

## 1 Introduction

Participation has gained increasing attention and become a popular concept in recent years. However, participation is not a new word in the health field, it has been referred to frequently in international health documents since the 1970s, for instance, the Alma-Ata Declaration and Platform for Action developed at the International Conference on Population and Development in 1994, as well as the documentation from the Fourth International Women's Conference in Beijing in 1995 (WHO 1978; UNFPA 1994; UN, FWCW 1995).

The word 'participation' can also be found in policies and guidelines for health work in China. In the early 1950s the government set up four principles for national health work, and integration of health work with mass movements (implicitly referring to participation by the public) was one of them (Gu 1991). In new guidelines drawn up in the 1990s one of the six new principles has been to motivate the participation of the whole society in health work which explicitly shows that participation is formally promoted by government. In the following years, participation as a term appeared frequently in many national and local health documents. However, in all the above-mentioned documents there have rarely been concrete explanations on what participation is, how it will happen and what advantages it will bring.

Participatory rural appraisal (PRA) was first introduced into China at the end of 1993. PRA has been defined as a growing family of approaches and methods to enable local people to share, enhance and analyse their knowledge of life and conditions, and to plan and act (Chambers 1992). Based on six years' experience in applying PRA in the health field in China, this article describes two cases; these will try to explore what participation means, how it can happen, what advantages it can bring and what constraints it faces, as well as its future development in the context of China.

## 2 Engaging Participation through the Maternal and Child Health Poverty Subsidy Fund Programme

Yunnan Province is a poor and remote province located in the southwest of China with much

# Participation

## *A Way to Better Health Outcomes?*

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higher maternal mortality rates (MMR) and infant mortality rates (IMR) than national average level. In 1995, a maternal and child health (MCH) cooperative project between the World Bank and China was established called the World Bank Loan Health Project VI (WBLHP VI) involving 300 poor counties of China. Yunnan Province participated in this project. Approximately US\$19 million, of which 60 per cent came from the World Bank loan and 40 per cent from the Yunnan government, would be used to improve MCH service provision in forty counties in this province over five years (1995–99) (Yunnan Provincial Project Office of World Bank Loan Health Project VI 1996).

However, it was soon realised that if poor families in those counties could not afford access to the improved services, this would pose a major limitation to the success of the WBLHP VI. Therefore, it was decided by the World Bank that, as a precondition for conducting WBLHP VI, each participating province should set up a MCH poverty subsidy fund (MCHPSF) to support access of the poorest families to the improved services. Based on this requirement, Yunnan Provincial Health Bureau issued a policy which required each of the forty counties to allocate an amount of money from the county government budget on the basis of 0.1 yuan (equal to \$0.012) per capita per year as MCHPSF to support the poorest families covering the five specific MCH service items. The five MCH services were:

- Routine prenatal and postnatal care
- Hospital delivery for high risk pregnancies
- Emergency care for severe obstetric complications
- Outpatient treatment for infant pneumonia and diarrhoea
- Inpatient treatment for severe infant pneumonia and diarrhoea

Simultaneously, a study was designed by the provincial health bureau to evaluate the impact of the MCHPSF. Two years later, it was found that many counties had not implemented the MCHPSF as intended by the policymakers. Some counties had not spent the money, although people in those counties are very poor; some had used the money only for obstetric emergency care in order to reduce MMR. Reasons given by those counties included:

the county government had not allocated the money in time; the money was too little to be useful; poor people did not come to use this fund; the money was very limited, so it was used on emergency cases; they were afraid that the money would be used up too soon, so they wanted to control it strictly etc.

Given this situation, the provincial health bureau felt that it was hard to assess the impact of MCHPSF. Thus they decided to launch a new MCHPSF project in two counties in order to observe its impact. The Institute for Health Sciences (IHS), a research and training department in Kunming Medical College, was invited to host the research. After careful analysis of the situation, IHS decided to introduce participatory methods into this project. Although the design of the programme had been completed by provincial level people, the implementation of the programme (nearly completing its second year) was the responsibility of local government, health providers at village, township and county levels and communities. It was firmly believed by IHS that without good communication and full exchange between the two sides (designers and implementers), the programme would not succeed. IHS felt that participatory planning could let the two sides discuss the issues and problems, reach a common understanding, and make an action plan for the next stage of the process.

## 2.1 Creating space for participation

IHS persuaded the key actors at the provincial health bureau of the benefits of using participatory methods in this programme. Through a series of discussions, agreements were reached between IHS and the provincial health bureau with the following major components:

- Without changing the principle components of the programme, a participatory planning workshop will be held, attended by all major stakeholders, to discuss and plan the project and its implementation.
- The project will be implemented according to the plan developed by all stakeholders through the workshop.
- Wealth ranking (a PRA tool) will be employed to identify the poorest families for using MCHPSF.

## 2.2 Participatory planning workshop

In May 1998, the participatory planning workshop was held in one of the two counties with representatives of major stakeholders:

- Service providers at all levels (provincial, district, county, township and village)
- Health officials and managers at provincial, district and county levels
- County and township government leaders

It was the first time that village doctors could sit together with senior officials to discuss and plan. Two experts from Yunnan Participatory Research and Action Network were invited to give an introduction to PRA, and a variety of methods were employed to encourage equal participation among stakeholders during the workshop. After five days' of discussion and exchange, all participants reached a common understanding of the purposes and objectives of the project. They identified the roles and responsibilities that each stakeholder should play in the programme and shared the experiences gained from the past two years' work. Each stakeholder also raised and discussed their concerns and the difficulties they envisaged in fulfilling their roles. For example, county officials worried that the money would be used up too quickly if the MCH-PSF was made widely known to poor people; township health providers expressed their need for support from higher levels; village doctors wanted further training on treatment of diseases, and so on. Finally, an action plan was developed by all the workshop participants. This detailed what to do, how and when, and who should do it.

## 2.3 Implementing the action plan

Based on this plan, the project was implemented in the two counties. There was regular communication among stakeholders through meetings and monitoring activities to discuss issues emerging during the implementing phase and to find solutions. For example, as the project went on, one county wanted to stop using the MCHPSF at village clinics because they worried the money would be used up soon, but they knew the plan had been agreed upon by everyone, so they discussed this with IHS. Both sides analysed the situation and found a solution together; then the county returned to implement the plan.

## 2.4 Evaluation

One year later, the preliminary evaluation revealed that people who had participated in the planning workshop were more active in the implementation process. Village doctors were glad to use wealth ranking to identify families who qualified for the MCHPSF, and they considered this method more effective than traditional ones (based on income). However, county project officials felt that this approach required more time and energy, as they had to visit townships and villages more frequently. One county official expressed his unwillingness to continue this project because of the heavy workload. Some township doctors also said that this approach required much more time in order to reach the poorest. Regarding the outcome of MCH-PSF, data showed it had increased the utilisation of the five MCH services by the poorest families, and the IMR of poor households had also decreased to some extent, which suggested that implementing MCHPSF in a participatory way could achieve better results.

## 3 Integrating Reproductive Health Improvement and Micro-Financing Activity

Yunnan Reproductive Health Research Association (YRHRA) is an NGO established in 1994 with a mission to improve disadvantaged women's reproductive health. Research findings by YRHRA showed high mortality and morbidity associated with reproductive health among poor women and extremely low utilisation of essential reproductive health services as women had no money to pay for them. Therefore, YRHRA decided to launch an integrated project of reproductive health improvement and micro-financing activities targeted at poor women, with the hope that, as the income controlled by women increased, they would invest more in reproductive health.

### 3.1 Process

A participatory planning workshop was held in a township to initiate the project, at which the YRHRA project team, the Women's Federation (a department of local government) and representatives of poor women sat together to discuss and plan. It was clear to the YRHRA project team even before the workshop that, although poor women receive little education, they have their own views on health issues and

**Table 1: Evaluating 'satisfaction' with the project**

	Satisfaction	Dissatisfaction
Women	Have loan for generating income; more chances to meet, share and support each other	The loan for development was too limited
YRHRA	Changes happened to women, e.g. increased confidence, undertaking activities, etc.	No actions taken nor progress made in the health aspect. The situation of RH remains same

their own ways of expressing them. Therefore the workshop was run using local language as much as possible, and simple exercises such as role-playing, games, cartoon pictures etc. After five days' work, including one day of village-based activities consulting with more women, the three stakeholder groups reached a mutual agreement:

- Women would form small groups on a voluntary basis.
- Each group would be provided with two loans: a group development fund (300 yuan per person) and a group health fund (20 yuan per person). The former could be borrowed by group members to undertake income-generating activities; the latter could be used on health activities decided by the group.
- Each group would decide how to manage the money, including who can borrow, what the interest rate on the loan would be, and what to do if any member fails to repay etc.
- Each group should decide on a plan for health activities.

By the end of the workshop the three stakeholder groups had finalised the project plan, identified roles and responsibilities for each of them and made a detailed timetable of activities. The women had also required YRHRA to sign a contract with them, because they were afraid they might be cheated.

### 3.2 Implementation of the plan

After the workshop, many women's groups were formed. Groups, which met the agreement reached at the workshop, were provided with money to conduct their activities, and some simple health education materials were distributed to those groups.

### 3.3 Evaluation

Six months later an evaluation was conducted by YRHRA. The result was that women were found to be participating actively in microfinancing activities: they formed groups to support each other; illiterate women began to learn writing and calculating; and women were more confident to speak out about their needs. However, none of the group used the health fund to conduct health activities, only a few women borrowed the money to seek health care, and they spent little time reading health education materials.

The women were pleased with the income generation aspect of the project, requesting materials for vegetable growing, pig and chicken raising. They wanted to borrow more money or even use the health fund for income generation activities, saying 'if we are happy, we will have no diseases'. However, the reproductive health situation remains the same, with 99 per cent of women delivering at home attended by untrained people; miscarriage and premature birth are frequent; and reproductive tract infection (RTI) symptoms are quite common.

Based on these findings the question arises as to whether this project is successful. Using 'satisfaction' as an indicator, the different judgements of the women and the YRHRA were recorded (Table 1).

The two groups had different aspirations for the future of this project: the women wanted further loans to generate income, whilst YRHRA wanted to conduct reproductive health activities. The question was, which direction would the future of the project take? Three options were possible, though none of them seemed ideal:

- To agree to what the women wanted. But how about the mission and objectives of YRHRA and accountability to its donor?
- To insist on what YRHRA want to do. But would women participate as actively as they had done in the microfinancing activities? Is YRHRA being participatory or not?
- More negotiations between the two sides. What does this mean in terms of time and other costs?

#### 4 Issues Arising, Lessons Learnt

These two case studies provide a number of lessons about the use of participatory approaches in health projects. They also illustrate a series of challenges that raise wider questions about the use of participation in programmes aimed at health improvement.

- *Joint planning gives better results.* The MCHPSF programme illustrated that participation by a greater variety of stakeholders in the planning and implementation of a health programme could achieve better results than a programme planned only by senior health officers. Senior health officers may have rich knowledge and experience of macro health issues; but they may not understand very well the context within which the programme will be conducted, and do not necessarily share the same concerns as grass-roots health providers. In contrast, local people are more familiar with the local situation and more aware of the constraints and difficulties to be encountered. Participation provides a chance to share that knowledge and experience, express interests and concerns, and build a sense of ownership of a project. Participation also aids the identification of the roles and responsibilities of each stakeholder and makes them transparent, which in turn leads to mutual accountability.
- *Beneficiaries' voices need to be heard and understood.* In the MCHPSF case study the beneficiaries of the project had no voice in the planning and implementation of the project: all workshop participants were from the provision side. That could be considered a major shortcoming. However, if poor people are invited to participate in the planning and are provided with a chance to express their needs, some difficult

issues will need to be overcome. As Case Two shows, poor people often have different perceptions, needs and priorities for health issues that are unique to their local knowledge system. Could health professionals and decision-makers have sought to understand local people's knowledge, on their own terms? Even if local perceptions can be understood by decision-makers, to what extent are they really taken into account in decision-making? Where views differ strongly, whose voice is strongest and makes the final decision?

- *Appropriate communication is important.* In the second case study, the stakeholders showed bigger differences in power, perceptions and values; thus the way of communicating between them is very important. One experience gained from this case is that it should be the stakeholder with more power who learns to use tools that can be easily understood by stakeholders with less power.
- *Is participation always appropriate?* Case Two showed that poor women acted little to improve their reproductive health. It can be argued that solving such health problems is beyond the capabilities of poor women, and it should be the duty of other stakeholders. However, for YRHRA or the local health department to perform well, they need the participation of the local women (to seek health care, pay for services, monitor and evaluate, etc). The question arises: will women be willing to participate in these health services; and what type of participation is this?

We could conclude from these two cases that participation means the involvement of all stakeholders from an early stage, and the sharing of responsibilities and power openly among stakeholders through a process of communication and negotiation.

#### 4.1 Feasibility of participation in the current context of China

So far the application of participatory methods in the health field in China has been limited to research, projects and programmes sponsored by international donors or small government programmes like MCHPSF. Participation has not been widely accepted in its real meaning, although the term is frequently used in health policy and

documents. Current health reform in China suggests that participation might have an important role to play, e.g. in urban medical-care system reform, establishment and management of rural collective medical schemes, and district health planning. The decrease in government health budgets accompanied by the rapid increase in user fees in health services imply that the government cannot bear the full cost of health care, but it needs communities, social groups and individuals to share the responsibility and make contributions. However, once communities assume such a role, they should be empowered, and given rights to demand adequate services, and have their needs and interests satisfied. This might be achieved by participation.

#### **4.2 Constraints to participation**

Although there is a need and also a possible space for participation, the practice of participation in China still faces many constraints, which need to be overcome one by one.

There is still a lack of motivation for participation among stakeholders. As shown in the two cases, participation was facilitated or promoted by people who believed in it, and people who pushed and created space for it. Participation does not happen automatically. For many years, health issues have been the domain of health professionals; ordinary people, particularly the poor and disadvantaged, do not feel they have an important role to play. This creates a huge power difference between professionals and

common people. Within the health system itself, hierarchical structure also makes equal participation hard to achieve. If this constraint is to be overcome, then the next step will be the creation of mechanisms to make participation happen. Experience shows that participation usually occurred in studies done by researchers or donor-sponsored programmes, thus they were temporary, costly and time-consuming. There is a need for sustainable mechanisms to make participation affordable.

Communication between the different knowledge/value systems is still lacking or unequal. The different knowledge systems could be considered as the two sides of a coin. What can serve as a bridge to create mutual understanding? Once this is achieved, the next step is to integrate the two knowledge systems in practice, and when they are in conflict, to find a fair way to make decisions.

#### **4.3 Prospects for participation**

Participation in the health field might be a potentially important approach toward solving some of the problems that occur during the social reform period, such as lack of access to services by poor people, poor quality of care, and rapid increases in medical care fees. Nevertheless, a great deal of work needs to be done to make this potential a reality. What is needed are more examples of successful participatory practices that can be used to advocate the creation of more space for participation.

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