

## **Popular Participation and the State: Democratising the Health Sector in Rural Peru**

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**Abstract** Despite dramatic health gains in the last 25 years, the world's poorest people continue to experience disproportionately high levels of morbidity and mortality. Though health services play an important role in the promotion and protection of health the quality and coverage of ambulatory services are widely thought to benefit from greater participation by the community in planning, administration, management and supervision of public resources. However, comparisons between individual communities indicate that health policies, which promote popular participation, produce widely different results. This is a reflection on the different socio-economic, socio-political factors that impact upon individual communities and the limited importance government policy-makers attach to them. Taking the Local Health Administration Committees (CLAS) from the second Fujimori government (1995-2000) as an example, it is shown that for self-motivated rural communities to work in harmony with the state, there must be willingness to defer to the varying levels of social integration and social support.

### **Introduction**

Despite dramatic health gains in the last 25 years, the world's poorest people continue to experience disproportionately high levels of morbidity and mortality. Though improvements in health services play an important role in promoting and protecting health, the inability to significantly improve the health status of rural people only reflects a growing international consensus that previous approaches have been largely unsuccessful. Translating these concerns into lessons that can be incorporated into future health sector activities has done little to diminish international interest in the role of popular participation in health amongst health planners, policymakers and activists. Instead, a steadily emerging agreement about the role poverty and equity should play in shaping international health policy means that popular participation continues to generate a great deal of interest amongst international health policymakers and planners. Less visible are the lessons that the international community has taken on about the value of popular participation in practice and its impact upon the survival and quality of life of people located in rural communities. Is this the result of some deeply-embedded reluctance to go beyond the endless cycle of disputes about how participatory methods can be best incorporated into a cumbersome bureaucracy? Or is it because governments and donors are unconvinced by the contribution state-sponsored participation makes to any improvement in health? The reasons are both wide-ranging and profound. In the health sector, interest in participation means understanding the various issues that go into the design and implementation of effective, workable partnership models. Some of the most important issues – such as rural development, poverty, education (especially of women), remoteness and isolation – are located outside the health sector. Although these issues do not directly affect the development and administration of state-sponsored health programmes, they are nevertheless important to any state initiative that seeks to improve the health of its rural population, and therefore need to be incorporated into any discussion about participation.

Other issues that fall inside the health sector remit, such as the limited use of local health facilities or inadequate performance monitoring, also need to be understood from a socio-historical, socio-political, socio-economic perspective. The implication is that the full extent of participatory development's potential for misuse in rural health programmes will only be exposed if it is informed by empirical evidence and analysis; it also means not ignoring the ways in which the blueprint approach to participation excludes information about the local social and historical background; and it means going beyond assumptions about the idea of an homogenous community. In this context, five basic questions emerge: What is the evidence supporting state-sponsored participation in health? Do state-sponsored participatory approaches in health reflect the interests and priorities of the people that live in rural communities? How is this incorporated into health sector programmes? Is state-sponsored participation in health able to protect and guarantee the interests and priorities of people from rural communities? How do health sector programmes fulfill these responsibilities in practice? To understand the implications of state-sponsored participation for rural health programmes we therefore need to establish whether it can adapt itself to specific intra-community differences. Even if health sector reforms have incorporated the principle of participation and established new institutional frameworks to support participation in health, it is not always clear how the intervention will turn out or whether participation can protect the health needs of the rural poor. It is therefore important to ask NGOs and civic organizations the same questions so that international, national and local initiatives can become more responsive and better attuned to the development of more effective and equitable forms of people's involvement in health and medical care. The difficulty of incorporating the different levels of social integration and social support into any intervention strategy is therefore a central aspect of this paper.

In Peru state-sponsored participation was introduced to improve the quality and coverage of ambulatory services at the primary health level through greater community participation in planning, administration, management and supervision of public resources. The local health administration committee (CLAS) is the most important expression of state-sponsored participation and forms the principal focus of this research. The Ministry of Health has defined CLAS as "a decentralised administrative model where the state shares its efforts and resources with the community." It is non-profit making, legally authorized and fully integrated with the local health sector. CLAS is made up of committees of community members who administer public facilities to implement population-based local health plans financed by the government; it works alongside health officials to develop a local health plan, define the budget to implement the plan, and monitor expenditures and the provision of health services to the community. In 1998 a study of 66 low-income urban health facilities found that CLAS facilities have higher rates of popular participation and have been quicker at introducing improvements in primary health services than non-CLAS health services.<sup>1</sup> Of course, this picture of improving coverage, quality and opportunity of services and community satisfaction is somewhat over-simplified. CLAS has worked better in the less-poor urban communities, where users can afford the costs of health services and where a higher formal education and the presence of community members with skills in management and accounting contribute to its overall success.

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<sup>1</sup> This is taken from data collected in the Region of Arequipa - Altobeli, L. (1998)

These factors, which are generally not present in rural and very low-income areas, need to be taken into consideration. In the first place, if evidence about the local situation is excluded, policymakers will be unaware of the varying levels of social integration and social support and the influence this has on state initiatives to improve popular participation in health. Another major problem is that ignorance about how different rural communities and social groups pursue their interests and grievances will inevitably translate into a limited understanding of community-state relations and the relevance of joint community-state co-operation to the design and implementation of participatory mechanisms. On this basis, demographic factors such as geographic location, level of income, and composition in terms of sex and age are no more relevant to the implementation of participatory health programmes than the cultural and socio-historical characteristics of the population. In place of the “one size fits all” rural development panacea a range of different types of evidence are needed if national planners and health officials are to make more effective, informed interventions. The most important of these can be categorised as follows:

1. Demographic and socio-economic data
2. Measures of access to health services and other basic needs
3. An inventory of public and private resources
4. An assessment of clinical practice (eg. infrastructure, manpower and money)
5. An assessment of the political, social, institutional and managerial environment in which health policy is made.
6. Measures of health outcomes (morbidity and mortality levels).<sup>2</sup>

In the course of this research, it was found that participation in health programmes in Peru was implemented without information – or any adequate information – about some or all of these types of evidence. Though information from these different categories is sometimes available, it has rarely been systematically collected, whilst evidence that it has influenced the content of state-sponsored participation in health programmes is nil. Unfortunately this situation is by no means uncommon: taking information about the political, cultural, social and institutional environment to the wider context of policy implementation make financial and other demands that are normally beyond the health sector’s own limited resources (Cortez, 1998; World Bank, 1999: 47). However, translating policy into operational programmes is not the only problem to confront the health sector: it also concerns the political issues that shape policy in the first place.

Though developing countries might have a well-established commitment to social welfare, there is no guarantee that the political process will be entirely sympathetic to the promotion of state-sponsored participation; even if it is, other problems such as a lack of sufficient capital and human resources will cause national planners and health officials to make decisions that impact upon any eventual outcome. In this respect, the lack of empirical evidence about the impact of participation might cause national planners and health officials to question its’ importance altogether (Mosse, 2001). If state-sponsored participation is not essential to improving health, it’s supporters will be unable to contend with the more powerful political forces surrounding it.

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<sup>2</sup> This table is adapted from Peabody, J. Omar, R. et al (1999: 34), Policy and Health: Implications for Development in Asia.

Such factors are likely to have a significant influence upon policymakers, national planners and health officials; it will transform the health sector's political goals about participation into ineffective operational programmes that will be damaged by budgetary constraints and assessed by unsatisfactory criteria (Mosse, 2001: 17).

So long as international health mandates continue to promote the introduction of participation into national health programmes, policymakers, national planners and health officials will continue to produce initiatives that are under-resourced or subject to interference from other objectives. If Ministry of Health personnel are to overcome these difficulties, it is vital that they are better acquainted with information drawn from the various types of evidence listed above (Cleaver, 2001: 54). In terms of the complex interactions between the structures of participatory projects and the interests of poor people, national planners and health officials need to understand how these various types of evidence impact upon participatory approaches to health.

More specifically, these various types of evidence need to be seen as critical for determining whether and how those excluded by poverty and discrimination benefit from the opportunities extended to them by state-sponsored participatory initiatives. In this respect, national planners and health officials should benefit from qualitative evidence taken from empirical studies that provide in-depth analyses and focus on the institutions, spaces and strategies local people make and shape for themselves; qualitative evidence about the interrelationships between rural communities and the existing participatory projects, and information about the linkages between the participation of poor people and the furthering of their health will also be included.

This paper explores the local action environment in which participation in health programmes have been implemented in four rural Andean districts of the departments of Cajamarca and Ayacucho in Peru. The primary objective of the research was to explore how health care users, health professionals and others viewed and reacted to the health sector's incorporation of CLAS into its overall strategy for the geographical expansion of health services in rural areas. In the course of this research, several constraints to the successful implementation of CLAS were identified, including the limited importance attached to rural health services by local people, and the high degree of emphasis placed upon the improvement of health outcomes and the performance of health systems at the expense of wider aspects of popular participation and the socio-political context in which a rural health service is required to operate.

This paper will argue that in a rural environment such as the rural Andes, information about the relations of power and the variability in people's perceptions of the costs and benefits of individuals' motivations shape generalised conceptions of popular participation.<sup>3</sup> Patterns of popular participation activities among a rural population-based sample of Andean communities are explored to exemplify more general problems with participation in health programmes. The analysis shows that rural people affected by conflict, discrimination, isolation or remoteness are particularly vulnerable to the actual design and implementation of participatory mechanisms in a variety of ways. Of the 20 communities included in this research, only three felt that the local health facility was likely to enhance the future well being of the community.

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<sup>3</sup> See Cleaver, (2001: 54).

In all other cases state-sponsored participation in health was either discounted out of hand or made subordinate to other participatory activities such as security, education, mother's clubs, irrigation and sanitation, nearly all of which had been initiated by the communities themselves. For policy makers to be aware of the varying levels of social integration and social support and the influence this has on state initiatives to improve participation in health, further empirical evidence and analysis is vital. In this respect, information about the effects of popular participation in health involves the examination of whether and how the structures of popular participation in rural health systems include, protect, secure the interests of poor people (Cleaver, 2001: 54). Some of the more useful questions we need to ask include:

- What are the current links between the participation of isolated rural communities and the improvement of their social and economic welfare?
- How can a study involving isolated rural communities and the experiences of popular participation and health be unaffected by the consequences of the blueprint approach to popular participation?
- Is it possible that the future of this complex interaction of government and other outside forces, with the local social and organisational environment, could be the vehicle for the improvement of rural health services?
- If we strengthen the local social and organisational environment, will isolated rural communities in the Andes really suffer fewer of the corrosive effects of inequality, or will it all just be re-distributed according to the various influences of a new group of local elites?
- Is outside intervention able to promote social support, good social relations and strong supportive networks in remote and isolated communities, as well as at health post and at district level?
- To what extent are the current health sector arrangements responsible for the standardization of intervention?

An overview of the methods that were used and a summary of the findings are provided. This is followed by an outline of the difficulties involved in the interpretation of findings and a commentary on the significance of the results from the methods employed. The results of the investigation are drawn from the various levels of importance respondents attached to each of the methods employed and more generally to the local opinions obtained from within the local social and organisational environment.

### **Methodology and conceptual framework**

This research forms part of a larger study comprising material from social epidemiology, medical anthropology and ethnography. For the social epidemiological component the quality and range of popular participation in 20 communities in four rural Andean districts of the departments of Cajamarca and Ayacucho were studied, the aim being to establish whether health sector changes have helped to provide the necessary enabling environment for improved levels of participation at community level. To examine whether health sector changes have affected participatory mechanisms, improved the outcomes of rural health service intervention and enhanced the accountability, quality and equity of rural health services, it is important to direct our attention towards the entire range of interactions between the health sector and civil society.

To establish whether health sector changes have helped to provide the necessary enabling environment it is important to look at the impact these changes have had upon the number and frequency of individual contacts each community has with these various initiatives. It is also important to establish whether the type of support (emotional, practical or instrumental) the community receives from any specific initiative has been affected by the health sector changes. Information is taken from a series of Participatory Research Analysis (PRA) exercises conducted in five communities from each of the four districts that were the focus of the four provinces of the investigation. Selection of the communities was made according to the convenience sampling method when specific difficulties with access to local health authorities occur and an internal Ministry of Health guideline recommending that health service activities should focus on rural communities within 2 hours of a local health facility.

In practice, this resulted in a selection of 20 communities that are more than two hours' walk from the nearest health facility, with a journey time of anything between 2-8 hours and 2-3 days on foot. In each community Participatory Poverty Assessments (PPA) exercises were conducted with approximately 50-100 community members, using a combination of Rapid Rural Appraisals, Participatory Rural Appraisals, SARAR (self-esteem, associative strength, resourcefulness, action planning and responsibility), semi-structured interviews, group discussions and detailed questionnaires with community leaders, community council members, the self-defence committee, the women's clubs, the water and sanitation committee, teachers, health workers and TBAs. Through such an arrangement it was possible to identify changes in the priority attached to different types of initiative by the local community, obtain information about people's perceptions of available health services and elicit reasons for the non-use of existing public sector or NGO programmes.

### **Health Worker Questionnaire**

At community level the interactions of the Health Workers (HWs) and Traditional Birth Attendants (TBAs) with the community and other stakeholders (ie. elected committees) are a fundamental aspect of the acceptability of the relationship between the client and the service provider. Insofar as they fulfil a vital role in participatory structures within key health processes, their contribution to the future of popular participation is critical. Using a random sampling process, a questionnaire was developed and submitted to 87 HWs and 35 TBAs at community, district, and provincial levels. The questionnaire was made up of a list of options from which respondents were subsequently invited to comment on. If the answer was unclear the response would be left blank and the respondent would be asked to comment about the issue afterwards. The questionnaire sought to identify problems in relation to their own concerns on their conditions of service, lack of resources to deliver adequate quality care and occupational risks in the face of little or no support from the community.

### **Local Health Official Questionnaire**

On the basis that local health officials share a commitment to enhancing health goals in terms of coverage, access and effective use of health care facilities, as well as improved prevention of disease, it was important to consider the contribution key health processes have made to participatory structures.

Using a stratified random sampling process, two questionnaires were developed and submitted to 64 local health authority and NGO officials (doctors, nurses, health technicians, local health administrators, NGO administrators), at district, provincial and departmental levels. The first questionnaire sought to identify problems in the role of participatory structures within key health processes, whether policy had been developed, whether plans and action had been organised and implemented and whether results were evaluated. Its purpose was to establish the importance of functional participatory structures to local health authority and NGO staff. If health is generally perceived as a public good and not as a common good, it is likely that many participatory structures within key health processes will be dysfunctional, embryonic or non-existent because no action has been taken to strengthen them. To test how far local health officials are able or willing to facilitate participatory structures, a second, more detailed questionnaire was submitted to 29 employees from local health authorities and the NGOs.<sup>4</sup> If health officials are prepared to conceive of participation as no more than community involvement it is likely that they will think it preferable to keep each of the various aspects of the health system under the control of the public sector, rather than as a common good. If the promotion of a shared vision of health service provision is considered important, the interviewee is then asked for details about how it is actively promoted. The interviewee was also asked for evidence of a written plan of action to implement the proposed rural health service initiative and the extent to which improved user input had influenced the activities of other organisations.

### **Problem Identification**

Local health officials were asked if there were difficulties in the promotion of different aspects of Primary Health Care (PHC),<sup>5</sup> health awareness and goals. In the context of the key health process of health promotion, prevention and care of illness local health officials were asked if participatory structures to co-ordinate health provides and sectors on agreed health goals was a problem. They were also asked if participation in decision-making on health priorities, budgets and monitoring quality of rural health services was a problem.

### **Policy Statement**

Local health officials were asked for their opinions on the roles of the participatory structures within key health processes associated with health promotion, information gathering and exchange, mobilisation and allocation of resources and monitoring quality of care. If participation in decision-making on health priorities, budgets and monitoring quality of health services were a problem what course of action might improve the situation.

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<sup>4</sup> Many of those that agreed to take part did so on the understanding that their names and positions would not be revealed. In some cases this was prompted by a desire to protect their professional position on the grounds that their opinions were not ones that were shared by their employers, irrespective of whether they were state or NGO, local, national or international. In other cases it was fear of reprisal as a direct consequence of their role (and experience) of the recent conflict.

<sup>5</sup> In the joint WHO-UNICEF conference on Primary Health Care at Alma Ata in 1978 the PHC strategy was identified according to five universal principles: equity, health promotion and prevention, community participation, appropriate technology and the multi-sectoral approach. The original eight components that were devised to reflect the original five principles are health education, nutrition, sanitation, MCH, vaccination campaigns against major infections, prevention and control of endemic diseases, treatment of common diseases and injuries and the provision of essential drugs.

They were asked if there was a general commitment to use participatory structures to assess health and health development needs, propose, review and monitor policy goals and strategies, identify and communicate health system and public health priorities, targets and standards, review equitable distribution of rural health system strategies.

### **Strategy or Plan of Action**

Wherever possible evidence of a written strategy or plan of action designed to improve health awareness of the eight component parts of PHC, rural health goals, or the co-ordination of health providers and sectors on agreed health goals was sought. Did the plan seek to improve the identification and mobilisation of community inputs in health intervention? Were improvements to the administration of health programmes ever included in the plan?

### **Action to address the Problem**

Local health officials were asked to identify what initiatives they had taken to improve health awareness of the eight component parts of PHC, rural health goals, or the co-ordination of health providers and sectors on agreed health goals. If no action had been taken local health officials were asked for reasons as to why this was and the extent to which it was within their own powers to resolve the obstacle that prevented them from taking action.

### **Assessment or Evaluation**

Local health officials were asked to specify how often assessments or evaluations about the role of participatory structures within key health processes took place and the importance that was attached to them. If no assessment or evaluation had been undertaken local health officials were asked for reasons as to why this was. If an assessment or evaluation had been undertaken local health officials were asked to specify what consequence this had had.

### **Results (success or failure)**

Local health officials were asked to state if they thought the actions that they had taken to improve participatory structures within key health processes had been successful and why.

### **Group Discussions**

Using the results of the local official questionnaire as a starting point, discussion groups were used to obtain the views and opinions of various groups on the roles of participatory structures within key health processes and why they were not working. For the group discussion composed of local government officials, health officials and NGO officials the main focus of attention was on the manner in which social structures and institutions are inclined to formalize mutual expectations of co-operative behaviour and undermine meaningful feedback to communities. By contrast focus groups with TBAs and HWs focused on the nature and implications of interaction between the health sector and the community and between grassroots organisations and other institutions for information gathering and exchange. In one group discussion HWs and TBAs discussion focused on their self-acknowledged exclusion from the identification of health priorities, targets, health standards and plans.

Group discussions with local people focused on the lack of meaningful feedback by health service providers to the community, whether this had changed in recent years and the reasons for the lack of interest amongst health staff in local participatory structures. In spite of efforts to ensure that the gender composition of each group was balanced, this was not always possible since most doctors, health technicians and HWs tend to be male.

### **In-depth interviews with key informants**

In-depth interviews were recorded with more than 200 key informants: local government employees (25), local health authority employees (48) and NGO directors (33), management and staff (46), HWs (27), TBAs (15), community leaders (16), teachers (5), women's groups (29). To make this selection a sampling method was used based on each individual's experience of participation in the different phases that describe community-level development.<sup>6</sup> Extracts from the interviews are introduced to supplement the findings of the different questionnaires and to illustrate the different levels of communication between the organisations that describe the local rural environment and between the multi-purpose workers and the local communities. Interviews were divided into two parts: the first part was composed of 30 questions, the answers to which were tape-recorded. The second part of the interview consisted of a detailed discussion based around their own perceptions of the role of participatory structures within key health processes. Its purpose was to examine the impact health sector changes had made upon popular participation and participatory structures. Questions were grouped into four different categories that were designed to reflect the various aspects of rural health service provision, with which popular participation is associated (human resources, contextual factors, institutional factors and task network influences). A specific questionnaire was used with key informants from the local health authorities, local government and NGOs and subsequently adapted for HWs, TBAs and other community officials.

## **RESULTS**

### **Reform and the functions of Participatory Structures**

In spite of a 50% increase in public and private spending in real terms during the period 1994-7, and an increase in the number of primary health clinics of almost two thirds between 1992-6, the use of health facilities by the poor is low. As we have seen, 73% of the MINSAs health centres have seven or less daily consultations per health professional, whilst 70% of health posts have less than three. In its analysis of the government's failure to successfully prioritise and deliver health services to the poor, the World Bank has identified direct and indirect costs of health services, inefficiencies in the management of key programmes and human resource issues as the principal obstacles (1999: 9-55). Of these, human resource issues are seen as the root cause of many inefficiencies and inequities, on the grounds that medical training has not kept up with the shift towards Primary Health Care (PHC), and with the corresponding shift to community and rural health delivery models (Cortez, 1998; World Bank, 1999:7).

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<sup>6</sup> These include needs identification, planning, co-ordination, implementation, advocacy, monitoring and evaluation (See Lenneiy, 2000: 24).

Such an interpretation suggests that the problems of access to health services, and the difficulty of increasing user input in the management and design process, is subordinate to the problem of the use of unsuitable human resources. Not only does this relegate engagement with the rural poor and the local environment to the margins of any intervention strategy, it also re-affirms the view that CLAS does not work as effectively in rural communities as in peri-urban and less-poor, urban communities. In view of the inequitable impact this has on rural communities, it is striking that internal MINSA guidelines recommend that health service activities should focus on rural communities within 2 hours of a local health facility.<sup>7</sup> Though not every rural community more than 2 hours from a health facility has been affected, the general impression from within the health sector is that the guidelines have been respected “more or less unanimously.”<sup>8</sup> Under such conditions, the empowerment of local people has been made subordinate to issues about high turnover, deep cultural and socio-economic gaps and powerful professional incentives (Nelson and Wright, 1995). Even if community groups are able to inform the health system of its views, it is likely that the information will fail to affect any future health strategy, because the health sector information system is ineffectual. Such weaknesses arise from a combination of factors that include failure to use the information that is available, duplication and the existence of incentives not to provide information (World Bank, 1999).

"No agency collects or monitors information about expenditures incurred by all MINSA providers or by all MINSA programmes or even by all externally funded programmes. Production statistics are no longer collected and published regularly.... There is no official source for inpatient consultations. Each programme produces its own data and there are few serious attempts to consolidate it in a way that would allow monitoring of activities at an aggregate level. Similar problems exist with the measurement of inputs, even for high-cost items such as staff training, or the provision of equipment, since each programme or funding source maintains its own records and there is neither a human resource or an infrastructure office in MINSA to effectively consolidate such information." (World Bank, 1999:6)

In a recent study conducted by the World Bank, it was discovered that estimates of the production of key health services vary by 200% (1999:47). For 1995, estimates of the production of ambulatory consultations were found to range from 30 to 68 million for the sector as a whole, whilst estimates for ambulatory consultations were found to vary between 15 million (official statistics), to 27 million (household survey estimates). In the absence of any specific Constitutional mandate to develop regional services, or any initiative that would provide sources of revenue for local authorities, services and 94% of revenue will continue to be delegated to regional government by central office. Not only is the inability to generate local revenue likely to exacerbate regional and social disparities, it is also likely to mean that resources to fund any regulatory and enabling role through training and infrastructure development will be unavailable (Conyers, 1983; Gonzales-Block, 1989; Ugaz, 1997).

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<sup>7</sup> See *Lineamientos de Política Sectorial para el periodo 2002-2012* and the *Principios Fundamentales para el Quinquenio* (August, 2001-July, 2006)

<sup>8</sup> Pers. Comm from ex-MINSA official, Ayacucho

To understand how the various participant organisations and participatory structures have sought to overcome these difficulties, it is important to look beyond the mechanisms for information flows between health systems and the public. This implies a more active engagement with the nature of information exchange and dialogue between community groups and the state. It implies looking at the processes of information sharing and decision-making within health systems and local government, as well as the local structures that interact with the various public groups and health providers. However, the mechanisms for information flow, for expressing, negotiating and arbitrating on the different interests that this development gives rise to, are less important than the achievement of having rural concerns taken on board by established political organisations from local government or from well established NGOs.

According to the Analysis of the Internally Displaced in Ayacucho, 1993-1997, one of the reasons why communication breaks down is that there is "a real gap between the propaganda about community participation, and what the State actually does."<sup>9</sup> The norms, networks and trust that provide links with socially and economically marginalised peoples do not always happen, or they simply fail to actively and capably represent local interests. Instead, insufficient information and inadequate processes, capacities and resources mean that the rural poor are generally excluded from making decisions about their own development initiatives. This encourages technocratic or paternalistic approaches to participation, which fail to enhance community capabilities for health, because they avoid any deliberate emphasis on specific situations informed by empirical evidence. For a system with such a low level of public input or consultation, decisions are likely to be subject to over-generalisation and theoretical or universal formulas, and made at high level with rural people at several stages removed from the negotiating process. Through allowing the lack of resources to guide the development process, the local health authorities have ignored those issues that are the generally accepted basis under which participation can take place. It reneges on any commitment to redress the imbalances of development activities, and opens the door to broader interpretations of participation that might be legitimate for other purposes but unlikely to make any reference to the organised efforts of specific groups or movements.

### **Improvements in Participatory Structures**

Instead of health activities being planned by the regional health authorities, all CLAS institutions prepare annual local health plans which contain a diagnosis of the health conditions in the community, the targets, the activities and the required budgets to implement those activities. Of the different levels at which the analysis of participatory structures and processes may be best focused, the specific challenges that exist within rural health services mean that the manner and extent to which policy accountability is met at local level is likely to be the most critical. Since the unlawful dissolution of Congress and the Judiciary in April 1992, the local share of public spending in Peru has been 6% compared with 15% in Brazil; in addition, overall municipal spending has contracted to 4% and in 1996 to 3.4%. Funding available to basic social services' has fallen in relative terms and declined as a proportion of GDP expenditure (3.4% in the early 1990s).

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<sup>9</sup> *Diagnostico de Desplazamiento de Ayacucho, 1993-1997 (CEPRODEP, 1998).*

While 25% of the government budget was allocated to social expenditure at the beginning of the 70s, this proportion fell to 19% in the early 80s and then returned to 23% in the early 90s. However, the fall in social expenditure has been more substantial in absolute terms. For example, in 1992, expenditure was equivalent to only 49% of the total expenditure for 1980. To this end, information about building public accountability in the development and execution of health policies needs to be supplemented from processes that are outside the health system structure, and the public sector altogether.

### **CLAS: Deficiencies and Advantages**

For an environment increasingly associated with the centralization of power and the erosion of local political culture, CLAS not only represents a renewed interest in regionalization, but a willingness to consider local public health services from a perspective that is different from conventional regional health authorities. Instead of health activities being planned by the regional health authorities, all CLAS institutions prepare annual local health plans which contain a diagnosis of the health conditions in the community, the targets, the activities and the required budgets to implement those activities. However, direct financial support for operational costs, resources and some staff salaries from MINSA has brought CLAS into open dispute with regional health authorities.<sup>10</sup> No attempt has been made to combine the CLAS administrative structure with local government; instead, it is allowed to function alongside regional health authorities. Such a parallel structure represents an effective challenge to local government capacity; it also raises questions about the entire future structure of local government. Instead of leaving development strictly to the market mechanism of economic costs and benefits, CLAS seeks to employ a more integrated approach to development. CLAS represents an advance over the “one size fits all” rural development panacea. However, without greater clarification, it is difficult to know how CLAS will operate in the future: as a replacement for local health authorities, or as a limited concession to the dispersal of decision-making and greater popular participation. In a recent evaluation of health services, the source of the problem was identified as a lack of clarity about the statutes that govern their authority as unclear and lacking in specific instructions.<sup>11</sup> To overcome this problem, the author found that some sub-regions would establish their own rules, organization and demands; which suggests that the relationship between individual CLAS establishments and local authorities range from close and well informed to indifferent.<sup>12</sup> For CLAS establishments in both Cajamarca and Ayacucho, this author found that health personnel were unable to modify their structures, or make any purchases of medical equipment without the authorization of the sub-region. Such a high level of public exclusion from the decision making process can stimulate the development of participatory mechanisms outside the formal health system. In this situation, popular participation inside the health system is reduced to a set of conditions that are shaped by how the manager of the CLAS establishment chooses to define his relationship with the community.

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<sup>10</sup> The granting of new permits for the expansion of CLAS has been suspended since 1997.

<sup>11</sup> See *Equidad Y Calidad de los Servicios de Salud: El Caso de los CLAS* by Rafael Cortez, *Universidad del Pacifico*, September 1998.

<sup>12</sup> See Cortez, (1998:22).

In practice, this encourages a situation in which the management establishes an alliance with community representatives, in which the latter dominate the former; or an alliance with the doctor or the health team; or an entirely vertical relationship in which the manager simply issues directives.<sup>13</sup> Such low levels of interaction are exacerbated by a failure to enlist the long-term commitment of personnel through training programmes in public health. This, together with the emphasis on hospital training, means that MINSA is responsible for a succession of appointments to a CLAS structure with little or no interest in the specific needs of a rural health system (Cortez, 1998:18). A separate, but not unrelated matter, concerns the short-term contracts that are issued to all local health authority staff. Most of the local people questioned regard this issue as perhaps the most critical obstacle of them all, on the grounds that it makes the development of any relationship between the community and the health centre almost impossible. In Huaracasca community in the district of Saurama, PRA analysis found that some women would not leave their community to visit the health centre because of arrogance, disinterest and a constantly changing series of health staff. The teacher from a community in Condebamba, Cajabamba said that the high turnover of local health officials obscured the more important problem of securing an immediate replacement for the person who had left. Such shortcomings are symptomatic of an organisational problem that affects many aspects of the CLAS structure, and its capacity to increase popular input into the delivery of rural health services.

In the course of discussions with personnel from more than 40 rural health posts, this author found that the CLAS establishment is unreceptive to greater inputs from the community, because it is subject to too many constraints of its own. Health service personnel interviewed for this study insisted that the CLAS establishment is unable to operate as an effective participatory mechanism because it lacks the resources to do so. Insufficient transport for community visits, constant changes in personnel, team members who leave and are not replaced, long absences by team doctors and other health professionals, and a lack of basic equipment, drugs and medicines, all contribute to a situation that prevents greater interaction with the local community.

Such difficulties are a significant influence upon the level of interaction with the local community; it also means that participation is far more likely to be assigned a passive role during the implementation of health actions, such as prevention, care and information sharing. Not one of the 20 communities visited by this author said that recent health sector activities had given them a sense of greater ownership, particularly in relation to decision-making, health priorities, budgets and monitoring quality of health services. Instead, rural people see CLAS and other local health facilities as something that has been introduced from outside: in communities more than two hours from the nearest health facility, its impact upon community ownership has been so slight that local people do not really understand that initiatives to promote greater participation in the governance of health systems are actively promoted by the state. The lack of any general consent shown by MINSA about the activities and responsibilities of CLAS is evident from the low level of awareness about the difficulties facing HWs. Interviews with MINSA officials conducted by this author found that few were aware that a majority of HWs experience serious difficulties in setting aside the 2 hours 20 minutes per day that MINSA recommends.

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<sup>13</sup> See Cortez (1998:25).

For all those interviewed for this study almost no one made any distinction between employment conditions under CLAS and ordinary rural health posts and health centres.

### **The Importance of Medical Services to Rural Communities**

Only three of the 20 communities visited by this author, identified the health post as one of the six most important organised activities operating within the community. Only two of the 20 communities said that the health post was more important to them now than it was three years ago. When asked if this was because local people preferred to use the local health centre this was categorically denied. In seven out of the 10 communities visited in Cajamarca the most important community activity was the maintenance of the drinking water system, whereas in Ayacucho eight out of the ten communities said that the most important community activity was either the self-defence group or the community administrative committee. The low level of importance attached to the medical services is confirmed by the results of the questionnaire conducted with HWs and TBAs, which found that 97.9% of respondents felt that local people prefer to use traditional medicine than health services provided by MINSA or the NGOs.

Such unwillingness to engage more closely with local interests suggests that the centralization of health policy and planning will continue, and that the wide gap between the commitment to provide universal access to basic health service provision and the reality is likely to remain. Though communities identify the health committee, the community committee and the women's clubs as important, this is not on account of the participatory role they play in the governance of the health system. As participatory structures they possess characteristics that are similar, but unrelated to the governance of the health system and outside any formal health process. In a series of community group discussions, this author found that participation was regular, voluntary and continuous, even though the management and administration provided by the community committee and the MCH promotion organised by the women's clubs was more *ad hoc* than regular. In all cases, however, decision-making was a shared process because its content concerned something that affected everyone. The importance of the health committee on the other hand - CLAS administered or otherwise - is perceived as more a matter of status over substance.

### **Information Systems**

To assess how the powers legally granted to CLAS and other public health facilities are exercised in practice, and how actively participation is fostered within them, it is important to establish how much information is communicated by them to the community, and by the community to the CLAS structure. It is equally important to establish whether information exchange and communication are adequate and comprehensible. Are the mechanisms and capacities for public reaction fully effective? Is the manner in which public feedback influences decisions effective? In general, information gathering and exchange is dependent upon inter-institutional and grassroots co-ordination that is undermined by an environment characterised by isolation, remoteness, poverty and ineffective forms of communication.

To incorporate and reflect the opinions and priorities of social groups under such conditions is either very difficult, or simply not done. This means that any participation in the governance of the rural health system is reduced to one-off initiatives, such as vaccination campaigns or through the health promotion activities of the HW and the TBA. In the context of an inflexible local infrastructure without the resources to adapt to new demands, follow-up to any intervention or specific health priority is as difficult as the achievement of specific objectives.

In the local health official questionnaire, almost two thirds (65.5%) of the respondents admit that information about the views, opinions and priorities of rural people was not gathered by the local health authorities and that advance information about health activities was not passed to the community. In addition, the same respondents said that information about earlier activities did not flow back to the communities. This means that communities are rarely told anything in advance; health teams either arrive on a day that is not the same as the one originally specified, or simply appear without any prior notice. Such obstructions to effective communication and any meaningful interpersonal relationship mean that local health officials are perceived as out of touch, uninterested or indifferent to the lack of any transparency in either planning or in their activities. Local HWs included in this study feel that the greatest difficulty rural communities have for improving information access and exchange is the difficulty in obtaining access to the local health centre and rural health services. Though distance from the health facility is a key issue, information gathering and exchange is also affected by weaknesses in the mechanisms for popular participation. In an interview with a representative of the self-defence committee in Muchkapata in the district of Saurama, this author was told that visits by health officials are "disrespectful" to the community. Health officials arrive without prior notice, information is delivered as a series of statements, and no response is expected or encouraged. If most of the community is away or working on their smallholdings, those present at the meeting are told to tell the others of what is going to happen. Information is not presented in *Quechua*, and no effort is made to encourage individuals to represent the community in subsequent meetings. Health officials interviewed from the health centre in Vilcashuaman about the lack of interaction with the community, point to the low level of investment in the area, in spite of the recent reconstruction programmes. Fear that pockets of Shining Path remain active in the surrounding districts, mean that health officials are reluctant to visit communities with no access to roads, or which are more than five hours' walk from the district capital. In Vilcashuaman, 83.3% of HWs and TBAs said that even if health officials were to use them to gather and organise information, it would be difficult to report on because the health centre was so far away. All of the HW and TBA respondents said that the journey is not worth making, because there is no opportunity to participate in the design and construction of a programme suited to the particular needs of their community.<sup>14</sup>

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<sup>14</sup> Other common explanations for not making the journey to the local health centre are that family responsibilities prevent them from making the journey, that they cannot afford to or that they would have to stay away from the community for too long because the distance is so great.

These various weaknesses mean that local people have little or no confidence in the rural health service, and this is reflected in the fact that the health centre is nearly always subordinate to the GROs, in the order of priority agreed upon by the community. In PRA exercises and group discussions at community level, this author was told that community leaders and social leaders are excluded from the health process. In spite of local participatory structures, including women's clubs, self-defence committees, water and sanitation committees, with a capacity to function as consultative fora, negotiate or reach decisions, none are encouraged to advise the health centre or other institutional management structures.

In PRA exercises and group discussions, local people were asked to specify what kind of information gathering and exchange there was, who was involved, and who was responsible for the overall organisation of information, and the investigation of specific issues arising from the collection of that information. Using findings obtained from PRA exercises from all 20 communities included in this study, the results show that effectiveness and the importance attached to each participatory structure is largely a consequence of the emotional, practical or instrumental support each initiative is able to provide.<sup>15</sup> *The importance of the self-defence committee, for example, was a consequence of the night patrols, the security its regular operation brought, and the prompt information it was able to relay to the community on a regular basis. In community group discussions, this author found that participation was regular, voluntary and continuous, even though information gathering and exchange would sometimes take place on an ad hoc basis. In all cases, however, information was obtained and shared with the community, because its content concerned something that affected everyone. The fact that the activities are community initiatives, managed and administered by the community; that they reflect the wishes of the community and that a good proportion of the community is involved in their day-to-day operation is critical.* More often than not district, provincial and departmental representatives are regarded as remote, out of touch, and lacking in any close community relationship. In spite of general agreement from local health officials, NGOs and local people that information gathering should be strengthened across all dimensions of the rural health system, cultural differences remain a powerful obstacle. Lack of training in public health, failure to speak *Quechua*, difficulties of access, remoteness and lack of available time are familiar obstructions to the kind of horizontal relationship needed to gather and exchange information.

### **Structures of Power and Influence**

In Peru the rural health system operates as a deconcentrated organisation, which means that it is able to function without actually devolving power to local people in the form of local government. Use of decentralized resources without clear mechanisms for monitoring how allocation guidelines are met, without public information on the fund or its use, and without mechanisms for allocation and management of such funds for PHC services, can lead to resources not reaching the clinic or community health interventions.

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<sup>15</sup> The evidence that social support is beneficial to health has helped to generate literature about the precise form this support should take. Stansfield, (1999) argues that an examination of the quality of support is likely to generate a much greater richness of analysis. Use of these different types of support (emotional, practical and instrumental), has been made during the fieldwork stage of this research.

Such factors constrain participation, because it means that local officials and other responsible parties are not accountable to ordinary users. In practice, organizational culture, management custom and the absence of any regional policy mean that interaction with the local social and organizational environment is weak, and dominated by ineffective communication and the wider physical environment. For example, 86.2% of the respondents said that local officials are out of touch with the rural communities. In 20 randomly selected communities, the number and frequency of contacts with district, provincial and departmental representatives diminishes in relation to the distance between the communities and the local health centre.

No communities included in this investigation, and located more than six hours walk from the local health post in Chancay district, had been visited for at least six months. In the district of Saurama, the more remote communities are as much as three days' walk from the local health centre, and had not been visited for even longer. Not only is this likely to cause rural policy and planning to "artificially homogenise the needs and aspirations of the communities" affected, it also damages the already fragile relationship between indigenous culture and Western-style authority.<sup>16</sup> In practice, this means that state-sponsored participation in rural health programmes fundamentally contradicts itself; a programme that is designed, financed and then implemented without prior consultation cannot be participatory at the same time. How can state-sponsored participation be successful if the communities are not consulted beforehand? Insufficient authority and resources on behalf of the local administration only help to exacerbate the relationship between civil society and the state still further.

This has given rise to much disillusionment with the local health authorities by the rural communities, and helped to minimise the relationship between the health authorities and the rural communities. For example, the President of the Centre for Health Workers and Midwives in San Marcos (which is located within 10 minutes' walk of the provincial hospital), told this author that there was no contact at all with MINSA staff, in spite of their relative proximity to each other. Information about access to, and control over community resources such as land, labour, capital, services and income is restricted to vague assumptions, whilst information about the participation of local people is restricted to first-hand impressions. Asked why the local health centre is not a priority for local people this author was told that it is because health personnel are rude and condescending, unable to communicate in *Quechua* and composed of people who make promises and then fail to keep to them.<sup>17</sup> Information about the daily activities of women is generally lacking, and visits to the rural communities are rarely organised around times that are appropriate to women. The expectation that everyone should simply drop everything for a visit from the health centre is commonplace. In this context, limited knowledge about the local social and organizational environment is a powerful obstacle to effective participation (Rahman, 1990:45-49). In the local health official questionnaire, 79.3% of respondents said that women are too busy to participate in health programmes. Not only does this suggest that outside intervention is neglectful of women's participation, but it also implies that health strategies are gender blind.

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<sup>16</sup> See Morgan (1993:4ff); Booth, (1997:8ff).

<sup>17</sup> In the PRA exercises carried out by this author only four of the 20 communities put the local health centre higher than sixth place in order of priority.

## **Characteristics of Life in a Rural Community**

The provision of rural health services has emphasized the importance of one specific type of approach to intervention for so long that the outsiders' beliefs and values are rarely brought into question. The idea of poverty as a multi-dimensional phenomenon, and concerned not only with material deprivation but also with isolation, dependence and subordination, absence of organizations, lack of assets, vulnerability to natural disasters and insecurity is scarcely acknowledged. However, 72.4% of local health official respondents admit that knowledge of the local social and organisational environment is low, whilst 86.2% think poor communication from personnel damage relationships with the communities. Under such conditions, accountability to the community is diluted to the point that the responsibilities and obligations associated with any partnership between a service provider and the user are inexact and insensitive to local needs. In this context, things and infrastructure take precedence over people and capabilities. In a context of limited social capital networks, norms and trust do not flourish, and this means that rural people do not act together to pursue shared objectives. Under such conditions it is unsurprising that 60.4% of the HWs and TBAs consider that rural people do not respect their roles as HWs and TBAs. In a context of limited resources, the high levels of investment in vertical-style health programmes make the absence of training in public health and the limited interest in the local social and organizational environment easy to justify.

To what extent, then, are community organisations capable of providing ordinary people with the capacity to defend mutual interests, identify priorities and challenge authority? Can the emerging ideas about social capital provide a vehicle for building public accountability in the development and implementation of health policies? If participation is able to benefit the rural poor, we are only likely to find out if our approach places much more focus on process, on power dynamics, on patterns of inclusion and exclusion. To this end it is important to look at local norms of decision making and representation, of how changes are negotiated, of how people may indirectly affect outcomes without direct participation. The different ways in which local people have adapted themselves to a specific set of conditions suggest that the participatory mechanisms most likely to engage the commitment of local people cannot be automatically assumed. In practice, ideas about community organisations and their importance to the community are often based on unclear ideas about why they are successful, or able to engage the attention of so many more people than those from outside the community. As a form of participatory mechanism, the community organisation is often seen as the "yardstick" by which all others must be measured.

The assumed inability of outside intervention to integrate itself with existing community organisations is evident from the implementation procedure adopted by many initiatives from outside the community, despite the multifarious ways in which local people continue to adapt themselves to new and changing conditions. An emphasis on clear administrative arrangements and the exclusion of so many varied political, economic and social issues from outside intervention highlights the need for much greater reflection on local social and organisational arrangements. Under such conditions one should not look towards the introduction of some pre-determined model so much as a set of conditions that allows popular participation to continue to adapt to every new obstacle.

## Role of NGOs and Other Actors

Findings from a recent report about the re-integration of local people into rural life since the conflict ended indicate that any visible response to locally identified needs as the criterion by which both the health sector and NGO interventions are organized is largely disregarded.<sup>18</sup> Instead, both health sector and NGO activities are defined according to their own limited resources. At local level this means that certain aspects of community development plans are neglected in favour of others, that NGO intervention is widely dispersed, and that limited co-ordination between individual NGOs and between NGOs and the health sector, have a disproportionate effect upon any outcome.<sup>19</sup> Of the local health officials who replied to the questionnaire, 86.2% regard inter-institutional and grassroots organization co-ordination as superficial and an obstacle to effective local participation. There is, however, general agreement that inter-institutional and grassroots co-ordination is dominated by divergent interpretations of how organizations should co-operate if outside intervention is to have a successful impact upon participation in rural health. However, for the most part attention is drawn towards the difficulty of moving a bureaucratic process away from a static, hierarchical approach to co-ordination, to one that is non-hierarchical, co-operative and compatible with the local social and organizational environment.

The exclusion of so many different aspects of the local social and organizational environment from rural health service provision increases the chances that the poor will continue to look to other forms of outside intervention. Starting from the premise that a rural health service cannot be developed and sustained without an inter-sectoral perspective (de Kadt, 1983; Rifken, 1986), local health official respondents were asked if they thought national policies and guidelines are implemented and evaluated within the context of an inter-sectoral approach. Nearly nine tenths (86.2%) of respondents said that inter-institutional and grassroots co-ordination is superficial. Under the present system, short-term employment, sectoral divisions, standardization and individual action reduce the prospect for greater openness amongst organizations, which affects co-ordination and the manner in which it is interpreted. Mechanisms to ensure the effectiveness of inter-sectoral co-ordination are often described by local health officials as effective at departmental or provincial level, and ineffective at district level. Under such conditions, the exchange of information between district level health structures and rural people is limited, particularly on issues of quality, equity and access. Such obstacles to collaboration mean that individuals from NGOs and MINSA are reluctant to work together. Under such conditions, any evaluation of the improvements in collaborative behaviour must look beyond the quantitative aspect of the interaction between the service providers and the user and focus on the qualitative aspect of the relationship. Failure to do so will mean that the quality of the emotional, practical and instrumental support the community receives from the service providers will be ignored.

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<sup>18</sup> See *Diagnostico de Desplazamiento Ayacucho 1993-7 – CEPRODEP 1998*.

<sup>19</sup> This refers to the *Zonas de accion concentrada* proposal put forward by the state and the NGO focus on districts in the high Andes located either in Huanta or in parts of Tambo with the *Comites de Reconstruccion y Desarrollo Local (CORDEC)*.

## BIBLIOGRAPHY

- Adrianzen, A. (1996), *La Descentralizacion y Los Espacios Locales: Un Nuevo Sentido de la Reforma Politica*. (manuscript).
- Altobelli, L. and Leon, F., (1997), Changing Community Perceptions of Reproductive Health Services and Reducing the Unmet Need for them in Peru's Highland: A Baseline Study. Final report of INOPAL III Sub-Project, Lima: Population Council.
- Altobelli, L. (1998), A Comparative Analysis of Primary Health Care Facilities with Participation of Civil Society in Venezuela and Peru, IADB
- APRISABAC, (1997), *La Brecha entre la Oferta y la Demanda en el Area Rural*, Cajamarca, Peru.
- Bainbridge, V., Foerster, S., Pasteur, K., Pimbert, M., Pratt, G., I. Yaschine Arroyo (2000), *Transforming Bureaucracies: Institutionalising Participatory Approaches and Processes for Natural Resource Management*, London, IIED.
- Bebbington, A. (1999), Capitals and Capabilities: A Framework for Analyzing Peasant Viability, Rural Livelihoods and Poverty. *World Development* Vol. 27 No. 12, pp. 2021-2044.
- Bebbington, A. (1993), Sustainable Livelihood Development in the Andes: Local Institutions and Regional Resource Use in Ecuador, *Development Policy Review* Vol. 11, 5-30.
- Bennet, S., Russel, S. and Mills, A. (1996), Institutional and Economic Perspectives on Government Capacity to Assume New Roles in Health Sector: A Review of Experience. Department of Public Health and Policy Publications, No. 22. London: London School of Hygiene and Tropical Medicine.
- Bhatnagar, B. and Willimas, A. C., (eds), (1992), *Participatory Development and the World Bank: Potential Directions for Change*, World Bank Discussion Paper, 183, Washington D.C.: World Bank.
- Blackburn, J., with Holland, J., (eds), (1998), *Who Changes? Institutionalising Participation in Development*, London: Intermediate Technology.
- Blair, H. (2000), Participation and Accountability at the Periphery: Democratic Local Governance in Six Countries. *World Development*, Vol. 28 No. 1 pp. 21-39
- Booth, D. & Widmark, S. (1997), *Democratising the State in Rural Bolivia*, Stockholm: Development Studies Unit and Department of Social Anthropology (mimeo).

- Brock, K. (1999), *It's Not Only Wealth that Matters - It's Peace of Mind Too: A Review of Participatory Work on Poverty and Ill-Being: Consultations with the Poor*. World Bank, Poverty Group
- Chabot, H. T. and Brenner, J. (1988), *Government Health Services versus Community: Conflict or Harmony*, *Social Science and Medicine*, 26: 957-62.
- Chalmers, D. Martin, S. & Piester, K. (1997), *Associative Networks: New Structures of Representation for the Popular Sectors?* in Chalmers et al. (eds.) *The New Politics of Inequality in Latin America*. Oxford: OUP.
- Chambers, R. (1991), *The State and Rural Development: Ideologies and an Agenda for the 1990s* in Colclough & Manor (1995), *States or Markets*, Oxford, Clarendon Press.
- Chambers, R. (1994), *Challenging the Professions: Frontiers for Rural Development, Intermediate Technology*.
- Chambers, R. (1997), *Whose Reality Counts? Putting the First Last*, Intermediate Technology.
- Choksi, Armeane, (1997) *Reforma en el Sector Salud: Los Retos de Hoy y Manana, Seminario Internacional Reforma del Sector Salud*, MINSA, 1997
- Cleaver, F. (2001), *Institutions, Agency and the Limitations of Participatory Development* in Cooke, B. and Kothari, U., (eds) (2001), *Participation: The New Tyranny?*, London: Zed Books.
- Cohen, J. and Uphoff, N., (1980), *Participation's Place in Rural Development: Seeking Clarity Through Specificity*, *World Development*, 8: 213-235.
- Collier, P. (1998), *Social Capital and Poverty*, Social Capital Initiative Working Paper No. 4, World Bank.
- Cooke, B. and Kothari, U., (eds) (2001), *Participation: The New Tyranny?*, London: Zed Books.
- Cornwall, A. Lucas, H. and Pasteur, K., (2000a), *Accountability through Participation: Developing Workable Partnership Models in the Health Sector* in Institute of Development Studies Bulletin, (2000), *Accountability Through Participation: Developing Workable Partnership models in the Health Sector*, Vol. 31, Number 1, January.
- Cornwall, A. and Gaventa, J., (2000b), *From Users and Choosers to Makers and Shapers: Repositioning Participation in Soc. Policy*, *IDS Bulletin*, 31(1):1-13.
- Cornwall, A., (2001), *Beneficiary, Consumer, Citizen: Perspectives on Participation for Poverty Reduction*, *Sida Studies* no. 2, Stockholm.

- Cortez, R., (1998), *Equidad y Calidad de los Servicios de Salud: El Caso de los CLAS*, Universidad del Pacifico
- Degregori, Coronel and del Pino, (1998), Government, Citizenship and Democracy: A Regional Perspective, in Crabtree, J. & Thomas, J., (1998), *Fujimori's Peru: The Political Economy*, Institute of Latin American Studies, University of London.
- Figuroa, A. Altamarino, T. Sulmont, D. (1996), *Social Exclusion and Inequality in Peru*. Geneva: International Labour Organization.
- Fox, J. (1997), *The Difficult Transition from Clientelism to Citizenship: Lessons from Mexico in The New Politics of Inequality in Latin America* (eds.) Chalmers, Vilas, Hite, Martin, Piester, Segarra.
- Garcia de Chu, I. and Carmen Piazza, M., (1998), *Sociedad y Gobierno Local*, DESCO.
- Gaventa, J. (1998) *Poverty, Participation and Social Exclusion in North and South*, IDS Bulletin, Vol. 29 No. 150-58.
- Goldman, I. (2000), *Micro to Macro: Policies and Institutions for Empowering the Rural Poor*, report for DFID (available through website [www.livelihoods.org](http://www.livelihoods.org).)
- Gujit, I. and Kaul Shah, M., (1998), *Waking up to Power, Conflict and Process*, in I. Gujit and M. Kaul Shah (eds) *The Myth of Community: Gender Issues in Participatory Development*, IT Publications, London.
- ILLS/UNDP, (1997), *Social Exclusion and Anti-Poverty Strategies: Project on the Patterns and Cases of Social Exclusion and the Design of Policies to Promote Integration. A Synthesis of Findings*, International Institute for Labour Studies/United Nations Development Programme, Geneva.
- Kahassy, H. M. and Baum, F. (1996), *The Role of Civil Society in District Health Systems*, Hidden Resources ARA Division, World Health Organisation, Geneva
- Kahassy, H. M., Olowu, B. and Okiwelu, T. (1997), *The Role of Local Government In Health*, WHO/IWC/97.3 Geneva.
- Krishna, A., Uphoff, N. & Esman, M. (1997), *Reasons for Hope: Instructive Experiences in Rural Development*, West Hartford, Conn.: Kumarian Press.
- Loewenson, R. (1999), *Public Participation in Health: Making People Matter*, IDS Working Paper no. 84, Institute of Development Studies, Sussex.
- Loewenson, R. (2000), *Public Participation in Health System in Zimbabwe*, in *Institute of Development Studies Bulletin*, (2000), *Accountability Through Participation: Developing Workable Partnership models in the Health Sector*, Vol. 31, Number 1, January.

- Mangelsdorf, K. L., Luna, J. and Smith, H. L. (1988), Primary Health Care and Public Policy, World Health Forum, 3: 509-13.
- Marmot, M and Wilkinson, R. (1999), Social Determinants of Health, Oxford University Press
- Midgley, J. (1986), Community Participation, Social Development and the State, Methuen & Co.
- Ministerio de Salud (1995), *Politica de Salud 1995-2000: Hacia la Equidad, Eficiencia y Calidad en Salud*, Lima.
- Ministerio de Salud (1996), *Disposiciones Technicas que Norman el Funcionamiento de los CLAS*, Lima.
- Ministerio de Salud (1996), *Los Comites Locales de Administracion de Salud (CLAS): Organizacion y Modelo de Gestion -El Programa de Salud Local*, Lima.
- Morgan, L. (1993), Community Participation in Health: The Politics of Primary Care in Costa Rica, Cambridge University Press.
- Morley, D., Rohde, J., Chatterjee, M. (1993), Reaching Health for all, OUP.
- Mosse, D., (2001), People's Knowledge, Participation and Patronage: Operations and Representations in Rural Development in Cooke, B. and Kothari, U., (eds) (2001), Participation: The New Tyranny?, London: Zed Books.
- Muller, F. (1983), Contrasts in Community Participation: Case Studies from Peru. In Practising Health for All (ed. D. Morley), pp. 190-207. OUP.
- Narayan, D. (1999), Bonds and Bridges: Social Capital and Poverty, World Bank.
- Nelson, N. and Wright, S. (1995), Power and Participatory Development: Theory and Practice, Intermediate Technology Publications, London.
- Oakley, P. (1991), Projects with People: The Practice of Participation in Rural Development, Geneva, ILO.
- Oakley, P. (1995), People's Participation in Development Projects, Occasional Papers Series No. 7, INTRAC.
- Panfichi, (1997), The Authoritarian Alternative: Anti-Politics in the Popular Sectors of Lima, in The New Politics of Inequality in Latin America (eds.) Chalmers, Vilas, Hite, Martin, Piester, Segarra.
- Parpart, J., (1999), Rethinking Participation, Empowerment and Development from a Gender Perspective, in J. Freedman (ed), Transforming Development,
- Paul, S., (1987), Community Participation in Development Projects, World Bank Discussion Paper, 6, Washington DC: The World Bank.

- Peabody, J. Omar, R. et al. (1999), *Policy and Health: Implications for Development in Asia*, Cambridge University Press.
- Perry, H. et al., (1999), *Attaining Health for All Through Community Partnerships: Principles of the Census-Based, Impact Oriented (CBIO) Approach to Primary Health Care Developed in Bolivia*, *Soc. Science and Medicine*, 48: 1503-1067.
- Putnam, R. D. (1993), *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton University Press, Princeton NJ.
- Rahman, A., (1993), *People's Self Development: Perspectives on Participatory Action Research*, Zed Books.
- Reich, M. R. (1994a), *Political Mapping of Health Policy: A Guide for Managing the Political Dimensions of Health Policy*, Data for Decision-Making Project, Harvard School of Public Health, Boston.
- Reich, M. R. (1994b), *The Politics of Health Sector Reform*, Harvard School of Public Health, Boston.
- Richardson, R. and Waddington, C. (1996), *Community Involvement is not easy*. *International Journal of Health Planning and Management* 11: 307-315.
- Rietbergen-McCracken, J. and Narayan, D. (1998), *Participation and Social Assessment: Tools and Techniques*, Washington, D.C.: World Bank.
- Rifkin, S. and Walt, G. (1986), *Why Health Improves: Defining the Issues Concerning Comprehensive Primary Health Care and Selective Primary Health Care*, *Social Science and Medicine*, 23: 559-66.
- Rifken, S., Muller, F. and Bichmann, W. (1988), *Primary Health Care: On Measuring Participation*. *Social Science and Medicine* 26 (9): 931-40.
- Rifkin, S. (1996), *Paradigms Lost: Towards a New Understanding of Community Participation in Health Programmes*, *Acta Tropica* 61 (2).
- Robb, C., (1999), *Can the Poor Influence Policy? Participatory Poverty Assessments in the Developing World*, World Bank, Washington D.C.
- Robinson, M. (1998), *Democracy, Participation and Public Policy: The Politics of Institutional Design*, in Robinson, M. and White, G. (eds). *The Democratic Developmental State*, Oxford: OUP.
- Schneider, R. (1999), *Participatory Governance: The Missing Link for Poverty Reduction*, OECD: Policy Brief No. 17.
- Schonwalder, G. (1997), *New Democratic Spaces at the Grassroots? Popular Participation in Latin American Local Governments*, *Development and Change*, 28/4:753-70.

- Slater, D. (1989), *Territory and State Power in Latin America: The Peruvian Case*. Basingstoke and London: Macmillan.
- Stansfield, (1999) *Social Support and Social Cohesion*, in Marmot, M and Wilkinson, R. (1999), *Social Determinants of Health*, Oxford University Press
- Stiefel, M and Wolfe, M. (1994), *A Voice for the Excluded. Popular Participation: Utopia or Necessity?* Zed Books Ltd. and UNRISD.
- Sulmont, (1997), *Ciudadana y Estrategias Politicas en la Sociedad Peruana. Algunas Reflexiones*, Paper given to the First Interdisciplinary Seminar on Political Studies (Lima: PUCP).
- Tanaka, M., (1998), *The Changing Boundaries between Society and Politics in Fujimori's Peru* (eds. Crabtree, J. & Thomas, J.).
- Tandon, R and Cordeiro, A (1998): *Participation of Primary Stakeholders in World Bank's Project and Policy Work: Emerging Lessons*, Contribution to the International Conference on "Mainstreaming and Up-Scaling of Primary Stakeholder Participation - Lessons Learned and Ways Forward", Washington, Nov 19-20, 1998.
- Tarimo, E. and Webster, E. G. (1996), *Primary Health Care Concepts and Challenges in a Changing World*. Division of Strengthening of Health Services. Current Concerns. SHS Paper no. 7. Geneva: WHO.
- Tendler, (1997), *Good Governance in the Tropics*, Johns Hopkins.
- Thompson, J. (1995): "Participatory Approaches in Government Bureaucracies: Facilitating the Process of Institutional Change" in *World Development*, Vol.15, No.4, December.
- Tulchin, J. & Bland, G. (1994), *Peru in Crisis: Dictatorship or Democracy?* Lynne Rienner Publishers, London.
- Ugalde, A. (1985a), *The integration of Health Care Programmes into a National Health Service*, in C. Meso-Lago, (ed), *The Crisis of Social security and Health Care*, Latin American Monograph and Document Series No. 9, Centre for Latin American Studies, University of Pittsburgh, Pa.
- Ugalde, A. (1985b), *Ideological Dimensions of Community Participation in Latin America Health Programmes*. *Social Science and Medicine* Vol. 32: 41 - 53.
- Ugarte, U. O. (1997), *Equity and Reform in the Health Sector*, Peru Solidarity Forum.
- Uphoff, N., (1992), *Learning from Gal Oya: Possibilities for Participatory Development and Post-Newtonian Social Science*, Ithaca: Cornell University Press.

- Uphoff, N., Esman, M. & Krishna, A. (1998), *Reasons for Success: Learning from Instructive Experiences in Rural Development*, Kumarian Press
- Valderrama, C. and Hamilton, K. (1999), *Strengthening Participation in Local Governance*, Institute of Development Studies, Brighton.
- Vargas, (1998), *Desarrollo Local y Participacion Politica en Ilo: Nuevas Formas de Articulacion y Representacion Social y Politica*, Documento de Trabajo, No. 95 Instituto de Estudios Peruanos.
- Vilas, C. (1997), Participation, Inequality and the Whereabouts of Democracy, in *The New Politics of Inequality in Latin America* (eds.) Chalmers, Vilas, Hite, Martin, Piester, Segarra.
- Walt, G. and Gilson, L. (1994), Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis, *Health Policy and Planning*, 9: 353-70.
- Webb, R. & Baca, G. F. (1997), *Peru en Numeros 1997, Anuario estadistico*. Lima: Cuanto S.A.
- Werner, D. & Sanders, D. (1997), *The Politics of Primary Health Care*, Healthwrights.
- White, S., (1996), Depoliticising Development: The Uses and Abuses of Participation, *Development in Practice*, 6 (1): 6-15.
- Wilkinson, R. (1996), *Unhealthy Societies: The Afflictions of Inequality*, Routledge.
- World Bank, (1999), *Peru: Improving Health Care for the Poor*, Washington D.C.
- World Bank, (2001), *Community Based Rural Development: Reducing Rural Poverty from the Ground Up*, Coirolo, L., Mclean, K., Mokoli, M., Ryan, A., Shah, P., Williams, M. Produced By Rural Development Strategy, Washington D.C.
- World Health Organization (1988), *District Action Research and Education: A guide to Improving Health Care in the District*, Geneva.