Translating Rhetoric in Reality: A review of community participation in global health policy

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Objective

• To review the interest in community participation in health policy over the last 60 years.
• To highlight its perceived importance to health improvements.
• To review some of the evidence of the link between better health and community participation by examining assumptions about this link.
A brief historical background

- CP in health is not new.
- It is carried out in families and communities in all cultures.
- Institutional development link lay people with the professionals has been tried in the 1920s in China with the Rockefeller Foundation.
- In Africa with missionary doctors.
- In the Peoples’ Republic of China with the “barefoot doctors.”
CP in Global Health Policy

• A key element of the Alma Ata Declaration on Primary Health Care
• Initially taken by several governments with Community Health Worker Programs
• Put aside in the 1980-1990s with financing concerns as priority
• Back on the agenda in 2000 with UN emphasis on poverty alleviation and empowerment
WHO as the UN technical agency on medicine and health

• 1978 PHC
• Lead on policy agenda taken over by the World Bank in the 1990s
• PHC back on the agenda in mid 2000
• 2008 The World Health Report- PHC: Now more than Ever
• 2008 Report of the Commission on the Social Determinants of Health
CP today

• Increasing interest
• More publications about the link between cp and improved health
• Challenge is assessing the contribution of cp
• The “gold standard” is no available. Peoples choices introduce too many confounding variables.
The challenge of turning rhetoric into reality

- Assumptions about the contribution of community participation (cp) to health
- These assumptions have shaped both the policy and implementation of community participation in health outcomes.
Assumption 1: People want to participate in decisions about their own health care.

- Put forward as a key to PHC
- Experiences from small NGO programs (Indonesia, Korea) and government programs (China) supported this
- Null hypothesis supported by studies in NGO programs (Rifkin, 1985) and McCoy, et. al (2011)
- People want health care when they are sick; incentives are needed for further participation
Assumption 2: Providing information will change peoples’ attitudes and behaviours resulting in improvement of their own health.

- People don’t change attitudes and behaviours because they don’t have information.
- Ottawa Charter (WHO 1986) focused on “empowerment” which has come to replace “participation” and health promotion rather than education.
- For policy implementers, empowering people often becomes an objective. It does not deal with “power” and overlooks struggles as part of changing peoples views.
Assumption 3: Through empowerment people act the way policy makers think they should.

- Assume people think like us.
- Do not appreciate cultures that do not function in a scientific understanding of the universe. (Examples of contraceptive injections in Africa; and complementary treatments of traditional and allopathic medicine in China)
Assumption 4: The term “community participation” need not be clearly defined before interventions are identified and started.

- Community often defined as geography or “targets”. Does not account for “non-members”
- Participation is means/end; active/passive—contribution, consultation, decision-making
- Without clear working definitions causal linkages difficult to define.
Assumption 5: Five Health is a human right not a commodity for consumption.

- Assumption moves from service provision to the larger area of human activity and ideology.
- Has come into the participation dialogue within the last 10 years with support of civil society.
- Existing political environment of “neo-liberal” approaches challenges the assumption as people as defined as consumers rather than as individuals with choices about health improvements.
Assumptions Redux:

- Where experiences investigate assumption and have positive outcomes in linking better health with community participation
Assumption 1: People want to be involved

- Yes, with the right incentives. Example CHWs
- India’s Rural Health Mission, CHWs 80% reasons for joining both monetary and community respect.
- Reviews suggest where have government support, good supervision, learn new skills, gain respect, have expanded care and better health outcomes.
Assumption 2: Information empowers people

- Information alone is not empowering.
- Needs support of health professionals and government based on systematic review by McCoy.
- It also needs to confront and engage in the question of power—who has it and how it is shared.
Assumption 3: Empowered people act the way we think they should

• Building dialogue creates situations of shared views by professionals and community.

• Community based action research has good results—USA, Brazil
Assumption 4: Definition of terms is not important

• Preston and colleagues examine this assumption.

• Systematic reviews suggest links between health outcomes and participation possible to define when objectives clearly stated.

• There is no “gold standard”. To date there are case studies and individual programs that show link with clear definition of terms.
Assumption 5: Health and human rights

- Assumptions here are often ideological.
- In present dialogue often mutually exclusive.
- Human rights demand government accountability for resources; consumer views demand profit to produce better health.
- Are examples where mobilized communities get more resources from governments.
- Need for dialogue.
- Need discussions about responsibilities as well as rights.
Conclusion

• There is evidence of a link between community participation and improved health outcomes.
• There is no “gold standard” because the scientific framework that produces this standard is too rigid to account for confounding variables of human behaviour.
• Best evidence of the link comes from research done deductively rather than inductively.
• Engaging intended beneficiaries in all aspects of program implementation has the dual benefit of collecting and examining evidence and empowering those beneficiaries.
For References:

• Translating Rhetoric to Reality: A review of community participation in health policy over the last 60 years