Review

Rhetoric and Reality of Community Participation in Health Planning, Resource Allocation and Service Delivery: a Review of the Reviews, Primary Publications and Grey Literature

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Abstract

Introduction: This paper synthesises reports on community participation (CP) concept and its practicability in countries' health service systems, much focus being on developing countries.

Methodology: We narratively reviewed the published and grey literature traced from electronic sources and hard copies as much as they could be accessed.

Findings: CP is a concept widely promoted, but few projects/programmes have demonstrated its practicability in different countries. In many countries, communities are partially involved in one or several stages of project cycles - priority setting, resource allocation, service management, project implementation and evaluation. There is tendency of informing communities to implement the decisions that have already been passed by elites or politicians. In most of the project/programmes, professionals dominate the decision making processes by downgrading the non-professionals or non-technical people's knowledge and skills. CP concept is greatly misinterpreted and sometimes confused with community involvement. In some cases, the community participates in passive manner. There is no common approach to translate CP into practice and this perpetuates debates on how and to what extent to which the community members should participate.

Conclusion: Persistent misconceptions about CP perpetuate inequalities in many countries' health systems, suggesting more concerted measures towards making a desired difference.

Key words: community, participation, priority-setting, equity, care-reform, developing countries

Introduction

Reforms in the health sector of many countries have been ongoing and have been associated with critical debates on who should take an active part in making informed decisions regarding setting priorities related to resource allocation and service delivery. Of the issues usually discussed critically is how to involve local communities in the reform processes and the role of professionals in which case controversy arises when some observers find the professionals downgrading others considered to be lay persons in the priority-setting process. [1] Community participation (CP) in health is most advocated for providing a mechanism for potential beneficiaries of health services to get involved in the design, implementation and evaluation of activities, with the overall aim of increasing the responsiveness, sustainability and efficiency of health services. [2] Oakley [3] argues that CP should be seen as a fundamental right of the population and that it is a principal factor in the success of development programs, as it allows individuals to choose what they like or don't like. In 1978, the Alma-Ata Declaration organized by member states to the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) set a number of principles to guide the planning, implementation and evaluation of community oriented health programmes. The fourth principle of the latter Declaration stated that "*The people have the right and duty to participate individually and collectively in the planning and implementation of their health care*". [4] The Alma-Ata Declaration required and promoted maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care (PHC), making fullest use of local, national and other available resources, and to this end develop through appropriate education the ability of communities to participate. [5] Thus, CP was and is still viewed as one of the key driving factors towards the achievement of PHC goals. [6]

In light of the latter Declaration, WHO-UNICEF member states had been striving for making the 'CP' concept one of the key elements of their national health policy and development programmes. However, translation of CP concept into practice has tended to vary between projects, programmes, countries and even within and between countries. Persistently the debate has been about what CP actually means and how successful achievements or failures have been. Emphasis on the CP concept is aimed at making health service delivery agents/authorities and local participatory structures become responsive to local people's priority health needs.

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Included in the strategies for promoting CP is the policy arrangement of decentralization in priority setting, financial planning and management at various local government levels. Such arrangements provide a room for allowing both the lay (non-professional) persons and elites or professionals participate in local health management committees or similar teams to set priorities and take responsibility including setting and managing PHC facilities. [7] There is increasing evidence on the formation of health facility committees or boards involving community representatives even though still actual implementation of decentralization strategies to ensure full potential of CP remains limited in a number of countries, especially in the developing world. [8-11]

Review of the literature to synthesize evidence on country experiences with CP and its status in the health sector today and proposals on future research and implementation agenda is so far limited. In this paper, we present a narrative review and synthesis of many (even if not all) of the debates on CP in the health and health-related sectors around the world, emphasis being on developing countries. We finally identify and discuss several agenda for research in relation to CP in developmental programs in the health sector and health-related sectors.

Materials and Methods

Objectives and scope of the review

Commissioned by the Regional Network for Equity in Health in Southern Africa (EQUINET), we carried out the first extensive literature review in 2003 and the objective was to explore, analyse and synthesise evidence on mechanisms for inclusion of community preferences, responsiveness and inputs in health planning, resource allocation and service delivery. [11] Special attention has been to 'what CP means in theory and practice', the link between community and service managers, planners and policy decision-makers at different stages or levels in the health system, and implication of prioritisation or negligence of CP agenda on (or relationship with) on equity in health. Additional evidence was solicited from original experience based on recent original case studies/ research and other authors' review of the literature in attempt to give our readers an update of the status of CP in countries striving to strengthen their health systems through effective health interventions.

Search terms

The main source of studies was from a search of MEDLINE (PubMed) using key word searches.

For the majority of the key articles that were displayed directly after typing the key words using the appropriate search engines, other 'related articles' on the PubMed website were searched, revealing other articles not contained within the original search. The MEDLINE search was conducted using combination of search terms (Table 1), contained in either the title, abstract or key words of the article. The search was configured so that articles were identified that have the word 'health', and one of the terms describing participants (community, public, civic), and one of the terms describing input type (response, participate, preference, input, involvement), and one of the terms describing the processes (plan, service delivery or provision, resource allocation, and priority-setting). These words were shortened with * so that different endings of relevant words would be captured. Note that (community) health care financing was not included as a search term (e.g. user fees, community health insurance), as this was not a focus of the review, although the issue surfaces frequently in the presentation of results. The search was further refined by requiring one of the following geographic areas to be contained within the title, abstract or key words: 'africa', 'asia', 'latin america' or 'south america'.

Table 1: Search terms used to find relevant documents in MEDLINE

Sector	Participants	Input Type	Process Involved In
Health	Communit* Public* Civic*	Responsiv* Participat* Prefer* Input* Involve*	Plan* Service deliv* Service prov* Resource allocat* Priorit*

* was used so that different endings of words would be captured

Selection of articles

Recognizing the enormous literature on this subject of public/popular/civic involvement in planning, resource allocation and service delivery, the present review could by no means exhaust all the ranges of approaches that have been adopted all over the world nor all the studies that have been published in the public health area. For instance, there are many published and unpublished reports covering other important disease related areas such as HIV/AIDS, tuberculosis, malaria, guinea worms, onchocerciasis, lymphatic filariasis, dangue, nutritional problems and many others and non-disease issues such domestic violence and maternal and child health, and environment conservation, sanitation and hygiene as well, which have attracted interventional programs addressing CP approaches.

We, therefore, identified what we found to be relevant articles and base our discussion on these, and as commented by Tenbensel, [12] doing this kind of task sounds ambitious but would be too complex and of dubious value.

The titles and abstracts of the identified articles were reviewed separately by the two authors, as well as 'related articles' identified by MEDLINE. Also, other articles that were agreed upon by the two reviewers as being relevant were sought from various sources (from the websites of the journals with the access of the University of Basel), from the Swiss Tropical Institute (STI) Library, or had been requested through inter-library search and copy of articles from the correspondent (mainly principal) authors of such articles. The articles were entered in Endnote © for cataloguing and bibliography purposes. Other articles were searched later over the internet using Google and HINARI search facilities. We concentrated on articles written in the English language because it is the language we could master easily and better.

Analytical approach

Framework for review

As indicated (Figure 1), a framework developed by EQUINET Steering Committee under the Theme 'Equity and Governance in Health' (in short GovERN) in 2002 was applied with some little modification to evaluate a selection of successful case studies – identifying and analysing underlying factors, proximal factors, and outcomes influencing (or in relation to) CP.

- Underlying factors were been categorized into formal sources (e.g. legal), political sources (e.g. mandates), and technical sources (e.g. recognition by health management).
- Proximal factors have been defined to include things like capacities and attitudes of stakeholders, communication and information flow, mechanisms for community involvement, and incentives for effective functioning.
- Impact/outcome variables from CP were translated in terms of allocation of resources, responsiveness of care, and community knowledge of health.

For example, mechanisms and processes for adjudicating claims, communication systems, resources for outreach, social networks, etc.

(Source: Mubyazi & Hutton [11] designed with reference to Loewenson and Chikurumbirike on 'A Conceptual Model developed by EQUINET / TARSC / CHESSORE /CWGH / INESOR In collaboration with IDRC (Canada), Harare, September 28, 2002

Figure 1: Expanded EQUINET framework for understanding Community Participation in health and other social affairs

Outcomes – real & perceived impact	Health
	Knowledge
	Responsiveness
	Resource allocation
	Participation
Proximal factors	Trust
	Incentives
	Stakeholder capacity
	Community organs
	Functioning of mechanisms & health system*
Underlying factors	Community voice
	Policy documents
	Political mandates
	Legal framework
	Ideological and political frameworks

As the topic under review is robust by itself by covering all the three key dimensions of participation, it was not easy to organize the structure of presentation of our findings. However, we have tried to set the themes under synthesis into subheadings organized by separating the so-called 'rhetoric or philosophy' and reality – *practical experience* in relation to the CP concept while maintaining the same subheadings under each to enable the readers trace the linkage or diversity.

Table 2: Classification of articles reviewed by type of evidence/information presented by authors

No.	Method/Type of Study	Number & % of papers	Papers by type of participation and as % of the 85 papers				
			H-Plann.	Res-All.	GovERN	S-Deliv.	All
1	Experimental	32 (38%)	31 (37%)	23 (27%)	22 (26%)	29 (34%)	17 (20%)
2	Observational, exploratory	47 (55%)	38 (45%)	25 (29%)	31 (37%)	40 (47%)	23 (27%)
3	Review/Discussion	36 (42%)	20 (24%)	27 (32%)	18 (21%)	20 (24%)	15 (18%)
4	Commentary	10 (12%)	10 (12%)	10 (12%)	9 (11%)	10 (12%)	9 (11%)
5	Both methods 1 & 2	12 (14%)	12 (14%)	7 (8%)	9 (11%)	11 (13%)	7 (8%)
6	Both methods 1& 3	3 (4%)	3 (4%)	2 (2%)	1 (1%)	2 (2%)	1 (1%)
7	Both methods 2 & 3	6 (7%)	5 (6%)	3 (4%)	3 (4%)	5 (6%)	3 (4%)

Classification of the published articles reviewed

In order to identify the areas in which CP has been most evaluated, published articles under this review were categorized according to the type of information detailed in each article: health planning, resource allocation, governance, service delivery, or a combination of these themes (Table 2). Furthermore, the area(s) of focus of each study were cross-tabulated with the information source, whether an experimental study, an observational/exploratory study, a review and discussion paper, or an author's commentary.

In light of the framework highlighted above, we have attempted though not strictly following its flow systematically, to shaped our presentation by identifying the projects/programs which have demonstrated some remarkable achievement and some failures in CP based on the documented evidence and their linkage with the theoretical proposition (ideological, political, economic and policy expectations) and the practical experience.

Results

Articles identified

The initial key word search done in 2003 including geographical regions gave 546 articles. Following review of the titles and abstracts of these articles by the two authors, 49 articles were agreed as being relevant for the review. These articles, combined with the articles identified from following up related articles, the reference lists, and contacts of the authors, a total of 85 relevant articles were available for the review.

A brief look at the topic areas shows diverse central foci of the studies, including disease control or disease surveillance, primary health care or health promotion, women's involvement, vulnerable groups, empowerment and preference elicitation, and planning and budgeting. Most of the authors have paid much attention on specific sub-topics – but have at least touched on issues addressed in this paper, including planning, resource allocation, and service delivery.

Table 2 shows the areas in which the authors published in the literature reviewed in 2003 have most concentrated in talking about CP. It has been noted that the greatest interest in the presentations of the CP concept and its application as indicated by primary studies has been on health planning processes and service delivery, although resource allocation and governance are not far behind. Nine out of ten of the commentary articles focused on all the participation processes. The element of governance or leadership in health was given more weight by articles based on observational studies (31 out of 47) than the rest of the methods. Exploratory studies also focused on CP in health planning and service delivery proportionately more than other types of the articles in the presentation of evidence. More specifically, we noted that most of the authors presented articles on CP describing exploratory surveys [47/85 (55%)], followed by review/discussion papers [36/85 (42%)] and lastly those presenting experimental studies [32/85 (38%)].

As indicated (Table 2), the articles developed out of exploratory studies had a focus on CP in health planning and service delivery proportionately more than other types of the articles. Also, as readers can see, the majority of the articles cited are those published in the period between mid 1980s and 2006, indicating that the topic under review has been more prioritized by editors researchers/evaluators and journal editors probably more than it seems the recent years.

The philosophy of 'Community Participation' and debates about the rhetoric and reality

Conceptual overview on CP

The concept CP (sometimes called '*Public or Popular Participation*') could be broadly or narrowly defined depending on the dimension, levels and stage at which the 'participation' is (or has been) considered and the perspective of the interpreters which is influenced by divergent philosophical viewpoints. [7] Just to inform the community about a project to be launched for the perceived benefits could be viewed as CP from other perspectives, but what if they do not actually participate in implementing the project? According to Flower and Wirz, [13] there is a lot of rhetoric about community participation worldwide. In contrast, Abbot [14] claims that there is general impression that the existing interpretations of CP are flawed as most of the talks focus on the failings of community development without capitalising on the successes achieved with CP. This point is partly supported by an argument from other authors. For instance: (a) whether debates about CP in reality are based on technical/professional perspectives or viewpoint of the community concerned is something to be considered carefully because different techniques used to collect public's views about participation may give different results. [15-17]

Although the problem of defining and practising CP in many countries was even recognised by WHO in 1989 continue to be reported by many other authors from different countries, both in the developed and developing world, CP is still valued as a fundamental right each member of the society has in getting

an opportunity to decide what they like and what they don't. Development proponents have noted that local communities including lay persons can participate in decisions related to resource allocation for health in order to make health providers more accountable to the communities they serve. This does not mean that lay people should be only told or directed on what to do even if it is for their own benefit, but should also to be empowered to make decisions that motivate them participate e.g. by giving their labour input, assets, or ideas that are constructive to yield the desired outcomes. This sounds realistic, although the challenging question has been, and remains to be, *what lay participation really means and to which extend should lay persons be let to participate.* [18] Based on the vast literature reviewed as elaborated further below, it can be noted that different authors stress the point that distinction be made between *forced participation* whereby one is more or less induced to participate passively, from *voluntary participation* whereby one is informed and gets a an internal psychological or heartfelt stimulation/drive to get involved in the process.

The question "*what constitutes CP*?" would probably be well answered by looking at areas in which the community has been involved in different countries and how the terms 'community' and 'participation' and 'CP' have been interpreted more or less differently. Before entering into much of the debates, we have quickly observed that different authors view CP as a mechanism potential to bring the general public and planners and other decision-makers such as programme/project managers and policy-makers together in discussion forums and other actions aimed to achieve a common goal such as tackling particular social (public) health problems. In every article reviewed, the authors have identified the apparent lack of a clear general definition of the word 'participation', 'involvement', 'community' and 'CP' which in other scientific disciplines could be regarded as international standard units. At times, participation and involvement are used interchangeably even if they do not absolutely carry the same meaning.

In this paper, particularly in the present section, we highlight only some of most relevant out of the many useful definitions found in the literature. As defined by some authors, the word '*community*' refers to '*a group of people living in the same geographic area with some degree of common interest*' (p7). [7] Madan [19] views that, "*Ideally, community involvement should mean that the initiatives come from the people, and the government and other agencies provide assistance*" (p615). Similarly, Perry *et al.*, [20] contend that, "*Broadly, public participation means 'taking part in the process of formulation, passage, and implementation of public policies [through] action by citizens, aimed at influencing decisions which are, in most cases, ultimately taken by public representatives and officials*" (p16). Other authors emphasize the shifting of power, greater social equality, and collective action. CP could mean the voice of people and empowering the poor to become aware of inequalities and to reform the political and social system through collective action. [7, 21-22]

CP is also associated with empowerment of the society to choose or perform things of their interest. According to Laverack and Labonte, [23] "*Community empowerment denotes the shifts towards greater equality in the social relations of power*" (p255). Promoters of good governance see CP as a key component within the decentralisation policy frameworks. [7-8, 24-25] Under such policy frameworks, CP is regarded as the act of communities taking control of their destiny by understanding the problems they face and how to properly address them in a participatory way. [26] Under the so-called 'Empowerment Framework, CP is considered as giving people power over their health choices… and this is a process whereby communities are strengthened in their capacity to control their own lives and make decisions outside the direction of professionals and authorities. [27] Experience shows that public health strategies including those geared for eradication or control (prevention and treatment) of diseases succeed if there is active involvement of the local communities right from the planning stage. [28-31] This has been demonstrated by projects/programs implemented in different countries, as described further later in the subsequent sections.

As summarised in Table 2, significant performance in working with local communities towards addressing various public health problems demonstrated by projects/programmes have focused on some form of CP in planning, resource allocation, service delivery, or programme evaluation. However, in most countries these projects or programmes have been either in their experimental (pilot) stages or somewhere in the midst of their actual implementation, therefore, limiting their ability to justify their potential successes for the time being.

Participation in health planning

Planning begins at the stage of needs assessment or situation analysis. [32] but it is not always easy to have health care policies created with a full or realistic reflection of community values. This arises from the fact that no single society is made up of single 'community', and therefore the process of sorting out which community values are incorporated into

health care policy becomes inevitable. [33] A number of authors depict that the recognition of CP in resource allocation, for instance, for health is based on the belief that scarce resources would be more equitably and efficiently allocated and accountability to local needs achieved if key stakeholders (including local communities rather than technical/professional people alone) are involved in the priority-setting, project/program implementation and management processes. [6] Where possible, CP should be reflected in the monitoring and evaluation processes in the existing programs/projects. [34-36]

The CP concept in health remains a high political and policy agenda as far as priority-setting scenarios are concerned in both developed and developing countries. However, much thrust for the past thirty years or so has been in developing countries where the resources highly constrained. [6, 27, 37] It is viewed as part of a democratic process in development activities and an indication of good governance. [37-39] Even where decentralization is strictly enforced/emphasized including having local decision-making structures representing the needs of the community, there must be representatives of community (either nominated from the bureaucracy or elected by the community) at district/provincial and national levels. [7]

Furthermore, proponents of democracy insist that CP from the early stages makes the public members develop a sense of being recognised and respected for their potential role to play on development affairs, increases their self-awareness, self-confidence and self-reliance in self-examination of problems and seeking/appraising solutions for them. [40] They also argue that active CP makes it more explicit and easier to identify who currently benefits from the programme and should be targeted next. [11]

CP in decision making is assumed to not only create a sense of ownership among the community members, but also increases the confidence among those working within the community that should there arise the need for the community to contribute their efforts or resources the community will not hesitate to share the responsibility. For instance, Purdey *et al.*, [41] contend that, '*community-based development empowers villagers to develop community cohesion and confidence, increase their ability to identify, analyse, and prioritise their needs, and organise the resources to meet these needs*' (p 329). A similar view was expressed by Greene [29] who argues that "*Communities are deliverers of policy and creators of solutions as well as the context in which problems have to be understood*" (p 110). The growing emphasis on CP in health care decisions arises from the desire to make providers more accountable to the community they serve [4] and unlike the liberitarians' claim, egalitarians argue that health care cannot rest on individual achievements instead it should be approached by society as a whole if equitable access has to be ensured to all populations. [42]

In other experts' view, CP (a) can lead to cost-effective health care interventions because without proper or effective involvement of communities in the so considered novel cost-effective interventions, the program/project goals may not be achieved. [43-44] Krogstad and Ruebush [28] view that although disease control programmes must be based on solid biological foundation, not every biologically effective strategy will be effective as a community-based intervention, and therefore, CP and including education of the community members to participate in health programs are justified because of their facilitation to biologically based interventions and ultimately their impact on effectiveness of these interventions. [45] Other critics argue that the cardinal approach to cost-effectiveness analysis is biased to emphasis on policies directed by professional health economists and medical professions and there is challenged for its inability to reveal how people really want to set health priorities and foster self-reliance or freedom of dependency on professionals [33, 46, 49]; and (b) how it acts as an important means of changing people's attitudes towards the causes of ill-health and to avoid the under-use or misuse of health service resources. [27]

Participation in resource allocation

Some of the authors have viewed CP more pragmatically as a way of mobilising community resources to supplement public sector health services, by mobilising untapped resources in the community through mechanisms such as voluntary contributions of labour and/or finance. [49-53] It is, however, argued that even with high recognition of the importance of CP in development issues including participation in discussion on resource allocation, it is crucial to bear in mind the levels at which rationing decisions are (actually or to be) made because the eventual effectiveness of CP will be determined by its eventual influence on resource allocation decisions at each level, including the (i) national level - e.g. between health and education; (ii) level of commissioners deciding about priorities between services (e.g. disease focus) and between primary, secondary and tertiary care; and (iii) micro levels deciding about priorities within services, including resource allocation between different types of treatments and patients. [54-56]

Participation in service delivery issues

In light of the Bamako Initiative (BI) launched in 1988 under UNICEF's support, the following points have been presented by several authors regarding CP as a precondition leading to the increased control of the health centre: that CP (i) would lead to the development of local skills and competencies which could be used for future community development [52] and could be extended to yield beneficial effects on other aspects of people's lives; [57] and (ii) should be viewed as a 'virtuous necessity' towards improvement of the quality and reliability of health services', enabler of un-bureaucratic employment of local or community staff and allows greater flexibility in executing activities outside normal working hours. [58-59]

Practical field experience with CP

General Overview

In general, evidence on the ability of authorities or existing local structures to achieve a remarkable level of CP in developing countries is mixed, and sometimes controversial, as a number of cases cited below indicate. As countries struggle to achieve the Millennium Development Goals (MDGs) by ensuring effective, efficient and sustainable health interventions, the necessity of CP in planning and implementing health programs remains acknowledged, albeit debate prevails on how to accomplish it due to the noted failures of some programs that have shown little involvement of local communities. [6] Greene [29] depicts the critical nature of the planning and resource allocation, including budgetary systems in any decentralization policy setting, although it is often neglected in most of the developing countries. He depicts the limited nature of decentralisation arrangements in health planning and resource allocation contrary to policy advocacy of many developing countries. Kinnunen *et al.* [60] also observe that, '*although prioritisation has been a much discussed topic both nationally and internationally, there is a general lack of studies based on empirical evidence*' (p 218). This implies that the studies that have examined the link between health planning (needs assessment and budgeting) and actual resource allocation processes and their equity implications are still few.

While Fowler and Wirz (2002) hold that there is a lot of rhetoric about CP worldwide, other analysts argue that it is increasingly becoming evidence that CP is a central feature of the `new public health' as it has proven to be a powerful component of the programs that have been successful, in both developed and developing countries. [34] A recent report from a multi-country study of community directed interventions for major public health problems in Africa establish that evidently the role of the community has been great since community members have: (i) collectively discussed health problems and possible interventions/ solutions from their own perspective taking into account relevant community knowledge and additional information provided to them. This includes whether they decide the health intervention to be delivered at community level, when and whether they are ready to take some responsibility in resource contribution and execution of the intervention(s). [61]

Drawing experience from Australia and other countries, Davis [37] observes that even in developed countries like England, CP is widely used in the design and delivery of government services and policies and local priority-setting, but has often not been translated to the involvement of communities in resource allocation decisions. Sometimes CP is seen to work through community representatives democratically elected under decentralization arrangements, but turns out to be less realized in practice due to loss of accountability on the part of the community representatives. [10] In addition a summary of the evidence regarding CP cited from the literature reviewed previously and in Annex Table 1, [11] it seems that achievement of CP depends mainly on the condition '*if well implemented*, but the question remains '*how to implement it well?*'.

McIntyre and Gilson [62] observe that the traditional policy goal of many countries since the Alma Ata Declaration has been to attain equity in health-care resource allocation by ensuring universal coverage of health services under the notion '*equal access for all*' to a uniform set of services. However, as they argue, this policy ambition runs a risk of maintaining the existing levels of relative disadvantage by ignoring the differences in the current levels of service availability and differential levels of need between geographical localities and population groups especially in large, multiethnic and multiracial countries like South Africa and Brazil.

Participation in health planning

Variations in the meaning of the term 'community' apparently contribute to limit community CP in health development issues including planning processes. In England [63] and Canada [64] for example, difficulties emerged in terms of choosing the right mix of people to represent the community. Experience shows that while the wish may exist on the part of the health

system representatives or bureaucrats to provide for involvement of the community in participatory processes. A number of analysts/authors, as cited by Mubyazi and Hutton [11] this occurs due to several causes or factors such as: (i) a lack of a common approach on how to involve such communities and this occurs partly due to lack of knowledge among the officers responsible for planning and management systems on the approaches or models for ensuring effective participation or their commitment. The latter point includes the bureaucrats and medical professionals not being in favour of translating the concept of community participation into practice, for example, politicians and professionals feeling vulnerable when their muddled thinking and inadequate evidence-base are exposed to external scrutiny; (ii) gender imbalance and neglect of women and other minority groups; (iii) difficulty in choosing appropriate mix of representatives to ensure public views are incorporated in decision making; (iv) Overemphasis on cost-effectiveness and efficiency as selective approach to planning, resource allocation and delivery of PHC; (v) Communities being given a chance to express their needs/preferences, but not necessarily coming up with the same interests or sometimes the community capacity to contribute to public health decisions being low or absent even if they wished to; (vi) Personal time expenditures, information compilation and dissemination limit involvement of community members; (vii) Complexities resulting from communities being heterogeneous both in terms of demographics and interests; (viii) Community representatives such as community health workers may not be capable to serve the community in the right way; among others.

As community-based or community-directed interventions are perceived to offer prospect for future achievement of the goals both in terms of processes and outcomes/outputs as well as for the sustainability of programmes, conclusions cannot be drawn obviously regarding which interventions should involve the community successfully. [65-66] In some countries, low CP was precipitated by local health committees seem to have been contributed by district level managers undermining or questioning the ability of local community leaders to represent their people at district council meetings. [9, 67-68] In Mukono district, Uganda, weak planning approaches and social, economic and cultural barriers to public participation in priority setting had been observed, [69] the experience that has been shared by other countries. [43] In The Philippines, municipal health officers disliked devolution because of the local government units falling to salary increases and other benefits as per the law, while departmental health representatives opposed devolution because their own positions were not devolved. [66] From the Republic of South Africa and Zambia, Gilson *et al.* [46] report a tendency to exclude non-elites in the policy-making process despite potential trends of governments' initiatives to involve all the key actors. Evidence from Honduras indicates that although there has been some systematic organisational forms of CP in the user fee system with the aid of local community health boards, municipal health committees and *patronato* health committees, there emerged conflicts in interpreting the decentralisation policy between the among the different departmental officers and between such officers and the community. This has been a result of lack of mutual interests. [70]

Given a chance to set priorities the community can suggest even though not all their suggestions can be taken in wholesale. From Uganda Community Directed Treatment with Ivermectine (CDTI) Project resulted into notable achievements by mobilising local communities to suggest how the drugs should be distributed and stored, in selecting local health workers and in meetings to evaluating the Programme. [71] Similar experience has been reported from case studies in other African settings involving the interventions addressing other public health problems such as malaria, tuberculosis, and vitamin A deficiency. [61]

Participation in resource allocation

A good example of CP in resource allocation in the field of health financing is given by the case of community health funds (CHF) and community insurance schemes implemented in several countries [72] or 'mutuelles de santé' in francophone Africa. [26, 73-74] Thus, the implementation of cost sharing schemes in several countries through health-care user fees and community-based prepayment schemes, for instance, in Africa and Asian countries, is acknowledged for having had significantly benefited from effective CP in setting priorities for the services. This has been demonstrated when it comes to the issue of allocation of the revenue collected under supervision by local health committees which in most cases have been elected by the community members. [7, 50] Celedon [75] report from Chile, however, reveals that community health financing schemes have been introduced prior to adequate consultation of the communities and without putting in place some instruments to enable the local people to manage the schemes. This experience supports the observation by Brownlea *et al.*, [76] that, '*participation may be seen not so much as influencing the decision, but rather more achieving a platform for the acceptance of a decision already made elsewhere in the system*' (p 605).

Another experience supporting the latter contention is from the Bamako Initiative (BI) programme which has been criticized for its 'top-down' approach on user fees as being the most conspicuous element in government's health reforms, especially in sub-Saharan Africa (SSA) whereby implementation has not been truly community-based. [77]

Supporting observations presented by other authors based on field experience, Atim [26] adds that voluntary community-based health insurance schemes have failed to reduce inequity in access to health services and to show their potential for protecting the poorest groups in the society, despite their achievement in resource mobilization through CP. This observation is supported by the evidence from the Bamwanda Health Insurance Scheme in the Congo and similar schemes in Ghana and Cameroon. [27] The design of the scheme matters as it may affect the ultimate achievement of the goals. According to Gilson *et al*., [46] failures in community financing schemes have partly been rooted from their poor design and limited dissemination. In addition, other authors depict that although CP in cost recovery programs is viewed as a mechanism through which governments or agencies running health care programs can realize some savings, it is evident that this is unlikely to happen if the community itself does not appreciate (perceive positively) the quality of care and if they lose trust in the local representative structures such as health facility committees or existing service providers, as recently reported from Tanzania. [78-79]
In Uganda and Sierra Leone, [80] community involvement in construction or renovation of health buildings has been remarkably noted as in other developing countries under support from government authorities and/or bilateral and multilateral agencies including international non-government organizations (NGOs). Thus, the bilateral and multilateral agencies offering foreign assistance to developing countries have been directing their budgets to aid toward improving the quality of governance in the recipient countries, including their emphasis on CP as crucial element of the wider development perspective toward achievement of equitable allocations and utilisation of health resources. [11, 81]

Among other projects reportedly to have shown remarkable demonstration of CP, but have not been cited in Table 2 above is the Participatory Hygiene and Transformation Project (PHAST) implemented in several countries of East and Central Africa. [82-84] Under PHAST project, a participatory consultative process has been employed with the aid of local health committees through which local populations have been sensitised and actually volunteered their labour and out of pocket payments to supplement Project budget allocated for various activities such as constructing of water wells. They have also been involved in the planning and evaluation of PHAST performance and this is due to strong government support through the ministries of health, agriculture and natural resources that has been appreciated both by the PHAST staff and the communities in the respective countries.

Among other shortcomings reported in the literature on CP experience include the issue of the seemingly maintenance of the traditional style of most priority setting. This includes resource allocation decisions in public health sectors being over-driven by economists, medical personnel, and epidemiologists and other professionals in the justification of efficiency in resource allocation or cost-effectiveness of public health interventions. [1, 85]

Participation in service delivery

There is mixed experience from actual CP in making decisions related to resource allocation. Positive field experiences demonstrate that development projects in which local people are actively involved prove to be more successful, [43, 53] as supported by field-evidence from a number of countries in SSA. [65, 86-92] In several countries, also CP has been demonstrated by introducing cost-recovery programs involving local health committees and has shown their potential for being responsive to the preferences of the local populations in terms of the health services needed, hence leading to a positive effect on the acceptability of the cost-recovery program. [26, 93-94] In Australia and other industrialized countries community preferences have even been accounted for in transplantation organ allocation decisions, [95, 96-97] as in other resource allocation priority setting towards achieving equity [4] and it is not uncommon for the patients and clinicians to share decisions regarding how to deliver certain medical care services. [81, 98]

Discussion

In light of vast literature-based evidence and arguments presented above, we acknowledge that CP in health is internationally advocated for its potential advantages to community-oriented initiatives. However, the possibility that programmes or organisations are able to gain much from CP depends on numerous factors that are partly systemic and partly socio-culturally and economically contextual and not all being easy to control or predict. We agree with Achoki *et al*., [99] that CP should not be seen as enough to solve the existing health problem involving a particular intervention

program, other systemic factors need to be addressed as well. The review has established a range of definitions and approaches employed in relation to CP and comes to our observation that due to the multifaceted nature of many health problems whose control requires a broad range of methods, it becomes obvious that even the way the members of the public can be involved in tackling such problems are diverse.

The point raised by a number of authors that the ambiguity and lack of a common definition or interpretation of the concept 'CP' contributes to low CP in practice in many countries, is true. This suggests a common definition of, and objectively clear ways to arriving at, CP in reality. What is important is to have mechanisms in place that can make people themselves feel to participate rather than being forced. It should be borne in mind that possibly even with strong persuasions to communities to ensure they participate in development issues, their traditional beliefs and cultural lifestyles may influence some community members not to decline against participatory approaches proposed by professionals or pressure groups such as NGOs. Therefore, it is suggested that mechanisms for motivating the public to participate should be devised to help find out solutions to social, cultural and economic barriers that discourage them. [69, 100]

The 'CP' concept may confuse professionals who please themselves being final to make decisions on behalf of the population around them as they feel being part of the community (society) in which they live. It is not strange to find people debating among themselves on the terms 'involvement' and 'participation' as meaning different things. [19] In our view, CP can be described in terms of *actual* community involvement which ranges dramatically from relatively passive involvement in predetermined activities to full actual control of organisations or affairs. In its passive form, it is the community may wait to be approached/intervened through, for instance, 'community outreach'. In most cases, 'CP' should be used in recognition of input required from the community whether the concerned persons are laymen or professionals as long as the objectives can be achieved. Therefore, we stress that CP defined whatever way one defines it should touch on elements such as *the desired informed involvement of members of public in development programmes/issues, and the word 'community' represents all members of a given society irrespective of their gender, level of education, profession/occupation background, race, ethnic origin, or other distinctive classes*. By the term informed 'involvement' or 'participation', we are referring to a situation whereby individual or group members of the general public (society) are consulted to contribute their ideas, efforts or material resources in support of an initiative oriented to yield benefits to the public as a whole or to specific members of the public (such as disease vulnerable groups, the disabled, the poor, the elderly, immigrants, and other disadvantaged). We agree with the fact that the failure and success of priority-setting processes, including the issue of CP in real world practice is an outcome of the way the concept CP within a priority-setting framework is interpreted. [101]

In connection with the latter point, we can see the relevance of the statement made by Sibbald *et al.*, three years ago that "*Normative approaches tell us what ought to be done, empirical studies tell us what is being done, and we are still left with a lack of consensus on an appropriate approach to successful priority setting. There is a need to define successful priority setting, to provide a common language, and to come to some agreement on conceptual basis for the concept*". [102] Thus, the issue of what stage or level in the health system should members of the public (community) be involved is a critical one since it does not make sense to make policy prescriptions at a higher level and let the community swallow (implement) them with little motivation to do so and eventually narrowing the chances for the expected outcome to be realized. Even though the non-medical community members may not know the right prescriptions for a particular disease, they may be important in deciding *how*, *when* and *where* certain services relating to such prescriptions can be delivered. Even conclusions or inferences derived from cost-effectiveness analyses of particular health interventions normally conducted based on randomised controlled trials are likely to remain arbitrary if the social dimension of community preferences including the way they would prefer the intervention services to be delivered are underrated or ignored.

Conclusion and research and policy options

Based on this wide review of the literature, we have noted some good as well as some bad evidence on CP approaches in different countries. Most authors analysed CP in health focusing mainly on one or selected dimensions of participation and this signifies a difficulty in undertaking a comprehensive analysis on this multi-dimension concept. Many authors concentrated on discussing the mechanisms available for inclusion of the expressed public preferences and priorities in health programmes while a few others evaluated the actual CP schemes whether being in the pilot phase or that part of ongoing national development programmes or individual project life cycle. The debate on CP prevails due to lack of a universally accepted and correct definition of and approach to CP, but as Ubel [33] suggests

that perhaps finding out a universal approach could not be necessary, as the existence of different approaches allows the strengths and weaknesses of each approach to complement each other.

We also agree with other authors who insist on the need for keeping in mind the key elements for good CP because if these elements are not put into practice through the appropriate channels and mechanisms, it will all be for nothing. Using a wrong approach could even lead to counter-productive effects upon the society concerned, for example, reducing feelings of trust and solidarity, access to the poor, or the resources available for health. Despite many alternative approaches for CP widely documented in the literature, it is imperative to consider that each of these only works under certain circumstances or with other pre-existing factors (e.g. political support, laws supporting governing bodies, and community interest). It is a challenge to the researchers and policy makers that knowing which mechanisms are appropriate is not obviously simple as it requires an in-depth knowledge of the country as well as the local (community) setting, even down to the very individuals that make up the community and their positions or role within it. As illustrated in Figure 1, establishment of new participatory mechanisms that likely to be effective for a particular community context would essentially depend on analysing first the capacities of that community, the current mechanisms operating in the health and other sectors, and the traditional roles of the State (including the legal framework in place) and the community.

Moreover, it is crucial to avoid mechanisms that could enforce communities to participate suddenly or 'over night', as this may not only lower their motivation, but also it may take years for them to get right on the track by building the necessary capacities and to realize the anticipated benefits or positive outcomes. Also, there must be a careful balance of power between the health providers' representatives (e.g. medical and paramedical staff, administrators, planners and managers) and the community members for which the health system or health programme is intended to benefit. The community may be competent to know their true needs, but may not have the technical expertise for identifying the best way to meet such needs. For example, in some if not most situations communities prioritise services that are *not affordable* or *not cost-effective* to them and/or to the health system, and in this case some expert guidance (*professional know-how*) and over-ruling becomes crucial to show the way forward.

Furthermore, we do support suggestions by Chabalala [103] and many other authors as acknowledged by Rifkin [70] that there is need for more work to operationalize further the concept 'CP' while recognising the actual experiences of limitations of schemes implemented by outsiders and with external funds. It is important to identify and counteract the forces working against CP, and this may include analysis of the extent to which bureaucratic, systemic and social-cultural legal elements/factors such as those listed in Figure 1 have promoted or inhibited the achievement of CP. We also agree with a statement given by Subrahmanian [39] that, '*Even where preferences are picked-up through participatory processes, they would not necessarily have an impact on the way services are managed, hence upward feedback must be strong, and control over decision-making sufficiently devolved to translate preferences into systematic change*' (p 74). It is important for the designed health interventions to contribute achievement of the MDGs especially in developing countries' health systems that are predominantly weak [104] and this can be achieved if further research is undertaken involving communities on how the existing gaps can be bridged. This review in part responds to a call made by Tenbensel [12] who among other things suggested that 'the most important clues for best practice could be from an analysis of existing practice instead of simply trying to devise best practice from first principles. Thus, the present review brings together a synthesis of many (even if not all) of the debates found in the literature as well as experience in CP in health and allows the identification of a research agenda. Commends be given to the prevailing advocates of CP including a wider development community and agencies who consider the full involvement of community as a key means of improving governance including the equitable allocation and utilization of resources in the health sector. [11]

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Authors' contributions

Both authors worked on the extensive literature review while working together in Switzerland and on writing the report submitted to the Regional Network for Equity in Health in Southern Africa (EQUINET). Thereafter, GM (PhD) set the first draft of this MS and received substantial comments from GH (PhD). At the time of conducting the work, GH was at the Swiss Tropical Institute. The two authors are health economists and policy analysts.

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