

Best Practices at MGIMS Sevagram

1. Title of the Practice

Community Mobilization for Health Action

2. Objectives of the Practice

The Department of Community Medicine, MGIMS, Sevagram engages in community mobilization with the following objectives:

- To mobilize and empower community networks (with focus on women) for leadership in health
- To create platform for community dialogue in health
- To catalyze partnership between health and ICDS sector on one hand and Panchayati Raj Institutions, Village Health Nutrition and Sanitation Committees and other Community-based Organizations on the other hand for health gains

3. The Context

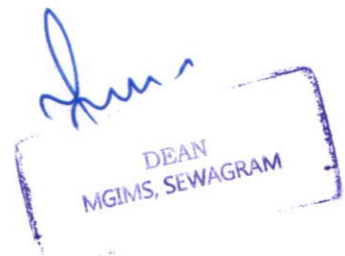
Community Participation is a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change. It is an active two-way process that may be initiated and sustained both by individuals and community and by local authorities, health authorities and other local organizations.

A high level of community participation is very important for any programme to succeed. Under NRHM, several strategies were included to get a high degree of community participation in health. However, implementation of these strategies has been extremely poor in most of the states of India.

The Department of Community Medicine at MGIMS, Sevagram, is working with community-based organizations in more than 80 villages in Wardha district for almost two decades and has developed a model of community mobilization for health action.

4. The Practice

Over the last two decades, in the field practice area of MGIMS, Sevagram, a strong community network has been developed. The process of development of community network started with community mobilization and formation of community-based



organizations. In an average-sized village a minimum of 3-4 women's self-help groups (SHGs), one 'Kisan Vikas Manch' (KVM - Farmer's Development Association) and one 'Kishori Panchayat' (KP - Adolescent Girls Forum) was constituted. These community-based organizations were oriented on health issues in the rural areas through discussion held during their monthly meetings. Later, Village Co-ordination Committee (VCCs) was constituted in every village by including representatives from each of these community-based organizations, Gram Panchayat, village informal leaders and frontline workers from health and ICDS.

The community-based program operated through the Village Co-ordination Committees (VCCs), thus constituted. These village committees entered into an agreement under this project where the VCC will ensure provision of essential maternal and child health services to the villagers, while MGIMS, Sevagram took responsibility to build capacity of these committees and develop tools and techniques for community-based activities to be done by the committees. With strong and sustained capacity-building in form of regular handholding for more than a year, the VCCs could take charge of community-based activities at village level. In most of the program villages, the VCCs participated in assessment of community health needs, developed village health plan, implemented the activities decided in coordination with other stakeholders, and monitored the community-based health activities in their respective villages. The community networks were especially effective in disseminating health messages in the village and for creating new social norms.

When guidelines for formation of Village Health Nutrition and Sanitation Committees (VHNSC) were issued by Government of Maharashtra under NRHM, we engaged with them and worked to build their capacity. Currently, we are working in more than 80 villages in Wardha. There are total 275 Self Help Groups and 89 Kishori Panchayats functional in the three PHC areas adopted by the department of Community Medicine. We also conduct Kiran clinics (Community owned health clinics) in 26 villages.

5. Evidence of Success

The following table shows the changes observed endline and compares it with baseline level:

Table: Change in MCH indicators from baseline to final estimate after implementation of CLICS (Community-led Initiatives for Child Survival)

Indicators	Baseline Estimate 2004	Final Estimate 2008
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% mothers of <1s receiving ANC package (at least 3 visits, 2 TT, consumed 100 IFA tablets)	11.6%	58.9%
% of husbands aware of at least 3 pregnancy danger signs	13.2%	42.2%
% mother of <1s delivered in health facility	72.8%	90.7%
% children <3s with at least 36 months interval after previous surviving child	29.3%	49%
% of children born Low Birth Weight	29.4%	25%
% mothers of <1s initiating breastfeeding within 1 hour:		
- knowledge/awareness	0.6%	68%
- practice	0.9%	67.9%
% mothers of <1s knowing at least 3 newborn danger signs	11.3%	94.2%
% of children (12-23 months) fully immunized	62.4%	98%
% of children (12-35 months) received Vitamin A dose in last 6 months	53.6%	98
% mothers of <3s knowing at least 2 signs of childhood illness requiring treatment	29.5%	98.5%
% of <3s suffering from diarrhea in last 2 weeks who received ORS/HAF	6.8%	62.2%
% of <3s -3 SD from the median weight for age	22%	11.6%

We also assessed maturity of Village Health Nutrition and Sanitation Committee using institutional maturity index specially designed for this purpose; it changed from first phase to the next phase. It changed from 58 to 77.

Several innovative activities have been initiated by the community-based organizations in every village of the program area.

6. Problems Encountered and Resources Required

Some of the challenges, we encountered in the process are:

- To bring people together from different socio-economic groups
- Community groups require a lot of initial “hand holding”
- Difficult to introduce health as a priority in their lives
- Bringing on board health department, ICDS and PRI is challenging
- Sustaining the motivation and enthusiasm of community-based organization in absence of funding support


While we were developing this program, we required a trained community organizer (a social worker) for every 4-5 villages. We also required provision for capacity building of community-based organization. For sustaining these activities, a social worker for 10-15

villages may do. However, what is more important is the community contribution of resources, mainly in terms of their time and interest.

7. Notes

We acknowledge the support provided under various projects from Aga Khan Foundation (India), Aga Khan Foundation (USA) and USAID from 2000 to 2009. These supports were critical in developing the model of community mobilization for health action. After completion of Community-led Initiatives for Child Survival Program, MGIMS, Sevagram has made provision to sustain several elements of the initial program. Staff support under Phase III clinical trial on Bovine-Human Rotavirus Reassortant Pentavalent Vaccine (BRV-PV) from SIIL and PATH Vaccine Solutions and ICMR Advance Center for Community-based Research in Maternal, Newborn and Child Health been of great help.




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