

[https://www.researchgate.net/publication/260336920\\_Lessons\\_from\\_community\\_participation\\_in\\_health\\_programs](https://www.researchgate.net/publication/260336920_Lessons_from_community_participation_in_health_programs)

# Lessons from community participation in health programmes

SUSAN B RIFKIN

*Department of Human Nutrition, London School of Hygiene and Tropical Medicine, UK*

Although primary health care emphasizes community participation and many health care programmes attempt to develop participation, good analysis of these developments is still rare. This paper, based on a review of about 200 case studies, examines some of the lessons for planners which are emerging from experiences of the last decade. These lessons focus on the problems of defining the term 'community participation', of gaining and sustaining broad-based community participation, of failing to recognize the political implications of the concept and of attempting to develop a management model of community participation for health. Based on these lessons, a planning framework is suggested that seeks individual programme answers to three questions: 'Why participation?', 'Who participates?', 'How do they participate?'. The answers to these questions will help to define a programme's objectives and to monitor and evaluate its development.

## Introduction

In 1978 the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) sponsored a conference in Alma-Ata which declared primary health care (PHC) as the means by which radical health improvements might be achieved for the majority of the human race. PHC was defined 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 and country can afford'. (WHO/UNICEF 1978:34) This emphasis on community participation shifted the focus from existing methods of health care delivery in which medical professionals defined and dominated the health care system. PHC meant that community people would become involved in both the delivery of and decisions about health and health services in order to provide the type of health care most appropriate to their own circumstances.

Since 1978 member nations of the World Health Organization and many non-governmental organizations (NGOs) have accepted PHC as the basis for their health care system and have emphasized community participation as the

'heart of primary health care' (Ahmed 1980). This acceptance has increased the need for planners in health programmes and in funding agencies to understand the way in which community participation develops. The search for understanding has not always been fruitful. In frustration, planners have all too often taken the rhetoric of community participation, but failed to analyse the reality. As a result, many planners and agencies are supporting programmes which merely have the cloak of a new, community-based approach under which the traditional health care delivery system remains.

The purposes of this paper are:

- 1 to draw out some of the lessons beginning to emerge from health care programmes in developing countries which have focused on community participation.
- 2 upon this basis, to suggest a conceptual approach for planners and funding agencies who wish to help health programmes based on community participation to become strong, self-sustaining programmes in the future.

This analysis is based on a review of over 200 case studies undertaken by the author on behalf of WHO and UNICEF (Rifkin, in press).

## Lessons from the past

A number of insights emerge from this case study review. There are certainly a large number of specific lessons that can be learned from even a cursory reading of many of these experiences. Rather than attempt to do this, we shall instead concentrate on four major lessons relevant to the concept and the framework in which planners seek to develop community participation in health programmes. In focusing on the wider implications of the case study experiences, we address the general concerns of planners and agencies and examine the basis on which programmes develop.

### Lesson one:

**It is not possible or even useful to have a universally acceptable definition of community participation.**

In reviewing the many case studies it became apparent fairly early that planners, even those in the same programme, defined community participation in different ways. This was not merely an academic problem about the meaning of words but rather more critical. It was concerned with how programme objectives were defined.

#### *Three approaches to community participation*

From the literature we can suggest that, in fact, three approaches emerge despite the loose articulation of definition. These approaches describe how planners and agencies develop community participation in health programmes (Rifkin 1985). They rest upon, firstly, the way in which planners define 'health' and, secondly, how planners think the community should respond to this definition. These approaches, in turn, dictate programme objectives.

The first approach may be called the *medical approach*. It defines health as the absence of disease. Community participation is defined as activities undertaken by groups of people following the directions of medical professionals in order to reduce individual illness and improve the general environment. The second approach is called the *health services approach*. It defines health in the WHO sense of the word: 'the physical, mental and social well being of the individual'. It defines community participation

as the mobilization of community people to take an active part in the delivery of health services. The final approach is the *community development approach*. This defines health as a human condition which is a result of social, economic and political development (Sterky 1980), and community participation as community members being actively involved in decisions about how to improve that condition.

#### *'Top down' and 'bottom up'*

In terms of developing community participation, the critical difference in this analysis is the difference between the first two approaches and the third. The first two focus on health services as the most important factor in health improvements and blatantly or tacitly suggest that health professionals should decide how the programme should progress. The third approach believes that people's perceptions of health and their motivation to change health care are the critical factors; it stresses the importance of community people learning how to decide the ways in which change can best be achieved. These two views have often been distinguished by the terms 'top down' and 'bottom up' planning. While they are not incompatible in the same programme, some of the assumptions on which they are based are incompatible.

One assumption of those who take the 'top down' approach is that health professionals, based on their experience and the present state of health technology, can define and solve the existing health problems in a relatively short time. The assumption of those who follow the 'bottom up' approach is that the solution is not as important as the changes (recognized to come about relatively slowly) in attitudes of both planners and community people as the latter seek to carry out some of the basic health interventions that professionals are trained to do. The differences in views about both the time frame and the expected impact of health interventions has tended to lead to conflicts.

#### *Variations between people and over time*

Why has it been so difficult to find a definition of community participation which will enable planners to set clear and measurable objectives? A major reason appears to be that often health planners, many of whom are medically trained, perceive community participation as they do a

solution to a disease problem. They try to identify it in terms of cause and effect. Communities are composed of people. Knowledge about why people, as individuals and as groups, choose certain actions over others is still in the pioneering stage. A general theory about how people choose what they do choose has so far eluded the predictability of the scientific method.

Another reason is that the concept of community participation does not share a defined terminology which conveys precise meaning. There is often a large gap, for instance, between what health planners mean by community involvement in decision-making and control of resources and what community people mean. Too often this gap is increased by the fact professional and community people not only do not share, but also do not discuss, expectations of a programme. As a result, language and related action does not mean the same thing to the various people involved in the same programme.

In conclusion, the critical lesson is that programmes *do* proceed without a precise definition. The experiences of the case studies – studies which span a time range from the early 1970s to the present and which vary in size, history, culture and environment – suggest that the search for a definition may in fact be futile. Community participation appears to be a dynamic process which is in a constant state of change. People in the same programme over a period of time and with increasing experience may not hold the same definition today as they did five years ago. For this reason, planners should view community participation as being in a dynamic rather than a static state, and should remain flexible as people and objectives change.

### **Lesson Two:**

**It is not possible to build broad, self-sustaining community participation through health services activities alone.**

It is widely believed that health services provide credibility for community work. In many programmes planners and agencies have tried to build on this and mobilize ‘target groups’ to form the basis of community participation.

Viewing participation as an epidemiological exercise, they have sought ways of getting local people to make use of health technology to solve health problems which the planners have identified, e.g. contraceptives for family planning. They have hoped that by addressing a specific group which has a specific or potential health problem, they could mobilize people to create a community-based programme.

In addition, planners have sought to motivate community people to share their views of health problems and solutions to them, i.e. the provision of health services with community support. Evidence which prompted the call for PHC suggested that solutions to health problems involved more than health services alone, yet many still attempt to solve such problems by gaining community support to attack diseases.

It appears that those who have taken an approach to community participation which focuses mainly on the delivery of health services have been disappointed in their attempts to achieve broad and long-term community participation. While there are few studies which have done any in-depth analysis of community participation in health care, a high proportion of those which have support this statement.

Philip Coombs (Coombs 1980) worked with indigenous researchers to examine a number of NGO health programmes in Asia. One conclusion was:

A program that subscribes to the values and ethics of a community-based service has to subordinate its immediate and narrow objective – be it the acceptance of contraceptives, or the treatment of parasites, or vaccination against preventable diseases – to the ultimate needs and interests of the community people. These needs and interests of the community as perceived by the community can be the only basis for an authentic community-based service program. (Coombs 1980: 206)

Ledivina Carino and her associates at the University of the Philippines (Carino et al 1980) studied five community-based health programmes in the Philippines and reached similar conclusions. My own case study work (Rifkin 1985) also supports this analysis. An American Public Health Association study on community participation, which reviewed 35 projects,

stated: 'Project experience shows a correlation between high participation and an integrated approach open to community priorities not strictly related to health care.' (APHA 1983: 47).

#### *Why health services are not enough*

We can define several reasons why a programme which promotes only health and health-related services limits community participation.

The first reason is that, as we have seen in our discussion about definitions of the term, community participation appears not to be the product of a planning solution to a health problem, but rather a process of changing individual perceptions over time as the dynamics of community interaction change. This process is very complex and as yet is not sufficiently defined.

The second reason, closely related to the first, is that, as has been found in research (Elliott 1975) and in case study experience, health care is often not a priority. Most lay people define health as curative services and they want these services only when they are ill. What is more, when asked what they want most, more income, food, shelter and clothing rank above health services in terms of priority needs.

A third reason is that few lay people have had any experience in providing health care services. They have received services from professionals on payment of a fee, by an act of charity and/or by the right given to them by the government; few lay people see any scope for their own involvement.

A fourth reason is that all too often planners and agencies, relying on their expertise, pre-empt the community's role in planning their own health care programme. Rather than seeking community views about community problems and learning to discuss possible solutions with different people (whether or not the problems raised are health service problems), they present the community with the problems and give health services as the solution. If planners and agencies have decided that health services are what the community will receive, there is often little scope for the development of active participation.

The lesson is that, while the provision of a single-sector health service programme often builds credibility, it also often limits the possibility of gaining widespread and sustained community participation. Community people will gladly accept the benefits, but not as easily accept the responsibility planners have expected. Wide participation develops as part of a process which addresses a range of community needs. While health services are a necessary part of health improvements, they appear not to be sufficient in themselves to deal with health problems as defined by the PHC approach.

#### **Lesson three:**

##### **It is not possible to consider community participation outside a political context.**

There appears to be a prevalent myth among planners and agencies that, because the delivery of health services is seen to be relatively void of political implications, that community participation in health programmes is also void of these implications. On this assumption, planners set up health committees, ask community people to choose CHWs, organize community financing schemes and then appear to be surprised when conflict arises. They view community participation as another programme component and approach it in the same manner as they would the inclusion of an additional health activity to an existing programme.

Experiences from case studies suggest that any programme which chooses to address the issue of community participation must realize that it is also addressing the issue of power.

##### *False assumptions about community participation*

Political implications of community participation have been examined by people involved in the research and programmes of the community development movement of the 1950s and 1960s. As George Foster (Foster 1980) has pointed out, some of their conclusions are directly relevant to the concept and implementation of community participation in PHC. Foster suggests that the lessons of the community development movement need to be noted by those involved in community participation in health care. He says

the wrong assumptions made about community participation in community development tend to be repeated in the health field. Among these assumptions, three deal directly with the issue of power and are relevant to this discussion:

- 1 *Communities are homogeneous.* In reality, communities are generally not homogeneous, nor do they by instinct see reasons for always co-operating for the 'common good'. Experience shows that, particularly in the areas of poverty, individual concerns often over-ride community goals. Only when extreme scarcity of resources is removed and people are economically better off can co-operation take place.
- 2 *Community leaders act in the best interests of their people.* Community leaders do not always act in a way which benefits the entire community. People who have been identified by the community as having influence often use new opportunities to enrich themselves and their families. Thus a programme designed for the poor often promotes those who are already better off.
- 3 *Government and community workers share the same goals for community development.* Often, government planners and community workers do not share the same objectives. Government staff want local resource mobilization to free capital for other national programmes. Community workers want to instil community people with confidence and self reliance. This conflict of interest often creates difficulties for community development programmes.

From case study analysis, we may add another false assumption:

- 4 *Working for social justice among the poor serves the best interests of the poor.* In fact, programmes directed towards the poor, especially in countries where political stability is questionable, often make the plight of the poor more difficult in the short term. At best, programmes compromise the position of the local community in terms of their relationship to the government and/or the local elites. At worst, planners choose or are forced to leave and the poor remain to carry the brunt of the turmoil started by outsiders. There are many examples of this situation, particularly in Central America. In Guatemala, where the

political situation has deteriorated over the past few years, planners have found themselves in programmes in which they have compromised the local people and have accelerated inherent conflict in the community (Heggenhougen 1984). The problems of dealing with the poor demand far more than merely good intentions.

#### *Shifts in power*

The lesson is that any decision which involves people who traditionally have not been included in that decision is a question of power and control. In most cases, it means those who have had a monopoly on a certain kind of power are asked or forced to give up that monopoly. The transfer of power is likely to result in a range of conflicts which reflect both policy and implementation. For planners and agencies to consider community participation in health care as a component of a health programme, rather than a process of change, risks ignoring the critical political issues and the potential conflict which might endanger the entire programme. Community participation in health care is not merely a means by which to develop more efficient and effective health service delivery. It can prompt people to ask why that service is delivered, who benefits most from that service and whether that service is really necessary.

#### **Lesson four:**

**It is not realistic to propose a model for managing community participation in health programmes.**

As PHC becomes more popular and more acceptable to both national governments and NGOs, there is an increased interest in seeking a universal model for the implementation of PHC programmes. This search focuses both on translating small pilot programmes into large national programmes and on translating one national programme to another national programme.

One of the early efforts to tackle the issue of replication through analysis of case study experience was a publication undertaken by APHA (APHA 1983). This study analysed community participation in terms of managerial issues such as 'How can the community participate?' 'What participation is desirable?'

'How can participation be organized?' and 'How do the project and donor agency elements affect community participation?'. The result was a descriptive document with some general conclusions from a range of case studies. However, it was not, nor could it be for reasons suggested below, the manual on 'how to do it'.

Similar attempts to define the critical factors in community participation and propose an analytical model designed to predict success and failure have been undertaken by Askew (1984) and Diaz (1985). Both suffer from the same weakness as the APHA paper. They fail to convince the reader that the factors which they identify as critical are:

- 1 the complete range of influential factors.
- 2 capable of predicting success or failure of the programme.
- 3 singularly or collectively amenable to influence by planners and/or agencies in all situations, under all circumstances and in all cultural contexts.

In other words, these attempts fail to convince one that there is a model for analysis and implementation that allows fairly predictable outcomes.

It may be said that the failure to develop a model is due to the fact that at present there is still relatively little in-depth work which has analysed the development of community participation in health care. Most case studies (of the nearly 200 reviewed for the WHO/UNICEF study) are mainly descriptive. It well might be that those that have developed successful community participation are never written up because they need neither the publicity nor the donor agency support. There are the few which have attempted to identify and explore community participation issues in the wider global context (APHA 1977, 1983, Carino et al 1982, Coombs 1980, Rifkin 1985, Ugalde 1985 and WHO/UNICEF 1977). There is also a compilation of case studies undertaken by Morley et al (1983) of varying quality, which does provide some specific insights. However, the literature in the field is not strong enough to suggest a description of a universal model of implementation of community participation in health programmes.

### *Why has no model been developed?*

It may be argued that the reason a model has not been developed is because community participation itself is not suitable for analysis with a view to telling planners 'how to do it'. We have already explored in some detail some of the reasons for this. These include the inability of planners and agencies to find a universally acceptable definition of community participation and the unsuitability of considering community participation as a component of a health care programme. There are other reasons worth mentioning.

Firstly, community participation cannot be viewed as an 'intervention' to improve health services and/or health care. Unlike other medical and health interventions, such as the provision of outreach MCH/FP services or mass vaccination campaigns, its inputs and outcomes are not easily defined. Motivation, not resource allocation, is the major ingredient. As we discussed and as case studies have shown, what motivates individuals under what circumstances appears to be context-specific and not universally defined.

This reason is supported by a second reason which is that community participation is very heavily influenced by factors such as culture, history, government policy and social, political and economic structures (WHO 1977). While we can cite these factors in general terms, their impact on community participation reflects specific, very specific, contexts. As Williams and Satoto (1983) point out, it is not even possible to transfer a community-based programme from one district to the next in the same area of the same country without various and complex problems. Community participation grows out of specific situations. It rarely manages those situations.

Finally, as we have continually emphasized, community participation is a dynamic process which undergoes constant change. It reflects changes in decision-making, in resource control and in attitudes of all those involved in the programme. Its dynamic nature demands a flexibility on the part of planners and agencies if participation is to be growing and self-sustaining.

### *The planners' role*

All this suggests that to ask for a model for community participation in health programmes is to ask the wrong question. Accepting PHC has required certain changes in attitude. It has meant accepting the analysis that health services alone will not radically improve health for the majority of people in the world. It has meant accepting that those who have the right to better health must learn to take some responsibility for improving their health and that those who can provide services must recognize and support this responsibility. Most importantly it has meant recognizing that a new way of thinking about health improvements has begun to emerge. This thinking is based on the view that attitudes of community people to health care cannot be controlled in the same manner as health service delivery. Although difficult for planners to accept, it may well be that, to gain improved health status, they will have to surrender their dominant position in programmes and let community people decide in which way programmes will develop using planners and agencies as resources not directors.

### **Application of these lessons**

How can planners and agencies take account of process and flexibility? Rather than setting a set of rigid and replicable steps for programme development, they can seek answers to three questions which help to clarify both programme direction and programme activities. The answers to these questions can be seen as a statement of specific programme objectives to help to avoid the abyss of rhetoric into which many health programmes fall. As such they can provide the basis for monitoring and evaluating the programmes. These questions are: 'Why participation?' 'Who participates?' and 'How do they participate?'. These questions are far from original. Cohen and Uphoff (1980) lay the analytical basis for this perspective in a seminal article on community participation in rural development. They argue that participation must be examined by asking questions about its concrete component. They ask the three questions: 'What kind?', 'Who?' and 'How?'. I have slightly modified this approach to more closely reflect the concerns of planners and agencies in the health related fields.

### **Why participation?**

Various reasons have been put forward as to why planners may choose to pursue community participation. We can summarize these in the following statements:

- 1 They believe that the most important changes in health improvement will be realized as people in the community change their attitudes about and actions towards the causes of poor health. In programme terms, this answer lays emphasis on activities addressed to the educational process and dialogue to define how these changes might be brought about.
- 2 They believe that health services are being misused and underused and that this condition can be corrected if those who need the service can help plan the service. In programme terms, this suggests that community participation should focus on improved service delivery to make it more acceptable, accessible and affordable, especially to the underprivileged community members.
- 3 They believe that community people have untapped resources in terms of money, manpower and materials which will help expand health services. In programme terms, emphasis is placed on mobilization of these resources in such activities as community financing and CHW schemes.
- 4 They believe that health is an issue of social justice and focus on a redistribution of resources in favour of the poor. In programme terms, emphasis is laid on using health as an entry point to gain credibility for planners in order to attack the larger social, economic and political issues in the long term.

Planners may answer the question 'Why participate?' with any one or combination of these beliefs. How they do so will suggest how specific, measurable objectives are set and how they answer the other two questions.

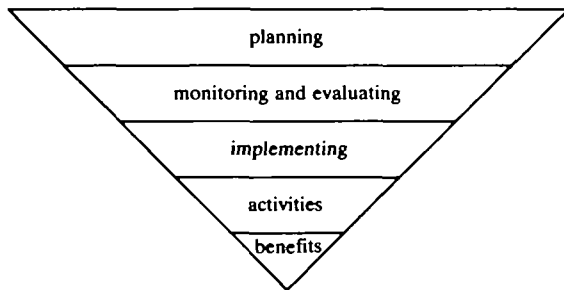
### **Who participates?**

This question has two dimensions. The first looks at numbers of people. PHC is concerned with using scarce resources to ensure improved health for the majority of community people. At this level, the answer to the question 'Who participates?' will help to define participation in terms of majority benefits.

The second dimension looks at which groups are participating. Communities, as mentioned above, are not homogeneous. They are composed of different economic and social groups. In defining which groups are critical for participation to reach programme goals, planners and agencies define groups which reflect programme objectives. Investigating whether these groups are involved in the programmes will reflect whether their objectives are being achieved.

### How do people participate?

We can see the ways in which people participate in programmes as a fan-shaped image (see Figure 1). The first level is the narrow base. As people participate in more ways, the type of participation broadens in both range and depth.



**Figure 1.** How community people participate – as people participate in more ways, the type of participation broadens in range and depth.

- 1 People participate in *benefits* of the programme. Community people are recipients of services and education provided by planners and agencies. In many cases, these benefits may demand only their presence at a clinic or a small fee for the services or medicines provided by health staff and/or the government and, thus, their 'passive' participation.
- 2 People participate in *activities* of the programmes. Community people contribute land, labour and money to health programmes. At this level, people who participate in activities do so actively. However, they do not participate in the choice of what activities are to be undertaken and how they will be carried out, as these choices remain in the hands of health planners, agencies or government.
- 3 People participate in *implementing* health programmes. Community people choose the

site of a clinic, run drug purchasing schemes, run baby-weighing and nutrition clinics. At this level, those involved in activities have some managerial responsibilities. They make decisions about how these activities are to be run, but do not decide which activities are undertaken and how these activities pursue programme objectives because this remains under the control of planners. Community people refer to planners for advice, supervision and approval.

- 4 People participate in *monitoring and evaluation* of programmes. People in the community help planners to judge whether the programme objectives have been met and possibly, if not, why not. At this level community people are involved in deciding how to measure objectives and in monitoring activities, but are not involved in developing programme objectives. This role is still the prerogative of the planners. This stage of participation is perhaps the one where there is least experience, in part because in many programmes only lip service is given to monitoring and evaluation and in part because programme objectives, particularly in terms of community participation, are often not clearly articulated and, therefore, cannot be measured.
- 5 People participate in *planning* programmes. People from the community (usually leaders and key members such as teachers etc.) actually decide what health programmes they wish to undertake and ask health staff, agencies and/or government to provide the expertise and/or resources to enable the activities to be pursued. This is the level at which community participation is the broadest in both range and depth. It is the articulated ideal for which many programmes strive.

### A conceptual framework

We suggested that the answers to these questions can help planners and agencies apply the lessons we previously identified and can help in clarifying and implementing programme objectives. The answers to these questions need to reflect the specific thinking of planners and agencies at the time the question is asked.

It might help to think about these answers as corresponding to points along a continuum. At

one end are those planners and programmes who answer the question 'Why participation?' with 'Because it improves health service delivery', who answer 'Who participates?' with 'Defined target groups' and who answer 'How do they participate?' with 'As beneficiaries of the programme'. At the other end are programmes and planners who answer the question 'Why participation?' with 'Because it empowers the poor', who answer 'Who participates?' with 'All community members, but especially the poor and very poor' and who answer question 'How do they participate?' with 'Through involvement in decision-making, planning, implementing and evaluating the programmes'. There are further characteristics of the extremes of the continuum. At the health service end, programmes are mainly concerned with health service management approaches and see community participation as a programme component. At the other extreme programmes focus on community development activities and give priority to community decision-making at the cost of efficiency. They view community participation as a process.

There are no right or wrong answers to these questions. Obviously, a programme which sets as its objective a mass vaccination campaign will have answers which fall towards the health service end of the continuum. The same programme, should it want wider participation, would move towards the community development end. There are only answers which reflect the thinking of planners at a given stage in programme development.

In addition, the importance of asking these three questions is not to give value judgements about the programmes. Rather the purpose is to help planners in health programmes articulate precise programme objectives. This is not an easy task as, all too often, objectives are defined in terms of ideas and ideals and lack a clear conception of who in the community might undertake what actions for what purpose.

## Conclusions

In conclusion, we may make two points. The first is that the understanding of community participation in health programmes will be greatly enhanced as in-depth analyses of specific programmes are undertaken. We now have a

more than adequate collection of programme descriptions. We need more studies of what went wrong in programmes, some of the reasons they went wrong and some suggestions as to how the same mistakes can be avoided in the future.

The second point is that this study of community participation in health programmes suggests that we need analytical tools and action programmes different from those which are traditionally used for the delivery of health services. This paper suggests one alternative. It certainly is not the only one. What is clear, however, is that there is a need to begin to develop new attitudes among planners, agencies and community people concerning the role of lay people in the delivery of health care and the expectations of all parties about how that role will be carried out. These attitudes and expectations are not easy to develop. However, unless we take the lessons we have learned so far and seek to apply them to programmes, we risk letting health care become once again a bottomless pit of resource absorption and a commodity out of reach of those who need it most.

## References

- Ahmed M. 1980. 'Community participation, the heart of primary health care.' In Rifkin 1980. See below
- APHA. 1977. *The state of the art of delivering low cost health services in developing countries*. Washington DC: American Public Health Association
- APHA. 1983. *Community participation in primary health care*. Washington DC: American Public Health Association
- Askew I. 1984. *An analysis of community participation in the JIOCFP project at Caramoan, Philippines*. University of Exeter, UK
- Carino L et al. 1982. *Integration, participation and effectiveness: an analysis of the operations and effects of five rural health delivery mechanisms*. Manila: The Philippine Institute for Development Studies
- Cohen M and Uphoff NT. 1980. Participation's place in rural development: seeking clarity through specificity. *World Development* 8: 213-35
- Coombs P (ed). 1980. *Meeting the basic needs of the rural poor*. New York: Pergamon Press
- Diaz R. 1985. *Community participation in urban projects with emphasis on health and family planning*. Paper presented to a workshop on Community Health and the Urban Poor, Oxford, 7-12 July
- Elliott R. 1975. Is primary health care the new priority/Yes but . . . *Contact* 28, August
- Foster G. 1982. Community development and primary health care: their conceptual similarities. *Med Anthropol* 6: 183-95

- Heggenhougen HK. 1984. Will primary health care efforts be allowed to succeed? *Soc Sci Med* 17: 217-24
- Morley D, Rohde J and Williams G. 1983. *Practising Health for All*. Oxford: Oxford University Press
- Rifkin SB (ed). 1980. Health, the human factor: readings in health, development and community participation. *Contact*. Special Series No 3, June
- Rifkin SB. 1985. *Health planning and community participation: case studies in Southeast Asia*. London: Croom Helm
- Rifkin SB. (in press). *Community participation in MCH/FP programmes: an analysis based on case study material*. Geneva: World Health Organization/United Nations Children's Fund
- Sterky. 1980. 'Towards another development in health.' In Rifkin 1980. See above
- Williams G and Satoto. 1983. 'Sociopolitical constraints on primary health care: a case study from Indonesia.' In Morley et al. 1983. See above
- Ugalde A. 1985. Ideological dimensions of community participation in Latin American health programmes. *Soc Sci Med* 21: 41-55
- WHO/UNICEF. 1977. *Community involvement in primary health care. A study of the process of community motivation and continued participation*. Geneva: World Health Organization
- WHO/UNICEF. 1978. *Primary health care*. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Geneva: World Health Organization

## Biography

Susan B Rifkin, BA, MIA, CTMCH, PhD, Honorary Senior Lecturer in Health Planning, Liverpool School of Tropical Medicine, Pembroke Place, Liverpool L3 5QA, UK.

Susan Rifkin took two degrees in Chinese area studies and became interested in health in developing countries through her research into health care in China. Having done the certificate course at the Liverpool School of Tropical Medicine, she worked for the Government of Zambia for two years as a Health Education Officer. Returning to Hong Kong in 1975, she spent nine years working with indigenous Asian non-governmental organizations, helping to found the Asian Community Health Action Network (ACHAN) and serving as its first co-ordinator. She came back to England in 1984 and has pursued work at the London School of Hygiene and Tropical Medicine in community participation and in developing training materials for health care workers. She now has a joint appointment from the Liverpool School of Tropical Medicine and the School of Public Health, Boston University, to undertake research into primary health care among the urban poor in the developing world.