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Paradigms Lost: Toward a new understanding of community participation in health programmes

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Community participation has been a critical part of health programmes, particularly since the acceptance of primary health care as the health policy of the member states of the World Health Organisation. However, it has rarely met the expectations of health planners/professionals. This paper argues that the reason for this failure is that community participation has been conceived in a paradigm which views community participation as a magic bullet to solve problems rooted both in health and political power. For this reason, it is necessary to use a different paradigm which views community participation as an iterative learning process allowing for a more eclectic approach to be taken. Viewing community participation in this way will enable more realistic expectations to be made. Community participation in disease control programmes focusing on community health workers is used as an example to show the limitations of the old paradigm. Participatory rapid appraisal is used to illustrate the new.

Key words: Community participation; Paradigm shift; Community health workers; Rapid appraisal

1. Introduction

Community participation in health programmes, and indeed in health care is not new. History records some type of participation in nearly all communities in health care provision. However, its popularity and prestige was boosted in the post World War II period. Community participation became one of the main principles of primary health care (PHC), the health policy put forward in Alma Ata in 1978 by the World Health Organisation (WHO) and the United Nations Childrens Fund (UNICEF) and subsequently adopted by the member states of WHO (WHO, UNICEF, 1978). The acceptance of community participation was the result of experiences in health and other community development programmes and reflected an environment within in the United Nations agencies focusing on involvement of people, not only professionals, in decisions about development.

Community participation was identified as the “key” to PHC and was expected to bring about the following benefits (Rifkin, 1990 p. 10–11):

1. people would better utilise existing health services and would ensure sustainability of new services by being involved in decisions about the development of the services;

2. people would be able to contribute resources of money, manpower and materials to support the scarce resources allocated for health care;
3. people would change their poor health behaviours when they had been involved in exploring the consequences of this behaviour, and;
4. people would gain information and experience which would help them gain control over their own lives and thus challenge the existing social, political and economic system which had deprived them of this control.

The history of community participation in health care and health programmes is long, fascinating and too complex to explore in this article; many articles and books have done so (Macdonald, 1993; Muller, 1980, Oakley, 1989, Rifkin, 1990). A review of experiences does suggest that community participation has not met the expectations we described above. Why does this gap between rhetoric and reality exist?

One major reason for this situation was that there was no common agreement about how to best develop community participation to gain these benefits. Those responsible for health programmes, namely policy makers, planners and professionals, working with community people, lack a common frame of reference. It could be argued that the framers of the Alma Ata declaration purposely left the concept of community participation vague and flexible recognising that unlike a vaccination regime, it could not be imposed on a target population. The concept, like PHC itself, became many different things to different people. As a result, it has been difficult to reach generally agreed upon definitions, let alone objectives, for developing community participation in health care.

The purpose of this paper is to review the experiences of community participation in health programmes with a view to enable programme planners and managers to make more realistic assessments about its contribution. We will do so by first briefly reviewing planners' approaches to community participation in health programmes and then by describing the frames of reference in which community participation developed in health programmes. We shall analyse the translation of these conceptual frames into practice by examining community health worker (CHW) programmes. Finally, we shall suggest that a major barrier to implementing successful programmes is the existing paradigm because it engenders unrealistic expectations. (a paradigm is a pattern or universal exemplar of events or phenomena (Kuhn, 1962) We shall suggest an alternative paradigm, which may enable policy makers, planners and managers to more realistically set objectives and implement programmes incorporating community participation. Because this special issue of *Acta Tropica* focuses on community participation in disease control we shall use many examples from this field.

1.2. Frames of reference

In order to understand the different frames of reference in which health planners and managers view community participation, it is valuable to examine past experiences. A review of community participation in health programmes suggests that planners have taken two distinct approaches to community participation in health care giving rise to different expectations. I described these approaches in detail in an earlier book (Rifkin, 1985) and will briefly review them here.

The first approach is one in which planners/professionals decide the specific

objectives of a health programme and then attempt to convince community people to actively accept these objectives. Two distinct variations can be described. The first, and the one with the longest tradition, is the situation in which professionals try to convince community people to accept a specific health intervention. Examples include mass vaccination campaigns and promoted use of oral rehydration therapy. In this case, planners expect that community participation will motivate most local people to come to health units to receive the benefits of an intervention and/or take steps defined by professionals to improve their individual and collective health. The second variation is the situation in which planners/health professionals seek more than mere acceptance. They want a community contribution to the programme/intervention which they have defined. Examples include the range of CHW programmes which we will describe later. Both variations expect local people to participate, within the context defined by the planners/professionals, to bring about improvement in their health status.

The second approach is one in which community people are encouraged to take decisions about resource allocations and priorities and then ask professionals to respond to these decisions. This approach emerges from the belief that the reasons for poor health are due, in large part, to the unequal distribution of existing resources. The argument goes that a more equitable situation can be brought about by structural changes (i.e., democratisation of decision making) at the local level. This frame addresses health improvements in the political context. It often has been accompanied by conflict with the existing local authorities. Some of these experiences in Peru (Muller, 1983) and Indonesia (Williams and Satato, 1983) have been described in *Practising Health for All* (Morley et al., 1983). Here the expectation is that community participation in health programmes will act as a catalyst for social change by empowering local populations to become involved in the political process.

These approaches are the translation into practice of two distinct frames of reference which have dominated thinking about health improvements in the so-called developing countries since the end of the Second World War. The first frame of reference might be called the *target-oriented frame*. Its roots can be found in the Western scientific tradition and the biomedical model of health and illness by the end of the 19th century. (Macdonald, 1993) It views present day health improvements as mainly the result of discoveries of science and technology. As a consequence, it defines the aim of community participation to improve the health status of people. In the past, the implementation of community participation has been dominated by medical professionals but more recently social scientists, mainly anthropologists, have been involved. It is believed that those who understand human behaviour can tell those trained in medicine how to manipulate behaviour to gain acceptance of medical advice. This frame of reference is often referred to as the “top down” approach.

The second frame of reference can be called the *empowerment frame*. Its roots might be traced to the historical situation emerging from the post War and ex-colonial period. (Morgan, 1993) in which inequities in resource distribution were highlighted as a major cause of poverty and poor health for the majority of the world’s population (Seers, 1979). Its principles were intensified with the Cold War, where much of its shape was influenced by Marxist thought (Hulme and Turner, 1990). It sees people as subjects not objects of technological improvements and social change. Thus, poverty cannot be eradicated by new technology alone but only in conjunction

with a change in the existing system of power and control. In the health field, the theory came to practice in the ideas of the Brazilian educator, Paulo Friere (Friere, 1972), who saw information as power and promoted education as the means by which the poor could challenge control by the elite. This view has been taken up in the work of non governmental organisations (NGOs) in Asia and Africa, such as the community-based programmes developed and supported by the African Medical Research Foundation (AMREF) and the programmes supported by the Asian Community Health Action Network (ACHAN). Basically, the frame sees community participation as the result of community people, essentially the poor, gaining information, access to resources and eventually control over their own lives rather being dominated by the authorities (elites) by whom they have been exploited. It is referred to in the literature as the “bottom up” approach.

These frames of reference can be more clearly defined by looking at their approaches to three questions: Who makes the decisions about resource allocations? What is the expected outcome of these decisions? How is this outcome to be assessed?

In the target-oriented frame, decisions about resource allocation are firmly in the hands of professionals. Consultation with community people may be undertaken to insure better acceptability and sustainability of the programme. Professionals interact with community people, often with the view of having local people change behaviour in order to improve health status (Sornmani, 1992). With this orientation, outcomes of programmes in which community participation is present are seen in terms of the product. Community participation is a means to the end of health improvements. As such, it is often viewed as a component of a health programme and conceived within the same framework as a specific intervention such as immunisations. Because of this product orientation, the evaluation of success or failure is based on quantifying the results. The underlying question is how many? An increase in uptake reflects the success of the intervention. The ultimate evaluation is the improvement of health status measured in rates.

Community participation in disease control has contributed substantially to the literature which reflects the target oriented frame. For example, a review of articles which appeared on a Medline search for 1990–93 for the key words “community participation” produced abstracts of articles of which approximately one half focused on community participation in disease control. These articles can be divided into three main categories. The first is articles which report the use of community health education to change behaviours to prevent specific disease. Examples of this include articles which describe the effect of health education on control of dengue fever in urban Thailand (Swaddiwuhipong et al., 1992); in schistosomiasis control in Kenya (Katsivo et al., 1993); in control of Chagas disease in Brazil (Garcia-Zapata and Marsden, 1993) and in HIV/AIDS control in an African community in Toronto (Nakyonyi, 1993). The second category is programmes which mobilise community people to perform disease control tasks. In the next section we shall examine those people who work directly with the health services, the CHW. However, articles here also describe mobilisation of the general community to undertake specific actions. These include: residents participation in well digging and water filter installations for control of Guinea worm in Nigeria (Brieger et al., 1991); household use of a trap for catching tsetse flies to prevent sleeping sickness in Uganda (Okath et al., 1991) and in the Congo (Gauteux and Sinda, 1990); and setting up local infrastructures in order to respond positively to control programmes for onchocerciasis in Nigeria

(Braide et al., 1990). The third group of articles are those which concern cost recovery through community contributions for disease control. Although several of the previously cited articles do address this issue one specifically looks at community financing of health centers to support EPI (Expanded Programmes of Immunization) in Benin. (Gbedonou et al., 1991) These publications illustrate the objective of community participation as a means to mobilise local resources, allow providers to give more acceptable services and/or to involve the community with a view to sustain the programme.

The empowerment frame sees decisions about resource allocation as the result of active involvement of community people. As we noted above, this has often led to conflict and confrontation with each other and with professionals and more drastically, with authorities (Stark, 1985). In this frame, participation is an end in itself, an end to enable local people to have power over decisions which affect their lives. Thus, community participation is viewed as a dynamic process which enables local people, through involvement and experience, to gain access and control to health care resources. This process cannot be measured in the numbers of people who are involved in activities. Rather, it describes how community members perceive social change. Qualitative methods are most appropriate for this type of evaluation as they are flexible, allow for iterative information analysis and reflect peoples', rather than professionals' priorities and concerns.

Articles which take this frame of reference are more likely to appear in journals for social rather than medical sciences. This is due in part because much of the experiences come from community and rural development. However, the concern in the health field, does appear in the same Medline search we cited above. The empowerment view, for example, is reflected in an article concerning participation in family planning, which warns that managers should not encourage "greater involvement" unless they are prepared to reorganise strategies and programmes to reflect, community, not professional needs (Askew and Khan, 1990). An article on involving women in health care by advocacy on issues reflecting needs, such as employment child care, and describing activities to give women more knowledge and power is published on work in Sao Paulo, Brasil. (Pedalini et al., 1993) Another, arguing that women's needs are often suppressed by existing professional attitudes and social institutions, reflecting the situation in Canada, continues the analysis of empowerment in the gender framework (Wuest, 1993). Two articles reflect the role of social and cultural factors and their critical importance in addressing the key questions we have asked (Woelk, 1992; Stone, 1992). Finally, it is worth noting, that a special supplement on social and behavioural aspects of malaria control was published in the *Southeast Asian Journal of Tropical Medicine and Public Health* (Vol 23, suppl 1, 1992). In her introductory article, Lenore Manderson, an anthropologist, highlights the difficulties in addressing community participation for specific disease control programmes in the empowerment frame. Firstly, she says most programmes in this area are taken by a government department or unit and therefore, are rarely based on community initiative. Secondly, most programmes choose key community people to carry out prescribed tasks and do not seek broader based involvement of the community (Manderson, 1992). These articles are reflective of those that define the objective of community participation to challenge the existing inequitable power structure and to give local people power to choose strategies to improve their own lives.

2. Rhetoric into reality: the community health worker

In the years which followed Alma Ata, national governments sought many ways to incorporate the principles of PHC into health policies and programmes. Among the most popular was the creation of CHW programmes. These programmes were identified as a way of addressing community participation in health care. They were designed to train local people who were accountable to their community and supported by health staff to undertake basic health care tasks and in many cases, act as “change agents” to rapidly and radically improve health of the rural poor. These programmes often became equated with PHC and it has been said the success of PHC may depend on the success of these programmes (Annett and Nickson, 1991).

The inspiration for CHWs can be traced to China’s barefoot doctors who appeared in massive numbers during the Cultural Revolution beginning in 1965 (Sidel and Sidell, 1982). China provided an example of how health care could be expanded to reach the rural poor by using local people for service delivery. It has been also argued that the barefoot doctors reflected the revolutionary Chinese spirit by incorporating lay people in health care and thus, might be considered as part of the empowerment frame, challenging professional (elite) domination over health care (Rifkin, 1978). Thus, the Chinese barefoot doctor inspired both frames of reference. For the target-oriented frame it set examples of local, lay people with rudimentary education undertaking simple curative, preventive and health education tasks. It highlighted the possibility of tapping resources to supplement a critical lack of allocations for health care, especially for the poor. For those who were within the empowerment frame, it set an inspired example of local, rural poor people concentrating their energy and knowledge to provide for their own self defined needs. It also challenged medical professionals (and by extension the existing power structures) whose power and influence had imposed the existing health system. To be a bit simplistic but basic about expectations, the target-oriented frame saw the CHW as an untapped resource potential to expand service delivery and manipulate behaviour for health improvements; the empowerment frame saw the CHW as an “agent of change” to liberate the poor from the oppressive social/economic/political structures and to provide health care defined by their community, not imposed by external professionals.

Experience suggests that both frames had unrealistic expectations. Articles which examine the CHW in the context of disease control programmes provide examples of the expectations within the target-oriented frame. The description of CHWs in a malaria control programme in Kelantan, Malaysia provides a prototype of how such programmes are undertaken (Riji, 1992). A first step is to have the government and its attendant committees, health units and responsible officers agree to implement a scheme involving local volunteers for the disease control programme. The plan is then discussed with local health units and with the target communities. Volunteers (who may be paid or not paid) are selected by several methods including community nomination, appointment by the local community head or nomination by the local health staff. Criteria for acceptance include willingness to participate in the programme and commitment to training which often takes account of attainment of a certain level of education. After the training, tasks are assigned and then provision is hopefully made for supervision and evaluation. In the context of this frame, quantitative analysis concerning reduction in disease prevalence, use of appropriate

interventions by the community, assessment of CHW drop outs and level of CHW knowledge about their task is the basis for evaluating the programmes.

Articles have also described the potential of including new interventions for disease control into ongoing CHW tasks. Chuit and his colleagues (Chuit, 1992) requested CHWs in rural Latin America to include sensor boxes and portable mini-pumps distribution to households to detect the vectors of Chagas disease. Houses were then sprayed. As the traditional method was to send professionals to assess whether the house had a high enough infestation to require spraying, this method was deemed most effective and suitable for large-scale application. It was cited as a contribution of community participation to health care.

More elaborate investigations attempt to assess the performance of CHW in disease control have been reported by Ruebush et al. (1992a,b). They assessed the malaria surveillance and treatment tasks undertaken by unpaid volunteers in Guatemala. The authors equated community participation with the results of malaria case detection and treatment done by the volunteers and conclude that modifications made to the programme in the area in which they worked greatly improved the programme.

Yet, the above examples raise a number of questions about whether the CHWs have in fact provided additional (and therefore without additional costs) resources for improving the health status of community, especially poor community, people. Firstly, as the publications reviewed above show, the health services must spend time, and most often funds, in reorganising the delivery structure to accommodate lay people. This includes mobilising local support, providing training and often equipment for people to undertake the tasks. The programme also must account for the continually reported high turnover of CHWs which incur the loss of initial training expenses and the additional cost of training new people. Secondly, as the Walt study, discussed below, confirms (Walt, 1990), for workers to perform effectively, supervision by health professionals is necessary. This also creates the need to allocate time and money. Finally, there is the question of motivating people to become involved in programmes (disease control) which are most often not their priorities (Manderson, 1992). Volunteers who receive no pay for their work are not the norm. So funds need to be found either in the existing government allocation or in payment by community people. It also raises the question of whether the poor, for whose needs most CHW programmes have been designed, should be further burdened with contributions, time or money, which they can ill afford (Mburu, 1994).

Within the empowerment frame, although early successes mainly within the NGO sector have been recorded (Morley, 1983), many of these CHW programmes did not survive long. In the context of large-scale implementation, three case studies undertaken by Walt and her colleagues in Botswana, Colombia and Sri Lanka highlight the developments of CHWs as agents of change (Walt, 1990). In all three countries, the CHW programmes examined were in response to the PHC policy. All three began with the view to involve community people in health care as a way of changing attitudes and releasing untapped community potential by creating a context for community involvement in health decisions. Success was seen to be a self-sustaining health programme responsive to community needs and accountable to community people.

In Botswana, CHWs, called Family Welfare Educators (FWE), first trained in

1969, were local women who knew their communities and could respond to community problems as well as give immediate and on-the-spot help to minor health problems including those related to the needs of mothers and children. The original idea that the FWE would be community based quickly gave way to attaching these women to a health facility. As a result, their role became to extend the mother child care related services rather than a promoter of community change (Walt, 1990 p. 110). In Colombia, despite views that local CHWs were important for community development, the role for which they were most appreciated in the communities was that of providing curative services. As a result, even the context in which they could promote social change, that of preventive work and health education, was limited both by the choices of the communities and the authorities who appreciated having more health manpower at a relative cheap cost. Only in Sri Lanka did the wider role of community change agent have some substance. The authors suggest that this was due in good part to the Buddhist culture which gives "merit" for compassion and support for the less fortunate and the long history of volunteerism within the country. It was difficult, due to the nature of the programmes, to assess the contribution to both community change and health improvements. The authors did believe, however, there was evidence to suggest that the programme also narrowed from its formerly expansive community development work to become an extension of the government health programmes. Thus, the authors in posing in the title of their study "Community health workers in national programmes: just another pair of hands?" answer this question with an almost resounding "yes".

It can be argued, based on the experiences described above, that both frames of reference had very different but equally unrealistic views about the potential contribution of CHWs. They highlight the problems of making concrete the illusive concept of community participation. They further highlight the inability of professionals, health and social service people, to manipulate social change in the direction of their own preconceived notions of progress and development.

3. Analysis

This section argues that analysing community participation in a singular frame of reference, be it the target-oriented or the empowerment, restricts our understanding about and expectations from community participation. This is because the paradigm in which the frame of reference is embedded views community participation as an intervention and analyses it as linear, causal and contributing to a system which is viewed as a sum of all its parts. Experience suggests that community participation is better seen in an adaptive change analysis. This analysis does not view community participation as an intervention but rather examines it as an influence on an entire system. It recognises that these influences are not linear nor always causal but result in a adaptive, learning process of a system in which the sum is greater than its parts. Thus, a new paradigm (a pattern of interpreting existing events and relationships) is needed.

These two frame of reference, the target-oriented and the empowerment, can be said to view community participation from diametrically opposite and mutually exclusive positions. Such interpretation is supported, for example, by WHO (WHO, 1991) in its technical discussions on community involvement in health (CIH) where,

borrowing from David Werner cited below, it contrasts community oppressive approaches/conventional health care (target oriented) to community supportive approaches/CIH (empowerment); by editorials in *Tropical Doctor* (Tropical Doctor, 1991) which asks whether PHC is to be a variety of hospital medicine delivered to the community (target oriented) or a partnership through participation of local communities with doctors (empowerment); and by David Werner's article entitled "The village health worker: lackey (target oriented) or liberator(empowerment)?" (Werner, 1981).

To summarise these views: The target-oriented frame sees community participation as a way of mobilising community resources to supplement health services; a means to an end; passive by responding to professional direction; a product of a PHC programme and evaluated by quantitative methods. The empowerment frame sees community participation as a way of giving people power over their health choices; a means in itself; as active and based on community initiatives; as a process whereby communities are strengthened in their capacity to control their own lives and make decisions outside the direction of professionals and authorities and evaluated by qualitative methods.

However, if we look at a deeper level, it can be argued that both frames of reference share a paradigm which has influenced the perceptions of the potential and value of community participation. This paradigm is rooted in scientific discoveries of the past century and is one which is linear, causal, describes itself as objective and sees the sum of any phenomenon as merely the a collection of all its parts. (Lewontin, 1991) It may be said to have the following characteristics: it is dogmatic-based in absolute truths; it is exclusive—one interpretation of events and/or relationships precludes other interpretations; it seeks causality—tending,thus, toward a linear analysis. The paradigm not only gives rise to the mutual exclusiveness of each frame. It also defines community participation within both frames of references as an intervention by which to achieve a proscribed objective (health status improvement and/or a change in political relationships at the community level). Thus, it assumes that this objective can be controlled and predictable. Nor does it see community participation as a result of a learning process by which outcomes are the result of adapting to change as change occurs. It does not perceive community participation as an outcome of a dynamic interaction among all those involved in developing a specific health programme in which the outcome is neither controlled nor predictable. As a result, planners have been constricted in their views about community's capacities and have created programmes which often reflected to their own conceptions of progress rather than those of the people whom they plan to serve.

This paradigm, it has been argued, is beginning to shift. In the natural sciences, the emergence of the theory of relativity and quantum mechanics and the resulting chaos theory rejects the linear paradigm (Capra, 1976). In the social sciences, much work has been done in the area of rural development by Robert Chambers (Chambers, 1992) and his colleagues (Scones and Thompson, 1994) in Great Britain and Norman Uphoff (Uphoff, 1992) at Cornell in the United States. Uphoff's work has examined the underpinnings of the old paradigm and its consequences for the analysis for community participation in development programmes. It is to this analysis which we now turn in order to help us review our expectations about community participation in health care.

Uphoff, while acknowledging that the single frame of reference, which is rooted

in the existing paradigm, provides a critical rigour for analysis of a situation, argues that using a singular frame of reference limits our understanding of human behaviour in the same way it inhibits our understanding of patterns in the natural sciences. This barrier can be overcome by applying different frames of reference in examining a specific situation. He states "Several positions that are inconsistent within a single frame of reference can reasonably be held if more than one frame is applied, according to mutually agreed criteria such as utility and coherence." (Uphoff, 1992, p. 309).

Uphoff explores an alternative paradigm which he distinguishes from the old one by calling the latter an "either-or" analysis and the former a "both-and" analysis (Uphoff, 1992, Chapter 10). He suggests that using this alternative paradigm will enable us to not only see a situation as a holistic situation where the sum is larger than each of its parts but also include an "either-or" analysis to insure rigorous analytical methods are applied to the study. In other words, reviewing his own experience in community participation in an irrigation project in Sri Lanka using this paradigm, he states "we were not giving up all conventional ways of thinking, since that would itself be inconsistent with the both-and principle, but were enlarging and enriching our mental armour with more expansive, less rigid concepts." (Uphoff, 1992, p. 289).

The "both-and" paradigm has relevance to our understanding of community participation in health. Both in terms of theory and practice, this analysis gives rise to ways of overcoming the limits and thus, the expectations emerging from the two apparently contradictory frames of reference. In the context of our concerns, we might suggest that in analysing community participation in health programmes, both the target-oriented and empowerment frames are consistent within themselves but are too constricting to help create realistic expectations about programme outcomes. It is no longer useful to formulate questions in terms of whether community participation has the objective of adding resources or empowering people; is a means for health improvement or an end in itself; whether participation must be active or merely passive; whether it means that professionals or community people should control the programme; whether community participation is a process or a product in a health programme; whether community participation should be evaluated in quantitative measures or qualitative assessments. Rather, it now can be argued that these apparent differences should both be examined and both make contributions to our understanding.

In terms of planning for programmes, it can be argued that the "both-and" paradigm helps us to accommodate different views about how change happens, thus expanding our understanding rather than limiting it to accommodate a single framework. For the planner/professional, there are several implications of using the new paradigm. Firstly, it will be necessary to develop new skills and attitudes which provide an openness for new ideas and approaches. Paramount is the skill of clear communication and the attitude of respecting local (lay) knowledge and people. Professionals will need to recognise the validity of views presented by people who lack rigorous training and clear articulation. Creating mutual respect between professionals and community is the key.

Secondly, it will be necessary for planners/professionals to refrain from hasty judgement emerging from their professional and personal experiences. An openness and flexibility is required to allow new ideas to be examined and approaches to be

changed if necessary. It also requires a willingness to engage in exploration of views which are radically different from ones now held.

Thirdly, the “both/and” paradigm suggests that planners/professionals will need to base expectations on particularistic responses to specific situations rather than universalistic models for widesweeping change. In other words, community participation can be seen as a set of views and activities which reflect a solution to a specific set of circumstances. The process under which solutions develop might have some universal characteristics but the solution itself will be local.

Finally, it will mean that the planner/professional cease to look for community participation as the “magic bullet” for programme success. They will need to drop the expectation that community participation tied to a single frame of reference will either radically improve health or be the catalyst for structural change.

4. The new paradigm: an example

One area where the application of the new paradigm is accumulating experience is in the use of rapid appraisals for community needs assessment. There are a variety of approaches to rapid appraisal in the health field (Manderson and Aaby, 1992). However, the one which illustrates the shift in paradigms is based on guidelines developed for WHO (WHO, 1988). It is now called rapid participatory appraisal (RPA). Here, the application relies upon the more rigorous disciplines of epidemiology and anthropology and the more eclectic experiences of needs assessment in the fields of agriculture and rural development (Chambers, 1981).

Essentially, RPA is a method used for community needs assessment in which multidisciplinary teams of professionals share with community key informants a variety of tasks including: information collection, information analysis and priority setting based on the analysis. The multidisciplinary team carries out the needs assessment using observations, key informant interviews and document reviews. Initial findings are given to key informants and on the basis of this information, priorities are set in consultation with community leaders. Once priority problems are identified, community leaders are asked to help with solutions and in depth examinations may be made to map the extent of the problem. A plan of action is drawn up accordingly. It combines the qualitative, iterative techniques for problem identification with the quantitative techniques for indepth investigations once the problem has been identified. The RPA is seen as the first step in a planning process and not an end in itself. Thus, it exemplifies its iterative, adaptive nature. As an example, one planner noted, the RPA he undertook allowed change to be brought about during the data collection process (Murray and Graham, 1995).

RPA has been used in a range of communities from rural Camerouns (de Koning and Bichmann, 1933) to a low income area in Edinburgh (Murray et al., 1994). The objectives of the exercise have been defined both to identify areas of programme priority and to involve local people in decisions about future developments. The results suggest that both objectives can be met.

The basis of RPA is its flexibility. It does not emerge from a set of pre-defined expectations about outcomes. Rather it enables planners to respond to situation as they arise. Firmly placed in the “both/and” paradigm, it escapes the constraints of the linear “either/or” paradigm which in the past has led planners to reject

community identified options; or equally restricting, has led planners to interpret community views in terms of professional perceptions of the problem.

5. Conclusion

Conceptually, the “both-and” paradigm removes community participation in health programmes from the mechanistic to the probabilistic context. Planners have a framework in which to understand why a health intervention results in different responses in different communities. They have a framework which enables them to relinquish the expectation that it is possible to identify a single solution to a complex set of problems which do not share a common history of creation. Concretely, this paradigm suggests that community participation in health programmes cannot solely result in either improved health status or in empowering community people. Community participation has the potential of doing both. This paradigm allows this potential to be recognised.

Critical to the success of these efforts, however, is the appreciation of all those involved that there is no absolute reality. Different people bring different assessments to a situation and these assessments must be taken into account. The “both-and” paradigm legitimises different experiences and different views as well as different types of evaluations. In the past community participation in health programmes has tended to be paralysed by the insistence of planners that there is only a single way (frame of reference) forward. This new paradigm may be a critical way to release community participation from its present moribund state and release community energy to become more centrally involved in community health and health care.

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