

LONDON
SCHOOL of
HYGIENE
& TROPICAL
MEDICINE



Rifkin, SB (2003) A framework linking community empowerment and health equity: it is a matter of CHOICE. *Journal of health, population, and nutrition*, 21 (3). pp. 168-80. ISSN 1606-0997

Downloaded from: <http://researchonline.lshtm.ac.uk/15166/>

DOI:

Usage Guidelines

Please refer to usage guidelines at <http://researchonline.lshtm.ac.uk/policies.html> or alternatively contact researchonline@lshtm.ac.uk.

Available under license: <http://creativecommons.org/licenses/by/2.5/>

A Framework Linking Community Empowerment and Health Equity: It Is a Matter of CHOICE

Susan B. Rifkin

*London School of Economics
London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT, UK*

ABSTRACT

This paper presents a framework to explore the relationship between health equity and community empowerment. It traces the progression of the concept of participation to the present term of empowerment and the links among empowerment, equity, and health outcomes. It argues that the relationship can best be described by using the acronym CHOICE (Capacity-building, Human rights, Organizational sustainability, Institutional accountability, Contribution, and Enabling environment). Based on the concept of development as freedom put forward by Nobel Laureate Amartya Sen, the paper describes how each factor illustrates the relationship between equity and empowerment in positive health outcomes, giving appropriate examples. In conclusion, it is suggested that these factors might form the basis of a tool to assess the relationship between equity and empowerment and its impact on health outcomes.

Key words: Empowerment; Health equity; Community participation; Health outcomes

INTRODUCTION

In the field of healthcare, the principles of equity and participation, over the past five decades, have been increasingly identified as key factors for health improvements. The recognition of their importance was confirmed by the Alma Ata meeting in 1978, sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) when primary healthcare (PHC) was ratified as the health policy of all member nations of WHO (1). In the PHC strategy, it was argued that health improvements were not merely the result of biomedical and technological advances. In a study undertaken by WHO and UNICEF in 1974, examples showed that both at national and 'grassroots' levels, a focus on the poor and community participation in healthcare also contributed to positive health outcomes. This study provided examples from 10 case studies covering a range from the national health programme of

the People's Republic of China to a small Christian programme in Indonesia to illustrate the importance of equity and participation (2). Data collected by WHO gave evidence that addressing the problems of those most in need and of involving intended health beneficiaries in decisions about how to solve these problems made a critical contribution to health improvements.

In re-defining health problems in a context wider than only disease problems, the PHC strategy recognized that health is rooted in the social, political and economic environments. The PHC strategy set forth a vision of health improvements that was considered revolutionary because: (i) it gave priority to the health problems of the majority of the world's population who were poor and rural and (ii) it questioned the total dominance of professional people in identifying ways to improve the health (3). Although PHC still remains the stated health policy of WHO member nations, the strategy still struggles to be implemented. Most governments pay lip service to equity and participation (now often reconceptualized as empowerment as will be explained in the next section). However, resource allocation and policy concerns remain rooted in a model of health that sees health as the absence of disease (3,4).

Correspondence and reprint requests should be addressed to: Dr. Susan B. Rifkin
Flat 5, 63 Haverstock Hill
London NW3 4SL
UK
Email: sbrifkin@tiscali.co.uk

Despite reluctance to shift views about healthcare, growing evidence and interpretation of this evidence support the more radical PHC approach (5-7). Two recent publications have made major contributions to the explanation of this relationship. Although these neither focus directly on the relationship between equity and empowerment nor its impact on health outcomes, these provide the wider context in which this link can be established. The first is the World Bank's World Development Report 2000/2001 titled "Attacking poverty", which pulls together data describing the situation of the poor and identifies three areas for policy action by national governments (8). One area is empowerment (and the other two are opportunities for improvements and security).

The second publication is written by Nobel Laureate Amartya Sen. In his work titled "Development as freedom", he gathers data to show the link between equity and empowerment (9) and argues that oppression and deprivation are the results of constraints on opportunities to develop individual capacity. The lack of freedom limits the choice of people to act in their own best interests and those of the society. As an example, Sen quotes Bauer who sees economic development arising from a range of choices. Choice enables people to realize their full potential (10). The major reason why this potential is limited, at the present time, is inequity in distribution of resources and opportunity, and also the weak or non-existing mechanisms to allow people to engage actively in decisions about resource allocation and to insure that consensual decisions are transparent and carried out.

How can recent concepts and practices help us better understand the value of the PHC strategy for health improvements? The purpose of this paper is to present a framework that identifies areas to examine for assessing the influence of equity and empowerment on health outcomes. The concept of choice gives a context in which to pursue this purpose because it helps us look at the evidence that suggests: good health is a result of social, political and economic factors and medical interventions. The framework is a first step towards developing a tool to enable policy-makers and programme managers to pursue and develop the PHC strategy aiming at making health improvements substantial and sustainable for the majority of people.

The first section of this paper briefly reviews the theoretical underpinnings of equity and empowerment

in relation to health outcomes. The shift of the concept of participation to the broader concept of empowerment is discussed. Empowerment is then linked to equity in the context of health outcomes. To expand these ideas in the next section, Amartya Sen's views of choice are used by turning it into an acronym (CHOICE), and case studies are also used for illustration. The work of Sen helps focus on the active processes of change and transformation rather than merely static outcomes for health improvements. In conclusion, how the framework might contribute to the development of an assessment tool and why CHOICE is important to pursue the PHC strategy are discussed.

THEORETICAL UNDERPINNINGS

Empowerment

In the 1990s, the term 'empowerment' began to replace 'community participation' (11). Empowerment has conceptually evolved from the idea of lay participation in technical activities to a broader concern of improving life situations of the poor. This evolution can be traced historically in the areas of policy and in community activities. In the policy area, Rifkin proposes that three theoretical constructs can be identified to trace the changing view of participatory approaches from consensus building to empowerment (12). These correspond to the political and economic environment of the time. These are described below.

Community development construct: The first one is the community development construct that came out of the Anglo-French traditions of supporting people in their former colonies and in the industrial world out of problems of the urban poor (13). Participation came on to the social development (health, education, and welfare) agenda in the post-World War II period. It was seen as a way of addressing problems of poverty among the majority of the world's populations. Its early focus was on improving living and health situations for the poor in both urban areas of the industrial world and so-called developing countries struggling with poverty, lack of resources, and decolonization. This construct assumed that communities were homogenous and were able to agree upon health actions when professionals educated and supported their efforts (13,14). It could be argued that its underlying principle was to keep the status quo so that the links between the ruling elite and those they were to serve could continue smoothly.

People's participation construct: The second, the people's participation construct, was a response to the weaknesses of community development construct. By the 1960s, it was clear that the answers to poverty and health improvements could not be found in merely mobilizing communities. The assumption that communities were homogeneous—wanting the same things at the same time proved to be false (15). Problems of poverty, it was pointed out, were problems of inequities caused by the skewed social structures. The United Nations, under the term 'people's participation', focused on changing social, economic and political structures in order that the minority that commanded resources would share the decisions about allocations with the majority (16,17). Indirectly addressing power relationships, this construct advocated the need for structural changes in the existing political system.

Empowerment construct: The third is the empowerment construct that began while the 'people's participation' construct was still dominant but came to the forefront with the fall of the communist states led by the Soviet Union. During the 1980s, the global economic crisis and the increasing global information system began to moderate aspirations of the 'people's participation' approach. The changing environment focused the interests in participation on providing environments whereby local people would be able to manage their own lives rather than attacking the structures that kept them impoverished (18,19). Addressing the issues of poverty alleviation, the emphasis was placed on transforming individual abilities and aspirations, shifting the concerns from revolution to empowerment. The empowerment construct emphasized individual and collective (community) actions focused on capacity-building and shifts in power and control of decisions and resources.

Cornwall traces the conceptual development of empowerment in addressing problems of poverty alleviation focused on activities and views of community people (20). She notes that the terms applied to those in poverty-alleviation programmes were developed to address changes in historical periods parallel to those Rifkin has described. In the 1970s, popular participation aimed at involving people in projects that were intended to benefit them. In the 1980s, participation was operationalized to address issues of efficiency, sustainability, and effectiveness for supporting development issues.

At present, much of the focus of both community participation and empowerment is placed on participatory

approaches. Under the umbrella of Participatory Learning and Action (PLA), these approaches promote a process that enables intended programme beneficiaries to define, implement, monitor, and evaluate programmes of their choice. The theory and practice of PLA, based on the work of Robert Chambers (21), (i) recognizes the ability of the non- or poorly-educated people to make and carry out rational and successful decisions and action that were formerly the responsibility of experts; (ii) allows innovation to be spread by peer groups not only by professionals; and (iii) brings about a role reversal where local people become colleagues of professionals, thereby generating a change in attitudes and behaviours of the professionals. Using visualizations, role plays and draw and write techniques as the basis for generating information, PLA has been used in a wide range of situations for supporting empowerment goals (22). While participatory approaches are not a panacea to social and health development (23), these do go a long way in addressing both principles of equity and empowerment (24).

The historical development of the concept of empowerment helps explain why there is no universally-accepted definition of empowerment (25,26). Although it means different things to different people, countries, and cultures, the concept does share certain common characteristics. These include the following: (i) it applies to the individual and the collective/community; (ii) it addresses the issue of power and control over resources and the direction of one's own life; (iii) it addresses issues of capacity and confidence-building of both individuals and communities; and (iv) it sees active participation as necessary but not sufficient contribution.

The literature gives evidence of the terms 'participation' and 'empowerment' being used interchangeably. However, arguments have been made that this is a misconception.

Gita Sen states that empowerment cannot happen without creating the conditions for transformation inherent in the concept of empowerment (27). For example, people can participate in bringing children for immunization without having any change of attitude or behaviour about using health services. Laverack and Wallerstein put forward the proposition that the difference in the two concepts is in the agenda and purpose of the processes (28). Empowerment explicitly addresses the issues of social and political changes and looks at liberation, struggle, and community activism. It confronts the issue of power. Participation does not necessarily do so.

In the field of health, empowerment is often seen as an intervention rather than a political process (29). This view tends to stress empowerment as a linear process that can be reached through a proscribed set of changes and avoiding the issues of conflict and control. A recent article titled “Community empowerment paradigm drift and the primary prevention of HIV/AIDS” is typical (30). It focuses on level of community participation and on capacity-building and does not discuss the very real prospect that these issues can and often do lead to confrontation between lay community people and professionals/planners.

Pursuing empowerment, thus, raises a critical question for planners and policy-makers: Can people and/or communities be empowered by those who are outside or can only people and communities empower themselves? It has been pointed out that if those who have power initiate actions to give power to those who do not have it, is this not an attempt powerful to keep control of the process and thereby remain in power? (31). It is argued that power cannot be given to those without power (22,27). The process of empowerment is that of having the powerless take control and exercise power from themselves.

Despite inherent difficulties in definition, in the literature, empowerment as a concept has slowly begun to replace participation. The shift has taken place partly because empowerment highlights the importance of capacity-building among individuals, partly because it fits well in the current socioeconomic and political environment which stresses privatization—a shrinking role for central government, a wider contribution to welfare from individuals, and individual choice.

Equity

Equity in health refers to addressing differences in health among groups of people that reflect unfairness and that are avoidable (7). It is rooted in the discussion of social justice expanded in detail by Rawls (32). It continues to be a foundation for both conceptual and practical concerns of equity.

There is an extensive literature on equity and health outcomes. The work of Sen on famine and of Wilkinson on the health effects of inequality are two of the most influential conceptual writings (33,34). Recent investigations into the results of inequity in health outcomes include the work of the Rockefeller Foundation (7) and its supports of country teams engaged in developing and testing Equity Gauges.

On the conceptual level, the links between empowerment and equity are explored in the writings of Aday (35). Defining three models of justice—deliberative justice, distributive justice, and social justice—she suggests that the first model focuses on this linkage. The model describes how healthcare is underpinned by community participation and empowerment in the design of social and health programmes. It relies, among others, on the work of Labonte, Green, and Robertson and Minkler (36-38). It advocates the idea that health programmes are judged to the extent to which the intended beneficiaries are involved in shaping the programme.

Despite its conceptual strength, evidence to support the importance of deliberative justice is not so strong. One reason is that, although the concept demands a shift in decision-making and power from professionals to lay people, there are very few experiences where this has actually happened. However, an area where the potential to expand the concept is found exists in programmes where professionals and lay people form partnerships. These are emerging in the areas of managed care and in areas where behaviour change is crucial to improvements, such as child abuse, high-risk pregnancies, and victims of violent crimes. The success of these approaches will depend on seeing: who profits and who does not from the partnership; are issues of equity truly addressed?; and how does conflict get resolved in the partnership?

This approach has been advocated and supported through case study evidence published in the *Lancet* (39). The authors argue: the conclusions of the studies they presented are that intended beneficiaries of programmes need to be able to negotiate their inclusion in the health system and demand adequate care. Their evidence argues that:

“For public health to succeed, it must be re-crafted in a framework that locates organised and active communities at the centre as initiators and managers of their own health. In this paradigm, non-governmental, governmental, private sector, and international stakeholders form the periphery—listening to and learning from the people, then, discussing and making decisions jointly” (39:845).

Aday argues that, although the model of deliberative justice is the least developed and the hardest to assess, it presents a challenge to public health and the health service research community to incorporate this innovative concept into a solid contribution to benchmarks of fairness in healthcare (35). Evidence that this challenge is worth pursuing is presented in the next section of this paper.

In summary, empowerment and equity are the twin pillars on which the PHC strategy rests. There is increasing evidence and discussion about their influence on health outcomes and a continuing search for assessing their impact. Their importance has been highlighted and documented in a special issue of the Social Science and Medicine titled "International health in the 21st century: trends and challenges" (40). Confirmed here is the need to continue to examine these concepts in relation to health outcomes in a rapidly changing world.

CHOICE: A FRAMEWORK FOR ASSESSING HEALTH OUTCOMES

The above discussions help explain why empowerment and equity are relevant to improving health outcomes, and why, returning to the arguments of Sen, expanding choices for people enable them to improve their future development.

To reiterate, choice stresses the importance of the active engagement of people to address the situation responsible for their condition. By taking the idea of choice and turning it into an acronym CHOICE, I explore the influence of empowerment and equity on health outcomes in concrete terms. In the box below are the areas of critical importance to both process and outcome of choice.

C	Capacity-building
H	Human rights
O	Organizational sustainability
I	Institutional accountability
C	Contribution
E	Enabling environment

CHOICE is a framework that, based on the literature, identifies six areas that are critical to examining the influence of empowerment and equity on health outcomes. It is the first step towards developing an assessment tool. By collecting evidence in each of these areas, we can begin to develop indicators for the assessment, and in the longer term, a concrete strategy to pursue PHC in creating and sustaining health policies and programmes. The framework takes up the challenge put forward by Aday to develop ways to examine the role of deliberative justice in health improvements. It helps focus on a line of inquiry that, to date, has been mainly based in rhetoric and antidotes rather than scientific investigation.

To present this framework, in the next section, I take each of these areas, pose a thematic question to structure

the search for evidence, explain the significance of the area, and use specific case examples to argue for the contribution to the CHOICE framework.

Capacity-building

Question: Can local people obtain and act upon new skills and/or knowledge to improve their health?

Capacity-building has been defined as the process by which people gain knowledge, skills, and confidence to improve their own lives (41). In the context of poverty alleviation and focusing on those on the margins of society, the term is seen as an intervention to improve the lives of intended programme beneficiaries.

Rappaport, an influential psychologist, was one of the first to examine empowerment and equity in the context of capacity-building (42). He argued that empowerment should be defined in the context of both capacity and equity to ensure that communities solved their own problems and got a fair share of resources. Capacity-building, in this context, is not merely the acquiring of new skills and knowledge; it also involves an adjustment and application of these new insights to the political, social and economic environment (42).

One major issue is the role of indigenous knowledge. Traditionally, capacity-building has been seen as training local people to use 'modern' methods and approaches to improve their situation. While recognizing that local people have experience, culture, and traditions that contribute to this process, in practice, it has usually resulted in professionals telling local people what to do and how to do it (43). Such approaches, it can be argued, do undermine the values of empowerment and, often by extension, equity.

In the field of health, evidence for the role of capacity-building is found in several areas. On the negative side, Wallerstein has provided data to show those who feel that they lack capacity and confidence over their own lives have worse outcomes in terms of morbidity and mortality than those who do not feel this way (18).

However, positive experience also supports the linkage among empowerment, equity, and improved health outcomes. Recognizing the need to use and support indigenous knowledge is a good example. Too often the value of indigenous knowledge is more rhetoric than reality as professionals pay lip service to traditional values, and then impose their own ideas. However, the use and popularity of participatory methods emerging

from participatory learning approaches made significant changes in this process. For example, much of the work around sexual health and, particularly HIV/AIDS, has provided evidence of the value of indigenous knowledge. A typical example is that of a sexual health programme in Mumbai where project staff have local youths to help design, implement, and evaluate the programme. The youths are involved in needs assessment and in using data gathered to develop learning materials and activities. They train peer educators in the schools and other community groups to use these materials. Using the community views and ideas not only helps improve the programme but it also allows the youths to gain new skills that provide potential for further employment (22). Alice Welbourne confirms such experiences in her review of participatory approaches in HIV/AIDS programmes (44). She concludes that having community people involved in generating information by discussions and visualizations based on their own views and knowledge helps people both to understand the problem and explore ways of dealing with it.

Issues around gender are also good illustrations about the influence of empowerment and equity on health outcomes in the area of capacity-building. Women, particularly in, but not limited to, low-income countries, have been denied equal access with men to jobs, income, and basic needs of resources, such as food, clothing, education, and healthcare. Evidence from programmes suggests that capacity-building of women has had a range of effects in health equity and improvement.

The UNDP-assisted South Asia Poverty Alleviation Programme (SAPAP) pilot project in three districts of Andhra Pradesh began in 1966. The project strategy relied on a three-pronged strategy of social mobilization of the poor, skill development, and capital formation. A majority of the poor mobilized under the programme were women. In a recent assessment of the programme, the findings showed that the difference between the well-being of members and non-members varied across the different poverty indicators (Murthy R *et al.* Personal communication, 2002). The well-being of members and their children was significantly better than that of non-members with respect to four indicators: infant survival, school attendance, access to gas, and elimination of seasonal migration.

Addressing equity and empowerment for health improvements does not necessarily start with tackling health issues. An often-quoted example of capacity-

building is that of SARTHI (Social Action for Rural and Tribal Development) (45). Professional programme staff wanted to improve the lives of women in a poor rural area in the state of Gujarat, India. They introduced a cooking stove into the small airless huts to reduce smoke. As a result of these improvements, local women, decided to form themselves into a group of investigators and working with the staff, defined poor health as a major problem. With new skills and knowledge, the women proceeded to set up a holistic programme that included a maternal and child-health programme, a participatory action research programme and gynaecological training through self-help. The confidence of these experiences has allowed women to address issues of concerning their rights and to expand the programme to allow other women in the area to participate.

In summary, capacity-building is a necessary step for empowerment for both individual improvement and for ensuring that issues of health equity are identified and addressed. The examples above give evidence that there is a relationship between empowerment and equity for health improvements. This relationship focuses on enabling those who are without power and, thus, without the means to influence decisions to gain skills and knowledge to engage in a process developing the direction of their own lives.

Human rights

Question: By exercising their rights, can the poor influence the circumstances that produce their poverty?

The case for human rights, particularly civil and political rights, as a key issue for the relationship between empowerment and equity is best expressed in the concept of democracy. This is a key concept in the work of Sen (9). For Sen, human right is a moral and ethical, not a legal, concept. He argues that people are better able to address and sustain their own well-being when they are able to participate in decisions about their own lives. Democracy is a process where people are able to exercise choice. The choice may be active or passive. However, it does mean that people are not coerced into accepting decisions made of those more powerful or with more resources.

The concept of human rights has increasingly gained a prominent place in the dialogue about development. International meetings and widespread discussions are exploring the implications of human rights as the foundation for improving situations of the poor. The

Peoples' Health Assembly held in Dhaka in 2000 published the Peoples' Charter for Health (46). In this document, there is a statement that reflects the emerging views about the role of human rights in this area. "Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over the economic and political concerns" (46:3).

Examples in the field of health illustrate this range of experiences. The right to be involved in dialogue and influence decisions has had critical outcomes in the field of reproductive health. Sen gives the example of family-planning policy in India. The state of Kerala in India has a relatively low fertility rate. In Kerala, widespread female education and the engagement of women in social dialogue have brought about this situation. The environment that has encouraged women to be actively engaged in reproductive choices has had a greater impact in India than earlier repressive measures taken in the 1970s during the Indira Gandhi government. At this time, government targets for contraceptive use were forcibly pushed on the population, particularly in the northern states. As a result, the Gandhi government fell, and reproductive health programmes suffered severe setbacks in gaining acceptance from the population.

Another example comes from Sen's own work on famines. Famines lead to the worst health scenario of wide-scale problems of disease and death. Drawing on early work of this theory of 'entitlements', the reason for famines, Sen argues, is not the lack of food (33). Rather, it is the limited political freedom and economic resources that reduce capacity of the poor to obtain food. This situation exists because they have little ability to develop networks through labour, production and/or relationships to secure food when it is scarce. Famine is a result of weak exchange conditions and lack of information to take or command action. It is the result of the inability to exercise any power to change the crisis situation that could be rectified by expanding and insuring human rights through the development of democratic processes.

Supporting and ensuring human rights is one critical way in which the process of empowerment directly influences equity in resource distribution and decision-making. People are able to forge new futures by engaging in civil and political actions and gaining confidence when their commitment succeeds. Conversely, not taking action and/or allowing inequities to continue to exist leads to poor health outcomes among other consequences. It is an area of increasing importance in the equity/empowerment relationship.

Organizational sustainability

Question: Can organizations be developed and maintained to ensure sustainability of health gains for the poor?

Successful health improvements, particularly for the poor and marginalized, depend not upon a single intervention, they rather depend on long-term organizations and structures that ensure continuity. Early approaches to PHC focused on allocations for programmes, such as provision of immunizations, contraceptives, and oral rehydration therapy. These interventions were scientifically proven to change poor health outcomes. However, the initial success faltered when enthusiasm and support for these programmes receded (47).

More recent studies that examined PHC programmes in a range of low-income Asian and African countries highlighted the difficulties of maintaining policy commitments to address the needs of the poor and involve lay people in healthcare decisions (48). They pointed out that, although structures and organizations were existing on paper, they failed to function for various reasons. The most important was the lack of financial resources to maintain policy commitments. In many poor countries, this situation is the result of donor dependency. A glaring example is the rapid decline of social development programmes of Vietnam (49) because of the dissolution of the Soviet government that mostly financed these programmes. An equally glaring example is where donors failed to generate resources from national governments for programmes that donors had created or defined as priority, or where donors' demand for quick results to ensure continuity of funding resulted in irreparable conflicts between funders and intended beneficiaries (50).

Where equity and empowerment have been tackled in different manners, outcomes have been different. A national programme addressing women's health needs in Western Samoa provides an example (51). The programme has its roots in the period of New Zealand administration in 1923 when the Government created a community-based self-help system on nursing care and neighbourhood associations that were already working in New Zealand. Noting failures of other community programmes to commit resources, respond to local concerns, establish community organizations, monitor and evaluate programmes, the Samoan Government took careful step to avoid these pitfalls. When women's committees were established to meet health needs, they were given support, resources, and prestige—critical for them to function effectively in their own communities.

This support was developed over a relatively long period of time and was continually maintained. The outcomes not only included better health status. An unexpected outcome was the change in attitudes and functioning of women committee members. Role perceptions about their ability to work changed. Women became more authoritative, began to undertake activities to raise money for health facilities, with improved sanitation in their villages, and became involved in income-generating activities. The committees did so well that, after about 20 years of existence, they were seen to be a traditional organization in village life and were accorded authority as such.

The literature suggests that the creation of organizations without attention to the process of creation and maintenance is not sufficient to ensure that programme objectives will be met. In addition, if organizations do not address issues of equity and empowerment, health gains are difficult to pursue. The results are different where the process and the produce are seen as equally important. Attention to process ensures critical learning that takes place to guide programmes towards their objectives.

Institutional accountability

Question: Can mechanisms be developed to ensure resource allocation and decisions benefit those most in need?

While accountability is a core concern of all members of governing institutions, its impact is most pronounced among the poor in all countries. Those on the margin have little space or possibility for manoeuvre to ensure that their concerns are taken aboard. In the field of health, this limitation becomes all the more stressing as services are decentralized and privatized. Without state support for healthcare, new strategies need to be developed.

Problems of accountability and misuse of resources plague all countries. In the more developed democracies, rules and regulations afford some control on excesses in some measure. In countries that have histories of one person rule (dictatorships) and/or unstable political situations, opportunities for corruption are greater. In all cases, misuse of resources is always damaging the poor and powerless. Without their active involvement in curbing these abuses, equity is unattainable.

In the field of healthcare where equity and empowerment have been on the policy agenda officially since 1978, the present economic environment is devolving services from the centre to the district and

moving from free service to fee payments, and new opportunities are being created. Mechanisms for accountability in health services offer an entry point for community involvement in shaping the services and tempering service response to community needs (52).

A special issue of the IDS Bulletin in 2000 reviewed a number of experiences in which poorer members of the country gained experience in developing accountable relationships with health service providers to ensure that health needs are met (52). A workshop that discussed information provided in articles in this special issue identified the following five criteria for developing accountability in programmes:

- A shared vision
- Transparency of resources and information
- Role and responsibilities agreed upon
- Representation of interests of all concerned parties
- Agreed upon ways for solving conflicts.

In this issue, several case studies describe how accountability is being developed. Cambodia, where the Catholic Relief Service is running two pilot projects at health centres, provides a good illustration. The Government of Cambodia is promoting community and health centre co-management and co-financing. The two pilot projects are exploring ways to implement this policy. To start the process, a committee was created consisting of two elected representatives (one male, one female) from each village in the centre's catchment area; two members of the health centre staff—the chief and midwife/accountant (trained recently in accountancy skills) and a committee leader, deputy leader, and recorder (who cannot be the health centre chief). The first issue they tackled was setting fees for service and identifying those who were exempt from fees. They then began drafting a health centre/community contract to cover all areas where co-financing was to be applied. In return for services, for example, the community agreed to pay fees, participate in elections of the committee, and provide information and feedback. The contract and all meetings are recorded, and the documents are available for everyone to see. One result is that in the two pilot areas, attendance at the health centres had increased over 90% (53).

Without mechanisms for accountability and transparency in decisions concerning resource allocation, discussions about meeting the needs of the poor and poverty alleviation have proved to be illusory (6).

Accountability is only possible when those affected by decisions have ways to ensure that their needs and concerns are dealt with fairly. Without accountability, policies that claim to address equity and empowerment generate little confidence or credibility.

Contribution

Question: How does the contribution of a programme's intended beneficiaries reflect its development?

Health planning today uses the term 'stakeholder' to indicate all those who have a vested interest in a plan or programme (24). The term covers professionals, funders, service-delivery staff, and the intended beneficiaries. It is defined by the Oxford Dictionary as "one who holds the s. or stakes of a wager, etc." (54). In modern parlance, it no longer rests on wager but stakeholder still implies that the person has a stake, a commitment to achieving better health.

This commitment is based on a contribution of some type to healthcare. The contribution defines the interest and gives space in the decision-making process. Obviously, the larger the contribution, the more space a person can command. The poor have little to contribute. In this situation, inequity often prevails, and without empowerment, the poor have little voice in decision-making.

Contributions can be made in two main areas. The first is in the contribution of resources which include money, materials, and human resources. In this area, the stakeholders are often given little choice about that to which they contribute. Most often it is to the cost of maintaining health services. Limited by resources, the poor may contribute labour towards building or maintaining health facilities, or more often, serve as community health workers, and be mobilized to join community-financing schemes (55). These schemes enable people to contribute to the cost of drugs (56) or insurance for the cost of care when ill (57). While they claim to address the issue of equity by targeting support for those most in need, they do little, in practice, to address empowerment. A recent study by Gilson *et al.* concluded that issues about ensuring equity in an environment of reduced government support for health services were very complex (58). To protect the poor from the burden of payment, there needed to be a balance between central and district-level decisions and decision-making structures where intended beneficiaries (civil society) would be represented.

The second area of contribution is in terms of time and energy to support the initiation, implementation, monitoring, and evaluation of a programme. This contribution is less tangible but most often more critical than contribution of resources. Moving from mere programme recipients to programme developers, from 'users to choosers' (59) not only allows change in the provision of health services (i.e. the more the services for females, the more are preventive services) but also improves the responsiveness and quality of services provided (53).

This transformation is possible when professionals act as facilitators to work with community people to collect and analyze information to identify health priorities using the tools and approaches of PLA. On this basis, they develop a plan of action and monitor and evaluate the implementation. A well-developed example of this process can be found in the Participatory Integrated Development (PID) Programme in Kenya (22). Tackling improvements on a holistic rather than sector basis, community people start by articulating a vision of what they want for their community. Most often, health is a major component if not a priority. Then they plan how to achieve this using criteria of cost, length of time, need for external resources, sustainability, and effectiveness. They draw up a community action plan (CAP) and manage funds for implementing it. They monitor and evaluate CAP based on their original vision. In this case, people's contribution is calculated in commitment rather than money. The benefits based in equity and empowerment include better healthcare and better health. Conversely, when this energy is not generated and used, the reverse is often the case.

The above example shows how people with little still can have a contribution to improved health outcomes. Without some type of contribution, people cannot be stakeholders in plans for healthcare improvements. They remain objects not subjects of healthcare plans. Contributions, whether resources or time and energy, ensure that people can have some influence in direction of a programme. It ensures a legitimization of this influence on the way policy and programmes are developed and implemented.

Enabling environment

Question: What is the contribution of the existing environment to pursuing equity and empowerment for health improvements?

The existence of an enabling environment is the glue that sticks all these factors together. It is an essential ingredient for issues around equity and empowerment

to be acted upon and sustained. Such an environment at the national level demands the existence and reinforcement of laws to ensure that rights and problems of the marginalized are addressed. At the local level, it means that actions for empowerment and equity are reflected in programme structures, and the concepts are institutionalized.

An enabling environment can be created through changes in attitudes and behaviours of those who have resources and power to make decisions. Here is an example. Using a method titled “health workers for change” developed in South Africa and Kenya, participating countries held workshops with all health workers and support staff based on participatory methodologies targeting gender issues in service delivery (60). Using the methods of problem-posing developed by Paolo Friere (19), the workshops created an environment where participants could examine issues of health concerns that particularly affected women. These issues included low pay and status in their work and inadequate training for dealing with health issues, for example, counselling on HIV/AIDS. In addition, their knowledge and awareness helped workers to provide better services. In an impact study, Onyango-Ouma reported that changes included increased privacy for female patients, greater promptness in seeing patients, improved availability of drugs and supplies, great cleanliness, and improved communication (61). Such changes made both staff and patients empowered by helping them to have some control over the situations that previously gave them little influence (62).

An enabling environment is also promoted through issues around information. First, information must be made available to all those who are affected by information. Only when this situation occurs, can the poor know what resources are available, what rules and regulations apply, and how decisions are made. Second, intended beneficiaries can be empowered in the process of information generation—that is collection, analysis, implementation, monitoring, and evaluation—of a programme (22). This process allows lay people to gain skills and confidence to ensure that such an environment continues. It also provides ownership of information by programme beneficiaries—another ‘stake’ in working for health improvements.

Examples of these issues through participatory planning are described in the sections above. These planning approaches provide mechanisms for feedback and accountability—both critical features of an enabling environment. These mechanisms help local people to

partner, on an equal basis, with professionals supporting programmes. They create structures for accountability. They also allow lay people to gain skills and experience that can increase income-earning capacities. They can be empowering because they address issues of power and control, of skills and confidence-building, and of creation of community commitment to improve individual life chances.

EQUITY, EMPOWERMENT, AND HEALTH OUTCOMES

The above section described the relationship between health equity and community empowerment in six critical areas. It also gave examples where equity and empowerment have led to positive health outcomes. However, the evidence is still weak in establishing these links. More data are needed.

A recent inquiry into the links between equity and health outcomes produced evidence to support the observation that poor people have poor health and began to describe the nature of this link (7). It also stated that there was a need to gather data to assess the link at country level and the lower level. To date, there is no systematic approach to collect evidence of empowerment and health outcomes. This situation argues for the need to create an assessment tool to evaluate this relationship. This tool must be practical, valid, and reliable, and must also be responsive to assessment of local situations that are influenced by culture, history, and current social, political and economic factors.

The framework presented here is the first step towards creating such a tool. The next step would be to develop indicators for assessment. To do this, evidence would be collected to answer the thematic question posted in each area in a series of case studies. From the descriptions, a set of core indicators could be identified. These indicators could be used for assessing how strong or weak the area is in the context of equity and empowerment. The assessment then would be placed alongside indicators for health outcomes. With baseline information collected either retrospectively or in the first phase of the assessment, the relationship between empowerment and equity and its impact on health outcomes could be examined over a period of time. Reviewing several specific case studies will make it apparent whether universal indicators in some or all of the areas exist.

In the broader context, a framework for CHOICE is an important contribution to underpinning and pursuing the strategy of PHC in which equity and empowerment

are keys. It relies on the work of Amartya Sen who provides theoretical structure for the framework. He put forth his arguments in a tightly-constructed presentation of an economist. It, thus, appeals to those whose priorities are cost, efficiency, and effectivity. This contribution strengthens the support for PHC and also provides support for those who are pursuing a PHC strategy.

CHOICE also relies on the experience of programmes that highlight and link the six areas to positive health outcomes. Each area addresses the issue of link between equity and empowerment and its relationship to health. The links are critical to making health outcomes sustainable. Providing more resources to the poor without supporting the transformation in thought, behaviour, and opportunity have not made crucial changes to their life situations.

CONCLUSION

PHC is really about choice. In the first instance, it is about creating situations where intended beneficiaries of health and development programmes can exercise their concerns and develop their skills and capacities. However, at another level, it is about the choice each of us as individuals are prepared to make. This includes the choice of planners to gather and act upon evidence to pursue and implement policies that address empowerment and equity, i.e. the choice of intended beneficiaries to become actively involved in their own health and healthcare; the choice of all people to recognize that increasing poverty not only harms those living in that state but threatens to affect the life styles of everyone because it creates political, social and economic instability. This paper has shown that choice on any level is not easy. However, if we do not exercise our choice, we potentially become victims of the very situations we are trying to change.

ACKNOWLEDGEMENTS

The author would like to acknowledge the important contributions made by Pat Pridmore, Manus Kaushik, and two anonymous reviewers. The author would also like to thank Glenn Laverack for his extensive comments on earlier drafts.

REFERENCES

- World Health Organisation. Primary health care: report of the International Conference on Primary Health Care. Geneva: World Health Organization, 1978. 79 p.
- Newell KW. Health by the people. Geneva: World Health Organization, 1975. 206 p.
- McDonald J. Primary health care. London: Earthscan, 1993. 191 p.
- Carpenter M. Health for some: global health and social development since Alma Ata. *Community Dev J* 2000;35:336-51.
- Braveman P, Tarimo E. Social inequalities in health within countries: not only an issue for affluent nations. *Soc Sci Med* 2002;54:1621-35.
- Victora CG, Wagstaff A, Schellenberg JA, Gwatkin D, Claeson M, Habicht JP. Applying an equity lens to child health and mortality: more of the same is not enough. *Lancet* 2003;362:233-41.
- Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, editors. Challenging inequities in health: from ethics to action. Oxford: Oxford University Press, 2001. 348 p.
- World development report 2000/2001: attacking poverty. Oxford: Oxford University Press, 2000. 335 p.
- Sen A. Development as freedom. 1st ed. New York: Knopf, 1999. 366 p.
- Bauer P. Economic analysis and policy in underdeveloped countries. Durham, NC: Duke University Press, 1957. 143 p.
- Alinsky SD. Rules for radicals. New York: Random House, 1972. 196 p.
- Rifkin SB, Lewando-Hundt G, Draper AK. Participatory approaches in health promotion and health planning: a literature review. London: Health Development Agency, 2000. 126 p.
- Brokensha D, Hodge P. Community development and interpretation. California: Chandler Publishing, 1969. 222 p.
- Mezirow J. Dynamics of community development. New York: Scarecrow Press, 1963. 252 p.
- Karunaratne G. The failure of community development programmes in India. *Community Dev J* 1976;2:95-118.
- United Nations. Department of Economic and Social Affairs. Popular participation: emerging trends in community development. New York: United Nations, 1971. 273 p.
- Steifel M, Wolfe M. A voice for the excluded: popular participation in development: utopia or necessity? London: Zed Books, 1994. 249 p.
- Wallerstein N. Empowerment and health: the theory and practice of community change. *Community Dev J* 1993;28:218-27.

19. Freire P. *Pedagogy of the oppressed*. Harmondsworth: Penguin, 1972. 186 p.
20. Cornwall A. *Beneficiary, consumer, citizen: changing perspectives on participation for poverty reduction*. Stockholm: Swedish International Development Agency, 2000. 92 p. (SIDA studies).
21. Chambers R. *Whose reality counts?* London: Intermediate Technology Publications, 1997. 297 p.
22. Rifkin S, Pridmore P. *Partners in planning: information, participation and empowerment*. London: Macmillan, 2001. 155 p.
23. Cooke B, Kothari U. *Participation: the new tyranny?* London: Zed Books, 2001. 207 p.
24. World Bank. *The World Bank participation sourcebook*. Washington, DC: World Bank, 1966. 259 p.
25. Albertyn R. How to design and approach a measuring exercise. Working Seminar on Methods for Measuring Women's Empowerment in a Southern African Context, 17-18 October 2001. (www.qweb.kvinnoforum.se/measuring/mamibiareport.htm).
26. World Bank. *Empowerment and poverty: a sources book (draft)*. Washington, DC: World Bank, 2002. (www.worldbank.org/poverty/empowerment/index.htm).
27. Sen G. *Empowerment as an approach to poverty*. Background paper to the Human Development Report, 1997. (www.hsph.harvard.edu/Organizations/healthnet/Hupapers/97_or.pdf).
28. Laverack G, Wallerstein N. Measuring community empowerment: a fresh look at organisational domains *Health Promot Int* 2001;16:179-85.
29. Rifkin SB. Paradigms lost: toward a new understanding of community participation in health programmes. *Acta Trop* 1996;61:79-92.
30. Beeker C, Guenther-Grey C, Raj A. Community empowerment paradigm drift and the primary prevention of HIV/AIDS. *Soc Sci Med* 1998;46:831-42.
31. Nelson N, Wright S, editors. *Power and participatory development: theory and practice*. London: Intermediate Technology Publications, 1995:1-18
32. Rawls J. *A theory of justice*. Cambridge, MA: Harvard University Press, 1971. 607 p.
33. Sen A. *Poverty and famines: a essay on entitlement and deprivation*. Oxford: Clarendon Press, 1981. 257 p.
34. Wilkinson RG. *Unhealthy societies: the affliction of inequality*. London: Routledge, 1966. 255 p.
35. Aday LA. An expanded conceptual framework of equity: implications for assessing health policy. *In: Albrecht GL, Fitzpatrick R, Scrimshaw SC, editors. Handbook of social studies in health and medicine*. London: Sage Publications, 2000:481-92.
36. Labonte R. Health promotion and empowerment: reflections on professional practice. *Health Educ Q* 1994;21:253-68.
37. Green LW. A theory of participation: a qualitative analysis of its expression in national and international health policies. *In: Ward WB, Salisbury ZT, Kar SB, Zapka JG, editors. Advances in health education and promotion, v. 1, part A*. Greenwich, CT: JAI Press, 1986:215-40.
38. Robertson A, Minkler M. New health promotion movement: a critical examination. *Health Educ Q* 1994;21:295-312.
39. Macfarlane S, Racelis M, Muli-Muslime F. Public health in developing countries. *Lancet* 2000;356:841-6.
40. Zwi AB, Yach D. International health in the 21st century: trends and challenges. *Soc Sci Med* 2002;54:1615-20.
41. Gibbon M, Labonte R, Laverack G. Evaluating community capacity. *Health Soc Care Community* 2002;10:485-91.
42. Hawe P. Capturing the meaning of 'community' in community intervention evaluation—some contributions from community psychology. *Health Promot Int* 1994;9:199-210.
43. Hobart M. *An anthropological critique of development*. London: Routledge, 1993. 235 p.
44. Welbourne A, editor. *Participatory approaches to HIV/AIDS programmes*. *PLA Notes* 1995;23:57-80.
45. Khanna R. Participatory action research (PAR) in women's health: SARTHI, India. *In: De Koning K, Martin M, editors. Participatory research in health: issues and experiences*. London: Zed Books, 1996:62-71.
46. People's Health Assembly. *People's Charter for Health*. Dhaka: People's Health Assembly Secretariat, 2002. 9 p.
47. Walt G. Health care in the developing world, 1974 to 2001 *In: Webster C. Caring for health: history and diversity*. Buckingham: Open University Press, 2001:235-95.
48. LaFond A. *Sustaining primary health care*. London: Earthscan Publications Ltd., 1995. 218 p.
49. Hien NT, Ha LTT, Rifkin SB, Wright P. The pursuit of equity: a health sector case study from Vietnam. *Health Policy* 1995;33:191-204.

50. Bossert TJ. Can they get along without us? Sustainability of donor-supported health projects in Central America and Africa. *Soc Sci Med* 1990;30:1015-23.
51. Thomas P. Empowering community health: women in Samoa. In: Pencheon D, Guest C, Melzer D, Muir Gray JA. Oxford Handbook of public health practice. Oxford: Oxford University Press, 2001:532-59.
52. Cornwall A, Lucas H, Pasteur K. Introduction: accountability through participation; developing workable models in the health sector. *IDS Bull* 2000;31:1-13.
53. Deigle G, Sameoun M. The experience of the Catholic relief services community-based primary health care programme. *IDS Bull* 2000;31:74-7.
54. The shorter Oxford dictionary. Oxford: Oxford University Press, 1973:2102.
55. Walt G, editor. Community health workers in national programmes: just another pair of hands? Milton Keynes: Open University Press, 1990. 180 p.
56. Jarrett S, Ofosu-Amaah S. Strengthening health services for MCH in Africa: the first four years of the 'Bamako Initiative'. *Health Policy Plan* 1992; 7:164-76.
57. Supakankunti S. Future prospects of voluntary health insurance in Thailand. *Health Policy Plan* 2000;15:85-94.
58. Gilson L, Kalyalya D, Kuchler F, Lake S, Oranga H, Ouendo M. Strategies for promoting equity: experience with community financing in three African countries. *Health Policy* 2001;58:37-67.
59. Cornwall A, Gaventa J. From user and chooser to maker and shaper: repositioning participation in social policy. Brighton: Institute of Development Studies, 2001. 34 p. (IDS working paper no. 127).
60. Haaland A, Vlassoff C. Introducing *Health Workers for Change*: from transformation theory to health systems in developing countries. *Health Policy Plan* 2001;16(Suppl 1):1-6.
61. Onyango-Ouma W, Thiong'o FW, Odero TMA, Ouma JH. The *Health Workers for Change* impact study. *Health Policy Plan* 2001;16(Suppl 1):33-9.
62. Vlassoff C, Fonn S. *Health Workers for Change* as a health systems management and development tool. *Health Policy Plan* 2001;16(Suppl 1):47-52.