From these groups the VHCs were formed. Though it was mentioned that the subsequent VHCs showed a more representative of the community, there was no information on how the VHCs were selected, or if they were accepted by the community. They were rather regarded as AMREF's people and they never completely fulfilled the roles intended for them. It seems that the pronounced hierarchical structure of organisation found in the government health services was reflected in this scheme. The level of organisation was thus described as "restricted".

Leadership The leadership was dominated by AMREF and the health department staffs who could not be regarded as part of community. The report did not explain the leadership pattern in the communities. VHCs took initiatives in the selection of CHWs and in the water projects, however under the supervision of the health staff. The level of leadership was therefore described as "mean".

Management: The overall control of the project laid with the AMREF Medical Director. In the course of the scheme, more responsibilities were given to Kenyan health staffs who may not be regarded as members of the community. CHWs and TBAs who are members of the community were more responsible to the project staff than to the community. Therefore, the mark on management was placed at "restricted".

Resource mobilization: The main financial fund was through AMREF. Other financial contributions were from clinic users, collected as small fee-for-service charges at health facilities and clinics, and cash reward to CHWs by communities. In-kind resources were in the form of provision of food for the mobile team, CHWs and in-kind provisions to CHWs. The community provided labour for building clinics, constructing wells and maintaining the operation of such systems. Trained village health staffs trained CHWs who subsequently educated community members on health-related issues. The decision on how to mobilize resources and how most of the resources are to be used was done by AMREF staffs. Thus the indicator for resource mobilization was described as "restricted".

Action orientation: From the underlining philosophy and objective of providing adequate health coverage to a wide scattered population, it appears as though there was no plan in the project toward partnership and citizen's control of community members over their lives and activities. The process was concentrated

on providing treatment and meeting basic needs first, and then preventive health activities. This was mere extension of health services and benefit with little or no empowerment techniques towards the development of the people. Since the action was process oriented and more curative than preventive, the mark on the continuum was ranked as "restricted".

Evaluation: The scheme was evaluated at different periods by professionals employed by AMREF. CHWs were sometimes interviewed. However, there was low communication level between CHWs, TBAs and AMREF health staffs, and none between the entire community and AMREF. There was also no feedback information to the community. Therefore the indicator for evaluation was described as "restricted".

The breadth of participation is shown in Figure 5.

6.3 CONCLUSION

As a community-based health project, the Kibwezi Rural Health Scheme has been recognised as a successful model health programme carried out in collaboration with the Ministry of Health and which could be replicated by government organisations and NGOs elsewhere in Kenya (Ferguson, 1983; Johnson et al, 1989). The health of the people has been affected dramatically and
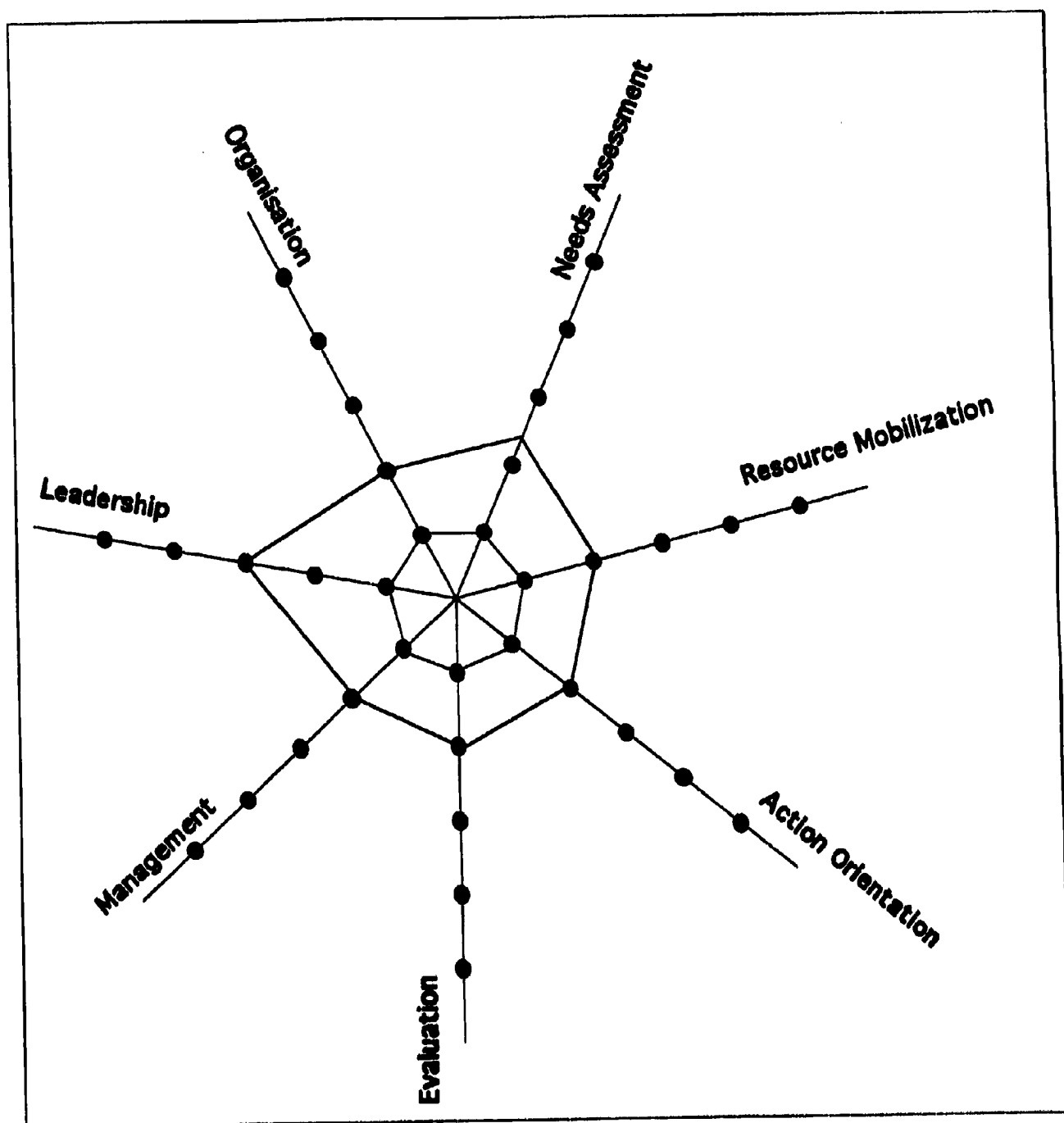
Figure 5: **The Breadth of Community Participation in the Kibwezi Rural Health Scheme**

visibly through the use of almost conventional, simple health techniques in the provision of food, water, education and other health services. This however, is not the case with the analysis based on the framework developed. More could have been achieved with a wider level of participation of the entire community. Success is not judged only by indices like infant mortality, number of wells constructed or number of CHWs trained. The success of a programme should include, a sense of community responsibility and involvement, a functioning community organisation and self sufficiency in all important matters. It should also include a reliance on outside resources only for emergencies and an understanding of the uniqueness of each community (Newell, 1975).

The rank on almost all the indicators were described as "restricted" except for leadership which was "mean". Sensitization of the community to community-based care and invariably to the project was considered critical to the success of the project. It could be observed however, that this sensitively was in the form of adapting the community to the pre-planned strategies of the project staffs. The Ministry of Health ran the medical aspect of the project while AMREF controlled the public health aspect. The staff did not know, nor did they try to understand the dynamics of the community. Socio-cultural issues like traditional beliefs and superstitions were not addressed (Nzioka, 1994).

Though it is reported that the programme showed a genuine understanding of a decentralised and community-based approach, community involvement was manifested as mainly the involvement of CHWs and VHCs who were regard by

the community members as AMREF people. The people could not identify themselves with the project. As noted earlier, the Akamba tribe is known by their exceptional ability to cooperate in initiating and implementing projects. This is evident from the report given on numerous projects accomplished by many self-help groups from the tribe. In the case of the Kibwezi Rural Health Scheme, it was ascribed as "their" project. In recent years however, there has been a noticeable difference in the people's attitude toward greater interest and participation in the project, especially with increased responsibility taken over by the Kenyan Ministry of Health (Nzioka, 1994). Community members have begun to identify themselves with the project and are more willing to get involved in decision making and management.

Community participation is hampered by a wide range of factors such as, a difficult terrain, inegalitarian social structure, tendency to depend upon others for meeting basic needs, and ill-conceived understanding of such ideas as health and illness (Madan, 1987). It is suspected that some of these factors which had already been described as context of participation, could have also affected the level of community participation in this project.

CHAPTER VI - CONCLUSION AND RECOMMENDATIONS

7.1 CONCLUSION AND RECOMMENDATIONS

There are certain similarities and differences that could be observed in the two projects analyzed. Both could be referred to as participatory health projects since they encourage the participation of community members. Both are also NGO's projects. Being in the continent of Africa, the socio-cultural settings are somewhat similar. However, the Michika Health Development Project differ from the Kibwezi Rural Health Scheme in that it was a small project, which involved four health workers and three villages, and lasted for only 3 months. The project was funded by one agency, thus limiting the stakeholder. The project leader had control over the project. On the other hand, the Kibwezi Rural Health Scheme was funded by at least 5 donors. It involved 203 villages, and has lasted for more than fifteen years.

The basis of the analysis is not to point out how successful one projects is compared to the other. The variation in the nature of the two projects may hinder a justifiable comparative analysis. Nevertheless, one lesson which could be learnt from both is that the level of participation achieved depends to a greater extent on the interpretation given to participation at the onset of the project. Though it has been mentioned that the framework does not confirm whether wider

participation is "good" or "bad",it is apparent that wider participation produces greater results in development programmes. Authentic participation which is regarded as a process toward empowerment of people is reflected at the wider end of the framework. Empowerment is achieved when the majority of community members are involved in decision-making toward the assessment of their needs, the management and evaluation of programmes, and the mobilization and utilisation of resources. Empowerment also involves the ability of people to take active leadership positions, to form their own organisations and, to be involved in actions which leads to capacity building, awareness and consciousness-raising.

This framework allows the assessment of health programmes and projects in a varied relationship accounting for both progressive and retrogressive periods and analysis of relative changes. It gives a baseline to measure participation, at different times in the same programme, by different assessors of the same programme, and by different participants in the same programme. However, the assessment in this study is done at one particular time and by one assessor. It is believed that other assessments can be done on these projects at other periods of the project cycle and by other assessors.

In the course of this work, certain concerns are raised in the mind of the author. One of these is how to ensure that members of the community who will benefit most by participating are involved. The non-participation of some community members which may extend into many spheres of social life, is a function of the inequalities of wealth, social status, sex and also age. How can

primary health care work towards achieving community participation that encompasses all sections of the community?.

Equal weight was accorded to each indicator. It would be important to determine whether it would be necessary to grant a greater or lesser weight for certain indicators. Again, there may be other indicators which this framework did not identify. Due to the specificity of the indicators, the resulting assessment reveals an objective reflection of the community's situation. However, subsequent studies could be done to determine the degree of objectivity of evaluator(s) who assess community participation.

The methodology outlined in this study is certainly not a general answer to assessing the level of community participation, however, it is a framework which could be adapted and used depending on the local conditions of each community. Though further studies need to be done to confirm the validity and reliability of the framework, it seems to be an appropriate one which could be easily adapted for diverse projects and for different settings.

7.2 SUMMARY

Community participation still holds a central position in development thinking and practice and continues to be one of the most controversial issues. The basic principles, acceptable to most of its proponents are that, community members should be actively involved in the initiation, implementation, monitoring and evaluation of development programmes; people have the right and responsibility to make that choice; and there are mechanisms that need to be put in place for participation to take place. Since participation is a descriptive term, there is much room for confusion on its meaning and practice. It is therefore necessary to be very specific about what is meant in any particular situation if the issue has to be addressed adequately. Participatory projects should be defined based not only on the activities carried out but on who are involved, and how participation is occurring. Emphasis should be placed on the practice of community participation rather than on defining it. This study reaffirms that though a complex task, it is possible and very necessary to measure the level of community participation in a development project.

There are no universal models or guide-lines to follow in the practice of community participation, however there is a broad strategy that could be applied. Participation should not only address the physical problems in the context of a project but also the structural issues affecting people's participation. Moreover, focus should be on how to empower the poor and not strictly on the agency that

initiate or direct the empowerment process. It will be encouraged that a community initiate and maintain control over the empowerment process, and probably approach an agency for support. However, it is still believed that where people are not capable of doing this (which has been a common belief), external facilitator may prove to be an efficient agency. Nevertheless, the primacy and interest of the people still remain the underlining factor. A development agency cannot push a community to go at a faster pace than they are able to. Long term commitment is critical in achieving authentic community participation.

Community participation should be evaluated based on qualitative impact on the people and not merely on measurable end products. Participation is a potentially complex process whose direction cannot be predetermined, nor the qualitative change easily predicted. Therefore, planners should become less insistent on manipulating people to gain immediate quantifiable and visible results.

Community participation in health is not an isolated phenomenon. Its main aim should be toward development, therefore other sectors that are related to health apart from health care should be looked into when addressing community participation in health. Health is influenced by a complex of environmental, social-cultural and economic factors ultimately related to each other. Health planners need to find ways of both theoretically and practically integrating health with other aspects of community development. Again, projects operate within a wider cultural, social, economic and political context. Socio-cultural and ethnic factors must be taken into consideration in the planning and conducting of health

programmes. Also the bureaucratic dynamics of the community as well as the developing agency involved cannot be neglected. However, the emerging and growing dynamic of a process of participation can bring about the contextual changes if necessary.

Community participation in health involves a radical reorientation in the design and delivery of community health services. Health services and community participation are not mutually exclusive. Health services is one part of the programme for total community development. However, the orientation has to be shifted to give priority towards achieving the latter. This calls for a fresh view by planners towards their goal and objectives. The degree of participation desired must be made clear at the onset. Nevertheless, objectives must be realistic making allowance for some element of unplanned, qualitative changes to occur. An emphasis on health services often inhibit the possibility of realizing active community participation. It places community members in the position of passive recipients and reinforces their dependency on external support. Community participation as a process is not just an end, but it is more than a means of providing health services.

In the past two decades, PHC has received significant attention from both national and International agencies. Yet despite the great need and opportunity to improve rural health through authentic participation of the people, political, ideological and constitutional factors continue to pose real obstacle to the implementation of PHC. The practice of community participation must receive

constitutional and legal support if it is to operate effectively as a principle of health care and development. A strong commitment to rural development policies at the national level is required if the impact on the problem of rural poverty is to be effectively broad-based. There must also be adequate financial support. Genuine community participation will require a change in attitudes, beliefs, behaviour and approach not only by the community, but more especially among the staff of development agencies, health professionals and the elites in general. Addressing the problem of political control when participation challenges the powers of the existing elite is a complicated task which may not have a direct answer. Overcoming this obstacle is a protracted process which required much effort, time and commitment from all sides. However, the pace of such structural changes should be in line with what the community concerned can handle.

Most communities need financial and organisational support especially at the initial stage of a project. It is important however, to avoiding creating new patterns of dependency through this. This could be achieved first by recognising and treating community members as equal partners in the development process. Though rural people may not have a lot to contribute in terms of finance, there are many other areas in which they can make their contributions. Moreover, the assurance that their ideas and ways of life is respected would help to build up their self-esteem. Very few planners are trained to trust, respect and accept community views about their own living situations. Development workers should have the implicit faith that people, whatever the condition of their poverty and

oppression, can progressively transform their environment with the help of, but not dominated by, external agents.

In the discussion and practice of community participation, the place of women as equal constituents of the rural people should be examined. It is wrong to assume that since community comprise of men and women, participatory development programmes affect both alike. Women have their specific needs and aspirations which are most often neglected when community is treated as a entity. Women should be recognised, not through mere re-orientation of delivery services so that resources previously available only to men are now made available to them, nor by deliberately seeking to divide them from men. Women should rather be treated as equal partners, addressing their practical and strategic needs, and realising that their greater involvement in development constituted a major challenge to existing perceptions of development processes.

Though it is accepted that NGO-sponsored projects tend to promote people participation more than government projects, it is wrong to suggest that all governments are unwilling or even hostile to the notion of wider participation. On the other hand, characterising all NGO projects as participatory is false. Both government and NGOs should learn how to combine their complementary strengths in community development to achieve wider community participation. An external agency's understanding of participation and the role of the agency in the process are critical factors that affect community participation.

In this study, a framework consisting of seven process indicators have

been used to analyze community participation in two health projects. This method allows one to address different aspects of participation and to describe the process of community participation. This framework is found useful in understanding participation as a process.

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