Concept Paper

Community Participation

Community participation was one of the main principles of Primary Health Care (PHC), the strategy proposed in Alma Ata in 1978 by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) and adopted by 150 member states of the two organizations. It was meant to revolutionize the practice of health care and health development, leading to health for all by the year 2000 (WHO, 1978). Not that the concept was new; in 1950s and early 1960s, it was used within health programmes and health care; but also broadly in social practice and development. Monopoly and control of health care delivery systems by professional health staff resulting from technological complexity and centralization of national health services however, culminated in the Alma Ata declaration calling for the halting, or even reversal of the trend (Kahssay & Oakley, 1999). So by the time of the Alma Ata declaration, the environment within United Nations agencies was focused on the involvement of people in decisions about development.

Definition of community participation at Alma Ata

The Alma Ata definition was, as usual, lengthy and went as follows: "community participation is the process by which individuals and families assume responsibility for their own health and welfare and those of the community, and develop capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development instead of passive beneficiaries of development aid…..". – One interpretation given of this definition vaguely is: "… that community people would become involved in both delivery of and decisions about health and health services in order to provide the type of care most appropriate to their own defined needs and circumstances" (Rifkin, 1986). However, many questions remained unanswered; for instance: 'Why participate?', 'Who participates and who benefits?', 'How do community people participate?', 'With what?' and, 'How would outcomes be assessed?'

Rifkin, (1996) has argued that the framers of the Alma Ata declaration purposely left the concept of community participation vague and flexible in recognition of the fact that countries presented diverse contexts. (Were the seeds for the abuse of the concept or those of simply more rhetoric than reality planted then? Perhaps) Anyhow, as a result, the concept became many different things to different people; making it difficult to reach generally agreed definitions, let alone objectives, for developing it in health care. A plethora of different interpretations and meanings were given to the concept of community participation and its practice. What follows is illustrative.

Principles of community participation

Community participation means the involvement of people from the earliest stages of the development process, as opposed to simply asking their opinion of project proposals that have already been developed, or for their contribution to the implementation of projects imposed from outside.

Participatory approaches have been widely tested in the fields of water, sanitation and hygiene, and experience has shown that involvement of the community can produce wide-ranging benefits. The main principles are:

Communities can and should determine their own priorities in dealing with the problems that they face. The enormous depth and breadth of collective experience and knowledge in a community can be built on to bring about change and improvements. When people understand a problem, they will more readily act to solve it. People solve their own problems best in a participatory group process.

Community-focused programmes therefore aim to involve all members of a society in a participatory process of: assessing their own knowledge; investigating their own environmental situation; visualizing a different future; analysing constraints to change; plan- ning for change; and implementing change.

Health planners used three approaches to define community participation based on three similarly differing definitions of health:

• The Medical approach - which defines health as absence of disease. Community participation is then defined as activities undertaken by community people following the directions of medical professionals in order to reduce individual illness and improve the general environment; for example using health services or cleaning the environment. It is based on the notion that health improves as a result of biomedical science and technology.

• The Health services approach – which defines health in the WHO sense of the word: 'physical, social and mental well being of the individual'. It defines community participation as the mobilization of community people to take an active part in the delivery of health services; for example using community health workers (CHW), recruited from and by the community, trained and supervised by health professionals and 'accountable' to the community to deliver health care;

• The Community development approach – which defines health as a human condition which is a result of social, economic, and political development. It defines community participation as community members being actively involved in decisions about how to improve that condition; essentially, that health will improve with eradication of poverty brought about by a change in the existing system of power and control relations.

The first two came to be known as the 'top-down' and the last and third one as the 'bottom-up' approaches. In the former approach, the health professionals have the predominance in decision-making; in the latter, stress is placed on the importance of community people learning to decide what is best for them and the process of how to achieve the change they desire. In short in the latter approach, the solution is secondary to the process that leads to the change that ensues in community members' attitudes and behavior.

Justification:

1. Health services alone are neither enough to foster community participation nor solve health problems;

2. Authentic community participation has to be premised on the broad needs and interests of the community as perceived by the community; and quoting research findings (Elliott, 1975), health services are usually not a priority to lay people except when sick. ("When lay people were asked what they want most, more income, food, shelter, and clothing rank above health services"). Wide community participation therefore develops as part of a process that addresses a range of community needs;

3. Community participation is interwoven with the issue of power. It is therefore erroneous to assume that communities are homogeneous; that leaders always act in the interest of the communities they lead; and that government and the community share the same development goals. Indeed to illustrate the above, experience showed that in areas of poverty, individual concerns often over-ride community goals; people who have been identified by the community as having influence often use new opportunities to enrich themselves; and governments want to mobilize local resources so as to free capital for other programmes, respectively;

4. Community participation is not and should not be considered as a component of a health programme, or an intervention to improve health services and/or health care, but as a process of change that is context- specific. Motivation among community members seems to be the major ingredient;

5. Community participation is heavily influenced by factors such as culture, history, government policy, social, political and economic structures; it is therefore dynamic rather than static. A common history of struggle seems conducive to community participation in terms of community motivation, organization, and structures;

Ministry of Health & Family Welfare has approved a **Community Support Committee (CSC)** structure with the specific TOR (attached). Mayor, Pourosova is the chairperson and Hospital Superintendent is the Member Secretary and Civil Surgeon will act as a Coordinator of the Committee.

Details of Terms of Reference of Community Support Committee

(a) To ensure support the hospital authority for effective clinical service delivery
(b) To ensure the provision of all the non-clinical services and other amenities including provision of transport, drinking water, waiting rooms & safety & security to the patients and their attendants.
(c) To provide assistance for proper supply/availability of required medicines, equipment reagents, furniture, other consumables like X-ray/USG film, ECG Papers, stationery etc
(d) To provide support for implementation of all sanitary and hygienic measures including provision of cleanliness, toilet facilities for the patients and their attendants.
(e) To provide assistance for support staff like cleaning, security, laboratory and radiology, nursing aids etc.
(f) To provide assistance timely maintenance hospital building including premises and to encourage community participation in these activities.
(g) To utilize fund for timely maintenance and repair of hospital equipment, machinery & other assets subject to the guidelines.

(h) To ensure the rights and responsibilities (health service responsiveness) of the service recipients through installation of Public Information System, Signage system, display a Citizens' Charter, display of referral maps and chain and other mechanisms.
(i) To provide assistance for effective in house and out house waste management.
(j) To provide assistance for introduction of patient centered service.
(k) Committee can coopt any members.

Should not contradict :

The **CSC** shall not have the power to take any decision contradictory to policies and programmes of MOHFW.

Focus of Community Support Committee

(1) To review and suggest measures for improvement regarding following activities:
(a) Cleanliness of Hospital premises, indoor & outdoor;
(b) Display of referral map and chain, citizen charter, Drug availability stock,
(c) Quality of Diet;
(d) To review the financial account, income & expenditure statements of **CSC**
(2) To encourage and appreciate the hospital staff for the good performance
(3) To constitute sub-committees for specific purposes

5. TOR of member secretary of Community Support Committee (CSC):

(1) The Member-Secretary shall have the power to take decision and incur expenditure within his power as mentioned in the annex.
(2) In addition to the power & function mentioned elsewhere in this guideline, the Member-Secretary of the **CSC** shall carry out and exercise the following functions and powers-:
(a) To manage day to day administration of the **CSC** with the help of Secretarial Support Unit.
(b) To make all correspondence on behalf of **CSC** on all matters
(c) To arrange for safe custody of all records and moveable properties of the **CSC**
(d) To convey and arrange meetings of the **CSC** or any sub-committee, record proceedings and resolution and act up on them
(e) To assess and rationalize the requirement of manpower, materials Construction / expansion of the physical infrastructure..
(g) To collect feedback, complaints, suggestion from the service recipient and members of public and to take appropriate measures on a regular basis.
(i) To implement, monitor and supervise the activities as per approved plan of **CSC**
(j) To distribute the work related to **CSC** amongst the various staff who shall do this as part of their work without any extra remuneration.
(k) To prepare & maintain the Accounts of **CSC** and arrange for Auditing of the **CSC** accounts as and when required
(l) To undertake any other activities that is consistent with the aims and objectives of the **CSC**.

Meeting & Agenda

(1) The meeting of the **CSC** shall preferably be held at least once in a month in the office of the member-secretary on a fixed date/day each month. Every notice calling meeting of the HSMC shall state the date, time and place.
(2) The Chairperson shall Chair the meetings of the **CSC**. In his/her absence, the Executive chairperson or any member selected by the HSMC from among the members present shall act as Chairperson of the meeting.
(3) One third of the members of the **CSC**, including the substitutes nominated and present in person, shall form a quorum at every meeting of the HSMC. Absence of any member shall not invalidate the decisions taken in the meeting.
(4) The minutes including resolution of the **CSC** meeting shall be placed before the **CSC** at its next meeting.
(6) Any decision once resolved in the meeting need no further approval. The Member- Secretary can take approval of the Chairman/Executive chairman/vice chairman through note sheet for any decision particularly regarding expenditure which is urgent in nature and if the meeting of **CSC** can not be convened in time. Such decisions shall have to be ratified in the next meeting of **CSC.**

Fund Management

(1) The funds of the **CSC** shall ordinarily be consisted of the following:
(a) Receipt of Grant from persons, society, organization, zakat etc.
(2) The **CSC** shall have the power to accept contribution, gift, Grants and donations in form of cash, kind or service from any trust, organization and individuals.
(3) The **CSC** C shall not have any power to raise money through disposal of assets.

Bank Account

(1) The Account shall be named and operated jointly as **CSC**. The bank account will be operated by three persons , selected by **CSC** (Member secretary, treasure and one member, any two)