UNIT 3 COMMUNITY AND COMMUNITY PARTICIPATION

Structure

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3.0 OBJECTIVES

After completion of this unit, you should be able to:

- explain the meaning of community;
- differentiate between society and community;
- explain the characteristic of Indian village; and
- describe the concept of community participation in public.

3.1 INTRODUCTION

The focus of this unit is to expose you to community participation in public health. It is important that you are aware of the types of community, Indian village life and other characteristics of Indian society. Learning this would enable to work in community with greater confidence and understanding.

3.2 MEANING OF COMMUNITY

The definition given by WHO Expert committee on community is as follows: “A community is a social group determined by geographical boundaries and/or common values and interests. Its members know and interact with each other. It functions within a particular social structure and exhibits and creates certain norms and values, and social institutions”.

3.2.1 Types of Community

There are two types of community, i.e. Rural and Urban. Village and village society did not spring up all of a sudden, but they developed slowly as result of adjustment with environment.

a) **Rural Community**

Rural community is a simple community of primary relations with low population based primarily on agricultural life. In rural life, where the family is relatively dominant and self contained, a group responsibility prevails. The status of the individual is likely to be the status of his family. Property is likely to be thought of as a family possession.

The dominance of the family explains, in large measure, why social control in the rural community is exercised with minimum of formality and a maximum command. The group mores, reflecting a commonly shared system of values, are themselves effective as social pressure, in little need of support from specialized agencies.

b) **Urban Community**

Urban Community is different from village community so far the exercise of social control is concerned. Urban community is complex as compared to the rural community, so is the complex system of social control. In the towns and cities, the pattern of social behaviour are informal. The formal methods of social control work in such a society. Relations here are contractual. The mechanisms of social control are largely legal and exercised by state and secondary institutions.

3.2.2 Difference between Society and Community

You have read about society and communiy in Block 1, Unit 2 under section 2.2. **Society** is defined in simple terms as an organisation of member agents. The outstanding feature of society is a system – a system of social relationships between individuals. The importance of society lies in the fact that it controls and regulates the behaviour of the individual both by law and customs. It can exert pressure on the individual to confirm to norms. **A Community** is a social group determined by geographical boundaries and/or common values and interests. Its members know and interact with each other. It functions within a particular social structure and exhibits and creates certain norms and values, and social institutions.

3.2.3 Village Community in India

The village community consists of a group of related or unrelated persons larger than single family, occupying a large house or a number of dwellings placed close together, sometimes irregularly, sometimes in a street and cultivating originally in common a number of arable lands, dividing in the available meadowland between them and pasturing their cattle on the surrounding wasteland over which the community claims rights as far as the boundaries of adjacent communities.

The word ‘village’ is used generally for inhabitation of agricuturals.

a) **Characteristics of Indian Villages**

Most of the characteristic features of Village Community in India are very similar to those elsewhere in the world, but there are certain peculiarities of Indian village. The peculiarities of Indian villages are:

1) Joint family system

2) Caste system

3) Jajmani system – Under this system, members of caste or many castes offer their services to the members of other castes

4) Agriculture is the main occupation

5) Most simple Living

6) Homogeneity in social life

7) Stronghold of public opinion

8) Lack of social mobility

9) Importance of religion, customs, traditional mores

A large number of studies had been carried out with the assumption that the Indian village was not ‘static’, isolated’ and ‘homogeneous’, but that it was changing, had connection with wider society. Migration, village exogamy, inter-village economic ties, dependence upon towns for market, division of labour and visits to religious places have also been basic feature of the Indian village.

The famous French sociologist Louis Dumont refers three meaning to the term "village community": (1) as a political society, (2) as a body of co-ownership of the soil, and (3) as the emblem of traditional society and polity. " a watchword of Indian patriotism''.

Check Your Progress 1

1) What do understand by the term 'community"?

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2) How are rural community different from urban community?

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3) What are the characteristics of Indian village? Write at least five differences .

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3.3 SOCIAL INTERACTION AMONG DIFFERENT GROUPS

Social interaction among the different socio-economic groups shall be discussed with special reference to the Indian social context on the basis of ownership of land and means of production:

a) **Land-lords**

i) own largest share of land, agricultural technology and livestock

ii) get their land cultivated by hired labour

iii) richest sections of population and act as money lenders

b) **Farmers**

i) work whole time physically in the field

ii) also employ others to work on their land

iii) do not work on others land

iv) include big or middle farmers

c) **Poor peasants with land**

i) own small bits of land

ii) use own family labour

iii) cannot afford to hire labour

iv) work on others land as share croppers or labourers to add to family income

d) **Poor peasants without land**

i) work for survival on others land

e) **Non-agricultural labourers**

i) have no direct relation to land

ii) earn their livelihood as non-agricultural wage labourers

3.4 ORGANISATION OF SOCIETY AND RISE OF DIFFERENT MODES OF SYSTEMS OF PRODUCTION

Historical evidence reveals that the nature of social organisation also grew complex with the development of society from simple to complex. The primitive society worked out an efficient system of division of labour, whereby the males would go to distant places for hunting while the females, children and the old did the gathering activities.

As settlements began around fertile soil and water, numerous clans came together and this ultimately paved the way for the 'slave' system. Let us discuss in brief some of the features of each mode of production.

1) **Slavery**

a) It evolved as an institutional system;

b) Large scale employment based on slave-labour;

c) Slaves toiled hard throughout their lives;

d) Became bounded to the tyranny of their rich masters.

2) **Feudal System**

a) With further progress of civilization and technological development, agricultural processes grew complex requiring individual attention and decision. Thus, the stage was set for feudal mode of production.

b) Slaves transformed into tenants, artisans, craftsmen and soldiers.

c) Masters became petty chieftains, lords and priests.

d) Social control was mainly through control of land.

e) Tenants were called serfs.

f) Serfs cultivated landlord's land.

g) Serfs had no right to ownership of land but had hereditary rights to occupy land allotted to him.

h) Serfs fully entitled to the produce – his and family's labour from occupied land.

3) **Capitalist System of Production**

a) Growth of trade and manufacture marked the beginning of transition from feudalistic to capitalist economy.

b) Money was in flow and profits were reinvested to make further profits.

c) New class of merchants developed.

e) Scientific and technological discoveries lead to the process of industrial revolution.

f) Great upheavals to place in social, economic and political sphere.

g) New merchantile class acquired wealth as well as political status.

h) Industrialisation revolutionarised agriculture and production reached new heights.

i) Large factories and concentrated production brought about collective production.

j) This collectiveness promoted awareness among industrial workers a sense of common interest as a workers class.

Check Your Progress 2

Match the following :

	Social Groups		**Socio-economic Conditions**
1)	Land-lords	a)	use own family problem
2)	Farmers	b)	work for survival on their land
3)	Poor peasants with land	c)	get their land cultivated by hired labour
4)	Non-agricultural labourers	d)	work whole time physically in the field
5)	Poor peasants without land	e)	have no direct relation to land

3.5 COMMUNITY PARTICIPATION IN HEALTH CARE

"Primary health care starts with people and their problems, and since they have a major role to play in solving these problems they have to be actively involved in doing just that rather than being passive recipients of care from above." This was the statement by Halfdan Mahler in his address to World Health Assembly in 1986.

When the idea of primary health care was launched, community participation was one of the most important components. Community participation was also part of the more recent idea of health promotion. However, this term has not been very well understood as a concept.

1) The Concept of Community Participation

The most important question that one needs to first consider is, what does community participation really mean? What does it really mean when we say the community needs to be involved and participating in improvement of health?

In fact, the word 'community' itself means that just a group of people who live close together; it implies that they live not only in the same geographical area, and share common interest at a local level, but also it implies their sharing and working together in some way towards the achievement of some common goal.

In this sense, community participation in health care can be explained as a process by which people (individuals, families and other social groups) assume certain responsibilities in not only prevention of disease but also promotion of their own health and welfare. As individuals and as groups, people in the community know their situation better and feel motivated to solve their problems by searching the possibilities for change in their own environment and develop the capacity to contribute towards their own community development.

Before proceeding further, it is essential to know that health care delivery has to be based on the felt needs of the community.

2) Concept of Felt Need

Felt needs include:

a) person's or community's assessment of the present situation and potential change;

b) these judgements may depend on beliefs about the extent and nature of health problems, their causes and prevention and cure; and

c) these beliefs are influenced by people's own previous experience, education, understanding of epidemiology and biology. In short, what the people 'feel' or their 'wants' are.

However, it may be mentioned here that often these felt needs are distinguished from their 'real' needs which often lay hidden and overlap with their felt needs. The 'real' needs are the epidemiologically defined needs of community.

The social dimensions of epidemiological approach tends to translate the technically defined epidemiological parameters of the health problems into problem of a human suffering, as perceived and felt by the people in a given social, and economic milieu. This concept of felt need is of far reaching significance in formulating a community health programme. When there is an overlap of epidemiologically defined area (or 'real' need) and the area defined by the need that is actually felt as a problem of suffering by the people/patients, obviously, this area of overlap becomes the over riding priority for action by administrators of the Community Health Services as shown in Fig. 3.1 below.

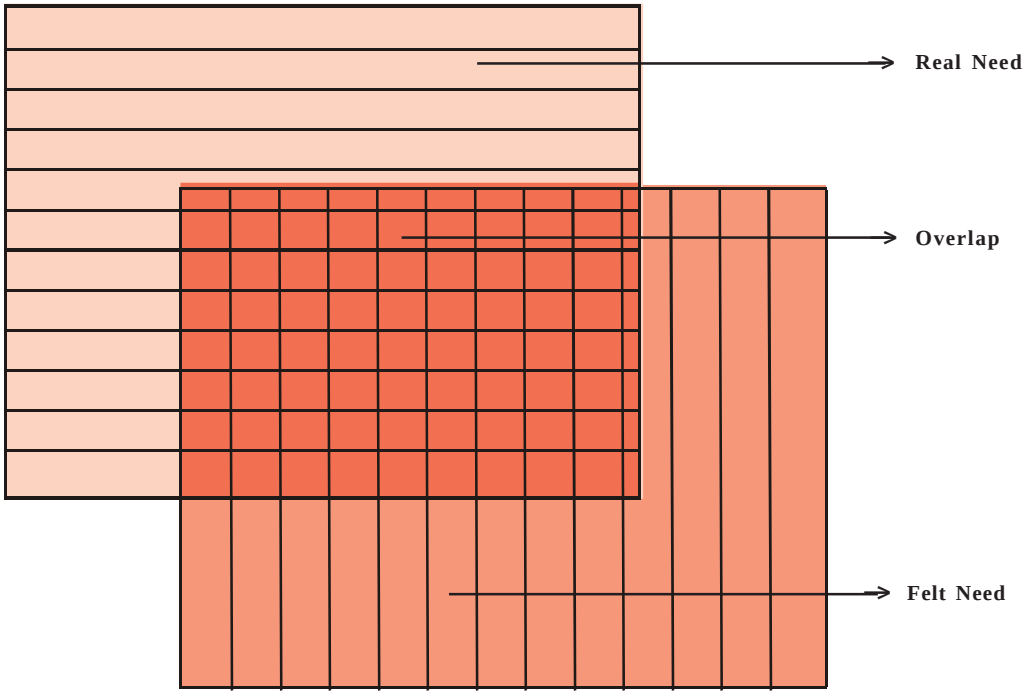

Fig. 3.1

This is possibly only by 'going to the people and learning from them' the various social, cultural, economic and political facts of their lives along with an understanding of their 'health culture' against the broader background of the overall way of their lives. A people-oriented health service system can be evolved on the basis of such an understanding which forms the basis of community participation in health services.

3) **Degree of Community Participation**

David Werner and Susan Rifcin have evolved a check list of following questions which can be applied to ensure how much participation is really taking place.

- Is the community involved in planning, management and control of health programme at the community level?
- Where the felt needs if the community found out at the outset of the programme?
- What forms of social organization exists in the community and to what extent have they been involved in decision making?
- Is there a mechanism for a dialogue between health system personnel and government?
- Is there a mechanism for community representatives to be involved in decision at higher levels?
- Are the deprived groups, such as poor, landless, unemployed, women adequately represented in the decision making process?
- Are the local resources used in terms of labour, buildings, transport and money?
- Is the community involved in evaluating the programme and in drafting the final report?

This checklist is applicable in the Indian social context, especially during the era of the panchayat raj, where there is the provision of the election of representation of women and scheduled castes as their members.

4) **The Community Approach**

The community approach to primary health care aims at building self-reliance and gaining social control over the infrastructure and health related technologies. In this respect, realizing the fact that a community is capable of becoming the change agent of its own development, there is a need to involve the local people in planning, implementation, maintenance and restoration of health care services. Here the role of the health care provider is very important in identifying, selecting and apprising the local people who would involve themselves in health care programmes with adequate and appropriate information required for the purpose.

5) **Community Involvement and Community Action**

Involvement of local people in health care programmes enable them to:

a) assess the health problems in general;

b) define the specific health problems prevailing rampant;

c) prioritise the health problems;

d) develop self-reliance, confidence, empowerment and problem solving skills;

e) plan actions by developing better relationship with health care providers; and

f) make decisions to implement the programmes in a locally relevant and socially acceptable manner.

6) **Types of Community Groups**

a) Representative groups of the community;

b) Pressure groups, e.g. activist groups;

c) Traditional organizations, e.g. mahila mandal/mahila swasthya sangh, rotary clubs etc. who are well established groups, usually meeting the needs of a particular section of the community.

d) Welfare groups exist to improve social welfare of the people, e.g. voluntary organizations, youth groups and non-governmental organisations running schemes like DWACRA, TRYSEM and other community development programmes.

3.6 COMMUNITY PARTICIPATION AS A PROCESS

Community participation is an active process of working groups to define needs of the community. This takes place based on dialogue, sharing of understanding and ensuring that the needs that are acted upon are based on informed decision making and represent the interest of all sections of the community. The phases of community participation can be explained as shown in Fig. 3.2.

1) **Entry Phase: Getting to know the Community**

The starting point of any community-based activity is to get to know the community. This requires informal discussions with opinion leaders, community groups, families, women groups, field workers from government and non-governmental organisations. This helps to make a community profile regarding:

- social structure of the community;
- what community feels are its needs;
- success/failures of previous health programmes if any;
- minority sections with their needs;
- any conflicting interests of vested power groups etc.

Application of Sociological Concepts

Listed here below is a range of information that you as a health care provider find useful in planning your programmes along with the local people:

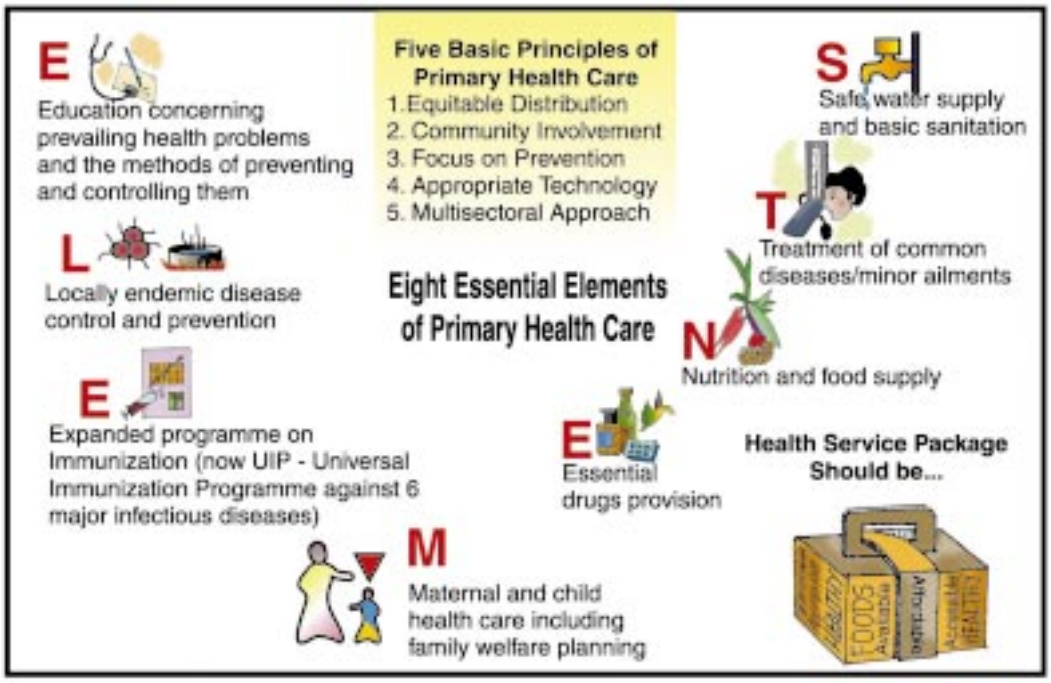

Fig. 3.2 (a)

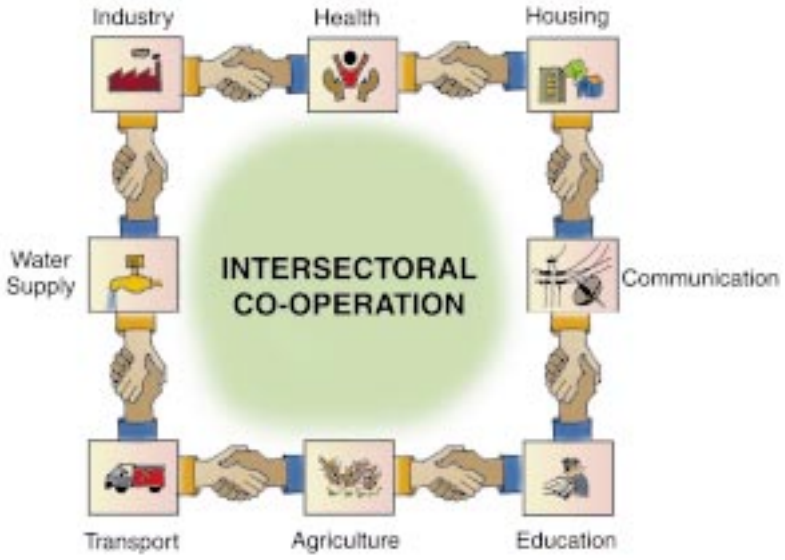

Fig.3.2 (b)

Fig. 3.2 (c)

Information Required for Making the Community Profile

Environment: geography, urban/rural, transport, land use, recreational facilities, housing.

History: history of area, activities of local groups, issues that the community have expressed concern about in the past; previous government and NGO activities on health, previous history of community action.

General data: total population, age distribution, children under 14 years, population 65 years, under-fives, turnover of population, birth rate, family sizes, vulnerable groups, e.g. single-parent families and handicapped, ethnic groups, religion, social class, employment.

Health and other services: utilization of hospitals/clinics/private doctors, traditional healers; social services, agriculture, community development, adult education, schools: other government services; relationships with community and other agencies; degree of conflict and cooperation between agencies.

Perceptions of area: residents perceptions of problems of area, attitude towards other residents, agencies, officials, local politicians, attitudes and beliefs concerning health and felt needs for health education and health care services.

Community structure, norms and traditions: networks of information, influence and care: family structure; opinion leaders, divisions and conflicts; power structure; norms that determine people's attitudes to taking action to achieve some norms that govern the role of women, norms that govern health and illness behaviour.

Organisation: religious organisations: women's groups, youth groups, non-governmental organizations;

Communications: local newspapers, newsletter, notice boards, radio, television.

Power and leadership: existing community organisations, committees, etc., businesses; trade unions; elected politicians, political parties; local political forums, such as ward councils; officials in health services, housing and education, etc

The Contribution of Local Leaders to Community Health Education

1) Bring people to meetings.
2) Arrange for and find meeting places.
3) Help reach more people by telling others.
4) Help people in the community know you and gain confidence in you.
5) Give general information about the programme and help interpret it to the people.
6) Help Identify problems and resources in the community.
7) Help plan and organize programmes and community activities.
8) Help plan and organize any services that might be provided.
9) Give simple demonstrations.
10) Conduct meetings.
11) Lead youth groups and various individual projects.
12) Interest others in becoming leaders.
13) Help neighbours learn skills.
14) Share information with neighbours.
15) Serve as an office in an organization or chairperson of a committee.

Benefits of Community Participation

Emphasizes community rather than individuals.

Makes programmes relevant to local.

Ensures community motivation and support.

Improves take-up of services

Promotes self-help and self-reliance.

Improves communication between health workers and community.

Enables the development of primary health care.

Adapted from Peace Corps (1978), *Community Health Education in Developing Countries–Getting Started.*

2) **Phase of Initial Actions**

This involves holding discussions and community meetings and working with large groups which provides an opportunity for everybody to participate and know their problems which lie even beyond the health section. This gives an insight to the issues related to establishment of intersectoral co-ordination. The success of these initial actions depend much on the power structure and opposing vested interests of the community. In this regard, areas of common interest concerned with the welfare of the common masses will have to be pooled out so that the different groups can to some extent agree upon the proposals.

A Community-based Approach to Reproductive Health Care

Maternity care and family planning remain the major concerns of the present-day reproductive health care system in the country, while gynaecological care is, more often than not, neglected. The situation is even more acute in the rural areas where due to social taboos and cultural constraints women do not articulate their gynaecological and sexural problems. In order to develop a *community-based approach to comprehensive reproductive care*, SEARCH, an organization based in the Gadchiroll district of Maharashtra, has initiated a programme which does not perceive women simply as mothers but encompasses every aspect of their lives in designing an appropriate health care delivery system.

Life for women in Godchiroll is very difficult. For four months, most women work in the paddy fields and for the remaining eight months, they survive by selling their labour for daily wages. While a man splurges his wage on alcohol, a woman's daily income is barely sufficient for the family's survival let alone healthy living. Dowry demands and wife-beating are common-place. The literacy level is exceedingly low and superstitions and taboos about normal bodily functions abound. Communication and transportation are extremely poor. During the rainy season, many areas are cut off for four to six months. *The isolation, poverty and the low status of women contribute to manifold reproductive health problems.*

The few health care services that exist focus on maternity care and family planning, while there is a desperate need for safe abortion services, care for gynaecological and sexually transmitted diseases and sex and reproductive health education. Unwanted pregnancies and clandestine abortions are major threats to women's health. The health workers in their quest to meet the government targets of acceptors neglect the quality of contraceptive care. Unsuccessful tubectomies or vasectomies, for instance, are not uncommon. Instead of questioning the efficacy of the surgeon's scalpel, the woman's fidelity is suspected and she is forced to resort to 'illegal' abortions. Abortion services are generally provided by some incompetent persons because safe services, though legal, are not available. The district headquarters is the only place where diagnosis and treatment of complicated cases can be provided. Non-availability of female doctors and the distance to the district headquarters compel women to depend on traditional birth attendants (TBAs).

In such a situation, SEARCH undertook participatory research into villages of Wasa and Amirza to study gynaecological diseases. The people were very enthusiastic and provided space for the operation theatre and celebrated the event with community dinner. Village leaders and volunteers mobilized all the women to participate in the study which involved a half-hour, in-depth interview about the *women's sexual and reproductive life, physical and pelvic* examinations (a first experience for most of them), and various pathology investigations and minor operations like dilatation and curettage (D&C), cervical biopsy or cauterization.

About 650 women, age 13 years and above, with or without gynaecological symptoms, were interviewed and examined. The mean age was 32.1 years and mean gravidity was 3.99. About 55 per cent of women had one or more gynaecological symptoms and the rest were asymptomatic. Ninty-two per cent of the women suffered from one or more gynaecological or sexual diseases and the average number of these diseases per woman was 3.6. The common diseases were menstrual disorders, psycho-sexual problems, vaginal infections, pelvic inflammatory disease, symphilis, cervical erosion, cervical dysplasia and metaplasia. Ninety-nine per cent of the symptomatic and 84 per cent of the asymptomatic women had gynaecological diseases.

While these diseases may not kill, they do cause immense hardships to women. Difficulty in occupational and domestic work because of chronic backache, foetal wastage or stillbirths, neonatal infections from birth canal infections, anaemia, sterility, sexual problems, anxiety and stress are common. In spite of intense promotional efforts by the state government, the women blamed contraceptive methods for most of their problems. Adolescent sex education and health care are critical needs not yet met by government programmes.

After the study, the SEARCH understood a mass awareness building programme. Based on discussion with women's about health awareness was designed and taken to eleven villages. It was attended by about 30,000 people. The findings of the study and other issues

of women's lives were highlighted through exhibitions, side shows, contests, plays, songs and demonstration lectures. STDs, sexual and reproductive organs and their functions, and various related health and social issues also formed a part of this educational effort. A play entitled 'When the Husband Gets Pregnant' was immensely popular. In the play, the husband finds himself accidentally pregnant and goes through all the physical and social strains that women normally undergo. Scientific principles behind many so-called 'miracles' performed by village magicians to exploit women were also demonstrated.

As a result of mall participation and population demand for more health education, a series of three-day camps was organized and women and youth groups were formed for further action on women's health and social problems. These groups have been staging their own plays and a movement against men's alcoholism is emerging. Men in many areas have demanded a similar study of STDs among males as it appears to be a major health problems, both for them and their wives. Signature campaigns were conducted in three villages to voice this demand.

SEARCH trained thirty village-based nurses in diagnosis and treatment of common gynaecological problems to meet the ends of the women who did not know where to seek medical attention in the absence of female doctors, and hospitals which are located far away. These *nurses* are provided gynaecological care to women in fifty villages. *TBAs* are also being trained to educate women on sexually and reproduction. They are also learning *simple treatment* for vaginal discharge. These female workers, though medically less qualified than male doctors to the women in the villages and hence are more acceptable. These village based female workers also refer women to the clinics when the problems require specialized treatment.

The SEARCH endeavour suggest that even in an orthodox society where sexual matters are usually taboo, people can participate in research and action to improve their own reproductive health. Awareness and community activity are essential, along with a simplified and appropriate technology and delivery system.

3) **Phase of Further activities and Organisation Building**

These are related to further inputs of initial actions taken. The success of this phase will depend upon the initial phase where the community looks for benefits accrued as a result of working together, gaining self-reliance and confidence and attracting more people to join in activities. Out of the large meeting, small group is often formed, e.g. the Village Health Committee that are working in the State of Madhya Pradesh in the field of health and family welfare programme. As a result of their total involvement, individuals in the community begin to acquire new skills and at the same time identify needs for the knowledge and educations. In this phase, health care provider plays a less active role and encourage the people to take more responsibility for maintaining their health at the desired level.

4) **Phase of Evaluation and Reflection**

This is the phase of test for any community. After having gone through the initial phase of 'Conscientisation' or consciousness-raising, the community is encouraged to critically reflect on their citation, their achievements and share in making long term plans for the future and how they might transform it through action. This helps to empower the community to action which are socially acceptable, locally relevant and epidemiologically meaningful activities.

Check Your Progress 3

1) Explain the concept of community participation with relevance to health care.

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2) What are the benefits of community participation?

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3.7 LET US SUM UP

In this unit we have learnt about basic concepts about, community, village, Indian village and its characteristics. The understanding of this is important for all of us who work at community level. The power structure of villages has bearing on accessibility of health services. The physical presence of health facilities does not mean that every one in the village access these services. There are differences in accessibility due to caste. While we think of community participation these factors have to be kept in mind.

The focus of this unit is to understand that before we talk of community participation, we must understand, what do mean by community, and how urban and rural community is different, and characteristics of Indian village.

In this unit, we have also talked of community participation as involvement of local people in implementation of concrete community action, including health care.

3.8 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) The term Community has been defined differently. The definition given by WHO Expert committee is "A community is a social group determined by geographical boundaries and/or common values and interests. Its members know and interact with each other. It functions within a particular social structure and exhibits and creates certain norms and values, and social institutions".

2) The rural community and urban community are different on many accounts. Rural Community is a simple community of primary relations with low population based primarily on agricultural life. The status of the individual is likely to be the status of his family. Property is likely to be thought of as a family possession. Urban Community is complex as compared to the rural community, so is the complex system of social control. In the towns and cities, the pattern of social behaviour are informal. The formal methods of social control work in such a society. Relations here are contractual. The mechanisms of social control are largely legal and exercised by state and secondary institutions.

3) Most of the characteristic features of Village Community in India are very similar to those elsewhere in the world, but there are certain peculiarities of Indian village. These are:

- Joint family system
- Caste system
- Jajmani system
- Agriculture is the main occupation
- Most simple Living
- Homogeneity in social life
- Stronghold of public opinion
- Lack of social mobility
- Importance of religion, customs, traditional mores

Check Your Progress 2

1) c
2) d
3) a
4) e
5) b

Check Your Progress 3

1) Refer to Section 3.5.

2) Refer to Section 3.5 and 3.6.

3.9 FURTHER READINGS

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