Building Community-Based Leaders

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Background

Ever since independence, Bihar has been known for its poor social development and health indicators, caused by poverty, illiteracy, lack of political will, poor health infrastructure, weak implementation structures, and shortage of trained health personnel. In particular, the high infant mortality rates and maternal mortality ratios in the state have attracted the attention of development organizations and government agencies alike, but appropriate resources have been inadequate to address these problems satisfactorily.

While the launching of the National Rural Health Mission (NRHM) made it a priority to improve health standards for the rural population throughout India—especially the most disadvantaged groups, including women and children—the existing system was not able to deliver established services effectively to intended recipients. With proactive efforts clearly needed to promote decentralization and facilitate community ownership and authority to demand services, community-level leadership was identified as the missing link to bridge that gap.

Scope of the Project

Following an initial study, IDF conceived a program to create grassroots community leaders from the district to the village levels, drawn from a wide range of community stakeholders—accredited social health activists (ASHAs) (through NRHM), Anganwadi workers (AWWs), auxiliary nurse midwives (ANMs), members of Panchayat Raj Institutions (PRIs), youth, and self-help group (SHG) members—covering 100 *panchayats* (local councils) in 10 blocks in the districts of Patna, Muzaffarpur, and Vaishali.

Goal

The goal of the project was to build leadership capacity at the community and local self-government level, thereby strengthening the government health system and furthering the larger NRHM goals of reducing infant mortality rates and maternal mortality ratios, guaranteeing universal access to public health services, and stabilizing the population and gender balance.

Objectives

- To develop 400 community leaders to act as a link between members of their community and NRHM institutions.

- To build the leadership, organizational development, and capacity of the PRIs and/or village health and sanitation committees (VHSCs) in the target communities.
- To expand the ASHA program in order to improve access to health care at the household level.

Activities

Induction of IDF staff

Staff from the community leadership program (CLP) and other programs led a two-part workshop to help IDF project staff understand the CLP's organizational mission and objectives. The workshop was designed to provide the staff with information about all ongoing programs and to design collaboration strategies for the most efficient implementation of the CLP. IDF's chairman and director also participated in the workshop.

Environment-building workshops

Ten block-level workshops were held in all three districts to establish a conducive and supportive environment for the project among the various stakeholders and to sensitize them to the role community leaders would play. All 10 workshops focused on the NRHM and the role of leadership. Stakeholders such as the block development officer**,** welfare officers, *mukhiyas* (village heads)**,** NGOs, ANMs, ASHAs, and Integrated Child Development Services (ICDS) workers participated along with regular community members in the workshops and question-and-answer sessions.

Orientation at the community level

To ensure maximum community participation in the task of developing effective strategies and building leaders, IDF held orientation programs in all the *panchayats.* Major community-level stakeholders—such as PRI and VHSC members, ward members, ASHAs, ICDS workers, ANMs, members of self-help groups (SHGs), and community members—participated in these programs. Project staff familiarized the community with the program objectives and the role of community leaders in promoting universal access to health services.

Group discussion on communication ability and volunteerism

To test the trainees' communication ability and willingness to volunteer, a group discussion process was organized. Each group discussion used a checklist to assess the level of the trainees' positive attitude and communication skills. All of the designated leaders were able to respond well to questions related to their day-to-day life and surroundings, demonstrating their fitness as leaders with the right spirit to strengthen their community.

Selection of community leaders in *panchayat*-level open meetings

Village-level meetings were organized to involve community members in the selection of those to be trained as leaders. Following initial briefing by IDF staff, participants then set their own criteria for the selection process, which was completed democratically through nominations

and voting. After community members submitted a total of 1,234 nominations, 743 community members (475 women and 268 men) were chosen, with 400 (four from each *panchayat)* selected for final leadership training.

Training of community leaders

A comprehensive, 30-day residential training module was conducted at the district level. The 400 participants were drawn from four key groups in all 100 *panchayats*: PRIs, ASHAs, SHGs, and youth. The module comprised five separate units: (1) understanding community and volunteerism; (2) leadership and effective communication; (3) NRHM and reproductive and child health; (4) participatory community planning and (5) monitoring and evaluation. This major activity was designed to train the potential leaders to act as change agents. In the reported year, only the first three units were covered.

Follow-up of community leaders

IDF began its follow-up immediately after the first unit of the residential training model had been carried out, so that feedback could be incorporated into forthcoming sessions. Using a checklist, staff assessed the trainees' retention of the material, potential initiative in taking action, and problems experienced in training. The follow-up was carried out using a checklist developed for the purpose.

Networking with stakeholders

Networking and liaison activities were a major component of the CLP. From the outset, liaison activities were carried out with various stakeholders—block-level health and ICDS officials, PRI representatives, SHG members, village-level leaders, and the community—through personal contacts and group meetings. In addition, stakeholders from all sections were invited to block-level workshops conducted at each operational development block, and local NGOs and district-level health officials were also contacted. Project staff also cultivated good relations with district-level government agencies and successfully solicited other organizations involved in rural development, such as Hariyali, to express their support for the program. Given the key role of media in sensitizing the stakeholders, IDF regularly informed media representatives of all the block conventions to help generate awareness of the CLP in the broader community.

Outcomes

Following is a selected list of outcomes of the intervention for the reported year:

- Altogether, 228 community leaders completed the first cycle of the training module.
- Follow-up was conducted with 179 of those who completed the training module.
- VHSCs that had lapsed were reconstituted.
- ICDS centers that had been open irregularly or closed completely began to function properly.

Achievements and Challenges

The major achievement of the CLP program is the training of 400 new community leaders who now advocate on a sustained basis in the areas of reproductive health and family planning. This newly created grassroots level of leadership has established the crucial missing link between government service providers and community members and has made considerable headway in bridging the gap that previously existed between these two elements. Block- and village-level health officials have become much more sensitive to the needs of their community constituents and appreciative of the community leaders' active promotion and dissemination of key information about the services they provide. As a result, community members' use of public health services has significantly increased. The community leaders are also communicating basic reproductive health information effectively throughout the community, and although the long-term effects cannot yet be measured, the outlook is promising. Through the new framework of community leaders and newly established links to NRHM institutions, IDF has significantly strengthened the effectiveness of those institutions.

Despite all these gains, health infrastructure weaknesses at the state level remain, which continue to make it hard for government health providers at the local level to deliver the services they are mandated to offer.

Case Studies

Leadership initiative for water and sanitation

After completing the first training unit, Dharamshila Devi of the Sadallichak village in Bheloara, Dariapur, swung into action. The president of a women's SHG group in her village, she started promoting health and hygiene awareness among her neighbors and other SHG members. After observing the unhygienic condition of the government-provided hand pump in her *tola* (hamlet), which for a long time had contained stagnant water and waste on the platform, she convinced the women users of the hand pump of the health risks of this situation and persuaded some of them to help clean the hand pump platform and surrounding area, and also to channel the waste water to a distant place. The condition of the pump is now being monitored regularly and is no longer a threat for waterborne diseases.

Assertiveness yields results

When Nutan Kumari, of the village of Baradih in Katra *panchayat,* was trained as a community leader, she very soon found the opportunity to put her training to use. One ASHA worker told Nutan that she was being paid only Rs 300 for attending deliveries, just half the incentive mandated by the government. In addition to being a clear violation of regulations, this underpayment was demoralizing to all ASHA workers. Nutan marshaled her new community leadership skills and went to the Katra PHC to complain about this improper conduct and to find out who was behind it. When she discovered the accountant responsible, he succumbed immediately to the community leader's pressure, apologizing profusely and asking her not to

divulge his misconduct to his superior. He pledged not to withhold payment from ASHA workers in the future.

As a result of this simple act of assertiveness by the community leader, ASHA workers of Katra block now receive the full incentive of Rs 600 per delivery. According to Nutan, it was the confidence and knowledge she gained during the CLP training that motivated her to take action.