COMMUNITIZATION PROCESS

1. **What is CAH?**

CAH stands for **'Community Action for Health'**. This is a project that continuation of a pilot process known as *Community Based Monitoring and Planning (CMP)*. The CMP pilot process was implemented as part of the communitization aspects of the National Rural Health Mission(NRHM). The process was initiated by the *Advisory Group on Community Action (AGCA)* under NRHM. The AGCA proposed a pilot process in 9 states to actualize the concept of Community Based Monitoring and Planning that was conceptualized by the NRHM in its Framework of Implementation. It was decided to request a number of civil society organizations to lead the process in the different states in partnership with the state governments. The pilot phase was funded by the central government. It was expected that after the pilot phase the state governments would take over the ownership, running and funding of the process. In Tamilnadu, it was decided to change the name from Community Monitoring and Planning to *Community Action for Health* after the Pilot phase.
It is important to note that the name of the process was changed from Community Monitoring and Planning to Community Action for Health to emphasis that without **'action'** the process is incomplete and that the whole process is driven by a **'joint learning approach'** with openness and spaces for reflection.

2. **What is the aim of the CAH process?**

As mentioned earlier the idea of the CAH process is to actualize the concept of communitization that is introduced in the Framework of Implementation of the NRHM. The concept of communitization involves increasing the ownership of the community for the health system. This increased ownership is seen to increase both utilization as well as accountability of the system to the people. This combination of increased ownership, utilization and accountability will contribute to health system strengthening and the achievement of the goals of the NRHM. This overarching framework also provides space and opportunity to take forward the community health approach predicated on inclusive community involvement. Visit this link Vision and Mission of this CAH process.

3. **What are the steps of the CAH process?**

The following are the basic steps of the CAH process:
• Village Health Water Sanitation and Nutrition Committee (VHWSNC) expansion to include wider representation for all community groups and geographical areas of the panchayat. This expansion was done by holding meetings in all the hamlets of the project area and explaining the NRHM mission and its goal, the CAH process to the people and getting volunteers and suggestions from the community for VHWSNC members. The team is finally rapporticed in the first committee meeting with explanation of roles and responsibilities of the member.
• Orientation and training of the VHWSC committee members is the next major step. The whole committee is oriented to the process. Subsequently 2 to 4 per committee is intensively trained on the health, health care, health rights and CAH process.
• The next step is the monitoring process where a set of tool developed by the state nodal NGO in consultation with the other process partners SHS, DPH and partner NGOs, the people is used to collect the perspectives / assessments of the services available at the village and PHC by the committee

member/people. The scoring will be marked in colours as red, Yellow and green representing the status of the particular service asseeking attention, moderate, good

• After this the information collected is collated into the Panchayat Health Status Report Card (HSRC). Thus one Report card is evolved for each Panchayat.

• In the next step of the process is the Panchayat Health Planning Day (PHP). In the Health Planning day the VHWSNC members present the Panchayat Health Status Report Card to a group consisting of the representatives of the Public Health department including the Village Health Nurse(ANM/VHN) and the Medical Officer (MO), the Panchayat President (PRI), the Aanganwadi workers (AWW) and members of the community. During this meeting the various questions / sections receiving a 'red' color are discussed in detail with an aim of converting this 'red' score to'green' in six months or with in the next cycle of monitoring. Thus a Panchayat Health Action Plan is evolved.

• Subsequently this is shared with officials at the PHC, Block and District level.

• Every month the VHWS committee meet and discuss the issues arising out of the Panchayat Health Plan and its follow up.

• The whole monitoring and planning cycle is repeated every six months.

4. **Have the VHWSNC members been able to the use the tools easily?**

The tools were built after many rounds of discussions and pilot testing. In fact there have been minor and a few major changes with each round of monitoring based on feed back received. Based on an external evaluation and the feedback of the the people and the government officials the tool used in the pilot phase was extensively modified to bring it to its present generic shape.

The major challenge we faced was teaching the members the logic behind the various health entitlements so that the monitoring could be linked to action. Apart from this one area of difficulty was the names of the equipment, however this was overcome by inserting pictures of the relevant instrument / infrastructure.

Given its piloting and iterative feedback the tool is quite understandable and usable.

One of the interesting finding is that tool not only helps capture people's perceptions on health, but in addition by probing a number of dimensions also spread a lot of awareness and initiated interesting and in-depth discussions on health.

5. **How much time does it take to fill the tool and complete one cycle of monitoring and planning?**

It has been found that a full set of tools covering all the dimensions of health services will take 5 days of time. In addition the PHC and HSC facility survey and exit polling take 1 day. Thus in all the committee members have to spend 6 days every six months on monitoring activities. Individual interviews (for the immunization and ANC / Delivery / PNC) take about 40 minutes to 1 hour per interview. Group discussions (for school health / adolescent health / village services) take about 30 to 40 minutes.

In terms of planning about 3 days of preparations are required for every day of Panchayat Level planning.

Every month there is a VHWSNC meeting to follow up the various action plans.

6. **What is the human resource pattern of the CAH project?**

The project is implemented through the state nodal organisation (SNO) at the state level, district nodal organisation (DNO) at the district level and cluster/block nodal organisation (CNO) at the cluster/block level.

At the state level there is a state resource/training team consists of 6 individuals from NGO and 2 more from department.

At the district level the project has district resource/training team consists of 2 individuals from NGO and 1 more from department.

At the cluster/block level there is the cluster/block resource/training team consists 2 individuals from NGO and 1 more from department.

At the panchayat level there is one coordinator for every 10-15 panchayats (in all there are 150)

7. **What is the governance structure of the project?**

There is a project governing body consisting of eminent academics and civil society representatives who governs the entire process.
The primary group that advises the State Nodal Organisation is the State Implementers Group consisting of the Implementing NGOs, representatives of the civil society, representatives of the SHS and the DPH.
At the district level there is the district mentoring committee which mentors the process at the district level in which DDHS, implementing NGOs, representatives of the civil society were members.
SOCHARA has a special sub-committee to provide internal mentorship and over-sight to the implementing team.

8. **What is the role of the Civil society groups in the process?**

The role of the civil society groups in the project are as follows:

- Capacity building of the VHWSC committees. This is done in collaboration with the local health staff including the VHNs and the Health inspectors.
- Facilitating of the work of the VHWSC. This is done through the interaction with PRI officials and the Public health sector workers and facilitating their cooperation with the process.
- Sensitization of all involved about the potential impact of the process.
- Developing systems of sustainability of the process.

9. **How does the project propose to strengthen the public health system?**

As mentioned in the Framework of implementation of the NRHM the one of the 5 pillars of the NRHM is Communitization. By increasing ownership of the public health system by the community the process not only hopes to increase demand and utilization of the public health services but also in parallel increase the accountability of the system to the people.

Apart from this the data generated at each level is unique and these dimensions are not collected by the

routine HMIS. Thus the process provides valuable information to the health system at different levels. This information will go a long way in identifying gaps in the system and enabling the system to fill these. This is through not only the Panchayat Health Plan but also through the block, district and state level consolidation and analysis of the data.

Moreover as this designed to initiate community action for health following the Panchayat Health Plans, it hopes to further strengthen the system by the process where people get a deeper understanding of their entitlements as well as the constraints within which the system works. The process also allows the system a chance to understand the people's perceptions of the services and thus enable the system to see the perspective of the people. This two way enhancement of understanding will contribute to system strengthening.

Systematically / programmatically this approach has led to a deeper understanding for the need of the perspectives of the health providers to find greater space within the initiative (and indeed overall governance of the health system). Community Support mechanisms for the PHC and the HSC can be evolved. Also critically workers' rights components and occupational health dimensions of public sector workers needs greater attention.

10. What are the innovations by the CAH project in Tamilnadu?

Some of the key innovations by the project are as follows:

• The development of a simple visually rich tool that not only collects information but also provides awareness of the various entitlements.
• The capturing of caste disaggregated data.
• The use of SMS for the efficient transmission of data.
• The evolution of a worksheet for the evolution of a Panchayat Health Action Plan.

11. What are the key learning from the implementation of the Community Action for Health Project in Tamil Nadu?

We present the learning from the implementation of the CAH project under the following heads:

Learning about the health services at the Village and PHC level gathered during community monitoring and planning sessions.

• While the availability of services is very good in rural Tamil Nadu, the quality of these services and especially the educational component of the services are poor. Thus in the study of immunization services while the proportion of 'green' answers for the question on availability overall is 87%, the proportion of greens to the question on quality falls to 77%, and further to 48.5% with regards to the educational / awareness components. Similarly while 93% reported having at least 5 AN check up of them only 59% were informed / counseled about the changes that would occur during pregnancy and informed about the danger signs to look out for.
• The system is hugely skewed to the Maternal and Child health services while the other services seem to be neglected. Thus for example as reported earlier roughly 87% report having at least 5 AN check ups while only 28.2% of adolescent girls contacted reported the presence of an adolescent group in the village, and only 56% of the people met reported availability / accessing treatment of minor illnesses at the village or sub-center.
• Further even within the MCH services while immunization and ANC and promotion of institutional deliveries is focused on, post natal care is very poor. Thus while 87.4% reported receiving all

vaccinations (for children) on time and ANC is reported as 87%, not more than 25% of mothers who delivered in the last six months reported receiving any Post natal care at the village level.
• One of the interesting findings that have emerged is that there seems to be a clustering of indicators at the block level – thus some blocks are good performers in all services and some are consistently poor. This probably underscores the importance of the health team in the provision of good quality health services.
• Even 6 years after the launch of the NRHM a number of indicators of transparency and accountability of the health system are very poor. Thus not more than 26.3% of groups of people we met reported the presence of a citizen's charter in the PHC, only 9.2% knew about the Patient Welfare society and about 31.7% knew about the VHWS committee.
• The people continue to feel that staff in PHC treat them rudely – the overall proportion of negative replies is 27% (range 51% to 8%). Similarly people report a high level of corruption with only 66.4% (range 80% to 2%) saying they did not give any money to the staff during delivery, and only 57.8% (range 83% to 4%) reported not giving any money to the VHN for availing of the maternity benefit.

Learning relevant to the long term sustainability of the process

People
• The people are greatly enthusiastic about the process and the project has been able to identify at least 4-5 individuals at each panchayat level who have received training and seem capable about taking this process forward.
• The people continue (even in a state like Tamil Nadu) to consider government services as those of first choice and especially so if some of the problems of the system like the attitude of the staff and corruption are taken care of.
• People recognize the systemic constraints under which the peripheral health workers work and are very forgiving in their attitude towards them, especially when they see attempts by the health worker to provide services to them under difficult circumstances. Thus despite the fact that Post Natal care was supposed to be home based care, a number of women answered 'green' to the question though they were asked to come to the PHC for this service – justifying this by saying that the VHN was doing a lot of work, told her come to the PHC and looked after her very well there.
• We need to appreciate the fact that while in the present project mode people are willing to come and take part in the VHWSC meetings voluntarily and with a lot of enthusiasm, there are a huge number of systemic constraints (alluded to in later sections) that need to be recognized. Most importantly the indirect costs borne by these individuals also need to be recognized. Thus the system needs to be seen as more responsive to the people if this process is to be sustained.

Panchayat Raj Institution
• The newly elected panchayat presidents seem very enthusiastic to do something for the community that elected them (elections were held in September 2011). This gives us a unique window of opportunity to strengthen the panchayat ownership of this process and getting them to take a more proactive and leadership role.
• The panchayat representatives including the presidents did not have any awareness about the role of the VHWSC and about their role vis-a-vis the health system. This was true not only for those elected for the first time, but even for those who have been reelected and who have had a number of stints in positions of power.
• There seems to be very little constructive and supportive interaction between the health system and the panchayat representatives. Thus while the panchayat is supposed to be the third rung of

government etc. there is very little interaction. This impacts greatly on the long term sustainability of the process as it is embedded in the panchayat system.

• Interaction with panchayat presidents also reveal a number of evidences of a fractured community on the basis of caste, political party and gender. Thus panchayat presidents are known to discriminate against people of other castes, of a different political party etc. during these processes. While this is a reflection of the larger reality of society, such issues have a major impact on the long term sustainability of the process.

Health System

• One of the major findings of the project has been that the health staff themselves have very little awareness about the NRHM its scope and activities. Thus our staff were some of the first to bring about awareness about the term and what it means to many of the staff at village and even block level.

• There seems to be no orientation of staff at all levels about the process and its importance.

• The system itself is extremely hierarchical and thus staff at each level are very hesitant to respond to the people's demands. This constrains system responsiveness to a great extent.

• The system continues to see people as ignorant and sees / treats people very patronizingly.

• The peripheral workers are working under huge systemic constraints. Thus for example in one meeting at the PHC level the people were
requesting the VHNs to share their monthly tour program with the VHWSC so that they could mobilize people to make full use of the VHNs visits. However the VHNs refused and explained how the PHC had all the posts vacant a number of years, so it was the VHNs who were deputed to the duties of the various staff including the pharmacist etc. under these circumstances though she had a monthly tour program, she knew very well she was not going to be able to follow it!

12. What were the key constraints for the implementation of the Community Action for Health Project in Tamil Nadu.

Constraints for the implementation of the Community Action for Health project in Tamil Nadu can be discussed under – social context, health system related and larger political context.

Social Context

• One of the major constraints that the project has faced has been the 'indirect' costs faced by the community members who are expected to voluntarily take part in the various activities of the VHWSC. These include the following:

• Most of the marginalized communities and especially the women usually attend the MNREGA work and depend on these for wages. Thus when meetings and work are expected and it means give these up obviously it reduces the chances that people living in such in secure conditions will be able to participate. However these are the very people who we aim the process at.

• Given the above 'competition' with MNREGA and coupled with the number of NGOs that give people sitting fees for all trainings and meetings there is a general tendency to expect money for this type of work.

• Communities are riddled by caste and gender differences, this obviously affects the full implementation of the process. Thus in villages people of different castes refuse to sit together and it is very difficult to build up community wide ownership of the process.

• Alcoholism has been reported from a number of districts as problematic. A number of meetings are disrupted by people who are drunk. Similarly project staff (especially women) and VHWSC members who are women are especially insecure.

• The lack of transport is another constraint for the mobility of the members both between villages in a panchayat and between their village and the PHC and HSC.

• In one of the districts the presence of a large number of industries and even a proposed SEZ in the area has led to a fracturing of the community and an inability of implementing such programs smoothly.

Health System related

• It has been found on a number of occasions that people are not very motivated to hold the government system accountable. This is for the following reasons:
• Most people are unable to access government schemes due to middlemen or corruption, thus they are not very interested in spending more energy on these schemes.
• The more educated and wealthy even among the marginalized communities corner most benefits thus leaving the most marginalized more frustrated.
• In general the more wealthy and influential capture the benefits.
• In addition the above the government is seen as poor in many situations and due to rudeness most people prefer going to the private sector. Thus not wanting to spend too much energy holding the public sector accountable.
• Frequent transfers of the doctors and officers means that those in decision making posts even at the local level need to repeatedly be oriented to the process thus leading to a lack of continuity.
• The health department views the community either as ignorant or as not interested in their own health little appreciating the structural factors leading to this (some as described above). This attitude of superiority and patronage is not conducive for processes to develop transparency accountability.
• The peripheral workers are working under severe systemic constraints and in a very hierarchical system. Unless this is sorted out these workers will only get more and more frustrated and will be unable to engage with such processes.

Larger political context

• Regime change leads to a the introduction of a whole new set of schemes and the consequent ignoring or sidelining of older schemes. This leads to a lot of uncertainty and lack of continuity in schemes like this requiring longer term support.
• Political parties have their presence even at the village level, this has led to problems in getting people of different political parties together for health issues.
• Local influential people have a tendency to hold the key to participation from the community, lot of care needs to be given to developing a rapport with these people, else there is a danger of their making the situation very difficult for the implementation of the project.

13. Have there been any studies that have evaluated the process externally?

Yes, a number of studies have been done on the project as well as specific components of it. These are listed below:

• Ramanathan S, External Evaluation of the Community Monitoring and Planning Pilot Phase - 2009. Submitted to the AGCA. Government of India.
• Garn, Kristine. "If men were angles... Dynamics of Accountability in the Community Based Monitoring of Health services program, Tamilnadu, India. 2010. Thesis M Sc Public Health. University of Copenhagen.
• APAC- VHS. Gender Audit of the Tamilnadu Government Health services - 2011. Submitted to Government of Tamilnadu.
• Santosh S. Qualitative study on awareness and attitude of community towards the CAH process in Pulicat area, Minjur Block. 2011. Study as partial fulfillment of Community Health Learning Program. Society for Community Health Awareness Research and Action (SOCHARA).

• Tajne, Satish and Sharma, Shweta. Critical Evaluation of the Community Monitoring Project as an Innovative Intervention Directed at Health Improvement Focusing on the Role and Involvement of PRI Representatives in the Process. 2011. Project Report of Internship period with TNVHA. Tata Institute of Social Sciences, Mumbai.
• Tajne, Satish and Sharma, Shweta. Costing Study On Expansion And Training Of VHWSC 2011. Project Report of Internship period with TNVHA. Tata Institute of Social Sciences, Mumbai.
• Apart from this a documentary film of the whole process is being developed.

14. What are the key steps to be taken by the government that will help support the implementation of the process in the future?

• Formation of a multi-stakeholder group at the state and district level to mentor this process as well as learn from it. This is similar to the AGCA at the Central level.
• Urgent and proactive steps by the government to orient staff to the philosophy and advantages of this process at the earliest.
• Steps to conduct regular inter-sectoral meetings to ensure action / responsiveness to the peoples demands by all departments concerned.
• Institutionalization of feedback from the community and grievance redressal in the health system.
• Introducing elements of this process into routine HMIS system to motivate health staff to take this seriously.
• Commitment to expansion of this process not only to other levels of the health system like secondary and tertiary levels, but also including private sector and also other departments. Only when this becomes a universal phenomenon will it be really sustainable.
• Further expansion of the project to other parts of the state – which will include active learning from this effort as well as a multi-stakeholder consultative process and the inclusion and involvement of academic institutions.
• Structural reform within the system to enable all workers to respond at their level to the community.

For more details, please visit http://cahtn.in/faq.php#1._What_is_CAH

COMH-101.

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2. What is the aim of the CAH process?

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Learning relevant to the long term sustainability of the process

People

• The people are greatly enthusiastic about the process and the project has been able to identify at least 4-5 individuals at each panchayat level who have received training and seem capable about taking this process forward.

• The people continue (even in a state like Tamil Nadu) to consider government services as those of first choice and especially so if some of the problems of the system like the attitude of the staff and corruption are taken care of.

• People recognize the systemic constraints under which the peripheral health workers work and are very forgiving in their attitude towards them, especially when they see attempts by the health worker to provide services to them under difficult circumstances. Thus despite the fact that Post Natal care was supposed to be home based care, a number of women answered 'green' to the question though they were asked to come to the PHC for this service – justifying this by saying that the VHN was doing a lot of work, told her come to the PHC and looked after her very well there.

• We need to appreciate the fact that while in the present project mode people are willing to come and take part in the VHWSC meetings voluntarily and with a lot of enthusiasm, there are a huge number of systemic constraints (alluded to in later sections) that need to be recognized. Most importantly the indirect costs borne by these individuals also need to be recognized. Thus the system needs to be seen as more responsive to the people if this process is to be sustained.

Panchayat Raj Institution

• The newly elected panchayat presidents seem very enthusiastic to do something for the community that elected them (elections were held in September 2011). This gives us a unique window of opportunity to strengthen the panchayat ownership of this process and getting them to take a more proactive and leadership role.

• The panchayat representatives including the presidents did not have any awareness about the role of the VHWSC and about their role vis-a-vis the health system. This was true not only for those elected for the first time, but even for those who have been reelected and who have had a number of stints in positions of power.

• There seems to be very little constructive and supportive interaction between the health system and the panchayat representatives. Thus while the panchayat is supposed to be the third rung of

government etc. there is very little interaction. This Impacts greatly on the long term sustainability of the process as it is embedded in the panchayat system.
• Interaction with panchayat presidents also reveal a number of evidences of a fractured community on the basis of caste, political party and gender. Thus panchayat presidents are known to discriminate against people of other castes, of a different political party etc. during these processes. While this is a reflection of the larger reality of society, such issues have a major impact on the long term sustainability of the process.

Health System
• One of the major findings of the project has been that the health staff themselves have very little awareness about the NRHM its scope and activities. Thus our staff were some of the first to bring about awareness about the term and what it means to many of the staff at village and even block level.
• There seems to be no orientation of staff at all levels about the process and its importance.
• The system itself is extremely hierarchical and thus staff at each level are very hesitant to respond to the people's demands. This constrains system responsiveness to a great extent.
• The system continues to see people as ignorant and sees / treats people very patronizingly.
• The peripheral workers are working under huge systemic constraints. Thus for example in one meeting at the PHC level the people were
requesting the VHNs to share their monthly tour program with the VHWSC so that they could mobilize people to make full use of the VHNs visits. However the VHNs refused and explained how the PHC had all the posts vacant a number of years, so it was the VHNs who were deputed to the duties of the various staff including the pharmacist etc. under these circumstances though she had a monthly tour program, she knew very well she was not going to be able to follow it!

12. **What were the key constraints for the implementation of the Community Action for Health Project in Tamil Nadu.**

Constraints for the implementation of the Community Action for Health project in Tamil Nadu can be discussed under – social context, health system related and larger political context.

Social Context
• One of the major constraints that the project has faced has been the 'indirect' costs faced by the community members who are expected to voluntarily take part in the various activities of the VHWSC. These include the following:
• Most of the marginalized communities and especially the women usually attend the MNREGA work and depend on these for wages. Thus when meetings and work are expected and it means give these up obviously it reduces the chances that people living in such in secure conditions will be able to participate. However these are the very people who we aim the process at.
• Given the above 'competition' with MNREGA and coupled with the number of NGOs that give people sitting fees for all trainings and meetings there is a general tendency to expect money for this type of work.
• Communities are riddled by caste and gender differences, this obviously affects the full implementation of the process. Thus in villages people of different castes refuse to sit together and it is very difficult to build up community wide ownership of the process.
• Alcoholism has been reported from a number of districts as problematic. A number of meetings are disrupted by people who are drunk. Similarly project staff (especially women) and VHWSC members who are women are especially insecure.
• The lack of transport is another constraint for the mobility of the members both between villages in a panchayat and between their village and the PHC and HSC.

• In one of the districts the presence of a large number of industries and even a proposed SEZ in the area has led to a fracturing of the community and an inability of implementing such programs smoothly.

Health System related

• It has been found on a number of occasions that people are not very motivated to hold the government system accountable. This is for the following reasons:
• Most people are unable to access government schemes due to middlemen or corruption, thus they are not very interested in spending more energy on these schemes.
• The more educated and wealthy even among the marginalized communities corner most benefits thus leaving the most marginalized more frustrated.
• In general the more wealthy and influential capture the benefits.
• In addition the above the government is seen as poor in many situations and due to rudeness most people prefer going to the private sector. Thus not wanting to spend too much energy holding the public sector accountable.
• Frequent transfers of the doctors and officers means that those in decision making posts even at the local level need to repeatedly be oriented to the process thus leading to a lack of continuity.
• The health department views the community either as ignorant or as not interested in their own health little appreciating the structural factors leading to this (some as described above). This attitude of superiority and patronage is not conducive for processes to develop transparency accountability.
• The peripheral workers are working under severe systemic constraints and in a very hierarchical system. Unless this is sorted out these workers will only get more and more frustrated and will be unable to engage with such processes.

Larger political context

• Regime change leads to a the introduction of a whole new set of schemes and the consequent ignoring or sidelining of older schemes. This leads to a lot of uncertainty and lack of continuity in schemes like this requiring longer term support.
• Political parties have their presence even at the village level, this has led to problems in getting people of different political parties together for health issues.
• Local influential people have a tendency to hold the key to participation from the community, lot of care needs to be given to developing a rapport with these people, else there is a danger of their making the situation very difficult for the implementation of the project.

13. Have there been any studies that have evaluated the process externally?

Yes, a number of studies have been done on the project as well as specific components of it. These are listed below:

• Ramanathan S, External Evaluation of the Community Monitoring and Planning Pilot Phase - 2009. Submitted to the AGCA. Government of India.
• Garn, Kristine. "If men were angles... Dynamics of Accountability in the Community Based Monitoring of Health services program, Tamilnadu, India. 2010. Thesis M Sc Public Health. University of Copenhagen.
• APAC- VHS. Gender Audit of the Tamilnadu Government Health services - 2011. Submitted to Government of Tamilnadu.
• Santosh S. Qualitative study on awareness and attitude of community towards the CAH process in Pulicat area, Minjur Block. 2011. Study as partial fulfillment of Community Health Learning Program. Society for Community Health Awareness Research and Action (SOCHARA).

• Tajne, Satish and Sharma, Shweta. Critical Evaluation of the Community Monitoring Project as an Innovative Intervention Directed at Health Improvement Focusing on the Role and Involvement of PRI Representatives in the Process. 2011. Project Report of Internship period with TNVHA. Tata Institute of Social Sciences, Mumbai.
• Tajne, Satish and Sharma, Shweta. Costing Study On Expansion And Training Of VHWSC 2011. Project Report of Internship period with TNVHA. Tata Institute of Social Sciences, Mumbai.
• Apart from this a documentary film of the whole process is being developed.

14. What are the key steps to be taken by the government that will help support the implementation of the process in the future?

• Formation of a multi-stakeholder group at the state and district level to mentor this process as well as learn from it. This is similar to the AGCA at the Central level.
• Urgent and proactive steps by the government to orient staff to the philosophy and advantages of this process at the earliest.
• Steps to conduct regular inter-sectoral meetings to ensure action / responsiveness to the peoples demands by all departments concerned.
• Institutionalization of feedback from the community and grievance redressal in the health system.
• Introducing elements of this process into routine HMIS system to motivate health staff to take this seriously.
• Commitment to expansion of this process not only to other levels of the health system like secondary and tertiary levels, but also including private sector and also other departments. Only when this becomes a universal phenomenon will it be really sustainable.
• Further expansion of the project to other parts of the state – which will include active learning from this effort as well as a multi-stakeholder consultative process and the inclusion and involvement of academic institutions.
• Structural reform within the system to enable all workers to respond at their level to the community.

For more details, please visit http://cahtn.in/faq.php#1. What is CAH

COMH-101.

स्वास्थ्य के लिए सामुदायिक प्रयास

मिल जुल करें अब नई तैयारी,
जन–स्वास्थ्य हो सब की जिम्मेदारी

स्वास्थ्य के लिए सामुदायिक प्रयास के छः चरण

1 जागरुकता लाएं

मुफ्त सरकारी सेवाओं, स्वास्थ्य अधिकार, सेवा प्रदाताओं की भूमिकाओं और जिम्मेदारियों के बारे में जागरुकता लाएं।

आपकी भूमिका

- योजनाओं या सेवाओं के बारे में पूरी और सही जानकारी लें।
- समुदाय में जानकारी का प्रचार प्रसार करें।
- बेहतर स्वास्थ्य के लिए उचित व्यवहार को बढ़ावा दें।

2 ग्राम स्वास्थ्य, स्वच्छता एवं पोषण समितियों (वी.एच.एस.एन.सी.) को मजबूत करें

स्वास्थ्य को बेहतर बनाने और सामूहिक प्रयास को बढ़ावा देने के लिए गांव स्तर पर ग्राम स्वास्थ्य, स्वच्छता एवं पोषण समितियां बनाई गई हैं। यह नियोजन, कार्य को करने और उसकी निगरानी में समुदाय की भागीदारी सुनिश्चित करती है।

आपकी भूमिका

- स्वास्थ्य, स्वच्छता एवं पोषण समितियों की मासिक बैठक में भाग लें।
- बच्चों, किशोर–किशोरियों और गर्भवती महिलाओं में कुपोषण, साफ पीने का पानी न मिलने और सही तरीके से न चलने वाले उप–स्वास्थ्य एवं आंगनवाड़ी केन्द्र जैसी समस्याओं को बैठक में सामने लाएं।
- स्वास्थ्य अधिकारियों द्वारा सेवाएं न देना या खराब व्यवहार की घटनाओं की सूचना दें।
- मुक्त राशि का सही प्रयोग सुनिश्चित करें।

3 सेवाओं की निगरानी करें

गांव और स्वास्थ्य केन्द्र, दोनों स्तरों पर सेवाओं की गुणवत्ता की परख और निगरानी सरल प्रपत्रों के उपयोग से की जाती है। इससे सामुहिक रुप से कमियों व मुद्दों को पहचानने और स्थानीय समाधान ढूंढने में मदद मिलती है।

आपकी भूमिका

- निगरानी प्रक्रिया में स्वास्थ्य, स्वच्छता एवं पोषण समितियों के सदस्यों की मदद करें और अपने अनुभव बताएं।
- जहां भी आपको या अन्य लोगों को सेवाएं नहीं मिली, उन घटनाओं की जानकारी दें।
- स्वास्थ्य प्रदाताओं के पास मुफ्त दवाओं या गर्भनिरोधकों या आंगनवाड़ी केंद्र में पोषाहार न मिलने पर समिति को बताएं।
- जहां सेवाओं की पहुंच नहीं है, उन क्षेत्रों और परिवारों के बारे में सूचना दें।

4 ग्राम स्वास्थ्य योजना बनाएं

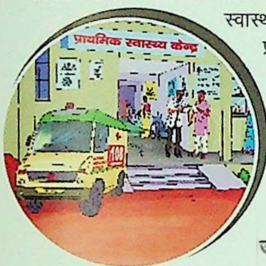
निगरानी प्रक्रिया के दौरान पहचानी गई कमियों और मुद्दों के आधार पर वी.एच.एस.एन.सी. वार्षिक ग्राम स्वास्थ्य योजना विकसित करती है। यह योजना जिम्मेदारियों और समय सीमा के साथ–साथ, कमियों/कमजोर क्षेत्रों का पूरा विवरण प्रस्तुत करती है।

आपकी भूमिका

- पहचानी गई कमियों पर चर्चा में भाग लें और मिलकर संभव समाधान ढूंढे।
- ग्राम स्वास्थ्य योजना बनाने में मदद करें और इसे लागू भी करवाएं।
- जो समस्याएं गांव के स्तर पर हल नहीं हो पा रही हो उन्हें अगले स्तर यानि प्राथमिक स्वास्थ्य केन्द्र, ब्लॉक एवं जिला स्तर की समितियों या जन संवाद में उठाएं।

5 समितियों का गठन करें और उन्हें सशक्त बनायें

प्राथमिक स्वास्थ्य केन्द्र (पी.एच.सी.), ब्लॉक, जिला और राज्य स्तरों पर रोगी कल्याण समितियाँ (आर.के.एस.) और नियोजन व निगरानी समितियाँ हैं। उनमें सदस्यों के रूप में स्वास्थ्य, महिला एवं बाल विकास, लोक स्वास्थ्य यांत्रिकी विभाग एंव पंचायत और स्थानीय गैर सरकारी संगठनों के प्रतिनिधि हैं। सभी सदस्य मिलकर स्वास्थ्य के मुद्दों पर चर्चा करते हैं और उचित कार्यवाही करते हैं।



आपकी भूमिका

- इन समितियों में सेवाओं से संबंधित मुद्दे जैसे स्वास्थ्य एवं आंगनवाड़ी केन्द्र की सेवाएं, पीने का साफ पानी न मिलना, खराब पड़े नल, पानी के पाइप आदि को इन समितियों या जन संवाद में उठाएं और उनके समाधान की मांग करें।

6 जन संवाद आयोजित करायें

जो कमियां और मुद्दे गांव के स्तर पर हल नहीं होते हैं उनको ब्लॉक एवं जिला स्तरीय जनसंवाद में उठाया जाता है। सामुहिक रुप से समस्याएं बताई जाती है और उनके समाधान के लिए एक स्वतंत्र पैनल (जिसमें जिला व ब्लॉक स्तर के पंचायत प्रतिनिधि एवं स्वास्थ्य और अन्य विभागों के अधिकारी सम्मिलित होते हैं) के सामने चर्चा होती है। सभी पक्षों को सुना जाता है और निष्पक्ष रुप से पैनल द्वारा उचित निर्णय लिया जाता है। निर्णय के अनुसार संबंधित अधिकारियों, सेवा प्रदाताओं या समुदाय के लोगों की समयबद्ध कार्य योजना तैयार होती है। इसे लागू करना अधिकारियों और समुदाय दोनों की जिम्मेदारी होती है।

आपकी भूमिका

- जन संवाद में सक्रिय रुप से भाग लें और पैनल को सेवाओं से संबंधित अपने मुद्दे बतायें और समाधान की मांग करें।
- स्वास्थ्य कर्मचारियों के अनुचित व्यवहार, सेवाओं की अनुपलब्धता या सेवा देने से इंकार करने की घटनाओं को बताएं और कार्यवाही की मांग करें।

स्वास्थ्य के लिए सामुदायिक प्रयास क्या है?

स्वास्थ्य के लिए सामुदायिक प्रयास राष्ट्रीय स्वास्थ्य मिशन (एन.एच.एम) की एक प्रमुख रणनीति है। इसका उद्देश्य स्वास्थ्य के प्रति समुदाय की सक्रियता और भागीदारी को बढ़ाना है। इस प्रक्रिया के माध्यम से, समुदाय और सेवा प्रदाताओं द्वारा सेवाओं की गुणवत्ता की नियमित रुप से जांच होती है जिससे उनकी कार्यक्षमता और जवावदेही बढ़े।

इस प्रक्रिया के क्या फायदे है?

सामुदायिक प्रयास की प्रक्रियाओं से कई राज्यों में महत्वपूर्ण परिणाम प्रदर्शित किये गये हैं। उनमें से कुछ हैं–

1. स्वास्थ्य अधिकार, सरकारी सेवाओं और योजनाओं के बारे में जागरुकता व उनके उपयोग में वृद्धि।
2. सेवाओं की समुदाय तक पहुंच और गुणवत्ता में सुधार।
3. ग्राम स्वास्थ्य स्वच्छता एवं पोषण समिति (वी.एच.एस.एन.सी.), उप स्वास्थ्य केन्द्र, प्राथमिक स्वास्थ्य केन्द्र और सामुदायिक स्वास्थ्य केंद्रों पर स्थानीय प्राथमिकताओं के आधार पर मुक्त राशि का उचित उपयोग।
4. सेवाएं न मिलने तथा स्वास्थ्य पर अनौपचारिक खर्चों में कमी।

अधिक जानकारी के लिए संपर्क करें:

एडवायज़री ग्रुप ऑन कम्युनिटी एक्शन

सचिवालय

पापुलेशन फांउडेशन ऑफ इंडिया

बी. 28, कुतुव इंस्टीट्यूशनल एरिया

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