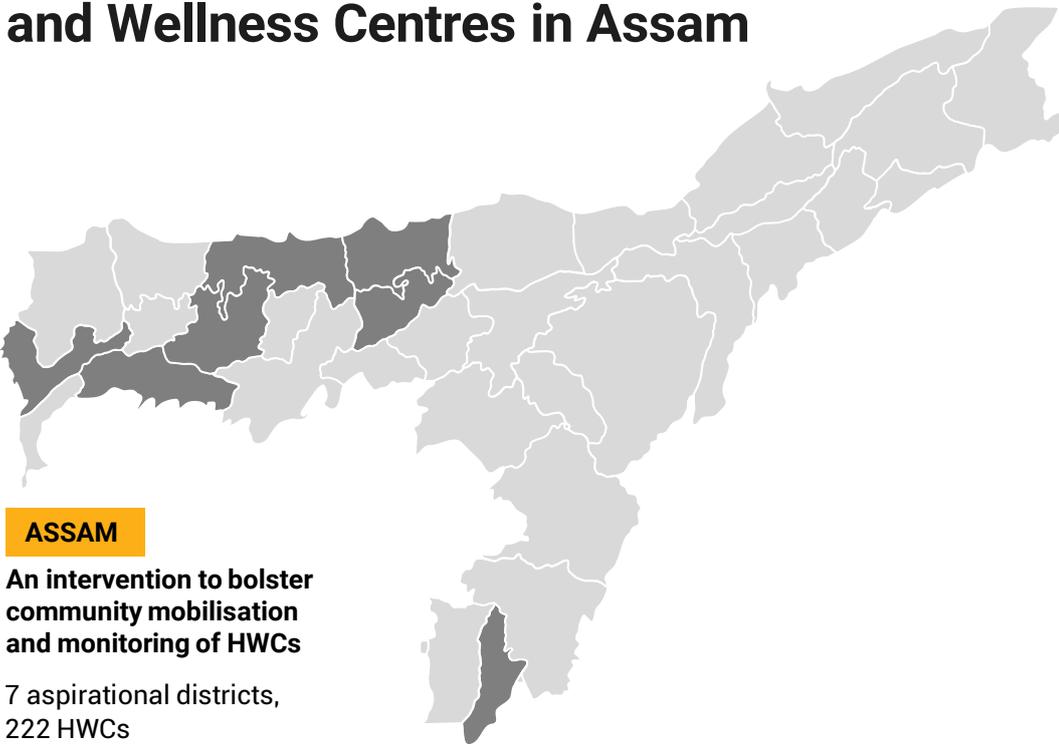


COMMUNITY ACTION FOR HEALTH

Bringing public into public health

Empowering the community to actively engage and monitor services at Health and Wellness Centres in Assam



ASSAM

An intervention to bolster community mobilisation and monitoring of HWCs

7 aspirational districts,
222 HWCs

India's commitment to quality, accessible care has received a further boost with the ambitious Ayushman Bharat scheme to provide comprehensive primary health care through Health and Wellness Centres (HWCs) across the country. As India strides towards its year 2022 goal of upgrading 1,50,000 existing Sub Health Centres (SHCs), Primary Health Centres (PHCs) and Urban Primary Health Centres (UPHCs) into HWCs, it is crucial that people be at the centre of this change. Local communities must be involved to ensure that the public health system makes quality care available and accessible to fulfil people's health needs.

Community Action for Health (CAH), a key strategy under the National Health Mission (NHM), Government of India, has demonstrated an innovative approach in Assam to promote community mobilisation and monitoring of HWCs. Its pilot has showcased a simple but effective strategy to secure the community's participation in accessing and demanding services, monitoring the availability to services and providing feedback, thereby facilitating improvements in the quality of health care.

This brief summarizes the processes adopted to strengthen community mobilization and monitoring of HWCs and how the community's feedback led to corrective actions on the ground.

#1

INNOVATION SERIES

An intervention for community mobilisation and monitoring of Health and Wellness Centres

CONTEXT

Assam initiated community-based monitoring in 2007. Currently, CAH implementation in the state focuses on seven aspirational districts: Baska, Barpeta, Darrang, Dhubri, Goalpara, Hailakandi and Udalguri, covering a total of 55 blocks with 1,110 Village Health, Sanitation and Nutrition Committees (VHSNCs).

Assam is establishing 1,720 HWCs at the Sub Health Centre level. During the pilot's implementation (2018–19), 222 of these HWCs were set up in the seven aspirational districts. The state NHM designed and piloted a community-side intervention under CAH to mobilise the community and promote their active involvement in the formative stages of HWCs. The pilot was implemented by the State Community Processes Unit (SCPU) in December 2018. The Advisory Group on Community Action (AGCA) gave support to the pilot by guiding the implementation processes, designing tools and co-facilitating training of trainers with NHM.

INTERVENTION

The pilot intervention focused on building the community's capacity to monitor how well the HWCs are functioning and what gaps and issues need to be addressed to ensure people receive the intended quality of comprehensive primary health care at HWCs. The key steps of the intervention are listed below:

A. Preparatory and facilitative processes

- 1. Development of a tool kit:** A tool kit was developed to build VHSNC members' awareness about what services are available at HWCs and how feedback can be collected on the functioning of HWCs and the issues being faced by patients. The tool kit was made available in English and two local languages (Assamese and Bengali).
- 2. Creation of a pool of master trainers at the district level:** Thirty-four personnel, including Block Community Mobilisers, ASHA Supervisors and Assistant Block Programme Managers, were trained as master trainers. The training was facilitated by SCPU and AGCA.

Health and Wellness Centres represent India's bold commitment to secure comprehensive, quality health care at the primary level. Active engagement of communities will be crucial to achieve the goal of improving the availability of and access to quality health care by people.

ENGAGING COMMUNITIES TO DEVELOP LOCALLY RESPONSIVE HEALTH CARE: A SNAPSHOT



Orientation of district master trainers



Orientation of VHSNC members



VHSNC members monitor services at an HWC



Patient feedback is collected



VHSNC members hold a dialogue with the HWC's Community Health Officer and ASHA Supervisor

3. Creation and training of village-level feedback teams: Local feedback teams at the village level were developed to create awareness and seek independent feedback about the functioning of HWCs and the issues patients were facing. The feedback team for an HWC comprised three active members from each VHSNC falling in the catchment area of the HWC. ANMs and ASHAs selected feedback team members from among the community representatives that were part of VHSNCs, including panchayat members, young mother's groups, farmer's groups, etc. A total of 3,200 VHSNC members were selected and trained to collect feedback about HWCs' functioning, the costs being incurred by patients to get treatment, identify gaps and conduct discussions with HWC staff to find solutions.

B. Field implementation

4. Monitoring of HWCs and collection of feedback: The feedback teams, comprising trained VHSNC members, went to HWCs on a bi-monthly basis to identify gaps and get patient feedback. Information was collected and recorded on feedback forms about whether staff such as Community Health Officer (CHO) and Multipurpose Health Worker (MPW, male and female) were available; whether the intended health services, diagnostic tests, drugs and other commodities were being provided to people; and whether facilities such as a clean waiting area, a usable toilet and drinking water were available. Feedback was collected from patients about the behaviour of health staff and the

out-of-pocket expenses being incurred. The feedback teams also held preliminary informal discussions with the CHO, ANMs and MPW on the identified gaps and sought ways to plug these gaps.

5. Analysis of feedback and action plan to fill the gaps: The feedback teams held a focus group discussion with the CHO and the HWC staff to discuss the findings. An action plan was put in place, including the corrective action(s) required to fill the gap(s), the person/body responsible for the action and the timeline for action. Data from different feedback forms was fed into Google forms for compilation and analysis at the state level to identify and analyse critical issues.

IMPACT

Based on feedback from the community, the state NHM Mission Director issued instructions to Joint Directors at the district level to act on the gaps the community had identified. Among the gaps highlighted by the community at several HWCs were: infrastructural issues like lack of power back-up, seating arrangements and drinking water facility; irregular supply of medicines; vacant positions of health staff and need for labour room equipment. Informed by such feedback from the ground, the concerned district authorities are taking actions to resolve issues and improve the quality of health care at HWCs. The illustration below shows two examples of how feedback from the ground has led to corrective actions.

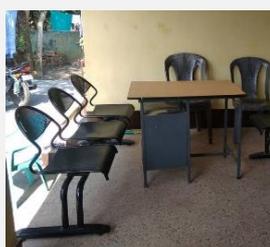
COMMUNITY FEEDBACK PROMPTS CORRECTIVE ACTIONS: A FEW EXAMPLES

ISSUES HIGHLIGHTED BY THE COMMUNITY

Irregular supply of essential drugs

CORRECTIVE ACTIONS

Letter issued by the Office of the Joint Director of Health Services, NHM, Goalpara district, to drug management personnel to ensure proper flow of essential drugs to HWCs



Lack of power back-up facility, inadequate provisions for waiting area and drinking water supply

Office of the Joint Director of Health Services, NHM, Udalguri district, ensured repair of the generator and setting up of waiting area and drinking water facilities



BRINGING COMMUNITY VOICE INTO HEALTH SERVICE DELIVERY

COMMUNITY MEMBERS SHARE THEIR FEEDBACK ON AN HWC IN ORANG BLOCK, UDALGURI DISTRICT, ASSAM

- “The community of this village and the hospital staff are committed and working together to improve this Health and Wellness Centre. Things have really changed at this HWC, and we are happy with the services provided.”
- “The doctor is available 24-hours and we get consultations, medicines and tests. If the ultrasound and X-ray facility could also be made available here and also some small things, like a few more chairs and racks to keep medicines, this HWC will become even better.”
- “Although this HWC is for four villages, people from at least six to seven adjoining villages, and even far off villages, come here for delivery. It is because the doctor here is always present and the staff is very dedicated.”
- “The onset of summer brings several ailments. The doctor here gives good attention to everyone, but his workload is too much... About 25–30 deliveries are conducted at this HWC every month! An additional doctor is needed here to share this workload.”



LESSONS LEARNED

- Identification of real issues on the ground requires independent feedback from the community. Creation of a village cadre — feedback team — that was devoid of frontline health workers and HWC staff allowed real, unbiased information about gaps and issues to emerge.
- Empowering and training community members to take up the responsibility of monitoring health services gave them a sense of ownership, pride and confidence, which are critical to foster active community engagement.
- Mentoring and continuous engagement can help lay the foundation for mutual trust between health functionaries and the community. The state, district and block NHM teams owned the processes and supported the initiative to promote community participation.
- Providing the community members with an easy-to-use tool kit, as provided by the pilot, can motivate and enable them to contribute effectively. The illustrated tool kit was easy to understand and use and served as a composite resource that built the community's

awareness and enabled assessment of HWC services, collection of patient feedback, and discussion with HWC staff to plug the identified gaps. It, thus, proved to be a useful mechanism to bring in the various steps of monitoring, which reduced delays in initiating corrective actions.

- Prompt redressal of the issues raised is necessary to keep up the motivation and interest of the community.

THE WAY FORWARD

The intervention has demonstrated its effectiveness in securing community participation to improve the quality of local health service delivery. In FY2020–21, Assam will scale up the intervention to 58 more HWCs in the seven aspirational districts. Some key aspects of the intervention, such as an in-house pool of master trainers and a tested tool kit, augur well for scaling up this initiative in other states as well. All the states already have ASHA and VHSNC trainers at the district and block levels, and this resource could be leveraged to roll out the intervention swiftly and efficiently.



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