A Rapid Assessment of Communitization Processes of the National Rural Health Mission in Jharkhand, Orissa and Bihar

Jan – March, 2009

Community Health Fellowship Programme

Public Health Resource Society

New Delhi

www.phrnindia.org

This report is a consolidation of rapid assessment studies done to assess the status of the community processes in the district initiatives under NRHM in the states of Bihar, Jharkhand and Orissa. These studies were done by the community health fellows over a period of three months in various districts of the above mentioned states under the aegis of community health fellowship programme.

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Introduction

This report is a consolidation of rapid assessment studies done to assess the status of the community processes in the district initiatives under National Rural Health Mission (NRHM) in the states of Bihar, Jharkhand and Orissa. These studies were done by the community health fellows over a period of three months (Jan – March 2009) in various districts of the above mentioned states under the aegis of community health fellowship programme.

Background

The Community Health Fellowship Programme is a two year full time programme launched by Public Health Resource Network in three Indian states of Orissa, Jharkhand, and Bihar on 1st January, 2009. Public Health Resource Network through this fellowship programme envisions

- Support to NRHM with a special focus on community processes
- Support to the network of community health workers, public health activists and leaders in India

The fellowship programme provides young development professionals a strong background in the field of community health. The programme nurtures, grooms and educates the fellows towards engaging with district health planning and management and strengthening of various community processes in NRHM at the district and grassroots level.

This programme imparts multidisciplinary knowledge to the fellows that is relevant to the context through a learning process that has action and reflection built into it. The fellows are mentored during the entire course of the programme. The fellows also get to interact during the period with some of the leaders in the field of public health and social action. The mentoring process and the field engagement would indeed help the fellows develop strong analytical and functional skills in community health. The focus is on creating community health professionals with high motivation and technical competencies to work with people, civil societies and the state to further the ideals of "Health for All".

Under this fellowship programme 27 fellows were inducted in Jan 2009 for the three states. They went through a comprehensive Induction workshop at SEARCH, Gadchiroli, an administrative district in Maharashtra, India between 15th and 21st January, 2009. This induction programme was jointly organized by Public Health Resource Network (PHRN) Society for Education, Action and Research in Community Health (SEARCH)

National Health System Resource Centre (NHSRC) and ICICI Centre for Child Health and Nutrition (ICCHN).

On the last day of the induction workshop, a work-plan for the fellows to be done in the first quarter was charted out. The activities planned for the first quarter included:

- Rapid appraisal of the district
- Getting to know the various players in the district
- Positioning within the health system
- Assisting in the preparation of the PIP (2009-2010)

Rationale of Rapid Assessment

The idea of Rapid Assessment was conceived and introduced to the fellows at the induction programme in Gadchiroli. These studies were seen as the entry point for the community health fellows in their respective districts and also to provide the context for all their future activities.

Thus the objectives of the rapid assessment studies were

- To have a firsthand understanding about the respective district and the district public health system
- To understand the health situation of the district and also locating the district situation with that of state and national situation
- To learn about the NRHM activities and to assess the status of the community processes in the district initiatives under NRHM
- To get to know and acquaint with the district health officials, civil society organizations and other stake holders in the process
- To have an exposure to PRA tools
- To identify areas of intervention/action through this process
- To position the fellows within the district
- To use the knowledge gained for taking action on community processes at various levels (village, block, district and state)

Methodology

The rapid assessment studies had a set of common tools of data collection across all the three states. These tools were developed with an aim to enable the fellows to initiate his/her engagement with the district. Through these studies the fellows would get a practical exposure and knowledge to different community level processes of public health programmes in the districts. Since the rapid assessment studies were done with the common framework, the activities/reports of the fellows also could be uniformly assessed across all the states.

The method /technique of rapid appraisal was used to link community perceptions of need to local provision of services. Given different contours in the states, the many service providers and schemes from many different agencies, the many health problems and the range of specific needs of diverse groups of people, the method of rapid appraisal was found to be appropriate in understanding the ground situation. Local agencies with appropriate engagement with community were partnered to gather information, gain insights into the needs of traditionally excluded groups. The rapid appraisal was also aimed at promoting cooperation by convening regular meetings of local agencies. The use of PRA exercises tried to capture and address the diversity and homogeneity of local needs and the priorities and concerns of all sections of the local community, including those less easily identified.

The rapid appraisal of the district had three major components:

Rapid Assessment I

1. ASHA community perceptions- Group discussion with women
2. ASHA functioning- Interview with ASHA
3. Maternal Health Gurantees- Interview with JSY beneficiary
4. Janani Suraksha Yojana- Interview with JSY beneficiary
5. Janani Suraksha Yojana- Group discussion with women
6. Rogi Kalyan Samiti- Interview with Medical officer
7. Village Health and Sanitation Committees/Village Health Committee- Interviews and FGD with key informants

Rapid Assessment II

8. Preparing *Village profile* of any 3 villages with *diverse backgrounds* in the district- Interviews and Group discussion.

Rapid Assessment III

9. Rapid appraisal of the district

Areas covered under the rapid assessment

The rapid assessment studies were done in the following districts:

Orissa- Angul, Baragarh, Dhenkanal, Koraput, Mayurbhanj, Nayagarh, Rayagada and Nuapada

Jharkhand - Khunti, Hazaribag, East Singhbhum, West Singhbhum, Sahebganj , Godda , Dhanbad and Simdegga.

Bihar – Nalanda, Gaya, Samastipur, Araria, Muzaffurpur, Vaishali, Rohtas, Aurangabad, Jehanabad

Processes involved in the PRA

Training workshops were held in the respective states and the fellows were trained in the PRA tools before beginning the exercise. The PRA tools were prepared with elaborate guidelines taking into consideration all the ethical guidelines. The collection of data was done by the fellows from three sources: existing documents about the district and selected villages, interviews with a range of informants, and direct observations to build a profile of the community, environment and the health care system. The rapid assessment survey was the first initiative by the CHFs in their respective districts. The problems identified by the fellows based on the survey and actions taken are the first interventions by them in the districts.

This report is organized in terms of various themes that have been assessed/studied by fellows in the states of Orissa, Bihar and Jharkhand. Though the rapid assessment study contained various themes, this report only focuses on themes that are related to community processes initiated under the NRHM. The themes are organized as strategies for community processes - beginning with Accredited Social Health Activist (ASHA), Rogi Kalyan Samiti (RKS) and Village Health and Sanitation Committee (VHSC) - under NRHM and finally the actions initiated by the fellows in this process. The literary style of the each state will distinctly differ from one another since it is a compilation of the reports done by the states. There will also be a difference in the subject approach amongst the states since the NRHM activities and dynamics in each state is distinct from one another. For instance in the Orissa report, Janani Suraksha Yojana has been separately assessed and commented since they feel ASHA programme is very much connected to JSY. Similarly at the time of this assessment Rogi Kalyan Samiti was non-existent in Jharkhand and almost all strategies of community processes were still at infancy in Bihar during this assessment

and the fellows were mainly engaged in initiating them and also participation in the process of preparing the District Health Action Plans.

The major findings based on the assessment made by the fellows of the statuses of these programmes in their respective states are:

Findings Based on Assessment

1. ASHA

Orissa: ASHA and Janani Suraksha Yojna

In Orissa the fellows studied the people's perception of ASHAs, their functioning and the problems faced by ASHAs.

Community perceptions on ASHA: Group discussions were initiated with 10-15 women members in each sample village that represented the community. In some cases more than one group discussion was initiated in the same village to capture the entire social configuration.

The general findings on the perceptions of the community are as given below:

- In the five districts where rapid assessment was done it revealed that before the intervention of ASHA the situation was grim and no one was able to even think of accessing public health care facilities. Especially the children remained neglected and it was due to lack of information and proper counseling.
- The only information they received was from the ANM which was completely inadequate. The ASHA has been a solace to many of their woes as they have been able to get an opportunity to interact frequently on care during pregnancy and newborn care.
- There has been an overwhelming response of the community in stating that the ASHA was playing a critical role in facilitating the process of registration, administration of TT, consumption of IFA, chemoprophylaxis, colostrum feeding, exclusive breast feeding, immunization etc besides giving routine counseling. Further the intervention of ASHA resulted in dispelling various blind beliefs and they were able to avail proper medical counseling and services on time regarding care during pregnancy and new born care.

- ASHAs not only accompanied pregnant women for delivery but also stayed through the delivery and till the mother reached home. In many cases the ASHA was reported to have stayed for more than 3 days due to complications and delay in delivery. It can be further noted that barring few exceptions in almost all the cases the ASHA reached the household within 6 hours of delivery and have counseled on new born care including colostrum feeding, exclusive breast feeding, immunization and basic hygiene.

- The ASHA also played a major role in organizing monthly health days for immunization and other health services. The ASHA collected the names of beneficiaries for the health day and informed them in advance to ensure maximum participation.

- The community further responded that though ASHA played her role in providing medicines on time for simple illness like fever, diarrhea, cough etc there was a perennial problem of shortage of medicine.

Assessment of functioning of ASHA: Direct interviews were organized with ASHAs in the sample villages to assess their current functioning and analyze their relevance to the mandate of NRHM as envisaged through ASHA. Further inputs were also taken regarding the problems that they encounter in functioning effectively.

The following are the general findings on the functioning of ASHA:

- The Village Health and Nutrition days (VHND) were observed every month where ASHAs participated in collaboration with the ANMs and AWWs in almost all the villages. In a few villages the SHGs also joined the Village Health and Nutrition Days. The ASHA got the information of pregnant and lactating mothers, Grade-III and Grade-IV children from the ANM and AWW before the day was observed to have effective coordination. In general the following activities were done in the VHNDs including: a) Weight measurement of pregnant woman and Children with the age group of 0 to 3 years. b) BP and abdominal check up of pregnant women, c) Referral check up of sick children and d) medicine distribution.

- No specific refresher training was given to the ASHA by any resource person or the ANMs. It was stated by the ASHAs that they sometimes try to clarify certain questions during the ANMs

visit. Though no refresher training programme had been done the 4th round training was completed.

- The observations revealed that ASHAs felt that advising pregnant women for institutional delivery was one of their prime agenda and they have not failed in that aspect.
- It was also reported that the ASHA started rigorous counselling after knowing the Expected Date of Delivery (EDD) of the patient regarding the benefits of institutional delivery.
- In all the cases the ASHA accompanied the pregnant women who go for institutional delivery. In most cases they had to stay with the patient in the hospital for 2-3 days till they were discharged and ultimately returned with the mother.
- The ASHA had referred the patients in a timely manner to the nearest PHCs/CHCs. The cases included patients suffering from TB, Malaria, skin disease and leprosy. In most cases the follow up had not been possible and there was difficulty in knowing whether the patient received the right treatment or not.
- The ASHA received the financial incentives according to the norms fixed by NRHM. Though no substantial delay in payment was reported by the ASHA, however they raised concerns over delayed payments in case of slide collection, net impregnation and immunization.

The problems faced by the ASHA included:

- Non availability of drugs for the drug kits on time
- Mobility within the health centers due to lack of communication facilities.
- Lack of proper coordination with beneficiaries and other service providers due to non-availability of mobile phones.
- Gradual loss of skills as no refresher training was given.
- Problem in residing in hospital when they accompanied the pregnant women to the hospital as there was no special room for use.
- Sufficient uniforms not given to them for daily use.
- Frequently moving to the respective PHCs/CHCs for collection of incentives which became extremely painstaking and incurred cost as payments were not made on the spot. In many cases they reported of travelling many times to a particular PHC/CHC to enquire the status of their incentives.

Janani Suraksha Yojana (JSY):

Quality of services received through JSY: To assess the quality of services received by the beneficiaries of JSY, group discussions were initiated with women in the sample villages who had delivered in the last 3 months either

in an institution or at home. The beneficiaries were made aware about the various entitlements in the context of maternal and child health.

The following are the general findings:

- The beneficiaries reported that the ANMs registered the beneficiary's name after confirmation of pregnancy. Further the study revealed that ANMs did not significantly contribute to the recommended 4 times examination of BP and abdomen prior to delivery. In most cases the beneficiaries had their examination at the sub divisional /district head quarter hospital. In cases where ANM had done the examination, the BP checkups were mostly neglected.
- The beneficiaries had received the right dose of IFA from the ANMs. In many cases it was stated by the beneficiaries that the ASHA played a critical role in following up the actual consumption of IFA of severely anemic cases. Apart from IFA, chloroquine was given to prevent malaria during pregnancy.
- All the beneficiaries received TTs from ANMs on time. However beneficiaries who had done their ANCs in hospitals had received the TTs directly from the hospital.
- In almost all the cases it was reported that the blood and urine of the beneficiaries were not taken for examination by the ANMs.
- Though the ANMs referred the beneficiaries for institutional delivery they stated that they were more influenced by the ASHA.
- Further the ANMs attended the beneficiaries at least once after delivery.
- The ASHA attended all the home deliveries and all the beneficiaries received regular diet from the AWW.

Quality of service delivery of Janani Suraksha Yojana (JSY): The Janani Surakshya Yojana was pioneered with a vision to increase institutional deliveries. In this context to assess the quality of service delivery of Janani Suraksha Yojana, the JSY beneficiaries were interviewed in the sample villages.

The general findings are:

- All the beneficiaries who had institutional delivery were accompanied by the ASHAs.
- Though all the beneficiaries who had institutional deliveries received the amount there was a concern in its timely disbursement. In many cases the payment was delayed even beyond a month.
- In case of home delivery the beneficiaries who were in the category of a BPL family, were above 19 years of age, had a

maximum of 2 live births and attended by an ANM/TBA during delivery received an amount of Rs.500/-.As per the norms, the amount was not paid in case of still births. The beneficiaries reported delay in receiving money due to procedural bottle necks. After the delivery the ANM registers the birth and then took all the details including the BPL cards, the birth registration certificates to the MOI/c. The money was drawn from the account where the sarpanch and the ANM's were joint signatories. The Sarpanch certified the documents after verification.

Awareness on Janani Suraksha Yojana: The increase in institutional delivery could be envisaged if the beneficiaries were aware of the programme. In this context group discussions were initiated to know the level of awareness of the beneficiaries on JSY.

The general findings are:

- The respondents were aware about the JSY scheme but the awareness was mostly confined to the financial benefits that they would receive The ANM and the ASHA had not discussed with clarity regarding the entire benefits envisaged through the scheme.
- The JSY coupons were available with the ANMs and they were filled up during the time of registration. In most of the cases the ANMs handed over the JSY cards to the beneficiaries after the first ANC.

Jharkhand: SAHIYYA

The study by the fellows brought out the democratic, participatory selection process and the gains within but the whole process of grooming *Sahiyya* still lacked the comprehensive approach of capacitating them as a community based workers and this became obvious from their ignorance about guidelines and haziness in roles and responsibilities.

Selection

Most of the *Sahiyyas* were aware of the existence of guidelines but were unable to elaborate on guideline details. They were selected democratically with a meeting at village level with the help of the ANM and most of the time NGO coordinator. The *Sahiyyas* were elected with consensus amongst villagers present at the village meeting. Though most of the Sahiyaas were selected in the initial stages of the program (2005) there were few who got elected in 2007-2008, though rarer there were still geographical areas (Block-Barkhatha, Hazaribag) where VHC and *Sahiyya* did not exist. (There is an opportunity to map these areas)

The support system for *Sahiyya* within the community was with the local community which at most of the places (12) was appreciative and perceived Sahiyya as a extended helping hand in matters of health but in couple of places the Sahiyya was scoffed at, partly due to inefficient working, negligent behavior and the perception of the community that the Sahiyya earned commission on various health activities.

Role and Responsibility

The responses of *Sahiyya* on daily activities were in the range of:-

- Helping pregnant women in getting JSY incentives.
- Accompanying pregnant women to the *anganwadi* centers for Tetanus Toxoid injections.
- Mobilizing people for vasectomy and tubectomy
- Ante-natal check-ups
- Accompanying pregnant women to the primary health centre for delivery.
- Distribute medicines from the anganwadi centers to the village
- Helping ANM with routine immunization and pulse polio drive.
- Home visits, once or twice a week basically for identification pregnant women and high fever cases.

Most of the Sahiyya's had accompanied only 2-3 cases for institutional deliveries until now.

The above mentioned findings indicate that there was a gap between NGO and Health functionary's perception about Sahiyya's role and the ground reality, though they were not optimally groomed in all (expected areas) aspects, they were well motivated and needed support for their sustainability and community processes.

Role of Sahiyya for Below Poverty Line (BPL) population

Sahiyyas could not define her roles specifically for BPL population but asserted that they worked for women and children who belonged to families surviving on daily wages or families having small business like bamboo products. There were also instances where Sahiyya were unable to serve the hard to reach areas (difficult geographical terrain)

Capacity Building

In most of the districts 4 rounds of training had taken place but the reading material was not provided to all the Sahiyyas. In most of the places 4 rounds of training had taken place but only 2 modules were provided.

A few Sahiyyas were provided only 2 rounds of training and astonishingly there was a Sahiyya with no training at all.

Most of the Sahiyyas were not able to give the details of the topics covered during the training except for Module-1 and Module-2.

Most of the Sahiyyas felt that though the training was very useful Sahiyya from-village-Lal Bazar; Block-Bandgaon; District-W.Singhbhum. *"Haan training faydemand tha, pehle itna jaankari nahi tha, ab to humlog sabko bata pa rahe hain"*. (Yes, the training was very useful, initially we did not know much, but now we are able to tell other people) but due to lack of revision and follow-up, the knowledge was not up to the mark. Almost all the Sahiyyas felt the need of re-training with competent trainers and interactive sessions. They also felt that they should get some posters and IEC materials so that they can spread the awareness on health easily. The training was largely lectured based and participation was not encouraged so most of the Sahiyyas perceived training as boring due to lack of participation and interaction.

In almost 50% of the cases Sahiyyas were not paid the travelling allowance though they were provided food. Many Sahiyyas feel that the training should be residential.

Though the training helped Sahiyyas towards leadership but lack of *"Quality"* training, complete lack of supportive supervision and utter absence of continuing education (Revision of Modules on regular basis) is making this painstaking journey a far sighted dream.

Support

Most of the Sahiyyas get support from trainer/NGO coordinator and in few places by ANM and AWW. Self-help groups help Sahiyyas financially if the need arises such as arranging transportation for institutional deliveries. Most of the Sahiyyas were supported by the family members as they perceive it as a respectable job. Most of the Sahiyya were aware of the NGO that coordinated with them.

Incentives

Most Sahiyyas did not get incentives in time which often becomes a de-motivating factor. "S*ince September 2008 we are not paid incentives for JSY*

and we do not know why""Since September 2008 no incentives on JSY has been paid because MOIC is not sanctioning it and when we request, MOIC's talks badly and staff says that until madam signs, we cannot give you anything".

This survey brought out that in most of the places ANMs and *Anganwadi* workers looked at Sahiyya as their helping hand or to be more precise as their assistant. Incentives were given for the following activities:

- Polio duty
- Family planning services
- Immunization
- DOTS for TB patients
- JSY

Most of the Sahiyyas felt that support from AWW & ANM is not adequate and they also felt that ANMs should teach them new things like seeing patients, how to check anaemia in women, antenatal check-ups, training of skill birth attendants, *malaria ki jaanch.*

Mobilization Activities

Most of the Sahiyyas mobilize children under 5 for routine immunization. They also mobilize men and women for vasectomy/tubectomy. They also mobilize people for other activities like distribution of bleaching powder, repair water hand pumps, sprinkling of kerosene oil in sewage ducts.

Achievements

The major duties that they preformed were:-

- Accompanying the pregnant women to the hospital for delivery.
- Give medicines in cases of fever if they had medicines in their dawa bag.

Most Sahiyyas did not receive incentives for her support for transportation for institutional delivery.

Sahiyyas are not given any target or task though she has been asked often by ANMs and occasionally by MOIC's to get vasectomy and tubectomy cases, children for pulse polio.

Dawabag

Most of the Sahiyyas got *Dawabag* consisting:-

- Fever-Chloroquine
- Fever & Pain-Paracetamol
- Iron tablets-pregnant women

- ORS- Baby suffering from diarrhea
- Mala N & Condoms
- Thermometer- fever (but no one knows how to measure fever)
- Cotton & bandage

There was no clarity on medicine for diarrhea and medicine named ‘Mandoor’ was still a mystery. At few places calcium tablets were also seen in the bag.

Over all it’s the Paracetamol tablets which were at utmost demand and are being used frequently for fever and pain, at places Mala N and condoms were also distributed regularly. Since Paracetamol tablets were exhausted due to their excessive use, they were being replenished or were in the process of replenishment with the order of MOIC but refilling of *Dawabag* is still to be implemented.

Many Sahiyyas who got *Dawabag*, were not trained on utilization of the same but still most of the Sahiyyas use Paracetamol tablets in fever cases, which were most common ailments the Sahiyya is approached for. Among other reasons community approaches her were for Condoms and Mala N, Iron tablets, ORS, malaria tablets (though she did not know how to use Chloroquine tablets).

Bihar: ASHA

The fellows in Bihar conducted interviews with ASHAs in the sample villages to assess their current functioning and to understand the roles they perform under the mandate of NRHM as envisaged through ASHA. Further inputs were also taken regarding the problems that they encounter in functioning effectively. The scenario in Bihar offered a bleak picture.

- The ASHAs had been trained first module and the subsequent trainings on other modules had not yet commenced in those districts.

- ASHA kit was not available in most of the cases.

- ASHAs had reported lot of grievances in getting incentives.

- It was found that they were mostly involved in promoting institutional delivery.

- ASHA were not involved in – counseling, promoting ANC, other health relative awareness drives etc.

- ASHA day was not functioning as envisaged and turned out to be a token activities or a ritual.

2. Rogi Kalyan Samiti

Orissa

Assessment of the functioning of Rogi Kalyan Samiti (RKS): The RKS was constituted with the objective of ensuring compliance to minimal standard for facility, hospital care and protocols of treatment as issued by the government; ensure accountability of the public health providers to the community; introduce transparency with regards to management of funds and upgrade and modernize the health services and infrastructure of the hospital. Thus it is pertinent to assess the effective functioning of RKS which plays a critical role in bettering the quality of health care services.

To assess the functioning of the RKS the interviews were taken with MOI/Cs. In each district at least two RKS one at the district level and the other at the block level were taken.

The general findings of the functioning of RKS are as follows:

- Meeting of RKS-The meetings of the RKS were not regular in almost all the cases. In most of the cases the governing body meeting was more irregular than the executive body meeting.
- Patient Charter-There was no patient's charter in any of the RKS under the study. The MOI/Cs also reported of not having any knowledge on having a patient's charter and no one has sensitized them in this regard. However it was observed that sporadic attempts were made in some cases to display public information on services provided and the user fees and the current stock of drugs available.
- Collection of feedback from the patients and redressal of grievances-There was no specific mechanism initiated by the RKS for collection of the feedback and redressal of grievances of the patients. However there were few exceptions where complaint and suggestion boxes are placed but the RKS has not been effective in attending to the concerns on time.
- Important decisions taken at the RKS for proper functioning of the hospital-The decisions taken by the RKS members in general were mostly confined to renovation of old buildings, construction of toilets, ensuring safe drinking water, providing uninterrupted electric supply to Operation theatres, labour rooms and for maintaining cold chains, appointing contractual

non-technical support staffs for better functioning of the hospital and maintenance of hygiene within and outside the hospital campus and collection of user fees.

There were no such significant decisions taken on developing systems for enhancing transparency, accountability and credibility of the public health initiatives. Further the decisions also did not reflect any initiatives for collection of feedbacks and suggestions of patients for redressal of grievances.

- Expenditure of RKS funds-The study revealed that maximum RKS under study were formed in 2006-07.The transfer of money as per the norms has been timely but the expenditure was sporadic in the initial phase of its formation. However as the frequency of meetings increased the decisions on patient's welfare were taken and various activities initiated. This year the expenditure has been mostly on infrastructure development and renovation activities.

Jharkhand

The formation of Rogi Kalyan Samiti in Jharkhand was not prominent during this assessment process. However, in many places RKS were formed but in none of the places these were registered during the study period.

Bihar

Rogi Kalyan Samiti is slowly evolving as an institutional mechanism to ensure patient facilities at the facilities. Fellows had observed that there is a need of strong initiation and orientation of members on the objective of RKS.

3. Village Health Sanitation Committee

Orissa

Assessment of the functioning of Gaon Kalyan Samiti (GKS): The Gaon Kalyan Samiti acts as the unit of planning, monitoring and implementation of various public health initiatives at the village level. In this context it is pertinent to assess the current status with respect to its existence, formation, composition, capacity building, funding, activities and monitoring. Focussed group discussions were initiated among the GKS members of the sample villages.

The general findings of the functioning of the GKS on the basis of the above mentioned components are mentioned below:

Existence: At the village level there was indeed a Gaon Kalyan Samiti (GKS). In very few villages the GKS were registered under the Societies registration Act-1860. Besides the GKS the other committees which exist at the village level include Village Education Committee(VEC), Banasurakshya Samiti

(BSS), School Sanitation Committee (SCC), Village Sanitation Committee (VSC),Parent Teacher Association (PTA) and the Mother Teacher Association (MTA).These committees did not focus on health related activities. There was no Panchayat or hamlet level health committee in existence.

Formation: The formation of the GKS was the responsibility of the ANMs. Almost all the GKS were formed by a democratic process through active participation of the villagers. The ANMs in consultation with the ward members fixed suitable dates to organize village level meetings where all the ward members, president and secretary of all the SHGs, president and secretary of youth clubs, NGO representatives and 10-15 influential members of the village were invited to attend the meeting. The information regarding the meeting was given at least 7 days before the meeting. The ASHA and AWW workers assisted the ANM in mobilizing the people to participate in the meeting.

In most of the cases NGOs were given responsibility of the formation of the GKS. They worked in association with ANM, AWW and ASHA. On the date of the meeting information was shared regarding the aims, objectives and roles and responsibilities of the office bearers of GKS members. However the GKS members stated that they could not have clarity on their roles and responsibilities and required more orientations for proper functioning. A resolution was passed in the meeting regarding the formation of the GKS and the nomination of the president, secretary and other members. The signatures of the participants were maintained in the register. The respondents stated that there is a detailed guideline in place regarding the formation of the GKS and that there was no significant problem regarding the formation of the VHC.

Composition: The Gaon Kalyan Samiti was headed by the ward member of the village. The other members of the committee were the following: a) Convenor - Anganwadi Worker, b) ASHA c) SEM (Self Employed Mechanics under RWSS) of the area c) President or Secretary of 3 women SHGs d) President of watershed development committee e) Representative of any NGO working in the village. The study revealed that the members have very minimal clarity on the roles and responsibilities of the GKS and the members as clearly stated in the guidelines.

Capacity Building: There was no structured capacity building initiative taken to strengthen the GKS. However there were sporadic attempts in building capacity on record maintenance, preparing village health plans and maintenance of accounts. The MOs, BPOs, BEEs and BADAs were the trainers.

Funding: The GKS was designated to receive Rs.10000/- as untied funds per year. These funds were deposited in their bank accounts where the chairman and the AWW are the joint signatories. They were authorized by the committee for financial transactions. The withdrawal of the money was

only after the approval of the members of the GKS. The AWW maintained the accounts. The MOI/C was the certified authority for the funds utilization. The members lacked in awareness about financial transparency like social audit. All the GKS maintained registers which contains resolutions and expenditure details. Recently they were given printed resolution and accounts books to ensure transparency in financial transactions. However they were unable to maintain the records as no training has been given in this regard. As maximum of the GKS were formed at the last quarter of the previous financial year the spending has been limited to Rs.2, 500/- on an average. This year the transfer of money were not uniform and seemed erratic due to lack of timely release of money to the DPMU by the state mission directorate. Therefore the spending was not significant. The amount spent was mostly towards preparing the Swasthya Kantha, conducting monthly meetings, giving honorarium to AWW & ASHA and cleaning of village drains and minor repair and cleaning of drinking water sources. There was no prior estimation of expenses done by maximum of the GKS.

Activities: The monthly meetings of the GKS were not regular. No major activities were planned or taken up at this stage as they do not have clarity on how to plan their spending. However there have been sporadic activities on developing swasthya kantha, organizing cleanliness drives, repairing and cleaning drinking water sources.

Monitoring: There was no mechanism to monitor or supervise the VHC.

Jharkhand

Village health committee (VHC) is one of the important stake holders under NRHM's broad perspective of community participation. VHC and Sahiyya were envisaged to work in synchronicity with health functionaries to achieve the more pragmatic goal of comprehensive health.

The following findings were based on FGD's with VHC members and were ever possible in-depth interviews (IDI) with office bearers of VHC.

- Existence
- Formation
- Capacity Building
- Funds
- Felt Need/Perception
- Activity
- Bottlenecks

Existence

Most of the VHC's were formed in the last quarter of 2007 or the first quarter of 2008 with the exception of couple of places where the VHC's were formed in 2004-05 (prior to NRHM). There were a few places where VHC's were yet to be formed. Almost all the VHC's had members in the range of 4-15 with the exception of 1 VHC, where members were more than 15. The VHC's composition invariably consists of women and the office bearers were mostly women with the exception of few places where one of the office bearers was a male member. In most of the places the VHC meetings were not regularly held monthly, except in few places (Churchu) where monthly meetings had taken place regularly. Though most of the office bearers know that monthly meetings have to be organized but due to non compliance of members and attitude towards VHC meetings the monthly schedule suffers a setback. In almost 50% of the VHC the representation of members was "Tolawise"

The inherent cause of not conducting the VHC meetings regularly indicated the process of VHC formation which was devoid of any orientation or training on VHC functioning. Though the NGO responsible for the VHC formation informally explained the role of VHC to the VHC members and the villagers most of the VHC members feel that they required training on how to conduct VHC activities.

"*We don't know about guidelines but we were told that we had to assess Sahiyya. We are not aware of any sensitization workshop which was held at Zila level. We were selected through Gram Sabha where someone proposed the 11 of us and it was seconded. We were selected amongst the mahila mandal members, so all of us are women".*

In most of the places where VHC meeting takes place the issues discussed were in the range of:

- To conduct monthly meetings
- To get aware of the health problems
- To solve Sahiyyas problem
- To disseminate important information to the villages.
- Reach out for suffering people
- Cleaning & sanitation
- Untied funds
- Agenda for next meetings

Formation

Most of the VHC's did not know anything about the guidelines but were told informally about their role and responsibilities by the NGO coordinator who was instrumental in formation of VHC. VHC members in most of the places were not aware of any sensitization workshop or meeting at State/District/Block level.

The process of VHC formation was democratic involving all the villagers at all places except few where the NGO coordinator did not follow the participatory process.

"*On the first day the NGO coordinator informed the villagers about the meeting to be held the next day. Thereafter on the second day meeting was held near the school. The NGO coordinator explained to the villagers about the VHC and the roles of the Sahiyya. The formation of the VHC and the election of the Sahiyya were done on the third day.*

According to the VHC members and office bearers the roles explained to them were;

- To conduct monthly meetings
- To get aware of the health problems
- To solve Sahiyya's problem
- To work for pregnant women

According to the VHC members and office bearers the perceived roles are:-

- To disseminate important information to the villages.
- To address marginalized & suffering population.
- Cleaning & sanitation
- Utilization of untied funds on cleanliness and sanitation and helping pregnant women and marginalized population.
- Cleaning tube well surroundings
- Put bleaching powder in wells
- Fill "*moram*" in places of stagnant water
- Giving money to the families during marriages
- To take care/monitor of the Sahiyya and encourage in her efforts
- Disease related work on Malaria and Diarrhea
- Vaccination

Most of the VHC's felt that their role for women should be to take care of women during pregnancy and the role of women in VHC is to take care of women and child health and ensure benefits such as JSY.

The responses for the role of VHC for the below poverty line families were incoherent as most of the VHC members did not answer the question specifically but few responded in the following manner:

- Support them during emergency
- All the families are BPL

Composition

Most of the VHC's compositions were accordingly:

- President
- *Kosha-dhyaksh (Treasurer) and*
- Secretary

Most of the VHC's had at least 2 women members as office bearer and few with only women members as the key office bearers.

Perceived roles and responsibilities of each office bearers

President-would call meeting, discuss agenda, discuss on the issues with the group and find solutions

Secretary- Record keeping and register maintenance

Treasurer-matters related to money, expenditure, will also help in decision making as to where the money should be utilized.

Capacity Building

Most of the VHC's were not trained formally on VHC functioning. It was observed that VHC's which were trained and were followed up met regularly, more regular than those VHC's who were not trained.

Activities

Since most of the VHC's were not aware of their roles and responsibilities the efforts towards activities were taken by the member's perception. The activities performed up-till now were:

- Cleaning of village to prevent malaria and diarrhea
- Monthly meetings
- Repair of hand pumps
- Sprinkling of kerosene oil in pits

- Using bleaching powder to disinfect the wells in rainy season
- Repair of Anganwari center and purchase of *dari* and chairs.

Few places were exceptions to have initiated following activities also:

- Maintain dairy/register regularly
- Keep record of births and deaths
- Ensuring availability of medicine
- Taking report on pulse polio from Sahiyya
- Regular meeting with Sahiyya

In most of the places the VHC meeting was taking place monthly and in few places bimonthly.

In most of the places where VHC meeting was taking place it happened once in a month on a specified date but invariably at all places all the members did not attend the meeting for various reasons such as:

- Household work
- No information about the meeting
- No interest in the meeting

On the response towards major achievements majority of the VHC members gave the following responses:

- Regular meetings
- *Angan-wari* center management
- Regularity of ANM visit
- Health awareness and JSY awareness among women
- Reduction in malaria cases
- Confidence in public health services
- Reduction in superstitious behaviour
- Gradually more members are showing interest in VHC.
- Women have started talking about their health ore often

On suggestion for improving VHC functions the majority of the VHC members responded:

- VHC training
- Meetings should be held regularly
- Sahiyya should inform about the meeting
- Everybody should come together and decide

- Organization of VHC *Sammelan* in every 6 months where everybody should participate and sharing of best practices from other VHC's.
- Training on utilization of untied funds

Funds

In most of the places neither funds were allocated nor any guidelines and there were places where VHC's had yet to open a bank account.

It was found that most of the VHC's were scared to utilize the funds due to lack of directions and nobody wanted to take responsibility. In few places where the funds are allocated, MOIC's have guided the VHC members informally but there were VHC's where MOIC's were not releasing the funds, as they were not sure of the monitoring and evaluation of the utilization of the funds.

In places where the VHC untied fund was allocated the budget heads were the following:

- Repair and whitewash of AWC
- Purchase of *dari* and chairs for AWC

But the book/accounts s not maintained and the reason given was the lack of training.

Most of the places the account was operated by the VHC and Sahiyya and the consensus on expense was sought in VHC meetings but this was not verified. The VHC's that were yet to receive funds expressed their desire to come up with a plan to utilize the funds but also stressed that it would have been better if they got formal training in doing so and few said that the planning would get initiated once the funds arrived. There was no one who formally certified the expenses nor there existed a mechanism to ensure transparency.

"*It would be better to get some training in utilization of funds so that we use the money in right places*"

Monitoring

In most of VHC's there was no monitoring mechanism neither anybody knew the concept, except a few VHCs (Churchu) where the NGO coordinator does regular monitoring though formal indicators for monitoring were not set there too.

The process of monitoring was as follows:

- NGO's coordinator reviews the report prepared by the VHC and give feedback in VHC meeting.
- They also compare VHC reports with other VHC's and give feedback on improvement.
- NGO had also engineered a federation at block and sub-center level to give VHC a dynamic platform.

Bihar

The formation of **Village Health and Sanitation Committee** in Bihar is under process. Hence this important village level institution is non existence.

Actions initiated by the Community Health Fellows on the basis of the findings

Orissa

1. Strengthening of GKS in the sample villages

Situation of GKS prior to intervention

a) Irregularity in meeting
b) Minutes of the meeting not recorded
c) The funds utilization was only up to Rs 500/-
d) The members were unaware of their roles and responsibilities.
e) There was no plan with estimated budget.

Actions Initiated

i) Organized a meeting with the GKS members to share

a) The village health profile prepared from the PRA exercise,
b) The objectives behind the formation of GKS and
c) The Untied Fund given to the GKS and its probable use with the villagers.

ii) Shared with the DPM and District ASHA coordinator about the status of the GKS and the need for organizing orientation and capacity building of the GKS members for better functioning.

iii) Imparted training to the convener about writing minutes, maintaining the Cash Book and preparation of SOE in association with BPO and BADA.

iv) Assisted the GKS members in preparing a health plan with an estimation of Rs10, 000/-.

v) Met with District Manager of OVHA, an MNGO working towards strengthening the GKS in Angul Block with support from UNFPA.

vi) Presented the findings in the District Coordination meeting of MO I/Cs and CDPOs as well as in the monthly meeting of the BPOs/BADAs regarding the intervention and the follow up support required.

vi) Discussed with the GKS members for taking steps for Nutritional activity like promoting the kitchen garden, promotion of sanitation drive etc.

vii) Sent a letter suggesting possible interventions for enhancing the performance of the GKS to the M & E consultant, NRHM, Orissa

viii) Initiated intensive discussions with the DPM regarding the preparation of Health Plan in every GKS in the district with the help of OVHA, the MNGO and the DPMU with technical guidance from the CHF.

ix) Planned to do Village micro plan in five villages on a pilot basis for scaling up of the same in the entire district.

Current Status

i) Improvement in regularity of the meeting.

ii) Regular writing of Resolution about the decision taken by the members.

iii) Involvement of the GKS members in the campaign against Liquor consumption.

iv) Involvement of the members in some welfare activities like organizing "Jalachhatra" for heat stress management.

V) The expenditure of Rs 10,000/- is done and the SOE and UC are submitted. The next amount for this financial year has not been received yet.

vi) Members are aware about their role and responsibilities.

2. Enhancing the quality of functioning of ASHA

Situation prior to intervention

i) No structural body in existence for redressing the Problems of ASHAs. There should be a help desk working for ASHA in the District for immediate redressal of their grievances.
ii) Some ASHAs having low educational background have no clear cut ideas about their financial incentives prescribed for various services. There should be a written chart with individual ASHA showing the details of financial incentives.
iii) Irregularity in payment of incentives to ASHA.
iv) There is a need for skill upgradation through ASHA refreshers training.

Actions initiated

i) Discussed with the District ASHA coordinator regarding the current situation.

ii) Presented findings in the District Coordination meeting of MO I/Cs and CDPOs as well as in the monthly meeting of the BPOs/BADAs and explained the need for strategic intervention to strengthen the ASHA activity in the district.

iii) Discussed with the concerned District Programme management Unit and BPMU for streamlining the ASHA payment.

Current situation

i) The findings during the Rapid Assessment have been addressed in the District PIP 2009-10.

ii) A printed leaflet explaining the work with prescribed financial incentives has been supplied to all the ASHAs by the DPMU only due to the Intervention of the CHF.

iii) Though there is no ASHA help desk but the Mobile No. of ASHA coordinator and the Contact no. of the DPMU have been supplied to each individual ASHA through BPMU.

3. Enhancing the functioning of ASHA

Situation before intervention

a) Non availability of drugs on time
b) No timely disbursement of incentives
c) Delay in referring of cases by the MOI/Cs to the SDH and DHH

Actions initiated

Discussions were initiated with the concerned ANM, BPO and BEEs of both the blocks and the ICDS Supervisors on the following aspects:

- Discussed with ANM for ensuring availability of essential drugs with ASHA.
- Discussed with the BPO and ICDS Supervisor for streamlining medicine supply.
- Discussed with DPM and concerned the BPO regarding the quick release of the incentives of ASHA.

Current Situation

In Nuhamalia and Gopinathpur village of Saraskona block, ASHA received essential medicines regularly. ORS received both from ANM and ICDS regularly while the ANM is supplying essential drugs including paracetamol.

4. Making JSY effective

Situation before intervention

The beneficiaries were facing problems due to substantial delay in getting the JSY money.

Actions initiated

A discussion was initiated with BEE, BPO and MOI/C about the issue. They assured appropriate action in releasing the money on time.

Current status

After the discussion 2 delivery cases have been reported to receive their JSY money within 7 days.

5. Making Maternal Health Guarantees effective:

Situation before intervention

In certain villages the ANM was reported not visiting the PNC cases on time. Further the ANM and AWW were also not filling up the IMNCI formats.

Actions initiated

Discussions were initiated about the issue with the ANM and AWW and requested them to visit the PNC cases at least three thrice within every 10 day period.

The issue was also discussed in the ICDS sector meeting and orientation was given to the AWWs on filling up of the IMNCI format. The ICDS Supervisor was requested to follow up the matter.

Current Situation

The ICDS supervisor followed-up regularly in the sector level meetings.

6. Initiating formation of Rogi Kalyan Samiti:

Situation before intervention

There were two RKS which were not formed in certain blocks due to lack of initiation.

Actions initiated

i. Discussions were held about the issue of formation of 2 RKS in a block with the CDMO, DPM and ASHA Coordinator.

ii. At block level discussions were initiated with the MOI/C, Sector Medical Officers, BEE and BPOs to chalk out a mechanism for its formation.

iii. The RKS was formed with support of the BPO of the concerned block as per the norms.

Current Situation

All the related documents have been submitted to the District ASHA Coordinator for registration purpose.

7. Strengthening of RKS in a Block.

Situation before intervention

The block of Rayagada District which is situated 60Km away from the DHQ. It has a population of around 90 thousand. It has its PHC which is situated in the village and the RKS was not functional. There was poor attendance of the members which was evident after verifying the attendance records. The proceedings of the meetings were also not recorded. The meeting was irregular and no significant decisions were taken.

Actions Initiated

After several informal meeting and discussion with MO and BPO, a meeting was organized for the RKS members. The local NGO named SHAKTI also expressed interest in supporting the initiative of sensitizing the RKS members. Two rounds of training were conducted for the RKS members where the MO, BPO, individuals from SHAKTI, and CHF acted as resource persons.

Current Status

The meeting was conducted by the RKS with full attendance. Decisions regarding patients' welfare were getting featured in the meeting. The local civil society which was also a member of the RKS was taking the lead in ensuring full participation. Further they were also monitoring the activities of RKS regularly. The RKS was in its initial stage and had taken the right course for ensuring patients welfare in the future. Regular follow-up by the CHF planned to ensure its effective functioning.

8. Participation in IRS activities

As per the rapid assessment findings malaria has been one of the major problems affecting the community. The pregnant women and the children are the worst victims.

Actions initiated

As per the suggestion of the CDMO, there was participation in the block level sensitization meeting on IRS activities in a block. Further one Sub-centre level GKS sensitization meeting on IRS activities at block was also conducted. The monitoring of the IRS activities was done at village level sensitization meeting on IRS activities. The IRS programme at the block was also monitored and reports were submitted to the CDMO.

Current Status

Based on the monitoring report and the immediate actions initiated as per the suggestions of the CDMO, the GKS members were sensitized on IRS activities. As a result spraying was completed successfully.

Jharkhand

In Jharkhand, after the rapid assessment study which was conducted in collaboration with CINI it was strongly realized that there is a need to go back to the community and the district to strengthen the community processes. Initiatives were taken up in the districts of Sahibganj, Godda, Dhanbad, East Singhbhum, West Singhbhum, Khunti, Hazaribag and Ramgarh to rejuvenate the VHCs and enable them to access the Untied Fund.

The main issues discussed during the capacity building processes were to understand the role and functions of the VHC; and to prepare the Village Health Plan. It was communicated that the untied fund of Rs.10000/- should be spent with care and diligence making the plan and purpose of expenditure transparent among VHC members and office bearers.

The action taken to make and strengthen the VHCs in each of the above mentioned districts has been detailed below:

Action taken for VHC Strengthening, preparation of Village Health Plan and training of Sahiyas in various districts

Sahibganj District

In Sahibganj district the VHCs had never received any training on their function and role. They were also unaware of the Untied Fund.

1. The community health fellow carried out a detailed study on the status of the VHCs in the district, i.e. their emergence, process of formation and account status. It was found that the VHCs had not opened their accounts and therefore, there was no question of UF transfer from the district and state. The community health fellow pushed the process of

account opening in one of the blocks- Rajmahal on a pilot basis. In the first phase he managed to do so with **30 VHCs** who received the UF.

2. A total of **69 members of 43 VHCs** were trained. During this process other VHCs had started opening the bank accounts.
3. The pilot phase of the VHC training could be organized after an intensive 20 days follow up and discussion and with the support of the state PHRN team, the VSRC team, the DPM and the Civil Surgeon. The state Programme Management Unit also played a vital role in this. The first one day orientation of VHCs on the roles and responsibilities of VHCs and its members, Untied Fund Utilization and preparation of Village Health Plans was organized in Rajmahal block of the district. An official order was issued by the Civil Surgeon in this direction to organize and conduct the VHC orientation by the Community Health Fellow of PHRN. The first VHC training conducted by PHRN won the trust of the Civil Surgeon and the district health system.
4. As an outcome of the training there was an immediate speed up of the VHC account opening process in the district and transferring the UF to the VHCs. Within a short period of one month the process of transferring the UF multiplied with more than 70 percent UF demand generation by the district to the state and transfer of the same to the district and VHCs.
5. A detailed training plan for rest of the VHCs in the district was drawn up and the process of transferring of funds is on.

The first orientation of VHCs here opened the path for other VHCs and the district health team to take it forward. The Civil surgeon appreciated the entire efforts. Later he attended and participated in the district PHRN team's first meeting and assured to extend all possible support to the initiatives taken up by the CHF in the district.

Godda District

Godda district, which was least supportive in the initial six months, became supportive in the latter part. The community health fellow in Godda continuously followed up and helped in analyzing the status of VHC in the district.

1. CHF along with the district PHRN team prepared a detailed report of the VHC with their account and UF status. The report was converted in to an action plan that helped the district in preparing and sending a requisition to the state in the tune of Rs.13140000/- (One crore, thirty one lakh forty thousand).The same was followed in the state.
2. After receiving the fund in the district, the district team facilitated transfer of funds to the VHCs.

3. The CHF with the district team drafted and developed a plan to train the VHCs on a pilot basis on how to use the untied fund, developing a village health plan and on the roles and responsibilities of the VHCs. The training of all the VHCs in the block was completed and reports of use of untied fund have started to come. A total of **187 VHCs** have been trained with a total of **165 VHC members and 137** Sahiyyas as participants.

4. The team developed unique modules of training the VHC members, i.e. pictorial methods as one means was developed as the literacy level of the block population is too low.

Dhanbad District

1. VHC training- A total of 195 VHC's have been trained in three blocks (85 VHCs in Topchanchi, 65 in Dhanbad and 45 in Baliapur block) as of now, on VHC functioning, UF use, record keeping and developing Village Health Plans.
2. Outcome of the trainings in Dhanbad has resulted in preparation of Village Health Plans by 45 VHCs in Dhanbad district.
3. Convergence meeting on pilot basis was started in Topchanchi block of Dhanbad district involving AWW, ANM, VHC members and Sahiyya on cluster basis by the Community Health Fellow and has been regularized now in the block. This has resulted in sorting out the problem of non-payment of incentives to Sahiyya for immunization that was pending for long. The amounts have been released now to the VHCs to make payments to the sahiyyas.
4. UF has been released to 350 VHCs with the efforts of the community Health Fellow. Untied Fund utilization reports have started to come with few requisitions for release of the next year's UF to the VHCs.
5. Special trainings were organized by the CHF in collaboration with the district malaria officer, for the Sahiyyas on RDK use for Malaria programme. As a result of this Sahiyyas of 4 Panchayats helped the Malaria department in IRS after the training on Malaria.
6. A total of 120 Sahiyyas have been trained for the 3rd round of training and the Block Level Trainers Team has been trained for the 4th module to scale up in the entire district.

East Singhbhum District

1. Integrated Village Health Plans have been prepared for **3 (three) Villages in Ghatshila block** of East Singhbhum district. This involves the orientation of the village on different plans and programmes along with preparation of comprehensive village development plan with the details of village, its resources and various linkage development with the line department.

2. **VHC and UF use:** 62 VHCs in Bahragora and 17 VHCs in Dumaria block have been given one day orientation on VHC functioning, UF use and Village Health Action Plan preparation.

3. In East Singhbhum too like Godda, the CHF have helped the district in collating and analyzing the information on VHC status. The community fellow helped the district in compiling the VHC UF status, UF requisition and sending the same to state. This was followed in the state by the state team to release the fund which has now reached to the VHCs. There is coverage of more than 80 percent UF release to the VHCs in the district.

4. The other activity that CHF initiated was to identify and train the block level trainers in the district with VSRC. Through the Block Level Trainers Team (BTT's), CHF was able to give training to **342 VHCs in all the 9 blocks** of the districts. For rest of the VHCs, training plan had been developed and finalized to conduct the same in 11 batches. This has been done as a result of scale up of the first two trainings organized in Baharagora and Dumaria and later by the BTTs. Letter from the Civil Surgeon was issued by the Civil Surgeon in this respect.

Khunti District

1. A total of **110 VHCs** have been trained in Khunti district in Karra and Murhu block whereas in Torpa and Rania Block, problem of existence of VHCs have been sorted out by the CHF. After the problem solving in these two blocks UF was released to the VHCs. Khunti district has regularly tracked the use of UF and has streamlined it. Rania block received a sum of Rs. 13 Lakhs for the first time to its UF account.

2. It has been reported that 75 VHCs after the training to 45 VHCs in Murhu block have started to use the UF. Here too, requisition from some of the VHCs for the next years UF has been placed.

West Singhbhum

Community Health Fellow had organized a large meeting of 700 Sahiyyas on Women's day on 8th March. This was followed by training on drug kit used by the Shaiyyas in Chaibasa. In addition to this the CHF has been actively involved in strengthening one of the Rogi Kalyan Samiti of Chakradharpur PHC.

Simdega District

Simdega district has taken off slowly. However, the district has been able to gear up the process of account opening of VHCs in two blocks-Jaldega and Bano. To speed up the process, the Deputy Commissioner issued a letter to speed up the process after bringing the slow progress of VHC and Sahiyya in the district. It was a difficult task in the district to trace the information

about the VHC and Sahiyya as the promoting NGO had not submitted any reports to the district in this regard.

Hazaribag and Ramgarh District

Both the districts have shown a significant amount of work taken up by VHC and Sahiyya. CHF in Hazaribagh district have helped the district in initiating the processes of sorting out and finalizing the lists of VHCs and its UF status in the district, pilot trainings in three blocks for VHC strengthening and mapping out health sub centre wise maternal and child health plan in Barkatha and Bishnugarh block. In addition to this CHF has helped in Gola block of Ramgarh district to improve the health service delivery system of the PHC. Starting a Sahiyya help desk in Gola block is in the process. First and second rounds of the meeting have already been conducted and a large meeting of Sahiyyas have already been planned to be held in the month of December, before the start of Sahiyya help desk at PHC.

Bihar

Major actions taken by fellows and their achievements:

Muzaffarpur

The Community health fellow in Muzaffarpur district of Bihar has worked towards the formation of district health action plan. He has established his position in the district health system and has coordinated and facilitated in the preparation of DHAP. He was also associated with strengthening the participation of Pramuks (PRIs) in the Rogi Kalyan Samiti. He organized a meeting with them and made them aware of their roles and responsibilities and that has resulted in minimizing the gap between the PRI members and their participation in health system. Further he discussed with local Self Help Groups on health related issues. Muzaffarpur has been a red zone for Kala azar. CHF visited spraying area and advocated preparation of an action plan to combat kala azar. He also visited villages and prepared them for spraying. He mapped the kala azar problem areas in Muzaffarpur.

Gaya

The CHF of Gaya district worked in the preparation of DHAP of Jehanabad district. He visited the district and facilitated preparation of their health action plan. He did the survey of various PHC and HSC and attended the meetings of Rogi Kalyan Samiti. His survey report of Gaya government

hospital was used as a tool for advocating to the state regarding free laboratory services for every patient in all the health facilities. And it is his contribution that at present all the laboratory services in the Health Facilities in the Bihar state are made absolutely free for all patients. He facilitated the use of untied fund at the sub centre level so as to improve the condition and services provided in the villages.

Rohtas

The CHF of Rohtas assisted the District in finalizing their DHAP. He organized a district level orientation programme for members of Rogi Kalyan samiti in Rohtas. This is the first district which has taken this step to orient the members. This orientation programme was covered by the newspaper of the State and has paved way for the participation of community in the health delivery system. He worked towards formation of VHSC in Rohtas district and actively participated and presented the issue in the monthly meeting held in the district.

Araria

The CHF in the Araria district of Bihar worked towards strengthening the role of PRI members in the functioning of Rogi Kalyan Samiti. He used the IEC material of RKS and provided it to each members. This technique of providing information of their role and responsibilities had a positive effect and helped in regularizing the meeting and utilizing the funds.

Vaishali

The CHF of Vaishali District was involved in strengthening ASHAs role as a community mobiliser. She initiated ASHA Day in one PHC,and made it a regular activity. She actively engaged with ASHAs and made them aware of their roles and responsibilities.

Nalanda

The CHF of Nalanda District positioned herself in the district health system and facilitated the preparation of their DHAP. She worked with Adolescent girls and her effort has resulted in the opening of separate clinics for the adolescent in the PHC. She was selected for the National Level Training Team of ASHAs. She brought out the gaps of ASHA training organized by NIPI. Her report was presented in the State Health Society and further advocacy was done in this matter. Further her advocacy has resulted in

100% opening of account of VHSC in Nalanda district though other districts are still in process.

Samastipur

The CHF of Samastipur district of Bihar worked with ASHAs and capacity building. She facilitated ASHA day in the PHC. She utilized her experience as a trainer for the benefit of ASHA and their capacity building.
She participated in the preparation of District Health Action plan of Samastipur. As Samastipur was also affected by Kala Azar, She visited the field during spray and created awareness in the villages regarding Kala azar, its prevention and causes.

East Champaran

The CHF of East Champaran played an active role in the formation of District Health action Plan. She worked towards strengthening Rogi Kalyan Samiti in the District. She visited and collected the report of RKS from two PHCs and participated in the meeting of RKS. She presented the priorities to the PHC members. Her participation was appreciated and the fund was utilized effectively as per the priority and report was given. As east Champaran is Kala Azar prone area she visited Kala Azar affected villages and with FGD created awareness regarding Kala Azar, its causes, prevention, preparation and monitoring of spraying activity. She attended the ASHA Day and identified gaps. She did advocacy with the MOICs for regular, agenda-based organization of ASHA day.

Due to active participation of CHF in the DHAP of 2009-10 that this year all the 33 districts was facilitated by the PHRN and NHSRC team. CHFs were also playing facilitator role in more than one district in preparing Block Health Action plan and thus meeting the aim of decentralized planning and participation.

Major recommendations based on findings in three states

The findings of the rapid assessment need to be understood in the context of analyzing the current status of various components of communitisation processes of NRHM.

The findings are direct observations and do not compare with any previous findings or recommendations. The recommendations are on the basis of the

findings from the rapid assessment undertaken in the 20 villages of the 5 sample districts in each of the three states. The recommendations are:

A) **Ensuring regular supply of drugs with ASHA**- The drug kit supplied to ASHA should always have the essential drugs to ensure timely distribution to the community. The MOI/Cs and ANMs should play a critical role in ensuring the timely supply of drugs to ASHA and maintenance of stocks.

B) **Making the Village Health and Nutrition Day (VHND) more effective**- The coordination of ANMs and AWW with the ASHA should be made more effective for ensuring greater participation of the beneficiaries. The participation of SHGs should be initiated as they could be potential agents to

   a. Follow-up on the activities of the VHND,

   b. Discuss issues at closer quarters and with regularity

   c. Advocate for causes which emerge at the local level.

C) **Enhancing the skills of ASHA**- There should be refresher trainings of the ASHA on all 4 rounds of trainings given to them. This shall help in upgrading their skills by bringing more clarity regarding their responsibilities.

D) **Strengthening of referral & follow-up of cases by ASHA**- Trainings on specific diseases like TB,HIV/AIDS, Leprosy and other ailments can help the ASHA in identifying symptoms and refer cases on time. The VHSC should play a critical role in recording the referral cases done by ASHA and monitor the follow-up of ASHA to ensure that the patient gets the right treatment.

E) **Streamlining the payment of ASHA**- The payment of ASHA with respect to slide collection, net impregnation and immunization should be streamlined. Further in case of additional incentive based work is designed to be given, it should be clearly defined and budgetary provisions should be made clear to keep the morale of ASHA intact.

F) **Providing mobility support to ASHA**- ASHA should be given at least the minimum mobility support to ensure timely interventions and reduce difficulties in her operation.

G) **Increasing awareness on JSY-** Campaigns to increase awareness on JSY should be organized at the community level involving the VHSC, ASHA and ANMs so that institutional delivery is promoted.

H) **Strengthening the VHSC-** There is a need for structured capacity building programmes to:

- **a.** Sensitize the VHSC on their roles and responsibilities
- **b.** Preparing health micro plans
- **c.** Maintenance of financial transactions and social audit for monitoring the service delivery.

The NGOs support the capacity building programmes to a large extent by

I) **Developing systems for monitoring the performance of VHSC-** A proper system for monitoring the performance of VHSC needs to be developed in consultation with various stake holders including the community. The mechanism should be developed in a participatory approach so that it is viable and sustainable.

J) **Strengthening the RKS-**The RKS members need to be sensitized on their roles and responsibilities. They need to be transformed to a vibrant body which breaks from the traditional pattern of initiating infrastructural development and renovations to a group which ensures transparency and accountability of the services, establishes effective monitoring mechanisms of health care delivery, makes systems of grievance redressal, makes strategies for financial sustainability using a pro poor approach.

K) **Developing understanding of the community on health related entitlements-** The community should be empowered so that they advocate for their health related entitlements. Massive awareness needs to be generated involving the VHSC, ANMs and the ASHA.

It is also clear by the kinds of preliminary action taken by the community health fellows, and the outcomes of these actions, that this kind of a cadre which has a very specific mandate can play a distinct facilitatory role in enhancing the communitisation processes of the NRHM. Scaling up of this approach should be considered to speed up and potentiate these processes, specially in ‘difficult areas’ where civil society organisations are also hard to find.