

## *From the editors desk....*

Dear Readers!

We at Public Health Resource Network are very delighted to present the first edition of our newsletter: "*Swasthika*". PHRN made its presence in Bihar in the year 2008 and has slowly carved a niche. This Newsletter is a small initiative to share our experiences and opinions with all of our friends. We hope this newsletter will be enriching and also help the readers to be more familiar and to get associated with us and with the issues of public health.

Based on the indicators, mostly related to primary health care infrastructure and reproductive and child health care the state of Bihar ranks at 35th position in the country (DLHS 2002-04). The Rural Healthcare of Bihar represented by 1641 PHC out of which only 208(13%) have labour room and 218 are with OTs (Times of India, 22 November 2007).

Moreover, Bihar is amongst one of the States ranked lowest on Human development Index. High Maternal Mortality Rate of 312 (SRS 2004-06) , low Rural Institutional births 18.6 (NFHS 3) High Total Fertility Rate (4.2,NFHS 3) and High Infant Mortality rate 52/1000 (SRS Bulletin, volume 45 No.1) of Bihar keeps reminding us about how much more work needs to be done on this front before the goals of NRHM could be realized. This also makes the role of all development partners & NGOs including PHRN imperative to supplement & complement states efforts in this direction.

PHRN, Bihar since its inception from the year 2007 is taking best possible efforts to strengthen Public Health system by networking and partnering with various Individual and agencies striving for "Health for all" with special focus on our engagements with state & district health societies.

Health as we all know has complex and multidimensional aspects .We will through this newsletter try to capture issues mostly pertaining to accessibility, availability and effectiveness of Public Health service delivery under the aegis of National Rural Health Mission.

We cordially invite your valuable suggestions and comments for enrichment of the Newsletter.

*With Best compliments*

*Swasthika Editorial Team*

## पब्लिक हेल्थ रिसोर्स नेटवर्क..... एक नजर

जिला स्तर पर तकनीकी संसाधनों के व्य आदान-प्रदान और लोक स्वास्थ्य तंत्र के सुदृढीकरण में योगदान देने तक है। इसका त्वरित उद्देश्य है, जिला स्तर पर स्वास्थ्य आयोजन व कार्यक्रम के इच्छुक समर्पित व्यक्तियों व संगठनों के नेटवर्किंग की नितांत आवश्यकता क्रियान्वयन में राष्ट्रीय ग्रामीण स्वास्थ्य कार्यक्रमों को बल मिल सके।

जन स्वास्थ्य संसाधन नेटवर्क एक क्षमता विकास कार्यक्रम है जो सरकारी एवं गैर-सरकारी संगठनों के स्वास्थ्य कर्मचारियों के साथ जुड़कर राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के कार्यक्रमों को जमीनी आधार प्रदान करता है। यह नेटवर्क उन सभी व्यक्तियों, संस्थाओं, एनजीओ, राज्य स्वास्थ्य समितियों तक पहुँच बनाने एवं उनकी योग्यता का विस्तार कर स्वास्थ्य के स्वरूप में बदलाव लाने को प्रेरक है।

पीएचआरएन सन् 2005 से छत्तीसगढ़, झारखण्ड, बिहार एवं उड़ीसा राज्य में कार्यरत है। यह स्वास्थ्य से संबंधित कार्यक्रमों में राजस्थान, हरियाणा, उत्तराखण्ड एवं उत्तर-पूर्वी राज्यों में सहयोग प्रदान करता है। जहाँ पीएचआरएन एक ऐच्छिक नेटवर्क है जिसमें अनेकों जन स्वास्थ्य कर्मी जो श्रमसजी वित्त सस्र के लक्ष्य को प्राप्त करने में अपनी क्षमता विकास कर प्रयत्नशील हैं, जुड़े हैं। वहीं जन स्वास्थ्य संसाधन समिति एक कोर ग्रुप है जिसने इस नेटवर्क की शुरुआत की है। पीएसआरएस कुछ सदस्यों एवं फुल टाईमस का समूह है जो पीएचआरएन को नेतृत्व प्रदान करता है और इसके क्रियान्वयन को संभालता है।

### Our efforts and achievements....

PHRN, Bihar has been consistently involved in supporting community participation in health programs and capacity building for enhancing community processes under the NRHM. In this regard, in the year 2010, we were involved in VHSC orientation in Rohtas, Jehanabad, Vaishali, Araria and Nawada. We were also part of the Training of Trainers as a nodal capacity building agency, for the “Rogi Kalyan Saptah” observed in the month of August across all thirty eight districts of Bihar. We were directly involved in orientation for the formation and functioning of Rogi Kalyan Samitis and follow up on action in Araria, Banka, Kishanganj, Bhagalpur, Kaimur, Bhojpur, Buxar, Rohtas, Nawada, Nalanda, sheikhpura, Lakhisarai, East Champaran, Siwan, Betiah, Vaishali, Muzaffarpur, Samastipur, Jehanabad, Aurangabad.

One of the core programs of the organization has been the Community Health Fellowship Program, a two year full time programme, which provides young development professionals a strong back ground in the field of community health. The programme nurtures, grooms and educates the fellows in the states of Rajasthan, Bihar, Jharkhand and Orissa towards enhancing and strengthening of community processes in the NRHM in the districts and grass roots level. The fellowship programme imparts multi-disciplinary knowledge to the young professionals that is relevant to the context through a learning process that has action and reflection inbuilt into it. The focus is on creating community health professionals with high motivation and technical competencies to work with people, civil societies and the state to further

the ideals of 'Health for All'. The first batch of this fellowship graduated in December 2010, under which we made some remarkable achievements.

In Bihar, we started this journey with ten fellows (placed in 10 districts), while five left before the completion of the fellowship, five more stood with us till the end.

As a result of the consistent and dedicated action of our community health fellows, placed across ten districts in Bihar we have managed to bring about some useful and important changes. Some of them worth mentioning are:

- Introduction of RK-39 KalaAzar Testing Kit at peripheral level in Jehanabad
- Free Radiology and Pathology Services in all government hospitals of Bihar was the result of the survey report of the CHF in Gaya and Darbhanga.
- Adolescent Clinic opened in the PHC (Noorsarai) of Action Research.
- Development and strengthening of health network
- First district level workshop on RKS was conducted in Rohtas

Jay Krishna

•Rohtas

Raveej Ranjan Singh

•Gaya

Seema

•Nalanda

Shefali Kuntal

•Jehanabad

Jalaluddin Khan

•Muzaffarpur

Shweta kumari

•Samastipur

Nazish Neyaz

• Araria

Arun K Singh

•Aurangabad

Farhat Yasmin

•Vaishali

Saroj Kant Choudhary

•Darbhanga

## कम्युनिटी हेल्थ फेलो के रूप में मेरा अनुभव

जय कृष्ण  
सीएचएफ, रोहतास

कम्युनिटी हेल्थ फेलो के रूप में दो वर्ष मेरे कार्यजीवन का एक महत्वपूर्ण पड़ाव रहा है। इन दो सालों में मैं बहुत सारे नए तथ्यों से अवगत हुआ व कई महत्वपूर्ण षखिसयत से मिलने का अवसर प्राप्त हुआ जिनके विचारों ने मेरे आगामी कैरियर की दिशा को भी प्रभावित किया है। सिर्फ जीविकोपार्जन के लिए नौकरी करना मेरा शुरू से ही ध्येय नहीं रहा क्योंकि मेरा मानना है कि अपनी प्रतिभा व कौशल का उपयोग स्वहित में नहीं बल्कि जनहित में हो तो श्रेयस्कर है।

मैं अपनी कैरियर की शुरुआत स्वास्थ्य पत्रकारिता से की तथा फेलोशिप के पूर्व मैंने यक्ष्मा नियंत्रण कार्यक्रम में दो साल तक कार्य किया है। इस दौरान मैंने यह महसूस किया है कि सरकारी व्यवस्था के अंदर कार्य करने वाले कर्मचारियों में कार्य करने की प्रेरणा का अभाव है और यहां काम न करने के तरीके ढंढे जाते हैं। ऐसा नहीं कि सारे लोग ऐसे हैं पर जो अपनी पूरी उर्जा के साथ काम करना चाहते हैं उन्हें प्रोत्साहित करने के बदले हतोत्साहित करने का प्रयास भी किया जाता है। विगत दो साल में राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के साथ सघनता से कार्य करने के दौरान मुझे यह लगा कि इस कार्यक्रम में जितने संविदा आधारित कर्मी हैं उनमें कार्य करने की प्रवृत्ति भी है और उर्जा भी। हालांकि

पुरानी व्यवस्था ने उनको भी प्रभावित करने का पुरजोर प्रयास किया और कुछ लोग प्रभावित हुए भी परंतु कुल मिलाकर एक कार्यशील संस्कृति का निर्माण हुआ है जिसे आगे ले जाने की जरूरत है।

ग्रामीण समुदाय में स्वास्थ्य चेतना तथा उपलब्ध सरकारी सेवाओं की जानकारी का अभाव है जिसकी वजह से वे सरकारी स्वास्थ्य सेवाओं का समुचित लाभ नहीं उठा पाते दूसरी तरफ जो लोग सरकारी स्वास्थ्य केंद्रों पर पहुंचते हैं उन्हें भी गुणवत्तापूर्ण सुविधा प्राप्त नहीं हो पाती जिससे सरकारी सुविधाओं के प्रति उनका विश्वास प्रभावित होता है। हालांकि राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के तहत सरकारी स्वास्थ्य केंद्रों की सुधरती हालत ने लोगों में एक नई आस जगाई है और लोग सरकारी स्वास्थ्य केंद्रों पर आने लगे हैं लेकिन अभी भी स्वास्थ्य केंद्रों पर गुणवत्तापूर्ण स्वास्थ्य सुविधा बहाली की दिशा में बहुत काम होना पेश है साथ ही साथ स्वास्थ्य जागरूकता बढ़ाने की भी ज्यादा जरूरत है। मैंने इस दिशा में सार्थक प्रयास किया। जिला स्वास्थ्य की मासिक बैठकों में मैंने स्वास्थ्य कार्यक्रमों के अनुपालन में व्याप्त अड़चनों की तरफ अधिकारियों का ध्यानाकृष्ट किया। सामुदायिक बैठकों का आयोजन कर मैंने लोगों को स्वास्थ्य के प्रति जागरूक करने का प्रयास किया। मैंने पंचायत प्रतिनिधियों को स्वास्थ्य कार्यक्रमों के प्रति उन्मुख करने तथा उन्हें स्वास्थ्य सेवाओं को जनसुलभ बनाने में अपना योगदान देने की पैरोकारी की।

मेरा जन्म गांव में हुआ और ग्रामीण परिवेश से मेरा जुड़ाव रहा है इसलिए ग्रामीण समुदाय की जरूरतों से मैं पूर्वपरिचित हूँ परंतु कम्युनिटी हेल्थ फेलो के रूप में कार्य करते हुए मुझे ग्रामीण समुदाय की स्वास्थ्य जरूरतों व स्वास्थ्य समस्याओं के बारे में नजदीक से जानने को अवसर मिला।

किसी भी कार्यक्रम की सफलता में सामुदायिक सहभागिता का महत्वपूर्ण योगदान है इसके बिना स्वास्थ्य कार्यक्रम को जनसुलभ व जनहितकारी नहीं बनाया जा सकता। इसी मुद्दे को ध्यान में रखते हुए राष्ट्रीय ग्रामीण स्वास्थ्य मिशन में सामुदायिक प्रक्रिया का सम्मिलित किया गया है। रोगी कल्याण समिति, ग्रामीण स्वास्थ्य व स्वच्छता समिति व आषा कार्यक्रम इसके महत्वपूर्ण घटक हैं। कम्युनिटी हेल्थ के रूप में मैंने रोहतास जिले में देखा कि जिला स्वास्थ्य तंत्र इन विशयों पर अपेक्षित ध्यान नहीं दे रहा है। मैंने उपरोक्त मुद्दे पर सकारात्मक काम किया तथा इन विशयों को जिले के स्वास्थ्य योजना में महत्वपूर्ण स्थान दिलाने के लिए पैरोकारी की। मैंने जिले में रोगी कल्याण समिति, ग्रामीण स्वास्थ्य व स्वच्छता समिति की सुदृढीकरण की दिशा में महत्वपूर्ण काम किया। इसके लिए जिला व प्रखंड स्तर पर उन्मुखीकरण कार्यशाला आयोजित करने के लिए मैंने पैरोकारी की जो सफल रही। ऐसे उन्मुखीकरण कार्यशालाओं का सदस्यों पर काफी सकारात्मक प्रभाव पड़ा है।

लोगों की स्वास्थ्य आवश्यकताओं की पूर्ति के लिए लोक स्वास्थ्य तंत्र व सिविल संस्थाओं का प्रभावी समन्वय आवश्यक है। चर्चा के दौरान मैंने यह महसूस किया कि दोनों पक्षों का एक दूसरे के प्रति कुछ नाराजगी है जिससे दोनों पक्षों के बीच फलदायी गठजोड़ बनने में अड़चनें आती हैं। कम्युनिटी हेल्थ फेलो के रूप में मैंने लोक स्वास्थ्य तंत्र व सिविल संस्थाओं के बीच की कड़ी के रूप में काम किया तथा एक दूसरे की आवश्यक साझेदारी की पैरोकारी की जिसका सकारात्मक प्रभाव पड़ा। मैंने यह महसूस किया है कि जिले के स्वास्थ्य व्यवस्था में कम्युनिटी हेल्थ फेलो की महत्वपूर्ण भूमिका हो सकती है और राष्ट्रीय ग्रामीण स्वास्थ्य मिशन की सफलता के लिए लिए जिला स्तर पर ऐसे स्वास्थ्य कर्मों की जरूरत है जो समुदाय और तंत्र के बीच सेतु का काम कर सकें।

# गाँव की आशा

By Mukund Singh Munda

घर – घर जाकर जो बतलाती

जीवन की परिभाषा।

जरा गौर से देखो इसे

ये है गाँव की आशा।।

ये उनकी जिम्मेदारी।

नियमित टीकाकरण में रहती

इनकी भागीदारी।।

ज्यादा पढ़ी नहीं है फिर भी

स्वस्थ्य का पाठ पढ़ाती।

जच्चा-बच्चा की देखभाल

कर अपना फर्ज निभाती।।

हर व्यक्ति को स्वस्थ बनाना

इनका पहला काम।

ग्रामवासियों के लिए तो

ये ही एक वरदान।।

रोग मुक्त हो देश हमारा

इनका पहला नारा।

महिला और बच्चों की खातिर

ये एकमात्र सहारा।।

हर मुश्किल में हम लोगों को

देती साथ दिल से।

जरा गौर से देखो

ये है गाँव की आशा।।

## सत्य अनुभव

### ● जननी एवं बाल सुरक्षा योजना का लाभ

जननी एवं बाल सुरक्षा योजना राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के तहत शुरू की गई एक ऐसी योजना है जिसके अन्तर्गत प्रसव के लिए प्राथमिक स्वास्थ्य केन्द्र में आयी गर्भवती महिलाओं को प्रसव के बाद अन्य सुविधाओं के अलावा 1400 रु0 का आर्थिक लाभ मिलता है। हालांकि हजारों गर्भवती महिलाओं को इसका लाभ मिला फिर भी कुछ ऐसी परिस्थितियाँ हैं जिनपर ध्यान देना जरूरी है।

### केस स्टडी ब्लॉक. नूरसराय

ब्लॉक नूरसराय के अन्तर्गत एक छोटा सा गाँव है किशुनपुर। इस गाँव में महादलित मुशहर जाति की बहुलता है। हालांकि गाँव वालों की मुख्य पेशा खेती है परन्तु विशेषकर मुशहर जाति पड़ोस के गाँव के सम्पन्न किसानों के खेत में मेहनत मजदूरी करके अपना जीवनयापन करते हैं। गाँवों में प्रवेश करते ही मिट्टी का घर एवं फूस की छतों का सिलसिला शुरू हो जाता है। इन्हीं घरों में एक घर शीतल माझी का भी है। शीतल माझी की पत्नी गर्भवती थी। और एक 'आशा' जो कि बगल के गाँव से दो एक महीने में एक बार कभी आ जाती थी, के सौजन्य से जननी बाल सुरक्षा योजना का पता चला। प्रसव होने के लिए सरकारी अस्पताल की मुफ्त सुविधाओं के अलावा 1400 रु0 के लाभ को सुनकर शीतल

मांझी के साथ-साथ उनकी पत्नी भी काफी खुश हुई। आशा के नहीं आने पर शीतल मांझी ने स्वयं ही पत्नी को प्राथमिक स्वास्थ्य केन्द्र ले जाकर टी0टी0 के दो टीके लगवाये। सभी चीजें सही चल रही थी परन्तु एक रात अचानक उनकी पत्नी को प्रसव-पीड़ा शुरू हो गई। रात में किसी सवारी की सुविधा उपलब्ध नहीं होने के कारण शीतल मांझी ने समझदारी दिखाते हुए प्राथमिक स्वास्थ्य केन्द्र में एम्बुलेंस के लिए फोन किया परन्तु अस्पताल में बहुत देर तक किसी ने फोन नहीं उठाया। फिर बार-बार कोशिश करने पर फोन से जबाब मिला कि अभी एम्बुलेंस की सुविधा उपलब्ध नहीं है। अंततः शीतल मांझी की पत्नी को अपने गाँव की अप्रशिक्षित बुढ़ी दाई का ही सहारा लेना पड़ा। हालांकि जच्चा-बच्चा दोनों स्वस्थ हैं, लेकिन दोनों पति-पत्नी को इस बात का मलाल है कि तमाम एहतियात बरतने के बाद भी उन्हें प्राथमिक स्वास्थ्य केन्द्र की सुविधा और जननी बाल सुरक्षा योजना का लाभ नहीं मिल सका।

सवाल यह उठता है कि समाज में हाशिए पर डाल दी गई जाति के एक परिवार ने उस लाभ को उठाने का सपना देखा जिसकी सफलता की डंका पीटते हम अघा नहीं रहे हैं और कहीं न कहीं उन गरीब लोगों पर 'परदे के पीछे' से एहसान भी जता रहे हैं। पर जमीनी सच्चाई फिर भी कुछ अलग कहानी कह रही है।

प्राथमिक स्वास्थ्य केन्द्र के 24 घंटे की सुविधा उपलब्ध कराने के लिए यह जरूरी है कि स्वास्थ्य केन्द्र पर एम्बुलेन्स या अन्य वाहन अधिक संख्या में मौजूद रहे या उपकेन्द्र पर भी प्रसव की सही व्यवस्था दी जाए ताकि फिर किसी प्रसव पीड़ा झेल रही महिला को सचमुच हम सारी योजनाओं का लाभ दे सकें।

सीमा

सी0एच0एफ0 नालन्दा

### • Kala Azar: A situation analysis

Participatory Rural Appraisal was organized in the village Bungari of Chakia Block of east champaran district. This is the village in which maximum people were affected by kala azar and east champaran district is a district which is highly effected by Kala azar epidemic. Kala azar test is done in each of the PHC and patient is given Rupees fifty per day for the number of days he or she is admitted. All the doctors in the PHC and District Hospital are very active and keen towards Kala azar cure. No patient of Kala Azar is ignored in the facilities and all the curation steps are taken effectively.

I went to bungari village of chakia block as there were 7 patients of kala azar in that month in the PHC of this village. Visited a patient of Kala azar who was on the death bed. All the treatment has been taken by him from PHC. Further pity was that his wife was also having Kala azar and had also become weak . She was also taking treatment from PHC. When I further enquired the couple had called their daughter who was married in the nearby village as no one was in the house to prepare food and take care of them. Their daughter was also looking pale and ill. So I asked her if she is having any problem. She complaint of having fever since last week. But she had not yet went to PHC.

All this situation made me to further check the awareness level and prevention strategy that the family knew about Kala azar. This inquiry really lighten the fact that they knew that it might be due to mosquito and prevention steps was out of their thought. The nature of sand-fly, the importance of spraying, the need to clean their houses was never told to them. Only

taking clinical steps was not sufficient. Their houses was dark and wet. Small space and all beds on floor.

After visiting the other houses in the village and many patients of Kala azar, need for awareness, prevention strategies and community participation in running this epidemic out of the village came up. Only clinical aspect is not enough. There is a need for bringing drastic changes in the living pattern of people and all this with their participation and under their ownership.

Still this epidemic has not been controlled in the District.

**Shefali Kuntal**

**CHF, Jehanabad**

- **My Anganwadi is the best Anganwadi**

AWW Shamima Khatun of pokhaira village in Marwan block as been facing a problem on community level due to her minority identity. Some unsocial element used to stop people to use the facility provided through Anganwari, like Nutritious food, routine immunization etc. Due to this the health of children of this village affected seriously. Meanwhile I was on the way of visit to participate Mahila mandal meeting where I come to know about this problem and from then started making attempts to solve this problem. First of all i discussed with the AWW and tried to find out reality and then approach to local mukhiya and called a meeting of the villagers of this particular AWC. When we put all the outcomes and benefits of the services of AWC in front of the people and asked them it is your duty to look after the things happening at the centre, then they became ready to use the facility. Within a week a separate meeting with unsocial elements was conducted on this issue. After conversation with them we tried to find out their grievances and then it was found that the minority identity is not the problems of opposing them but they said selection of AWW (undemocratic way of selection) and the distribution of nutritious food was not properly given to the children. villagers suggested that this problem can be only solve when all people sit together and discuss upon. then it was decided that coming Mahila mandal meeting will the date to solve this problems in which all has to present. then at AWC a meeting was organize and AWW, complainers and community had sit together and ultimately sorted out this problems with the involvement of community and now this AWC with the full support of community is busy rendering its service for the children and women. Now that AWC *is one of the best running centre of this block.*

**Jalaluddin Khan**

**CHF, Muzaffarpur**

## **A Base line study: Assessing the status of exclusive Breastfeeding among Dalit and Muslim women in Araria**

**By Kundan Lal Sah**

**PGDDHM Intern, Araria**

In its 10<sup>th</sup> Five Plan, the government of India has set a target to increase the rate of exclusive breastfeeding during the first six months to 80 percents from the current level of 41.2 percent, and to Increase the rate of Initiation of breastfeeding within one hour to 50 percent from the current level of 15.8 percent. It also targets to increase the rate of complementary feeding for 6-9 months old infants to 75 percent from the current levels of 33.5 percent.

The 10<sup>th</sup> Five year Plan has also set state specific targets. For the state of Bihar these are to increase the rate of exclusive breastfeeding during the first six months to 80 percent from the current level of 55.2 percent (0-3 months), the rate of initiation of breastfeeding within one hour to 19.6 percent from the current level of 6.2 percent and increase rate of complementary feeding of infants aged 6-9 months from 15 percent to 33.6 percent.

This is a small account and a sneak peek into the results of the baseline study of breastfeeding practices among Dalit and Muslim families of two villages in Araria district of Bihar.

### **Background of the study**

It is estimated that worldwide 10.9 million children under five years of age die every year, of which 2.42 million deaths occur in India alone. The global strategy on infants and young child feeding, adopted by World Health Assembly (WHA), recognizes that two-thirds of these deaths occur during the first year and is related to inappropriate infant feeding practices. In terms of sheer numbers it comes to 16 lakhs deaths every year. Recently research on accelerating child survival published in the Lancet, clearly establishes that universal exclusive breastfeeding for the first six months is the single most effective child survival intervention-it reduce under-5 mortality by 13 percent.

Promotion of optimal infants and young child feeding practices is crucial of preventing malnutrition, early growth faltering, for reducing malnutrition, infant and neonatal mortality, and for promoting integrated early child development. Breastfeeding is a critical entry point for ensuring progressive fulfillment of children's right to survive, grow and develop to their full potential, without discrimination.

The enactment of the Infant Milk Substitutes, Feeding Bottles and Infant Food (Regulation of Production, Supply and Distribution) Act, 1992 (as Amended in 2003) is a major step forward in ensuring the best possible start in life for young children. It mandates that all mothers be empowered so that their Infants receive exclusive breastfeeding for the first six months. Thereafter, they shall receive optimal complementary feeding, along with continued breastfeeding up to two years of age or beyond. Scientific evidence is available that breast milk alone in the ideal nourishment for infants for the first six months of life, and their 'first immunization'. It contains all the nutrient, antibodies, hormones and antioxidants that an infant need to thrive- the 'nutrient provided by nature'. It protects babies from

diarrhea and acute respiratory infection, stimulates their immune systems and thereby prevents and reduces malnutrition, morbidity and mortality in infants and young children.

### **Status and 10<sup>th</sup> Five-Year Plan Goals for India and Bihar**

Data from NFHS-3 reflects that in India, 46.0 percent children under the age 3 years are underweight and in the state of Bihar, 55.0 Percent children under the age of 3 years are underweight.

According to the NFHS-3, in India, breastfeeding within one hour was initiated in only 23 percent of infants, only 46 percent of children of 0-5 months were exclusively breastfed. According to the Multiple Indicator Cluster Survey (MICS) 2000 of UNICEF India, the percentage of 'true' exclusively breastfed babies between 0-3 months is even lower (15.6 percent). Data from NFHS-3 also reflects that in the state of Bihar, breastfeeding within one hour was initiated in 4 percent of infants, which reaches 30 percent within 1 hour period. Also only 28 percent infants of 0-6 months are exclusively breastfeed.

After the age of six months, introduction of complementary feeding is critical for meeting the protein, energy, and micronutrient needs of the children. However according to NFHS-, in

India, it is delayed in the case of a substantial proportion of children. Only 56 percent of children (6-9 months old) who are breastfed consume solid or mushy foods. Further in Bihar, Only 15 percent children between 6-9 months of age receive complementary foods along with breast milk.

Recommended optimal infant and young children feeding practices

- Starting breastfeeding immediately after birth, preferably within one hour.
- Exclusive breastfeeding for the six months.
- Continued breastfeeding for two years or beyond.
- Introducing appropriate and adequate complementary feeding after 6 months.

### **Objectives of the study**

This study was done in Dalit and Muslim of Araria to accessing current infants feeding practices.

The study had the following specify objectives:

- To access the status of infants feeding practices in Dalit and Muslim of Araria.
- To understand the barriers of optimal breastfeeding practices.

### **Sample Selection**

The study was conducted in two villages like Hasa in Raniganj block and another Manikpur in Araria block. The total number of interview of mother in the study area was 100.

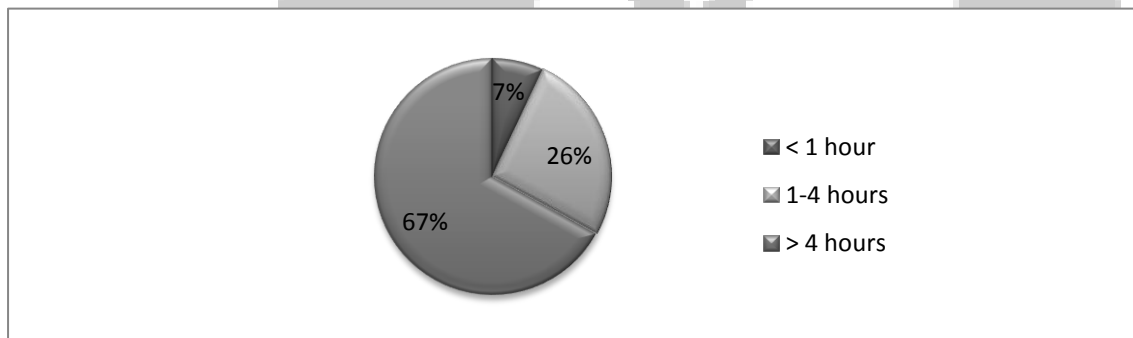
### **Profile of the sample**

Characteristics	Number	Percent
Age		

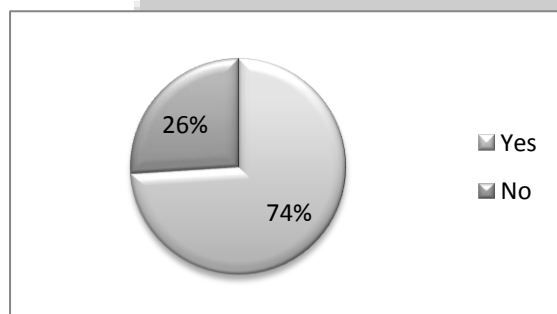
Up to 19 years	18	18
20-25 years	51	51
Above 25 years	31	31
<b>Education</b>		
Illiterate	72	72
Just literate/ formal education	10	10
Up to Primary	10	10
Up to middle	5	5
Up to Higher Secondary	3	3
Up to graduation and above	0	0
<b>Working outside house</b>		
Yes	62	62
No	38	38

## A glance on the key findings

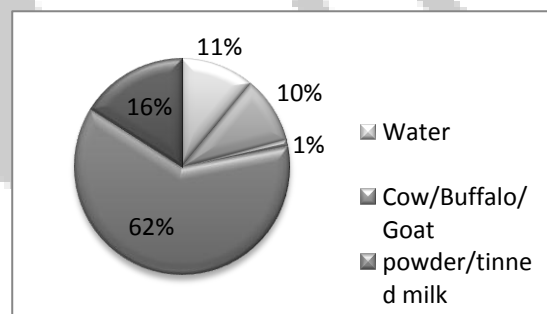
### Initiation of breastfeeding



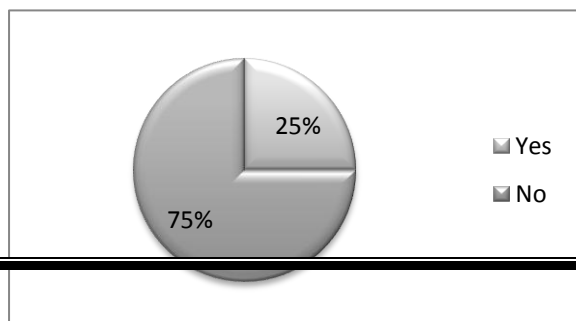
### Pre-Lacteal feeds



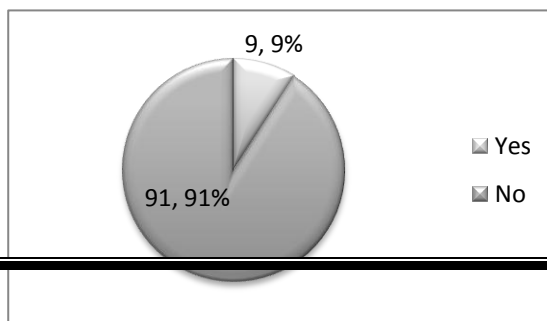
### Type of pre-lacteal feeds given to new born



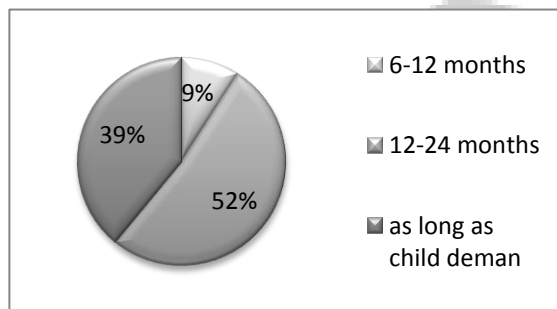
### Exclusive breastfeeding



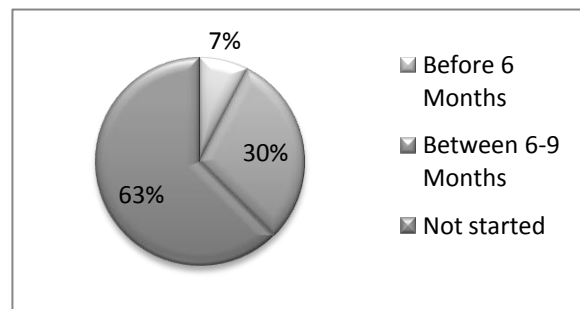
### Children 0-9 months using feeding bottle



### Continued feeding Plan to continue breastfeeding



### Starting complementary feeding between 6-9 months



### Challenges for adoption of Optimal Feeding Practices

- Mothers do not understand the advantage and importance of starting breastfeeding early.
- Mothers are not advised about starting breastfeeding, as well as the harmful effects of giving pre-lacteal feeds and water to the newborn immediately in the post natal period.
- Elders have influence on breastfeeding practices of mother; however, their knowledge about the most favorable infant feeding practice is sub-optimal.
- Mothers are not clear about the exact meaning and duration of exclusive breastfeeding.
- Family members do not support health workers for bringing about the necessary change.
- Knowledge and understanding of exclusive breastfeeding possessed by the health workers is not optimal. The confusing messages given by them are the major cause for sub-optimal infant feeding practices in this area. For example, some health workers advise starting complementary feeding after the age of 6 months while others after four months of the age.

### Conclusion and Suggested Action Ideas

The study shows that the breastfeeding practices followed in the Dalit and Muslim women in Araria district.

Following are the key finding of the study:

- Only 7 percent mothers initiated breastfeeding within one hour of birth.
- 74 percent mothers gave pre-lacteal feeds to their infants, the most common being sugar water.
- Only 25 percent mothers practiced exclusive breastfeeding for the first six months.

- Only 30 percent of children between 6-9 months of age were receiving complimentary feed like solid and mushy foods, also frequency of the complementary feed was not good enough.
- It was also observed that infant feeding practices among mothers were most influence by their mother-in-law, who themselves lack knowledge of optimal infant feeding practices. Therefore, efforts should be made to counsel mothers-in-law along with mothers during antenatal and postnatal period.
- Most health workers lack the knowledge of optimal infant feeding practices; hence all the health workers should be trained in this respect.
- Behavioral change in mother's breastfeeding practices is a long drawn process and requires a long term interaction of health workers with them.

## **Community participation in relation to the success of Public health Programs**

**By Rafay E. Hussain**

One of the most defining events in the global public health arena that gave community participation a prominent place in public health was the WHO and UNICEF sponsored conference on primary health care (PHC) at Alma Ata in 1978. The Alma Ata Declaration defined PHC as “essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO, Alma Ata Declaration VI, 1978, p.1). Some of the principles adopted at Alma Ata were proposed much earlier in the Bhore Committee Report 1946 that guided the formulation of the Indian National Health Policy 1983 (Deodhar, 1982). Following the Alma Ata conference, other developments such as the Ottawa Charter (1986) and Agenda 21 (1992) amongst others, have helped placed community participation high on the political and public agendas of nations.

The mission document of India's National Rural Health Mission, NRHM 2005–2012 (Min. of Health & Family welfare, Govt. of India, 2005) spells clearly the importance of community participation as part of the decentralized process of health care management. Community participation can be seen as an essential element in national health strategic plans or policies of nations like India, Sri Lanka, Brazil, Kenya and other developing countries around the world, and seems to indicate a growing consensus among policy makers on its importance for effective planning and implementation of development programmes including health.

The emphasis on community participation ushered a paradigm shift in health planning and health care delivery that called for the involvement of the community in both decision and delivery of health services most appropriate to them. The *Health For All by the Year 2000* campaign of the WHO having community participation at its core, led to the adoption of this concept by many countries as the means by which important health problems can be addressed. Further, national efforts emerged to establish and strengthen mechanisms for community participation in health through social policy, legislation and other public means (Oakley, 1989).

The Declaration of Alma Ata states in Para VII, “ Primary health Care ....requires and promotes maximum community & individual self reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate.” There are well known reasons for this emphasis i.e. A) a major part of the mortality & morbidity that people face are due to causes that can either be prevented through simple measures or treated with simple remedies or that can be managed by communities themselves. B) There is mismatch between people’s need and what services deliver leading to underutilization of services; C) People have both Rights & Duties to be involved in the decisions that affect their lives; and D) Communities possess resources of human power, natural resources like medicinal herbs, indigenous knowledge and even financial resources that can be used to enhance the quality of health care and effectiveness of health care services.

There are different levels of community participation: 1) People participate in the benefit of the program; 2) People participate in Program Activities; 3) People participate in implementing health Programs; 4) People’s participation in Monitoring & Evaluation and 5) People Participation in Planning Health Programs. In a democratic, republic country like India where much emphasis is on local self government and PRIs one needs to also see the community participation through PRIs in health programs.

Though, the term community participation has become so confusing that it can mean anything from consultation of a few select power-holders, to citizen empowerment through developing responsibilities and decision-making options to local citizens (Smith, 1991). Studies that have shown that: different people tend to understand the concept differently and planners, even those in the same programme, have defined community participation in different ways (Rifkin, 1986). One practical way is to look at community and participation separately and then applying that understanding in defining the concept as *‘a process by which people are enabled to become actively and genuinely involved in the defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change’* (WHO, 2002, p.10). An essential understanding is that effective community participation in health entails a side-by-side involvement of community members with health care professionals and a responsible sharing of both power and responsibility.

Though ‘Community Health Workers’(CHW) concept is well accepted now in India in the name of ASHA in NRHM but Community participation in health also involves other actors (organizations .. NGOs, CBO or groups of people like SHGs)). One example was the case of a malaria control programme in the Indian state of Karnataka, where a collaborative effort involving government and non-government agencies and local artists was successful in imparting health education using popular folk theatre (*Kalajatha*), resulting in an appreciable reduction of malaria cases (Ghosh et al, 2006). Programmes that maximise utilization of the existing human resources base within a community tend to achieve more in terms of community acceptance and participation.

“Community ownership means that local people must have a sense of responsibility for and control over programs promoting change so that they will continue to support them after the initial organizing effort” (Flynn, 1995, p. 28). This contributes in a great way for the sustainability of the program successes as well.

With certain examples one can always say with certainty that increasing community participation and ownership in health & other development programs would yield positive results. Nevertheless, it is not a process without challenges or even setbacks and it is imperative that policy makers, organizations, programme planners and the community members develop a common understanding and response to overcome the challenges or prevent failure in the varied processes of community participation.

It is important to understand that community participation is a dynamic process and there exist a host of influencing factors or determinants that can dictate the nature of outcomes of development or health programmes and their sustainability. Planners and professional development actors need to understand that in community participation, the emergence of issues from the community is a dynamic process where goals and strategies change over time (Hunt, 1990). The existing socio-cultural, political and economic environments within a community are likely to affect the degree of participation, the sustainability of which can be achieved only as long as the relevant actors (read Governments and its machinery & power wielding development partners) remain committed (Morgan, 2001). Further, communities entrenched in caste, class and gender hierarchies are likely to limit women's participation in health (Lahiri-Dutt and Samanta, 2002) and may well affect participation by Dalits & minority groups. Poverty is another issue that restricts people from participating in decisions that affect their health (Macfarlane et al, 2000). Hence having an understanding about the underlying issue/s within a given context may benefit programme planners in improving the prioritization and planning process while engaging with the communities.

The constraints that exist in a community also lend their effect to the environmental and contextual characteristics that can define or shape the strategies of health programmes, and hence it would not be farfetched to emphasize the need for a holistic approach in policy and planning to ensure fuller community participation and cooperation towards successful realization of programme goals and objectives. This would also be true with the realization of goals of NRHM in states like Bihar.

## **Village Health, Sanitation and Nutrition Day:**

### **Another step towards "Health for All"**

**By Suchita Kumari and Sharmishtha Nanda**

Village Health, Sanitation and Nutrition Day (VHSND) is envisaged as a medium to take primary health care delivery to every doorstep, under the NRHM. It provides a platform for the communities to easily avail of all the provisions of preventive and promotive health care services under one roof and in their own village.

The VHND is to be organized once every month (preferably on Wednesdays and for those villages that have been left out, on any other day of the same month) at the AWC in the village. This has been planned to ensure uniformity in organizing the VHSND. The AWC is identified as the hub for service provision in the RCH-II, NRHM, and also as a platform for intersectoral convergence. VHND is also to be

In the state of Bihar, the VHSND is a new concept to be expanded to all districts as per a mandated provision in the State PIP 2011-12. It was being field tested in two blocks of Khagaria District, i.e., Khagaria Sadar and Parbatta. As a part of this exercise, the PHRN team visited three PHCs. The intention was to get an overview of the state of VHSND in Parbatta block and to gauge the existing gaps.

seen as a platform for interfacing between the community and the health system. (VHND Guidelines, MoHFW, 2007)

According to the VHND guidelines, a number of activities have been defined for the ANMs, ASHAs AWWs in co-ordination and partnership with the other village level community groups such as the VHSC and PRI members for the successful completion of a VHSND for every Anganwadi centre every month. In totality, the following services must be provided on this day:

- All pregnant women are to be registered.
- Registered pregnant women are to be given ANC.
- Dropout pregnant women eligible for ANC are to be tracked and services are to be provided to them.
- All eligible children below one year are to be given vaccines against six Vaccine-preventable diseases.
- All dropout children who do not receive vaccines as per the scheduled doses are to be vaccinated.
- Vitamin A solution is to be administered, to children.
- All children are to be weighed, with the weight being plotted on a card and managed appropriately in order to combat malnutrition.
- Anti-TB drugs are to be given to patients of TB.
- All eligible couples are to be given condoms and OCPs as per their choice and referrals are to be made for other contraceptive services.
- Supplementary nutrition is to be provided to underweight children.
- Focused counseling on relevant issues to different groups (adolescents, pregnant and lactating mothers, couples eligible for contraception)
- Month wise thematic counseling and education on different diseases, issues of sanitation and nutrition.
- Identification of:
  - Children with disabilities.
  - children with Grade III and Grade IV malnutrition for referral
  - Severe cases of anemia.
  - Pregnant women who need hospitalization.
  - Cases of malaria, TB, leprosy, and Kala Azar.
  - Problems of the old and the destitute.
- Pay special attention to the SC, ST, the minorities, and the weaker sections of society

## **Key observations**

### **Observations and reflections on the organization of VHSND in Parbatta HSC**

The MOIC and BHM agreed that organising VHNSD is a very good strategy to reach to the maximum number of people and expressed their willingness to upscale the programme in all

HSCs. They said that the prevailing Strike of ANMs has affected the VHND programme and therefore only in 17 AWCs VHND has been organized.

Thereafter, the BHM accompanied the team to take stock of the organization of VHSND at three Anganwadi Kendras in the neighboring areas.

Before going further, a point to be noted here is that Parbatta is quite remote in terms of accessibility from the main roads. Moreover, the PHC itself poses accessibility issues to a large number of people. In this light, it was important to see how well the concept of VHSND was being implemented, since it assumes greater purpose and importance for the village population here due to lack of accessible health services.

### **Anganwadi Kendra Visits: a brief assessment**

In all the three centers, the ANM, ASHA, AWW and AW Helper were present at the time of the visit. It was revealed that though they are familiar with the term “VHND” and the roles and responsibilities attached to it but the understanding lacks among them. The Programme was conducted as Routine Immunization along with few other service deliveries.

Drugs were available and were being distributed. ANC and PNCs were being conducted though there was a lack of infrastructure required (such as an examination table and curtains). One centre (AWC 100) has been shut down and this area has not been allotted another AWC for years, however, for the purposes of VHND the space is being utilized every month. It is a verandah space granted voluntarily by the elderly widow who owns the house.

All the centers visited had some or the other equipment lacking or in a dysfunctional state which was very disappointing. It is necessary that the entire physical infrastructure is in place in order to utilize the investment being done in human resources in our health programs. Especially in the context of VHSND, it is important that when all the services are being brought to the community on a fixed day and fixed Place and the community is being urged to participate and make use of this facility, the workers are equipped with proper information as well as the means to deliver services to the people.

Due to lack of training and information VHSCs and PRIs were not very actively involved in the VHSND at this point, it was hoped that in future their inclusion will be sought for more comprehensive community participation. However the community participation was very active and were quite enthusiastic on the organization of VHSND

It was felt that the Coordination between ICDS and District Health society was smooth but PHED was completely out of scene hence the sanitation aspect was not addressed in the VHSND.

Although there is no doubt that sincere efforts are being made to make VHSND a success and it is effectively saving resources for both the workers and the beneficiaries, at some points there are huge gaps that need to be considered before moving forward. The most important constraint was

absolutely no training / orientation of the ANMs and ASHAs on the subject of VHSND. Since there was no fund disbursement for the purpose to the block, it is not expected that any training would have been conducted. Nevertheless, the BHM at Parbatta PHC had organized an informal meeting of the ANMs and given them a short orientation about VHSND which helped in the organization of VHSND so far.

### **Some recommendations made for a better implementation of the VHSND program**

Undoubtedly there has been a very sincere participation and initiative on the part of the block and village level workers for conducting VHSND to the best of their capacities. Despite this, however, a number of provisions must be made available for the program to be running more efficiently. Following are some suggestions based on the team's visit:

- Ensure fund disbursement on time: disbursement of funds, or the lack of it, often becomes a key factor behind the success or failure of programmes on the ground. Hence it is important that mechanisms for the flow of funds from the state to the block are made faster and smoother.
- Mandatory training of key personnel before field testing/program initiation: this is important to ensure that the frontline workers, as well as the supervisory staff are empowered with adequate information about the provisions of the program in question. Without information and orientation about a project/program, it is highly unfair and illogical to expect any outcome from its implementation.
- The orientation should be extended to include VHSC and PRI members of the village too so that they are aware of the activities and clarity about their roles and responsibilities is established.
- The Community Health Fellows in the PHRN team have put forward an idea that the “mahila mandal” meetings should be utilized to impart information about VHSND and at places where they have been stopped; the Rs. 150 allotted for it might be utilized for the same.
- Follow up visits from state level authorities need to be made more often to ensure smooth running of the program. Also to get direct information about minor hurdles that may be affecting the ground level implementation in a major way (such as, in this case, non availability of funds from the district level).
- A provision for incentives for ASHAs/ANMs/AWW must be in place for proper celebration of VHSND. One example might be to announce a prize for “best VHSND centre” in each village. The award may not consist of cash but of certain prizes in kind depending upon the need of the centre, such as a B.P Machine or educational toys and charts for the AWC etc.
- Stress on the involvement of local NGOs, SHGs and youth/adolescent groups for creating awareness and ensuring community participation for VHSND.
- To ensure the involvement of PHED in VHSND as presently there is no involvement of PHED for addressing the holistic objective of VHSND

## **ASTONISHED**

**By Arun Kumar  
Senior Program Coordinator**

Under NRHM, community process is one of the tools to improve the access of rural mass up to health facilities. State Health Society Bihar came up with an idea to organize Rogi Kalyan Saptah (16<sup>th</sup> -22<sup>nd</sup> Aug) and organized a TOT for the representatives of development partners including PHRN on 12<sup>th</sup> Aug.,10.

After training all the facilitators paired with representatives of other development partners and assigned districts for the facilitation. I was assigned with District Buxar, Bhojpur and Kaimur for orientation of members of Rogi Kalyan Samiti. When we entered in the district Buxar, we saw boards indicating Sub Health Centre, Primary Health Centre with distance in Km. I was surprised to know all this has been done through untied fund of Rogi Kalyan Samiti.

During the orientation of members of Rogi Kalyan Samiti in Bhojpur District, District Program Manager gave a presentation and informed that apart from other activities done through untied fund of Rogi Kalyan Samiti, white washing of district hospital, bed sheets of different colours for patients, green curtain in female ward for their privacy etc. has been done through untied fund of Rogi Kalyan Samiti.

I was astonished to see all these changes which I had never been experienced in these facilities. It was surprising for me and I can say that provisions of community processes under National Rural Health Mission and capacity building workshops (Fast Track) for District Program Management Unit by PHRN-NHSRC-SHSB human resource team has made it possible and hope many more facilities could be geared up for those needy clients, the last person of the community, who are unable to pay for the health services.

### **Showcasing the Fast-track Capacity Building Programme**

**By Suchita Kumari and Shefali Kuntal**

Fast track is the capacity building programme organized by NHSRC and PHRN jointly on district health planning for public health practitioners. This programme has been started to build the in house capacity of the District Health Societies to prepare their health action plans. In Bihar, this activity has been initiated by the State Health Society with the active support and participation of PHRN, Bihar and NHSRC. In the last three consecutive years the government health functionaries of all the 38 districts were oriented and trained on DHAP in three different batches. The batches comprised of ACMO, MOIC, DPM, DPC .M& E O, DAM and DIO etc

During the first year PHRN along with NHSRC was able to impart training to 187 government health functionaries, in the second year there were 192 Participants and during the third year, there were 221 Participants.

In this article, we have tried to capture and present a few exemplary changes that have accrued as in course of the fast-track trainings and the preparation of health action plans.

Though many factors contribute to the culmination of a desired change, the mentioned case studies are also success stories resultant of many factors. We feel they are worth mentioning because of our continuous involvement with the process and the people.

This is an endeavor to share a few cases studies that reflects the implications of the Fast track training gravitated towards decentralized planning although we believe similar or more significant tangible changes have happened at different levels across the state.

### **East Champaran**

East Champaran District is located at Northwestern Bihar constituted of 27 Blocks Its Headquarter is in Motihari. The District team participated in the first fast track training. Though the team was not very optimistic towards the realization of the objective of the Fast track as similar initiatives undertaken by other agencies have yielded futile results. The team participated amid apprehensions and reluctance as previous experiences have constructed their mindset that Plans are made but are not “of the District but for the District”. During these five days training the Participants underwent transformation in their attitude. They were now ready to re-engineer the process of planning. After the completion of the first fast track the team assured preparations of DHAP .They were also assured of continuous support from our end. When the team resumed office, amid several ongoing programmes the planning exercise was put at backburner though the team well recognized the importance of the exercise. The Team needed a force to initialize the Process and to conduct regular follow up.

This need was already anticipated by PHRN and NHSRC therefore Community Health fellows were assigned the task of nudging and providing support to the District team for the fulfillment of the objective. With the active support of the CHF and technical input by NHSRC the process of decentralized Planning initiated and gained momentum. They enthusiastically held discussion on the problems and gaps in the District Health system, thereby finding solutions for each gap was the most exciting and challenging activity for the team. This process nurtured the feeling of “ownership” among them which was the core success of the process. Finally the team prepared District Health action plan with the active participation of the whole team and hand holding support of the CHF and was submitted to State Health Society. This process augured decentralized planning in the District and inculcated confidence in the team. The joy of DHAP preparation and submission could be felt in each and every dialogue of the planning team in next meetings at the State. They said “Yes, We have made our plan”. The Executive Director of State Health Society praised and appreciated the efforts of the district team. The team assured of more diligence and realism in the plans for next years.

The District team further decentralized up-to block level and prepared DHAP by compiling Block Health action plans of the year 2010-11 .The team is now more confident and is heading towards complete decentralization by making planning at village level without any external support.

### **Jehanabad**

Jehanabad district is nearly 47 km. from Patna. The district consists of seven blocks and has a small geographical area. The district had successfully completed the DHAP of the year 2009-10. The Jehanabad District Team participated for the second time in the fast track. The team stirred many discussions during the review of previous fast track and its aftermath preparation of DHAP.

After second fast track the onus of preparation of DHAP comprising of BHAP was on the District team. It was a huge responsibility and also a step further towards decentralization but as it was second year of decentralized planning the focus was also on the review, process, quality and evaluation of planning. The second year was a crucial year as in this year evaluation of last year planning, its fund allocation and its implementation was done by each district. This period offered the districts team platform of their self analysis and learning for making more realistic and accurate planning for coming year's. In the second fast track, State Health Society to further build in house capacity and for assured participation of every level predefined certain steps and timeline. This steps included planning at the district level, orientation of the block officials at the district level, responsibility of district officials of different blocks, block level orientation and sensitization, compilation of block planning at the district level and thereby submission at the state level. The task was huge but Jehanabad team with the realization of the significance of decentralized planning took the responsibility with great enthusiasm.

The meeting in the district was held for DHAP and BHAP, orientation was done and necessary formats and resources were given to the block health Managers. Thereby each block had a workshop in which the responsible person of the district represented and sensitization at the block level was also done. The block team also appreciated the initiative of decentralized planning and embarked preparation of BHAP. PHRN team also participated in the process to assure the translation of the Fast track training strategies into actual plan and implementation and also regularly provided its technical support to district team.

In the block same chaos, which last year could be seen in the district team, was visible in the block team but they were gratified that they themselves have finally got the opportunity to plan in congruence to their need. This new responsibility accompanied with authority was a new experience for the Block teams. The block teams amid many constraints such as lack of electricity, extra load of work, less human resources poor infrastructure initiated the process with the active support form District team and all these efforts resulted in the preparation of Block Health Action Plan, its compilation at the district level and its submission at the State Health Society.