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ROLE OF COMMUNITY PARTICIPATION FOR THE IMPROVEMENT OF HEALTH CARE SYSTEM IN RAJASTHAN

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Abstract
The subject of community participation has been incorporated in the plan of the Government and non-governmental organizations, with regards to primary health mind, since the Alma Ata Conference and it was characterized as one of the mainstays of primary health mind. In spite of a few endeavours in Rajasthan, the achievement has so far been constrained. With regards to MCH-FP program, community participation has so far endeavoured through the inclusion of the agents of the local government or non-traditional communities/boards of trustees made by either Governmental or non-governmental organizations. Though the community individuals took an interest in such activities, their part is constrained since the control of the program as far as resources, planning, execution, checking and assessment constantly held by the staff of the actualizing office, be it governmental or non-governmental. Another part of the present strategy for guaranteeing community participation is based on the presumption that the projects started with outside help will, after at some point, be left with the community for operation.

1. INTRODUCTION

It is broadly trusted that the greater part of the worries will be taken care with compelling community participation The significance of community participation in MCH-FP program has additionally been underscored in the USAID strategic choices proposed for the period finishing in 2005.' In achieving the formed targets, a progression of institutional and automatic parts has been distinguished. The real segments incorporate social organizations and instructive projects, and decentralized health system. Association of the community in some frame or different has likewise been illustrated in answer to address the over two parts. While there is the little degree to contend despite what might be expected, plainly there is an absence of understanding about how community participation can be guaranteed. There have been more than 6,500 enlisted town based wilful organizations occupied with different welfare exercises in the nation.' It is sensible to imagine that community participation can be started for health and family planning related exercises. In this way, it is worth to do activity explore in such manner to discover approaches to [1]:

- Activate community initiatives to improve maternal and child health and family planning status;
- Establish a link between the community initiatives and the relevant public and private sectors;

- Ensure cost sharing by the community members in MCH-FP activities.

2. HEALTH PROMOTION AND COMMUNITY PARTICIPATION

➢ Community participation

Community participation is the active involvement of people from communities preparing for, or reacting to, disasters. True participation means the involvement of the people concerned in analysis, decision-making, planning, and programme implementation, as well as in all the activities, from search and rescue to reconstruction, that people affected by disasters undertake spontaneously without the involvement of external agencies. While the opportunities for community participation may vary greatly from place to place and at different points in the disaster-management cycle, a participatory approach to disaster-related activities should be promoted to achieve sustainable development [2].

➢ Health promotion

Health promotion was defined in the Ottawa Charter as "the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or community must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being".

➢ Health education and hygiene education

Health education is one important activity that is commonly undertaken to promote health. It is the communication of information that enables people to make informed decisions about health-related activities at all stages of the disaster-management cycle. Health education might involve subjects such as the risk of flooding in areas where people are building houses, the location of earthquake shelters, or the areas where safe defecation is possible in a new emergency settlement. Hygiene education is concerned specifically with communicating on those areas of health that are related to water supply, sanitation, vector-borne disease control, and hygiene practice [3].

➢ Hygiene promotion

Hygiene advancement follows an indistinguishable approach from health advancement, in that it is concerned with the transmission of information, as well as with understanding and advancing the limits of individuals to enhance their particular health, essentially through their capacity to: make the best utilization of winning environmental-health conditions and existing services and facilities; act to enhance environmental-health conditions; and roll out behavioural improvements to decrease certain environmental dangers at the family unit level [4].

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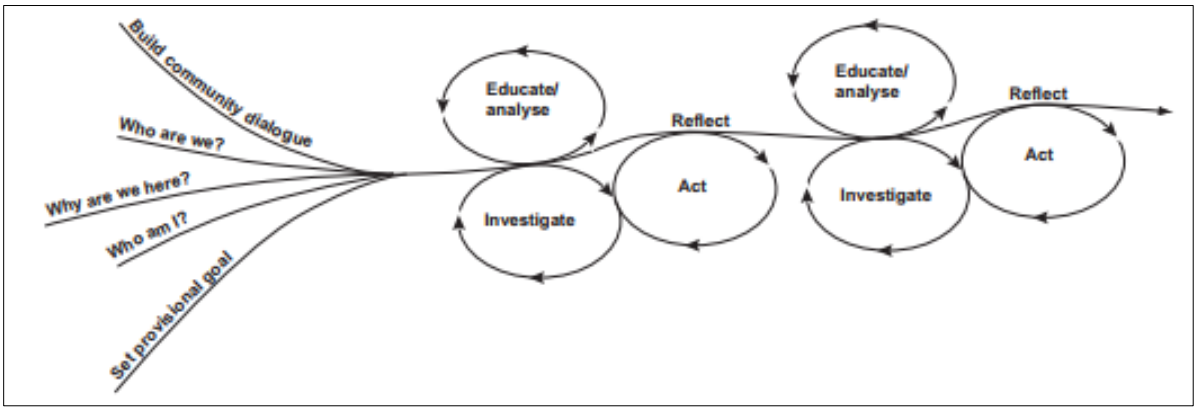

Figure 1: The Process of Participatory Action

3. PUBLIC HEALTH IN FIVE YEAR PLAN

The Community Development Program was propelled on a pilot premise in 1952 to provide for a considerable increment in the nation's agricultural program, and for enhancements in systems of correspondence, in rural health and hygiene, and in rural instruction. The community development program was quickly actualized. In 1956, before the finish of the first five year design period, there were 248 pieces, covering around a fifth of the population in the nation. Before the end the Second Plan time frame, there were 3,000 pieces covering 70 percent of the rural population. By 1964, the whole nation was secured.

In 1957, Balwantrai Mehta Committee studied the Community Development Projects and the National Extension Service and assessed the extent to which the movement had succeeded in utilizing local initiatives and in creating institutions to ensure continuity in the process of improving economic and social conditions in rural areas. The Committee held that community development would only be deep and enduring when the community was involved in the planning, decision-making and implementation process. The suggestions were as follows [5]:

- An early establishment of elected local bodies and devolution to them of necessary resources, power and authority,
- The basic unit of democratic decentralization was at the block/ samiti level since the area of jurisdiction of the local body should neither be too large nor too small. The block was large enough for efficiency and economy of administration, and small enough for sustaining a sense of involvement in the citizens,
- Such body must not be constrained by too much control by the government or government agencies,
- The body must be constituted for five years by indirect elections from the village panchayats,
- Its functions should cover the development of agriculture in all its

aspects, the promotion of local industries and other services such as drinking water, road building, etc

- The higher level body, Zilla Parishad, would play an advisory role.

4. NATIONAL RURAL HEALTH MISSION AND COMMUNITY PARTICIPATION

The National Rural Health Mission (NRHM) was propelled in 2005 to achieving sensational change in the health system and the health status of the general population, particularly the individuals who live in the rural territories of the nation. The Mission tried to provide universal access to impartial, moderate and quality health mind which is responsible in the meantime receptive to the necessities of the general population, lessening of child and maternal deaths and also population adjustment, sexual orientation and statistic adjust. In this process, the Mission would help accomplish goals set under the National Health Policy and the Millennium Development Goals [6].

➢ Selecting the Community Health Fellows

A total of 1200 applications were gotten of which 375 were screened for additionally shortlisting. Of this 13 % were getting from Bihar, 10% from Jharkhand, 25% from Orissa, 21% from Rajasthan and 25% from whatever is left of India (a couple of the screened applications did not determine the address). These 375 applications and their SOPs were scored according to the decided process. Three was the lowest score got on a resume though 15 were the highest score. More than 75 percent of candidates got scores in the scope of 7-12 on their resumes. At long last, in January 2009, 42 Fellows joined the Community Health Fellowship program of which 15 were to be based in Rajasthan, 10 in Bihar, 8 in Jharkhand and another 9 in Orissa. The three beginning and consequent opportunities that developed in the Fellowship program because of some early dropouts were utilized to develop and offer a Post Graduate Diploma in District Health Management (PGDDHM) temporary position program. Understudies enlisted in the IGNOU guaranteed PGDDHM program, offered out there mode, were upheld to assistant with the PHRN for 1 year, which was the duration of the course.

S.No.	State	Number of Fellows who joined	Number of Fellows who completed 12 months	Number of Fellows who completed 24 months[78]	Number of drop outs[79]	Number of Fellows who submitted their research projects
1	Bihar	10	8	4	3	7
2	Jharkhand	8	8	8	0	6
3	Orissa	9	6	3	6	2
4	Rajasthan	15	13	11	4	7[80]
TOTAL		**42**	**35**	**26**	**13**	**22**

Table 1: Completing the Community Health Fellowship

5. TRAINING AND MENTORING THE COMMUNITY HEALTH FELLOWS SYSTEM

The Community Health Fellowship Programme was essentially a capacity building initiative and hence the process of training and mentoring the community health Fellows was fundamental to its objectives. At the same time, the Fellows were also expected to contribute to positive health change in their allocated districts within the Fellowship period of 2 years. Therefore, their training process was expected to enable them to theorise from their existing field experience, apply theory to understand the current field area, act towards health improvements, reflect on the experience and learn from their actions. The training process included [7]:

- An initial one week orientation at Gadchiroli intended to introduce Fellows to build perspectives on public health concepts and community processes and to initiate a discussion on the research that the Fellows were to do in the community.
- Series of workshops at the National level through the Centre for Jawaharlal Nehru Studies of the Jamia Millia Islamia, New Delhi. These workshops were to build the capacity and skills of the CHFs on research methods and for organizing action research. Five workshops were held.
- Academic mentoring by national mentors, often from outside the state and few State level mentors.
- Field level mentoring through network partners and other civil society members.

In Rajasthan, all Fellows said that coaching should have been improved though, in Bihar, two Fellows felt that tutoring and checking could have been something more. In Jharkhand, two Fellows communicated the requirement for more noteworthy steady supervision, on-field bolster and regulatory help though, in Orissa, one Fellow distinguished the requirement for more noteworthy follow up. A thorough process of research preparing was made arrangements for every one of the Fellows. This included working out the exploration winding timeline over the time of the Fellowship and directing classes at various focuses to encourage the usage of significant advances [8].

➢ Difficulties and challenges

The Community Health Fellowship Program was a genuinely vast and aspiring activity regarding both extension and size. It expected to join field based work with scholastic learning and research with arrangement backing while at the same time endeavouring to connect communities with public health systems and the other way around. It was executed crosswise over 4 states and 45 regions by a community of organizations working in coordination and included region level work alongside state and national level coordination.

- **Positioning**

Fellows from Jharkhand and Rajasthan talked about the challenges they encountered in working with government functionaries. A Fellow from Jharkhand ascribed this to an absence of acknowledgment for the community health Fellowship character. A Fellow from Rajasthan grumbled about the absence of institutional help and said that there ought to in any event be some sitting course of action at the area level. The Fellow felt that area health authorities had little interest in or understanding on the most proficient method to use the Fellow as a human resource and the Fellow expected to discover his/her own particular course of work.

- **Honorarium and Human Resource policies:**

While most Fellows were satisfied with the honorarium that they got, one Fellow from Bihar felt that it was not sufficient and two Fellows, one from Bihar and the other from Jharkhand, were not satisfied with the approach of differential honorarium, given that the assignments were comparative. Another Fellow from Orissa felt that he had not been genuinely adjusted. A Fellow from Bihar felt that the terms and conditions of work were not clear while three Fellows from Jharkhand said that the human resource policies of the program required change.

- **Training and monitoring**

A critical number of Fellows recognized mentoring as a part of the program that required change. This included both scholarly and field based mentoring. Three Fellows from Bihar felt that mentoring could have been something more; another said that the Fellows ought to have been exceptional checked and their work designs all the more firmly adjusted to their abilities. In Jharkhand additionally no less than three Fellows recognized the requirement for better mentoring, on field and authoritative help. Two Fellows in Orissa said that there ought to have more grounded follow up of the work and more particular mentorship to have been provided. Every one of the Fellows from Rajasthan recognized mentoring as a zone of change for the program.

- **Programme design**

Several Fellows distinguished issues in the outline of the Fellowship program. A Fellow from Jharkhand remarked that the Fellowship included too wide a scope of activities and there was a need to concentrate on a couple of perspectives to guarantee that the Fellows obtained public health skills and information. Another Fellow felt that the Fellowship program focused on training over hypothesis and was not adjusted. A Fellow from Bihar felt that the duration of the Fellowship was too short for its destinations while a Fellow from Orissa recommended that the program ought to have scholastic acknowledgment.

- **Future prospectus and sustainability**

One of the imperative points of the Community Health Fellowship was to assemble public health limit in states where the health status is poor, and the health system needs dire strengthening. The

Fellowship Program chose 42 existing public health experts from the states of Bihar, Jharkhand, Orissa, and Rajasthan and improved their public health information and skills through a blend of guided field work, self-study and classroom preparing over a time of two years. An imperative measure of accomplishment for the program would be the sort of work that Fellows participate in, on moving on from the program, since that would demonstrate whether the preparation got is being used for achieving public health change.

States	NRHM associated	Job in allied service	Own NGO	In PHRN	Not Finalised	Total
Bihar	5	2		1	2	10
Jharkhand	4	2	1	1 (received Fellowship for higher studies abroad)		8
Orissa	2	2				4
Rajasthan	1	4	2	2	3	12
Total	**12**	**9**	**3**	**4**	**6**	**34**

Table 2: Employment Status of Fellows Completed 12 – 24 88 Months of fellowship

Fellows were asked for their suggestions on the form and design of the Fellowship programme in the future. These were as follows [9]:

- Role of the community health Fellow: the community health Fellow was seen as a bridge between the community and the administration at the district level – thinking, planning and acting for change in community health. S/he was conceived as an innovator who generates evidence, provides vital feedback on current programmes.
- Positioning: the role of the community health Fellow should not be institutionalised within the district health system as that would take away the Fellow's ability to engage with both the community and the system.

6. CONCLUSION

The contribution of the community is basic for diminishing helplessness to catastrophes, for encouraging recuperation after a calamity has struck, and for empowering community organization that is the reason for feasible development. Both research and useful experience have demonstrated that individuals are most dedicated to executing programs that they have helped design. This is as valid for calamity related projects starting at any others. Individuals ought to be urged to partake in distinguishing the perils that they confront, in assessing their powerlessness, and in planning approaches to building their readiness for a fiasco. For instance, agents from a community might be welcomed by emergency-management

organizers to review the region that they possess.

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