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Communitisation for health: The success and gaps in villages of Uttarakhand

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ABSTRACT

Communitisation can be referred as a mix of public and private systems. The idea of communitisation revolves around participative community. The community takes charges and becomes the driving force that ensures working of the systems in the most desired manner. Few motivated members of the community from different directions come together to make the systems work. This pedagogy shifts the community from the seat of just being a mere recipient to a force that administers, decides and supplies services for the larger community. Communitisation as a process ensures decentralization, participation and empowerment all at the same time. The state on the other hand is expected to partner, monitor and assist the community. The mission document of India's, NRHM 2005–2012 (Ministry of Health and Family welfare, Govt. of India, 2005) spells clearly the importance of community participation as part of the decentralized process of health care management. The policy document stated to achieve this through formation of committees at various hierarchical levels and the most basic being Village Health Sanitation and Nutrition Committees (VHSNC) at the level of each revenue village. VHSNCs which have been conceptualized on the foundation blocks of participation, distribution of power, recognition of rights and for solving problems related to the health and sanitation in the communities. A qualitative study was conducted in Ramgarh and Bhetalghat blocks of Nanital district of Uttarakhand to map communitisation at the village level, VHSNCs were considered to be an appropriate instrument for research. Six villages, three in each of the two blocks were visited. Emerging themes show that committee members were yet to realize the potential and power the committee held. VHSNCs were considered either ASHA's or Pradhan's domain. Lack of participation and ownership led to its charge being in the hands of a few members which resulted in poor functioning and more blame game. The members have not received any training or exposure by the government which results in limited output. No mechanism of keeping checks or monitoring was noticed. In villages where no NGO intervened the committees existed only on papers and performed negligible role.

Key Words : Comminitisation, Village health sanitation and nutrition committees, National health mission, Role of NGO

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INTRODUCTION

The World Health Organisation's global healthcare profile ranked India's healthcare system 112th out of 190 countries (2000). India is going through a demographic, societal and economic transformation however the health status of the country projects an uneven image and a large disparity in terms access, utilization, affordability and quality of healthcare. A total of 74% of the graduate doctors live in urban areas, serving only 28% of the national population, while the rural population remains largely unserved, (MoHFW, 2002) it is indeed a challenge for the Indian government to reach out to approximately two third of the population. India has a large, unregulated, poor quality, expensive and dominant private health sector, and an inadequately resourced, and declining public health sector, with the former having curative monopoly and the latter carrying the burden of preventive services.

India's public health system was established after independence. Since India has a federal system, the responsibility for health care lies in the hands of the states. Public health is a part of State List in Seventh Schedule of Constitution of India. Although the central government develops the policies and the National Health Programmes (centralized planning), implementation of these policies is solely state business (decentralized implementation). Multiple systems, various types of ownership patterns and different kinds of delivery structures make up a complex plurality that makes the development of an organized system difficult.

At present, India's health care system consists of a mix of public and private sector providers of health services. Networks of health care facilities at the primary, secondary and tertiary level, run mainly by State Governments, provide free or very low cost medical services. Concentrations of public and private health care facilities in the urban areas and missing facilities in remote rural areas have thus become a common feature of the Indian health system. The new National Health Policy (2002) focuses on decentralization and community participation as the measures to improve the quality of health care and to achieve comprehensive primary health care (MoHFW, 2002).

To recognize 'Right to health' and create a sense of demand for it, a community empowerment approach was envisaged in the National Rural health Mission now known as National Health Mission (NHM). The mission document of India's, NRHM 2005–2012 (Ministry of Health and Family welfare, Govt. of India, 2005) spells clearly the importance of community participation as part of the decentralized process of health care management. To deeply understand the process of communitisation of health care systems, which is one of the five pillars of NHM, a study was conducted in Ramgarh and Bhetalghat blocks of Nanital district of Uttarakhand.

Communitisation is an alternative approach in governance. It refers to a contract between the government and the community. Community becomes the owner of the government assets and is granted powers to manage and maintain institutions. Active involvement and participation of members ensures that people recognize their own needs and work towards fulfilling them. For the study, the process of communitisation was intended to be studied through Village Health Sanitation and Nutrition Committees (VHSNCs) which have been conceptualized as the foundation blocks of participation, distribution of power, recognition of rights and for solving problems related to health and sanitation in the communities..

The VHSNC is intended to be a part of the local self-governance structure of the Panchayati Raj Institutions specifically the Village Council called the Gram Sabha. The purpose of the VHSNCs is to build and maintain accountability mechanisms for community-level health and nutrition services provided by the Government. The NHM provides guidelines on the framework, functions and responsibilities of VHSNCs and has provided for a flexible untied fund of Rs.10, 000 per annum to support local actions. To map communitisation at the village level, VHSNCs were considered to be a appropriate instrument for research. The VHSNC were intended to function as a village level organization comprising of key stakeholders including Panchayat representative, ASHA, AWW, ANM, Teachers, Community health volunteers, representative from SHG, NGO, MPW and MSS etc.

To enable the Village Health and Sanitation Committee to reflect the aspirations of the local community especially of the poor households and women, it has been suggested that:

– At least 50% members on the Village Health and Sanitation Committee should be women.

– Every hamlet within a revenue village must be given due representation on the Village Health and Sanitation Committee to ensure that the needs of the weaker sections especially Scheduled Castes, Scheduled Tribes, Other Backward Classes are fully reflected in the activities of the committee.

– A provision of at least 30% representation from the Non-governmental sector.

– Representation to women's self-help group etc. on these committees etc. will enable the Committee to undertake women's health activities more effectively.

– Notwithstanding the above, the overall composition and nomenclature of the Village Health and Sanitation Committees is left to the State Governments as long as these committees were within the umbrella of PRIs.

Village Health Committees were conceptualized to facilitate in addressing the health needs of the entire village with the help of health providers and health institutions. VHSCs will play an important role in planning and monitoring of the health care services through community monitoring mechanism.

Responsibilities of key VHSNC members :

The Chairperson of the VHSNC should be a woman elected member of the gram panchayat (panch) preferably from among the SC/ST communities, who is a resident of that village. If there is no woman panch from that village, then preference should be given to any panch from the SC/ST. The Chairperson of the committee leads the monthly meetings and ensures smooth coordination amongst members for effective decision making. Member-Secretary and Convenor is ASHA, her role is to convene meetings, draw attention of the committee members on specific constraints and achievements related to health status of the village community and enable appropriate planning and maintain records. Anganwadi Worker has a critical role in enabling VHSNC to take action on addressing malnutrition. She helps in mapping the marginalized households needing nutrition services and extends support in forming and implementing nutrition component of the village health plan. She is also accountable for ensuring the provision of take Home ration for children of less than three age group, pregnant/ lactating mothers, and supplementary food for children 3-6 years. Auxiliary Nurse Midwife

provides information to VHSNC regarding available services, schemes, and services for maternity and child health. She enables the committee to prepare a village action plan to address this concern.

Emerging themes:

A component of larger ongoing research was to study the health seeking behaviour of people and their interactions with health care systems in Uttarakhand. This paper specifically focuses on community's experience with the existing health systems at village level and functioning of VHSNCs. Focus group discussions and in-depth interviews were conducted with people living in six villages of Ramgarh (three villages) and Bhatalghat (three villages) blocks of Nanital district, Uttarakhnad. As one of the objectives of the study was to observe changes in VHSNCs working with NGO support and without NGO support, hence these two blocks were selected. In Ramgarh NGO intervened with committees on a regular basis and in Bhetalghat there was no NGO intervention.

Community's perspective on existing health care system :

***Sub center synonymous with vaccination*:**

At the most peripheral level is a sub center which is the first contact between the community and primary health system. It was manned by Auxiliary Nurse Midwife (ANM). Not all villages visited had their individual sub centre; some centers were commonly shared between two – three neighbouring villages depending upon the population being catered to. The sub center was accessible only once a week, that day was referred as the clinic day. It was observed that community members visited the sub center primarily for vaccination or general check up on the clinic day. None of the ANMs resided in sub center or the same village hence it was not considered as source of health care in emergency times. One of the ANM supervisor revealed that ANMs do not live in the sub center because sub centers are build in isolation, they are unsafe for the women. They took weekly rounds (2-3 rounds/ week) in the village, motivated women to use contraception and did ante natal checkups.

Trust on private health system:

Before visiting Primary Health Centre (PHC) people had an option of referring to State Allopathic Dispensary (SAD) these were close to the village and comprise of a Doctor and Pharmacists. During the course of the study three SADs were visited, all three of them faced different challenges. Two SADs in Ramgarh, did not have a permanent doctor and they functioned on the basis of pharmacists capacity and knowledge. In one of the SAD there was a visiting doctor who came twice – thrice in a week. Community members reported that the pharmacists charged Rs. 2 in front of the doctor and during official working hours, but with a sole motive to earn money he invited patients to his room where is stayed before and after SAD working hours, he gave them medicines which he claimed were from his private stock and thus hisprivate practiced flourished .He lured patients to come to his room by telling them that private medicines were of higher dose, better quality and guarantee quick recovery. He charged close to Rs. 200 at his room and for home visits, he charged approximately Rs. 500 as expressed by the community members in a separate FGD. conducted

by men and women.

In Simalkha village (Bhetalghat block) a young lady doctor was appointed in SAD, who stayed in the village itself. According to her, people preferred private practitioner (unregistered) popularly known as the *'Bengali Doctor'*. She also added that because of lack of resources and medical equipments in SAD she refused to take cases which required proper medical precautions like giving stitches. Community women on being probed about what made them prefer private practitioner instead of low cost government service in SAD expressed that *'woh doctor dorr se sui lagati hai…pass mein nahi baitha thi'* (she injects from a distance and does not let us sit close to her).

SAD was just 50 meters away from *Bengali doctors* clinic and only charged Rs.2 for consultation and medicine still community preferred knocking at the doors of poor quality private system. People felt more comfortable with *Bengali doctor*, his 24 hours presence, ability to speak local language, be like one of them made him more acceptable in the community despite of not having a professional medical degree.

Lack of reliability on peripheral health workers*:*

ANM was not considered to be a reliable health worker in times of emergency. It was noted that ANM did not live in the same village, she came once a week to give duty at the sub – center. On the clinic day, ANM served her duty by doing regular checkups, distributed contraceptives and gave medicines to community members who came. Community was either not aware of the ANM or associated her role only with immunization. *'We don't know who the ANM is; we have never seen her on rounds'* – Community Men, Gurgaon (Ramgarh). ANM was not seen as a health worker who was available to the community in odd hours. She was not considered a referral point for health care at any point by people and her physical absence from the village added to that. Women only went to sub – centre to get themselves or their children immunized.

ASHA however was considered as reliable and trusted health worker. It was observed that she shared a good rapport with the community and was available even in odd hours. But in times of need even ASHA was helpless. ASHA workers informed that since 2012 they have not received any medical kit/ first aid / medicines or any help from the state. ASHA did not even have ORS packets or basic aid to be given in times of need. ASHA was mainly contacted for delivery cases, wherein she called the ambulance and assisted the pregnant woman till she delivered the baby.

Khushiyon Ki Sawaari (Ride of Happiness) making a difference *-*

108 ambulance service was much appreciated by the community. This was one state initiative which gave support to the community in times of need. Ambulance service for the first time was just one call away. Availability of free of cost service made life easier for critically ill and pregnant women living in hilly terrain. 108 and 104 were popular among villagers and were referred as *Khushiyon ki Sawaari* – The ride of happiness. The ambulance came up till the main road from where the patient was picked and dropped off at the nearest CHC or district hospital depending upon the case.

Functioning of VHSNC :

VHSNC meetings:

A date and venue was fixed every month to conduct VHSNC meeting. The meeting would generally last for an hour.. The records were mostly maintained by ASHA or NGO functionary. On an average 8 – 10 members attended the meeting. ASHA and NGO functionary were mentioned as most participative members. '*Kamla (ASHA) understands all the issues and participates the maximum*' – Committee Member, Gargaon. *'Sab mere sir par daal dete hai' (I am given all the responsibilities)* – ASHA, Chapar (Ramgarh).

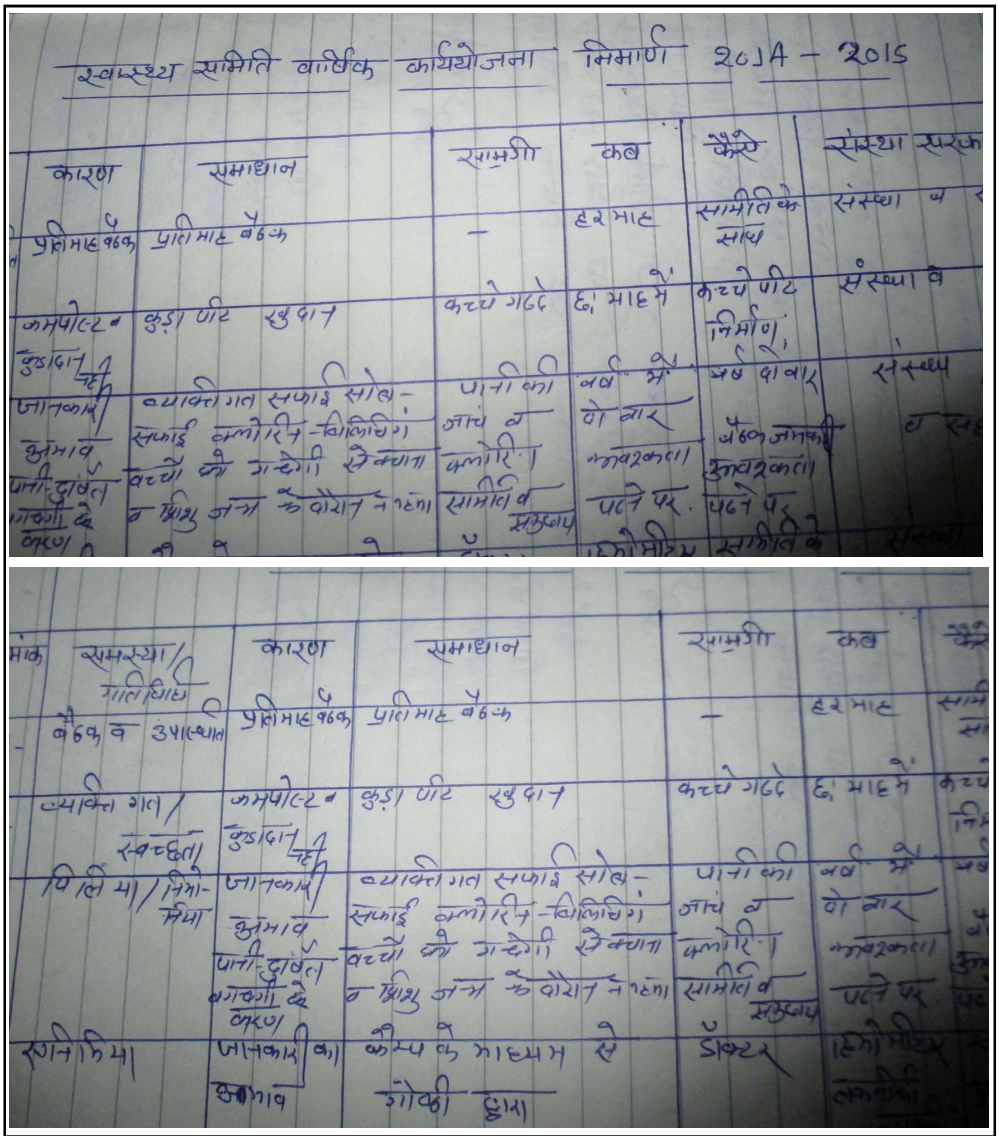

Fig. 1 : Annual health plan made by VHSNC members, Chapar

In Bhetalghat, this trend of meeting every month was found to be completely missing. The committee members reported that they met only once or twice in a year. In Haroli village, committee members had never attended any meeting. For data collection purpose *Pradhan* requested key committee members like ASHA, WARD member, Chairperson for a focus group discussion and that was for the first time they all come together to discuss about VHSNC.

In both the blocks representative from *Jal Vibhag* (water department), Chairperson (WARD member/Panch from minority caste) and ANM (Auxiliary Nurse Midwife) were irregular in marking their presence in the monthly meetings. ANM, who is expected to play the role of a facilitator in VHSNC meetings, never attended any meeting. AWW (Anganwadi worker) participated the least according to committee members.

Activities initiated by VHSNC:

Following are some common activities which were initiated by the committees: almost all committees visited celebrated *Poshan Divas* (Village health nutrition day) once a month. Children were weighed; pregnant, lactating and elderly women were given take away ration. The most popular issue around which awareness had been generated by the VHSNCs was cleanliness. For this committees organized cleaning of *Naula*, drains and *Jhaadi Kataan* (trimming of shrubs). Hemoglobin testing camp was organized with the help of intervening NGO. VHSNCs of Simayal, Ramgarh block was one of the active committee, it was led by a woman Gram Pradhan who was aware of committee activities and herself took many initiatives along with NGO's help. In Simayal, permanent *Khudadaan Peeth* (garbage bins) were constructed. Rallies were organized with school children to create awareness about the importance of cleanliness in the village. Committee members motivated people to maintain cleanliness and promoted the use of toilets. '*Sachal Ki Gadi*' initiative, committee members wrote a letter to CHC (Community health centre, Ramgarh), requesting for a mobile clinic; now a van now comes every month for check up of pregnant women. The mobile van comprised of required basic testing facilities and a doctor. Chlorine tablets were purchased and added in *Naula* (harvested spring) to improve the water quality.

***Challenges faced by the committee*:**

VHSNCs are founded on the principles of transparency, participation and bottom up approach. The power to take decisions and make changes lies with the people; however in reality the committee faced many challenges which hampered their smooth functioning. VHSNC members had never received any training or any guidelines from the government. It was only in villages where NGO intervened few members of the committee were trained. No orientation/training to members regarding their role, responsibility, functioning and objective of VHSNC resulted in a non – focused, scattered approach. Only selected members attended meetings, it was observed that government employees like school teacher, ANM, representative from water department hardly were present for the meetings. Committee did not receive untied funds since 2012- 13, this made them less active as they was no pressure to spend funds. This year only Rs.700 was credited in the committees account on the other hand Rs.500 was spent by ASHA to open the account. The committee members felt Rs.

10,000 was very less to bring any substantial change at the village level at least Rs. 50,000 per year was desired to make a visible change.

Conclusion :

Irrespective of government efforts to reach the last mile over the years to ensure quality of health to all; there are lacunae in the public health system. Though presence of public system can be seen in difficult terrains but from a community's perspective it's a mix of both the systems which is working for them. 24 hour availability, quick recovery, heavy dosage, local touch, lack of availability of resources and peripheral staff in public health system were few reasons which made Bengali doctors heroes in the times of need. On the other hand presence of ASHA, regular round of immunization, reliable medical assistance in CHC and district hospital made public health system a reliable option in times of critical times.

VHSNCs came into existence with an objective to take collective action on issues related to health and its social determinants at the village level. They were envisaged as a local level community body under NHM, on the foundation blocks of decentralization and participation 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. In reality, the functioning of VHSNCs is not as smooth as it is expected to be. Though the composition, functioning, dynamics of every village committee are different but there are some lacunae's which are common and serve as obstacles in reaching their full potential. It was noticed, in villages where few members took initiative, performed their duties and understood the power of committee did work irrespective of regular flow of untied funds on the other hand there were also villages where members did not even meet for monthly meetings.

In the villages surveyed it was noticed that committee members had never been exposed to any formal training by the government, because of which full scope, power and potential of committee went unnoticed. It was because of the NGO's intervention that they were aware of basic guidelines and some of the members had received training. Since last two – three years the committees had not received untied funds hampering their functioning of conducting regular activities.

In villages where there was no NGO intervention committee members were yet to realize the potential and power the committee held. VHSNCs were considered either ASHAs or Pradhans domain. Lack of participation and ownership led to its charge being in few members' hand which resulted in poor functioning and more blame game.

Lack of monitoring and sense of convergence within the committee led to the members not realizing their roles and responsibilities. It was noticed that even committee members thought that its ASHA's sole responsibility to conduct and oversee the functioning of committee. It was noticed that members representing government departments, including Pradhan and chairperson of the committee (mostly woman Panch from SC community) did not participated or showed interest in the committee activities. All this led to pressure on handful of people limiting the scope of the committee to achieve what it is truly expected out of them.

Functioning of health systems at the micro level, level of sanitation and nutrition can be further improved if VHSNCs become active. They have a very important role of bridging the gap between public and government systems, all malpractices can come to an end and people could get better services through right channel. For instance it was seen that government employed pharmacist in SAD would charge high amount for treating patients in his private room (clinic) everyone knows that he is wrong but no one raises voice because they have fear of conflict and lack of options in times of emergency. In such a scenario VHSNC could come into play and make a difference which would benefit people in the long run.

With increased participation at the local level, change in attitude of all committee members, basic training to VHSNCs regarding its objectives, structure and functioning, regular flow of untied funds and support system can make changes visible and help them reach their full potential.

REFERENCES

Department of Health and Family Welfare Nagaland: Kohima . (n.d.). Retrieved October 10, 2014 from *http://nagahealth.nic.in/communitization.htm*

Evaluation Study of National Rural Health Mission (NRHM) In 7 States (2011)

Fournier, P. (2006). *Outpatient care utilization in urban Kerala, India.*

Ganatra, B., and Hirve, S. (1994). *Male bias in health care utilization for under- fives in a rural community in western India*, *72*(1), 101–104.

Ministry of Health and Family Welfare, Government of India. Chapter I: Overview of the National Health System. Report: Task Force on Medical Education for the National Rural Health Mission; p. 9.

Murthy, R./ Klugman, B. (2004): *Service accountability and community participation in the* context of health sector reforms in Asia: implications for sexual and reproductive health *services.* Health Policy and Planning, Vol. 19, Suppl. 1, p.: i78-i86.

Mubyazi, G. M., and Hutton, G. (2012). *Rhetoric and Reality of Community Participation in Health Planning , Resource Allocation and Service Delivery?: a Review of the Reviews ,* Primary Publications and Grey Literature, *1*(1), 51–65.

National Rural Health Mission (2005-2012). Mission document. Government of India. http:// mohfw.nic.in/NRHM/Documents/NRHM Mission document.pdf

National Health Policy 2002. (2002). New Delhi. Retrieved from http://mohfw.nic.in/ showfile.php?lid=2325

Oommen, M. A. (2004). *Deepening Decentralised Governance in Rural India?: Lessons from the People ' s Plan Initiative of Kerala.* Centre for Socio-economic and Environmental Studies, (11).

Pandey, A., and Singh, V. (2011). *Tied , Untied fund?? Assessement of Village Health and Sanitation Committee involvement in Utilisation of Untied Fund in Rajasthan*.

Pandey, R S. Communitisation: The third way of governance. New Delhi, India: Concept Publishing Company, 2010.

Preston, R., Waugh, H., Larkins, S. and Taylor, J. (2010). Community participation in rural primary health care: intervention or approach. *Australian journal of primary health*, **16**(1) : 4–16. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21133292.

Welschhoff, A. (n.d.). *Community Participation and Primary Health Care in India*.

World Health Organization. (1978). *Declaration of Alma-Ata: International Conference on Primary Health Care Policy, Alma-Ata.* USSR. Retrieved from http//www.who.int/hpr/NPH/docs/declaration

Websites :

mohfw.nic.in. accessed on 10.3.2016

nrhm.gov.in. accessed on 2.4.2016

uk.gov.in. accessed on 12.3.2016

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