

COMMUNITY PARTICIPATION AND HEALTH GOVERNANCE : SOME LESSONS FROM POOR URBAN COMMUNITIES IN KOLKATA

Md. Hasan

Assistant Professor, Department of Political Science, Faculty of Post-Graduate studies in Arts, University of Calcutta, Alipore Campus, 1, Reformatory Street, Kolkata 700027, WB, India

DOI: 10.46609/IJSSER.2021.v06i12.019 URL: <https://doi.org/10.46609/IJSSER.2021.v06i12.019>

Received: 20 Dec. 2021 / Accepted: 30 Dec. 2021 / Published: 31 Dec. 2021

ABSTRACT

The notion of urban as well as its usages has moved beyond the conventional sense of the term. Urban studies explore into the variegated periphery of a city within the larger areas of an urban settlement. This paper has dealt with governance issues of the sanitation, cleanliness, and health effect upon poor urban communities in Kolkata. Similarly, there has been increasing recognition of community participation and community-based organizations (CBOs) in improving overall governance and accountability in the health sector. This is because community participation is considered a key to public health and central to fight any epidemic/pandemic that is experiencing the globe at present. Thus, the importance of active community participation has been highlighted in various forms from many theoretical perspectives like human development, good governance, decentralized planning etc. This research work has dealt with the details in the management and governance of basic services especially clean water and sanitation and their health effect in poor urban people in Kolkata, the capital city of the state of West Bengal, India.

Keywords: Health, sanitation, governance, community participation, KMC.

1. Introduction

In recent years, the UN and its specialized agencies have called upon to gather information on options and governance innovations that could hold promise for overcoming the challenges of exclusion and that contribute to bettering public governance systems and procedures. These should not only be transparent, but also should foster and sustain accountability and, most

importantly, produce pro-poor development initiatives. Accordingly, UN/DPADM¹ visualized a kind of public governance (exchanging the older one 'participatory governance') at the center of which is to be the 'people' and such 'civic engagement.' Public governance has on three vital areas as follows:

- Policy development;
- Service delivery; and
- Public accountability.

A close look at the political economy and public governance in most countries (including some of the advanced democracies) reveals that the poor and the disadvantaged face increasing marginalization. Among other regressions, they are moving further away from the decision-making processes of the state. This stems from a range of factors. Some are intrinsic due to institutional deficits in the political processes of the countries. The growing marginalization of the poor and the disadvantaged is also causing much dissatisfaction, even despair, at the popular level in many countries. Others are exogenous, exacerbating inequalities that already exist and disempowering citizens further.¹ Since democracy is expected to provide the most legitimate platform of participation, what precise conditions justify civic engagement? Greater civic engagement draws its rationale from the democratic political paradigm that emphasizes constitutional liberties and representative government as the basis of good political governance. This rationale also assumes that deepening civic engagement opportunities will make the existing system more representative, accountable, transparent, and equitable. Civic engagement in public governance today is evolving against a backdrop of several worldwide developments that are transforming the socioeconomic dynamics of countries with both opportunities and challenges. Indeed, the recent commitments to the Millennium Development Goals made by the world leaders at the global level reflect a shared vision of development and an effort by the international community to devise strategies that will simultaneously help minimize challenges and maximize opportunities. Civic engagement in public governance may well be a key strategy for serving these twin goals.

Any immediate image of an urban area, *inter alia*, are mostly linked with some civic amenities like health and sanitation facilities, water supply, waste management, better education, employment opportunities, social mobility and so on. Moreover, this type of imagination of the

¹ United Nations, Division for Public Administration and Development Management (DPADM) of the Department of Economic and Social Affairs (UNDESA)

city is very much applicable to the cities of India as most of the modern cities came after the Britishers used to be rulers of the country. Therefore, delivery of civic services, more or less, has been at the center of any strategy of city development and governance of the city in the present day world. Sustainable Development Goals ²(SDGs) also emphatically stresses on building the principle of “leaving no one behind” from access to civic services including zero hunger (SDG₂), quality education (SDG₄), clean water and sanitation (SDG₆), good health (SDG₃), etc. as a holistic approach to achieving sustainable development for all.

Box 1.1: City as an Imagination

‘City as an imagination’ is a philosophical stand where a city is portrayed as a solution to all kinds of socio-economic problems that usually face a rural area in comparison to a city. However, it is also true that there are several substantial reasons to evolve an urban area vis-a-vis the rural one. Many of these factors often attributed to pull factors like better employment opportunities, education and health facilities, social mobility etc. in the city or some push factors like unemployment, poverty, superstition, deadly diseases, lack of various civic amenities etc in rural areas. These types of imaging of the city are easily found throughout different literatures during the colonial period even in many cinemas after independence of India. According to Sassen (1996), modern city is an economic phenomenon and acts generally as a ‘logistic hub’. It is a product of industrial development and is now the agent and instrument of economic growth and industrial expansion in comparison to earlier cities in ancient civilization where the latter were mainly a centre of administration and owed its vitality to various religious and cultural forces.

Health has been a primary concern of human beings throughout history. We learn from the biography of Gautama Buddha that he was moved in particular by seeing the penalties of ill

² All 193 Member States of the United Nations General Assembly unanimously agreed to *Transforming our world: the 2030 Agenda for Sustainable Development* (the 2030 Agenda) in September 2015. The 2030 Agenda call all the member states to action to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity. The 2030 Agenda established 17 Sustainable Development Goals (SDGs) and 169 global targets, relating to development outcomes and means of implementation (MoI), for the period 2015–2030. These were designed to be integrated and indivisible and to balance the social, economic, and environmental dimensions of sustainable development. The 2030 Agenda further seeks to realize the human rights of all, and to achieve gender equality and empowerment of all women and girls. This ambitious universal agenda is intended to be implemented by all countries and all stakeholders, acting in collaborative partnership. Available at <https://www.undp.org/sustainable-development-goals>

health—by the sight of mortality (a dead body being taken to cremation), morbidity (a person severely afflicted by illness), and disability (a person reduced and ravaged by unaided old age). Therefore, health is intrinsic to living—no matter what one’s way of life. The good health of an individual not only ensures the development of the brain or conscience above all a peaceful life, it also reflects the overall development of that particular community. Health is the product and reflection of society’s attention to an adequate standard, available to all, in the conditions in which its population lives. When we talk about the good outcomes of a particular organization, for example the research output of a university which reflects the good academic health of the university, sometimes we consider it to be the good health of that particular organization. However, health is not simply an instrument for the purposes of other social functions; it is a societal end. As Sen in his Capability Approach provides an alternative and multidimensional concept for understanding well-being that focuses on ‘functionings’ and capabilities of individuals. He uses the terms ‘functionings’ and “capabilities” to define the standard of living in a way that is different from utility theories and commodity-based theories of the standard of living. Instead, Sen argued that well-being lies in the real freedoms, the effective capability that people have to achieve chosen ‘functionings’; and, therefore, just institutions should seek to equalize people’s capability, or their effective opportunities to lead valuable lives. Sen further specifies some basic capabilities that are essential to well-being, such as being nourished and sheltered, being educated and healthy, and appearing in public without shame.

Box 1.2: Capability Approach

Capability approach emphasizes the importance of health not only for individual but social ends. Society's obligation to maintain and improve health rests on the ethical principle of human flourishing - or human capability. Indeed, certain aspects of health sustain other aspects of human flourishing because without being alive, no other human ‘functionings’ are possible. This perspective views health as intrinsically and instrumentally valuable. It places emphasis on health capability - an individual's ability to achieve good health and be free of preventable morbidity and mortality. The idea of capability forwarded a more positive notion of overall freedom: "real opportunities" we have regarding the life we may lead. As Sen considered that “the societal conditions in which individuals can become active agents of change rather than passive recipients of dispensed benefit.” (Sen, A. (1999). *Development as freedom*. Oxford, UK: Oxford University Press, p.xiii.)

It should, therefore, come as no surprise that healthcare for all—“universal healthcare” (UHC)—has been a highly appealing social objective in most countries in the world, even in those that have not got very far in actually providing it.ⁱⁱ Although international cooperation to improve

public health started in the middle of the nineteenth century, the establishment of the WHO in 1948 that marked the birth of today's international public health regime. Member states of WHO agreed upon the principles that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" and that the "health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States." However, since the Alma-Ata Declaration (1978)³, community involvement and community-based approaches as social determinants in primary health care have become increasingly important, and many countries have been trying to implement these practices in healthcare since the 1980s and 1990s. Since then, there have been several critical global health policy initiativesⁱⁱⁱ taken and most of them also focused on the social determinants as a matter of social justice, the absence of which was "killing people on a grand scale."^{iv} From various studies and observations, it has become clear that the higher the involvement of community, the greater the results of healthcare delivery in the society.^v Thus, Involving communities, either as a complement to the formal delivery system or independently of it, has long been identified as a critical component necessary to achieve effective and sustainable programs for health improvement and to address the social determinants of ill-health.^{vi} Thus, in the light of a borderless world which resulted in the trans-border flows of people, ideas, goods and services, the idea of global health governance (GHG) has become a keen topic of interest and debate in the field of international health.^{vii}

As public health is conceptually distinct from medical services, no one can deny the importance of analyzing health governance is a primary consideration especially in the context of delivering vital services to the poor communities who constitute the majority in any modern cities. As 'World Urbanization Prospects: The 2018 Revision' produced by the UNPD (UN/DESA), today,

³ The International Conference on Primary Health Care was convened in Alma-Ata, Kazakhstan, in 1978, and was attended by virtually all the member nations of the World Health Organization (WHO) and UNICEF. The vision of Alma Ata was that health improvements were not merely the result of health service delivery and medicines. Reflecting recognition of social determinants of health that included social, economic and political concerns. The fourth article of the Declaration stated that, — "people have the right and duty to participate individually and collectively in the planning and implementation of their health care," and the seventh article stated that primary health care — "requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation, and control of primary health care." Thus, the Declaration emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care (PHC) as the key to the attainment of the goal of Health for All (HFA). Declaration of Alma-Ata, September 6-12 September 1978, Alma-Ata, USSR. Available at http://www.who.int/publications/almaata_declaration_en.pdf

55% of the world's population lives in urban areas and it is expected to increase to 68% that is two-thirds of the world's population will be living in cities by 2050. The report forecasted a dramatic upswing in the increasing urban population in India, China and Nigeria that together would account for 35 percent of the estimated growth in urban populations between 2018 and 2050. Report also estimated that that one in seven of the world's population will live in poverty in urban areas, and the vast majority of these live will be in the Global South – mostly in overcrowded informal settlements with inadequate water, sanitation, health care and schools provision.^{viii} The increased demand of these basic utilities compelled city authorities or governments to amplify resources allocation for delivering the stakeholders with effective and responsive services that eventually determines governance quality and efficiency of a good urban government.

Health service is also one of the key basic urban utilities that is not only important for human development in a given city but also is intrinsically related with the poverty level of poor urban communities in any modern city. As Sen. suggests that health equity “cannot be understood in terms of the distribution of Healthcare” but is realized when all people have the opportunity to achieve their full capabilities and potential for health and well-being.”^{ix} Recent growth experts also argues that human development that greatly rely on basic services - safe water and hygienic sanitation to prevent a number of infectious diseases, electricity to serve schools and health clinics, roads etc. and equitable access to these services are the key element for enabling opulence in the developing countries.^x Service failures and constraints may hamper the uniform and equitable distribution of economic benefits of urbanization and basic services to poor urban communities. As Rydin *et al* stated that poor communities are a manifestation of failures in planning, governance and legislation, so good local authority policies as promulgated by the ‘Health Cities movement’ are conducive to slum health as discussed in a Lancet Commission on urban health.^{xi} For instance a recent study comparing contiguous slum areas in India, one ‘notified’ and one not, showed markedly better outcomes in education and health in the notified area, for example an infant mortality rate 58 versus 25 per 1000 live births.^{xii} Thus, lack of reliable and available basic urban services further reduces the availability, uses of educational, social, and livelihood opportunities to poor urban communities.^{xiii}

Thus, it has been observed that the last fifty years attempts of improving urban basic utilities governance by the developing countries have been considered as experimentation with these different forms of arrangements. The aims of such experimentation has been to identify and resort to the “best-fit” option through “trial-error method”^{xiv} since improvement of urban basic

utilities delivery and management is increasingly being recognized as an accompaniment of good urban governance.

2. Brief overview of the study area: Kolkata Municipal Corporation

A brief account of the urban space of Kolkata is necessary before we look at our primary concern of municipal service delivery, especially water and sanitation facilities and their adverse health effects upon the poor city dwellers. Calcutta/Kolkata (from 2001), sometimes praised as *City of Joy*^{xv} (as French author Dominique Lapierre labeled it) is the capital city of the state of West Bengal, the third largest economy of the country, and also the cultural capital city of India. Kolkata is an unplanned city (except few suburban and satellite town areas e.g. Salt lake, Rajarhat Megacity) that has grown gradually to accommodate the influx of people from across the city, other states even a huge number of immigrants, refugees, migrant peoples from national borders. The Britishers were the first who built some civic amenities, only to the extent that they met their colonial interests, such as access to drinking water from the Hooghly River, underground drainage, street lighting, culverts etc. However, when they left the country, neither the central nor the state government took any steps to maintain or radically change these infrastructures in the post-independence period. As a result, the city is characterized by poor drainage resulting in water logging, waste effluent, and sewage, which in turn creates health risks for the city dwellers. In fact, the city has undergone certain clear phases of growth into a metropolitan complex. The most significant phases that have affected upon its socio-economic, cultural and political profile are the partition of Bengal (1905); the independence of the country (1947) Bangladesh War of independence (1971); pro-market reforms and the entry of the world market since 1990's and finally service sector based on information technology (IT) since 2000. These events also witnessed huge population displacements, refugees, impoverished rural-lags, and the plain fortune seeker found these moments opportune to relocate to the emerging eastern metropolis of India. All these events on the one hand sullied its slowly emanating 'urban' image (urban economy and lifestyle) and on the other heightened to almost institutional levels the revolutionary potential of service delivery for all sections of society. This to all intents did not allow the pure urban form to develop. On the other hand, the gross inability of the administrative structure to address the issues of growing poverty, health illness, destitute life and political non-representation of all the classes fuelled collective action, either as direct political agitation, or through written protest. Actually, Kolkata being a cosmopolitan city, it thrives amid seemingly insurmountable economic, social, political, and environmental problems. Yet for all of Kolkata's vitality, many of the city's residents live in some of the worst conditions, far removed from the cultural milieu. The city's energy nevertheless penetrates even to the poorest areas, as a large

number of Kolkatans sincerely support the efforts of those who minister to the underprivileged. The government has also sponsored a few *basti* (slum) improvement and resettlement programs. In short, Kolkata remains an enigma to many Indians as well as to foreigners. It continues to puzzle newcomers and to arouse an abiding nostalgia in the minds of those who have lived there.

Governance

Kolkata Municipal Corporation (KMC) is pivotal in the governing process of the city. KMC is constituted by three major municipal authorities' viz. Corporation, Mayor and Mayor-in-Council and functions on the basis of collective principles of parliamentary democracy as enshrined in the constitution. The jurisdictional area of KMC is divided into 144 constituencies that called wards. Again, there are boroughs that consist of 10-15 wards. Each ward elects a councilor as their representative to the general body of KMC called corporation. Each borough has a committee of councilors, each of whom is nominated to represent their respective wards. Corporation is the general body and functions as the apex regulatory body of the city. It is composed of one elected representative from each of the city's wards. The members of the corporation annually elect a mayor, a deputy mayor, and a number of committees to conduct the activities of the corporation. The Mayor is the most important person in KMC, and acts as a chief executive in the whole structure of city administration in Kolkata. Mayor-in-council, the second important executive body of the corporation, comprises Mayor, a deputy Mayor, and ten other elected members of the KMC. Mayor-in-council headed by the Mayor discharges its functions through different standing committees. KMC as the principal administrative agency oversees and manages the civic infrastructure as well development of the city including civic amenities of water supply, drainage and sewerage, sanitation, solid waste management, street lighting, and building regulation etc.

Besides KMC, a number of government agencies also administer the city. They are Kolkata Police headed by Kolkata police commissioner who is overseen by the Ministry of Home Affairs of the state government. Apart from taking care of the law and order of the city, the Police Commissioner also presides over various events and conferences in the city. The city is also a part of the Kolkata Metropolitan Development Authority (KMDA), an entity created to oversee planning and development on a regional basis. KMDA handles a large rural hinterland and urban agglomeration in the five districts around the city of Kolkata. There is also a constitutional body called Kolkata Metropolitan Planning Committee (KMPC), which is responsible for the statutory planning and development of the greater Kolkata Metropolitan Area. In fact, these two development agencies oversee and supervise the comprehensive development plans in the greater Kolkata. They integrate and ensure balanced economic development and social justice schemes

that are adopted by various municipal authorities, specialized agencies, and even semi-urban rural local bodies around the city of Kolkata. The Kolkata Port Trust, another central government agency, manages the city's river port, river transportation and such services.

3. Municipal services to the poor people in Kolkata:

Poor People in Kolkata

Fashioned by the colonial British in the manner of a grand European capital—yet now set in one of the poorest and most overpopulated regions of India—Kolkata has grown into a city of sharp contrasts and contradictions. As per Census of India (2011), Kolkata is the seventh –most populous city in India, with a population of 4.5 million residents with density 24,306 persons per KM² within the KMC's area of 185 Sq. km. As per the UN World Population Prospects, Kolkata will have a growing population of over 14.9 million residents in the Kolkata Metropolitan Area in 2021, making it the third-most populous metropolitan city in India. The striking aspect of Kolkata is that about one-third of its population lives in temporary urban settlements called *bastis* (slums). There is also a 69,798 house less population (from 12,250 families) in Kolkata, which is approx 1.55% of total population of the city. The census of India (2011) reveals that:

- In the Kolkata Metropolitan Area, about 3 million people live in 5,500 slums
- 90 percent of these slum dwellers have one room per family
- Usually each slum consists of nine “hutments” and each “hutment” consists of five huts. In the Kolkata Metropolitan Area, there are at least 225,000 huts, where one room is shared by at least 13.4 people (on average)
- About 1.7 million people out of the total of 3.3 million in the KMC lives in 13 million huts (338,000 slum rooms)

There are two broad categories of slums: those that are officially authorized called *bastes or bastis*. Total no. of such *bastees* in Kolkata city numbers 300,755 in which population of 1,409,721 resides. This is around 31.35% of the total population of Kolkata city. There are also a large number of unauthorized squatter settlements in the city. These *bastees* built on less than one-sixth of an acre (one-fifteenth of a hectare) lives on encroached lands—mainly along canals, railway lines, roads etc. The overall condition of informal urban slum dwellers is dominated by Semi Pucca in nature. 6.67% of slum households are Pucca houses, 16.67% are semi pucca houses and 16.67% are kachcha houses. These informal dwellings continue to grow with as they

are easily made up of mud, wood, straw and dry leaves. They have few sanitary facilities, and there is very little open space. They denied access to basic services like water, latrines, trash removal provided by the Kolkata Municipal Corporation. In fact, the majority of *basti* dwellings are tiny, unventilated, single-story rooms, often dilapidated. This concludes, in spite of slum dwellers possessing their own land rights their housing condition is very bad.^{xvi}

Table 3.1: Slums of Kolkata: Indicators of Material Deprivation and the Percentage of Households Deprived in them.

Indicators	Deprivation Condition (A household is deprived in the indicator if...)	Proportion of Deprived Households (%)
Over-crowding	Any household has three or more members per bedroom ⁴	71.20
Housing type	Any house is semi-pucca or kutchra; or the household lives in a temporary accommodation without any proper house	76.00
Leakage in house	Any household who lives in a house where water leaks in the house through roof or ground	39.10
Cooking Arrangement	Any household who uses biomass fuel for cooking, or cooks outdoor, or cooks inside sleeping room with no smoke outlet	45.40
Sanitation	Any household without any personal sanitation facility, or the personal facility is shared with other households	83.40
Water Source	Any household with non-improved water source, or with standpipe facility but time to the water source is more than 30 minutes, or with standpipe facility but the supply duration is less than two hours per day	21.50
Communication	Any household that does not have a land-line phone; and the number of cell-phones within the household is less than the number of its members in the age group of 22-64	59.90

⁴ This indicator is based on the UN-HABITAT (2006) guideline.

	years	
Assets	Any household having none of the major assets: refrigerator, computer, washing machine, four wheeler, AC/cooler	71.60

Source: Bag. S., Seth, S., Gupta, A. (2016). *A Comparative Study of Living Conditions in Slums of Three Metro Cities in India*, Working Paper No. 253, February, New Delhi: Centre for Development Economics, p.33

The majority of households in slums were engaged in occupations belonging to the informal sector (small business, shop owners, hawkers, etc.); 36.5% were involved in servicing the urban middle class (as house cleaners, drivers, etc.) and 22.2% were casual labourers. About 34% of the available labour forces in Kolkata slums were unemployed.^{xvii} While some skilled labourers at rail station, bus stops, hawker market found employment through connections with other workers and labour contractors, others adopted a different route: displaying their tools on the platform, publicizing their expertise as craftspersons and masons. According to one estimate, almost a quarter of the population's lives on less than 27 rupees (equivalent to 45 US cents) per day.^{xviii} According to a 2018 World Bank Report, this was not enough to provide livelihoods for millions of unskilled or semi-skilled workers in the city who are pouring out of the state's rural areas and from the poorer neighbouring states of Bihar, Jharkhand, and Orissa.

The poor sanitation in the 5,500 slums in the city directly affects the general population too. The majority of households in the slums have toilet facilities outside their premises (57.4% for migrant and 59.4% for non-migrant households). A third of (32%) of migrant households use flush latrines, and a high percentage (25.8%) use insanitary hanging type toilets. In a recent survey conducted by the bustee (slum) department of KMC, it has been found that around 4,000 pit or well latrines are being used by the city's slum dwellers. According to a 2011 census report, around 7% Kolkatans depend on latrines other than pit and water closet, which includes service latrines too, while 3.32% households in the city do not have any latrine at all. These dwellers defecate in the open causing different health problems.

Various health problems are prevalent in the community of people residing in these areas. It is observed that the people living in this area have health and hygienic problems such as allergic, asthmatic, bronchitis, skin irritation, and gastrointestinal diseases. Most of them have skin disorders and cough and cold is a common problem in almost every household. There are also chances of fecal contamination of rodents in the food as they hardly follow sanitation measures before taking a meal.

However, the poor people especially in the slums present the worst forms of health conditions. Their deplorable socio-environmental and economic conditions and less access to medical care make them highly susceptible to illnesses.^{xix} Due to these conditions, which result in malnutrition among children, there is always a high risk of Infant as well as maternal mortality rates in the slums. Because of their poor hygiene conditions people died of hepatitis, encephalitis, typhoid and rabies. The incidence of respiratory diseases like fever, viral infection, tuberculosis, skin diseases, diseases of the kidney and urinary diseases were high in the slums. According to KMC's health department records, after malaria, the next disease that is reported among the highest number of patients in Kolkata is diarrhea. The most conspicuous and highest degrees of incidence could be noticed for some special diseases: the incidence of tuberculosis was ten times higher in the slums than in the city as a whole, viral infections were 2.5 times higher, skin diseases 2 times, respiratory diseases 1.4 times, heart and circulatory system about 10 times and allergic diseases 1.9 times higher. As the slums have no open spaces and playgrounds, children in the slums developed mental complexes and physical imbalances.

Table 3.2: Slums of Kolkata: Sickness of the Residents and Availability of Healthcare Services

Type of Family	Number of Surveyed Member	No. family sick last 3 months	No. of member sick (Adult+ Child)	Treatment facilities available by no. of members						
				Govt. hospital	Private hospital	KMC Ward Health Unit	Private Doctor	Anganwadi centre (ICDS)	Others	None
Migrant ⁵	2242	293	345	150	2	24	135	0	9	0
As %		58.6	15.4	51.2	0.7	8.2	46.1	0	3.1	0
Non-migrant	2506	291	387	182	12	19	84	0	7	1

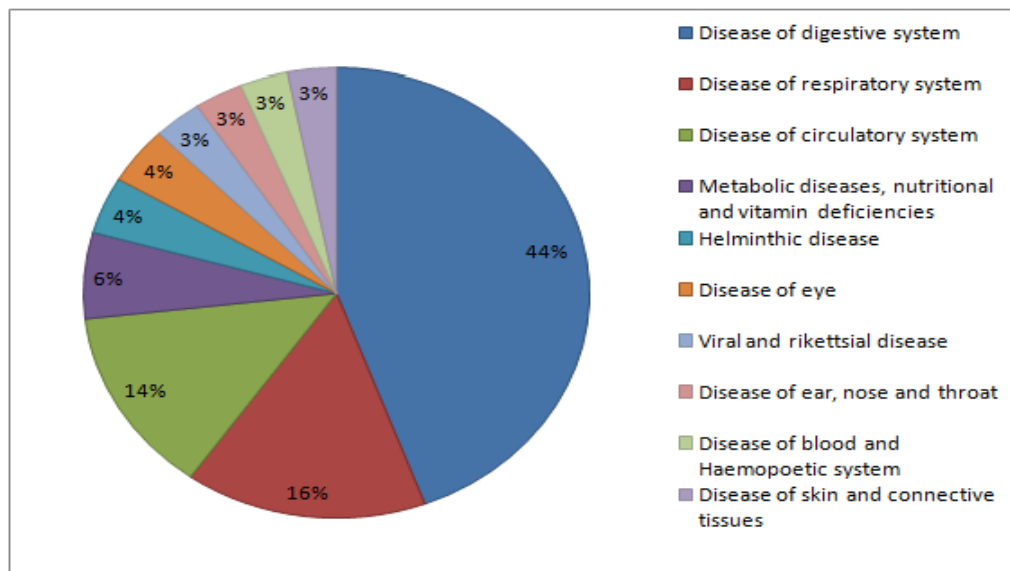
⁵ Some come from other mainly rural areas in West Bengal, by far the majority of migrants come from rural interstate regions. Among these, Bihar is by far the principal sending area, followed by others from Uttar Pradesh and Jharkhand. Banerjee A. (2016). *Migration in Slums of Kolkata: Examining Migrants' Labour Market Outcomes*, Working Paper for National Institute of Urban Affairs under SHRAMIC, p. 12

As %		58.2	15.4	62.5	4.1	6.5	28.9	0	2.4	0.3
------	--	------	------	------	-----	-----	------	---	-----	-----

Source: Bhattacharya, D. (2014). Children of Migrant Poor in Kolkata: A study on Human Development Perspectives, Institute of Social Sciences, Kolkata: UNICEF, p. 101

Even the community sanitation points (Pay & Use) are also not so good in terms of their cleanliness and freshness. Not only are those, some of them also occupied by local slum dwellers not for their urinary purposes but for a shop or something like that so that they can earn something from this place. As per KMC sources, several civic authorities have time and again highlighted how waiters or other kitchen staff in restaurants and food joints, many of who come from underprivileged families and live in slums or have a poor sense of hygiene, play a role in the spread of diseases such as typhoid, cholera, adenovirus infection, viral gastroenteritis and other diseases spread by bacteria in faces by going and using these community sanitation points. “A metro city should not have such a poor sanitation level’ said an engineer of KMC. “ Slums have always been treated as an eyesore and a nuisance to be dealt with only to ensure the safety, security and health and hygiene of the urban middle and upper classes,” a senior KMC official said. However, this attitude needs to change, he added.

Figure 3.1 Percentage of Slum Population affected by Different Diseases



Source: Kundu, N. (2006). Understanding Slums: Case Studies for the Global Report on Human Settlements 2003. The Case of Kolkata, India, Development Planning Unit. University College, London, p. 13

Health

Despite hundreds of hospitals, private clinics, free dispensaries run (185) by the Kolkata Municipal Corporation and charitable trusts, and state-operated polyclinics in Kolkata, the broad health picture especially in the poor community/slums present the worst forms of health conditions in the city. There are evidently several problems. Their deplorable environmental and economic conditions result in malnutrition among children. Infant as well as maternal mortality rates due to the low average age for marriage are very high in the slums. Due to poor hygiene conditions people died of hepatitis, encephalitis, typhoid and rabies. As the slums have no open spaces and playgrounds, children in the slums developed mental complexes and physical imbalances. Older women in these areas also suffer from anemia, asthma and jaundice at a significant rate.

Moreover, in case of the service delivery, which actually signifies the delivery of services right till the household level, there is no reason for complacency and considerable scope for improvement. The problems that people in slums, especially informal workers, have in accessing services described in paper one are compounded by severe limitations at the supply side, which Slum includes reluctance of clinicians to work in slums. The service is typically fragmented between private services, non-governmental organizations, pharmacists, and traditional healers. This scenario of service delivery shows that there are important gaps and areas of concern in the delivery mechanisms of health services. For instance, inadequate access to drugs in the public health care centers and hospitals even requires patients to provide or pay for the drugs that are used, beds for admission, preparation of medical reports, and transfer of patients from one hospital to another by govt.-owned ambulance and so on. Therefore, these are some areas in which efficiency; transparency, accountability, equity, and such social justice concerns need to be ensured in the service delivery system of public institutions.

Again, In terms of preventive and community health care, it would equally be important that public institutions have a lot of potential in terms of mobilization and ensuring effective vaccination and personal and community cleanliness which can not only contribute to the control of disease but sustainable environment and health conditions. However, to a significant extent this potential has not really been utilized in Kolkata so far. It has been observed that in some developed countries the most disease control occurred before medical interventions like vaccination were widespread, mainly through improved water supply, sanitation and better hygiene practices.

Another important aspect that may evenly affect the entire process of the health delivery systems is the involvement of the community. Public health system in Kolkata has been undermined by two major factors: the recent global and macroeconomic process; and high demographic pressure in the city. These factors have effectively reduced the ability of KMC to ensure the access of the people to safe, timely and effective healthcare in the city. This is not just because of the shortage of funds and investment in the health sector, which has mattered, but also in the inadequate number of staff available to fulfill the necessary duties involved in health service delivery. The growing reliance on private health care facilities even by the poor people, indicates the inability of the public health care system to cope with the requirements and points to the disturbing possibility that in future even more people will be denied health care because of their inability to pay. Ultimately, the community's health is in the hands of the community, and therefore it is important to ensure that adequate institutional frameworks are created so that they control their own health conditions. In fact, the role of community is crucial here.

4. Community engagement and health governance: The case of Kolkata

Even though community participation is the leading strategies for health care reforms in global health governance, studies about their impact on quality of health care and health status do hardly exist. Again, most of the studies that have been conducted examined the maternal, newborn and child healthcare in comparison to mass public health care at large.^{xx} However, few systematic efforts have been made to deal with the theoretical framework for community participation in health (Gonzalez, 1965; Rifkin, 1985; Rifkin *et al* 2000; Taylor-Ide and Taylor 2002; Hossain *et al* 2004; Bichmann *et al*, 1989; Miles, M./ Huberman, A. 1994; Curtis, S./ Gesler, W./ Smith, G./ Washburn, S. 2000; Verhasselt, Y.1993; Brunton G. et al. 2015; Cyril, S. 2015; Rosato, M. 2015). Again, it would not be an exaggeration to say that much of this literature follows a case study of community participation in the healthcare system ((Brown/ Ashman 1996; Blair 2000; Kumar 2002; Mosquera et al.2001; Murthy/ Klugman 2004; Ramiro et al. 2001). The new National Health Policy focuses on decentralization and community participation as measures to improve the quality of health care and to achieve comprehensive primary health care.^{xxi} Community participation not only provides all the necessary resources, support, initiatives for making health policies at the higher echelon, but also ensures comprehensive impact by taking its implementation to the very grassroots level. While there is little scope to argue to the contrary, there is an equal lack of understanding about how community participation can be ensured. Sometimes the degree of community participation in the health system is assessed through partnership approaches. The main advantages of this approach is that it's very helpful to generate knowledge about behaviour, intentions,

interrelations, agendas and interests of the relevant actors, which is essential for the understanding of the policy context and the assessment of the feasibility of future policy directions.^{xxii}

Figure 4.1 Framework for analyzing community empowerment in health programmes

Component of Participation	Community Participation Typology		
	Community mobilization	Community collaboration	Community development
<p>Leadership</p> <p>Of the community where the intended beneficiaries are living and of the professionals introducing the health interventions</p>	<p>Health professionals assume leadership of program – decide and direct program activities.</p> <p>Leadership within the community is not necessarily concerned with widening the decision-making base in the community. The community leadership does not question health professionals or its own role in program implementation.</p>	<p>Decision-making is collaborative between health professionals and community leaders.</p> <p>Local leaders seek ways to present the interests of various groups, particularly the poor.</p>	<p>Community members selected through a representative process who act in everyone’s interests leads program. They are accountable to the community and responsive to change. If community leadership is weak initially, health professionals train and support members to assume program leadership. Local leadership is a role model and ensures that the interests of various groups are represented in decision-making and /or provides opportunities for different groups to participate in decision-making, especially women and vulnerable groups.</p>
<p>Planning and</p>	<p>Health professionals conduct the needs</p>	<p>Health professionals collaborate with the</p>	<p>Partnerships between communities and other</p>

<p>Management</p> <p>How partnerships between professionals and the community are forged</p>	<p>assessment and decide the program's focus, goals and activities and provide necessary resources. Program timeframe is at health professional's discretion.</p> <p>Decisions are not necessarily transparent and no mechanisms are established to hold health professionals accountable to the community.</p> <p>Health professionals tell the community how they may participate. Minimal transfer of skills: technical training if necessary.</p>	<p>community.</p> <p>Professionals assess needs by asking local people for information.</p> <p>Health professionals have a predetermined remit, but invite the community to participate and respond to their priorities within that remit and in ways that are negotiated with and involve community members and existing community organizations. Program goals are negotiated. Processes and decision-making work toward transparency.</p> <p>Program timeframe has some flexibility.</p> <p>Both professionals and community members provide resources. Community members provide materials, money and human resources e.g. volunteers, local NGO participation. Some transfer of skills: capacity- building and training.</p>	<p>health care professionals are created or re-negotiated with representatives of the community and are institutionalized.</p> <p>Professionals act as facilitators to enable the community to plan and manage the program. Community conducts needs assessment, possibly with professional help.</p> <p>Program priorities are defined by community members and advocated by them. Local people's knowledge and understanding of an issue is the starting point for exploring solutions.</p> <p>Programs are integrated into existing organizations. Organizations are supported and members learn any program management and evaluation skills they lack and then assume these tasks.</p> <p>Mechanisms are</p>
---	---	---	---

			established for the community to hold health professionals and local program management accountable.
Women's involvement	Including women is not specifically sought outside of their traditional roles and they are told how to participate. Women's priorities are not investigated nor is their active participation seen as necessary for program success.	Women actively participate in some program aspects and their opinions are elicited. They contribute to the program, particularly when it affects them directly, however they have minor decision-making roles.	Women participate actively at all stages. They hold positions of decision-making and responsibility is a program objective.
External support for program development In terms of finance and program design	Program is funded from outside the community (Government / large NGO) on a scale and timeframe determined by the funder / health professionals. Health professionals acquire the funding, allocate it, and are responsible for it. Program components are designed by health professionals to address health outcomes they prioritize and in ways, they deem appropriate. Health professionals determine how	Most funding is external to the community. Local people are asked to contribute time, money, and materials to the program. Professionals determine resource allocation is although they may consult community members. Health professionals in discussions with community representatives design program. Role of each in the program is negotiated. The participation of	Community members decide program priorities and work to find ways to mobilize resources to meet them. This could include approaching external funders. They seek to maintain the program with their own resources, which could include micro financing and income generating activities. Program is designed by community members to address their priorities. Health professionals provide technical advice

	community participates.	women / minority groups is not necessarily incorporated into the design.	on request. Women / minority groups' needs and involvement are integral to the design, which is flexible and incorporates wide community participation.
<p>Monitoring and evaluation</p> <p>How intended beneficiaries are involved in these activities</p>	<p>Health professionals design M&E collection protocols, choose the outcomes, and analyze the data to suit their or their donor's information needs. Approach is mainly one of hypothesis testing and statistical analysis of health-related outcomes.</p> <p>Feedback from the community is not necessarily solicited.</p> <p>Health professionals define 'success'.</p> <p>Community members may be involved in data collection using methods prescribed by the professionals.</p> <p>Final evaluation findings are not always shared with communities.</p>	<p>Health professionals design M&E protocols and perform analyses, but community members are involved in data collection.</p> <p>Mixed methods (including qualitative methods) are used to capture wider outcomes and the context. Broad definition of 'success' used.</p> <p>Responses to monitoring findings are jointly decided.</p> <p>Information needs of health professionals are met and community feedback is both sought and given in an appropriate format.</p>	<p>Communities are actively involved in monitoring the program and in deciding how to respond to findings from monitoring data. Participatory M&E is an essential component of overall evaluation, which uses both quantitative and qualitative methods.</p> <p>Communities conduct an evaluation, which produces locally meaningful findings, and are involved in any wider dissemination. A variety of locally appropriate data collection methods is used. The community chooses indicators for success.</p> <p>Professionals provide advice and assistance where necessary and as requested by the</p>

			community. Communities contribute to any wider external evaluation conducted by/for the program funders.
--	--	--	---

Source: Rifkin,SB, G Hewitt & AK Draper (2007). *Community Participation in Nutrition Programs for Child Survival and Anemia*, Centre for Public Health Nutrition School of Integrated Health University of Westminster London, July, pp. 11-14

To apply and draw some practical lessons from this framework we need to examine some case studies in this regard in Kolkata. Accordingly, we have outlined three levels of community interventions that may consider being relevant to the community involvement in health governance in Kolkata.

The first level is disease prevention. There is a highly famous proverb that ‘prevention is always better than cure’. It applies to many different facets of our lives but we usually use it about our health. That is why preventive measures often considered more successful and less expensive but at the same time, it depends upon many socio-economic factors like food and nutrition, sanitation, water and conditions of shelter and such non-medicinal facilities. In other words, this level requires minimum basic urban facilities available for poor communities. Otherwise they could easily be vulnerable to various infectious diseases. Thus, the task of ensuring community participation is a challenging one and deserves special attention. A mere invitation to the community members for participating in a programme brought in by either any non-governmental or any public institutions may seem to them very outsiders. These initiatives are considered very simplistic and superficial as they may ignore various complex issues like social psychology, culture, and various other social issues. A study has been conducted in the slums in Kolkata and shows that those who live in huts rather than permanent houses are more susceptible for hypertension and blood related diseases. Although they are very much aware of their hypertension but they are incapable to control their situation mostly due to their poor socio-environmental conditions.^{xxiii} Another study found that where clean and pure drinking water is not available to the local populations, especially in poorer communities, cholera, diarrhea, typhoid, amebiasis, hepatitis, gastroenteritis, giardiasis, campylobacteriosis, scabies and many other waterborne diseases are more prevalent in these areas.^{xxiv} Thus, an effective participation requires full shares of beneficiaries directly to any services either from public or from private

sectors so that they can adequately understand and address the wider socio-economic circumstances of the poor people in society. This can be initiated from two broad areas. First, initiatives such as health and family planning at household level. This may include care of expectant and nursing mothers and birth delivery, care of pm-school children, control of chronic illness (leprosy and tuberculosis), prevention of blindness, treatment of physically handicapped, follow-up, and treatment of emergencies and family planning side effects etc. Secondly, initiatives of developmental activities. These may include income-generating activities to relieve economic pressure during seasonal unemployment or under-employment, promotion of unskilled and handcrafted products, provisions of self-reliance through small-scale investments, support for growing awareness of socio-economic disadvantages, earning from extra household activities, and arranging non-formal education etc.

Second, this level relates to control of communicable disease and health issues in which there are three different programmes: control, elimination, and eradication. In this context, community participation is seen as a missing link in enabling adoption of and adherence to the government's public health guidelines. It is supposed that as many participants engage themselves with disbursing facilities of health; outcome will be greater than the other will. Thus, instead of just notifying the rules and regulation of health as traditionally used to do, most of the public institutions in government no longer are considered as feasible now in the prevailing importance of participation of community members in health policies. Therefore, participation of community members not only ensures the efficacy of health policies among the targeted groups but also strengthens the interaction between community and its representative members on one hand and the relevant departments/sectors of the government on the other. However, this also depends on a number of factors including rate of participation, number of groups of participation and the experiences that a participant may share with other members of their community. A systematic study has been made in this regard in a Mumbai slum.^{xxv} The studies found that women's group practicing participatory learning and action was associated with reductions in maternal mortality and neonatal mortality. The maternal mortality rate has reduced by 37 percent among those who participated in the learning and engagement initiatives of government agencies. In another study that conducted in Kolkata^{xxvi} also found that apart from the government initiatives is equally important to build a trust relationship between the community-member and representative public institutions, between the leader-representative of the community and the followers of the community all of which requires a deep analysis of broader socio-cultural contexts. Another study found that community involvement is not only important for the proper implantation of an initiative but also sometimes requires necessary changes in the policy making process. For example Kolkata Urban Services for the Poor (KUSP) (2003-2015) aided by the DFID aims to

target the root of the problem by integrating the urban poor and the beneficiaries in the planning decision taking methods, and imposes conditional mechanisms for integrating financial and organizational performances of the urban local bodies with physical infrastructure development programs. Kolkata Municipal Corporation (KMC) wanted to experiment with this programme with a community led health initiative that would mobilize people to build and use toilets using their own resources rather than opting for scheme funds. In the initial mobilization phase, the scheme provision actually created confusion in one of the slums in Kalyani and they were not able to join in the KMC led initiative. KMC, in fact, had to pass a resolution and present it to the state department that they would not take the scheme funds yet attain the target of sanitation service provision in slum communities using a different approach.^{xxvii}

Third, this level relates to curative treatment. Curative treatment got much more importance after the independence of the country. Although the healing practices of health in India have been inherited from ancient scriptures for a long time, a number of traditional practices such as Ayurveda, Yoga-Naturopathy, Unani etc. are still practiced today. However, public health system has been practice since the colonial rule of the country, which emphasized on medicinal treatment of the disease. Not only the medical treatment, but also the practice of colonial rule at various levels of the country is still in place, leaving a large section of the population out of the treatment system. Even the Ministry of Health acknowledges "...there is no gainsaying the fact that the morbidity and mortality levels in the country are still unacceptably high. These unsatisfactory health indices are, in turn, an indication of the limited success of the public health system in meeting the preventive and curative requirements of the general population."^{xxviii} Some studies have suggested that the Ministry of Health does not fully meet its stewardship roles because it is too involved in direct management of health programs, of the wide range of institutions under its ambit, and other issues such as medical training.^{xxix} Another study found that the Ministry's score for social participation and people's empowerment was very low (0.19⁶).^{xxx} Sometimes it is also noticed that especially at a local level various factors like caste, religion, ethnicity, health beliefs, family structure, gender, poverty, education etc. determine the health status. Low social status for example being a member of scheduled caste or tribe can be associated with less access to immunization services and higher mortality rates.^{xxxi} Thus, the issue of disparity or just implementation of health care facilities through equitable distribution of financial and human resources among the poor has always been the subject of much research works as well as government reports.^{xxxii}

⁶ scores on a scale of 0-1, based on the average proportion of positive responses to the questions

From the above discussion, it is now clear that there are quite significant challenges, some of them are sustaining from a long period, and some of them are emerging, ranging from the very sources of problem to management of these problems, mechanisms of service delivery and above the whole process of governance of the city. Thus, if it really wants to become a *City of Joy* (Tillotoma in Bengali) for all, the city needs a remarkable reforms and updation with most scientific outlook, sophisticated mechanisms and above all best management and governance practices in the service delivery especially with regard to water, sanitation and health care system of the city.

5. Conclusion

Thus from the above discussion it is clear that the present global health crisis is not concerned primarily with one of disease, but of governance. In this respect, health could be understood in line with its definition in international law not simply as the absence of disease, but as physical, mental, emotional, social, and cultural well-being of a given community. Appropriate health governance requires a participatory process of public policy and interstate mechanisms that may further urge as an imperative of global restructuring. Thus a good health governance may require a much higher level of mobilization and engagement of political leaders, civil society organizations, governments and non-state actors and many private actors. Community participation in health could provide an alternative conceptualization of the social determinants of health that moved beyond exclusively outcomes-based top-down measures towards process-oriented, agency-based empowerment that broadened the scope of health interventions. The search for suitable options and methodologies that may contribute more effectively and efficiently to sustained economic growth and to the equitable distribution of the benefits of development goes to the heart of all debates concerning public governance. Thus, there is search for such public administration systems and processes that are not only to be responsive, but that engage their citizens proactively in the making of policy-decision as well implement them efficiently and effectively. Surely, there is an expanding literature as well as global level initiatives confirming the effectiveness of interventions to promote local engagement, action, and innovation and the more the community drives the intervention the greater the effect. Health services should be designed specifically to overcome barriers to utilization, such as distance and cost, for people who live in slums. People who live in slums and their organizations should be involved in the prioritization, design, implementation, and evaluation of interventions in slums. Enabled by this spatial construct, much more research is needed on slum health and how to improve it and a greater proportion of this research should be based on multicentre studies with contemporaneous controls. Further to this, we advocate the development of capacity for research

into slum health and the emergence of this as an academic discipline. We need to support the academic development of community health in the form of an interdisciplinary approach, multi-stakeholder partnership between policy makers, academics, and representatives of poor communities, even for different marginalized communities in terms of race, ethnicity, political power, economic status as well as against to beliefs and attitudes towards HIV, mental illness, addiction, and lymphatic filariasis, which can in turn lead to social isolation, depression, and hesitation in seeking care. Rifkin said that this kind of research requires a holistic view into economical, cultural, social, and political processes on different spatial scales.^{xxxiii} All these need to be included throughout the process of policymaking and implementation so that knowledge can grow in tandem with efforts to improve health and wellbeing of all human beings in society.

References

-
- ⁱ UNDESA (2008). *The 2008 World Public Sector Report, People Matter: Civic Engagement in Public Governance*, New York, p. 23
- ⁱⁱ Sen, A. (2015, Spring). *Universal Health Care: The Affordable Dream*, *Harvard Public Health Review*. Vol. 5, p. 1
- ⁱⁱⁱ World Health Organization Commission on the Social Determinants of Health, *Closing the gap in a generation: health equity through action on the social determinants of health* (2008), Available at <https://www.who.int/social-determinants/thecommission/finalreport/en/>; *Rio Political Declaration on the Social Determinants of Health*, October 21, 2011, Rio de Janeiro. Available at <https://www.who.int/sdhconference/declaration/en/>; United Nations General Assembly, 70/1. *Transforming our world: the 2030 Agenda for Sustainable Development*, A/RES/70/1 (2015). Available at https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_70_1_E.pdf; World Health Organization, *Social Determinants of Health. Health and development governance - Health in All Policies* (2018). Available at <http://www.who.int/social-determinants/healthinallpolicies-hiap/en/>;
- ^{iv} World Health Organization Commission on the Social Determinants of Health, *Closing the gap in a generation: health equity through action on the social determinants of health* – Final report of the commission on social determinants on health (2008), p. 26. Available at <https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1>

- ^v Rosato, M. A. (2015). Framework and methodology for differentiating community intervention forms in global health. *Community Development Journal*. 50(2):244-63.
- ^{vi} Assai, M., Siddiqi, S. and Watts, S. (2006). Tackling social determinants of health through community based initiatives. *British Medical Journal*, 333:854-6
- ^{vii} Richard Dodgson and Kelley Lee, (2002). "Global Health Governance. A Conceptual Review," In Rorden Wilkinson and Steve Hughes, eds., *Global Governance: Critical Perspectives* London: Routledge, p. 93
- ^{viii} United Nations, Department of Economic and Social Affairs, Population Division (2019). *World Urbanization Prospects: The 2018 Revision (ST/ESA/SER.A/420)*, New York: United Nations. p. 12
- ^{ix} Sen, Amartya. (2002). "Why Health Equity?" *Health Economy*. 11: 659–666.
- ^x Garmendia, C. B., Estache, A. and Shafik, N. (2004). *Infrastructure services in developing countries: access, quality, costs and policy reform*, World Bank policy research working paper 3468, December, Washington, DC. : The World Bank. p. 9
- ^{xi} Rydin Y, Bleahu A, Davies M, Davila JD, Friel S, De Grandis G, et al. (2012). *Shaping cities for health: complexity and the planning of urban environments in the 21st century*, Lancet (London, England), 379(9831):2079-108.
- ^{xii} Subbaraman R, O'Brien J, Shitole T, Shitole S, Sawant K, Bloom DE, et al (2012). Off the map: the health and social implications of being a non-notified slum in India. *Environment and Urbanization*, 24(2):643-63.
- ^{xiii} Mugabi, J., Kayaga, S. and Njiru, C. (2007). Strategic planning for water utilities in developing countries. *Utilities Policy* 15(1), 1-8
- ^{xiv} Garmendia, C. B., Estache, A. and Shafik, N. (2004). *Infrastructure services in developing countries: access, quality, costs and policy reform*, World Bank policy research working paper 3468, December, Washington, DC.: The World Bank. p. 3

- ^{xv} Adrienne Pielou, "India: Calcutta, the capital of culture," *The Telegraph*, 4 March 2011, accessed 12 December 2021.
- ^{xvi} Kolkata Study Report 2014 , *Government Led Exclusion of the Urban Poor- A Greater Contributor through a Lesser Recipients*, New Delhi: Society for Participatory Research in Asia, p.15
- ^{xvii} Kundu, N. (2003). "Urban Slum Reports: The Case of Kolkata, India" *Understanding Slums: Case Studies for the Global Report on Human Settlement*, Development Planning Unit. London: University College, p. 11 Online at https://www.ucl.ac.uk/dpu-projects/Global_Report/pdfs/Kolkata.pdf Accessed on 25.12.2021
- ^{xviii} Pagnamenta, R. (2014). End is nigh for Gandhi's after India's marathon poll, UK: *The Times*
- ^{xix} Misra, R., R. Chatterjee and S. Rao, (Ed.) (2003). *India Health Report*. New Delhi: Oxford University Press. p. 1
- ^{xx} Marston C, Hinton R, Kean S, Baral S, Ahuja A, Costello A, et al. (2016). Community participation for transformative action on women's, children's and adolescents' health. *Bulletin of the World Health Organization*, 94(376–382).
- ^{xxi} Ministry of Health and Family Welfare (MoHFW) (2002). *National Health Policy 2002*. New Delhi.
- ^{xxii} Brugha, R. and Varvasovszky, Z. (2000). Stakeholder Analysis: A Review. *Health Policy and Planning*, 15:3, pp. 239-246.
- ^{xxiii} Suvro, S. et all (2016). Prevalence, awareness, and control of hypertension in the slums of Kolkata, *Indian Heart Journal*, 68:3, pp. 286-294
- ^{xxiv} Das, M. et all. (2009). *Surveillance of vibriophages reveals their role as biomonitoring agents in Kolkata*, Federation of European Microbiological Societies (FEMS), Blackwell Publishing Ltd. *Microbiology Ecology*, 67:3, p. 502
- ^{xxv} Prost A, Colbourn T, Seward N, Azad K, Coomarasamy A, Copas A, et al. (2013). *Women's groups practicing participatory learning and action to improve maternal and newborn health*

in low-resource settings: a systematic review and meta-analysis. Lancet (London, England). 381(9879):1736-46.

- ^{xxvi} Caoimhe Nic a Bhaird, (2013). The Complexity of Community Engagement: Developing Staff–Community Relationships in a Participatory Child Education and Women's Rights Intervention in Kolkata Slums, September, *Journal of Community & Applied Social Psychology* 23(5)
- ^{xxvii} The World Bank Group (2016). *Community Slum Sanitation in India: A Practitioner's Guide*, New Delhi, p. 24
- ^{xxviii} Ministry of Health and Family Welfare (MoHFW) (2002). National Health Policy 2002. New Delhi, p. 4 (Accessed on 25.12.2021 Available at (https://www.nhp.gov.in/sites/default/files/pdf/National_Health_Policy.pdf)
- ^{xxix} Misra, Rajiv, Rachel Chatterjee, and Sujatha Rao. (2001). “*Changing the Indian Health System: Current Issues, Future Directions.*” Indian Council for Research on International Economic Relations, New Delhi.
- ^{xxx} Das Gupta, M. and Rani, M. (2004). *India's Public Health System. How Well Does It Function at the National Level.* World Bank, Policy Research Working Paper 3447, Washington. p. 7
- ^{xxxi} Misra, R. et al (2003). *India Health Report.* New Delhi: Oxford University Press. p.135
- ^{xxxii} Das Gupta, M. and Rani, M. (2004). *India's Public Health System. How Well Does It Function at the National Level.* World Bank, Policy Research Working Paper 3447, Washington. p. 1
- ^{xxxiii} Rifkin, S.B., Muller, F. Bichmann, W. (1988). Primary Health Care: on Measuring Participation. *Social Science & Medicine*, 26:9, pp. 931-940.

Selected Bibliography

1. Bichmann, W., Rifkin, S.B. and Shrestha, M. (1989). Towards measurement of community participation. *World Health Forum*, 10: 467-472.

2. Blair, H. (2000). Participation and Accountability at the Periphery: Democratic Local Governance in Six Countries. *World Development*, 28:1, pp. 21-39.
3. Brown, L.D. and Ashman, D. (1996). Participation, Social Capital, and Intersectoral Problem Solving: African and Asian Cases. *World Development*, 24:9, pp. 1467-1479.
4. Brunton G, Caird J, Stokes G, Stanisfield C, Kneale D, Richardson M, et al. (2015). Review 1: *Community engagement for health via coalitions, collaborations and partnerships - a systematic review*. London.
5. Curtis, S., Gesler, W., Smith, G. and Washburn, S. (2000). Approaches to sampling and case selection in qualitative research: examples in the geography of health. *Social Science & Medicine*, 50:7-8, pp. 1001-1014
6. Cyril S, Smith BJ, Possamai-Inesedy A, Renzaho AM.(2015). Exploring the role of community engagement in improving the health of disadvantaged populations: a systematic review. *Global Health Action*. 8:29842.
7. Gonzalez, CL. (1965). *Mass campaigns and general health services*. Public Health Papers No. 29. Geneva: World Health Organization.
8. Hossain, SM., Bhuiya, A., Khan, AR. and Uhaa, I. (2004). Community development and its impact on health: South Asian experience. *British Medical Journal*, 328:830-3
9. Jeppson, A., Okuonzi, S.A. (2000). Vertical or Holistic Decentralization of the Health Sector? Experience from Zambia and Uganda. *International Journal of Health Planning and Management*, 15:4, pp. 273-289.
10. Kumar, S. (2002). Does "Participation" in Common Pool Resource Management Help the Poor? A Social Cost-Benefit Analysis of Joint Forest Management in Jharkand, India. *World Development*, 30:5, pp. 763-782.
11. Miles, M. and Huberman, A. (1994): *Qualitative Data Analysis*. London

12. Mosquera, M., Zapata, Y., Lee, K., Arango, C. and Varela, A. (2001). Strengthening user participation through health sector reform in Colombia: a study of institutional change and social representation. *Health Policy and Planning*, 16:2, pp. 52-60.
13. Murthy, R., Klugman, B. (2004). Service accountability and community participation in the context of health sector reforms in Asia: implications for sexual and reproductive health services. *Health Policy and Planning*, 19:1, pp. i78-i86.
14. Rifkin, S.B. (1985). *Health Planning and Community Participation: Case Studies in South-East Asia*. Dover, NH: Croom Helm.
15. Rifkin, SB., Lewando-Hundt, G. and Draper, AK. (2000). *Participatory Approaches in Health Promotion and Health Planning: a Literature Review*. London: Health Development Agency.
16. Rosato, M. A (2015). Framework and methodology for differentiating community intervention forms in global health. *Community Development Journal*. 50(2):244-63.
17. Ramiro, L.S., Castillo, F.A., Tan-Torres, T., Torres, C.E., Tayag, J.G., Talampas, R.G., Hawken, L. (2001). Community participation in local health boards in a decentralized setting: cases from the Philippines. *Health Policy and Planning*, 16:2, pp. 61-69.
18. Sassen, S. (1996). Cities and Communities in the Global Economy – Rethinking Our Concepts, *American Behavioural Scientist*, 39:5, March/April, pp. 629-639
19. Taylor-Ide, D. and Taylor, C. (2002) *Just and lasting change: when communities own their future*. Maryland: John Hopkins University Press.
20. Verhasselt, Y. (1993). Geography of Health: Some Trends and Perspectives. *Social Science & Medicine*, 36:2, pp. 119-123.