REPORT

on

State Orientation on Community Action for Health

Organized by National Health Mission, Uttarakhand

Supported by AGCA Secretariat

Hotel Shubham, Patel Road , Nagar Nigam, Dehradun

15th and 16th of March, 2016

The Community Action for Health* is a key strategy of the National Health Mission (NHM), which places people at the centre of the process to ensure their health needs and rights are being fulfilled. It allows them to monitor the progress of the NHM interventions regularly in their areas resulting in active community participation and contribution towards strengthening health services.

The state of Uttarakhand to implement the Community Action for Health requested support from MoHFW, a team based at the AGCA Secretariat to provide technical assistance, which includes:

- Build capacities for implementation
- Develop and adapt guidelines, tools and communication materials
- Support to initiate and strengthen accountability mechanisms under NHM.

The Team from AGCA Secretariat arrived in the state on 14th of March, 2016 to conduct State Orientation on Community Action for Health from 15th to 16th of March 2016 the state welcomed Mr. Daman Ahuja and Dr. Narendra Gupta as resource person to facilitate state team and district teams from all 13 districts comprising of (Additional Chief Medical Officers- Garhwal Mandal, District Community Mobilizer, Block Coordinators).

The orientation started with introduction of resource persons followed by a ice breaking game for the participants which really helped in bringing all the participants on the same page. Mr. Daman Ahuja shared the agenda for the first day in and in his initial session he briefed all the participants on their curious question – What is actually AGCA?
He first discussed with participants the meaning of Accountability and got following feedbacks:

- Responsibility
- Participation
- Right Time
- Division of Work
- Division of responsibility

While explaining the accountability frame work (NRHM) and the following three prolonged approaches:

- External surveys
- Routine program monitoring
- Community based monitoring

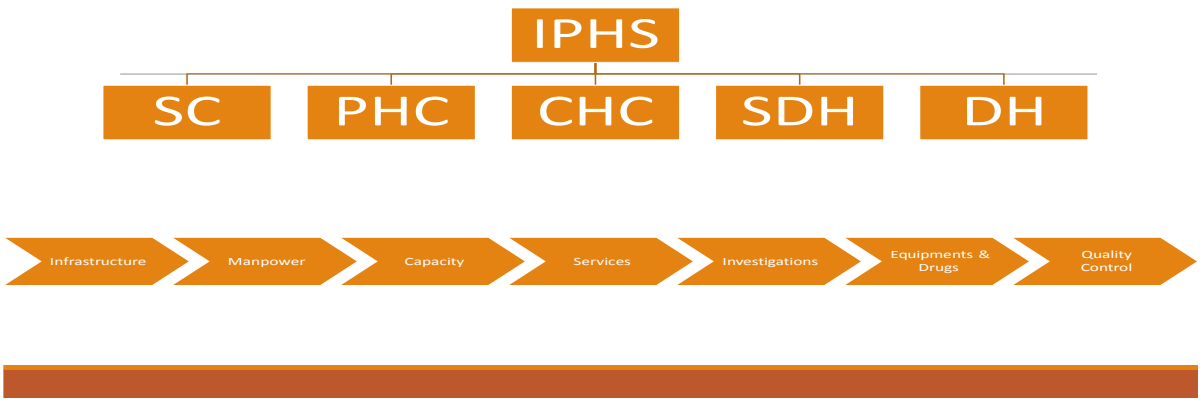
Further adding to this Mr. Ahuja said that AGCA is accountable to see whether services under NRHM/NHM are reaching to the last person or not? And the entire health system had evolved and improved to greater extent due to NHM. And the role of AGCA in this to advice, give feedback and replicate good models.

Mr. Daman Ahuja invited Dr. Narender Gupta to share "Right to Health and Health Entitlements of the people in context of - Service Guarantees at various level of citizen charter" . Dr. Gupta discussed about Rights mentioning that people should know their rights giving example of the disparity between Super Speciality hospital and the Rural Level Primary Health Care setup therefore right will be important for people deprived of basic Primary Health Care. He also spoke about the constitution of India giving many rights stating everyone should enjoy highest attainable level of health care for which the entire system has to be strengthened. He added Right to Live [Article 21] and everybody contributes to the society be it anybody so, water, education, health etc services should be provided to them and it should be provided by the specific secretariat of all states. And special emphasis should be given to the mass awareness for people to know that health services can be given free to them and it's their right under Right to health (Preventive, Promotive and Curative). Public health services are developed as per the demand. There are many programmes focuses on rendering various health services. The whole concept of right is to bring in the equity within the community. He shared the Social and Medical determinants and few indicators as follows:

- 25% Children are stunted, underweight
- Noth East of India has less IMR , MMR
- India GDP is 100 $ with 1.3 billion population
- China GDP is 170$ with 1.4 billion population
- United States of America GDP 300$ with .4 billion population.

After that Mr. Daman Ahuja reflected on the points shared by Dr. Narender Gupta and said "Awareness of Rights leads to Demand generation" after that he invited Dr. Nitin Bisht to speak about IPHS (Indian Public Health Standards).

Dr. Nitin Bisht first explained everyone what is Indian Public Health standards where he mentioned that IPHS are the set of standards envisaged to improve the quality of health care delivery in the country under the National Rural Health Mission since, the quality of services is not uniform, due to various reasons like non-availability of manpower, problems of access, acceptability, lack of community involvement, etc. He explained the entire structure of IPHS as following:



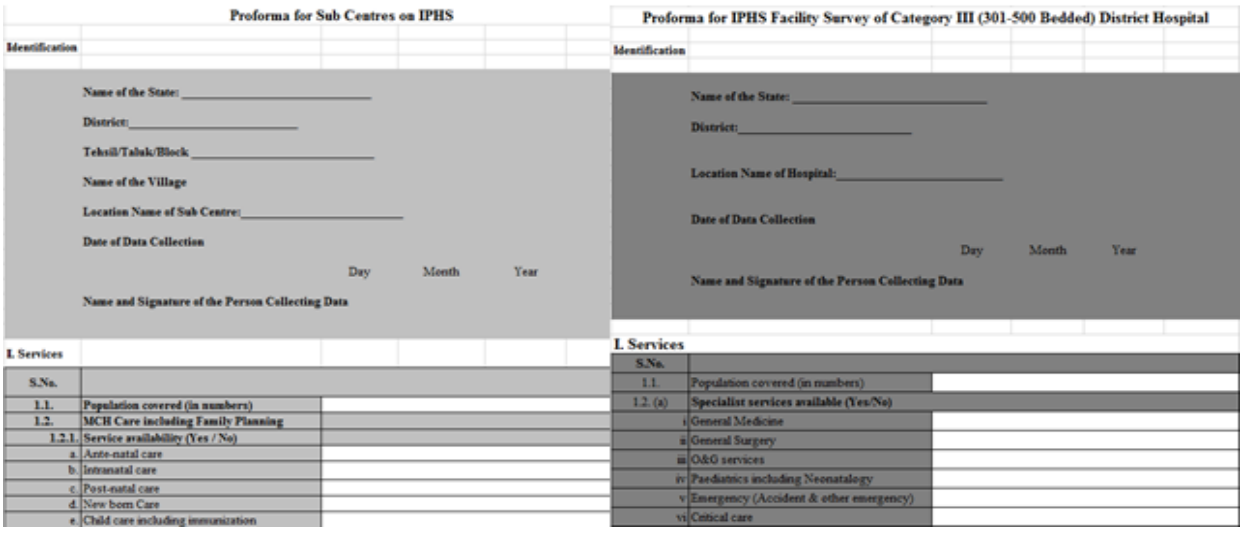
Dr. Nitin discussed about various facilities like Sub – Centre, PHC , CHC and District Hospital their Objectives and categorization as per IPHS as follows:

Sub Centre	PHC	CHC	District Hospital
As per population norms, there shall be one Sub-centre established for every 5000 population in plain areas and for every 3000 population in hilly/tribal/desert areas. Sub-centre should be located within the village for providing easy access to the people and safety of the ANM. As far as possible no person has to travel more than 3 km to reach the Sub-centre. The Sub-centre village should have communication net work (road communication/public transport/post office/telephone). Sub-centre should be away from garbage collection, cattle shed, water logging area etc. Visible Signage should be there.	PHCs should become functional for round the clock with provision of 24 × 7 nursing facilities. National Rural Health Mission (NRHM) provided the opportunity to set Indian Public Health Standards (IPHS) for Health Centres functioning in rural areas. Recommended for Primary Health Centre (PHC) came in early 2007.	4 PHCs are included under each CHC thus catering to approximately 80,000 populations in tribal/hilly/desert areas and 1,20,000 population for plain areas.	**Area and Space norms of the hospital** Land Area (Desirable) Minimum Land area requirement are as follows: ➢ Upto 100 beds = 0.25 to 0.5 hectare ➢ Upto 101 to 200 beds = 0.5 hectare to 1 hectare ➢ 500 beds and above = 6.5 hectare (4.5 hectare for hospital and 2 hectare for residential) ➢ Other Support Services ➢ Transport Services ➢ Separate Administrative and blood bank staff
Services at Sub Centre : ➢ Ante Natal Care ➢ Intra Natal Care ➢ Post Natal Care ➢ MNCI ➢ Immunization ➢ Village Health and Nutrition Day ➢ Home Visits ➢ House-to-House Surveys ➢ Community Level Interactions ➢ Coordination	A PHC Should give following services: ➢ OPD services ➢ 24 hours emergency services ➢ Referral services ➢ In-patient services (6 beds) ➢ Ante Natal Care ➢ Intra Natal Care ➢ Post Natal Care ➢ IMNCI ➢ Immunization ➢ MVA ➢ MMA	CHC is a 30-bedded hospital providing specialist care in ➢ Medicine, ➢ Obstetrics and Gynecology, ➢ Paediatrics ➢ Surgery, ➢ Eye Specialist services (at one for every 5 CHCs) ➢ Dental	Services at District Hospital: Essential : ➢ General Medicine ➢ General Surgery ➢ Obstetrics and Gynaecology services ➢ Family planning Services ➢ Paediatrics ➢ Emergency ➢ Critical Care/Intensive Care

and Monitoring ➢ Adolescent Health Care ➢ Family Planning and Contraception ➢ School Health Services ➢ Control of Local Endemic Diseases ➢ Disease Surveillance, Integrated Disease Surveillance Project (IDSP) ➢ Water and Sanitation ➢ National Health Programmes ➢ Promotion of Medicinal Herbs ➢ Record of Vital Events		➢ AYUSH ➢ X-ray & Blood Storage Facilities	➢ Anaesthesia ➢ Ophthalmology Desirable: ➢ Dermatology and Venerology ➢ Radiotherapy ➢ Allergy ➢ De-Addiction Centre ➢ Physical Medicine & Rehabilitation Services ➢ Tobbacco Cessation Services ➢ Dialysis Services

Dr. Nitin Bisht after discussing the above also shared the Performa for facility Assessment :

IPHS Performa for Facility Assessment



Proforma for Sub Centres on IPHS

Identification

Name of the State: _____

District:_____

Tehsil/Taluk/Block _____

Name of the Village

Location Name of Sub Centre:_____

Date of Data Collection

Day Month Year

Name and Signature of the Person Collecting Data

I. Services

S.No.		
1.1.	Population covered (in numbers)	
1.2.	MCH Care including Family Planning	
1.2.1.	Service availability (Yes / No)	
a.	Ante-natal care	
b.	Intranatal care	
c.	Post-natal care	
d.	New born Care	
e.	Child care including immunization	

Proforma for IPHS Facility Survey of Category III (301-500 Bedded) District Hospital

Identification

Name of the State: _____

District:_____

Location Name of Hospital:_____

Date of Data Collection

Day Month Year

Name and Signature of the Person Collecting Data

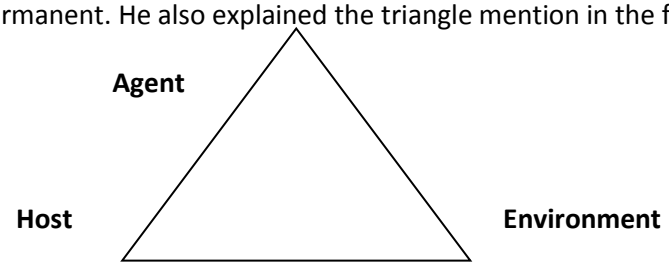
I. Services

S.No.		
1.1.	Population covered (in numbers)	
1.2. (a)	Specialist services available (Yes/No)	
i.	General Medicine	
ii.	General Surgery	
iii.	O&G services	
iv.	Paediatrics including Neonatalogy	
v.	Emergency (Accident & other emergency)	
vi.	Critical care	

Mr. Daman thanked Dr. Bisht for sharing the IPHS with the participants and also added that to aware others we as facilitators should know many things and IPHS was one of them after that he invited Dr. Nidhi – Assistant Nodal officer of ASHA Programme- Uttarakhand to share about VHSNC and Untied Fund where Dr. Nidhi mentioned that among the participants majority inclusive of District Community Mobilizer and Block Coordinators have already been trained in the VHSNC recently so there will be more like discussions on that she started discussing the composition and formation of VHSNC. She also discussed about the reestablishment of VHSNC and also discussed about how the reestablishment of VHSNC is desired. Further she discussed about the need of VHSNC to cater to health and sanitation of the community, she reflected to the morning session of Dr. Narendra Gupta on "Right to Health" and Government is responsible to full fill those rights.

After that a movie on VHSNC was shared with the participants and discussion was build on the same where Public Health Committees were discussed comprising of State Health Society, District Health Society, Rogi Kalyan Samiti and last but not the least Village Health and sanitation Committee and Utilization of Untied Fund and the purpose of the same was discussed which was not simply to spend it but to use as a catalyst for health planning and for executing the plan. The use of untied fund , Management of Untied Fund, maintaining record etc was discussed with the participants and since majority of the participants are implementing the same in their respective districts and blocks very health discussion was build up.

In the end of the first day of the State Orientation programme Dr. Narendra Gupta shared about access and barriers to health in context of determinants of Health where he first explained about Hardware facility as building infrastructure , instrument facility and appliances , Human resource, electricity water etc and things that are attached to it like Behaviour, accountability, work culture, monitoring/supervision, motivation, feedback, advocacy, capacity building, attitude, liasoning and networking. He also mention that even if there are limited resources those limited resources are not used optimally and if anyone has a attitude he will learn , gain knowledge and use the limited hardware optimally and again our job as facilitators is not to see deficiencies but to get some results, Change in attitude is always permanent. He also explained the triangle mention in the following way:



He also explained about the normalessness of the beneficiaries as they are generally from the poor background so there is a sense of hopelessness, powerlessness leading to normalessness he also mentioned that perceptive barrier can play a very vital role in presuming barriers stating to this he mentions that the community should be strengthen enough to maintain transparency and make the system to identify the issues. He discussed about Gender related barrier and mentioned that barriers should not be a hindrance they are many dynamic barriers though. He ended his thought provoking session with the note on Quality of life.

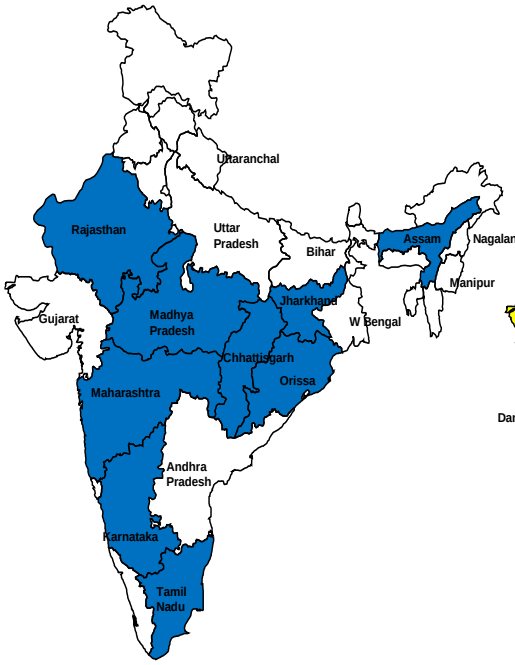
With this the first day state orientation programme on CAH was over.

The day two of the State Orientation programme on Community Action for Health was started by the Nodal officer – ASHA Programme where she discussed with the participants about their learning of the previous day where all the participants interacted and participated well. Followed by the meditation session by Mr. Daman Ahuja which indeed created positivity among the participants . Mr Daman Ahuja welcomed the new participants i.e the Additional Chief Medical officers from Kumaon Mandal after that Mr. Dinesh (DCM- Pauri), Sunil (BC- Pauri) and Sunil (BC- Uttarkashi) did a recapitulation session of the previous day. Mr Daman Ahuja briefed about the second day agenda and further took the session on AGCA and Accountability in detail:

While explaining about AGCA Mr Daman Ahuja mentioned that **Advisory Group on Community Action (AGCA)** is a Group of civil society experts constituted by the MoHFW in 2005 with Population Foundation of India (PFI) as the Secretariat. And its mandate is to **Advise** on developing community partnership and ownership for the Mission, **Provide feedback** based on ground realities to inform policy decisions – community monitoring , Common Review Mission (CRM) and fact finding missions **Develop models** on community action and **recommend** for further adoption/extension to national and state governments. He also shared the following coverage of the CAH programme as well as technical support at the National level:

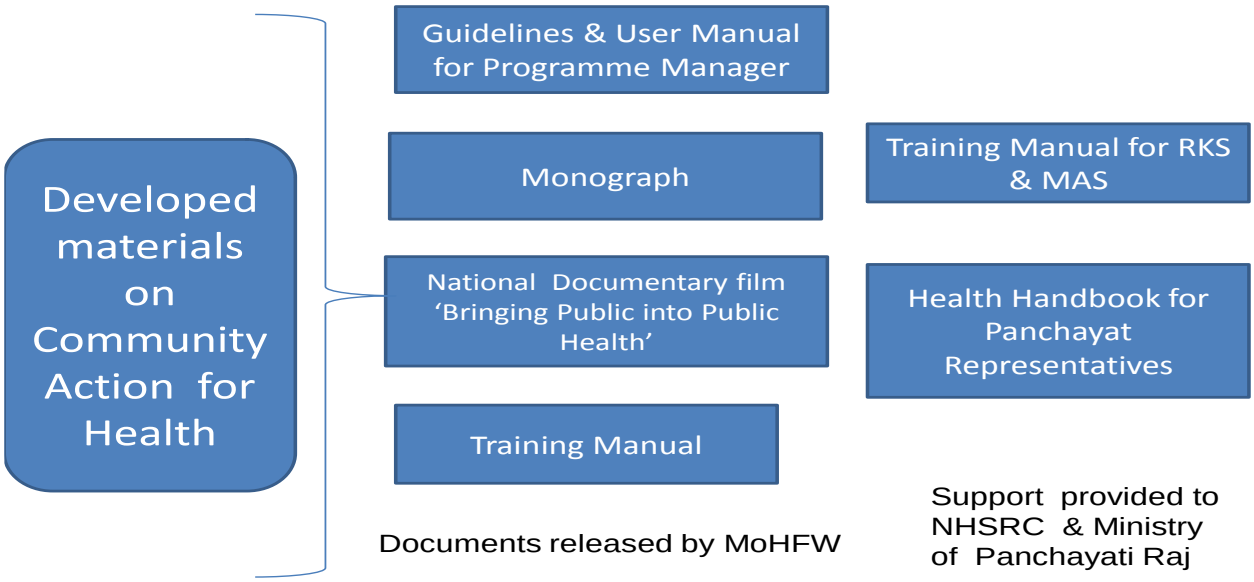
Coverage

Pilot Phase (2007-2009) - 9 States



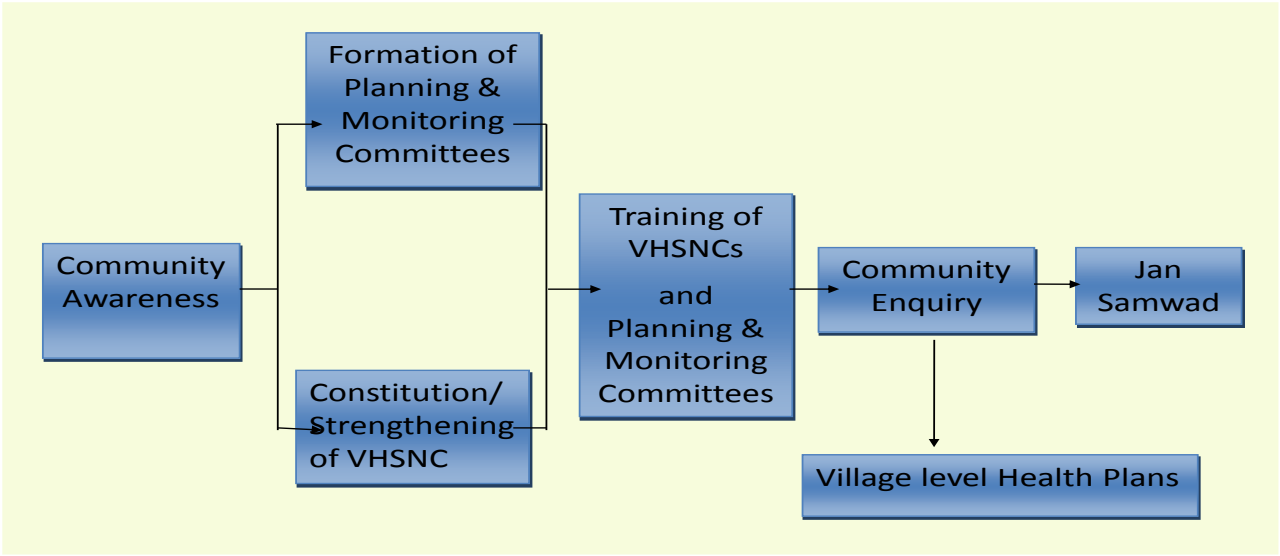
2015-16 - 22 States

Technical Support: National Level

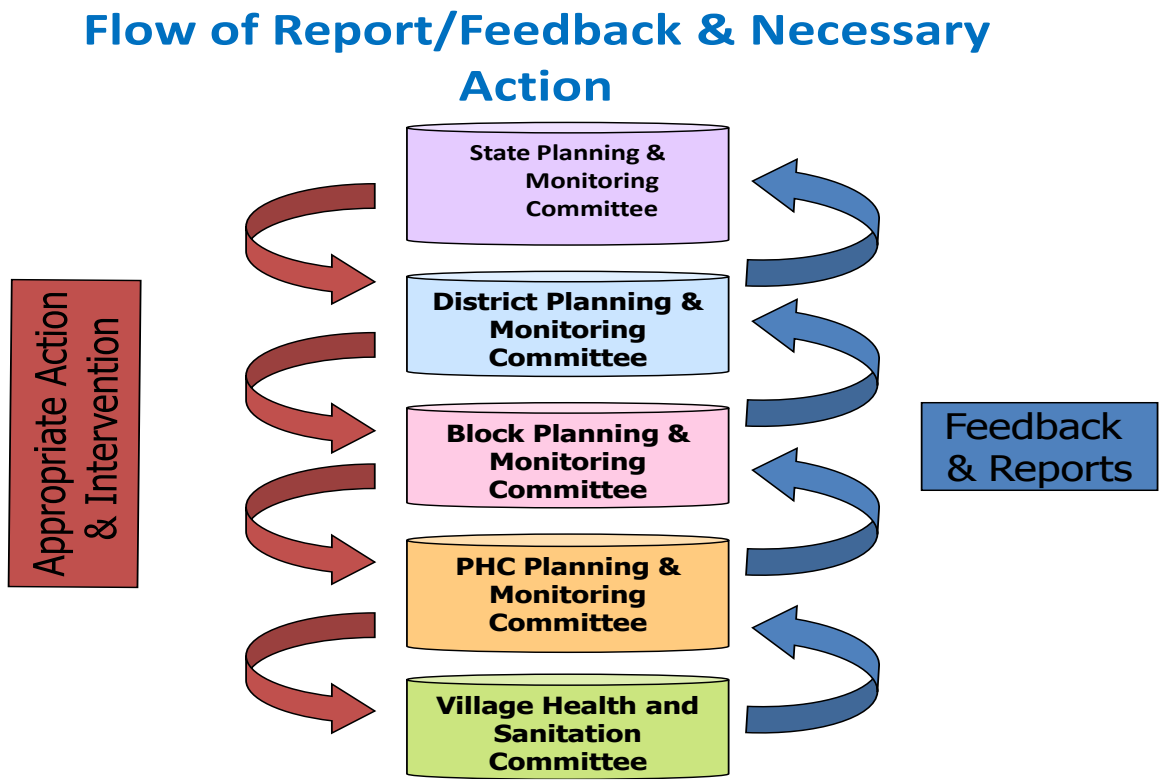


Mr. Daman Ahuja explained why we need community Action for Health? He showed all the participants the movie on Community Action for health and later build the discussion where participants said that after seeing the movie they are motivated and they feel "We Can Do it". Later Mr Ahuja shared the key features on Community Action, he shared the process of community Action:

Community Action for Health Process: Key steps



He also explained the flow of report/feedback and necessary Action :



Then he discussed about Roles and Responsibilities of Key stake Holders, District Community Mobilizer, Block Community Mobilizer, Additional and Chief Medical Officer. Mr. Daman Ahuja shared Community Action for Health Tool where he facilitated the participants that the Tool is meant to enable community representatives understand service delivery standards, entitlements and service guarantees and the community action for health has two sets of tool (a) For the community (b) For the health facility consisting of three levels- 1,2 and 3.

The community Level tool was :

Data collection and its methodology: Community level tools

S. No.	Tool	Methodology	Respondents	Number	Format Number
1	Maternal health services	Individual interview	Mothers who have delivered in the last six months	5 per village (3 from marginalised and 2 from general population)	Format No-1
2	ASHA	Individual interview	ASHA	all ASHAs in a village	Format No-2
3	Adolescent health	Focus Group Discussion	In-school and Out- of- school children of 11-19 age group (8 per group). mixed group	1 per village	Format No-3
4	Village health	Focus Group Discussion	A mixed group of 10-12 men and women	2 per village (one from marginalised and one from the general population)	Format No-4

Data collection and its methodology: Community level tools

S. No.	Tool	Methodology	Respondents	Number	Format Number
5	Child health services	Individual interview	Mothers of children aged 0-2 years	5 per village (3 from marginalised and 2 from general population)	Format No-5
6	ICDS Services	Focus Group Discussion	Mothers of children in age group 0-6 years	1 per village (one more group if there is a marginalised group)	Format No-6
7	Anganwadi Centre (AWC)	Individual interview/ Observation	AWW	1 per AWC	Format No-7
8	Mid day meal and school health programme	Focus Group Discussion	5-10 students	1 per school	Format No-8

Facility-level tools

S. No.	Tool	Methodology	Respondents	Number	Format Number
9	Sub Centre	Individual Interview/ Observation	ANM	1 per sub centre	Format No-9
10	Primary Health Centre (PHC)	Individual interview/ Observation	Medical Officer	1 per PHC	Format No-10
11	Community Health Centre (CHC)	Individual interview/ Observation	Senior medical staff	1 per CHC	Format No-11
12	Exit Interview at facility	Individual interview	Patient/attendant	5 per facility- include at least three women	Format No-12

Mr. Daman Ahuja explained to the participants how the tool will be used stating Community level formats will be administered by VHSNC members, Facility level formats will be administered by the members of the PMCs of the respective facility at each level.

For each question, response will be coded as follows:

- Good –Green-
- Average- Yellow
- Poor– Red.

The data will be collected in a abovementioned manner and will be compiled by the VHSNC or planning and monitoring committee members The scores derived from the formats will be

collated and presented in a report card. After village report card has been formed for each village; they are collated by the members of PMCs at PHC, block and district levels. And the collation criteria will be as follows:

Collation Criterion

Criterion	Final color
Number of boxes ticked GREEN is more than 75%	GREEN
Between 50 to 74% tick marked GREEN; Or If number of GREEN are less than 50% but total number of GREEN and YELLOW are more than those ticked RED	YELLOW
The total number of GREEN and YELLOW are less than the number of RED	RED

A detailed discussion was done on Jan Samwad which was explained as an opportunity for dialogue between the community and service providers. Jan Samwad will be conducted at block and district levels and a brief way forward was shared: District Orientation for all line departments, ASHA Facilitator training and VHSNC Training and Meeting.

After that all the participants were divided in three groups and were asked to prepare a Village Health Action Plan with respect to the individual case study that was given to them in the following structure:

- Gaps
- Reason for Gaps
- Possible Solutions
- Responsibility
- Time line Support Required

All the participants presented their respective role play and shared the Village Health Plan that they had developed.

Later the participants were asked to sit district wise and develop their work plan reflecting the activities, timeline and support required. Most of the District was of the opinion that with the optimum support they will be able to finish the Orientation Workshop on Community Action for Health at District level will be completed by April 2016 and the entire programme will get streamlined after that with formation of monitoring and advisory committee at District, Block level

followed by VHSNC. With this Mr. Daman Ahuja consolidated the entire workshop and the Vote of thanks was given by state representative.





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