

Waves of Change



CHETNA

For Women Young people Children

Acknowledgements

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CHETNA

For Women Young people Children

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New Delhi.

Our implementing partners



**Kutch Mahila
Vikas Sangathan
(KMVS)**



**Gramya
Vikas Trust**

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Lalbhai Rural
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Fund
(NLRDF)**



**Shroffs
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**Vedchhi Pradesh
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**Akhil Bhartiya Gramin
Utthan Samiti (ABGUS)**



ASSEFA



**Shikshit Rojgar Kendra
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**ALERT
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BODHGRAM**

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Introduction

The launch of the National Rural Health Mission (NRHM) in the year 2005 by the Government of India (GOI) is a welcome step towards improving the availability of and access to quality healthcare by people, especially marginalized communities like those residing in rural areas, the poor, women and children.

The Mission aims to carry out necessary architectural correction in the basic health care delivery system by increasing public expenditure on health, reducing regional imbalances in health infrastructure, pooling resources, integration of organisational structures, optimization of health human-power, community participation, etc.

To achieve the objectives of the Mission, the following core strategies have been included:

1. Enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
2. Promote access to improved healthcare at household level through appointment of Accredited Social Health Activist-ASHAs from amongst the local village women.
3. Health Plan for each village and community based monitoring of health services through Village Health Committees.
4. Strengthening facilities of Public Health Centres viz. Sub centres, Primary Health Centres and Community Health Centres for improved curative care.

Enhancing Communities' Access to Public Health Care Services

The NRHM recognizes the importance of improved communication for social change and increased participation of community in the health movement to reach the un-reached population, however access to public health services is a challenge for tribal and rural communities in remote villages. Participatory Communication conceives development as a transformative process at both individual and social levels through which communities become empowered to initiate a process of change.

The concern with communication in implementation of NRHM is two-fold: communities are unable to communicate their needs to health workers, and health workers, in turn, are unable to communicate effectively with the community. In an attempt to address this lacunae and building on the premise of *communication for social change*, the Participatory Communication Initiative has been undertaken through a partnership based network called Communication for Health India Network (CHIN) since 2008 in 40 districts of seven states of India.

As one of the CHIN partners, CHETNA implemented the project activities in five identified block of five districts each in Gujarat and Rajasthan states, covering a total population of 18,89,798 in both the states to enhance community's access to quality public health services as guaranteed under NRHM.

In Gujarat state, the project was implemented in 461 villages in selected blocks of Jamnagar, Kutch, Sabarkantha, Tapi and Vadodara districts and in Rajasthan state, it was implemented in 794 villages in selected blocks of Alwar, Banswara, Churu, Karauli and Udaipur districts. The selection of the districts was done in consultation with the Department of Health and Family Welfare keeping in view the indicators such as high infant and maternal mortality, lower rate of immunisation, Antenatal Care (ANC) and institutional deliveries.

In about 10 percent of the total number of villages, a participatory needs assessment study was conducted to assess the knowledge level of community members regarding availability of health services, available means of communication and training needs of service providers. The results of this study were shared with the existing groups at the local level, as well as at the block and district level. Based on the findings of the study, discussions were held on developing communication strategies.

The project adapted a multi-pronged strategy and a range of processes for different geographical areas viz. tribal, arid and desert areas and rural areas to reach out to the community. Regular awareness meetings, forum meetings were facilitated in each of these identified blocks, local public fairs¹/religious festivals like Janmashthmi, Navratri in Gujarat were used as an opportunity to interact and inform the communities about health entitlements. This enabled the communities in availing and demanding for health and nutrition services. For dialogue with the service providers, spaces within the existing programmes of the government were identified which proved useful for initiating a dialogue on community issues, better utilization of resources and services for the benefit of the community.

During the project implementation, information regarding health and nutrition services as well the entitlements was disseminated among more than three lakh community members each in Gujarat and Rajasthan states. For improving availability and accessibility of the services, training of more than 600 service providers were conducted at the block and district level and more than 1500 ASHAs were trained so that they could play their roles and responsibilities effectively.

Training of more than 3000 VHSNCs/CBO members was organised in order to generate awareness regarding their roles and responsibilities. Training of youth groups, self help groups were also organised for enabling them to take initiative for improving availability and accessibility of health services. After training they were provided guidance and support in their monthly meetings.

During the project, various participatory communication processes were adopted. This booklet presents the impact of some of these processes in the form of stories.

¹ Fairs in Rajasthan: Gangaur fair, Kailadevi fair, Swasthya Chetna Yatra
Fairs in Gujarat: Bhadarvi Poonam fair, Urs fair, School Health Campaign

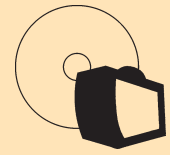
The traditional methods of communication deal with behavioural change in an individual where as participatory communication promotes individual as well as social change.

Social change signifies positive change in the life of people especially the marginalised group.

Community participation

Community participation is a critical component of any public health initiative. It is a process in which the community participates through influencing and sharing the control over development initiatives and decision and resources which affect them. A key to community participation is information and awareness about public health services and health entitlements. The participatory needs assessment carried out during the course of project revealed that only about 25% of the respondents were aware of government health schemes and entitlements. Through this initiative, by using participatory processes, the changes that have resulted have been presented in the form of stories.





Cable Network Brings Change

Kutch, located on the western-most tip of India in the state of Gujarat, is the largest district in the country. With more than 51% of its land covered by desert and with scant and irregular rains, it is under constant threat of drought.

Abdasa is one of the remote coastal blocks of the Kutch district. The area is arid and unproductive. It is inhabited by communities such as the Bhanushalis Kolis who are involved in fishing and wage labour, Maheshwaris who are primarily involved in farm labour, Rabaris who are small cattle herders and, Muslims and Darbars, who own both land and cattle.

Lack of clean drinking water, food, fodder and great economic pressures have forced many people to migrate to nearby towns. There is acute poverty and literacy levels are also very poor. CHETNA's partner NGO in this project-Kutch Mahila Vikas Sangathan (KMVS) has been working in the region for over a decade with the overall aim of empowering women to increase their sustainable income. The organisation is also extensively involved in local radio broadcasting projects in tribal dialect to support its community development work in the vast geographic area. Localised research has been a key approach for developing radio programmes.

One of the major issues that arose during routine village visits in Abdasa was the low awareness of the community about maternal and child health entitlements under National Rural Health Mission (NRHM). In response, awareness activities were carried out using posters, wall writings, street meetings and road shows. These were partly successful in some villages.

During village level interactions, it was suggested that since most of the people in the block had

access to radio, televisions and local cable network, Compact Disc (CD) could be used for communicating health entitlements. This would also help to reach out to a large audience at once.

KMVS picked up this idea, partnered with the local health department and produced an awareness capsule in the form of a audio CD, in local language (Kutchi). The aim was to educate the community about the importance of availing public health service, the interviews of Block Health Officials were included to help community members identify and recognise them.

The message in audio CD was given to the local cable operator for broadcasting repeatedly. It was also broadcast in the open: in village centres and in *anganwadis*. The health entitlements under NRHM were also given in the form of jingles/advertisements in Akashvani radio programme. The messages were reinforced with information given on the spot to make learning interesting and memorable. In all, 100 villages and four primary health centres were covered with the broadcast, reaching out to close to 26,000 people.

As a result, the demand for services at primary health centres increased rapidly. Over a period of next eight months the usage of '108' ambulance service and the number of institutional deliveries also increased.

Community members are reported to have said that this was the first time they heard about the mission and entitlements related to maternal and child health. They expressed their gratitude for sharing information in the local language. The format and content of the programme on the audio CD sold itself and a snowball effect brought about the desired result.



Here Come the ASHAs...

“Who is an ASHA? What have we got to do with what she does?” This was the response of people of Mulvasar village, Dwarka block, Jamnagar district, Gujarat, at an awareness meeting organised by the Gramya Vikas Trust (GVT), a local NGO and CHETNA's project partner working in the region.

The Rabari, Vagher and Dalit community people who live in this remote village mainly depend on wage labour for sustenance and belong to the below

poverty line population. Low literacy, lack of awareness and remoteness of the village contribute to lack of access to health knowledge and services.

Although there are 1,400 people in the village and the National Rural Health Mission (NRHM) prescribes one trained female community health activist or Accredited Social Health Activist (ASHA) worker for every 1,000 people, there was none in Mulvasar probably, like many other remote and interior villages of rural India.

Why have efforts to motivate local women to work as ASHA workers not been successful in this village and many such villages in the country? Even when ASHAs are present, why are they not performing their role efficiently? These questions need to be probed further. One possible reason could be that the key selection criteria for recruiting ASHA worker is that she should be a literate woman with formal education up to grade eight and preferably a daughter-in-law (who is likely to live longer in the village). Not many women venture out in this village due to lack of education and strict social and cultural norms for married women.

In 2011 as part of this project, the Gramya Vikas Trust (GVT) team made the Block Health Official aware that there was no ASHA in Mulvasar and that local women needed to be motivated to work as ASHA workers. He agreed that some action needs to be taken and also suggested that for optimal education in the community, instead of holding a standardized training programme it would be more appropriate to invite the existing ASHAs from other villages of the block to this village and demonstrate how they play an important role in implementing all MCH related schemes of NRHM.

In June 2011, in collaboration with the Block Health Authorities, GVT used the demonstration method to introduce ASHA workers to the village community. For this, 21 existing ASHA workers from other villages were invited. They conducted home visits and interacted with the community, assessed their knowledge on health entitlements, and gathered information on community concerns in accessing health services. The invitees also

shared their experiences of working as ASHAs with the people in the village especially, women. They motivated them to register as ASHAs.

Open-ended questionnaires were provided to the ASHA workers to gather information about the residents' level of knowledge and utilisation of health services. On the day of the demonstration, they were able to reach close to 350 villagers from 64 families.

When the ASHA workers compiled and presented their findings of the survey before the community and at the health sub-centre, it validated the fact that residents of Mulvasar had little information about maternal and child health services.

After this initiative the community members realised that it was crucial to have an ASHA worker in their village especially for maternal and child health services. Four women came forward to register as ASHA. Similarly women from two other villages also came forward to register.

GVT motivated and supported the women and shared this information with the District Health Officials. They appreciated this innovative effort as it provided an opportunity to see, hear, discuss and participate in the activity in the field and generated interest and enthusiasm among the community women for practice.

One of the women was selected as ASHA worker for the village. Needless to say, this methodology of demonstration and onsite mentoring will ensure better and efficient delivery of services by the ASHAs who represent the cornerstone of NRHM's strategies.

संगेफित महिला एवं बाल विकास

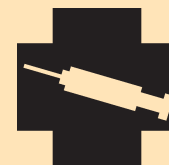
विभाग, राजस्थान

उद्देश्य

- माता एवं बालों के स्वास्थ्य को सुधार देना।
- बालों के उचित चिकित्सकीय, शारीरिक तथा सामाजिक विकास को नोबल करना।
- माता एवं बालों के स्वास्थ्य, कुपोषण, और बीजक में सुधार लाने की पहलकों में काम करना।
- बाल विकास को बढ़ावा देने हेतु विभिन्न विभागों में नीति निर्धारण और कार्यक्रम लागू करने में सहयोग प्रदान करना।
- उचित स्वास्थ्य सेवाओं के माध्यम से बालों के सामान्य और पोषण को सुधार लाना और माताओं को समता बढ़ाना।

टीकाका	संगेफित महिला एवं बाल विकास
संस्थापक	राजस्थान सरकार के स्वास्थ्य विभाग
संस्थापक	राजस्थान सरकार के स्वास्थ्य विभाग

Women's Self-Help Group: A Guiding Force for the Village



Kataron ka Talaab is a small village in the Anandpuri block of Banswara district, Rajasthan. It is populated by the Bhil tribals who live here in nearly 600 houses scattered over a large terrain. More than half the population here is illiterate with low awareness and utilisation of health and development services are low.

In spite of all the difficulties, the women of Kataron ka Talaab have been running a Self-Help Group (SHG) named 'Bhairavji' through which they have been involved in various income generation activities. In March 2011, a local NGO, Association for Aravali Sarva Seva Farms (ASSEFA), CHETNA's project partner in the district, introduced health related activities in the group. The organisation has been making efforts to create health awareness among the members and mobilise them to access health services available from the government.

The ASSEFA team encouraged members of the Bhairavji SHG to join the Village Health Sanitation and Nutrition Committee (VHSNC). They imparted training to the members and made them aware about the community level health and nutrition services available to them under NRHM, and the role and responsibilities of the VHSNC in ensuring the services.

Kamla, a 50 year old homemaker and mother of four, was one of the participants at the ASSEFA training. She had studied up to grade two, many years ago. Inspired by the training, she started door-to-door meetings with pregnant women and nursing mothers in her neighbourhood to spread awareness about maternal and child health entitlements available to them.

Sulekha is one of the residents of the village and her story exemplifies how Kamla's small efforts are leading to big changes in the community.

Sulekha, a mother of a two year old girl was pregnant for the second time. On Kamla's advice she diligently went for three antenatal check-ups and got two immunisation doses administered. The Auxiliary Nurse Midwife counselled her and ensured that she took her Iron Folic Acid tablets as required. Close to her delivery date, Sulekha was also told about the importance of institutional delivery and benefits available to her under the Janani Suraksha Yojana. She received all the necessary services and help for a safe delivery.

Kamla shared that due to extreme poverty, most of the men migrate to nearby cities in search of work. It is very difficult to contact and mobilise women and motivate them to avail health services as they stay in scattered houses in this hilly region.

Kamla has been able to reach out to many women like Sulekha in the village. The process of involving the SHG members in mobilisation, action and behaviour change on health related issues in addition to income-related activities has been tough. But there is hope because other SHG members are following Kamla's example and have taken the responsibility of promoting health awareness in their hutments.

For ASSEFA, this has been a lesson learnt. Along with a well organised primary and secondary health system, community ownership is critical for health awareness and utilisation of services.

Kamla rightly says, "*Shuruat toh karo, karwan khudh ba khudh jud jayega*" meaning – take the first step in the right direction and make a start; people will themselves join in and make it a movement.





From Confrontation to Cooperation

Late one night in February 2011, the *mukhiya* (village head) of Naal village, Gogunda, Udaipur, called “108”, the emergency medical referral service, so that a pregnant woman could be taken to the nearest community health centre for delivery. The staff who received the call informed that the ambulance would reach the village only at 5 am the next morning. The norms for the emergency referral service prescribe immediate action; this delay of about four hours in accessing adequate medical care could have major health repercussions for anybody. Fortunately, the woman was transported safely when the ambulance arrived in the morning.

This incident came to light during a round table of elected representatives, the *mukhiya*, ASHA workers, Auxiliary Nurse Midwife and staff of a local NGO- Active for Literacy and Environmental Renovation Task (ALERT Sansthan), which is also CHETNA's partner and is working in 151 villages of Gogunda block. ALERT team helped the *mukhiya* to probe the reasons for the delay in response from the 108 service.

A conversation with the ambulance staff revealed that the residents of Naal had pelted stones when the ambulance had entered the village on several occasions earlier. The staff had, therefore decided to stay away from the village during the late night hours for their own safety.

Naal is one of the remotest villages of the Gogunda block and is populated by the Bhil tribal community. Typically, the Bhils have a lower socio-economic status and they work on daily wages at nearby

construction sites. Traditionally they regard alcohol as “holy spirit” and many of them are involved in brewing and consuming illicit liquor.

When the *mukhiya* questioned the villagers about their strange behaviour towards the 108 ambulance service, they confessed that they were scared of the ambulance's siren. Some thought that the siren signalled that the police was there to arrest those involved in brewing illicit liquor. Others thought the ambulance would take their children away.

The ALERT representatives explained to the village *sarpanch* (elected village head) about how using a referral transport was a health right and entitlement of the villagers. A meeting was called at the village centre. The *panchayat* members, the Auxiliary Nurse Midwife, ASHA worker, school teachers, ALERT representatives and local community-based organisations were invited. The idea was to explain to the villagers how their resistance could lead to major and negative health consequences.

After lengthy discussions, those present at the meeting were convinced and decided to take responsibility of ensuring safe passage of the ambulance in their own hamlets on a 24/7 basis. The ambulance service staff was also informed about this decision.

Ever since then, the ambulance has resumed services in the Naal village. The story exemplifies how the matter of ambulance service was simply, but quite effectively, addressed by building trust through open dialogue. This helped people realise how the issue touched them personally and paved the way for their participation and ownership in their local health service.

Dialogic process

The Participatory Communication Initiative was built around debates and negotiation to create linkages between different stakeholders of NRHM, like panchayat. The Participatory Need Assessment (PNA) indicated to a lack of access of rural communities to forums for dialogue with service providers.

At the block and district level, meetings and consultations were organized with the health officials. The consultations focused on sharing the findings of the PNA, communication strategy and seeking their support in enhancing community's awareness about the public health services. The health department and the service providers provided support in organizing and implementing the activities. The results/outcomes achieved through the dialogue processes have been documented here in the form of stories.



Advocacy for Change



The National Rural Health Mission (NRHM) is a health program for improving health care delivery across rural India. It aims at reduction of maternal and child mortality rates, universal access to public service with emphasis on woman and child health, prevention and control of communicable and non-communicable diseases, population stabilization, revitalization of local health traditions, gender balance, etc.

Various factors are thought to be associated with maternal mortality: factors that influence delays in deciding to seek medical care, in reaching a place where care is available and in receiving appropriate care. The “108” free, ambulance service has been introduced mainly to transport pregnant women to the nearest health centre, so that they receive timely professional help. However, many questions remain around the efficiency of the service and its availability for all rural communities.

The concerns related to operational issues of “108” were shared at a ‘Training of Trainers’ organised by CHETNA for its district partners, in February 2010. The findings from a participatory need assessment conducted in five states indicated that the poor were discouraged from using the “108” service

because further referrals (from the nearest health centre) were available for a fee. The possibility of such a situation arising was discouraging women from opting for institutional deliveries altogether.

When the Mission Director, who was also attending the session, learnt about this, she took up the issue seriously and after the training, held a meeting with the concerned health officials. It was found that this was indeed a deterrent for poor, pregnant women all over the state. Within a week, a government resolution (RSD/Mission Director/D/10 dated March 6, 2010) was passed stating that any pregnant woman who is referred to the next health unit by a primary or community health centre will receive free referral transport support. In addition, the woman can avail of free transport service to return to her village from the health centre, after delivery.

Policy change rarely occurs quickly. But this striking outcome was a result of participatory and collaborative processes among the network of district partner organisations who are working with the common objective of improving the health status of women and children in the rural areas of the state as well as, the conviction and commitment of the Mission Director towards reforming the health services in the country.

મિસી



રાષ્ટ્રીય સ્વાસ્થ્ય સંનિધી યોજના
Rashtriya Swasthya Bima Yojana

Issued: Jan 2010



MUS MAEHANAJ BAGAM
AGE: 24yrs.
GENDER: FEMALE



0000 8601 1007 7250 7

મિસી કાર્ડ ઉપર

કર્ડ ની કોમ્પ્યુટર સાથે
કોઈ સમાનતા નથી
અને તે સમાનતા નથી
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અને તે સમાનતા નથી





Advocacy for Health Insurance

For a person living below the poverty line, an illness not only represents a grave threat to her/his income earning capacity, it is often the reason why a family falls into a debt trap. Often, the need for treatment is overlooked by the poor, not because of ignorance but because of lack of resources and fearing loss of wages. The Rashtriya Swasthya Bima Yojana (RSBY), a health insurance scheme, was launched by the government under the National Rural Health Mission (NRHM) to address this lacuna, to help the poor access services from hospitals.

In Valod, one of the tribal dominant blocks in Tapi district, issuance of RSBY schemes (and a card) had not been undertaken as envisaged under NRHM. Being a newly formed district, it had not been included in the RSBY information management system yet.

Valod has a population of 87,127 and a literacy rate of 48 per cent. There is high incidence of malnutrition (close to 75 per cent) and Tuberculosis. The average lifespan of the population is 35 years, perhaps due to the high rate of liquor consumption.

In 2009, CHETNA's project partner and a local NGO, Vedchhi Pradesh Seva Samiti (VPSS), conducted a

participatory needs assessment in the block. It emerged from the assessment that due to low awareness, NRHM services were not being availed of. With neither the RSBY card, nor the wherewithal to access private services, people were ignoring most of their health needs until it was too late.

Looking to the organisation's contribution in the development of the community in this area, the team was invited to a high level meeting with all the senior health officials of Tapi – the District Collector, the District Development Officer, Chief District Health Officer, and others. This was soon after the participatory need assessment in Valod. A presentation by district health officials spoke about the poor enrolment of RSBY in the district. The VPSS team put forth its observations from Valod. The officials disclosed that Tapi, was recently moved out from the Surat district, and was yet to receive a 'district code' from the central government, essential for issuing the RSBY cards.

The district development officer ordered the district programme coordinator to visit New Delhi to follow up on the district code. Within a week after the meeting, Tapi received its code and RSBY cards began to be issued!

सहभागी संचार द्वारा मातृ एवं शिशु
स्वास्थ्य सेवाओं कि पहुँच बढ़ाना





Small Efforts, Big Results

‘*Asha*’ in Hindi means ‘hope’ and as the name suggests, the ASHA worker is one, who inspires confidence of good health among the women and children of the deprived communities. She is the first port of call for any health related demands of the population, especially for women and children who find it difficult to access health services.

She serves as an interface between the community and public health system, creates awareness about health and its social determinants among the community and mobilises and facilitates them in accessing the available services. But do all villages have ASHAs?

Akhil Bharatiya Gramin Utthan Samiti (ABGUS) is a NGO and CHETNA's partner organisation working in Tijara block of Alwar district, Rajasthan. During a community meeting in the Fullavas village, it was found that people were not aware of the provision of appointment of an “ASHA” worker in the area and the health benefits that she could bring for the community. This was perhaps because of the lack of interest of the *sarpanch* (elected village head) in health related issues.

In subsequent community awareness meetings, it was found that there were many other villages where an ASHA was not recruited at all.

The ABGUS team went to the primary health centre and gathered more information about the situation of ASHAs in other villages, the eligibility criteria for their selection and the procedure for their appointment.

When this matter was discussed with the Medical Officer, he agreed that the health indicators in villages having ASHA workers were much better than those that did not have them and that this issue needed to be taken up with block level authorities.

Over a period of four months, six meetings were held with the Block Chief Medical Officer, Block Program Manager and Block ASHA facilitator to take action in this matter. The problems in recruitment of ASHAs, awareness of the elected village heads, and perception of the community were discussed at length. In the meantime ABGUS organised about 100 awareness meetings in the Tijara block.

After this, when a meeting of *sarpanchs* was held at the block level, the problems in the villages due to absence of ASHAs were discussed. Everybody present, including the *sarpanch* of Fullavas assured that they would take on the responsibility of identifying and appointing ASHA workers. The Chief Medical Officer of the block also sent out a written notice to this effect.

The collaborative effort of ABGUS team, Block Health Officials and Sarpanchs resulted in the recruitment of 25 ASHAs in the Tijara block in a period of four months. They are now spreading the light of health information in the community. Goes to show that small, simple actions can lead to big results provided enough of those small actions are put together in the same direction.



Community Monitoring: Making Health Functionaries Accountable to People



The Ribiya village lies 45 kilometres away from Churu block in the Churu district of Rajasthan. With a population of nearly 3,000 it has two *anganwadi* centres. One of CHETNA's partner NGOs, the Shikshit Rojgar Kendra Prabandhak Samiti (SRKPS), has been working in the Churu district.

In the last census survey it was found that the maternal and infant mortality rates here were higher than the national average. Although SRKPS has been creating awareness among the people about the services available under National Rural Health Mission (NRHM), it was observed that when needed, these services were not available to the community.

In June 2011, during a community awareness meeting, the Block Link Worker of SRKPS, Dhanpat Singh, shared details about the maternal and child health entitlements under NRHM. He also discussed the health status of the village with the Auxiliary Nurse Midwife (ANM) and *anganwadi* workers.

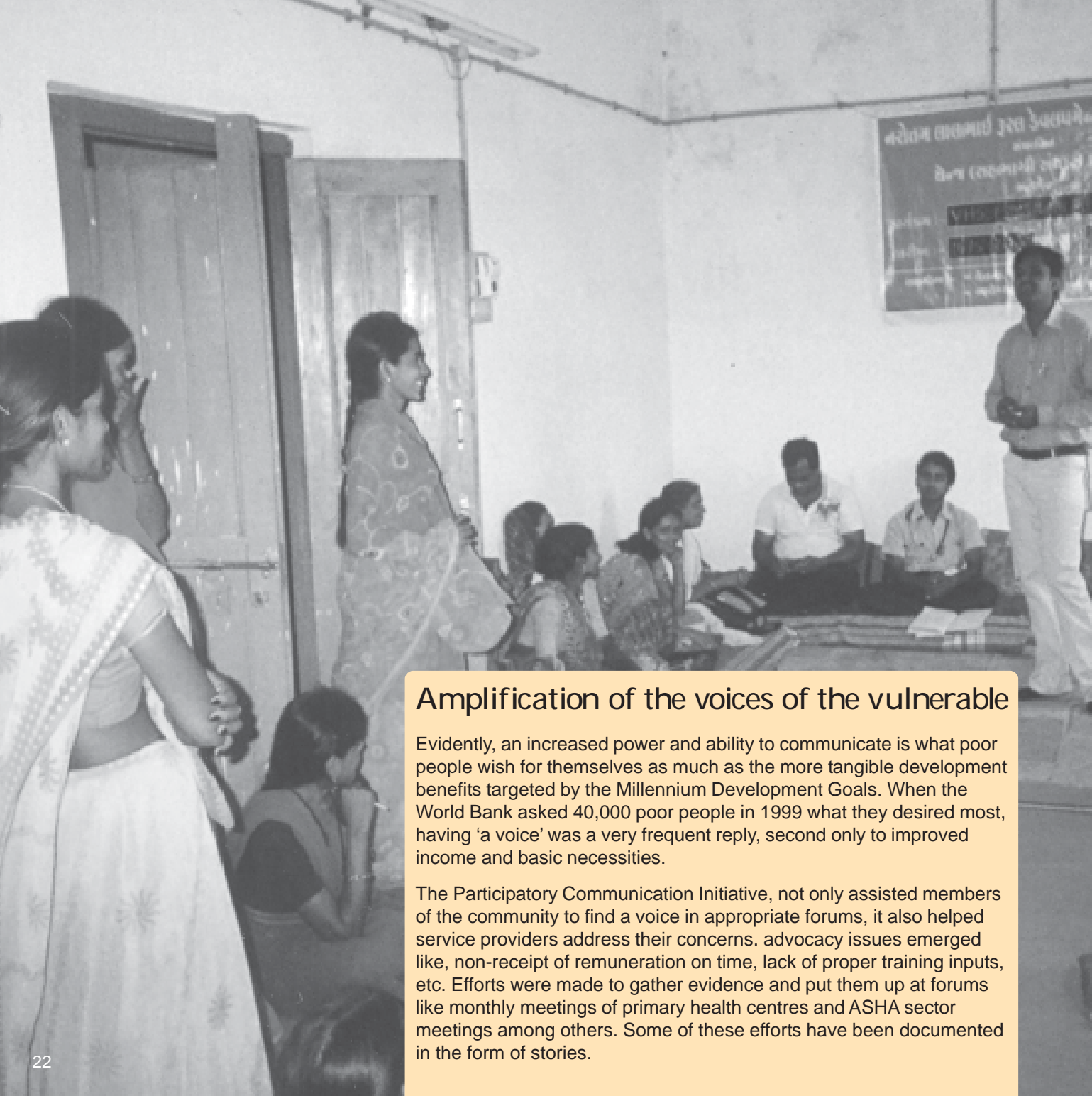
When Singh visited Ribiya village for a community meeting the next month, he found that the ANM was missing. Community members informed him that the ANM never opened the health sub-centre regularly. In fact the Maternal and Child Health Nutrition (MCHN) day was also not celebrated for the last seven months. Because of this, nutrition and other services were not available in the village. The community members requested Singh to discuss

these irregularities with the higher authorities. However, he thought it would be better if the community members take this issue up with the *sarpanch*. He encouraged them to do so.

In the next meeting in the following month, the community members informed Singh that the *sarpanch* paid no heed to their complaints. Singh, along with some community members, went and met the *sarpanch* and reminded him of his responsibility to ensure regular services at the sub-centre. The *sarpanch* was convinced that he should take some action and, after repeated follow-ups by the community, he sent a written complaint to the Medical Officer of the Primary Health Centre.

In response, the Medical Officer warned the ANM of strict action if services at the sub-centre were not regularised. Ever since then, the ANM has been opening the sub-centre regularly. The MCHN day is also being celebrated every month. The ANM counsels the community members on health related issues and performs other duties as well.

People here have realised that they have a right to health services. They are now ready to take responsibility to bring about regularity in health services being provided at their village and collectively solve any obstacles that come in the path of realising their right to health.



Amplification of the voices of the vulnerable

Evidently, an increased power and ability to communicate is what poor people wish for themselves as much as the more tangible development benefits targeted by the Millennium Development Goals. When the World Bank asked 40,000 poor people in 1999 what they desired most, having 'a voice' was a very frequent reply, second only to improved income and basic necessities.

The Participatory Communication Initiative, not only assisted members of the community to find a voice in appropriate forums, it also helped service providers address their concerns. Advocacy issues emerged like, non-receipt of remuneration on time, lack of proper training inputs, etc. Efforts were made to gather evidence and put them up at forums like monthly meetings of primary health centres and ASHA sector meetings among others. Some of these efforts have been documented in the form of stories.



Sustaining Commitment of Critical Health Workforce: The ASHAs

Under the National Rural Health Mission (NRHM), the Accredited Social Health Activists (ASHAs) are community based functionaries who have the responsibility of acting as a change agent on health at the village level. They are responsible for mobilising the community towards local health planning and increased utilization of existing health services. Their success depends on their motivation level and the training and mentoring support they receive.

Most of them work in difficult circumstances and try to deal with the community's problems that arise on a day-to-day basis. But what happens when they themselves face problems? Are they able to tackle the problems on their own? This story is thought provoking.

There were seven primary health centres in Khedbrahma block, Sabarkantha district, Gujarat, which is one of the most remote blocks, and is populated by the tribal communities. The health status of the community is poor. Government Primary Health Centres are located at least 10 to 15 kilometres apart and Community Health Centres are at a distance of about 40 to 50 kilometres from the interior villages. In addition, every house is over a kilometre away from the other making it difficult for the community to access health services and health workers to reach the residents. But the ASHA workers have been working tirelessly in all the villages covered by these health centres.

In 2009, a local NGO, Narottam Lalbhai Rural Development Fund (NLRDF) organised a training programme for these ASHA workers wherein they shared that although they were working with complete dedication, they had not received incentives (amounting to Rs.700-1200 per month) for the past eight months. Understandably, they were feeling demotivated. They did not, however, bring this to the notice of government officials for fear of annoying them and risking the renewal of ASHA contracts the following year.

The NLRDF team convinced the ASHA workers that they should all raise the issue with government health officials in their Primary Health Centre (PHC) and with the block level health officials. They also assured them of complete support to ensure that the renewal of their contract would not be at risk.

The ASHA workers from Dantral, Lambadiya and Delwada gathered courage and spoke to the health officers at their PHC. As follow-up they also kept reminding the officers over the phone about the issue of pending dues.

After repeated reminders from the NLRDF team and the Medical Officers, the BHO took up the issue at the district level. The district authorities gave priority to the issue and sanctioned the grants to the respective PHCs. Due to the collective efforts of the ASHAs, NGO representatives and the Health Department officials they received the incentives that they were entitled to within a period of 15 days.



And the Roadshow came to them...

The Khedbrahma block of Sabarkantha district, Gujarat has a population of about 2.5 lakh people of which over 60% comprises the Adivasis. In terms of maternal and child mortality, size of agricultural holdings, access to water and electricity or literacy levels, the tribal communities lag far behind the general population.

Remote location of villages, sparse, scattered settlements have resulted in poor acceptance and utilisation of health services. A Primary Health Centre (PHC) is located nearly 15 kilometres from the villages and a Community Health Centre (CHC) is at a distance of about 50 kilometres. On an average, 19 villages are serviced by one PHC. Over 80 villages are severely inaccessible because of their location. Government and non-government health workers' outreach is restricted to houses in the proximity of the PHC. The issue is further compounded by low

levels of literacy (42 per cent among men and 32 per cent among women) and associated myths and misconceptions about medical treatments.

CHETNA's partner organisation in this project, Narottam Lalbhai Rural Development Fund (NLRDF) is working along with the District Health and Family Welfare Department, Sabarkantha to promote communities' access to quality health services in the Khedbrahma block.

In order to reach out to people in the interior villages, NLRDF proposed to use an innovative approach of holding a two-week long "roadshow" in the month of June 2011. The idea was to go from village to village, share information about maternal and child health entitlements, help the community to understand the present status of health services in the villages; provide a forum to share concerns related to accessing health services; propose possible

solutions to address health concerns of communities and motivate them to access the services. This idea was shared with the Block Health Officer who encouraged and helped in charting out a route map of villages that could be covered by the roadshow.

The roadshow began on June 6, 2011, with jeeps displaying banners of health entitlements driving through villages. Announcements were also made on a public address system attracting community members to come and join the rally. Awareness meetings were organised; pamphlets and stickers were disseminated as takeaways to reinforce the

messages. In the course of the road show, the NLRDF team spoke with ASHAs, pregnant women and nursing mothers to assess their understanding of maternal and child health services, and experiences of availing them.

As the roadshow travelled from one village to another, volunteers, youth groups, members of self-help groups, health service providers and ASHA began to join in to help mobilise the community and to create awareness. Community members carried out a signature campaign to highlight both concerns and possible solutions to health issues.

Health Concerns and Solutions put forth by the Community

Concerns

Community members from 30 villages shared that for injections and for drips, money was being charged at the PHC.

In about 22 villages, the Janani Suraksha Yojana incentive was not being given on time.

Inappropriate utilisation of untied funds.

Problem with issuing health insurance card (Rashtriya Swasthya Bima Yojana) in Mamapipla village, Khedbrahma.

Solutions

Medical officers/block health officers should ensure free access to health services as it is a health right of the community.

Ensure timely payment of Janani Suraksha Yojana incentive to pregnant women for institutional delivery.

Share information with community members about how the untied funds could be and were used.

Information sharing on the benefits of health insurance cards and the criteria for getting the cards issued.

By the time the roadshow drew to a close after a fortnight, it had reached out to 9,000 community members in the remotest and most inaccessible parts of Khedbrahma. A couple of weeks later, at a meeting in the block health office, concerns and solutions put forth by community members were shared. The Block Health Officer assured of the availability of adequate medicines at the PHCs, facilitation of disbursement of Janani Suraksha Yojana funds to health centres the day they were received at the block. Thus, not only did the road show help to inform and involve people, it helped to create a valuable role for each member to play and also opened their channels of communication with the health machinery at the block level.





Fighting Problems in Health Care Delivery...A Struggle

In January 2009, a disturbing trend was brought to light at the monthly meeting of the Okha Mandal Shakti Sangathan, Dwarka (OSSD). The meeting was organised by CHETNA's partner NGO in this project, Gramya Vikas Trust (GVT), in the Dwarka block of the Jamnagar District, to raise awareness of maternal and child health entitlements under the National Rural Health Mission (NRHM) among the village community.

The OSSD self help group members shared that a ward boy had been employed in the Community Health Centre (CHC) at Dwarka. Instead of the health worker, self-help group volunteers and traditional birth attendants who were all women, and were usually present in the health centre, he would be present during labour in the labour room which was quite embarrassing for the women at the time of delivery. Further they complained that the ward boy would demand "tips" from the family members of women after the delivery of the baby. He also charged more than the stipulated amount (Rs 60/- instead of Rs.16/-) for issuing age proof certificates to senior citizens.

As decided in this meeting, the issue was raised with the Superintendent of the CHC in February 2009. However, no action was taken against the ward boy in the next two months. In May 2009, OSSD members submitted a written complaint to the Superintendent seeking necessary action. The following day, the Superintendent responded that the health worker and other women accompanying the pregnant lady are not allowed to enter the labour room for hygiene purposes. Also, due to the non-

availability of appropriate woman staff, the boy had been employed for cleaning the health centre. The Superintendent was open to considering women candidates for cleaning staff (ward lady) if OSSD recommended someone and agreed to pay her a salary of Rs 1,000 from the Rogi Kalyan Samiti's untied fund. He urged the members to make the community aware that there was no need to pay anything more than the stipulated amount for age proof certificates. He assured that stringent action would be taken against the errant ward boy and that OSSD must not hesitate to bring up any such issues in future too.

A ward lady was employed within a month. The ward boy's job responsibility was altered so that he remained out of the labour room. Although the process took five months, the group felt it was worth the effort. However, despite efforts by the community and members of the SHG, challenges continue to loom large.

A follow up by OSSD, in August 2011, revealed that the ward boy had been reinstated because the ward lady left the job and no other qualified woman was available.

Basic facilities and services at health centres are many a time insensitive to women's medical, social and psychological needs. Simple issues such as lack of privacy could be a cause for acute discomfort and embarrassment for women refraining them from accessing maternity care and other health care. Acts of corruption also impact the poor heavily, affecting health outcomes. It is a constant struggle to fill these loopholes.





Overcoming the Obstacle of Ignorance...

After going through two miscarriages will this 18 year old pregnant woman be able to have a safe delivery and give birth to a healthy child?

This story is about Munfida, who is a resident of the Milakpur Turk village, Tijara block, Alwar district, Rajasthan. She belongs to the “Meo” community, (a Muslim-Rajput community also called, Mewati), which is characterized by the practice of child marriages.

Due to factors such as social insecurity, low financial status, illiteracy, and ignorance about the consequences of early marriage, parents generally marry their children off at a very early age. Munfida was also married when she was 15 years of age and she now lives with her husband in a joint family.

Even though this was the fifth month of her third pregnancy, Munfida had not been registered for antenatal and prenatal services, and had not taken immunisation services due to lack of awareness.

During April 2011, Munfida happened to participate in an awareness meeting organised by CHETNA's district partner organisation- Akhil Bhartiya Gramin Utthan Samiti (ABGUS). It is here that she learnt about the various maternal and child health services offered by the government at the sub-centre, the importance of institutional delivery, and the objective of celebration of Maternal and Child Health Nutrition (MCHN) day. She attentively listened to all the

information shared at this meeting and eagerly waited for the next MCHN day celebration in her village.

When Munfida went to the sub-centre for the first time, she was very nervous. She hesitantly shared her previous experiences of miscarriages with the Auxiliary Nurse Midwife (ANM). The nurse refused to register her case saying that since she had not gone through the entire series of check-ups from the beginning of her pregnancy she was not eligible to get registered at this late a stage. The ABGUS team members, who were present to support frontline health workers on the MCHN day, overheard the conversation between Munfida and the ANM. They intervened and requested the ANM to register Munfida since she had herself come forward to avail the available services now.

The ANM registered Munfida and gave her Iron Folic tablets. Enthused by her new-found health awareness, Munfida visited the health centre for regular check-ups and took the second vaccination and the prescribed medicines. She continued to participate actively in all the awareness meetings held in her village.

A follow-up with the ANM revealed that Munfida gave birth to a healthy baby and availed the benefits under the Janani Suraksha Yojana at the time of delivery. Munfida's story shows that it is better late than never.





A Toilet Brings in a Revolution!

The toilet in the *anganwadi* centre of Sirsili village, Churu block, Churu district, Rajasthan, was in such an appalling condition that it became a huge problem for the children who visited the centre everyday as well as the women who visited the centre on Maternal and Child Health Nutrition (MCHN) day every month. The community members, ASHA worker and *anganwadi* worker repeatedly raised the issue with the *ward panch*, the *sarpanch*, members of the Village Health Sanitation and Nutrition Committee (VHSNC), but no action was taken to repair it.

The toilet issue came up at one of the health awareness meetings organised by Ms.Saroj, a Block Link Worker of a local NGO and CHETNA's partner organisation, Shikshit Rojgar Kendra Prabandhak Samiti (SRKPS). The Auxiliary Nurse Midwife (ANM) and ASHA worker shared that because of the dilapidated condition of the toilet the attendance of children at the *anganwadi* had dropped. Women were also reluctant to visit the centre on the MCHN day for the same reason.

In February 2011, Ms.Saroj raised the issue at a *panchayat* meeting attended by all village level health and *panchayat* functionaries. She also discussed the importance of MCHN day, complete

immunisation and the availability of untied fund at the disposal of the *panchayat*. She suggested to the *sarpanch* that some part of the fund could be used to get the toilet at the *anganwadi* centre repaired. Other members at the meeting also supported her on the need to get the toilet repaired. Convinced about the solution suggested, the *sarpanch* agreed to get the toilet repaired within a fortnight. As a consequence, the toilet and other facilities at the Anganwadi centre which needed repair were refurbished within a month.

Through this activity, the *sarpanch* realised the importance of meeting the health needs of the village people. He shared the health related concerns of the village in the monthly meeting of the *panchayat samiti* at the block level. The Block Development Officer asked the appropriate officials to ensure that all prescribed services were available and facilities maintained well at *anganwadi* centres in each village of the block. All *sarpanchs*, and *panchayat samiti* members as well as *zilla parishad* members were asked to participate in MCHN day proceedings and to utilise the untied funds as required.

The results of all these efforts are now visible. The utilisation of *anganwadi* services is reported to have increased dramatically by almost 80 percent.

Creating Ownership of and driven by internal change agents

The Participatory Communication Initiative has focused on developing ownership of accessing NRHM entitlements from within communities and community forums. In this view it has invested in building the capacity of village level functionaries and forums to play their part.

During the participatory need assessment, the members of *panchayat* and VHSNCs expressed the need for effective awareness programmes to be able to carry out their responsibilities better. Participatory communication initiative emphasizes that communities should be the main protagonists of process of social change rather than the passive beneficiaries made by external players.



Ensuring Improved Access to Health Care Services



The Vadsar village in Abdasa block, Kutch district, has a predominantly illiterate and tribal population. In 2009, CHETNA's partner NGO in this project, Kutch Mahila Vikas Sangathan (KMVS) carried out a participatory health needs assessment in the block. It was found that there was ignorance among the villagers about health services, including maternal and child health schemes of the government. The community members were unaware of the entitlements under the National Rural Health Mission (NHRM) and they were consistently paying for the services that are available free of cost at the government health centre under provisions of the Mission.

Although a Village Health Sanitation and Nutrition Committee (VHSNC) comprising 11 members were constituted in 2008, it was non-functional as neither the members themselves nor the community were aware of their roles and responsibilities. In one of the awareness meetings it was found that the VHSNC members had no idea about the health issues in the village. They were not aware of the untied funds available in the bank and how they were to be utilised. On investigation it turned out that the Auxiliary Nurse Midwife (ANM) had just joined and the earlier ANM had used some amount from the untied funds for

getting the village cleaned. An amount of Rs.6000/- was available in the bank.

KMVS organised a training programme for the VHSNC members to orient them and equip them to provide leadership as well as plan and monitor the health activities in the village. They were made aware of their role and responsibilities, provided clarity on untied fund and its use, and on the maternal and child health entitlements available under the NRHM. After this training, follow-up meetings were held with the VHSNC members regularly.

As a result the VHSNC members especially, women members, gained recognition in the village and were successful in preventing doctors from charging for "free" services. They ensured that community members ask for receipt for all paid services. They accompany pregnant women at the time of their delivery and, wherever necessary, explain to doctors about the government norms under NRHM. They have used the free, emergency ambulance service, gradually regularising its use in the village.

In a period of more than two years, KMVS has been successful in orienting the VHSNCs of the entire Abdasa block and this has improved the community's access to health services.





The Story of an Inspirational Sarpanch

Mohmadpura, on the banks of Mahi River, is one of the most remote villages of Padra block in Vadodara district. The population primarily comprises the Madi, Chauhan and Darbar communities whose main livelihood is agriculture.

A local NGO and CHETNA's partner in this project, the Shroffs Foundation Trust (SFT), has been working with the rural communities' in the Padra block to create awareness on maternal and child health issues and mobilise the community to access these services. During a training organised by the NGO which was attended by frontline health workers of the block, members of Village Health Sanitation and Nutrition Committees (VHSNCs) and Sarpanchs, the representatives of Mohmadpura shared a concern that the monthly 'Mamta day' (Maternal and Child Health Nutrition day celebrated once a month to provide essential reproductive and child health services at the anganwadis under the National Rural Health Mission) was not being celebrated in the village and this could be a cause for lack of awareness on maternal and child health needs and entitlements. On follow-up, the SFT team learnt that the residents of the village were not aware of NRHM and services and entitlements available under the mission.

In June 2010, seven meetings were facilitated by the SFT team in the village. Cultural programmes were organised in which health related information was shared in the form of "Bhavai" (popular folk theatre). Through the meetings, gradually, all maternal and child health related issues were discussed. The *Sarpanch*, Harman Padhyar, stayed in contact with the SFT team and acquired more detailed information about health services and entitlements. He initiated concerted effort to regularise Mamta day celebration. He would be present at every Mamta day celebration and advise village health functionaries on how to conduct it. *Anganwadi* workers spread the word about Mamta day and its importance among community members when they visited the anganwadi and through home visits.

Over time, not only was Mamta day celebrated regularly, immunisation statistics went up drastically (to nearly 100 per cent). Nutrition counselling was undertaken by frontline village functionaries and followed by mothers. In all this, Sarpanch Padhyar played a key role. If one is clear about her/his aim and is determined to bring about a change, then s/he is sure to find success.





Making a Difference-The Power of One

Madhuben, a traditional birth attendant in Mohmadpura, is determined to promote institutional delivery of babies in her village. She knows that institutional deliveries play a crucial role because of the availability of emergency obstetric care by trained health professionals if required. The maternal health components of National Rural Health Mission (NRHM) are especially focused on enhancing women's access to institutional delivery at government health centres.

Notwithstanding provisions for services, poor awareness of entitlements and little control on decision-making about their own health, force many women to opt for the private health care system. In general, there has not been much faith in public sector healthcare.

Mohmadpura is the last village in Padra, located nearly 25 kilometres from the block headquarter on the banks of Mahi river. Most of the Chauhan, Madi and Darbar people in the village are farmers; some work in industries in Padra block, Vadodara district in Gujarat. Low awareness led people to believe that institutional delivery, use of government ambulance service, etc. would cost a lot of money.

Consequently, home deliveries were rampant with its attended dangers, a trend that came to light at a community awareness meeting organised by Shroffs Foundation Trust (SFT), a local NGO and CHETNA's partner in this project.

The meeting was one of the many forums organised to raise awareness levels about maternal and child health entitlements and services in villages. The NGO approached Madhuben in June 2010, to help them in promoting safe deliveries. She is not only a

trained birth attendant, she is also a member of the Village Health Sanitation and Nutrition Committee and leader of a local women's group. She has good rapport with the community; they have faith in her and listen to her.

Although Madhuben has been working as a birth attendant for a long time, she realised her role beyond that of a TBA only when she participated in the awareness meetings organised by the SFT over the year. She learnt about how the risk of maternal and child mortality can be reduced through institutional delivery and referrals to specialists.

She made it her mission to promote institutional deliveries in Mohmadpura. The shift was gradual but people's faith in her helped to open their minds to understanding why it was necessary. She visited *Anganwadi* centres, attended women's forum meetings, 'Mamta day' celebrations and told mothers of children that shifting a new-born baby to a hospital can be dangerous. It is wise to have the delivery in the hospital itself. Since decision makers in most families are mothers-in-law, she followed up meetings with home visits.

Madhuben's tireless efforts over eight months ensured that 11 pregnant women registered themselves at the community health centre and that *all* deliveries were conducted at health centres and hospitals during this period. She accompanied three women to the Centre for delivery. Pregnant women themselves used the free ambulance service to go to health centres. The staff of the community health centre and *sarpanch* acknowledged Madhuben's role in enhancing the health status of women and the new borns in Mohmadpura.





Where there is a will, there is a way..

Narayani Paliwal is 31 years of age and has been working as an ASHA in Parodi village, Gogunda block, Udaipur district, Rajasthan, for the past four years. She goes from door-to-door, mobilising the community, encouraging and facilitating them to access health and nutrition related services available at the Anganwadi, sub-centre and the primary health centre. This includes immunisation, Ante-Natal and Post-Natal check-up (ANC/PNC), supplementary nutrition, sanitation and other services being provided by the government. She fulfils her responsibilities diligently.

What makes her case different from other ASHAs and is worth a special mention is that she does not let her physical disability due to Polio come in the way of her work.

Narayani was married off at a very young age and she lost her husband soon after giving birth to her three children. Her youngest child was only three years old then. Since she had a family to fend for, she enquired about vacant positions for the post of an *Anganwadi* worker in her village. There were none. However, there were some vacant positions for ASHA workers.

In 2005 the *sarpanch* and other *panchayat* members selected her for the post of ASHA and she took charge as an ASHA on 15th March 2005.

In 2010, a local NGO, ALERT Sansthan, which is a partner of CHETNA in this programme, organised training for ASHA workers which helped her and others gain clarity on their role and responsibilities.

The Pulse Polio Day is of special significance to Narayani. She goes door-to-door and administers Polio vaccine drops to children. She has vowed that she will not let any child in her work area suffer like herself due to the negligence of her/his parents regarding the available health services. Narayani says in spite of being physically very demanding, this job gives her immense satisfaction and ALERT has supported her at every step. Their training programmes have enabled her to understand her role and responsibilities better. Regular discussions with, and advice from ALERT staff has helped her to share her concerns about field realities with people with self-confidence.

Narayani's tireless efforts have begun to show results. There is more awareness about maternal and child health services among the community. With Narayani's help, 11 women availed Janani Suraksha Yojana benefits in a period of six months.

Narayani brims with self confidence. She says "where there is a will, there is a way". She is eager to put in more efforts towards ensuring health and development of the community.





A Little Handholding Goes a Long Way

Few years back, the dream of having healthy people in villages of Karauli district, Rajasthan, seemed farfetched. In May 2009, CHETNA's partner NGO in this project, Society for Education Conscientisation Awareness and Training (ECAT), Bodhgram, conducted a participatory health needs assessment exercise in 120 villages of the district. Strengthening existing Village Health Sanitation and Nutrition Committees (VHSNC) and enhancing universal access to public health services were highlighted as crucial needs in the assessment.

It was evident that community members were not aware about the role and responsibility of VHSNCs. In fact, even the VHSNC members themselves were unaware of their role and responsibility or about the provisions of untied funds under the National Rural Health Mission. Although the committees were in place in 2008, VHSNC members had not undergone any training until the assessment was done.

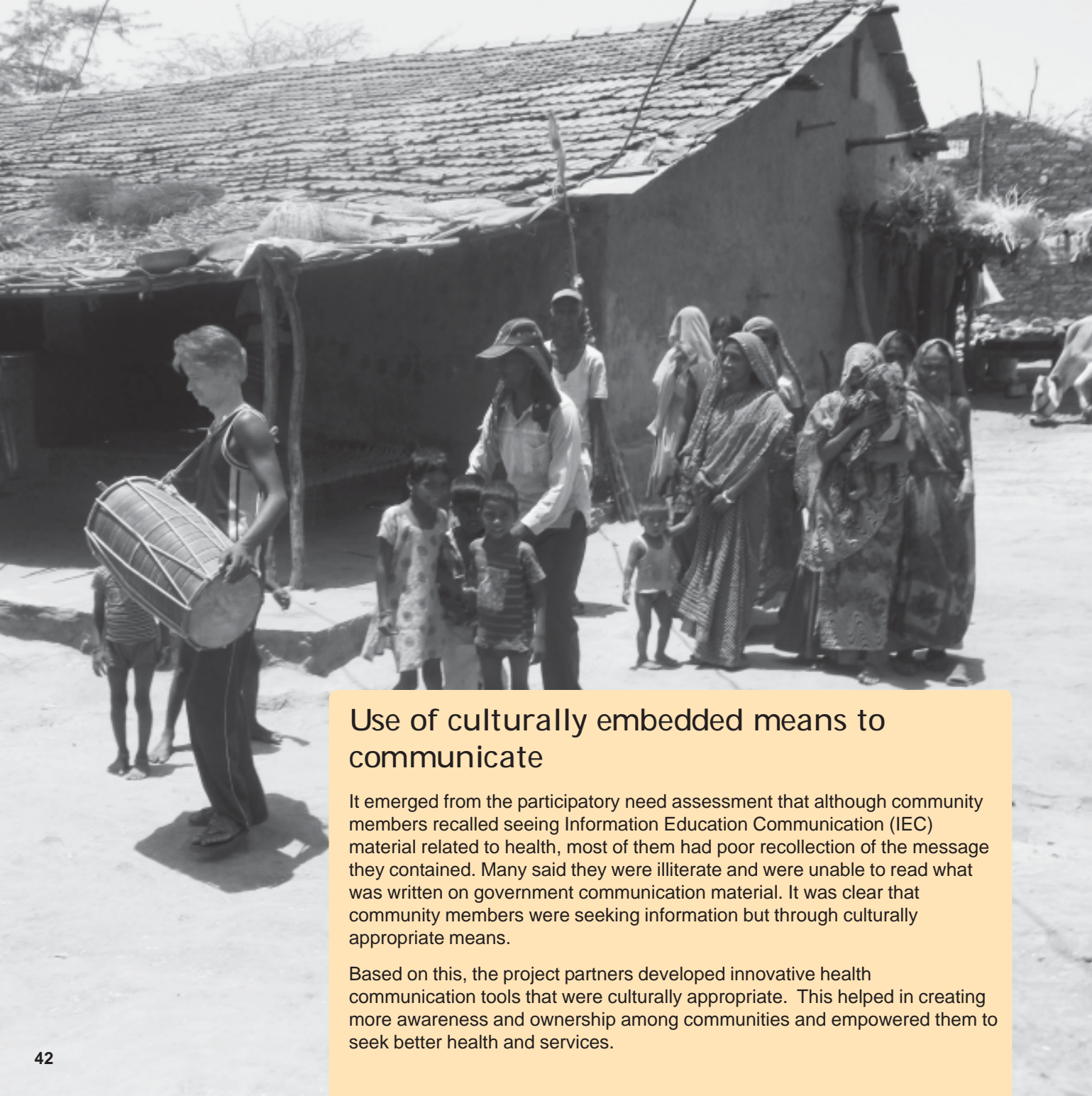
The ECAT team took on the challenge of reviving and strengthening the VHSNCs. The first step was to make the members aware of the significance of the committee, and their role and responsibilities as members. Further, they had to be motivated to participate actively and contribute in the functioning of the committees.

As the first step, in July 2010, the ECAT team visited Kiratpura village and interacted with the VHSNC members. The idea was to ensure that the meetings

are held regularly and the members are motivated to take action. The team also met the auxiliary nurse midwife, *anganwadi* worker, *ward panch* and other members of the *panchayat* and spoke to them about the importance of the VHSNC. Regular follow-ups were conducted throughout the year and this made sure that the VHSNC was working efficiently.

During a follow-up visit in February 2011, the ECAT team was informed that for the last two months nutritious food was not being supplied to the *anganwadi*. The VHSNC team was encouraged to bring up the matter during the next committee meeting. The *anganwadi helper* shared this concern at the meeting and wrote a letter to the Child Development Project Officer (CDPO) of Karauli informing about the situation on the field. The ECAT team also spoke to the CDPO over the phone. In a week's time, the *anganwadi* received the fresh, nutritious food supply.

Although this may seem like a small incident, it has encouraged the VHSNC members to continue working committedly towards creating a healthy village. VHSNC meetings are now held regularly in Kiratpura and people are actively involved in community health care services. The ECAT team has helped in regularizing the functioning of 15 VHSNCs in the Karauli block and the dream of having healthy people and healthy villages in this district does not seem unachievable anymore.



Use of culturally embedded means to communicate

It emerged from the participatory need assessment that although community members recalled seeing Information Education Communication (IEC) material related to health, most of them had poor recollection of the message they contained. Many said they were illiterate and were unable to read what was written on government communication material. It was clear that community members were seeking information but through culturally appropriate means.

Based on this, the project partners developed innovative health communication tools that were culturally appropriate. This helped in creating more awareness and ownership among communities and empowered them to seek better health and services.



Rhythmic Drum Beats for a Healthy Life

Most villages in Anandpuri block of Banswara district, Rajasthan, were performing poorly on maternal and child health indicators – the level of antenatal and postnatal check-ups, the extent of immunisation was worrisome. There was almost no awareness regarding the benefits of institutional delivery and entitlements under Janani Suraksha Yojna among the local community. One would expect the Maternal and Child Health Nutrition (MCHN) day celebrations to contribute in enhancing the maternal and child health, but the attendance during this programme in these villages was also dismal.

Under the National Rural Health Mission (NRHM) there is provision for the utilisation of untied funds of Rs 1,200 per year by the Village Health Sanitation and Nutrition Committee (VHSNC) for promotion of MCHN day every month. But due to lack of awareness, the untied funds were not being used for promotion of MCHN day in Anandpuri. The information about poor utilisation of the untied funds here was published by a leading regional newspaper, *Dainik Bhaskar*.

This article caught the attention of one of the staff members of Association for Sarva Seva Farms (ASSEFA), CHETNA's partner NGO in this programme, working in Banswara district. The organisation held a series of meetings with the Panchayat (local self government) members wherein the findings of an evaluation of the health status of the region were discussed. Information on roles and responsibilities of the panchayat members in implementation of NRHM, and the provision of untied funds was also shared.

Inspired by the discussions during these meetings, Devilal Masar, a member of the Navgaon panchayat, Anandpuri block, realised the importance of his role and decided to do something to create health awareness. He thought of using traditional folk media to promote the MCHN day. He used drums, which are a living tradition in the Indian social system and are popularly used in ceremonial and religious functions, to announce the MCHN day in four villages.

The initial response was slow. Women came out in small numbers. Those who did, thought there was a celebration in the village. They were not interested in MCHN day services. It took a lot of convincing to ensure that the initial curiosity generated by the beating of drums was converted into utilisation of services. The panchayat members found it difficult to generate and sustain the interest of the community members in women and child health related issues.

Over time, the *sarpanchs* of six more villages decided to follow suit and utilise the untied funds under NRHM for MCHN day promotion using drum beating. In these villages, the number of women attending MCHN day celebrations and utilising services has begun to increase gradually from four or five, to about 10 and 15. It is envisaged that this trend will continue and all eligible women and children will be aware of the benefits of MCHN day and they will actually utilise them. The story shows how Devilal harnessed the potential of traditional media wisely and, gradually now a simple communication initiative seems to be converting into community action.



जेस्टार शा.पं. कंचनपुर.
द्वारा रजिस्ट्रेशन शा.पं. में
हस्ताक्षर और मुद्रा में प्रमाण पत्र पाये

रजिस्ट्रार
श्री.पं. कंचनपुर



कट बो
करें
आप
हार्दिक स्वागत



This Magic Works!

The area under the Karauli block in the Karauli district of Rajasthan is commonly known as 'Daang'. The economy of this district mainly depends on mining activities. It is largely a rocky and forest covered area and is inhabited by a scattered population comprising people working in the mines, or those engaged in agriculture or animal husbandry. Their literacy and education levels are dismal; as is the awareness on maternal and child health services, especially, among the tribal community.

The Society for Education, Conscientisation, Awareness and Training (ECAT), Bodhgram - CHETNA's project partner, adopted a novel way to create awareness on maternal and child health services and entitlements among the community.

They used magic shows as forums to share health information. They felt it was an effective way of bringing those people together who did not attend meetings. It turned out to be effective in holding their attention, making them think and act.

Since January 2011, the ECAT team has been organising magic shows in villages. For this, they got in touch with a magician and discussed the information that was to be disseminated among the people. Team members visit the designated village in the morning and inform residents about the show, individually and using public address systems. Close to 300 people usually gather in the audience for the magic show, a majority among them are primary beneficiaries of maternal and child health entitlements.

The magician begins with items from his regular magic shows. Once the crowd is engrossed in the show, he begins sharing information about health

rights and entitlements typically in-between-items. He then speaks on various topics for example, the need for Tetanus Toxoid injections and how they can be accessed; the importance of complete immunisation (BCG, DPT, Polio, and Hepatitis) and where one can get immunised; importance of institutional delivery; the importance of nutritious food, etc. He sings songs to provide information about different diseases, precautions and treatments. The magician also demonstrates how to use the ambulance service ('108') (what information should be provided once the call is made) and the benefits of using the specialised service over other private vehicle services.

Such magic shows were held eight times in a month and were attended by nearly 2,000 people. At the end of each show, the ECAT team distributed leaflets containing information on maternal and child health and services.

A month after the magic shows, the Medical officer and staff of Kanchanpur Primary Health Centre in the region validated that the number of calls for '108' ambulance service had indeed gone up. The turnout at vaccinations had also increased.

The staff proposes that such magic shows should be organised throughout the block for awareness generation and utilisation of maternal and child health services.

This story shows how audience engagement was used to communicate messages on maternal and child health. It also goes to show that entertainment is probably more powerful than delivering sermons and that...this magic will surely work!

Listening to and Giving a Voice to the Marginalised

“It has been demonstrated that economic and technological inputs will go under-utilised without knowledge, and it is for the sharing of knowledge that communication is indispensable. For social change to occur there must be opportunities for dialogue” says Silvia Balit, a noted Development Communication Consultant.

The experience of implementing the “Participatory Communication Initiative for Improving Communities’ Access to Health Services” project demonstrated that health communication is much more than providing one way information to people. It is a powerful medium for a two way dialogue among all the stakeholders including the community, and can play a crucial role in empowering people to set their own agendas.

Participatory health communication can be a means to develop local effort, local alliances, and to promote a spirit of self help in the community leading to a demand for better health standards.

Stories in this booklet demonstrate that after the community members were empowered with health information, over a period of time, a cadre of change agents was created who were able to communicate, discuss and take action on health related issues and concerns and achieve outreach and accountability.

Learning: Participatory communication is a result-oriented process. It enhances the information, skills and self confidence of people and empowers them to gain control over the decision making on matters related to their lives. It is difficult to implement it within the rigid time frames (of project and donor requirements) for quick results because for social change to occur it is important to pay attention to the needs and priorities of the community members and take them along.

Interventions carried out under this project in 40 districts of seven states in India brought forth some important points which may be useful for the development of the other health programmes. They are:

- Community members are the main actors in the process of social change and not merely passive beneficiaries. They need to be involved from the programme planning stage itself.
- The health of the community especially, the marginalised community is influenced by their social environment which includes their personal behaviour. In view of this it is necessary that the campaign for social change is initiated by the community itself.
- Development should be seen as a transformative process (both at the individual and social levels) through which, communities become empowered to initiate a process of change.

On the basis of the experiences of the project, the following models were identified:

- **Integrating participatory communication in programmes:** Principles and pillars of participatory communication were used successfully at every stage of project implementation such as community needs assessment, capacity building, dialogue, as well as providing forums for advocacy.
- **Communitisation of health care:** Many a time, community participation in public health programmes is limited to them being passive beneficiaries. But in this project, the community members played an active role in determining their own health needs and priorities, raised their voices and exercised their right to better health services and standards.

સામાયોજના વિગેરેનું જન જાગૃતિ
મલનાર અભિયાન દ્વારા તાલુકાના
ગૃહ વિષયક સેવાઓની જાણકારી
મંથી બહાર લાવી આરોગ્ય વિષયક
ધરાશે. આ માટે ચિત્રાબેન ઐયર,
કેશભાઈ ઓડ તથા બ્લોક હેલ્થ
ઉદાવી રહ્યા છે.

अलर्ट संस्थान के सी.के. जुला ने बताया कि वह मैरिटाज व विल मेट्स काउन्सिलर के सहयोग से एनआरएफएल की योजनाओं की समुदाय, गांव व कस्बा स्तर तक पहुंचाने के पापसट प्रोजेक्ट पर कार्यरत हैं। योतन संस्थान अलर्टबाद की परिषदेजना प्रवक्ता पित्र अग्रवर ने कहा कि समुदाय स्वास्थ सेवाओं का अपेक्षित उपयोग नहीं कर सकते हैं, जब उन्हें इन सेवाओं और कार्यक्रमों का जानकारी हो। कार्यक्रम में अलर्ट, एक्ट आनस करवैल, एसआलेपीएस चुक, अग्रवास अलवर, असेका बॉसबाड़ा के प्रतिनिधियों ने हिस्सा लिया।

इसी के तहत सहभागी संस्थाओं के समुदाय स्तर पर रहे सफल अनुभवों को संकलित पुस्तिका 'सहरे परिवर्तन की' का विमोचन शिशु स्वास्थ्य अधिकारी डॉ. रमेशचन्द्र शर्मा की उपस्थिति में किया गया। संचालन सहभागी संस्था अलर्ट के संस्थापक बी.के. गुप्ता ने किया।

[illegible]

About CHETNA

CHETNA* meaning “awareness” in several Indian languages and an acronym for Centre for Health Education, Training and Nutrition Awareness, is a non-government support organisation based in Ahmedabad, Gujarat. Beginning its activities in 1980, CHETNA addresses issues of women’s health and development in different stages of her life from a “Rights” perspective.

CHETNA supports Government and Non-Government Organisations (GO and NGOs) through building the management capacities of education/health practitioners/supervisors/ managers enabling them to implement their programmes related to children, young people and women from a holistic and gender perspective and advocate for people centred policies and programmes.

CHETNA develops need-based training and education materials, which are widely disseminated at the State, National and International levels.

CHETNA's Information and Documentation Centre (IDC) is a rich source of information for the needs of individuals, organisations, academicians, researchers and students.

CHETNA has been identified as a Regional Resource Centre (RRC) for Gujarat State and the Union Territories of Daman, Diu and Dadra Nagar Haveli to provide technical assistance to NGOs to improve Reproductive and Child Health (RCH), facilitate GO-NGO partnership, document and disseminate successful approaches and provide inputs to Government of India (GoI) to ensure effective implementation of policies.

*CHETNA is an activity of the Nehru Foundation for Development, which is a public charitable trust, registered under the Bombay Public Trust Act 1950.

Regarding Communication for Health India Network (CHIN):

CHIN was established in 1998 in partnership of four institutes. They are :

- 1 Child in Need Institute (CINI), Kolkata, West Bengal
- 2 Christian Medical Association of India (CMAI), New Delhi
- 3 Centre for Health Education, Training and Nutrition Awareness (CHETNA), Ahmedabad
- 4 Rural Unit for Health and Social Affairs (RUHSA), Vellore, Tamilnadu

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About the Booklet

As part of the project "Participatory Communication Initiative for Improving Access to Public Health Services for Rural communities" under NRHM, CHETNA was involved in empowering communities in five identified blocks of five districts each in Gujarat and Rajasthan states of India, so that they demand and avail health and nutrition services available under the National Rural Health Mission (NRHM) of the Government of India.

The project adapted a multi-pronged strategy and a range of processes for different geographical areas viz. tribal, arid and desert areas and rural areas to reach out to the community to promote awareness on available public health services. It has been encouraging the people who are living with the daily challenges of poverty to take action for their own health and well-being. As a result of the project, a positive impact has been observed in the communities' health status in the project areas.

Some of the valuable experiences from this project have been documented in the form of this booklet "Stories of Change". The 20 stories capture and highlight how the project was helpful in leading a change through community participation, dialogic process, amplification of the voices of the vulnerable, creating ownership through internal change agents and use of culturally embedded means to communicate. The stories show how everyone can make a difference provided one has the will, patience and perseverance.

It is an effort to share the participatory communication processes that inform and inspire the collaborating project partners and how these were employed to enhance the communities' access to health and nutrition services in the intervention areas.

We hope that this booklet will throw light on creative approaches/solutions to some of the issues that are encountered at the community level and will inspire and motivate others who are engaged in the development sector, to extend the communicative experiences shared here and respond to unmet needs maybe in a different context.

We invite everybody to join us in firmly supporting the initiative of "Health for All".