Introduction

This paper reviews recent trends and debates concerning the concept of community participation in health, focusing on new ideas that were added to the debate during the 1990s, and focusing specifically on examples drawn from Latin America. There, as elsewhere, participation has captured the attention of health planners, policymakers and activists, and become well entrenched in mainstream health discourse. This widespread consensus about the importance of participation follows years of disagreement about what it meant and how best to create participation. Twenty-five years after the formalization of the concept at the Alma Ata Conference in 1978, advocates of participation tend to have a greater appreciation of the difficulty and complexities involved in enhancing participation than they did then. The analytic complexities, definitional disputes, and operational challenges have been thoroughly (even exhaustively) discussed and illustrated through case studies. Today, a middle ground has opened for researchers who focus on methodologies for monitoring and assessing participation and for making sure that the principle is woven into policy and planning at district and national levels in addition to international levels (Chambers 1995; Kahssay and Oakley 1999).

Because so much of the debate over participation involves conversations between anthropologists and epidemiologists, this paper will also address how the concept has been analyzed by anthropologists and other social scientists, and by epidemiologists, health service managers and policymakers. While their approaches often overlap, anthropologists are more typically concerned with conceptual issues such as what the concept means to those involved in implementation, while epidemiologists, managers and policymakers are often concerned with how to operationalize, implement and measure levels of participation.

The definitional divide: utilitarian and empowerment models

Community participation in health has traditionally been defined according to one of two distinct perspectives. Firstly, it can be a utilitarian effort on the part of donors or governments to use community resources (land, labour and money) to offset the costs of providing services. Nelson and Wright describe this as ‘participation as a means (to accomplish the aims of a project more efficiently, effectively, or cheaply)’ (1995 [1986], p. 1; emphasis in original). In the most recent and comprehensive World Health Organization (WHO) publication on the subject, Kahssay and Oakley describe one of the interpretations of participation as ‘collaboration’, in which people ‘voluntarily, or as a result of some persuasion or incentive, agree to collaborate with an externally determined development project, often by contributing their labour and other resources in return for some expected benefit’ (1999, p. 5; see Morgan 1993; Bronfman and Gleizer 1994 for reviews of this literature). On the other hand, participation can be defined as an empowerment tool through which local communities take responsibility for diagnosing and working to solve their own health and development problems. Nelson and Wright describe this as ‘participation as an end, (where the
community or group sets up a process to control its own development" (1995, p. 1); others describe this as an empowerment approach, or as people-centered development.

Each of these definitions itself encapsulates a range of meanings; for example, empowerment may be defined as simply allowing community representatives a seat at the table where policy decisions are made, or it may mean a process of democratisation whereby governments become more open and responsive to the needs of disenfranchised citizens. Some proponents herald participation for its cost-sharing potential and its contribution toward building sustainable programmes. Others emphasize the need for effective partnerships between government and civil society, and yet others stress the prospects for democracy that would follow if governments were accountable to citizens. How can one phrase carry so many definitions?

The proliferation of meanings attached to the phrase ‘community participation in health’ (also called ‘popular participation’, ‘social participation’ and ‘community involvement’) has allowed it to be analyzed as a political symbol capable of being simultaneously employed by a variety of actors to advance conflicting goals, precisely because it means different things to different people (Morgan 1993). Chambers lists as one of the definitions of participation its ‘cosmetic’ value, its ability ‘to make whatever is proposed look good’ (Chambers 1995, p. 30). Participation quickly became a regular feature of international health discourse in part because the word sounded so appealing and desirable, which may also explain why it was so heartily endorsed at Alma Ata. It is now an essential element of community health and other development programmes sponsored by NGOs and international donors.

That participation has been institutionalized in mainstream development discourse is evident in the fact that the World Bank has adopted the concept. After publishing several documents about participation over the last decade, the World Bank defines it as ‘a process through which stakeholders influence and share control over development initiatives and the decisions and resources which affect them’ (World Bank 1996). The Bank defines ‘stakeholders’ not as the poor or disadvantaged, as we might imagine based on the discussion thus far, but as all those who ‘could affect the outcome of a programme or project’ (Uphoff et al. 1998, p. 83). Even Robert Chambers, whose respectful approach to community work has won admiration in international health circles, admits that participation is never consensual, at least in the short run, for many projects (Chambers 1998, p. xvii). Many proponents of the empowerment approach to participation would like to ignore the uncomfortable fact that participation may require outside prompting; they would rather see spontaneous, self-generating conscientization and participatory action on the part of poor community members. Increasingly, however, they are willing to acknowledge that marginalized or disenfranchised communities are powerless to effect participation precisely because they have no power, and that outsiders might succeed in fostering community mobilization if they act with great sensitivity and humility.

‘A complex of factors, varying from country to country as well as community to community, maintains a political, economic, and social status quo that keeps the large majority of rural people from having much voice in or control over their lives. Poverty, prejudice, despair, paternalism, local power structures, legal and regulatory restrictions, adverse past experiences, and other forces commonly discourage people from playing more active roles in changing their circumstances and opportunities. Yet there are encouraging examples of emergent local activism and institutional development that can change the participation equation.’ (Uphoff et al. 1998, p. 83)

Today, facilitators and policymakers are more willing to assume the responsibility that is entailed by their desire to
ticed, even 25 years after the optimism generated by the Alma
crepancies over the way that participation is defined and prac-
Bank, for example, we can see that there are still great dis-
trast Muller’s perspective with that offered by the World
organizations; these are the specific manifestations of opposi-
mothers groups and neighborhood and peasant health
soup kitchens, the glass of milk programs, school lunches,
and in the demands for decent services they make of the Min-
marginalized people, expressed in traditional health services
'This kind of participation forms part of a survival strategy for
effort, but a local reaction to desperate living conditions:
context, he says, participation is not a state- or NGO-initiated
project, but the basis upon which it will operate. Furthermore,
participation cannot be assumed but has to be systematically encouraged, and means have to be created to make it effective (Oakley et al. 1999, p. 117). Processual understandings of participation make sense to those interested in theory and implementation, but they can compound the challenges of operationalization, measurement and assessment.

Operationalization and evaluation

WHO and UNICEF were the multilateral sponsors of community participation in health, and their names are still strongly associated with the concept. The WHO's most recent document on the subject, *Community involvement in health development: a review of the concept and practice*, proposes that participatory thinking needs to be institutionalized at district levels in national ministries of health (Kahsay and Oakley 1999). The authors argue that participation efforts in the 1980s and 1990s often bypassed national and district levels of health planning and policymaking. Participation was originally introduced as an international mandate, yet as part of the primary health care strategy it was often implemented at local levels. National ministries of health did not usually enlist the support of clinicians and other health professionals, nor did they seek the support of institutions that were not directly involved in primary health care. Consequently, Kahsay and Oakley say, there is still a great deal of resistance to participation among health professionals and institutions, especially at district levels. If these important constituencies continue to be excluded, participation will likely never become fully accepted and will always meet resistance. They argue, therefore, that project-level commitment to community participation, while important, is insufficient to ensure the sustainability of the concept; that what they call 'community involvement in health (CIH)' should be regarded as a principle rather than a programme. In order for participation to be sustainable, it must extend beyond the local (or project) level. 'For CIH this is the key issue; it is not just a question of people's participation in health activities or health projects but, more importantly, their involvement in district-level health services which is crucial to sustainable health development' (Kahsay and Oakley 1999, p. 18; emphasis in original).

Sceptics may argue that Kahsay and Oakley have taken an overly technocratic view of the concept of health participation, leading to a self-fulfilling call for professional training and development workshops, educational and curricular reform, and capacity building among health clinicians, planners, managers and labour organizations. The authors demonstrate familiarity with the political and situational complexities of participation, but in comparison to earlier documents, the implications of their analysis are specific to the health sector and do not emphasize the value of building democratic institutions or citizens. In this sense, the latest document to emerge from WHO can be analyzed within a larger global sociopolitical and economic framework, once the appearance of democracy was restored to most Latin American countries, the rhetoric of participation could be transformed into a reformist, technocratic project and shed its radical connotations. If this document is read as a portent of trends in health participation, we might expect international health agencies to adopt policies and support programmes that are more pragmatic and less idealistic.

Critiques aside, development planners are often under pressure to systematize and generalize concepts such as participation, so that other planners and technicians can 'consciously include this principle in their programme plans and evaluations' (Rifkin et al. 1988, p. 931), learning from them and thereby ostensibly maximizing their own chances for success. Donors usually also require that projects be evaluated. During the 1990s, these pressures led to a rapid proliferation of new methodologies and techniques both for assessing rural health and development needs, and for designing implementation, intervention and evaluation programmes. Oakley and colleagues, for example, have worked on a methodology for enhancing community involvement in health which entails training staff and setting up mechanisms at the project level to monitor participation and to evaluate its effect (Oakley et al. 1999, p. 115). A full review of these approaches is beyond the scope of this paper, but it is important to mention the proliferation of rapid appraisal techniques and participatory action research methodologies (Nichter 1984; Scrimshaw and Hurtado 1987; Fals-Borda and Rahman 1991; Manderson and Aaby 1992). Developed during the 1980s, these approaches turned into a booming business opportunity for qualitative researchers who generated a veritable mountain of books, documents and reports directed at community researchers (Rahman 1993). Analysts are quite cognizant of the multiple dilemmas posed by these trends:

'The situation today [1996] reveals two paradoxes in participatory development. The first involves the standardization of approaches. This trend contradicts one of the original aims, to move away from the limitations of blueprint planning and implementation towards more flexible and context-specific methodologies. A second, related, paradox lies in the technical, rather than empowerment-oriented, use of ‘participatory’ methods. A manual and method-oriented mania has led many to claim successful participatory development, despite only a superficial understanding of the underlying empowerment principles that were at the root of much pioneering work.' (Guijt and Shah 1998, p. 5; see also Rifkin et al. 1988)

Given the divisions within and outside the development establishment, anyone who watched the debates over participation in the 1980s could well have predicted the situation that would emerge in the 1990s. Just as ‘community’ is not a monolithic entity, neither is the development establishment, which contains within it both the propensity to standardize and to adapt to local circumstances. The tendency during the 1990s to pay heed to qualitative research was a positive event for anthropologists and other social scientists, who were finally able to bring local meanings and alternative social movements into mainstream conversations within the development establishment. Furthermore, the work provided for social scientists by the enthusiastic reaction to participatory research methodologies has allowed social science perspectives, theories, ideologies and politics (various though these are) to be debated throughout the development
enterprise. Consequently, the paradoxes articulated by Gujt and Shah will likely not be resolved; they will continue to co-exist, bounded by the exigencies of development demand a coterie of responses.

For example, donors are often pressured to operationalize community participation, even while they recognize that 'participatory processes do not necessarily follow structural, pre-determined and linear directions. Participation cannot be seen merely as an input to a project, but as an underlying operational principle which should underpin all project activities' (Oakley et al. 1999, p. 114). The penchant for operationalization and evaluation exists in spite of its recognized limitations. Donors often realize that it is hard to measure participation when participation is so hard to define. They recognize that it is difficult to measure a 'process' that has no fixed endpoint. They may recognize an additional paradox: the evaluation of participatory programmes often lacks community participation (Kalinsky et al. 1993, p. 123). Experience has shown that, even in the case of 'successful' projects, there is no guarantee that what worked in one situation will work in another, or will work in the future. The uniqueness of each participatory project resists the systematizing requirements of operationalization and evaluation.

Nevertheless, Rifkin et al. (1988) point out that the professionals who control the allocation of resources will not necessarily be inclined to support participatory initiatives unless the benefits can be demonstrated to them. Their matrix for measuring participation is a useful first step in the process of convincing the sceptical of the utility of participation; meanwhile, other pragmatic efforts to combine quantitative and qualitative approaches to community health have been tried, such as the census-based, impact-oriented approach recently implemented in Bolivia (Perry et al. 1999). The tendency to operationalize and measure participation was offset, however, by a countervailing trend to tailor participation to specific local, cultural and state contexts.

Culture, context and the state

Anthropological research into community participation in health has emphasized the importance of context. As Muller (1991: 26) says, 'Participation is an ambiguous concept because it cannot be defined outside of a social context'. 'Context', from an anthropological perspective, refers to the social relations and matrices of power through which participation must be effected. 'Culture' emphasizes the importance of understanding what participation means within a particular setting, beyond the bounded, formal political system and institutional structures. This does not mean, however, that a focus on culture need be apolitical. Anthropologists do not perceive 'culture' and 'politics' as two separate entities, but rather as 'simultaneous and inextricably bound aspects of social reality' (Alvarez et al. 1998, p. 4). They note that because participation usually involves a set of material demands (a redistribution of resources), its meanings will inevitably be contested, both at the level of rhetoric and in social practice. Anthropologists are often incorporated into the planning, implementation and evaluation of participatory endeavours because their observational skills and techniques are able to elicit the multiple (and often conflicting) meanings associated with particular development initiatives. They have, therefore, become the designated experts in community-level analysis of community participation.

Idiosyncratic local contexts are the sites where programmes succeed or founder. As Oakley et al. stated, 'Culture is not an obstacle to community participation, but it must be understood before participation is externally imposed' (1999, p. 123). This was the anthropologist's cue. For many years, anthropologists were cast as experts in 'the local'. They were called in to evaluate initiatives in situ. Can a given initiative be successfully implemented in a particular setting? What are the factors that facilitate or impede it? Does it result in the desired outcome? Who decides what the desired outcome is? The answer to many of these questions is presumed to lie in 'culture' (often glossed as 'local'). In 1992, Linda Stone reviewed the understandings of culture that have been utilized in the participation literature. Culture, she says, was initially viewed in one of two ways:

‘One view, held primarily by planners and health project personnel, saw culture as a set of “beliefs” and “customs” which were potential “obstacles” to the introduction of new health measures and ideas. A second view, sponsored primarily but not exclusively by social scientists, saw “culture” in the realm of health as “local knowledge” (indigenous medicine) on the one hand, and local “strategies” for securing health care on the other. Both groups, however, tacitly regard local culture as fairly static.’ (Stone 1992, p. 410)

There were a number of reasons why these understandings of culture fell into disfavour. Stone mentions that the relationship between traditional and modern medicine proved more complex and adaptable than many had predicted, and that communities exposed to primary health care often expressed a preference for curative care, which had not been predicted. More attentive now to the creative dynamism of culture, anthropological studies of participation of the 1980s and 1990s began to emphasize 'political relationships and processes' (Stone 1992, p. 413). Ugalde and Morgan, among many others, showed that community participation in Latin America in the early 1980s was often motivated by ideological and political factors that had little to do with improving health. Furthermore, participation programmes often took a patronizing attitude toward local communities, which were often regarded as passive and incapable of organizing themselves (Morgan 1990; Ugalde 1993; Zakus 1998; see also Woelk 1992). Stone says that this emphasis was important because it 'encourages an encompassing framework within which all levels of a health system can be simultaneously incorporated' (Stone 1992, p. 413), allowing for the integration of macro and micro level analysis. Social scientists began to study the meanings of participation among international and national experts, consultants, agencies and institutions, as well as among rural and poor people (Justice 1986; Foster 1987; Morgan 1993; Barrett 1996). They have shown that international health agencies have a near-hegemonic control over the definition of health problems and solutions.
worldwide. Consequently, they have become bloated bureaucratic machines, burdened by the vicissitudes of global politics and driven by ‘top-down’ planning, and prone to faddish trends (Werner 1993).

Concomitantly, anthropologists began to look at the effects of ethnic and gender (in addition to class) stratification on partici-patory initiatives. They expanded traditional anthropological critiques of the supposedly monolithic ‘community’, pointing to the effects of institutionalized stratification and discrimination on keeping certain people excluded, even as others were encouraged to participate.

The cutting edge of development practice in the 1990s is described in terms of ‘participation’, ‘community-driven action’, and ‘empowerment’. The broad aim of participatory development is to increase the involve-ment of socially and economically marginalized people in decision-making over their own lives. The assumption is that participatory approaches empower local people with the skills and confidence to analyze their situation, reach consensus, make decisions and take action, so as to improve their circumstances. The ultimate goal is more equitable and sustainable development.’ (Gujt and Shah 1998, p. 1)

This model is flawed, Gujt and Shah say, because ‘many par-ticipatory development initiatives do not deal well with the complexity of community differences, including age, econ-omic, religious, caste, ethnic, and, in particular, gender’ (1998, p. 1). They argue that development planners should not treat ‘the community’ as a benign entity with shared goals and values, because the relationships within particular communities can isolate or even harm some individuals and groups. In this sense, all development projects should con-sider the impact that they have on reinforcing or undermin-ing existing identities within stratified socioeconomic contexts.

If context is everything, then the case study format is essen-tial to presenting, analyzing and comparing experiences within and between countries and regions. Case studies both reinforce and reflect the assertion that participation is con-tingent upon local contexts. Even the most cursory review of the 1990s literature on participation turns up case studies from Argentina (Kalinsky et al. 1993); Brazil (Dias 1998); Central America (Barrett 1996); Costa Rica (Morgan 1993); El Salvador (Smith-Nomini 1997); England (Jewkes and Murcott 1996); Nicaragua, Peru, Colombia, and Guatemala (Muller 1991; Mexico Sheraden and Wallace 1992; Ras-mussen-Cruz et al. 1993; Zakus 1998); Africa (Touré 1994), including South Africa (Botes and Van Rensburg 2000); Turkey (Tatar 1998); and many others (Oakley 1991; Nelson and Wright 1995). Case studies can provide important lessons about the range of factors that might influence participation, but if ‘context is everything’ then case studies should not and cannot be used to predict what might happen in a different context. Nevertheless, case studies are vital for a variety of reasons. They allow new ideas to be tested and results to be compared and disseminated. They are useful to people designing their own programmes in different settings because they allow them to anticipate problems and implement pro-cedures that worked elsewhere. During the 1980s, for example, a number of case studies were published about Nicaragua, which were later invoked by British policymakers trying to democratize decision-making in the British Health Service (Crowley, undated).

Epidemiologists and policymakers working at international levels are not satisfied with case studies alone, however, because they need to formulate or derive principles of commu-nity participation that can be generalized and applied across a variety of national and political environments. To accomplish this goal, they must extrapolate from individual cases and summarize the results. This task has been accom-plished for rural development literature (not just health, per se) in two recent volumes by Krishna et al. (1997) and Uphoff et al. (1998). The first volume includes case studies from a variety of rural development projects, emphasizing the emic, or participants’, perspective on events. The second volume contains the etic, or analysts’, evaluation of events, focusing on the factors conducive to success ‘through amicable and respectful collaboration between external and community actors’ (Uphoff et al. 1998, p. viii). The authors are not overly optimistic about the prospects for success of rural development projects, which they note have often failed due to ‘the ways that governments, donor and international agencies, and some nongovernmental organizations usually proceed’ (1998, p. vii). According to the authors, impediments to par-ticipatory projects include changes in the development para-digm used by governments and donors to ‘neoclassical economic logic’, which led to structural adjustment and pri-vatization, trickle-down theories, etc. in the 1980s and 1990s. Uphoff et al. (1998, p. 2) say that, ‘Although this doctrine is still dominant, there is some evolving thinking that poverty alleviation needs to be resurrected as a prime concern, with concern for sustainable development now legitimating the incorporation of environmental considerations into policy and planning’. Impediments also include changing environ-ments: increased urbanization, population growth, landless-ness and unemployment, and environmental degradation (Uphoff et al. 1998, p. 2–3).

Zakus’ (1998) case study of community participation in health in Oaxaca, Mexico, during the 1980s, provides a useful theoretical perspective for analyzing and comparing partici-pation across national contexts. Zakus utilizes the ‘resource dependency model’ to argue that the Mexican Ministry of Health set up participatory initiatives because it was under tremendous internal and international pressure to expand health services. Because the Ministry lacked sufficient resources to extend services itself, it looked to the surround-ing environment for additional resources and ‘ironically ..., [found them] in the under served communities themselves’ (Zakus 1998, p. 487). Through a close evaluation of the struc-ture and implementation of the programme, Zakus concludes that the Ministry did not grant power or decision-making authority to communities; furthermore, it co-opted partici-pants (including communities and health workers) and failed to provide adequate training or supervision (Zakus 1998, p. 491). The resource dependency approach, Zakus argues, can help to identify and to anticipate organizational impediments.
to participation, in hopes that similar failures can be avoided in future programmes.

The social movements literature

In addition to the resource dependency model and other analytic frameworks for analyzing participation, the 1990s saw the emergence of a literature focused on social movements. The social movements literature examines how culture and politics are intertwined, that is, how they constitute each other; it provides another way to analyze the intersections of popular mobilization and government action in the post-1990s era. Elizabeth Jelin says it was unclear whether participatory movements in Latin America were ‘new’ in the 1970s and 1980s, or were merely a response to ‘the closing of institutionalized channels of participation’ caused by dictatorships, civil war and repression (Jelin 1998, p. 405). Likewise, the return to democratic rule may not have had the salutary effect on participation envisioned by some authors. Jelin (1998, p. 405) says the return to democratic rule ‘implied giving priority to political parties and making a renewed commitment to institution building, a trend that emphasized the construction of institutions within the political system, guided by the logic of “governability”. This effort often clashes with the less institutionalized collective means of expressing old and new social demands, and even with the more participatory pressures in the process of democratization.’ Meanwhile, income inequalities and poverty are on the rise in Latin America. The return to democracy is publicly heralded; support for formal democracy is ‘a hegemonic discourse’, but it is accompanied by the impoverishment of a large segment of the population, caused by inequitable economic relations (Jelin 1998, p. 408).

Jelin’s analysis has interesting implications for participation in health. It implies that participation stalls in conditions in which there is a modicum of civilian participation in public life, in which reformist governments channel dissident voices into political parties, in which formal democratic governments do not need separate participatory initiatives because the presumption is that the entire government is purportedly devoted to democratic participation, in which people have not (yet) organized themselves against the apathy and disillusionment that accompanies the spiral into deeper poverty.

Poststructural critiques of development published in the 1990s also provided new frameworks for analyzing participation, the 1990s

The poststructuralist critiques call for close examination of the relationship between historical events and social actions. They might ask, for example, what effect neoliberal policies and increasing privatization of government functions had on participation and community action. Under what conditions do impoverished communities become passive and apathetic? Under what conditions do they mobilize to protest the withdrawal of government services and accountability? How can a discourse such as ‘participation in health’ be co-opted (in a process similar to what Sonia Alvarez described for Latin American feminist NGOs) in ‘a move toward policy-focused activities, issue-specialization, and resource concentration among the more technically adept, transnationalized and professionalized NGOs’ (Alvarez 1998)? The cultural politics of co-optation are also discussed by Eric Dudley, who writes:

‘Participation used to be the rallying cry of radicals; its presence is now effectively obligatory in all policy documents and project proposals from the international donors and implementing agencies. Community participation may have won the war of words but, beyond the rhetoric, its success is less evident. Part of the problem is clearly political. True participation is a threat to powerful and vested interests.’ (Dudley 1995, p. 7)

A poststructural analysis would propose that international donors and development agencies win a major political battle by claiming to understand the many meanings of participation, while at the same time synthesizing those meanings into a single ‘definition’ that goes on to dominate participation discourse. The World Bank example cited at the beginning of this paper shows how an international donor can wield its considerable authority to define participation in self-serving terms.

Thus far, we have discussed trends that affected general participation discourses during the 1990s. The remaining sections of this paper focus specifically on trends related to community participation in health.

The intersectoral nexus

In the years following Alma Ata, participatory initiatives were often directed at primary health care programmes. Analysts quickly realized, however, that community members often defined health broadly. They identified impediments to good health that reached far beyond the health sector to encompass other issues including housing, employment and land tenure (see Asthana, undated; Morgan 1993). Furthermore, donors and governments recognized that they could not resolve many of the most pressing primary health problems without also addressing other aspects of development, including (in addition to the above) education, water and sanitation, agriculture and the environment, and economic development. Nowadays, advocates of community participation in health expect that participatory initiatives directed at one sector will have ramifications in others. Participation ‘in health’ is hardly ever just ‘in health’ (Kalinsky et al. 1993).

Health has never been easily compartmentalized; participation is even less likely to be confined to one developmental...
sector. In fact, some argue that the goal of participation is to ripple throughout a society, having a positive effect on democracy-building. Another consequence of this trend is that ideas about ‘community participation’ and empowerment have captivated the interest of development experts, activists, and educators far beyond the primary care sector. Community participation is now discussed with reference to health education (Cardaci 1997; Arenas-Monreal et al. 1999) and disease control (Manderson 1992; Briceno-Leon 1998). Advocates of the utilitarian and empowerment models agree that intersectoriality is both desirable and necessary.

**Biomedicine as an impediment**

Proponents of both empowerment and utilitarian models also agree that biomedical training and the hierarchical practice of medicine can impede participatory initiatives. John Macdonald offers an extreme rendition of this argument when he suggests that allopathic medicine is by its very nature non-participatory. Doctors are trained to be authoritarian; they are taught to retain the power to diagnose, prescribe and cure (and to target diseases rather than people). Therefore they do not know how to promote participation. Macdonald offers his analysis as a corrective to studies of health participation that focus on structural impediments. While he admits that there is considerable structural opposition to participation, he wants to highlight ‘the great strength of medical opposition to participation which mirrors and in a sense is part of the social and political opposition to a strong PHC [primary health care] with its emphasis on real participation and a move towards equity’ (Macdonald 1993, p. 105).

Macdonald’s analysis is important for our purposes because it offers one explanation for the tension between anthropological and epidemiological approaches. Epidemiologists, Macdonald says, are similarly tainted by the biomedical model that informs their training (see also Blum 1995). This explains why we rarely hear such terms as ‘participatory epidemiology’, which:

‘do not fit with what we have come to understand to be the scope and method of the work of epidemiologists. According to their training, they are ready to analyse data on morbidity and mortality and to suggest correlations and trends. But they have much less preparation in the skills of asking community members about their perceptions of their needs, what they think of the services provided, or the skills necessary to enable the community to be involved in future planning. Western scientific medicine sees the community as the aggregation of the sick or potentially sick individuals in it. It equips its practitioners to diagnose and tell, not to listen and plan in partnership’ (Macdonald 1993, p. 103).

Macdonald tends to exaggerate his case, overlooking the work of social epidemiologists who work alongside community members to define and resolve health problems, and who are committed to health services research and popular, public health education (American College of Epidemiology 1998; McKnight 1999). Nevertheless, his argument could be applied to Kahsay and Oakley’s case for community involvement in health. Their approach is rhetorically sophisticated but programmatically modest. They seize the intersections between participation and health sector reform, arguing that community involvement needs to become a central component of national health systems through intervention with policymakers. This could be seen as a pragmatic response to earlier attempts that placed responsibility solely on community members, when in fact those people rarely had the power to effect dramatic structural change. Kahsay and Oakley, by contrast, turn the onus of responsibility back onto those who control the allocation of resources. Their final recommendations are directed not toward community mobilization, but toward the need to incorporate community involvement ‘principles’ into health sector planning and evaluation. Critics might point out that this makes their analysis similar to that offered by the World Bank, which redefined participatory initiatives to direct attention away from the poor and toward ‘stakeholders’. This approach, while posing less of a threat to the status quo, is fraught with problems and dilutes the transformative potential of participatory rhetoric and programmes (Zakus 1998).

**Pragmatists, activists and the persistent challenge of participation**

Responses to the analytic complexities and persistent challenges of participation a quarter of a century after Alma Ata include both pragmatic and activist proposals. Pragmatists point out that participation has been ‘talked to death’. They doubt there is much new to say about it, yet they note with some urgency that development problems are deeper and more pressing than ever. Dudley says, ‘The challenge is now to get beyond the general principle and determine the practicalities of how participation fits into a larger picture of effective aid for just and sustainable development’ (Dudley 1993, p. 159). The pragmatic response has been offered as a justifiable response to cynicism and disillusionment (see Woelk 1992, p. 419), in spite of charges of utilitarianism. Pragmatists argue that even compromised, utilitarian action is better than the alternatives: to hold onto the romantic hope for a utopian democracy, to give up in frustration, to allow governments and donor agencies to focus on economic growth at the expense of poverty alleviation, or to allow governments to dump responsibility for rural development onto local communities with impunity. Pragmatists favour an approach of respectful collaboration among donors, community representatives, and governments (when possible) to achieve mutual goals. Pragmatic solutions require policymakers, managers and planners to identify the elements critical to success, which include ‘novel ideas and strong value commitments that outside resources could support and make more productive, once a significant learning process is initiated and carried through’ (Krishna et al. 1997, p. 3). Pragmatists are convinced that the poor will be better served by accepting self-reliance as a strategy rather than waiting for government or donor assistance.

In contrast to the pragmatists, activists argue that a sustained commitment to social justice and genuine democratic process
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is more important than ever. In a world ideologically and economically dominated by globalization and transnational capitalism, there can be no excuse for ignoring the underlying causes of the desperate poverty that affects an ever-greater proportion of the world’s population. There is too much at stake in this context for ‘community participation’ to be offered as a panacea for health and development problems. Activists argue that empowerment is essential; it is increasingly important, they say, to identify and dismantle the political, economic and social arrangements that foster increasing disparities between the rich and healthy, and the poor and ill. The activist agenda calls for supporting and strengthening collective political movements that share these goals. Activists do not want to see participation reinvented as a toned-down, moderate form of continuing education for professionals or of small-scale village programmes. They want to retain and strengthen the movement’s devotion to empowerment models, in which conflict is stimulated with the goal of achieving a more equitable distribution of power.

The complexities of participation are better understood today, and the possibilities for pragmatic compromise more widely accepted by a generation of seasoned planners, practitioners and analysts. Yet disagreements about participation persist, to a larger extent rehashing and reiterating the original schisms between empowerment and utilitarian models. Meanwhile, participation continues to be at once alluring and challenging, promising and vexing, necessary and elusive.

Endnotes


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Biography

Lynn M Morgan is Professor of Anthropology at Mount Holyoke College in Massachusetts, USA. She holds a PhD in Medical Anthropology from the University of California, Berkeley and San Francisco. She is the author of Community Participation in Health: The Politics of Primary Care in Costa Rica (Cambridge, 1993), and co-editor of Fetal Subjects, Feminist Positions (University of Pennsylvania Press, 1999). Recent articles about reproductive ideologies and practices in Ecuador and the United States have been published in edited collections and in Ethics: Journal of the Society for Psychological Anthropology, Feminist Studies, and Hypatia: A Journal of Feminist Philosophy. She is currently completing a book manuscript about the social history of human embryo collecting in the early 20th century.

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