Kathmandu University Medical Journal (2008), Vol. 6, No. 4, Issue 24, 526-532

Medical Education

Community participation in health: A brief review and the experience of Kathmandu Medical College with the Duwakot community

Vaidya A[1], Pradhan B[2]

[1]Deputy Hospital Superintendent, Duwakot Community Hospital and Lecturer, Department of Community Medicine, [2]Hospital Superintendent, Duwakot Community Hospital, Kathmandu Medical College, Duwakot, Bhaktapur, Nepal

Abstract

One of the principles of Primary Health Care (PHC), Community Participation is a process through which the stakeholders influence and share control over development initiatives and the decisions and resources which affect them. It is a complex issue that has been studied widely and continues to be of great interest among community health workers. This paper presents a brief review of various aspects of community participation. It then illustrates how it is practiced at Duwakot Community Hospital, Kathmandu Medical College, Duwakot, Bhaktapur, Nepal in collaboration with the local community.

Key words: Primary Health Care, Community Participation

Community Participation is a process through which the stakeholders influence and share control over development initiatives and the decisions and resources which affect them. In health, it was realized in the 1970s that the basic health needs could only be met through greater people involvement. Hence, it was included as a component of primary health care and was defined as the process by which members of the community, either individually or collectively, and with varying levels of commitment develop the capability to assume greater responsibility for assessing their health needs and problems, plan and then act to implement their solutions, create and maintain organizations in support of these efforts and evaluate the effects and bring about necessary adjustments in goals and programmes on an ongoing basis[1].

Community Participation was thought to be an essential strategy to provide PHC because 65-85% of healthcare is self care and by families; also, it provides opportunities to look for alternative resources as well as ensures that there is a fair distribution of resources and benefits. The basic principles behind the participatory approach are that the poor people are creative and capable; they should do own investigation, analysis and planning; the weak and marginalized should be empowered and that the outsiders have roles as convenors, catalysts and facilitators.

The concept of Community Participation was adopted by many countries as the means to address important health problems and became an essential element of health development programmes worldwide. The following years saw many examples of successful community participation in small scale projects. However, since its inception, community participation has been interpreted differently and after 30 years, the advocates appreciate the difficulty and complexities involved in enhancing participation than they did then[2].

Community participation in health is a complex issue that has been studied widely and continues to be of great interest among community health workers. The beginning of the idea and its conceptual development are primarily attributed to large multinational health institutions, particularly the World Health Organization. However, the implementation of community participation is the ultimate responsibility of local health programme initiators. The present article reviews the different aspects of community participation and presents its experience at Duwakot Community Hospital, Kathmandu Medical College, Duwakot, Bhaktapur, Nepal.

Features of community participation in health

Table 1 presents a synopsis of various aspects of community participation[3-6]. It highlights how community participation can become a felt need and outlines the foundation which is required to initiate and sustain

Correspondence
Dr. Abhinav Vaidya
Department of Community Medicine
Kathmandu Medical College, Duwakot, Bhaktapur, Nepal
E-mail: dr.abhinavaidya@gmail.com

community participation. It also presents how community participation can lead to various positive health changes. The table also points out the factors that can make or break community participation.

Table 1: Important features of community participation[3-6]

Factors that lead to community participation in health:
• Recognition of the right and duty of the people to participate in public and community affairs • Inability of the institutionalized health system to provide for health needs • Increased health expectations: increased standard of living, educational level • Concerns of costs; best use of limited resources • Diminished confidence in policies made solely by experts and managers • Perceived untapped resource of voluntary public input
Predisposing conditions for community participation in health:
• Supportive political climate • Regional and local circumstances, aspirations and needs • Individual and collective public awareness • Commitment to/experience with community orientation • Experience in intersectoral activity • Health should be a priority issue and interest for the community • The community should be committed and collectively willing to accept responsibility
Benefits of community participation:
• Heightened sense of responsibility and consciousness • Potential for greater diffusion of health knowledge • Greater use of indigenous expertise • Promotion of self help and self reliance • Improved communication between health workers and the community • Improved take-up of services • Development of programmes relevant to local situation • Health services provided at a lower cost • Added resources: fundraising opportunities & availability of volunteers • Resources directed towards 'felt needs' of the community. All these can ultimately lead to: • Change in health status • Social changes: e.g. change in the nutritional status, use of Oral Rehydration Solution, hygienic water • Economic development & quality of life
Factors affecting/influencing the success or failure of community participation:
• Leadership factors: commitment, flexibility, continuity • Collaboration with the government and other voluntary organizations • Sound referral back-up services: to build up community faith and acceptance • Not necessarily capital investment; also sheer human, managerial inputs • Ability to recognize and utilize the strengths of local community • Community based cadres of health workers
Factors that operate to diminish the success:
• Nature of actual communities: heterogeneity, legitimate representation (e.g. People with sufficient health expertise? Minority group itself prefers not to engage actively; Not all sub-groups within them feel adequately represented, Who has the right to speak for the 'community'? • Nature of participation: e.g. Valuing only some forms of participation in projects • Others: - political and bureaucratic unwillingness: threat to established power patterns - attitude of government: means to legitimize public policy - attitude of members: an opportunity to obtain direct power

Levels of community participation

Participation undergoes various steps before it grows in to a full-fledged one (Fig.1). The community participation may be limited simply to a contact whenever the health authority wishes to have or may be consulted only initially or periodically. A stronger participation develops when the community collaborates with the health professionals in a more firm manner forming the basis for genuine community participation.

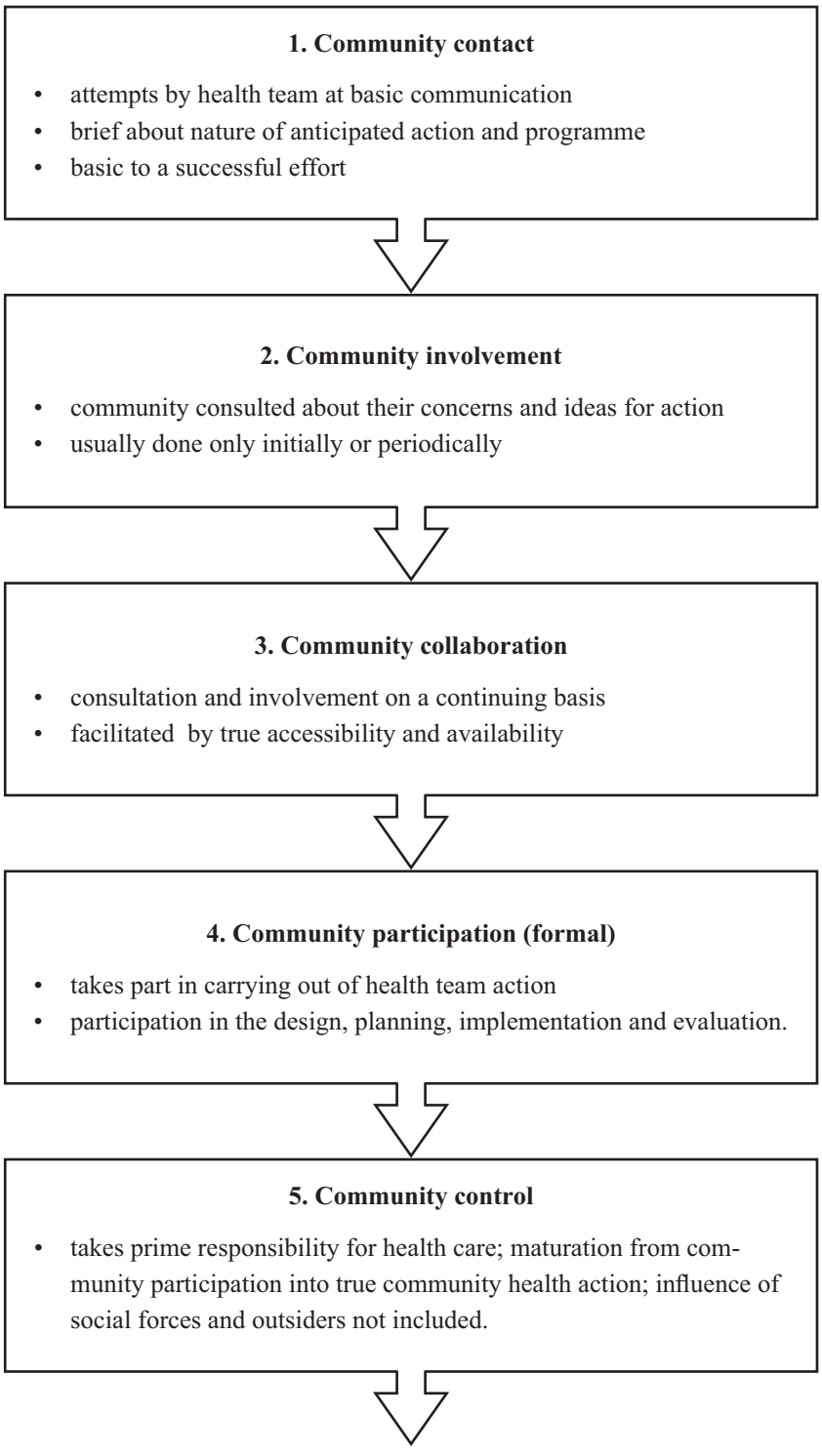

Fig.1: Spectrum of community participation in health[5]

Evaluation of community participation:
Community participation often becomes a clichéd term when any kind of involvement of the local community is termed as community participation. The box presents a checklist to measure if community participation exists and to what extent[7].

Check list: Measuring Community participation

- Is the community involved in planning, management and control of health programmes?
- Are the felt needs of the community sought? Are they considered in planning objectives?
- What forms of social organizations exist? How much are they involved in decision making?
- Is there mechanism for dialogue between health personnel and community leadership?
- Is there mechanism for community representatives to be involved in decision-making? Is it effective?
- Is there evidence of external agendas changing plan due to criticism from community?
- Are the deprived groups represented in decision making process?
- Are the local resources used?
- Is the community involved in evaluating the project?

Nepal's experience with participatory approach:
First phase of participatory approach can be said to have begun in the 1990s with the onset of privatization policy of which community forestry is a primary example. It was soon followed by the economic sectors in the form of co-operative and rural development banks. In the third phase came the trend of handing over the public schools and health centres to the local community to run. The National Health Policy (1991) and the Second Long Term Health Plan (1997-2017) of Nepal have given a high priority to community participation[8]. FCHVs (Female Community Health Volunteers) and TBAs (Trained Birth Attendants) are its successful examples. In the non-governmental sector also, community participation has been utilized, for example, in improving environmental situation in Panchkhal in 1980s by integrated parasitic control and low cost toilets[9]. Similarly, women's health groups in Makwanpur developed varied strategies to tackle maternal and child care, particularly the perinatal care[10]. Lack of community participation leading to poor results was demonstrated in a study involving two middle hill villages[11]; one with a NGO-run Community Health Centre at Ghandruk and another with a government-run Health Post in Sikles. Poor utilization of health services was observed in both the cases (30%), more than 90% of the villagers were unaware of a health committee and there was no cross-cultural involvement.

Unlike in Nepal, community participation has been more widely applied in India. A few examples with brief comments are given in the Table 2.

Table 2: Some examples of Community participation in India[12]

Rural health and socio-economic development projects		
1967	Rangabelia Project, West Bengal	- By a school headmaster Shri Tushar Kanjilal - Total community involvement
1971	Jamkhed Project	- By Dr. R.S. Arole and his wife
1974	Child-in-need institute, West Bengal	- By Dr. S.N. Chauduri - Comprehensive child maternal health services
-	Rural Unit for Health & Social Affairs (RUHSA)	- By CMC Vellore - Multi-sectorial approach
1972	Rural Health Research Project	- By Dr. NH Antia & Mr. MP Godrej
1984	AVR Foundation of Ayurveda	- Traditional medicine, immunization & Family planning
-	PHC for Tibetan refugees, Dharmasala in Himanchal Pradesh	- By Dalai Lama
Tribal health projects		
1975	AWARE, Aruranchal Pradesh	- Tribals and harijans
1979	Vivekananda Girijana Kalan Kendra, Mysore	- By Dr. H. Sudharshan - For Soligas tribes
Health cooperatives		
1958	Mini health care project	- Madras, urban health plan
1972	Mallure health project	- Knit by a successful milk cooperative
Hospital based outreach projects		
1972	King Edward memorial hospital, Pune	- Trained village health guides - Component of socio-economic development also added
-	Bandra holy family	- To the slums in the neighbourhood of the hospital
1971	Nutritional Rehab centre, Madurai, Tamil Nadu	- Family-based prevention
1976	Padhar hospital, community health project, Madha Pradesh	- Tribal village within 10 km radius
Health services for the organized sector		
1971	United planter's association	- Families of the tea, coffee, rubber, cocoa workers
Health projects at national level		
1970	Sulabh International	- Environmental mission
1980	Hyderabad slum project	- By municipality, assisted by UNICEF, urban development
-	Vishakhapatnam project	- Collaboration with medical college, private practitioners, volunteer agencies

Community participation experience of Kathmandu Medical College with the Duwakot Community

Duwakot is one of the sixteen village development committees (VDCs) of Bhaktapur District in the Kathmandu Valley[13]. Situated at 1367 meters above the sea-level, it covers 6.42 square kilometers of area. There are almost 1400 households in this village with approximately 7500 residents. Ethnic majorities such as Brahmins and Chhetris each constitute a third of the population followed by Newars (29%) and marginalized castes (5%). The majority (75%) of the villagers are in to agriculture and livestock while the literacy rate is 69.2% for the males and 49.08% for the females. Likewise, the average life expectancy is 56 years and 52.6 years respectively. The infant mortality rate of 41 per 1000 live births is better in comparison to the national average of 48/1000 live births[14].

Apart from the state-run sub health post with limited manpower and services, the locality is largely served by Kathmandu Medical College. The college, affiliated to Kathmandu University, has got its Basic Science block and a 50-bedded community hospital at Duwakot while the Tertiary Care Referral hospital is situated centrally at Sinamangal, Kathmandu, about 15 kilometers away from Duwakot[15]. The Duwakot Community Hospital, under the Department of Community Medicine, was started in 2003 and has been providing general and specialist preventive, promotive and curative services[16]. It acts as the focal point for health-related matter for Duwakot with a good magnitude of community participation (Fig.2).

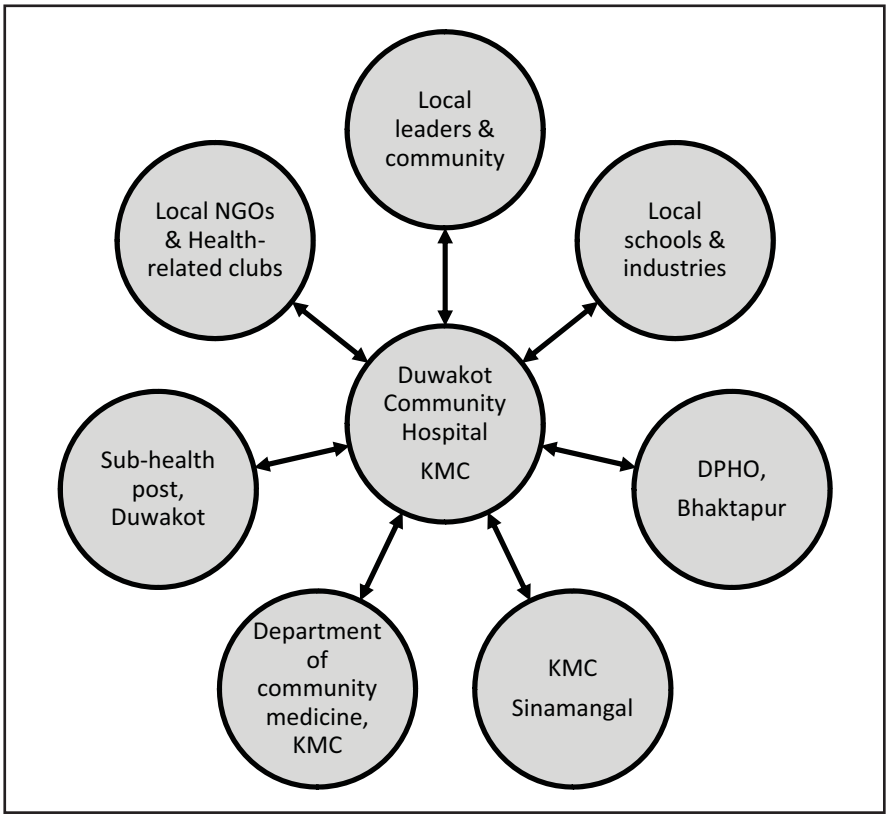

Fig 2: Current model of community participation at DCH

DPHO: District Public Health Office; KMC: Kathmandu Medical College

Following are some of the areas in which the hospital has been observing community participation:

1. The hospital promotes active community participation in all its activities.
2. Local people provide their input and feedback in many health programmes run by the hospital.
3. Local leaders and volunteers participate in the health programmes and collaborate with the hospital in organizing various health programmes such as cancer screening and blood donation programmes.
4. The hospital liaises with the local schools and industries to promote healthy behaviours among the students and the workers. Specific programmes include, for example, training of primary teachers to screen students with optical problems.
5. The hospital works in partnership with the Sub-Health Post and District Public Health office to plan, implement and evaluate various governmental health programmes including family planning and immunization.
6. Staff of the college who are from the local community actively participate as facilitators in the various activities of the hospital and college, mainly as the facilitators.
7. The Department of Community Medicine and the School of Nursing, Kathmandu Medical College organize Community Diagnosis Programmes to evaluate the health status of the community. These programmes also act as forums to interact and get feedback from even the most marginalized pockets of the community.

8. Other areas in which there has been collaboration with the local community include: construction of road leading to the hospital, use of the local houses as residence for medical students, and provision of job employment and some preference in MBBS and Bachelor of Nursing courses for the local candidates.

Conclusion

The concept of community participation continues to capture the attention of international health policymakers and analysts nearly a quarter of a century after it was formally introduced at the Alma Ata Conference. Sustainability of participation, to a large extent, depends upon the financial resources and efforts should be made so that costs can be borne by the locals without further aid. It is equally important for the policy makers to continually reinvent and reinvigorate the initiatives. Besides, participatory thinking needs to be institutionalized at all levels for optimal operation and evaluation. Finally, other components of primary health care such as the intersectoral coordination with other sectors such as education, industry, etc must be sought. Following these principles, efforts are being made at the Duwakot Community Hospital, Kathmandu Medical College also to incorporate the community in all its affairs to develop it into a model community hospital in Nepal.

References

1. Zakus J and Lysack C**.** Revisiting community participation. Health Policy Plan 1998;13:1-12.
2. Morgan LM. Community participation in health: perpetual allure, persistent challenge. Health policy and planning 2001;16(3):221-30.
3. Lankester T. Setting up community health programmes: a practical manual for use in developing countries. 2nd edition. London and Oxford: Macmillan Education Ltd; 2000.
4. Wilcox D. The guide to effective participation. United Kingdom: The Joseph Rowntree Foundation. Partnership Books; 1994.
5. Munt R. Building community participation. Stronger families learning exchange. Bulletin no. 2. Melbourne Australia: Australian institute of family studies; 2002.
6. Reid JN. Community participation: how people power brings sustainable benefits to the communities. United States of America: USDA Rural development; June 2000.
7. Rifkin SB, Muller F, Bichmann W. Primary health care: on measuring participation. Social Science and Medicine 1988;26:931–40.
8. Ministry of Health and Population, Department of Health Services. Annual report of Department of Health Services 2005-6, Kathmandu, Nepal. Kathmandu: Ministry of health and population; 2006.
9. Upadhyaya DP. Community participation in improving environmental situation: Panchkhal. JOICPP rev. 1983;(6):25-31.
10. Morrison J, Tamang S, Mesko N, Osrin D, Shrestha B, Manandhar M. Women's groups to improve perinatal care in rural Nepal. BMC Pregnancy and Childbirth 2005;5:6.
11. Sepehri A, Pettigrew J. Primary Health Care, community participation and community financing: two villages of Nepal. Health policy plan 1996;11(1):93-100.
12. Sahni A, Xirasagar S. Community Participation in Health and Family Welfare - Innovative Experiences in India. Bangalore: Indian Society of Health Administrators (ISHA) with financial support from UNICEF; 1990.
13. Duwakot Development Committee. A profile of Duwakot Development Committee, Village Development Committee. Duwakot, Bhaktapur, Nepal: Duwakot VDC; 2005. P. 1-5.
14. Ministry of Health and Population (MOHP) [Nepal], New ERA, and Macro International Inc. 2007. Nepal Demographic and Health Survey 2006. Kathmandu, Nepal: Ministry of Health and Population, New ERA, and Macro International Inc; 2007.
15. Kathmandu Medical College. Kathmandu Medical College, Kathmandu University: Annual Report 2006-7. Kathmandu: Kathmandu Medical College; 2007.
16. Pradhan B, Vaidya A. Duwakot Community Hospital, Kathmandu Medical College: Bringing Specialized Medical Services Closer to the Community. In: Baral MR, editor. Paediatric Update 2008 Memorabilia. Ed. Kathmandu: Kathmandu Medical College, Centre for Child Health, Development and Research; 2008. P. 140-3.