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Special Article

Community Participation in Rural Healthcare System:
A Narrative Review

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Abstract:

Community participation is one of the important components of the health system after the alma-ata declaration. To know the role of the community an electronic search strategy was adopted with broad domains like 'community participation', 'community involvement', 'rural health care system', and 'health and family welfare' using j-store and Google accessing Jawaharlal Nehru University, New Delhi library. The purpose of this narrative review is to collect evidence on the role of community participation in addressing health and family welfare. The findings are mixed in nature and the review suggests that community participation can be successful depending on the nature of participation, institutional setting, and socio-economic and political context.

Keywords: community participation, community involvement, rural health care system, health structure

Introduction

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity and it is the basic right of every human being to enjoy the highest level of health irrespective of their economic-social-political status, as per the World Health Organization. A long and healthy life (say life expectancy at birth) is one of the important factors in assessing the human development index. Understanding the importance of health in the development process, India adopted various policies, programs, and strategies and most importantly developed a

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healthcare system (say structure) to improve the health outcomes of its people. According to the World Health Organization, the health system comprises different components like infrastructures, human resources, information, technologies and communication facilities, supply of medicine, funding, strong health plans and evidence-based policies, quality assurance mechanisms, legislation, governance etc.

Before knowing details on the health system, it is necessary to know the Indian centuries-old health system because India has a rich legacy of medical and health sciences. Ayurveda which means 'science of life' originated from the Vedas (Rig Veda, Yajur Veda, Sam Veda, and Atharva Veda, commonly known as the compilation of knowledge), the backbone of Indian civilization, gives two important medicinal and surgical contributions, as Charaka Samhita and Sushruta Samhita, bear the testimony of the ancient tradition of India's scientific healthcare with holistic manner, as per national health policy 1983. Besides, Ayurveda has eight disciplines, in practice, known as Astanga-Hridaya/Ayurveda (Jaiswal & Williams, 2017). The basic difference between Ayurveda and others is that Ayurveda believes in practice and has its own philosophical framework. However, various other systems of medicine (specifically Unani, Homeopathic, and Allopathic) have evolved, practiced, and continued, though the allopathic system of medicine is ahead of time, with the intrusion of foreign influences (both in medieval and modern times) and assimilation of different cultures in India (Ravishankar & Shukla, 2007). One important observation is that different medicinal approaches in India are attached to different political patronage and culture.

The foundation of the health structure of modern India came into existence after the recommendation of the Health Survey and Development Committee popularly known as the Bhore Committee (1946), with a goal to access the availability of healthcare services to all citizens irrespective of their ability to pay with a special emphasize on a rural vulnerable section of the population through setting primary health centers (PHCs), according to Oxfam India's Inequality report 2021: India's unequal healthcare story. Again, both the Mudaliar committee (1962) and Chada committee (1964) recommended promotive, preventive, and curative healthcare services with a provision of one basic health worker in each PHC.

The National Health Policy 1983 also emphasized the need for comprehensive primary healthcare services, especially in remote parts of India, with a focus on health for all approaches. Besides, the policy focused on the all-round development of the community through community participation. Again, India introduced national health policies in 2002 and 2017 with some modifications based on ground reality but the concept of awareness through community is always in priority. Later, the government of India modified the basic healthcare delivery system and launched the historical National Rural Health Mission (NRHM) in 2005, in view to safeguard the quality of life of people in India. The mission adopts a broader concept of health

which includes the determinants of quality health like nutrition, sanitation, hygiene, and safe drinking water, and gives priority to the Indian systems of medicine to facilitate health care. Besides, the mission focuses on more public expenditure, unification of organizational structures, regional balance in health infrastructure, maximum utilization of health manpower, decentralization of health programs, community participation, management of health programs, and converting community health centers into functional hospitals in each block of the country.

After the continuation of NRHM, again to improve the quality of healthcare, the concept of equity and financial protection came into the limelight which brought a new concept named 'universal health coverage' (UHC) to the Indian healthcare system and it was implemented after the recommendation of planning commission of India (currently known as Niti Aayog) in October 2010. Expenditure on health pushed nearly 55 million people into poverty in a single year and 38 million of them fell below the poverty line due to expenditure on medicines in India, according to a study by the Public Health Foundation of India, reported by Rema Nagaranjan in 2018. According to WHO, UHC is a health system that comprises essential and quality health services from health promotion to prevention, treatment, rehabilitation, and palliative care and every individual and community has access to it without any financial hardships.

The latest national health policy 2017, in line with sustainable development goal (SDG) target 3.8, also envisages attaining the highest level of health and well-being for all ages through universal health coverage and also focuses on health as an integral part of development. Many countries like Germany and Belgium have achieved the UHC where nearly 99 percent of their population are protected against major and minor health risks, no doubt time and resources have played an important role. Interestingly, even middle-income countries like Thailand and Mexico also achieve it whereas the United States of America is not able to achieve the UHC (Ikbal F, Ghosh R and Bhinde P, 2022).

The message is clear that it is not necessary to be rich to achieve UHC. However, the importance of finance cannot be ignored and most importantly political will is the necessary foundation to achieve UHC. Multiple literatures focus on the success of UHC through the public healthcare system. In the context of India, both the center and state combined spend only 1.25 percent of the GDP which is the lowest among the BRICS countries, as per one report by Oxfam 2021. In Oxfam's Commitment to Reducing Report 2020, India ranks 154th in health spending, fifth from the bottom. So it is necessary, that India should increase its budget allocation to achieve UHC, even National Health Policy 2017 also advocates increasing the public health expenditure to 2.5% of the GDP by 2025.

Gradually the healthcare system focuses more on government-funded health insurance schemes rather than improving the public-funded health care system in India. The shift of focus from conventional health programs to health insurance was

more visible after 2000. However, this insurance concept was not new; it could be traced back to just post-independence era and the first two publicly funded insurance schemes of India were the employees' state insurance scheme (1952) and the central government health scheme (1954). Later, the universal health insurance scheme (2003) for below-poverty-line families and Aam Admi Bima Yojana (2007) for rural landless households were initiated. However, most of these schemes were not able to achieve the goals as targeted due to issues like implementation and the design of the schemes. However, learning from mistakes, a new scheme Rashtriya Swasthya Bima Yojna (RSBY) for the poor came into existence in 2008 and finally, Ayushman Bharat-Pradhan Mantri Jana Arogya Yojana (PM-JAY), the first step towards achieving UHC, was launched in 2018, subsuming both RSBY and senior citizen health insurance scheme, with an objective to provide health insurance of 5 lakh per year to 10 million vulnerable families (include roughly 500 million India, i.e. 40% Indian population) on the basis of socio-economic caste census of 2011(Ikbal F, Ghosh R and Bhinde P, 2022).

Though there is the provision of both state and center's financial contribution to PM-JAY, however many states have their own state-run insurance program and also health financing system. While implementing an insurance program, both center and state-level functionaries should focus on both non-beneficiaries availing insurance benefits and at the same time should also focus on the quality treatment of the people., without improving public healthcare standards as per SDG, mere health protection through insurance by the private healthcare system may increase the cost due to the profit motive of the private healthcare system. There are also various studies highlighting that non-beneficiaries are taking benefits from public sponsored programs. So a responsible state should understand this and take necessary action according to it.

Structure of rural healthcare system

The healthcare system addresses the health needs of people through both public and private healthcare systems in both rural and urban areas. However, the private healthcare system which is different from private providers, mostly caters to services in urban areas and here the literature has focused on the rural part because the accessibility and affordability of proper healthcare in rural areas is still a matter of concern as compared to urban areas, according to economic survey 2018-19. However, the policy level interventions should go beyond these mere comparisons like rural vs urban, and healthcare should be available, accessible, and affordable irrespective of an individual's background.

The public rural healthcare system delivers services through three levels generally known as primary, secondary, and tertiary level. Sub-center (SC) is the first

peripheral contact point between the community and the public health care system whereas primary health center (PHC) is the first contact point between the village community and the medical officer. Both SCs and PHCs are coming under the primary level. The population norm for the sub-center in the plain area is 5000 and for hilly or tribal areas it is 3000. The population norm for primary health centers is 30,000 and 20,000 for plain areas and hilly areas respectively. The primary health center acts as the referral unit of 4-6 sub-centers. Community health center comes under the secondary level and it is the referral unit for PHCs. The norm for community health centers is 120000 and 80000 for the plain area and hilly area respectively. Community Health Centre is established and maintained by the state governments. The tertiary level of the healthcare system generally performs at the district level and state level like district hospitals, medical colleges, etc.

Importance of Community Participation and Community Participatory Structure in Healthcare System

The health sector has improved immensely during the last 75 years in India. It has reached most of the corners too. However, it is evident from various rounds of NFHS-level data, that health inequalities exist across different population groups and also vary according to geographical locations. Health care is still not accessible to remote areas of society. The needy and vulnerable sections, especially the economically poor, still lack proper health care. When talking about healthcare facilities, it is often discussed curative part but the preventive part is more important which not only reduces the risk of diseases but also helps in preventing diseases studies show that the level of awareness is one of the strategies for the prevention of diseases. So to understand awareness, it is imperative to know the concept of community because ultimately any disease-preventive communications will be designed by the policy makers for the community and implemented by the community (say involvement of community leaders).

Though community participation has great importance in healthcare historically recently the concept of community participation again came to limelight due to COVID-19. So it is needless to say that community participation is one of the components of the health system. India has evidence of the participation of village committees in health structure through the decentralized model of governance. After a suggestion of the Bhore Committee for the formation of village health committees to improve community participation, the committees were implemented to revive primary health care in the 1980s (Srivastava A., et al. 2016). Later, the National Rural Health Mission (NRHM) with more emphasis on decentralized planning formed a village health and sanitation committee (VHSC) at each revenue village, a simple and effective management structure at the village level, to improve the community

participation at the village level having representatives from the village, especially health workers (ASHA, AWW, ANM) and members of community-level organizations like elected representatives from panchayati raj institutes, self-help groups, primary teacher association or mother teacher association, non-governmental organizations, youth club, president or secretary of Panipanchayat, user group representative and the socially marginalized group and an amount of Indian National Rupees (INR) 10,000 was provided to committee as untied fund annually to undertake planned activities on health, sanitation, and nutrition in the village (Mohapatra, 2018).

Understanding The Concept of Community Participation

Before going into the concept of community participation it is important to know the exact meanings of community and participation. Though the community is poorly defined in the literature still the definition is necessary as it is central to the issue. Mostly community is defined as a socio-spatial entity. Community is defined as a geographical entity and a sense on the basis of shared interests, values, concerns, and identity. Community may not always be homogeneous but rather heterogeneous entities (David et al., 1998). According to the United Nations, it is the lowest level of aggregation at which people organize for a common effort. Community is a word that has many meanings and uses. Some commonly used meanings of community are listed here; a. A geographical locality where people live and the inhabitants objectively have and subjectively feel a social and functional solidarity, b. A population group with similar characteristics, c. People are drawn together by concerns for which they feel allegiance for only one aspect of their new and more complex lives or as a concern that people share in common. A community can be said a target group also. Though there is an enormous amount of literature on participation still the concept has popularity but without clarity (Cohen and Uphoff, 1980).

Participation means active or passive community involvement. The aim of participation is “to achieve a special kind of power which belongs to the oppressed and exploited classes and groups and their organizations and the defense of their just interests to enable them to advance towards shared goals of social change within a participatory political system” (Borda, 1988). United Nations Economic and Social Council States (UNESCS) defined that participation needs the voluntary and democratic involvement of the people. According to Oakley (1989), participation means, to sensitize the people and thus to increase the receptivity and ability of rural people to respond to development programs as well as to encourage local initiatives (Oakley, 1989).

Nowadays the word participation is used for mobilization and empowerment. Community mobilization is defined as a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other

needs, either on their own initiative or stimulated by others. Empowerment is defined as the process and outcome of being powerless through gaining information, skills, and confidence and thus control over decisions about their own lives and can take place on an individual, organizational, and community level (Rosato et al., 2008). Terms such as 'community involvement', 'community development', and 'community mobilization' could all describe the collective involvement of local people in assessing health needs and implementing programs.

More recently, the terms 'community capacity building' and 'community engagement' have gained popularity and both of these processes involve community participation (Preston et al., 2010). The majority of studies highlight there is no standard definition of community participation and it is a structured word. It is only situation-specific, unpredictable, and not generalizable (Rifkin, 2014). Still, we try to define the concept of community participation in health.

Traditionally there were two perspectives in defining community participation in health. One is a utilitarian model and the other is an empowerment model. Participation is defined as a 'means' in the utilitarian model and as an 'end' in the empowerment model. In the utilitarian model community resources are used to deliver health care facilities whereas in the empowerment model, local communities are taking responsibility for healthcare delivery (Morgan, 2001). Community participation was defined as "an educational and empowering process in which people, in partnership with those able to assist them, identify problems and needs and increasingly assume responsibility themselves to plan, manage, control and assess the collective actions that are proved necessary" (Askew et al., 1986).

Community participation is a process where members of the community, either individually or collectively with different levels of commitment first take responsibility for health care delivery then plan and execute it by creating or maintaining organizations in support of these efforts, and finally evaluate the effects on an ongoing basis. Basically, it is a strategy that creates the sense of solving people's problems through sincere reflection and collective action (David et al., 1998). Community participation is a social process whereby specific groups with shared needs living in a defined geographic area actively pursue the identification of their needs, make decisions, and establish mechanisms to meet these needs (Rifkin et al., 1988).

Understanding the concept through historical lenses

Community participation in health programs is not a new concept rather its history can be traced back to the aftermath of the world war-2. There are two trends visible that laid emphasis on community participation. At the advent of decolonization, the inadequacies of the Western medical system were dramatically exposed (Rifkin,

1990). The new nations could neither afford the high costs nor have proper infrastructure. To deal with this health crisis, the emphasis was placed on preventive, decentralized, community care based on epidemiological priorities rather than Western medical services and new technologies. Health service delivery was viewed as social policy rather than technological development. Another trend recognized that public health policy was not only for curing disease but for the country's general development. Health was recognized as an investment in men (Myrdal and King, 1972). The sense of health services was now changed from mere medical profession to economic development planning.

Thus the debates of 'basic needs', 'social justice', and 'people's participation' started in health care. The development of these trends culminated in the concept of Primary Health Care (PHC). Community participation gained momentum in the global health policy arena as the member countries of WHO accepted primary health care as their official policy in the Alma Ata Declaration in 1978. The declaration stated that health is a human right that the inequalities in existing health status are 'politically, socially and economically unacceptable' and that essential health care must be made 'accessible to individuals and families in the community through their full participation'(WHO,1978).

The declaration started giving importance to social justice and linked it to equity and participation as the principles of primary health care. With letter and spirit, many countries created a cadre of community health workers (CHW) to serve poor rural people where the majority of the world's population lived in response to the call for community participation in the Alma Ata declaration. Community members like China's 'Barefoot Doctors' were trained to serve basic health care and referrals in the health centers.

The participation would lower the costs of health care because they were from the community and were supported by the community. In theory, the community members seemed as 'change agents' and had an impact on health behaviors and empowering the communities to make joint decisions about health care (Werner, 1977). Answering the call for community participation of Alma Ata, community health workers became synonymous with primary health care (Mburu, 1994). Gradually, the argument for the role of community people leads towards a more broad-based approach like 'participation' and 'empowerment' (WHO, 1986).

The Bamako Initiative stressed upon decentralization of health services with a sharp focus on accountability and governance from the center to peripheral units (Mehrotra and Jarret, 2002). The discussion of cost-effectiveness and sustainability came to limelight after the financial crises of the 1980s (Rifkin, 2014). The importance of social determinants of health, decision-making process, and power structure was highlighted in the World Health Organization Report of the Commission on the Social Determinants of Health (WHO, 2008a) and World Report on Primary

Health Care (WHO, 2008b). Finally, all these developments brought issues of empowerment, capacity building of local people, financing and program sustainability into the dialogue (Rifkin, 2014). There is a debate on how community participation is to be achieved in health care services. Planners have chosen two different approaches of community participation in health programs. The first approach is dominated by planners the most. They decide the various objectives of the health program and convince the people of the community to actively accept these objectives. This frame of reference is called a target-oriented frame. The roots can be traced back to the Western scientific tradition and the biomedical model of health and illness by the end of the nineteenth century (Macdonald, 1993).

According to this frame of reference, improvements in health are due to a result of discoveries in science and technology. The only motto of community participation is to improve the health status of the people. This frame of reference is also called the 'top-down' approach. The second approach is that community people are to make decisions about resource allocations and priorities. The unequal distribution of resources is the cause of poor health care and health status. The more equitable distribution of resources can be achieved through structural changes at the local level. Democratically, the structural changes can happen. This frame of reference addresses health improvements through the political context. The second frame of reference is called the empowerment frame. The root of the empowerment frame is traced back to the post-war and ex-colonial periods (Morgan, 1993). This frame of reference is also called the 'bottom-up' approach.

Literature on community participation and healthcare system

After understanding in detail the concept and structure of community participation now the author tries to collect the available literature on the role of community participation in health and family welfare which was searched with an electronic search strategy with broad domains of community participation, community involvement, rural healthcare services, health and family welfare in 2014-15 using both J-Store and Google accessing the library of Jawaharlal Nehru University, New Delhi. The works of literature are mostly from South Asia; however, studies on other than South Asia regions are also mentioned. The overall purpose of the review is to examine the role of community participation in addressing health and family welfare.

A study using the cluster randomized controlled trial (RCT) in Ethiopia found that proper mobilization of women's group has effectively treated malaria at home and reduced 40 percent of the under-five mortality (Kidane and Morrow, 2000). A study in the Makwanpur district of Nepal found that community mobilization by women's groups has reduced by 30 percent the neo-natal mortality rate as well as significantly lowered maternal mortalities (Manandhar et al. 2004). Using before and after analysis of a small population in Bolivia under the Warmi program found that due to community involvement, perinatal mortality has been reduced by 62 percent

(Rourke et al., 1998). The intervention of lady health workers and traditional birth attendants through proper health education and training has shown a decline of 35 percent in the perinatal mortality rate and a decline of 28 percent in the neonatal mortality rate in the intervention villages compared to baseline rates in Hala in Pakistan (Bhutta, 2008). The study found that the neonatal mortality rate was reduced by 34 percent in the final six months of the trial compared with the comparison group, with the help of trained female community workers who are providing a home care package including assessment of newborn infants on the first, third and seventh day after birth and treatment of sick neonates in Sylhet district of Bangladesh (Baqui et al., 2008).

The experiences from different pilot programs suggest that community participation can bring substantial reductions in mortality and improve the health status of newborn infants, children and mothers (Rosato et al., 2008). It is also observed that community leadership with transparency, accountability and decentralization will improve mutual trust and respect and largely contribute to service outcomes (Rosato et al., 2008, O'Meara et al., 2007, Broussard et al., 2003 and Coady, 2009).

It is found that community development has had an impact on the improvements in health indicators in recent decades but only a few small projects (as with Chakaria Community Health Project, Comprehensive Rural Health Project, Jamkhed, etc), have established the causal link (Hossain et al., 2004). The evolution of community development projects in South Asia has led to a drastic improvement not only in infant survival but also in other health development indicators. The shift of focus from a hospital-based system to a community-based healthcare system during the past decades is the success of public health. Community involvement may have a positive impact on the success of project development and implementation (Jewkes and Murcott, 1998). Participation may directly affect individuals by changing attitudes and actions towards the causes of ill health also promote a sense of responsibility and increases personal confidence and self-esteem. Involvement in the policy process may decrease alienation among socially excluded groups and change the focus of power relationships with the professional decision-makers. There is a strong relationship between community participation and improved health outcomes (Abad-Franch et al., 2011).

Effective participation helped in the control of diseases in Chagas but still further evidence was necessary. Effective involvement of all stakeholders would foster true empowerment and lead to improved health and living standards. The role of women's groups are the most cost-effective and realistic way to minimize maternal deaths and improve birth outcomes rapidly (Rifkin and Pridmore, 2001 Prost et al., 2013). Community participation activities work as the most successful way to implement primary health care for achieving the goals of health for all (Roy and

Sharma, 1986). Increasing the role of community participation in rural primary health care service delivery raises the likelihood of genuine community health sector partnerships and more responsive health services for rural communities (Preston et al., 2010). Despite many challenges, community participation has contributed to improvements in health at the local level, particularly in poor communities (Rifkin, 2009). The National Rural Health Alliance highlighted that community participation in rural health services is unquestioned. Participation by individuals, communities, and special groups is necessary for successful programs and services to maintain and improve their health. The need for social and physical capacity for planning and implementing local programs is also necessary for communities to improve their health.

There is also small but substantial evidence of the association between community participation and improved health outcomes in Australia (Bath and Wakerman, 2013). They suggested policymakers should strengthen policy and funding support for participatory mechanisms in primary health care. Community participation in health services increases local knowledge and skills promotes a sense of ownership in local health service, and strengthens local relationships and networks (Strasser et al., 1999). Community participation not only develops the social capital within the community but also incorporates the memory of health service which facilitates maintenance and continuity of services transcending idiosyncrasies and changes of health care providers. It is observed that community participation has played a key role in addressing communicable diseases like malaria in low and middle-income countries. However, the lack of proper definitions of 'community' and 'participation' questions the exact nature of community participation (Atkinson et al., 2011).

The Gothenburg consensus paper on Health Impact Assessments highlighted that community participation is the core ideal in almost all the contemporary major national and international declarations on health but little empirical work has explored the utility of participation in attaining objectives of the assessments. It is found that there is little evidence of the link between community participation and improvements in rural health outcomes. However, lack of evidence does not necessarily mean lack of effect (Preston et al., 2010). They stressed that community participation should be understood in terms of the expectations of time, resources, tools to measure and health development. They highlighted the role of community participation in the context of health planning, resource allocation and service delivery (Mubyazi and Hutton, 2012). Community participation has no common approach in the program due to lack of a standard definition of community participation. There is little evidence of a direct link between the participatory approach and a noteworthy impact on health and social outcomes (Smith et al., 2009). Community participation in health is a just slogan in rural areas of Zimbabwe and the promotion of community participation in health programs is time-consuming

and needs a lot of patience (Tumwine, 1989). The health workers and donor agencies should not be paternalistic. Proper training, education, and necessary skills can improve effective community participation in Sri Lanka (de Silva, 1975). It is observed that community participation results in higher community satisfaction with better health services and outcomes but evidences to support this assertion is limited (Kilpatrick, 2009).

It is noted that though community participation can be used in designing rural primary healthcare services, the outcome depends upon community receptiveness and varies from innovative models to passive protest (Farmer and Nimegeer, 2014). The design of acceptable local services depends on how community members are engaged. The failure of community participation in healthcare facilities is also observed (Rifkin, 1996). The reason for failure is that community participation was taken to be a magic bullet to solve problems rooted both in health and political power. He suggested the use of different paradigms where community participation should take a more eclectic approach as an iterative learning process. Treating community participation in this way will enable more realistic expectations.

It is also found that participation is time-consuming because communities often question the value of investing time and effort in a project (Glicken, 2000 Cornwall and Jewkes, 1995). Local people are often too busy in their daily business and unable to be involved in participatory activities and the legitimacy of those who participate is unclear. Communities are often heterogeneous by tensions and conflicts where certain vulnerable groups may not be willing or even unable to participate. Participation is intuitively appealing but it is clear that participatory approaches do not always run smoothly on health impact assessments (Parry and Wright, 2003). Nowadays a multitude of factors have played a role in improving health but the challenge remains to find definite answers regarding the shares between interventions and the process of implementation (influence of community development or empowerment) in improving the health of communities and at what level and scale.

Community participation should be used in the process of implementation of health programs for sustaining outcomes rather than as an intervention to improve health outcomes (Rifkin, 2014). Community participation as an intervention gathers people to think talk and act on health problems and services (Marston et al., 2013). The contribution of community participation to improve health depends on a variety of factors including system and socio-cultural factors. The contribution of health facility committees pointed out the lack of a standard definition of community and participation (McCoy et al., 2012). The outcomes not only depend on the process but also on the interaction between the intervention and the context.

The accountability of the community depends on the village health committee and ward committee, health center, and women's groups in low and middle-income countries (Molyneux et al., 2012). The success of the committee's performance

depends upon the selection process, the relationship between committee members, different groups, health workers, and managers, and the support of resources by local and national governments.

A comparative analysis of seven case studies of community participation projects implemented by Non-Governmental Family Planning Associations (FPAs) of India, Bangladesh, Pakistan, Sri Lanka, and Nepal found that despite the policy rhetoric, seeking greater community involvement and self-reliance in program implementation, FPAs most commonly use participation as a means to generate new demand for services by presenting family planning in a manner that is acceptable and appropriate to the communities involved (Askew, 1989). The committed and enthusiastic local person along with the doctor can mobilize the community members and gradually women participate in different income-generating activities and also steadily improve family planning use within the community in Bangladesh (Askew et al., 1987). Community participation strengthens the role of community development workers who provide service and organize activities in Nepal (Askew, 1988). Family planning was integrated with a variety of areas like health, agriculture and community development services.

A study in the tribal area of Madhya Pradesh of India found that family planning is integrated with many developmental programs and community participation through collective action is the major strength (Khan and Gupta, 1998a). The trained young community volunteers, basically female, act as resource persons on matters of family planning and healthcare in Sri Lanka. The local committee manages all the activities of these volunteers and together they mobilize the community participation in family health activities (De Silva, 1988). Community-managed family welfare centers provide Maternal and Child Health (MCH) care and family planning services in Pakistan (Ayub and Azam, 1988). The centers are managed by a committee of local leaders, basically male, to enhance the socio-cultural acceptability of family planning. An overview of the nature and extent of community participation in the national programs of Bangladesh, China, the Republic of Korea, the Philippines, and Thailand found a similar pattern of community participation in all the countries (Askew and Khan, 1990).

The study highlighted that the individuals of the community, often volunteers are providing the information and services and motivating the potential users. Community leaders are also encouraged to actively promote and support the program. The contribution of resources by community members is very little. Community members are not involved in the decision-making process related to program beyond identifying the community based service deliverers. The active community participation in planning and implementing program activities varies from limited to nonexistent. This limited form of participation was due to the bureaucratic organization system in national family planning programs. Rifkin (1986) highlighted

the role of community participation in health programs and pointed out that new attitudes can develop among the planners, agencies and community people to deliver health services and the expectation of all groups be also taken into account (Rifkin SB, 1986). The programs should be run by the community people rather than planners. The planners and agencies should act as resources, not directors. If attitudes and expectations are not taken seriously then health care becomes once again a bottomless pit of resource absorption and unmet services. The family planning program of Indonesia is the most effective in developing countries in promoting family planning services and contributing to fertility transition (Shiffman, 2002). This is due to effective community participation and the credit goes to the network of village family planning groups. The groups are basically female volunteers. They distribute family planning methods in remote areas of the country and act as agents of family planning motivation. Civil society organizations and community-based institutions such as panchayats and self-help groups should work creatively to mobilize communities and generate demand for contraception and other reproductive health services (Pachauri, 2009).

Accredited Social Health Activists (ASHAs), Anganwadi Workers (AWWs), and Self Help Groups (SHGs) should be more active at the grassroots level identify the groups with need, and give them proper information and services related to health and family welfare in India (Mohapatra, 2015). Community participation in the family planning program in Uttar Pradesh is very indifferent and passive (Bang, 1986). The feudal structure, elitist politics, lack of political will, and finally absence of political structure and process at the grassroots level (no grassroots election since 1971) in Uttar Pradesh severely limit the community participation in the family planning program. He also noticed that besides the village pradhans, all other leaders like caste leaders, teachers, and private medical practitioners are not asked to participate in the family planning program. Though village health committees are to be formed in the villages still many villages have no committee. Committees are completely inactive and their existence is only on paper. The reasons are as follows. These committees are formed by the pradhan and the panchayatsevak without any educational and participatory processes. The committee has no power or money at its disposal. The government machinery has a disrespectful and stereotypical attitude towards the committees.

Conclusion

The findings on the impact of community participation on both health and family welfare are mixed in nature. While some studies found that it has been useful, others observed that it has not really functioned well. It appears that community participation cannot be considered as a magic treatment however the success

probably depends on the nature of participation, the institutional setting and socio-economic and political context.

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