EXPERIENCES WITH COMMUNITY PARTICIPATION IN HEALTH CARE

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Of late, a lot of emphasis has been laid on the need for community participation in health programmes in order to achieve the goal of Health For All by 2000 A. D. Owing to a variety of factors like lack of health consciousness, low socio-economic status, illiteracy, poor sanitation and unsafe water, the health status of the average slum dwellers leaves much to be desired. It has been the endeavour of the governmental, municipal and voluntary agencies to improve the situation in the slums.

The authors in this article share their experiences as health professionals in Malvani, a slum area in the western suburbs of Greater Bombay, populated by about 70,000 inhabitants belonging to the lower socio-economic strata of the society.

A preliminary survey carried out to unravel the details about the prevalent problems in Malvani revealed that the primary immunization coverage was a bare 40 per cent. The incidence of diseases in the under five children accounted for: scabies 5%, helmintliiasis 20% and nutritional deficiency diseases 40%.

In fact, the water supply was adequate and minimal sanitary facilities did exist, but due to lack of civic sense among the slum dwellers, these facilities provided by the Municipal authorities were either misused or damaged.

Enquiries with the water supply department revealed that the pressure of water supply in Malvani was much higher than that in the neighbouring areas. However, the taps installed by the Municipal Corporation were stolen by the slum dwellers. Some taps were leaky while water was allowed to run waste from other taps till the Municipal supply was switched off; the water supply being intermitten in Bombay.

In many of the sanitary blocks, constructed by the Municipal Corporation, the doors were stolen and sold off. A few sanitary blocks were being used for storing locally distilled illicit liquor. Many closets got clogged as women threw sanitary pads in them. It is not uncommon to see children defaecating just outside sanitary blocks; even if these were fully functional.

Community involved

Thus it was decided that the community people should solve problems of their own making. Two representatives from each plot (one plot contains approximately 150 houses) were selected to act as a link between the health centre and the community. One representative was responsible for water supply and sanitation, who was provided with necessary guidance as to whom to approach in case of a problem. The second representative was responsible for organizing the other health activities in their respective plots. An outdoor clinic was already functioning in the area for minor medical care. The programmes for mass field immunization were drafted and one copy each of the same was handed over to the concerned representatives for organization of the immunisation programme and its publicity.

The initial response was encouraging but soon the decay set in. The community representatives started accompanying patients to the health centre and persuaded doctors to give VIP treatment to such

patients. Few among them even resorted to extortion of money from such patients for their services and alleged that doctors took a share of the money for their special services.

Watch-dog committees

However, some sincere community representatives formed watch-dog committees which were responsible for sanitation in the respective plots. The committees provided bins near the latrines where used sanitary pads were to be dumped; to be disposed of later. Such sanitary blocks were well maintained.

Political affiliations

After about six months, these representatives affiliated themselves with some political organisations and started devoting more time to political activities. Some of them contested the civic elections. In their election campaigns they claimed all credit for the services rendered to the community by the health care personnel and tried to project themselves as *messiahs* of the slum dwellers.

By the end of one year, the health staff had developed enough rapport with the community and so in a few plots it was decided to do away with some of these representatives even though they later tried to create nuisance by using their political clout. However, our relations with the other community leaders remained cordial and they were very cooperative with the health care personnel.

Community health volunteers

The other alternative to involve community members in health care was to appoint community health volunteers (CHV). They were selected from the community in such a way that they represented all religious and cultural groups and were paid a stipend of Rs. 100 per month by the Municipal Corporation. Their appointment did improve the performance of our health team, but the CHVs were unhappy over the paltry stipend of Rs. 100 p.m. They complained that they could earn much more money by working as house-maids without the responsibilities of a CHV. Out of 14 CHVs, six dropped out in the very first month following their appointment while the remaining eight continued in service, hoping for better prospects in the future.

We realized that programmes, in which person-to-person contact was established, were very successful, like the family planning programme where the husbands (decision makers in the family) were involved in the antenatal care programme.

However, some slum dwellers mistook the zeal of the health care personnel and the CHVs. They thought that the health care personnel had their own selfish motives when they came to work in the slums.

It can be concluded that no amount of health education or missionary zeal can help unless people realize that the profferred facilities are in the interest of their own health. Once they are convinced about the objective of the programme, a lot can be achieved in community participation. △