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Health Care

COMMUNITY ACTION FOR HEALTH IN RAJASTHAN - A LONG WAY TO GO

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ABSTRACT Engagement of community in planning, implementation and monitoring of development programs can give better results as understandings of needs of their own, ownership on resources, understanding on implementation mechanism and limitations and finally monitoring of programs based on community planning process will be in the hands of community its self. Though people are not experts of managerial issues, there may be lack of technical knowledge but with help of support system things can we achieved. In the Health Sector from Community Monitoring to Community Action for Health is long period of time but still pace of progress is very slow particularly in the state of Rajasthan. Present paper is an effort towards analyzing issues understanding context and Summarizing the process of community action for health in Rajasthan based on background of communicating health in Rajasthan

KEYWORDS : Universal Health Coverage, Community Health, Community Monitoring, VHSNCs, RMRS, Community Action for Health

After 40 years of Alma Ata, World Health Organization reframed 'Health for All' as 'Universal Health Coverage – Let's make it happen', in its yearly theme in 2018. "Universal" in UHC means "for all", without discrimination, leaving no one behind, this means ensuring that everyone, everywhere can access essential quality health services without facing financial hardship. The Organization will maintain a high-profile focus on UHC via a series of events through 2018, starting on The World Health Day on 7th April with global and local conversations about ways to achieve health for all.(1)

The Alma Ata declaration reflects the values of social justice, where every person has the right to make choices regarding their lives, and participation, where every individual has voice to make such choices. The underlying vision of the declaration was that good health could not be achieved without values related to democracy like empowerment, health promotion and collective action. It was expected that such empowerment, where people take charge of their own lives and act to change their own life situations, would result in improved health.

Since past 70 years governments and political leaders are talking and reaping the soul sense and recommendations of Bhore committee made in 1946.

India's Health Survey and Development Committee, under the leadership of Sir Joseph Bhore, recommended that for health care to become accessible to all people, a greater and more active involvement of community was required.*

As commented by Bhore - community health cannot be attained until "individual has learnt to realize that his neighbor's health is a matter of as much concern to himself as his own, that it is his own effort which must help to decide the health pattern of the community circle in which he lives and that only a combined co-operative endeavor on the part of all workers in the many fields of activity in that circle can yield results that are worth achieving." (2)

The concept of community action is receiving greater interest and support in NHM in India. Governments, communities and non-governmental organizations (NGOs) are exploring the possibility of creating innovative types of partnerships for health which could contribute to making the goal of "health for all" a reality.

In the NRHM Framework for Implementation, it is clearly articulated that communities must be "empowered to take leadership in health matters" in order for the program to reach every village. The Village Health Sanitation and Nutrition Committees (VHSNC) set up under the NRHM are "envisaged as being central to 'local level community action' under NRHM, which would gradually develop to support the process of Decentralized Health Planning. Thus VHSNCs are expected to act as leadership platforms for improving awareness and access of community for health services, support the ASHA, develop village health plans specific to the local needs, and serve as a mechanism to promote community action for health, particularly for social determinants of health."(3, 4)

The National Health Policy 2017 of Government of India also stressed in its goal about the attainment of the highest possible level of health and well-being for all, at all ages. This includes universal access to good quality health care services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery. (5)

Without ensuring the active role of community in health whether it is in the matter of planning or execution or the monitoring, it is very difficult to achieve the goal of Universal coverage of health. Community action in health has met with a mixed response and despite many instances of expressed interest, it has rarely been taken up vigorously at the central level or been systematically translated into broad national action.

First of all, we need make clarity on the concept of community action. There are various terms in use such as, community participation, community involvement, community ownership and community action. Each term has a different meaning and connotation. The increasing popularity of the term "Community Action for Health" responds to many of the conceptual and operational limitations inherent in the term "community involvement" Not only does it imply a partnership between the community and the health sector, but it goes further and also denotes a pro-active role for the community and the implicit objective and obligation of the formal sector to share power rather than merely to foster cooperation. In the context of community action for health, the community is an agent for health and development rather than a passive beneficiary of health and development programs. (6)

Ideally, community action for health should arise from the community itself, and then essentially run and supervised by the community using community-generated resources, with collaboration from the formal sector in the form of technical and financial support as and when required.

To address health in a meaningful way we must start by redefining what health is and considering the relationship between wellness and the key components of our living and working environments. "In many cases, solutions to our health challenges can be mounted at the local level, with people and communities taking the lead....It is within communities where collaboration can occur most effectively, where resources can be pooled most efficiently' and where the results of positive action and change are most manifestly recognized."(7)

Interest in community action has come about as a result of a variety of factors. First of all, there has been a growing realization that the involvement of the community in health matters is essential for reasons of both efficacy and impact. Secondly, major changes have occurred in political philosophy and practice which have favoured community action, making it both more feasible and "legitimate". Of the many factors that have enhanced community action, the move towards democratization in national and local government has probably been one of more importance. The process has been evident in most parts of

the world, and in many it has been quickly translated into both reform of the political system and programmatic action.

The involvement of communities in programmes relevant to their own development is not unique to the health sector. Much the same is occurring in other social sectors, where it has already been effective in bringing about policy reform, better planning, and a more egalitarian allocation of resources. Nore, as was indicated above, is the practice of community involvement new; it has occurred throughout history. Nevertheless, important changes have come about in the way in which the role of the community is regarded.

The practice of community involvement in its own development is not new, it has occurred throughout history. Success in terms of bringing about policy reform, better planning, and a more egalitarian allocation of resources has been seen in the social sectors including health. Important changes have come about in the way in which the role of the community is regarded.

But the few examples of practical application of the concept of community action have remained sporadic, limited in scope and not easily sustained. The policy-makers and health care providers have always been appeared to have remained skeptical about the benefits of the community engaging itself in health care activities. They have been even more hesitant about the community's role in defining health problems, prioritizing them and contributing to their solution. Health care has continued to be seen as essentially a question of medical care and has accordingly been entrusted to trained health professionals, with only limited involvement of community groups and the lay public.

This "distance" between the lay public and the decision making process in health matters has increased and become more problematic. On one hand, health care has become increasingly political, costly and administratively complex, and on the other there has been a growth in expectations as well as in the capacity of the public to express itself in this area, especially when dissatisfied with existing approaches. This change has not gone unobserved by the health planners and their appreciation of the role of the community has also taken a different course. The focus have now turned towards investing in preventive and promotive part rather than curative aspects of medicine and role of community has emerged as more participative than a passive receiver.

Community Action for Health (CAH) is one of the pillars of the National Health Mission (NHM) in India, which places people at the centre of the process of ensuring that the health needs and rights of the community are being fulfilled. It gives communities an opportunity to participate and provide regular feedback on the progress of the NHM interventions in their areas, thus contributing to strengthening health services and 'Bringing Public into Public Health.' The CAH processes is being implemented in 22 states covering 2,02,162 villages across 353 districts – that is nearly 32 per cent of villages and 54 per cent of the districts in the country.(9)

Community Action for Health in Rajasthan

Much of the progress towards reducing IMR, MMR and TFR till date has been the result of government efforts, multiple donor support and participation of civil society and other non-governmental organizations.

1970–1989: The United Nations Population Fund (UNFPA) invested in family planning services in 1974. Expansion in the 1980s supported the procurement and production of contraceptives nationally, strengthened management information systems, provided training, and promoted education and communication programs to increase awareness of and improve maternal, child health and family planning services. (10) With the support of UNFPA, State of Rajasthan initiated a scheme in the field of family planning to ensure access and utilization of family planning services at doorstep by appointing the 'jan-mangal joda' a married couple as volunteer in each village to ensure the home based supply of contraceptives. This Jan Mangal Scheme was first of its kind to ensure community participation ownership and management in health services. After piloting the scheme in two districts it was expanded in the entire state and continued till 2013. The Janmangal joda has now been replaced by ASHA, a female from the village itself, but somehow the male partner could not get a substitute to fully address the needs of males in family planning matters. (10,11) Under World Bank supported IPP IX Project State of Rajasthan initiated the Swasthay Karmi Project based on the successful implementation of Shiksha Karmi Project in Education sector. Under Swasthay Karmi Scheme- a local village women VIII standard education was selected to provide consoling and curative services. She has given one moth Training. A Medicine kit includes basic generic medicines, contraceptives ORS was given to her. She was also authorized to charge money from the local people minimum Rs. 2 per patients. This scheme was implemented through NGOs in selected Districts. Currently ASHA worker has the same profile under NHM. This scheme was discontinued after 2001 The Department of Medical & Health Services of Rajasthan took an innovative step in 1995 by setting up autonomous societies at the tertiary level health institutes to cater the infrastructure maintenance and equipment requirements. With the successful implementation at the SMS Hospital at Jaipur, it was replicated at other tertiary level hospitals and then at the secondary level institutes.. The success of this initiative has led the Rajasthan State government to support the setting up of such societies Rajasthan Medical Relief Societies (RMRS) at all hospitals having 30 beds or more, including Community Health Centres (CHC) and recently it has also been introduced at all Primary Health Care Centres (PHCs). Based on the success of RMRS Government of Madhya-Pradesh initiated the concept of Rogi Kalyan Samiti. Further RKS was formalized under NRHM to make the health system more accountable to people through people's participation. RKS is a registered society which manages the functioning of any of the public health institutions. RKS is known in different parts of the country as Hospital Management Committee, Jeewan Deep Samiti, or Swasthya Kalyan Samiti. Each Samiti consists of members from Panchayati Raj Institutions (PRIs), NGOs, local elected representatives and Government officials who are responsible for proper functioning and management of the institution. RKS is free to prescribe, generate and use funds for smooth functioning of the health care system and maintaining the quality of services. It has the authority to make investments in order to meet service requirements.(12) Under NRHM, selection of ASHA Sahyogini, formation of VHSNCs and its capacity building, Community Monitoring project in 6 Districts with involvement of NGOs is an attempt to ensure the community ownership, participation and engaging community leaders by giving responsibility of health to Panchayats but all these efforts have proved to be only casual and area specific.

Civil society organizations, engaged in advocacy initiatives and networks, civil society organizations have begun forming coalitions and networks to undertake research and advocacy in several domains, including maternal health. These networks bring together multiple organizations to raise the profile of maternal health issues. For example, WRAI, Janswasthay Abhiyan through organizing public dialogs raise the voice of community in health matters.

In the First phase of Community monitoring (now renamed as Community Action for Health), four districts were chosen, Alwar, Chittorgarh, Jodhpur and Udaipur in Rajasthan. The Community Monioring process was carried out in 180 villages, 36 PHCs and 12 blocks from September 2007 to November 2009. As per the first phase report of PFI and CHSJ the process of community monitoring not only helped in increasing the utilization of vaccination services but also motivated ASHAs to conduct door-to-door visits for service provision on a regular basis. The process also helped in effective utilization of public health services by the community. The doctors and other paramedical staff became more regular and devoted more time. Score card shows the improvement in most of the villages. Unfortunately this community monitoring process in Rajasthan discontinued as support from NHM has not been extended to NGOs responsible for the cause. (13) CHETNA has initiated and is anchoring the Surakshit Matratva Abhiyaan (SUMA) Rajasthan or the White Ribbon Alliance for Safe Motherhood as its secretariat since 2002. SUMA's Goal is to work towards reducing maternal and neonatal mortality in the state. Its actions are directed for awareness, action and advocacy. It has 71 listed members and Development partners. Under this initiation, citizens report card depicting status of maternal health services in 11 districts was prepared. Gram Sabha is a constitutionally mandated space for people's participation in governance. A baseline of 31 Gram Sabhas indicated the need to strengthen their functioning and take action for improving Maternal Health Services. The efforts of Suma members have resulted in 20 of the 26 Gram Sabhas (August to November 2014) in which a total of 616 women participated, most for them for the first time in their lives.

In the second phase, Community Action for Health has again been revived and six districts have been selected for the implementation by NHM. Training of trainers and further the district level trainings have been conducted but pace of progress of CAH in Rajasthan is still very slow.

Accountability mechanisms can help ensure that funding reaches its destination and that well-meaning policies and programs are implemented as intended, counteracting some of the barriers cited to accessing quality care such as poor provider practices, lack of facility resources, and corruption in the health system. Though community accountability is featured as a key quality assurance strategy within the NRHM, it has faced several political and other barriers to implementation to date. Several donors fund activities that mobilize community members to provide policymakers with information and feedback about community experiences and needs in the state. Accountability mechanisms, however, require the government and providers to be open to receiving and addressing feedback. (14,15)

Year back Mahatma Gandhi said on issues of sanitation "If we only realize that the public is a part of us and that we in turn are part of it, our unsanitary conditions would become impossibility and by freeing ourselves of disease etc would add to the nation's strength and even its wealth. This is applicable on all aspects of development including health but in Rajasthan we are far behind to make Community Action for Health a reality.

CONCLUSIONS

The motivation for increasing the involvement of communities and civil society differs quite widely depending on the group of stakeholders. Civil society and CBOs often employ rights based approach, Regardless of the model, there are some essential requirements to successfully implement any program that hopes to involve communities or civil society on a sustained and effective basis.

The requirements can be summarized as:

- A healthy community is a form of living democracy: people working together to address what matters to them. With the effective use of community action plan tool, one of the participatory tools used to build the capacity of community members in taking action in accordance with the problems, needs, and potential of the community, community action goals for health outcomes can be achieved.

- Without addressing the existing legal framework which defines rights of the people unambiguously, community action for health in Rajasthan cannot be achieved. The law needs to define a number of aspects like timeliness of implementation, feedback, institutionalization and redressal mechanisms.

- One of the crucial aspects of the legal and the policy framework is the involvement of the private sector. Another critical aspect is the regulation of the private sector. These and many other issues need to be well defined in the statutes for attaining the benefits.

- Another key aspect is of creating spaces and mechanisms for people/civil society to participate, like the formation of village level committees, institution level committees and a number of spaces where people and civil society can engage with the government, and mechanisms for this need to be evolved.

- Most important is the development of the 'spirit' of participation in society: this involves not only the people, but also sensitization to, and orientation about people's participation for public health staff and officers. There is also clear need to include this and related issues into the medical curriculum.

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