Best Practices at MGIMS Sevagram:

DR SUSHILA NAYAR SCHEME FOR PROMOTION OF UNDERGRADUATE RESEARCH
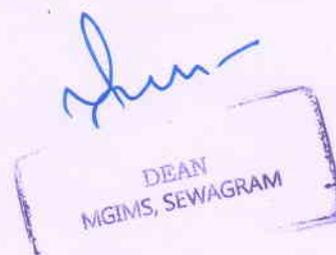
OBJECTIVES OF THE PRACTICE

To nurture the research culture at MGIMS, To provide financial support for undertaking research projects, To provide travel grants for attending conference/ workshop to undergraduate students, To provide incentives for publication of papers

THE CONTEXT

At MGIMS, Sevagram, over the last two decades, efforts have been made to build research aptitude of undergraduate students through provision of a capacity-building workshop followed by participation in community-based group projects under Problem Solving for Better Health initiative (PSBH), and later through a structured research mentorship programme for interested students. These efforts at the institute level succeeded in building a norm, and more and more students came forward to apply for research studentships offered by Indian Council of Medical Research short-term studentship (ICMR STS) and/ or Maharashtra University of Health Sciences short term research grants (MUHS-STRG).

THE PRACTICE

In order to nurture the research culture at MGIMS further, in 2014, an annual award was instituted for undergraduate research named after our founder Director, Dr Sushila Nayar. The award session provides a platform for young researchers to hone their skills in presenting scientific research and prepares them for dissemination of research findings in scientific fora. Beginning 2017-18, the undergraduate award was made part of a comprehensive approach to build a conducive environment for undergraduate research, known as 'Scheme for promotion of undergraduate research', and includes research grants, travel grants, incentives for publication of papers and periodic need based workshops in order to build the research aptitude of undergraduate students.

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Best Practices at MGIMS Sevagram:
## E-LEARNING USING MGIMS CLASSROOM

OBJECTIVES OF THE PRACTICE

To enhance the quality of teaching and learning using e-learning tool MGIMS Classroom so as to meet the learning style or needs of the students

THE CONTEXT

With the advancement of information technology, the atmosphere in which students learn today is different than it was few years back. E-learning has been found to be as effective as traditional didactic lectures and can be used to foster self directed learning among medical students.

THE PRACTICE

The web-based MGIMS Classroom is an initiative to enhance the learning experience of students at Mahatma Gandhi Institute of Medical Sciences, Sevagram utilizing the immense potential of information technology. MGIMS Classroom using Moodle platform offers interactive online classes developed by imminent teachers at MGIMS, Sevagram to support the classroom, clinical and community-based teaching of students. In the year 2020-21, more than 100 teachers used this platform for teaching learning process.

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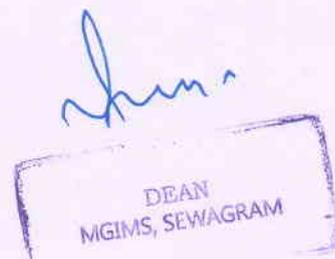
Best Practices at MGIMS Sevagram
Reorientation of Medical Education (ROME) Camp

1. Title of the Practice

Reorientation of Medical Education (ROME) Camp to prepare medical students for role of primary health care provider

2. Objectives of the Practice

The ROME Camp is a two weeks residential camp conducted at a Rural Health Training Centre (RHTC). It is conducted at the beginning of the sixth semester for every batch of medical students with the objectives:

- To help students understand the primary health care system and other support systems available in the community in India.
- To expose students to the organization and functioning of primary health centres and to demonstrate the implementation of National Health Programmes
- To help students understand the effect of family and social environment in the etiology of diseases
- To orient students to managing illnesses with limited availability of resources
- To impart skills to students to conduct community health needs assessment through use of quantitative as well as qualitative methods

3. The Context

The aim of the MBBS programme is to create a basic doctor, who is able to provide primary health care. Unfortunately the medical education system in India has miserably failed in producing competent doctors who are able to do this. Several MBBS graduates join the health care delivery system immediately after completing their MBBS. Most are not equipped to don the role of medical officers in the primary health care (PHC) setting.

In 1977, the Re-orientation of Medical Education (ROME) Scheme was implemented throughout the country. To fulfill the objectives of ROME Scheme, MGIMS, Sevagram came up with the innovative idea of conducting a two-week camp for medical students. Although by 1984, the implementation of this scheme discontinued almost everywhere, MGIMS continues to implement the ROME Camp.

4. The Practice

The ROME camp is a two-week residential camp conducted at one of the rural health training centres of the Department of Community Medicine (DCM). The students stay at the centre and conduct clinical case studies, surveys for assessment community health needs and other activities in the villages of field practice area of the RHTC.

The camp curriculum focuses on primary health care and attempts to create conditions for students to gain hands-on understanding of the nature of rural health problems. The camp is an integrated approach to public health and clinical disciplines where the field clinics for students are arranged within the patient's house. For one week daily in the morning hours (9 am-12pm) faculty members from Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, ENT and Ophthalmology visit the RHTC and clinical case presentations are made in the families from a nearby village. Attempts are made to acquaint budding doctors with the role of family, environment and culture on the origin, progress of the disease and treatment seeking behaviour.

Students are taken for exposure visits to various government health facilities, e.g. subcenter, primary health center, where they interact with health care providers. Discussions are held on the various roles of a PHC medical officer, importance and approaches for community mobilization and health promotion, management of health management information system etc. Interaction with District Health Officer and other District level Programme Managers are organized in which implementation of various National Health Programmes are discussed.

The students are given practical exposure to assessment of community health needs. After being trained in the methods of community health needs assessment, students identify some issues for community needs health assessment, develop plans, prepare tools, perform data collection, analyze data and present their final reports during the valedictory function.

During the ROME Camp, groups of students prepare health education materials for school children. These groups of students visit village schools and impart health education to school children on selected topics.

5. Evidence of Success

We regularly collect feedback from students after the camp. Other methods have also been utilized time-to-time to evaluate these camps. In a force field analysis conducted on students immediately after completion of their ROME Camp, the main perceived factors

which helped students learn: were their exposure visits to primary health centre, sub-centre and Anganwadi centre (94.7%). They saw this as an opportunity to directly interact and learn from Auxiliary Nurse Midwives (ANMs) and Anganwadi workers (68.4%) (see Note 2). The other positive factors were facilitation of a workshop on Problem-Solving for Better Health (PSBH) (63.2%), interactive sessions of short duration (57.9%) and their participation in community needs assessment surveys on immunization coverage and an exercise on focus group discussion (52.6%). The main factors perceived to work against learning were the fewer interactive sessions within the knowledge-based theory teaching and the statistics used in these sessions (57.8%), the use of lengthy PowerPoint presentations in the lecture sessions (42.1%), and the overly-busy schedule (36.8%). The other problem students noted was that there was too little time given to Epi_Info™ software.

6. Problems Encountered and Resources Required

The ROME Camp is organized at one of the rural health training centers at MGIMS, Sevagram. For a batch of 100 students, we have started organizing the camp at two places – Anji and Bhidi- simultaneously. The resources required for organization of the ROME includes the following:

- **Human resources:** Full support of staff at Rural Health Training Center (this includes Assistant Professor, Post-graduate students, Social Workers and ANMs) throughout the camp. Additionally, clinical specialists for conducting clinics in family environment, more faculty and post-graduate students from community medicine for workshops on community needs assessment, preparation of data collection tools, data collection and analysis.
- **Material resources:** The material resources required are:
  - Residential facility at Rural Health Training Center for organization of the camp, arrangement of a temporary kitchen for the camping students.
  - Classroom and additional space for group work at Rural Health Training Centers.
  - One vehicle to fetch clinicians and faculty members daily from our campus to the RHTCs. Additional vehicles are required on the day of survey for community needs assessment.

7. Notes

It is also important to understand Reorientation of Medical Education (ROME) Camp together with other curricular innovations at MGIMS, Sevagram.

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Best Practices at MGIMS Sevagram
Social Service Camp

1. **Title of the Practice**

   Social Service Camp: a community immersion program for medical students

2. **Objectives of the Practice**

   This Social Service Camp is conducted in the first year of MBBS around the Dussehra vacation with the following objectives:

   - To orient medical students to rural life and to sensitize them about environmental sanitation, socio-economic conditions and health problems of the individual, the family and the community in rural area
   - To provide them early clinical exposure by sensitizing them to the social and cultural factors responsible for health
   - To promote basic leadership and communication skills among students
   - To promote the importance of the practice of public health

3. **The Context**

   Medical education in India has become confined to the four walls of tertiary care hospital. This results in creation of doctors who are culturally and professionally ill-equipped to deal with the problems of rural communities.

4. **The Practice**

   For each batch of medical students, a village is selected within a distance of 25 Km from the medical college. For this, a resolution is passed by the Village Panchayat and a request is submitted to the institute.

   During the first year in medical school, around the Dussehra vacation, all students participate in a fortnight long village residential camp, where they experience the same conditions as the local inhabitants. They reside in the village and learn from the community. Each student conducts socio-demographic, dietary and health appraisals in three or four families. Due to this camp approach which uses community oriented training, medical students gain a heightened understanding of the need for adequate nutrition, safe water and basic sanitation, and of the influence of various socio-economic and cultural factors on health. The concept of family health care is brought home to students with the

help of auxiliary nurse midwives, social workers, health educators, sanitary inspectors, psychologists and social physicians working in the villages.

The roles of village health workers, school teachers and village health committees are examined. The students are also able to observe how villagers themselves identify and solve the health problems and how community leaders, social organizations and village health committee work together for health. This community–academic partnership offers unique opportunities for learning about the social and cultural determinants of health, health promotion etc.

All the individuals in the village are physically examined and OPD and Specialist services are given free of cost during the camp. Patients referred from the camp are also treated free of cost (both outpatient and inpatient care) at Kasturba Hospital if they visit the hospital within 10 days after the camp ends.

5. Evidence of Success

The feedback from all stakeholders (students, teachers and the community), both through quantitative and qualitative methods has always been extremely positive. We have evaluated this camp in several different ways. Medical students attending this camp strongly feel that this camp helps them learn about the realities of village life, socio-political environment affecting health and imparts them cultural competence (respecting diversity, gender sensitivity, compassion/empathy). They said that it helped them recognize the rights and equal value of all people, gave them the concept of health as a human right and made them believe in health equity. It helped them in developing several personal and professional attributes, e.g. communication skills, team work, leadership, being a change agent. And, it also helped them develop a research aptitude and prepare them as life-long learners.

6. Problems Encountered and Resources Required

As expected, organizing a residential camp for 100 students is going to have several challenges. Arranging for accommodation with the most basic amenities (e.g. toilets and bathrooms) for 100 students (boys and girls) and approximately 20 support staff (including teachers) who stay with them, getting prepared for power cuts, fear of insect bites, and occasionally problems arising due to the local village level politics are some of the challenges. However, 47 years of organizational experience in conducting these camps comes handy. It is team work which involves all academic departments and administrative

sections of the institute. Taking out two weeks of time from a packed schedule of preclinical subjects is also a huge challenge.

For almost all the students, it is for the first time that they stay in a village in a dormitory setting. However, the orientation camp at MGIMS, Sevagram when the students stay in Gandhi Ashram for 15 days prepares them to a large extent for this camp.

The resources required for organization of the Social Service Camp includes the following:

- **Preparatory activities** include several meetings with the villagers, survey of all households, which is supervised by a biostatistician and a social scientist and is conducted by 5-6 social workers/ ANMs over a week duration
- **Human resources:** Approximately 20 support staff (including one teacher, 3-4 post-graduate students, 3-4 ANMs and/ or social workers, one electrician, one security person, several safai workers and approximately a team of 8-10 persons to manage the kitchen) stay 24x7 in the residential camp. Apart from this, another 30 persons (including teachers from community medicine, specialists from different clinical disciplines, post-graduate students, social workers, ANMs, Pharmacists, Lab technicians, Health educator, Artist, Sanitary inspector, electrician, plumber visit the camp daily from MGIMS, Campus.
- **Material resources:** The material resources required are:
  - Arranging accommodations for residential stay for the students and support staff in the village, construction of toilets, plumbing, electrical fittings, Pendal for conducting camp activities, arranging for kitchen
  - Arrangements for running OPDs at village level – General OPD as well as OPDs for different clinical departments, drugs for dispensary, provision of investigations
  - Organization for health exhibition
  - Arrangements for organizing classes for students in camp setting
  - Two – three vehicles ply 3-4 times daily from the campus to the camp venue

7. Notes

After the social service camp, the students visit the adopted village every month on a Saturday, which forms the total community immersion experience of students at MGIMS, Sevagram.

It is also important to understand the Social Service Camp together with other curricular innovations at MGIMS, Sevagram.

MGIMS, Sevagram has strategically mobilized community for health action in all villages of its field programme area. During the Social Service Camp, students get to interact with the community-based organizations in the adopted village. This helps students learn how community participation for health could be best invoked.

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Best Practices at MGIMS Sevagram
Orientation Camp

1. Title of the Practice

Orientation Camp

2. Objectives of the Practice

This orientation camp is conducted for newly admitted students, with the objectives:

- To orient them to a value system based on Gandhian ideology
- To help students adapt to the new environment at MGIMS, Sevagram
- To sensitize students to the code of conduct followed at MGIMS, Sevagram
- To sensitize students to the need of developing personal and professional skills; e.g. working in teams, stress management, time management etc.

3. The Context

Most medical schools in India do not include components of value education. Education which does not inculcate values has great perils. An important question to be asked about contemporary medical education is: are we producing physicians with robust moral values? The Orientation Camp (together with other innovations in curriculum at Sevagram) is an effort to introduce students who have been admitted into the MBBS course to value education.

When students join medical school, they are excited, but also apprehensive about the new environment. There is need to build a system which helps students adapt easily to the new environment.

4. The Practice

Soon after admission to MGIMS, students attend a 15-day orientation course in the Gandhi Ashram at Sevagram. Eminent Gandhians and people who have dedicated themselves to the service of the underprivileged are invited to deliver lectures on Gandhian Thought. Students are thus helped to appreciate the humanistic dimensions of their profession.

The daily routine of the students includes morning and evening all-religion prayer, yoga classes and sports. The students engage in self-help and learn the value of dignity of labour by washing their own utensils and cleaning their own clothes. Students also participate in community activities like spinning yarn, shramdan and all religion prayer.

The students are taught about the relevance of Gandhian ideology in today's world with reference to personal hygiene, environmental sanitation and nutrition. During the camp, students are also oriented to alternate systems of medicine like yoga and nature cure and spiritual health.

Over the years, we have also made efforts to reorganize and modify the curriculum of the orientation camp in view of the recommendations of the Medical Council of India to develop it as a Foundation Course. Recently, we have started sensitizing students to need to develop personal and professional skills such as, communication skills, stress management and time management. A workshop on 'Values in healthcare: a spiritual approach' (VIHASA) adapted from the modules developed by the Prajapita Brahma Kumari Group for the Maharashtra University of Health Sciences was also piloted in the camp.

5. Evidence of Success

The feedback from students and alumni regarding the Orientation camp has always been positive. Students said that the camp made them aware of the current socio-political environment for health, helped them recognize the rights and equality of all people, gave them the concept of health as a human right and made them believe in health equity. The camp also helped them develop a sense of security and prevented feelings of homesickness and loneliness.

6. Problems Encountered and Resources Required

MGIMS, Sevagram has the unique advantage of being located in the vicinity of Gandhi Ashram in Sevagram. Organizing a residential camp for students, immediately after students enter the college, has its own challenges. Many students find it difficult to adapt to Ashram life and some of them do crib about this while they are attending the camp. However, all of them later vouch that it was a life-time experience which helped them in several ways.

7. Notes

The Orientation Camp is part of curricular innovation at MGIMS, Sevagram. It is important that it is viewed in totality together with other curricular innovations.

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Best Practices at MGIMS Sevagram:
Clinical Forensic Medicine Unit (CFMU)

1. Title of the Practice

Clinical Forensic Medicine Unit (CFMU) at Accident & Emergency Centre/ Casualty under Department of Forensic Medicine

2. Objectives of the Practice

- To improve the quality of medico-legal work of our hospital and to assist in proper disbursement of justice.
- To involve faculty members in handling clinical forensic work so that they can impart practical medico-legal skills to undergraduate and postgraduate students more effectively
- To involve postgraduate trainees in Forensic Medicine in actual handling of clinical forensic work.
- To relieve clinicians and radiologists from attending the court calls, giving evidence in court, preparing medico-legal reports, weapon reports etc.

3. The Context

Clinicians are often inadequately trained to deal with medicolegal issues and are not well equipped to handle judicial procedures. Previously postgraduates passed MD Forensic Medicine exam without even handling a single forensic case. As per MCI and MUHS regulations in Forensic Medicine, postgraduate trainees must be involved in actual handling of clinical forensic services; and to fulfill this mandate, the CFMU was created under the Department of Forensic Medicine.

To improve the quality of clinical forensic services we needed to modify the old formats that were being used since decades. We needed a separate space for postgraduates and faculty members to conduct medico-legal examination of all types of patients including sexual assault cases, preparation of medico-legal documents, weapon reports, final reports and also space for proper preservation of forensic samples till its handover to police.

4. The Practice

Since August 2012, separate space was provided to the CFMU in the Accident and Emergency Centre. MGIMS became the only institute in the country where the Department of Forensic Medicine offers all types of clinical forensic services in the casualty/ Emergency Medicine Department round the clock. The Forensic Medicine consultants collect data form of all patients who seek healthcare in the accident and emergency unit of hospital because of accidents, injuries and trauma, assess victims of sexual assault and also deal with such issues as estimating the age of the patients and determining whether or not the person is alcohol intoxicated

5. Evidence of Success

- Faculty members are getting hands on training in the practical intricacies of clinical forensic work
- PG students in Forensic Medicine are now actually handling clinical forensic work

- As CFMU has relieved the burden of clinical medico-legal work of clinicians we got good support from all the specialties especially Surgery, Orthopedics, ENT, OBGY, radiology and medicine. Clinicians can focus on their clinical work and no longer have to attend courts and cross examinations

6. Problems Encountered and Resources Required

Previously our department of Forensic Medicine use to run only from 9 am to 5 pm. But, now due to CFMU our department runs 24x7. So, problems of time scheduling will be encountered. Adequate manpower is also needed according to workloads to provide round the clock clinical forensic services.

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BEST PRACTICES AT MGIMS SEVAGRAM

HOSPITAL INFORMATION SYSTEM (HIS)

OBJECTIVES OF THE PRACTICE
Hospitals handle a lot of data. This includes patient related data, administrative, financial and personnel related data. Hospital information systems help in developing more efficient systems for data storage, organization and retrieval.

THE CONTEXT
Mahatma Gandhi Institute of Medical Sciences is a tertiary care hospital located in rural Central India. Each year around 700,000 outpatients and 50,000 inpatients—three-fourths of them from underprivileged backgrounds and poor literacy —seek highly subsidized healthcare from the hospital. The paper-based system that the hospital used was full of problems: long queues at the registration counters; multiple forms to be filled for each patient by tormented interns; nurses and pharmacists struggling to read poorly written doctors' notes and prescriptions; and discharge summaries that were illegible, inaccurate or incomplete. Because patients either misplaced their health records or would forget to bring them to the hospital, it was difficult for doctors to gauge their past illnesses. These often generated repeat tests, prolonged their hospital stay and increased the cost of healthcare. Most patients were unable to afford high costs, and hospitalization often meant loss of their daily wages. We wanted to design an electronic hospital information system that would enhance doctors' workflow and improve the quality of care.

THE PRACTICE
We asked a section of the stakeholders— interns, residents, nurses, paramedics, and doctors— about their wish list: reduce the drudgery of handwritten forms, prescriptions, data entry and discharge summaries and replace them with an electronic system in which health data could be easily entered, stored and retrieved. In addition, the health professionals expected that they should be able to access records anytime, anywhere on campus. We also needed a current and reliable clinical decision support resource to help us answer clinical questions quickly and easily at the point of care.

To do so, we (1) replaced the existing paper-based systems with an electronic hospital information system (HIS); (2) introduced campus wide wireless connectivity; (3) brought in a picture archival and communication system (PACS); (4) developed an app on iPad that brought data at the point of care.

The Hospital Information System (HIS) at MGIMS is a state-of-the-art, fully integrated hospital information system. The system provides the health workers in the hospital with a full suite of tools for registering patients, ordering tests, retrieving test results and generating electronic discharge summaries.

In 2005, MGIMS introduced HIS in the hospital. It took two years to conceive, design, test and implement this system. Faculty members and the HIS staff teamed with system developers from C-DAC, Noida to design this system that MGIMS is justifiably proud of. The entire project was funded by the Ministry of Information Technology, Government of India.

This system (2 servers, close to 300 desktops) captures, stores and retrieves all data related to half a million outpatients and 50,000 inpatients every year. Most laboratories are paperless now, and residents and consultants are able to access all test results, radiologic images— anytime anywhere. The wireless connectivity of the campus has greatly helped all caregivers access information, real-time. The system has close to 18 modules—all functioning—that capture data from registration, insurance, admission counters, outpatient departments, labs (Pathology, Microbiology, Biochemistry and Radiology), inpatient departments, blood bank, operating rooms, Pharmacy, Kitchen and discharge counter. A Picture Archival and Communication System (PACS) now enables doctors to access the radiology images (radiographs, CT images, MRI images and USG) on their desktops.

The unique addition to the system is the use of iPads at the point of care—now the doctors can access the patient data at the point of care. This application – specially designed and developed for MGIMS- has been introduced for the first time in India- few public or private hospital in the country are using iPads at the point of care. They can peep into the patients' records, review past histories, and generate electronic discharge summaries using this system

EVIDENCE OF SUCCESS

HIS at MGIMS has led to a dramatic transformation in the delivery of health care making it safer, more effective, and more efficient. The system has minimized human errors, increased the accuracy of data and improved patient outcomes.

Doctors can get a complete picture of a patient's present and past illnesses online. Laboratory investigations are immediately available to clinicians. Sometimes, by the time a patient goes back from the radiology department to his clinician, he can find his doctor viewing his Xrays on his computer. This radical decrease in turnaround times meant less waiting times for poor patients. Adding an evening outpatient department ensures that laboratory results are available within a few hours of the blood draw and patients can get a diagnosis and treatment and catch the evening train back home. The administration finds it easier to assess departmental performance and can use these data meaningfully for equipping the departments.

Doctors not only can access patients' data at the point of care on their smart phones and iPads, but by using UpToDate and other electronic knowledge resources at the patients' bedside, they can act on this information and treat their patients with evidence based interventions. Residents have learnt how to inject science into the art of medicine and use diagnostics and therapies that work. Easy availability of patient data on the rounds has reduced the frequency of diagnostic and therapeutic errors. Further, it is now possible to involve patients in their own health using graphs from the HIS to show how their health parameters are changing with medication. Residents are able to create discharge summaries from the comfort of their hostel rooms and interns don't have to collect reports. This paperless way of functioning has made life easier for everybody.

Nurses can now assign beds to patients electronically, and order stocks of medicines online. It has reduced wastage, controlled pilferage and cut costs. The two pharmacies in the hospital now dispense drugs to around 2000 patients daily. By creating an interphase between electronic cell counters and autoanalyzers, test results automatically find their way into the HIS, significantly reducing the time for manual entry of results.

Students now have access to a whole range of electronic knowledge resources through wifi.

The cultural hesitation in asking teachers questions on email is fast disappearing. Conducting research has become easier as patient follow up data are easily available. Google drives are used to share resources and Google made online forms are used to design innovative assignments.

A poster presentation on the use of Ipads at the point of care won the best paper award in an international conference in South Africa in 2015.

PROBLEMS ENCOUNTERED AND RESOURCE REQUIRED

The major challenge was not financial, but in getting people in a village to accept and use technology. This has been a slow, arduous process but our decade long experiment seems to have paid off.

Several meetings and workshops were held to familiarize and encourage health care personnel at all levels to use and try the system. Interestingly enough, it was the nurses and interns, rather than doctors who displayed most enthusiasm in accepting this change in their way of working. For both, it meant, doing away with paperwork and going through their daily duties much faster than before. Eventually, peer pressure and word of the mouth worked. Now all the laboratory technicians, nurses, health aides and doctors have acquired skills to use this system that provides them quick access to patients' medical information, helps them save time and devote it to achieve better patient outcomes.

To encourage use of technology, MGIMS twice negotiated with IBM and procured 600 laptops at discounted prices in 2005 and 2009. Students and faculty were given interest free loans to own these laptops. In 2012, MGIMS bought 60 iPads and a dozen Macbooks. This created a surge in the use of computers on campus. Workplaces became more productive and learning became fun

Further, the National Knowledge Network of the Government of India offered MGIMS broadband internet connectivity that offers a high speed wireless network to the students and staff on the campus. The network, spread over 25 kms, allows students and faculty many of whom are located in the peripheral rural centers off campus, the freedom to make use of wifi enabled devices to connect to the Internet at speeds of up to 1 GBPS.

Using a brainwave, in 2011, one of our students wrote to Google requesting a waiver to create an institutional intramail, and got 2000 email IDs free of charge. It changed the way we communicated and learnt. Students, interns, residents, faculty, administrative staff and paramedics are assigned unique IDs and passwords after their smartphones, iPads, laptops and desktops are registered at the HIS and enjoy being electronically connected with the world wide web, anytime, anywhere on campus.

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1. **Title of the Practice**

   Community Mobilization for Health Action

2. **Objectives of the Practice**

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

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

3. **The Context**

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

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

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

4. **The Practice**

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

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

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

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

5. Evidence of Success

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

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

Indicators	Baseline Estimate 2004	Final Estimate 2008

% mothers of <1s receiving ANC package (at least 3 visits, 2 TT, consumed 100 IFA tablets)	11.6%	58.9%
% of husbands aware of at least **3** pregnancy danger signs	13.2%	42.2%
% mother of <1s delivered in health facility	72.8%	90.7%
% children <3s with at least 36 months interval after previous surviving child	29.3%	49%
% of children born Low Birth Weight	29.4%	25%

% mothers of <1s initiating breastfeeding within 1 hour:
   - knowledge/awareness
   - practice
	0.6%
	0.9%
		68%
		67.9%

% mothers of <1s knowing at least 3 newborn danger signs	11.3%	94.2%
% of children (12-23 months) fully immunized	62.4%	98%
% of children (12-35 months) received Vitamin A dose in last 6 months	53.6%	98
% mothers of <3s knowing at least 2 signs of childhood illness requiring treatment	29.5%	98.5%
% of <3s suffering from diarrhea in last 2 weeks who received ORS/HAF	6.8%	62.2%
% of <3s -3 SD from the median weight for age	22%	11.6%

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

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

6. **Problems Encountered and Resources Required**

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

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

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

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

7. Notes

DEAN
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