Community Engagement in Health Governance

Mains: *GS II - Issues Relating to Development and Management of Social Sector/Services relating to Health, Education, Human Resource*

Why in News?

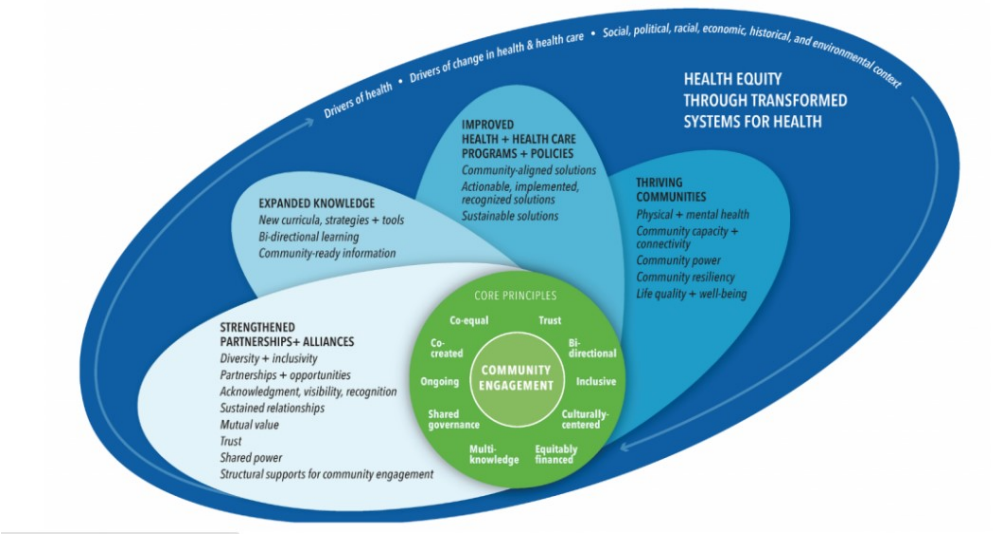
Recently, some states in India began to bring health care directly to doorsteps, to improve community engagement in healthcare.

What is community engagement in healthcare?

- **Community engagement** – It refers to the process of actively involving people in decisions and activities that affect their lives and well-being.
- **Community engagement in healthcare** – It involves building relationships, fostering communication, and collaborating with various stakeholders to achieve positive change in the health governance of the country.

Recent Examples From the States
• **Makkalai Thedi Maruthuvam** - **Launched by** – Government of Tamilnadu - **Launched in** – August 2021. - **Aim** – To deliver essential healthcare at the doorstep of the people • **Gruha Arogya scheme** - **Launched by** – Government of Karnataka - **Launched in** – October 2024 - **Expanded** – to all districts in June 2025 - **Aim** – to deliver health care at doorsteps for persons with non-communicable diseases.

- **Stakeholder inclusion** – It promotes inclusion of diverse actors such as *civil society, professional bodies, hospital associations* and trade unions.
- **Influences participation** – It operates through formal and informal social processes, *with power dynamics shaping participation and influence.*
- **Improves decision making** – It affirms *self-respect, counters epistemic injustice and upholds democratic values* by enabling people to shape decisions affecting their health and health-care services.
- **Strengthens governance** – Inclusive participation *strengthens accountability, challenges elite dominance and reduces corruption*.



- Without it, health governance risks becoming oppressive and unjust.
- **Increases trust** – It also builds mutual understanding and trust *between communities and providers*.
- **Improves collaboration** –It fosters collaboration with frontline workers, *improves service uptake, and supports better health outcomes.*
- The *national rural health mission* has a public engagement as the important component of the scheme

The National Rural Health Mission (NRHM)
• **Launched in** – 2005 • Institutionalised public engagement in India's health governance through various platforms. • **Rural area platforms** - Village Health Sanitation and Nutrition Committees (VHSNCs) - Rogi Kalyan Samitis. • **Urban area platforms** - Mahila Arogya Samitis, - Ward Committees - Non-governmental organisation-led committees. • **Aim** – To be inclusive, particularly of women and marginalised groups, and supported by untied funds for local initiatives. • **Challenges** – In some areas these committees have not been established, while in others where they do exist, • **Other issues –** These include - Ambiguous roles - Infrequent meetings - Underutilisation of funds - Poor inter-sectoral coordination - Deeply rooted social hierarchies.

What are the challenges in community engagement?

- **Defective mind-set** – Policymakers, health administrators and providers *often view communities as passive recipients of care* rather than as active participants in shaping health systems.
- **Less focus on implementation** – Programme performance is *typically measured through target-based metrics*, such as the number of beneficiaries reached.

- It has little reflection on how programmes are implemented or experienced on the ground.
- **Problem with the term** – The use of the term beneficiaries itself signals a deeper issue, *it frames citizens as objects of intervention, not as rights-holders or co-creators of health systems.*
- **Lack of commitment** – Although the National Health Mission promotes bottom-up planning, *including community participation in Programme Implementation Plans, such engagement is rare in practice.*
- **Dominance of western model** – Health governance spaces remain dominated by medical professionals, predominantly trained in western biomedical models.
- **Lack of effective leadership** – Health administrative leadership, is typically held by doctors who are expected to learn public health administration on the job.
- **Issues with promotion policy** – Promotions are often *based on seniority rather than public health expertise.*
- This reinforces a medicalised and hierarchical system that remains disconnected from community realities.
- **Other issues** – Scholarly work on health policy suggests concerns over
- Increased workload
- Greater accountability pressures
- Regulatory capture by dominant medical and capitalist interests
- Absence of a level playing field in governance processes

What could be done?

- **Change of mind-set** –Community engagement must no longer be seen as merely to achieve programme targets.
- **Treating people as ends in themselves** – Treating people as instrumental to health outcomes is not only reductive but also deeply disrespectful to their agency and dignity.
- **Improve participatory processes** – To enable meaningful community engagement in health governance, we must adopt following approaches
- **Empowering people** – Communities should be actively empowered.
- **Spreading of information** – Disseminating information about health rights and governance platforms.
- **Timely awareness** – Fostering civic awareness early will make people to engage in the process at the initial stages.
- **Reducing inequalities** – Making intentional efforts to reach marginalised groups and vulnerable sections.
- **Utilization of resources** – Equipping citizens with knowledge, tools, and resources needed to participate effectively in health care decision-making processes.
- **Sensitising health system actors** – Players of health system should move beyond blaming poor awareness as the sole reason for low health-seeking behaviour and health-care utilisation among people.

Reference

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