People's Participation in Health Care

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The methodology of paticipatory research and action including the major steps and stages involved in operationalising community participation has been discussed in this paper whose first part appeared last month.

We have so far depended on three types of sources:

1. Review of the health projects based on community participation being implemented in the country.
2. A critical analysis of the concept of community participation in terms of successful health projects implemented in other countries and as reported and reproduced by WHO and allied agencies.
3. Practical experience in conducting community participation based projects of NIHFW, in 43 villages of three districts in Madhya Pradesh.

STAGE I

Setting of objectives

The objectives are defined at two levels i.e. at the project level and at the community level. Two approaches are noticed at the project level. Some projects define the objective in a very general way. Other projects of participation have defined their objectives in more concrete and specific terms.

A strong case can be built for defining the objectives of the project in general terms on the rationale that community participation projects are essentially partnership projects, therefore, it would be against the essence of this approach to define a priori its objectives.

It seems more appropriate to help each community define its own task activities which become the specific objectives of the project at the community level. It is expected that at this level, to a large extent, there will be *congruence*/compatability between the '*Bottom up*' objectives framed by the community and the '*Top-down*' objectives of the regular health programmes.

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For defining the community (task) objectives, there is need to concretise the health concerns floating loosely within the community and observed by project workers during initial contacts. For this consolidation, the mechanism of existing or newly created community organizations can be made use of. These organisations could be existing Panchayats or activised Village Health Committees or newly created organisations such as Mahila Mandals and Children's Health Clubs.

In meetings of these organisations health needs survey findings as well as opinions of knowledgeable sources provide raw material for developing the community health plans, laying down the priorities, fixing implementation responsibilities and mobilising community as well as outside resources are deliberated and agreed upon. These, thus become the jointly planned health targets or the objectives of projects at the community level assigned by the people for themselves.

In NIHFW project—the general objective at the project level was "promoting the community competence to organise for and mobilise community and outside resources for meeting health goals of the community."

In so far as the community level tasks or targets are concerned in each village meeting of the health planning committees, Mahila Health Clubs and Children's Health Clubs were organised. In these meetings, besides the members of these organisations other knowledgeable and interested community members were also welcome to participate. The planning meetings of village health committees were held on two consecutive days. They started with presentation of health needs survey findings carried out by the project workers before the meeting. This presentation stimulated discussions and other health needs perceived to be important by participants but not revealed by the survey were brought out. As a next step, a combined list of health needs/problems as revealed by survey and as proposed by villagers was prepared. On the second day the meeting gave priorities to the listed health needs, and subject to availability of community as well as outside resources, three to four specific health programmes were decided upon. Responsibility for implementing each project was discussed. A time-frame for implementing was spelled out. And the community contribution and outside contribution necessary for completing it were discussed. Each community planned and assigned to itself the specific tasks or targets or objectives which they agreed to achieve within an agreed time frame. Thus, the first phase of

participatory planning was initiated in the project and responsibilities as well as norms were developed for implementing the tasks through the process of community participation.

STAGE II

A. Knowledge about the context of the project

Before initiating a project on community participation it is necessary to become fully aware of the context in which the project is to be launched. This involves a thorough analysis of three groups of factors: (a) *The environment*—social, cultural, political, organisational and other factors. (b) The health system. (c) The community setting.

In NIHFW project, the situation is characterised by the fact of a very backward and poor area of Madhya Pradesh with scant/inadequate respect for law and order procedures, caste factions widely dominant with development activities lagging far behind other areas.

B. The status, structure and image of health system

"In case of NIHFW-project the structure of health system was found to follow the normal pattern as prevalent in other parts of the country. Its achievements in some important programmes like family planning and immunizations were at par with the average of the state while in case of certain other important national programmes, such as, MCH services, national health programmes like T.B., Malaria, Leprosy, school health programme, blindness—its performance was deficient. In terms of preventive and promotive aspects of health very little was done. Overall image of health services was found to be very deficient. There was under-utilisation of services, health workers were either not known or popular with villagers and very little attention was given to local health needs of the people. Most of the utilisation was for high priority targetted programmes and wholly based upon individual contact of the workers. Health services were considered inadequate by people as doctors' visits were too infrequent, female workers not available and lack of medicine."

C. The community setting

NIHFW project conducted a Health Needs Assessment Survey of the Villages based upon the information of knowledgeable community sources. Extensive opportunities were created in the project for initiating dialogue on health issues within the community and with the project agency through general meetings, interest group meetings and discussions among the community leaders.

The health needs survey also included a survey of resources, personnel and other, particularly for health activities. The survey also documented existing local organisations, the leadership-base as well as process of decision making, structure within the community and as being practised through the formal organisation of village Panchayats. The experiences of communities in relation to community based project was also documented.

The importance of considering the above factors carefully consists in their power to influence greatly the structure, planning and Methology of the project and in setting general objectives and expectation of the project etc. There must be a good understanding with the existing situation and to enable the project to overcome obstructing factors.

STAGE III

Orientation and sensitising project workers

This stage is seen as one of the crucial stages in any community participation project. The workers orientation may consist of : (a) need and rationale of community participation approach to health, (b) sensitising the workers to the existing health systems and health programmes, (c) making workers aware of other development projects and resources available at PHC and district level, (d) guiding workers in how to work with individuals and community organisation—extension approach and his role as a linkage between community project and district authorities, (e) informing of procedures of reporting, monitoring and evaluating and facilities available to them in implementing the project.

In NIHFW project, the workers were knowledgeable about health system and its programme as they were taken from State health system. The one week training constituted mainly of illustrating them with examples of how to work and mobilise community for health programmes through community members and community organisations. They were also sensitised to the other development departments, their functions and their resources. Particular attention was given to the reporting and documentation procedures to be adopted by them. It was repeatedly emphasised to workers that this project was not parallel/alternative/independent programme to the existing health programme, and that this project was an attempt to further strengthen the existing health programme with additional input. Training was given in informal group discussion sessions using actual illustrations.

STAGE IV

Orientation and sensitising the community

This stage is concerned mainly with introducing the project and the project worker to the community. The main objective is to introduce the philosophy, aims, methodology of the project and potential benefits to the community. For doing this, a simple transfer of information of knowledge through traditional IEC methods may not be sufficient. At the outset a dialogue should be established in which an agency and the communities discuss the possibilities of the project. This dialogue should continue throughout the life of the project. The contents of this dialogue should cover, amongst other things, such factors as identification of health problems and needs of the community, priorities among various needs conduct-

ing health needs surveys and how the community can participate in meeting these needs through its own resources.

This is where agencies start motivating individuals to participate and mobilising community in well defined interest/target groups. Interest group organisation is likely to provide first initial motivating force for participating projects. For introducing the worker as well as the project into the community, one would find the channel of local leaders, opinion leaders, knowledgeable persons and village officials as very useful. Full care need be taken to include all the sections of the population, particularly the ones which have greatest health needs. The agency must ensure that participation and decision making structure of the community should not serve the interest of the influential groups of the community alone. When the agency finds that it has been successful, in establishing a dialogue within the community on several issues and concerns of health, which call for systematic consolidation and organisation, it may be said to have completed this important stage.

In NIHFW project—the workers (Action Research Officers) introduced themselves and the project to the community and for this they were already oriented during sensitisation phase of their training. They used the mechanism of open village meetings, individual contacts with important people, the existing song drama and other recreation groups. On every such occasion a deliberate and pointed reference was made to the fact that there is better utilisation, more commitment and improved services from things in which the community people thamselves involve in the entire process of deciding what to do, how it will be done, where from the resources will be mobilised and how will it be utilised. It was emphasised time and again that in this project there would not be orders from the outside, instead villagers would order themselves to carry out health related tasks which they considered important.

STAGE V

Project structure

All community participation projects need a project structure to operate a programme. This structure invariably would be of three or four tiers depending upon the context of the project. These are:

— a community level structure of the project.
— project organisation's structure.
— PHC and district level structure.

For developing local level structure there are three alternatives available to a change agency:

(1) to make use of the existing community institutions such as 'Bhajan-Mandals,' Drama Society, Village Panchayat, Health Committees, Schools, Village Health Guides, Traditional Dais etc.

(2) to create new institutions, if nothing apparently exists, these institutions can be organised; Health Committees, Mahila Mandals, Schools Health Clubs, Youth Clubs etc.

(3) To have a combination of one and two i.e. make use of whatever exists and to create new institutions specifically geared to meeting of health needs of the people.

Ultimate choice for project structure will depend on many factors notably the functioning of existing structure, the degree of local conflict, and appropriateness of local structures for enlarging their scope to include health aspects. Although, the utilisation of local structures may be easier, yet essential aspect of educational process of participation is learning to organise. Thus, a strong argument can be made for the development of an organisation structure within the community as an integral activity of community participation project.

The second tier will deal with organisational structure of implementing agencies. This structure will have three components of :

(a) community level workers,
(b) supervisory and monitoring structure of implementing agency and lastly
(c) the overall guiding and controlling structure at at the project level.

There may be a need of third tier at PHC and district level. This will be a further extension of the organization structure by creating a specific project related committee at the PHC and the District level. This, however, will depend on overall administrative structure of district for health, general and financial control.

In NIHFW project, for developing local structure, the use was made of third alternative making use of some existing organisation like Village Panchayat, VHC Activising institution like Village Health Committees and creating new institutions like MHC (Mahila Mandals), School Health Clubs (SHC), to provide an opportunity to the villagers of availing the advantage of the educational process of participation by learning to organise themselves for the health programmes.

At the organisational level the project conceived of creating role of Action Research Officers in a group of 10-12 villages with the sole purpose of acting as linkage between the community structure and the organisational structure.

In case of NIHFW project, at the community level the existing Panchayat and the Village Health Committees were reactivised. The Health Guide was given an important role in the whole projeet. In addition, new organisations of Mahila Health Clubs and School Health Clubs were formed for the purposes of the project. The project also made use of existing Bhajan Mandals and Dramatic Clubs in villages.

The implementing project structure consisted of 4 AROs—each working for a group of 10 12 villages. The role of AROs was mainly of linking the community organisation and their activities with the project and the district development departments and voluntary organisations. For continuous supervision guidance and monitoring one Research Officer has

been provided. At the top of the implementing agencies, the structure consists of Project Director, Assistant Project Director mainly responsible for supervision and documentation.

The project envisaged district level planning and review committee consisting of District Collector, District Chief Medical Officer, District Development Officer and chiefs of different other development departments with the project worker (Action Research Officer) as its secretary. This committee was not activitised at the initial stage of the project. However, the project has reached a stage where communities are engaged in implementing 'task activities' and it is felt that it is an appropriate stage when this committee can be usefully activised.

It may be noted that most salient points in the total three tier structure of the NIHFW project is to ensure establishing of effective linkages between the tiers.

STAGE VI

Mechanism of Implementation

It is in the process of implementation that the communities learn to organise and pick up basic elements inherent in the concept of community participation. During implementation the communities experience cooperation, conflict and adjustment. They develop a sense of achieving their needed things. When the services are achieved they face the problems of sharing the benefits. And through all these processes of mobilising individual efforts they develop a feeling or community improvement. During implementation they experience all these through concrete tasks. However, all this learning and growing may not take place and community may miss the significance of all these in the heat of action, unless the project has a mechanism to provide specific opportunities to see these as concrete processes take place.

Thus, the mechanism of the project becomes a key factor. The mechanism usually will be unique to each project as the concept of participation fosters adaptations to local perspectives and conditions. In order that mechanism meets the challenges involved in community participation projects it should have enough flexibility of responding to varying community situations. The agency mechanism should have strong and working linkages to complementary and supportive services and resources. It should have inbuilt capacity to respond to collective as well as individual needs of the community members. Special safeguards may be required to be provided in the mechanism to respond to the weaker and deprived sections of the community. Above all mechanisms should be such as to provide good community with wide coverage. Lastly, it should be simple enough as to be understood and operative by community members.

NIHFW project: This project is a part of DANIDA Area Development Project of Madhya Pradesh. In the project plan a provision has been made of certain amount of United funds for each of the eight districts of the DANIDA Health Care Project. This fund is known as community contingency fund and has been specifically earmarked to meet such directly or indirectly related health activities which may be of importance to community but for which there is no regular and instant provision of budget in health services. At the time of starting participatory project, the Director of Area Project very kindly agreed to see that in using these funds the demands of the participatory project villages get first preference. Thus the NIHFW project was to have flexible resource available to meet the needs of the participatory project. It was flexible in the sence it was not tied to the specific items of work. It was also adequate.

The procedures of its operation were little cumbersome and were invariably the casue of delay in responding to community needs immediately. To overcome this delay a small contingency advance of Rs. 5,000/- was provided to each project worker to get the things started while the procedure of contingency found was being gone through.

The NIHEW project developed a mechanism by which the village health committees were linked to the legal institutions of the Panchayat. On cach Village Health Committee either the 'Sarpanch' or one of the 'Panchayat Members' was also a member. The Village Health Cammittees were also linked with other project institutions i.e. Mahila Swasthya Samiti and School Health Club in the villages. VHGs and Dais were also the members of Village Health Committees. The Village Health Committes sent their decisions through the Panchayat to Collector who was controlling the community contingency fund. The District Collector also controlled several development funds which were not from the health budgets. The project authorities were successful in convincing the Collector to give special attention to such decisions of Village Health Committees which he could not meet from contingeney fund. In brief, a well linked comprehensive mechanism right from village level—to the District Collector level was evolved for the operation of the project. Our experience is that it has worked very satisfactorily.

NIHFW project, at the stage of implementing specific tasks, decided by Village Health Committees worked with the idea of Task Specific Committees. The committees come into action at the stage when the funds are available at the community level. In these committees usually in addition to one or two Village Health Committee members there are other influential members of the community. Their functions remain to mobilise the community participation part of each task, carry out the implementation of the task and render accounts etc. to the Panchayats through Village Health Committees. These Action Committees for detail discussions and decisions *meet on need basis* and wherever necessary they bring in their problem to VHCs for guidance and supports Action Committees also monitor the progress of assigned tasks.

In NIHFW project the research workers are on

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deputation from regular health system therefore the project does not face insurmountable problems in linking the community institutions with the health institutions except initially some problems of relationship were experienced. But the project is getting over them gradually. In the orientation training of the workers they were specially trained how to act as a 'Linkman' between the community and other development departments as well as voluntary organisations. Our experience is that workers to a great extent are successful in getting cooperation with other departments and institutions perticularly education department, industries and electricity boards and social welfare. The project has been successful in getting funds for several programmes from these departments. It is also a successful experience that the project has secured cooperation from 2-3 voluntary organisations in rural development. In the initial stages the workers of the project acted as the dominant links. A stage has now gradually reached when community institutions and community members are directly interacting with several official development agencies and the Non-Government Organisations.

STAGE VII

Phasing the Participatory Projects

Normally it is a useful and practical strategy for implementing any participation project to map out roughly various phases through which it is most likely to pass. Each project agency therefore, develops a tentative outline of the important phases of the project and makes use of it in planning as well as executing the programme. There are various alternative way of delineating these phases. Some projects divide the activities on temporal dimension such as the initial phase of planning followed by execution of activities phase and the termination phase of the project. Alternatively, some projects have divided the project phases on the basis of major activities to be performed in each phase. This approach may result in some such classification:

(a) Community awareness phase.
(b) Phase of integrating the project with existing health system.
(c) Integrating the project with other development agencies including NGOs.

There could be another approach of phasing wherein the project conceived of in two phases of (i) pilot phase, (ii) actual project implementation phase.

In the NIHFW project, the phasing out was done on the basis on activities. The first phase consisted of making the community aware, concerned and interested in health matters and in the general philosophy and approach of the project. The major activity in this phase were of educational nature through influential persons and holding of general meetings of the whole community as well as specific interest groups. During this phase, intensive use was made of village leaders, songs and drama clubs and indigenous health workers. Another major activity of this phase was to make the workers well-informed about the community dynamics, its resources and to create credibility of the project workers in the community. This phase did not require much financial expenditure and lasted about 4 months. In the second phase concentrated attempts were made to create useful and activity based interaction between the project workers in the health system as wellas between the health system and the community. During this phase serious difficulties were encountered in integrating the project workers with the health system because of their differential emphasis on working styles and emphasis on programmes. There was a conflict in the orientation towards work between the workers of health system and workers of the project.

It needed frequent interactions between top level project authorities and the project workers on one side and project authorities and health workers on other. At this point of time the project can not claim the desired integration and it would be fair to say that process is on. The project through the mechanism of District Collector and other District Development Officers has been in a position to initiate several activities which fall into the third phase of integration of project with other development agencies. It has been more easy to integrate with these agencies than integrating with health services, the reason lies perhaps in the ability of the project authorities in convincing other development agencies the need for their support for successful implementation of community participation schemes. Another probable reason could be that these agencies have found in the participation project an easy, immediate and effective means of achieving some of their targets for which they are being hard-pressed and which they found it difficult to fulfil because they do not have an effective mechanism of linking with rural communities in terms of extension workers.

In the end it is necessary to make an observation that these are not sequential phases in the project; it was observed that sometimes the third phase proceeded the second phase or phase one and two proceeded simultaneously. This approach to community participation was based on priority needs identified by the community.

Another important factor in relation to the implementation phase relate to the type and range of activities to be undertaken in a participatory project. In some projects this issue is also raised in terms of suitable entry point for initiating participatory projects. One guiding principle which should normally decide the range and types of activities as well as the question of entry point should be the self identified needs of the community. In practice, however, this basic principle gets compromised by the nature of expertise available with the project. The general objectives and the resources also needs to be considered in deciding about activities. A multisectoral approach through the coordination of agencies appears to be more a practical and feasible preposition in such schemes.

In NIHFW project, the Village Health Committees planning meetings were the major source of defining the activities. These meetings were also availed of to make people knowledgeable about health facilities and the programmes which the project can make them available. To the surprise of the project workers it was very frequently found that in the case of most of the communities a majority of community felt needs matched with the health systems' programme needs upto nearly sixty per cent or more. This was very helpful to the Institute's project as it had health related expertise and services readily available to it. The remaining about 40 per cent of identified needs fell in the domain of other development departments an as already stated the project was fortunate enough to avail of their support. In other words, there was an effective multisectoral approach and coordination in the Institute project. This enabled the project to cover a wide range of activities from 'SOKHTA PITS' to creation of educational facilities bringing in electricity to the village and having construction and as well as repair of roads etc.

STAGE VIII

Monitoring and Assessment

In the preceding several paragraphs we have come up to the stage of implementation and generation of several activities. At this stage agencies will normally feel a need for continuous monitoring and assessment to ensure that the project is developing on correct lines and the basic objective of increasing the competence of communities through participation is being achieved. For this, the agency will have to think of devising ways and means of continuously assessing/evaluating the progress of the project. This will also be necessary to provide mid-term correctives wherever necessary.

However, the very nature of participatory projects makes assessment evaluation difficult. As already explained the ultimate goal of such projects is to bring about a change both in terms of quantity and quality in the interactions of the community and its interactions with the larger society. These projects also attempt to change the work and life styles of the people with a bias to make them more self-reliant. It is very difficult to have a quantitative indicators to assess such changes. Attempts can usefully be made to have before and after surveys on the pattern of Knowledge-Attitude and Practice surveys. However, it is well realised that these surveys were found to be deficient in assessing fully the qualitative changes.

Another problem of evaluation or assessment of these projects arises from the fact that the participatory process itself is a learning process and the maximisation of this participatory learning can be achieved only when the community itself is involved in evaluation/assessment/monitoring of their own efforts.

Another dimension of assessment consists of assessing objectively concrete physical indicators such as number of meetings held, number of people participated, quantity of community mobilised resourses, number of tasks completed etc. etc.

NIHFW project has largely depended upon Daily diaries of its workers for assessing and monitoring concrete activities which can be measured quantitatively. Some of the major indicators used in the project relate to number of activities initiated, mobilisation of supportive resources from outside agencies, contribution of quantitatively measurable resources contributed by the communities etc. etc.

For assessing qualitative changes the project has not devised any concrete measures although it feels that the best achievement of the project has been in the area of knowledge and information level, competency to organise local resources, improvement in their interaction patterns and life styles. Work diaries of workers were supposed to provide some measurement in these qualitative changes but this expectation has not been fulfilled.

STAGE IX

Termination Phase

A community participation project must end its association, sooner or later, with the agency by which it has been started. The community must be competent enough to continue the process without the agency. It is the agency that should plan for its gradual withdrawal from the project scene. This also raises the perennial question of what should be the ideal period for such a project. In a review of such projects in the country it is noticed that very rarely projects have planned for such a phase. The result is that most of the projects seem to continue indefinitely inspite of the recognition that such a continuation argues against the very concept of community participation. In several other cases it is noted that the project has developed a continuing dependence on the leadership of the 'Chrismatic leader' responsible for it. What has actually happened is that such leaders have *replaced* government health agency by themselves. The people continue to be dependent on his/her leadership instead on regular health system.

In certain other projects it is noticed that there has been a sudden withdrawal of the agency depending upon termination of funds to the agency or because the 'Charismatic leader' has found some better opportunity for the exercise of his 'Charisma'. What is desirable is that the withdrawal should be planned gradually, with deliberation and full understanding of the community and ensuring that the good work initiated would be continued as an integral part of the community's style of healthy living.

In case of NIHFW project this consideration was purposefully incorporated in the training of the projecr workers. Likewise right from the community awareness phase of the project, this issue was being discussed in the community and its various organisations. They are continually reminded that ultimately they (people) will have to do all the work by themselves. However, the project did not decisively decide its duration. Normally it is felt that such a project should have a minimum life of 4 to 5 years as it in-

volves qualitative changes in the attitude, thinking and perspective of the villagers. There could be deviations from this ideal time period depending upon the community specific situation.

SOME PRINCIPLES FOR COMMUNITY PARTICIPATION

This section is an attempt to derive some tentative guiding principles which may be of use to those who want to plan and implement projects based upon the approach of community participation. These have been derived from the experiences of running such projects both in the country and outside. Particular strengths and validity of these principles have been derived from the experiences of actually organising and running such a project in villages of Madhya Pradesh by National Institute of Health and Family Welfare. Obviously, they need further testing and validation by several agencies in widely differing situations. As of now these principles can be best described as 'tentative' in nature. All the same, even in this tentative form they can serve as useful guide for workers.

1. There is no one single model or set of rules that can be adopted in all situations.

By the very definition—the nature, contents and approach of community participation based projects ought to be "community specific". Each project has to respond to its unique situation. Successful projects are successful because they have adapted to their settings. This fact is sometimes overlooked by those inclined to advocate the replication of suecessful projects as universal model. Perhaps more important than finding an universal model, there is need for developing skills and set of rules to look for and appreciate the differences into the given specific community situations and to develop community specific strategies for the implementation of these projects.

II. Successful projects have worked through community leaders and groups

Very often community participation projects have the dual purpose of extending use of health services and through it to bring about social change by increasing community competence for mobilising and organising itself. It, therefore, becomes necessary to involve all types of informal and formal community leaders, opinion leaders and various interest groups.

III. In case of participatory projects, particularly dealing with health and family planning, it is better to give direct identity to children and women as they are crucial for a majority of health and family welfare programmes.

IV. For a nationwide application of this approach it is necessary to have a political support as a prerequisite.

Luckily for India the political climate seems to be very favourable to this approach and considers this as necessary for fuller, better and quicker social change. Recently there has been increasing emphasis on this approach in the health sector as revealed by the National Health Policy and various health programmes.

V. Health projects based upon participatory approach must recognise the need for multiple support, linkages and intersectoral cooperation.

A detailed review of existing participatory projects in the Health field reveals that sooner or later a stage comes when they have to diversify their activities in fields other than health. This is primarily because health is a very broad blanket term including economic and social well being of individuals within a community; hence the need for intersectoral coordination as extra supporting links.

VI. Participatory project should make conscious efforts to ensure that their benefits flow to all sections of the society and do not get limited to certain groups.

VII. Participatory research projects in health require basic changes in programme organisation, style of work and attitude as well as skills of workers.

All successful participatory projects have felt and experienced a need for decentralisation and deprofessionalisation in decision making and programme implementation. They also feel a need of reorienting health worker to appreciate this approach.

VIII. Crucial elements of participatory approach are how the project goals are set, how the activities are evaluated and how control is exercised of the resources from the community and outside the community.

IX. In commnnity participation projects the agency must not be seen as some one giving the community what it feels it needs. The agency should make conscious efforts to seen as someone helping the community to use its own resources to improve its health.

The community participation approach envisages its cooperation in terms of two sub-systems; (1) Resource providers (policy makers, funding agency, health worker, implementing agency and the (2) community (service users, health worker, leadership, local organization).

Most importantly, this approach incorporates the linkage between these elements. Linkages are seen as both the channel for interaction and the types of behaviour used in the interaction. Human action, after all is the basic of any form of interaction.

X. Community participation approach should not be viewed as a panacea for all the ills.

ISSUSES FOR DELIBERATIONS AND FUTURE RESEARCH

The preceding description of community participation including its rationale, definition and stages has left several issues open on which deliberation is called for. In order that such discussion is made

possible by concerned scholars, an opportunity is taken here to list these issues so that wholesome concern can be developed for filling in the gaps in this approach.

Field workers adopting this approach will have to be made aware of the gaps which they may be required to face and decide upon in the light of their specific project situations. The list although comprehensive is not exhaustive.

ISSUES

— Cost effectiveness of the approach.

— Total community self reliance versus self help.

— What is community and its homogenity.

— Some projects exclusively rely on charismatic leaders. How far such a reliance is in line with the concept of community participation?

— Alternate to reliance on charismatic leadership appropriateness of basing the project on community organisation institutions existing or created for the project.

— Credibility and image of health agency and health workers.

— Collective actions versus individual actions or a mix.

— Limiting of the project to health and family welfare programme alone versus integrated development of community involving other programmes through intersectoral coordination.

— Community participation is an end or means.

— Community versus intended beneficiary targetted community.

— Use of traditional groups versus use of newly created groups or structures.

— Limitation to the ability to participate (time, energy, and enthusiasm of poor)—Burdening demands on the poor.

— Community participation on large scale as popular movement become threat to some classes and systems.

— Particular need may not be taken as felt need directly viz., Family Planning.

— Participation as programme or project from above or the initial 'motor' of participation does not lie outside the powerless.

— Focus on community participation is on "system maintenance" OR "system transforming".

— Central problem of evaluative criterion in community participation is establisning—

(a) what is good for the poor,
(b) what is good for the government,
(c) programme sponsor.

— Community participation may be successful at the local level but not at the macro level. ☐

APPENDIX 'A'

DANIDA INNOVATIVE HEALTHCARE PROJECT IN COMMUNITY PARTICIPATION IN MADHYA PRADESH

(i) Organising and Activising Village Health Committees

Rationale & Scope : Formation and Activisation of Village Health Committees is in itself an innovative idea incorporated in the project plan of DANIDA Assisted Health Care Project in Madhya Pradesh. This study attempts to find out the effectiveness of working of village Health Committees and their role in strengthening community participation for effective health care in village.

Objectives : The objectives of the study are : (a) to develop the methodology for operationalising the process of community participation through the forum of village health committees (b) Assessment of village health needs (c) Increase the information level to explore and utilise the resources available within and outside the community for betterment of community health through active participation of VHG is envisaged as specific objective of the scheme in this project.

(ii) Organising Women for MCH Programme—Mother's Health Club

Rationale & Scope : There is a policy commitment to provide MCH services to women on a high priority basis. To fulfil that commitment women's health needs in villages are to be met effectively. For this it is necessary that women's health groups are formed and organised for initiating systematic participation in utilisation of health care services.

Objectives : To provide village women an organised forum for 'dialogue' on maternal and child health related activities and to help them increase information level of available health services and help them to initiate activities for betterment of their own care and that of their children in village, through mother's health clubs.

(iii) Improving Health Care Delivery through Village Health Guide

Rationale & Scope : Although the Village Health Guide (VHG) has many plus points so far as communicator and provider of primary health care in village communities. However, a reasonable appreciation of Health Guide reveals that the training received by them do not sufficiently equip Health Guides for their role because of their otherwise low level of education and also the quality and quantum of training they have been provided. With this in background the innovative scheme of orienting VHGs have been aimed at to improve upon their skills particularly to act as effective communicators by providing continuing training in small units related to community specific health situation.

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Habit Disorders

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Complications: The notion that it is harmful to the child, came in the nineteenth century when it was found to be associated with enlargement of tonsils, spine problems, pain in abdomen, dental caries, digestive disorders (worms, diarrhoea etc.) and changes in the facial expression. A school survey in USA showed that 14 percent developed a deformity of the teeth as a result of thumb sucking persisting after the age of five years. The finger or thumb sucking should be terminated by 5 years of age to avoid any deformity in permanent teething.

Causes: The various identified stress-factors among the thumb-suckers were:

— Overprotection from parents
— Strict parents
— Neglected child or separation from parents
— disharmony among parents
— loneliness, boredom
— Jealousy, sibling rivalry
— overdemanding or critical parents.

Treatment: The children belonging to upper social class were brought earlier (between 2-5 years=84%) for treatment as compared to those of lower class (2-5 years=20%). In majority of children, thumb-sucking was not recognized as a problem, only during interrogation of parents, it was found to be present. Though it has many complications, if it is treated in time, it is fully curable. The longer the delay the worst the outcome.

Thumb sucking and the related habit problems are fully treatable. The common ingenious devices designed to prevent the hands from being brought to the mouth (e.g. putting chillies over fingers, tying the hands, scolding, beating, criticizing etc) should be discouraged as they may lead to further conflicts in the personality of the child. Psychotherapy remains the main tool of treatment. The removal of the known stress factors also helped in early cure of the disease. It was also noticed that after symptom removal, there was improvement of parent-child relationship and also in the child's socialization and school performance.

It is suggested that if any child in the family (especially if more than 2 years of age) suck the thumb or finger, the child psychiatrist or psychologist should immediately be consulted so that the child can be saved from this maladaptive habit leading to many complications and the conflicted personality development.

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People's Participation

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Objectives : To help Health Guides (HGs) to further develop their skills and credibility with community as well as health functionaries by providing better and effective preventive and curative services and also to help him develop better perception of community health problems assisting in the activisation of Village Health Committees.

(iv) Scheme of Organisation of Health Clubs in Schools

Rationale & Scope: Health as a programme of development and change must use schools (teachers and students) as institutional vehicle for community participation for more effective health care and education. The National Health Policy accords a high recognition to the involvement of schools as an effective tool for community participation in national health programmes. So the scope of this research scheme of organising of health clubs in schools will go a long way in meeting the well defined purpose of involving school population in promotion and betterment of health.

Objectives : The main objective of the scheme in the DANIDA Innovative (IEC) project will be to try out and develop methodology for organising health clubs in schools in villages, and to develop the pattern of organising and operationalising the functioning of the clubs. Small activity planning by the school children themselves for promotion of health care is also aimed at in this scheme.

(v) Clinic-cum-Orientation Approach to PHC Worker

Rationale & Scope : To increase the effectiveness of the Health Workers it is necessary to continue to educate them both in the clinic and in the actual fields area. It has to be a continuing educational process to be carried out on and by all for those responsible for the leadership, supervision and guidance of health workers in the field areas. The innovative scheme in the project is a step in the implementation of this idea of administrative participation for effective delivery of health care. To start with it will be tried in one block in one of the 3 selected districts.

Objectives : To develop a system of administrative participation through which medical officers and other medical and para medical staff work as a team in the field area to implement the national programmes. Another inbuilt objective is re-education and retraining of the staff through ongoing sharing and communication of all levels of Health Workers for effective functioning in meeting and felt demands of the community.

(Concluded)

(*Courtesy :* **Social Change**)