Participation and empowerment in Primary Health Care: from Alma Ata to the era of globalization

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Abstract

With the 1978 Alma Ata declaration, community participation was brought to the fore as a key component of primary health care. This paper describes how the concepts of people's participation and empowerment evolved throughout the last three decades and how these evolutions are linked with the global changing socio-economic context.

On the basis of a literature review and building on empirical experience with grass roots health programs, three key issues are identified to reinforce the concept of 'health through people's empowerment': The recognition that power, power relations and conflicts are the cornerstone of the empowerment framework; the need to go beyond the community and factor in the broader context of the society including the role of the State; and, considering that communities and society are not homogeneous entities, the importance of class analysis in any empowerment framework.

Alma Ata put community participation on the agenda

The 1978 International Conference on Primary Health Care reaffirmed the WHO's holistic definition of health as a "state of complete physical, mental and social wellbeing". It acknowledged that gross inequities in health are unacceptable and that it is a state's responsibility to ensure the health of its citizens. To achieve this end, the Alma Ata declaration advocated a concept of primary health care which promoted "maximum community and individual self-reliance and participation in the planning, organization, operation and control". The Conference declaratio[1)] popularized several innovative public health concepts that have continued to influence health care practices and debates to this day. Several authors have described, however, how major trends in the global economic and political environment have not been favorable to these general principles of Alma Ata[2,3]. In this paper we describe how the concept of community participation has evolved since 1978.

The roots of participation frameworks of the 1970s can be found in the ideas on empowerment and liberation developed by Paulo Freire, a Brazilian educator[4]. Freire defined popular education as a dialogue which involves respectful working with each other, rather than one person acting on another. Education is also action oriented. It aims at developing consciousness through education in the lived experience of participants. To this end, the "teacher" needs to transcend the divide with the "learner", which Freire called a 'class suicide' or the 'Easter experience' of the teacher.[5,6]

Community involvement and initiatives to promote community participation flourished in the years after the Alma Ata conference probably in response to the conference's powerful advocacy for primary health care. By the mid-1980s, Susan Rifkin

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could already look back at 200 case studies on community participation since the start of the decade. She identified three different approaches towards the involvement of the community: In the *medical approach* community participation is used by health professionals in order to reduce individual morbidity and improve sanitation. The *health service* approach aims to mobilize people to participate in the delivery of health services, while in the *community development approach*, community members are involved in decisions related to the improvement of the social, economic and political conditions that affect their health.[7]

Community participation in the time of structural adjustment

The development of experiences with participatory approaches was hardly surprising in the 1970's, a time when the social and political environment was relatively favorable for initiatives that challenged the status quo. The Alma Ata declaration itself reflected the global balance of forces at that time.[8] In 1974, the G-77 countries – mainly Third World countries, many of whom had recently liberated themselves from colonialism – had been able to put a New International Economic Order (NIEO) on the agenda of the United Nations. The idea of a NIEO, mentioned explicitly in the declaration, illustrated the G-77's increasing unity and defiance of Western political and economic domination on the world stage.[9]. The conference also reflected the strength of the then socialist world. The Soviet Union, where the conference was eventually held, together with China, played a key role in the declaration's genesis.[10] United Nations organizations such as UNCTAD, UNESCO, FAO, the World Health Organization, the Institute on Transnational Corporations, etc. were reoriented to promote and help implement 'social contracts' in favor of the Third World. In the health field, Alma Ata expressed the existing balance in international relations, one which allowed a progressive agenda – be it with serious limitations[11] – to be pushed through.

Not long after the Alma Ata conference, the Rockefeller Foundation's promotion of "selective primary health care" ushered in the counter-attack. Selective primary health care was touted as a more cost-effective alternative to the allegedly "costly and unrealistic" comprehensive primary health care model.[12,13] Selective primary care immediately stripped primary health care of its community engagement, its commitment to broader social change and its re-distributive vision.[2]

The socioeconomic context of the early 1980s reinforced this move to downplay the comprehensive and radical aspects of Alma Ata. The debt crisis and the IMF structural adjustment programs made the eighties a 'lost decade' for many Southern countries. [14,15] Dependence on foreign loans increased and the international debt burden became unbearable. [16,17]

In this context 'selective primary health care' was perceived as a more realistic approach.[19] Community involvement was likewise seen as a convenient substitute for the retreat of the state in health services delivery. The concept of community participation was purposely limited to cost-sharing (i.e. the imposition of user fees) and the co-responsibility for the organization of health services delivery. Rather than seeking to involve "the people" in defining their own development, 1980s-style community participation largely focused on engaging "intended beneficiaries" in development projects.

Apart from the "cost-cutting" potential of community participation, international agencies also appreciated its potential to act as a palliative neutralizing popular resistance towards imposed "reforms." [20,21]

In reaction to this, authors and practitioners started to stress the importance of empowerment as a process and an outcome. Rifkin[22], for example, opposes the 'target oriented framework' to the 'empowerment framework'. The 'target oriented participation framework', is one in which selected target groups, composed of beneficiaries of the program, work to improve health services delivery. The 'empowerment framework' by contrast mobilizes community members to participate in decision-making, planning, implementation, and evaluation of the program with the (main) objective of empowering themselves. While this empowerment model considers the participation

process important, nonetheless it is the final outcomes, i.e. the redistribution of resources and power in the political process and the increased ability of marginalized communities to control key processes that influence their lives, that are considered even more fundamental.

Empowerment and social capital since the 1990s

After the collapse of the Soviet Union and the Eastern Block, a 'new world order' was imposed in which global power relations became increasingly unilateral. The decade of the 1990s saw international financial institutions dramatically change the definition of their mission, intensifying their interventions in the national economic policies. [23] In the health field, the World Bank took over the initiative from the World Health Organization and became the dominant international institution for health policy formulation. As a result it imposed its neo-liberal vision on the health policies of the poor countries. The Bank prescribed to "invest in health" using (neo)liberal recipes involving privatization and liberalization.[24]

Stabilization policies became permanent features of government policies. Qualitative targets in terms of new legislation, financial and labor market reforms, and privatization of public assets, including health services and social security systems, were now routine demands of the International Financial Institutions[25-27]. These policies further contributed to the unequal distribution of wealth between socio-economic groups. By 1999 the WHO warned that – if public financing for social programs and health were not drastically increased, the global health situation would deteriorate further. [28]

In a context of increasing social end economic contradictions, it is not surprising that the concept of empowerment, which had entered the mainstream discourse of non-governmental organizations (NGOs) and health planners, became more controversial. Mayo and Craig argue that from the perspective of international institutions, most notably the World Bank, community participation and 'empowerment' should be contributing to overall goals of cost reduction for the public sector.[29] Observing that this constitutes a major divergence from original perspectives on empowerment, they rhetorically ask whether community participation and empowerment are "the human face of structural adjustment or tools for democratic transformation."

The international institutions also enthusiastically embraced the concept of social capital, which was defined by Robert Putnam as "norms of reciprocity and networks of civil engagement which are created by participation in civil organizations."[30] Several World Bank experts even heralded it as "the missing link" in strategies of development and economic growth.[31,32] The creation of social capital was seen as one of the pillars, and a prerequisite, towards bringing about empowerment.[33-35]

Putnam's theses on social capital stirred an intense debate as did the use of "social capital" as a determinant of better health. In review articles on prevailing hypotheses about the link between social capital and health, researchers observed that the concept of social capital is used in public health as an alternative to both state-centered economic redistribution and party politics, and thus represents a potential privatization of both economics and politics.[36]. It was likewise criticized that the focus on social capital was tantamount to "blaming the victim" at the community level while the real causes of health problems, that were to be found at the level of macro level social and economic policies, were ignored.[37] Others point out that the concept of social capital is incompatible with empowerment strategies towards health promotion because it presupposes that all community members have equal interests and access to resources, an assumption that is deemed unrealistic given the vast inequalities in health and distribution of wealth.[38] The World Bank's excitement with the concept of social capital is seen as an attempt to 'depoliticize' development, systematically evading issues of context and power[39], and to ensure the necessary social cohesion that should allow the free market to work the magic of the 'invisible hand.'[40]

The new millennium: attaining health through people's empowerment

"Poverty amid plenty is the world's greatest challenge," opens the World Bank's President's

foreword to the 2000/2001 World Development Report.[41] The report accepts poverty as encompassing not only low income but also low achievements in health, education and other areas of development. The Report propelled the Bank to the forefront of the debates on participation and empowerment, as the latter concept is identified as one of the three strategies towards poverty reduction.

Since 2000, empowerment has remained one of the Bank's key research areas. Its influence on the empowerment discourse been as important as controversial. The Bank defined empowerment as "the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control, and hold accountable institutions that affect their lives."[42]

References to power relations and social change are conspicuously absent in this definition, in contrast with earlier definitions by scholars and NGOs. Exactly a decade before, for example, Wallerstein described community empowerment as "a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life."[43]

Recent reviews of the experience with community participation and empowerment since Alma Ata reiterate their importance but also acknowledge that the full potential of community mobilization to improve health and reduce mortality is still to be unlocked.[44]. Hence empowerment and participation in improvement of health services are identified as the most neglected part of Alma Ata.[45].

Discussion

Looking back at the evolution of thinking about community participation and empowerment and their relevance for public health, it is apparent that many issues remain unresolved. Moreover, there seems to be a trend from a more 'radical' interpretation of these concepts, stressing societal change as an objective, towards more 'harmless' understanding that reconciles community participation with the prevailing social order. Based on these observations and our own experience in public health and development work,[46-50] we offer three insights as a contribution to the current debate.

1. Empowerment is about power

First, empowerment is about power. The gradual shift from community participation to empowerment over the decades reiterates the importance of power relations for health and development. Unfortunately, the World Bank's redefinition of empowerment in recent years has obscured this.

Recognizing the importance of power relations in empowerment, health becomes a political and hence conflictive issue. Empowerment is the recognition of the existence of basic rights, and of the need to challenge established hegemonies to assert those rights. It is the recognition of the necessity to foster the capacity to change power relations in society. Morgan[51] pointed out that conflicts can be essential to bringing about sustainable participatory and empowering practices. Instead of avoiding conflicts, she argues, they should be managed well. A recent WHO review on effectiveness of empowerment to improve health likewise concluded that "while participatory processes are at the base of empowerment, participation alone is insufficient if strategies don't also build capacity to challenge non-responsive or oppressive institutions and to redress power imbalances." [52]

2. The State and beyond

If we understand that empowerment as a highly political issue, our focus needs to be much broader than the local community. Pearce and Davey Smith have explained how the social capital discourse has the tendency to focus too narrowly on the community while neglecting the larger social context.[37]

Green considers that, although community action is essential in defining health needs and in areas related to health promotion, only government action can provide the framework within which substantive improvements can be made.[53]. Morgan also emphasizes the importance of the State to ensure the continuity and effectiveness of participatory Primary Health Care initiatives.[54]

In a report to the Commission on Social Determinants of Health of the World Health

Organization, representatives of civil society observed that "*in the current global context that is dominated by the neo-liberal paradigm, the struggles for health, development, and social justice, even in a remote village or slum, are inseparable from the global struggle for a more just world economic and social order.*" [55]

Zakus and Lysack[56] have warned, however, that governments can also 'hi-jack' empowerment approaches. For example, they can view community participation primarily as a means for legitimizing public policy and or as a means for diffusing public criticism and delaying action. Governments can also actively resist empowerment processes since they may be perceived as a threat to established power patterns. In addition, transnational companies and multilateral agencies can be an obstacle to empowerment because of commercial and financial interests.

3. Class heterogeneity

The third issue, the class heterogeneity of the population concerned, is not unrelated to the previous ones. Most communities are stratified and within a community, all people do not have the same values, the same needs, and the same interests. There is, for example, a universally observed relationship between measures of social class and various measures of health outcome, particularly mortality. In addition, people with influence or power can use their privileges and positions at the expense of the community[37,57] in their attempts to cement their own positions and maintain their ranking. The concept of social capital was therefore criticized as mistakenly giving the impression that "we're all in the same boat." [58].

The idea that we're agreeing about the destination but only debate among ourselves how best to advise the steersman of our boat in choosing a route, is flawed. Evans[59] argues that in a community or society the main conflicts arise over ends, not means. These are not only linked to political, gender, cultural and social differences, but are primarily rooted in fundamental conflicts of economic interests in every society.

Occupational social class, or the specific role of social groups in the system of production, has been identified as a strong indicator of socioeconomic differentials in mortality.[60] People's relations to the means of production (e.g. landless wage laborers, rural proletariat) or their role in the social organization of labor (e.g. trade unions) should be an important consideration in any empowerment framework. An empowerment approach taking class analysis into account also contributes to raising the self consciousness of the social position of underpowered groups progressively transforming them into collective agents of social change.

Conclusions

Concepts of participation and empowerment have evolved greatly since the 1978 Alma Ata Conference. Although they have enjoyed the attention of the public health community for the past 30 years, their interpretation has been the subject of continuous debate to this day.

We suggest giving more prominence to the following three principles:

Empowerment is about power. When power conflicts appear, we have touched on the core problem. Conflicts should not be avoided, they should rather be managed well.

Moving beyond the community, to address the society at large.. It is necessary to broaden the horizon of the empowerment discourse to the wider society and to the responsibilities of the State.

Class analysis. The concept of social class and the analysis of the people's economic status are essential when discussing power relations and empowerment.

The renewed attention for the principles of the Alma Ata conference during its 30th anniversary demonstrates that this discussion is still relevant. We believe these concepts can and should be further enriched by more empirical research as only concrete experiences are able to grasp the intricacies and dynamics of social relations.

References

1. WHO. Alma Ata Declaration on Primary Health Care, 1978. (www.who.int/hpr/NPH/docs/declaration_ almaata.pdf)
2. Baum FE. Health for All Now! Reviving the Spirit of Alma Ata in the twenty-first century: An Introduction

to the Alma Ata Declaration. Social Medicine 2007;2:34-41.
3. Italian Global Health Watch. From Alma Ata to the Global Fund: The History of International Health Policy. Social Medicine 2008;3:36-48.
4. Wallerstein N. Empowerment and Health: The Theory and Practice of Community Change. Community Development Journal 1993;28:218-227.
5. Freire P. Pedagogy of the Oppressed. Penguin, Harmondsworth, 1972.
6. Freire P. Pedagogy of Hope. Reliving Pedagogy of the Oppressed. Continuum, New York, 1995.
7. Rifkin S. Lessons from community participation in health programmes. Health Policy and Planning 1986;1:240-249.
8. Navarro V. Neoliberalism and its Consequences: The World Health Situation Since Alma Ata. Global Social Policy 2008;8:152-154.
9. Bair J. From the New International Economic Order to the Global Compact: Development Discourse at the United Nations *Paper presented at the annual meeting of the International Studies Association, Le Centre Sheraton Hotel, Montreal, Quebec, Canada*, March 17, 2004. (www.allacademic.com/meta/p73063_index.html)
10. Cueto M. The Origins of Primary Health Care and Selective Primary Health Care. American Journal of Public Health 2004;94:1864–1874.
11. Navarro V. A critique of the ideological and political position of the Brandt Report and the Alma Ata Declaration. Int J Health Serv 1984;14:159-172.
12. Walsh J & Warren K. Selective primary health care: an interim strategy for disease control in developing countries. NEJM 1979;301:967-974.
13. Werner D & Sanders D. Questioning the Solution: The Politics of Primary Health Care and Child Survival. Healthwrights, Palo Alto, 1997.
14. Payer C. Lent and Lost. Foreign Credit and Third World Development. Zed books, London, 1992.
15. Chossudovsky M. Policing Countries Through Loan Conditionalities. The Globalisation of Poverty. Third World Network 1997;51:72.
16. UNCTAD. Statistical Pocket Book 1989. UNCTAD, New York, 1989.
17. UNCTAD. Handbook of international trade and development: Statistics 1990. UNCTAD, New York, 1991.
18. UNDP. Human Development Report 1992. UNDP, New York, 1992.
19. Newell KW. Selective primary health care: the counter revolution. Soc Sci Med 1988;26:903-906.
20. Leal P & Opp R. Participation and Development in the Age of Globalization. CIDA, Ottawa, 1998.
21. Cornwall A & Brock K. Beyond Buzzwords "Poverty Reduction", "Participation" and "Empowerment". Development Policy, UNRISD Overarching Concerns Programme, Paper Nr 10. UNRISD, Geneva, 2005.
22. Rifkin S. Paradigms lost: Toward a new understanding of community participation in health programmes. Acta Tropica 1996;61:79-92.
23. Fairfield G. Managed care: origins, principles and evolution. BMJ 1997; 314:1823.
24. World Bank. World Development Report 1993: Investing in health. World Bank, Washington DC, 1993.
25. Burkett P. Poverty crisis in the Third World: The contradictions of World bank policy. Int.J.Health Serv 1991;21:471-479.
26. Brand H. The World bank, the Monetary Fund, and poverty. Int.J.Health.Serv. 1994;24:567-578.
27. Petras J & Vieux S. Myths and realities: Latin America's free markets. Int.J.health Serv. 1992;22:611-617.
28. WHO.World Health Report 2000. Making a difference. WHO, Geneva, 2000.
29. Mayo M & Craig G. Community Participation and Empowerment: The Human Face of Structural Adjustment or Tools for Democratic Transformation? In: Craig, G. and Mayo M. (eds) Community Empowerment: A Reader in Participation and Development. Zed Books, London, 1995.
30. Putnam R. Making democracy work: civic traditions in modern Italy. Princeton University Press, Princeton, 1993.
31. Grootaert C. Social Capital: The Missing Link? Social Capital Initiative Working Paper Series No. 3. The World Bank, Washington 1998.
32. Dixon J, Hamilton K & Kunte A. Measuring the Wealth of Nations. Expanding the Measure of Wealth: Indicators of Environmentally Sustainable Development. Environmentally Sustainable Development Studies and Monographs, Series 17. Washington, World Bank 1997.
33. Grootaert C. On the Relationship between Empowerment, Social Capital and Community-Driven Development, 2003. (http://*siteresources.worldbank.org/INTEMPOWERMENT/Resources/486312-1097679640919/think_pieces_grootaert.pdf)*
34. Baum FE & Ziersch AM. Social Capital. Journal of Epidemiology and Community Health 2003;57:320-323.
35. Bebbington A, Woolcock M, Guggenheim SE & Olson EA (eds). The Search for Empowerment: Social Capital as Idea and Practice at the World Bank. Kumarian Press, Bloomfield, 2006.
36. Muntaner C, Lynch J & Davey Smith G. Social capital and the third way in public health. Critical Public Health 2000;10:107-124.
37. Pearce N & Davey Smith G. Is social capital the key to inequalities in health? Am J Public Health 2003;93:122–129.
38. Erben, R., Franzkowiak,P. and Wenzel, E. People empowerment vs. social capital. From health

promotion to social marketing. Health Promotion Journal of Australia 2000;9:179-182.
39. Harriss J. Depoliticizing Development: The World Bank and Social Capital. Anthem Press, London, 2002.
40. Labonte R. Social capital and community development: practitioner emptor. Australian and New Zealand Journal of Public Health 1999;23:93–96.
41. World Bank. World Development report 2000/2001: Attacking Poverty. World Bank, Washington DC, 2001.
42. Narayan D. Empowerment and poverty reduction: a sourcebook. World Bank, Washington, 2002.
43. Wallerstein N. Powerlessness, empowerment, and health: implications for health promotion programs. American Journal of Health Promotion 1992;6:197–205.
44. Rosato M, Laverack G, Howard Grabman L, Tripathy P, Nair M, Mwansambo C, Azad K, Morrison J. qar Bhutta Z, Perry H, Rifkin S & Costello A. Community participation: lessons for maternal, newborn, and child health. Lancet 2008;372:962-971.
45. Walley J, Lawn JE, Tinker A, de Francisco A, Chopra M, Rudan I, A Bhutta Z, Black RE, the Lancet Alma-Ata Working Group. Primary health care: making Alma-Ata a reality. Lancet 2008;372:1001-1007.
46. Council for Health and Development. 25 years of commitment and service to the people, community based health programs (1973-1998). Manila: Council for Health and Development, 1998.
47. De Vos P. "No one left abandoned": Cuba's national health system since the 1959 revolution. International Journal of Health Services 2005;35:189-207.
48. Dilla H, Fernandez A & Castro M. Movimientos barriales en Cuba: un análisis comparativo. In: Vázquez A, Davalos R. (eds). Participación social. Desarrollo urbano y comunitario. 1er Taller de Deasarrollo Urbano y Participación. La Havana: Universidad de La Habana. Facultad de filosofía e Historia / Departamento de Sociología, 1996.
49. Flores L. Health of the People, Health of the Nation, Manila: Council for Health and Development, 2003.
50. Health Sector Palestinian NGOs Network. Siege is leading to a Health Catastrophe in Palestine, Press Release April 30, 2006.
51. Morgan LM. Community participation in health: perpetual allure, persistent challenge. Health policy and planning 2001;16, 221-230.
52. Wallerstein N. What is The Evidence on Effectiveness of Empowerment to Improve Health? WHO Regional Office for Europe, Copenhagen, 2006.
53. Green R. Effective community health participation strategies: a Cuban example. International Journal of Health Planning and Management 2003;18:105-116.
54. Morgan LM. The Importance of the State in Primary Health Care Initiatives. In: The Political Economy of Primary Health Care in Costa Rica, Guatemala, Nicaragua, and El Salvador. Anthropology Quarterly 1989, 3, 227-231.
55. Representatives of the Civil Society to the Commission on Social Determinants of Health of the World Health Organization. Civil Society's Report to the Commission on Social Determinants of Health. Social Medicine, 2007;2:192-211.
56. Zakus D & Lysack C. Revisiting community participation, Health Policy and Planning 1998;13:1-12.
57. Olico-Okui. Community participation: an abused concept? Health Policy and Development 2004;2:7-10.
58. Erben R, Franzkowiak P & Wenzel E. People empowerment vs. social capital. From health promotion to social marketing. Health Promotion Journal of Australia 2000;9:179-182.
59. Evans RG. Health for All or Wealth for Some? Conflicting Goals in Health Care Reform. In: Mills A. (ed.). Reforming Health Sectors. London, Kegan Paul International, 2000, pp. 25-53. (Proceedings of the Eighth Annual Forum on Public Health, London School of Hygiene and Tropical Medicine, London, April 20-24, 1998.)
60. Davey S, Hart C, Hole D, MacKinnon P, Gillis C, Watt G, Blane D, Hawthorne V. Education and occupational social class: which is the more important indicator of mortality risk? Journal of Epidemiology and Community Health 1998;52:153-160.

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