Creating Sustainable Action on Community Health

Project coordinator: Anju
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Background

Rural Bihar has long been known for its lagging health indicators, and despite the existence on paper of a wide range of national and state government health services and benefits, members of backward and particularly deprived communities simply do not have access to them in practical terms. There are two main reasons for this yawning gap between theory and practice. First, these communities have historically not viewed themselves as equally entitled to the programs that other citizens enjoy; second, those tasked with providing the services have at best been lackadaisical about their implementation and in many cases have diverted resources for other uses. In the effort to close this gap, two of the most important aspects of health care to focus on are women's reproductive health (RH) and child health care.

Scope of the Project

In this five-year project, funded by Simavi, IDF developed and implemented interventions in a total of 50 villages covering two blocks in the Patna district—32 in phase 1 and 18 in phase 2.

Goal

The long-term goal of the project was to improve the health of backward communities in sustainable ways, with a special focus on women's reproductive health.

Objectives

- To introduce and promote health education measures.
- To mobilize the targeted communities to claim their right to health services and information.
- To encourage the adoption of good health and hygiene practices in the targeted communities and thus prevent the spread of common diseases.
- To establish an effective nearby health delivery system.
- To ensure safe childbirth and regularize routine immunizations.

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Activities

Training

After identifying 55 self-help women’s groups (SHGs) in the target areas based on criteria such as distance from the primary health center (PHC), presence of excluded communities, and so

on, staff mobilized SHG members on RH and child survival issues (like immunization). Next was the training for the project team: how to identify SHG members who could be village health workers (VHWs) and orient them. VHWs subsequently underwent a five-day training. Later, traditional birth attendants (TBAs) and rural medical practitioners (RMPs) were also given training. The VHWs were given a three-day residential refresher course nine months later.

Health Kit

Health kits with basic drugs and supplies were created for community use. Even though RMPs were working in many villages, getting just one tablet for a headache late in the evening, for example, could be difficult and costly. The health kits solved this problem. They all contained simple, nonprescription remedies for headaches, colds, fever, indigestion, minor cuts, and general aches and pains, as well as anti-fungal skin ointment, oral rehydration salts, family planning items, and blades and thread for use in safe deliveries. Pictorial sheets were developed and provided to VHWs showing which item was to be used for each health condition. A system for replacement of supplies was set up, and a register was also used to record symptoms, drugs given out, and cash collected.

Community-based meetings

SHG meetings. Existing SHGs, which had already proved their sustainability, were used as a platform for the promotion of health education measures in weekly meetings.

Newly married couples (NMCs). Project staff began to identify NMCs and mothers of children under six who could be addressed in groups. After door-to-door visits and interviews, a total of 28 NMC groups were established. Regular NMC meetings were held to explain and discuss the importance of spacing and family planning methods, to educate husbands and wives to recognize the symptoms of reproductive tact and sexually transmitted infections and to seek treatment, and to promote routine childhood immunizations.

Government health workers. Auxiliary nurse midwives (ANMs) and Anganwadi (health center) workers (AWWs) were trained and encouraged to promote RH, family planning, birth registration, routine immunizations, and health kits. The IDF health team mobilized the community and helped ANMs in many practical ways, ensuring that they visited the villages on schedule.

Block-level government health officials. A workshop and annual meeting were held.

Capacity Building

The women of the community attended various exposure trips and workshops. Field workers, especially those at the cluster level (who are from the local community), received many additional capacity-building inputs. The results were reflected in their improved ability to document and report their work, as shown in the registers and management information system formats and well-documented case studies from the field. Their capacity to conduct

meetings and follow-up improved dramatically over three years. Methods used in these trainings were participatory.

Solidarity events

On International Women's Day 2010 a symposium on "Women's Empowerment and the Future of the Community" was organized for more than 200 participants from different villages. Community leaders spoke, and youth volunteers helped organize a quiz, song, and speech competition. Similar events were organized for World Breastfeeding Day, Safe Motherhood Day, and International HIV/AIDS Day. Government health officials and Panchayat Raj Institution officials participated in many of these sessions.

Awareness-building activities

Information, education, and communication (IEC) materials were developed to spread specific health messages throughout the targeted communities in ways that worked even for illiterate or semi-literate populations. Wall writings, *nukkad nataks* (street plays), and audiovisual shows were the main methods used. All of the IEC materials focused on the disadvantages of population growth, the importance of prenatal checkups and breastfeeding, and the right of all community members to information and services.

Outcomes

Following is a selected list of outcomes of the intervention for the first three years:

- 55 SHGs acted as a pressure group, mobilizing to promote routine immunizations, and were a convenient venue for IEC initiatives.
- 28 NMC groups promoted family planning and child immunizations.
- 55 trained VHWs provided simple remedies for common health problems from a self-managed health kit.
- 36 TBAs (one per village) were trained in carrying out safe deliveries.
- 26 RMPs were trained to improve the level of health services they provided.

Achievements and Challenges

Community awareness on health issues, especially RH and preventable children's diseases, improved considerably as a result of the intervention. Immunization rates increased. It is a significant achievement that in a setting where literacy among women is very low and pressure of day-to-day survival very high, mothers were now able to understand what is good for them and their children. SHG members' attitudes and perceptions changed markedly: they began to come forward both to play a more active role in the project-related activities and to demand their due entitlements—for example, sterilized syringes. This change in turn galvanized the government health workers (AWWs, ANMs,) to raise their standards. Although at first many mothers-in-law didn't allow their daughters-in-law to go to NMC meetings, gradually the older women were won over, and both sides discussed problems more openly.

Despite all these accomplishments, many challenges remain. Among other constraints, lack of literacy, poor livelihood options, and low social mobility among women make social change in these villages a slow process. Because the villages remain divided along caste lines, selection of a volunteer or of a place to conduct the meeting has to be considered in this light.

Case Studies

Behavioral change in the community

Pushpa Devi, 20, of the village of Baank in the Maner block in Patna district, was married in 2009 to Akhilesh Ram, whose first wife had deserted him. She later left her husband's house and returned to her parents' home, unwilling to go back to her in-laws' place. However, the other SHG members, including Pushpa's mother, eventually persuaded her to move back to her in-laws' place, telling her that in no circumstances should a woman leave her husband's home, or else she is doomed to social condemnation.

When she got back there, however, her in-laws were not ready to let her in, as she had left without informing anyone, but after the SHG members threatened to file a complaint against them at the *mahila aayog* (women's development center) and the police station, they reluctantly admitted her. The very next day Pushpa returned back to her parents once more. Finally, she told her family that she was not willing to stay with her husband because he was impotent, and she also mentioned that this was the reason his first wife had deserted him.

Members of Pushpa's family even spoke to Akhilesh Ram about it, but he refused to talk. Then the SHG members sought guidance from the project staff, and at a meeting it was decided that Pushpa had the sole discretion to make a decision on the matter. The SHG members then asked the in-laws to return the dowry that was given to them, at which point they said they would take the matter to the *panchayat.*

The *panchayat* was held, the entire issue was brought to light, and after Pushpa stood up and briefly explained her predicament, the *panchayat* ordered her in-laws to return all material given to them as dowry. Pushpa is now living happily with her parents again and looking forward to a better life.

Caste system still casts a shadow

One reason the poor are reluctant to use government health services is that caste-based attitudes, practices, and discrimination still survive among these providers, particularly in rural areas. When IDF staff discovered that Nema Devi's son-in-law, Shambhunath, had been suffering from a fever for 15 days, they advised her to take him to the government hospital immediately, but she was not willing to go. A project field worker somehow persuaded her and accompanied them to the hospital. Later, it came out that Nema greatly feared the dominant Yadav community, which included government doctors. Thus, although the public health center

is not far away from the village, people like her just don't go there, because they fear the dominant caste and believe they will be on the receiving end of discriminatory behavior by some staff. In this particular case, the IDF activist accompanied Shambhunath, who received appropriate treatment from the doctor and began to recover in a few days. Caste-based discrimination remains a frequent reality, however, even in public services.