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RETHINKING COMMUNITY PARTICIPATION IN HEALTH; THE SOUTH ASIAN EXPERIENCE

Sivaja K Nair
Indian Institute of Technology,
Madras

Introduction

The concept of community participation gained universal attention with its formalization in the Alma Ata Conference focusing on Primary Health Care held in 1978. Thereafter the concept has attracted many a health planners, activists and policy makers. Following Alma Ata declaration, global frameworks on health, especially the Ottawa charter for Health promotion, 1986 and Jakarta Declaration, 1997 gave thrust to the concept of community participation in health. The participating countries of these conferences and member nations of WHO were urged to frame national programmes and policies on health focusing on community participation. Furthermore, the debates and discourses around social capital and civic engagement within the development community supported by the international agencies like World Bank made community involvement through civic participation an integral part of any development efforts, especially in health promotion. Community participation was thus identified as the 'grant panacea' for all the problems relating to health promotion, especially for poor access. So this paper, taking into consideration the concept of community participation in health, within the framework of social capital discusses the country level experiences around community participation in health across South Asian countries and tries to analyse the lacunae in viewing community participation as built through 'civic engagement' and 'social networking', without taking into consideration, the ingrained social differentials of power on the basis of caste, class and gender.

Community participation in Health: country level experiences

Following the directions from the international agencies on health promotion, many countries have expanded their health systems by incorporating the ideas of community participation in health by involving civic community in health promotion and by training community health workers (CHWs) on a large scale, who became a part of government or national programs.

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This part of the paper briefly discusses the concept of community participation in health in the South Asian countries (Bangladesh, Srilanka, Bhutan, Nepal) with a focus on community health workers and discusses the Indian scenario in detail incorporating all the aspects of community participation.

According to WHO, "CHWs are men and women chosen by the community, and trained to deal with the health problems of individuals and the community, and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculations" (WHO 1990).

CHW's has been titled differently in these countries, as Shasthyo Sebikas, Village Health Worker, Village Health Guide and so on. In **Bangladesh**, the government has provided a few essential services and encouraged NGOs to work with communities to provide responsive health and development initiatives. So there is not any one standard model of community health program forced by government rather they have a large number of efforts by NGO's, most with a firm base in the community (Wyon et al 2002). One of the major initiatives was taken up by BRAC, one of the largest NGO in Bangladesh, through their unsalaried community health workers **(Shastho Shebikas)**, a programme which was initiated in 1977. "Shastho Shebikas are women, **'socially acceptable'**, age 25 to 35 years, married, youngest child's age above five years, eager to do work, preferably educated, not living near a local health care facility or big bazaar" (Hossain1999). They give health education, motivation, and mobilization regarding the five components of Essential Health Care program which consists of water and sanitation, immunization, health and nutrition education, family planning and basic curative services.

In **Bhutan**, Ministry of Health initiated the **Village Health Worker** (VHW) program in 1979. The major objective of VHW program was to establish a link between the community and the health services. The concept of Primary Health Care (PHC) was propagated to the community through these voluntary VHW's, towards the improvement of basic hygiene and sanitation, prevention of vaccine preventable diseases and other preventive and promotive aspects of health (Namgyal 1994). One of the criterions towards the selection of VHW's is

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that a VHW must be **"confident, trusted and popular in the community"** The VHWs are supposed to be primarily the link between the community and the health system. They are expected to provide health education towards better health care, provide simple first aid treatment for emergencies and minor illnesses, notification of the outbreak of any epidemics in the community, recognizing danger signs and symptoms of serious and chronic patients, and to play an important role in out-reach clinics and expanded program of immunization and referral to the nearest health centre.

In **Nepal**, first national Community Health Volunteer program was launched during the late 1970s; during the course of time it has changed and expanded into the current National **Female Community Health Volunteer (FCHV)** program (1988). In a study on the concept of volunteerism (Government of Nepal and Maternal and Neonatal Health 2003), **favouritism** was observed in the selection of FCHVs. Selection occurred through informal networks and its control was in the hands of local elites. The majority of FCHVs were selected or appointed by Village Development Committee members, political leaders, local elites or health workers. Several community members complained about excluding women who were poorer and from lower castes and ethnic groups in the selection process. The FCHVs played an important, role related to family planning, maternal and neonatal health, child health and select infectious diseases at the community level. They promoted the utilization of available health services and the adoption of preventive health practices among community members. They were recognized as health educators and promoters, community mobilisers, referral agents and community-based service providers.

In the case of **Srilanka**, the involvement of community leaders in health promotion could be traced back to early decades of 20th century, but the major growth of volunteer programs occurred in 1970's. The government developed its volunteer programme (**Community Health workers**) and trained volunteers for community action. Walt et al (1989) noted that although volunteers were supposed to be chosen by the community to which they were accountable this seldom occurred. Most of them **became health volunteers through their contacts** with other health professionals like public health midwife. Volunteers were

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supposed to undertake a multifaceted role as agents of development, spearheading community participation within their own communities, as well as being educators and communicators.

In **India**, community involvement in health has been undertaken through six broad areas (Gaitonde. R et. al) namely

a. **Community Health Workers**: the government of India introduced CHW Scheme across the country in 1977. The title of the worker and the scheme changed over time, from CHW in 1977 to Community Health Volunteer in 1980 and Village Health Guides in 1981. Community members, after getting short-term training, provide a range of services including curative, preventive and promotive interventions. They are expected to act like bridges between the health system and the community. Although their selection was to be made in an open meeting of the total village council, in practice, most often, only a few important village leaders were involved in the selection. During the 1970's men were selected as VHG's, but later on identifying the challenges to maternal and child health and its needs, stress was given to recruit more women and to phase out men from the programme but it was resisted by the organized male CHWs who brought political pressure and initiated legal procedures against their removal, paralyzing the scheme in most states (Chatterjee1993). Until the end of the program, about 80% of the VHGs were male. Following this the Government has implemented a massive programme of appointing ASHA's in each hamlet under the National Rural Health Mission (NRHM).

b. **Creation of models and other management inputs**: This is the case when Communities get involved in the health system through a number of civil society initiatives especially through NGOs. In these instances, the NGOs either put forth models providing a range of services, or the government contracts out various services that the NGOs provide on its behalf. But this has brought forth the question of accountability of these projects getting run through the NGO's.

c. **Community Health Insurance**: This includes a number of community based financial initiatives that have tried to improve access to, the health system by prepayment mechanisms and risk pooling. While there are success stories in a few

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countries like Thailand, experiments in India have shown mixed results (Gaitonde. R et. al).

d. **Community Monitoring**: communities getting involved in monitoring activities so as to hold the health system accountable. It focuses on availability accessibility, quality and equity of services. This demanded the participation of the communities from the very beginning stages of the projects and comprehensible reporting formats which seldom happens.

e. **Community planning**: communities were made part in the evolution of village health level plans. The organizing capacity and credibility stood as the threat towards community planning in many of the programmes.

f. **Inter-sectoral Convergence**: Involving communities in the actions that doesn't directly relate to health but that promotes good health. This is often hindered by miscommunication between the departments, and/or between the people and departments. The exact mechanisms and structures for inter sectoral convergence need to be evolved based on complex local realities for inter sectoral convergence as it is an essential component of primary health care.

Thus one of the important characteristics of the CHW programme as envisaged by its proponents is its ability to generate community participation, thereby making health a priority which motivates the community to access healthcare. Though the term was used diversely during the initial stages of the programme, by the 1980s it had achieved a universal global concept (Walt 1988). Moreover, the success of the CHW programmes across countries inspired the Alma Ata conference of 1978, where primary health care was declared as the key to achieve health for all by 2000 AD. Thus, the idea of community participation, one of the principles of primary health care also became a characteristic of CHW programme across the world (Joshi & George, 2012)

Problematizing community participation in health programmes

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Even after long years of formalization of the concept the analytical difficulties and definitional complexities are still discussed and debated on. The word meant different things to different people in different parts of the world but it was so appealing that it became an essential part of all the international interventions towards health. Participation was made an integral part of the development discourse by its institutionalization by international agencies for eg, world bank has adopted the concept to many of its developmental projects. Community participation was thereafter adopted as an approach towards primary health care by national governments (Morgan, 2001).

In the field of health, the concept of community often describes the group of people targeted by health programmes (Espino et al. 2004). The health programmes based on such a conception of community has been inadequate because of its narrowness as it fails to take into account the different social, political and cultural features of this group of people. Another common definition of community is based on geographical dimension, but this completely discards the non-geographical features of the communities, like sense of ownership, identity and traditions that could really make a difference when programmes are implemented.

As in the case of concept of community participation, it has traditionally been defined in two perspectives, one in a utilitarian perspective making it a means to accomplish the goal of a project with increased efficiency and effectiveness. In an empowerment perspective the concept is identified as an end in itself whereby the community take power over decisions that affect their lives and their health (Morgan, 2001). The ambiguity attached to its meanings and definitions contributed to the appropriation of the term by different actors. But what is missing through all these assumptions is the core idea that participation is all about power. For eg.Susan Rifkin (1996), one of the foremost analyst of participation in health argues that one of the major reason for the failure of most of the participation programmes to meet its expectations is that it is conceived in a paradigm that views participation as magic bullet that could solve all the deep rooted issues in health and politics of power.

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The major assumptions that underpin all the programmes and policies thrusting on community participation were that the structures for community participation create social capital from which the community will benefit. For, Putnam, who is the major proponent of social capital as it is considered in the development world, social capital is characterised by four factors; the existence of community networks, civic engagement (participation in these networks), local identity and a sense of solidarity and equality with other community members and norms of trust and reciprocity(1995). Such an assumption has gone hand in hand with the proliferation of nongovernmental organizations as civic communities.

In this sense as put forward by Putnam, people will participate in the structures of community networks as they know that they will get benefitted and these structures are embedded in the everyday spaces of community life and the informal social networks through which they live their lives. But in real the participation tends to be dominated by a small group of people who are mostly involved in a large number of governance and planning activities. For eg. As in the case of community participation programmes involving health in most of the south Asian countries, CHW's were the prime part of community networks. But the selection process of CHW's were managed by local elites, moreover the planning and organizing action was also initiated by elites in their interest, which was to be followed by the other community members. The policy mandates itself had the roots for this differential participation when they urged the CHW's to be '**socially acceptable', confident, trusted and popular person in the community.** Thus the social capital generated through such a kind of community involvement tends to be concentrated in the hands of a small group who are already in power and position. There is no guarantee that the wider community will benefit from this social capital, because formal networking structures are often not embedded in the informal everyday spaces of community life. Even the CHW's are discriminated by the community because of their caste and class. Chowdhury (2009) gives a brief account of caste based discrimination towards CHW's in Bangladesh.

Another argument on civic participation by Putnam was that participation in civic/voluntary organizations constitutes social capital, which then could be channelled towards good

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governance. Following this idea, supported by the international agencies, the national governments formulated health promotion programmes making civil society (NGO's) an integral part in implementing these programmes, stressing on good governance based on accountability and transparency. But the question to whom these civil societies are accountable to is left unanswered. Harris (2001) analyses this as a depoliticizing mechanism of neo liberal thinking in which states are demarcated from the realm of development. In the case of health promotion programmes too, nation states are found to have more inclination towards drawing private partnerships through NGO's and other agencies in its programme implementation. This has been clear through the Indian National Health Policy, 2002 which stressed on improving private partnerships in the provision of health services. The question of who gets benefitted through this and whose participation is ensured is a matter we need to think of.

Taking the case of civic engagement, Madan (1987) states that there are different realms of participation ranging from the communities initiating a project and seeking assistance from health professionals to external agents shaping programmes and persuading the communities to get involved. With regard to health promotion programmes, most of the programmes are established by adopting a top down approach as planned by the policy makers, it never takes the other way round, getting initiated by the real 'felt needs' of the community. For eg, in the case of ASHA's incorporated into NRHM, the whole programe is centrally planned and the priorities set by the ASHAs are more those of the health services system and not that of the community. There is no specific mechanism through which ASHAs can understand the felt need of the community and the programme in its current form has failed to generate community participation (Joshi &George,2012) In such an approach the priorities are imposed on the community which threatens the idea of ownership of the whole programme. This approach stresses on the idea that communities need external helps and questions the self efficacy of the communities in identifying and tackling their health issues. So the positive effect of such an approach towards building social capital is under scrutiny.

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Regarding the local identity and a sense of solidarity and equality with other community members, the idea is only a myth. Gujit and shah (1998) views that communities are not single entities with shared goals and values rather they have differential goals according to the differentials in stratification like age, gender and caste, which are embedded in the society, shaped by the history of differentials in allocation of resources. Often communities assumed by health planners as a single entity turns out to be heterogeneous in nature. The increasing plurality of the societies questions Putnam's idea of a unitary local identity (Campbell et.al). Communities are marked by complex local specificalities, and any programmes or conceptualizations without taking into consideration these complexities cannot sustain the test of time, and this has been exemplified by the failure of many community participation programmes.

While analysing through the propositions made by Putnam, it is understood that Putnam's ideas are not sufficient a framework to place community participation. It needs a broader framework that takes into account the obstacles created by Politics of power, complex cultural and local specificities rooted in the 'context'. Participation is a very abstract concept which can't be taken out of its context. The contexts give meanings to participation. Context in my view, relates to the social relations and power structures within the society. And participation in programmes, specifically in health programmes cannot be viewed in isolation apart from these contexts. In this term, the stratifications based on caste, class, gender, race and ethnicity has to be taken into account of while considering participation as a matter of discussion.

Conclusion

Participation is not only about theories. Rifkin (1996) has stated that the gap between theory and practice brings forth the uncertainty about community participation strategies. Participation is mostly about approaches in the field, so the dimensions in theories need to be feasible in praxis. So its dimensions needs to be multifaceted and empowering rather than narrowed down and directing. Concepts like Social capital applied in the field should be

extended so as to include frameworks on social exclusion and power relations so as to make the process of participation empowering, because community participation has the power to remake our system of service delivery bringing forth outcomes that are of national importance.

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