Foreword

Health is one of the key capabilities for human development. And creation of an enabling environment for a long and healthy living is one of the Millennium Development Goals. As per the conventional practice, provision of health care services was the sole responsibility of the State Government Department and its agencies. The service provider was considered unaccountable to the people served. Ownership and maintenance of facilities created were also viewed to be the responsibility of only the Government agencies. In this scenario quest was made to improve the delivery of services. This resulted in the enactment of the ‘Nagaland Communitisation of Public Institutions and Services Act, 2002.’

This report ‘Community and their Role in Health Sector’ is one of the seven thematic reports authored through the support of UNDP and Planning Commission, Government of India. It highlights the rich social capital that can be tapped and channelized to improve the delivery of services. Fostering partnership with the community by way of devolution of administrative and financial responsibilities to the local bodies, empowering the community, village councils and village development boards for procurement, construction and maintenance of the assets and monitoring of the service delivery mechanism has re-oriented and energized the community.

Under the guidance Professor Manoj Pant, of Jawaharlal Nehru University, New Delhi, the report has materialized through the efforts of Shri. Menuokhol John, Commissioner & Secretary, Health and Family Welfare, Government of Nagaland, Dr. Kika Longkumer and Shri. Chingmak Kejong of Elethusor Christian Society.

With selected case studies, the report illustrates the strong traditional bond among communities, community spirit, community action, trust and viability of partnership between community and Government agencies. Identifying strengths as well as deficiencies, the report has been able to signal the areas that require specific policy interventions in implementation of the communitisation policy.

I hope the findings of thematic report will be of value for future endeavours for communitisation of public services.

Alemtemshi Jamir, IAS
Additional Chief Secretary & Development Commissioner
Government of Nagaland
Acknowledgement

The thematic report ‘Communitisation and Health: the Nagaland Experience’ is an outcome of the inputs, efforts and support of many people. The project team acknowledges and express gratitude to them.

The authors Shri. Menukhol John, Commissioner & Secretary, Department of Health & Family Welfare, Government of Nagaland, Dr. Kika Longkumer, Deputy Director, NRHM, Government of Nagaland and Shri. Chingmak Kejong, Secretary, Elethusorus Christian Society Nagaland for the research and for documenting the report.

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Last but not the least we are thankful to the United Nations Development Programme and the Planning Commission, Government of India for the technical and financial support, without which the publication of this report would not have been possible.

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Abbreviations

ABL  : Activity based learning
ANC  : Antenatal Check up/Care
ANM  : Auxiliary Mid-wifery
APMC : Agriculture Production and Marketing Centre
ART  : Anti Retroviral Therapy
CHC  : Community Health Centre
CHSCC: Common Health Sub-Centre Committee
CIC  : Community Information Centre
DHDR : District Human Development Report
DH   : District Hospital
DPR  : Detailed Project Report
ECS  : Eleutherous Christian Society
GNM  : General Nurse Mid-wifery
HCMC : Health Centre Management Committee
HQ   : Head quarters
IAIA : International Association for Impact Assessment
ID   : Institutional Deliveries
IPD  : In-Patient Department
JSY  : Janani Suraksha Yojna
MOU  : Memorandum of Understanding
NA   : Not Available
NABARD: National Bank for Agriculture and Rural Development
NEPED: Nagaland Empowerment of People through Economic Development
NFHS : National Family Health Survey
NGO  : Non-Governmental Organization
NHAK : Naga Hospital Authority Kohima
NRHM : National Rural Health Mission
NSACS: Nagaland State AIDS Control Society
OPD  : Out Patient Department
PHC  : Primary Health Centre
RCC  : Re-enforced Concrete Cast
RCH  : Reproductive Child Health
SBA  : Skilled Birth Attendance
SC   : Sub Centre
SHG  : Self Help Group
TB   : Tuberculosis
VHC  : Village Health Committee
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Preface

One of the foremost challenges of governance is to ensure delivery of services. In particular, this involves essential public services like education, health, power etc. In general, the problem of delivery of public services essentially boils down to how to enforce accountability on the service providers. While in the case of private services the market delivers efficient outcomes, this is not necessarily true of public services. Here Nagaland has been in the forefront in passing the Communitisation Act, 2002 which was essentially a devolution of the management of services to the villages and local users. The communitisation involved devolution of both administrative and financial responsibilities to the local bodies. What enabled this was the existence of traditional systems of Village Councils and Village Development Boards which needed empowerment.

In this report, the authors have done a commendable job of documenting the genesis of the Communitisation Act and its operation in the case of health services. The authors then document the case studies of a few villages to show how communitisation has improved delivery by providing ownership to the local community. The authors have also suggested how the process can move beyond the basic service and include other areas related closely to the service delivery thus ensuring some kind of convergence of activities in a local body. The article ends with areas where future development of communitisation must concentrate.

Prof. Manoj Pant
Jawaharlal Nehru University
Lead Author and Coordinator, Thematic Studies
Executive Summary

GOOD HEALTH IS A SHARED RESPONSIBILITY

An approach to good primary health care lays emphasis on health care provision by the people. It centers on peoples’ participation in their own activities. Community based initiative encourages communities to identify local priorities and to build community capacity in order to meet their health needs. It motivates them to work together to improve their income, health, nutritional status and environment besides and enables them to undertake sustainable development activities to improve the quality of their own lives.

This document provides an introduction to community participation in practice and describes examples of some approaches and techniques through the “communitisation” policy in Nagaland.

A DEMOCRATIC SOLUTION FOR INEFFICIENCIES OF DEMOCRACY

Recognizing the need for community participation as a fundamental requirement for sustainable development of its rudimentary health care delivery system, the State Government launched the “communitisation” policy with the enactment of Nagaland Communitisation of Public Institutions and Services Act in 2002, paving way for harnessing its rich social capital.

As a revolutionary approach to strengthen the ailing public service systems, health institutions were communitised under the Communitisation Act by fostering partnership with the community and transferring the ownership of public resources and assets and management of health institutions and services to the community with maximum reliance on local resources and capital. The advantages of communitisation are:

- Privatize but in the hands of the user community.
- Leverage Government funds, expertise and regulatory power with the ‘social capital’ of the user community.
- If the empowered are not motivated, why not empower the motivated ones?
- Thus, combine the best of public and private sector worlds.
IMPACT OF COMMUNITISATION: GOOD PRACTICES

i. Health facilities are now being fully run by the community, the staff has become answerable to the community and as a consequence there is consistent accountability by the medical staff.

ii. The outcome of community ownership is their enthusiasm to develop the centre to meet all health requirements of the community even beyond the standard set by the Department of Health & Family Welfare through public contributions. The health facility has become a ‘community asset’ and is central to the core activities of the village life in Mopungchuket.

iii. The Communitisation Act has created space for those desiring to re-ignite community creativity and invent itself for positive action. Lack of health facility has made citizens come together to set up their own health unit as incase of ‘Changsang Range’.
IMPACT OF COMMUNITISATION : GAPS

While the communitisation policy has resulted in strengthening and revitalization of the health system in the State and has improved the service delivery to a large extent with the decentralization of management of the health units, good health for all is far from reality. The health gains have been unevenly shared with gaps between regions and among social groups still prevalent.

In some cases the communitisation process failed to take off while in other cases, despite initial success, the community could not maintain its momentum. It has been observed that the people have failed and not necessarily the concept. Some reasons for diminishing outcome of communitisation process are:

- **Quality of leadership in the community:**

  Where the process of communitisation was ‘Health Committee driven’ or ‘leader centered’ and not people engineered, the momentum shrunk once the committee members were replaced. The stories of Rüsuma and Merema show the need for responsibility sharing by both the management and the community to ensure sustainable change.

- **Lack of enabling environment:**

  Due to want of proper community mobilization and capacity building, handholding by the Government and lack of support system, the communitisation process has failed in some cases.
THE WAY FORWARD

The problems are mainly related to lack of capacity in terms of infrastructure and human development. These problems threaten to negate all the gains achieved so far in terms of the community’s goodwill, confidence and motivation.

Presently, community participation is limited to infrastructure development such as constructing buildings, donations in cash and kind etc. Community participation should not be limited to only cost sharing but should also include other problems in the health systems, such as:

i. Developing capable community and effective leadership:

Capable community and effective leadership are required to bring about sustainable health and social outcomes with community participating in the benefits, programme activities, implementation, monitoring and planning processes.

ii. Health administrative reform:

The Communitisation of Public Institution Bill paved the way for empowering the community to ensure ownership and involvement for sustainability of the services. Administrative reforms too are required to enable service providers to do better & improve quality of services.

iii. Infrastructure development:

Equal attention is required for the infrastructure development to create an enabling environment. Adequate funds may not be available but rational utilization and sharing the responsibilities through convergence and inter-sectoral collaboration can improve the health infrastructure.
Introduction
1.1. STATUS OF NAGALAND

Citizen participation is the essence of democracy. People have the right to participate … a right to be part of decision affecting their lives. They know more about where they live and what they want and what is best for them than do people from outside. Further, equipping people with right information and knowledge that is acceptable and compatible with the community will help them make healthy choices.

Human health and the physical and social environment are intricately linked. Health cannot be achieved in isolation as many of its determinants are beyond individual lifestyle choices (Table No.1.1) and outside the domain of the health system. To improve health and to narrow health inequalities, it is necessary to address all determinants of health. The self-sustaining approach to address the problem of ill-health, poverty and to improve access to basic needs, such as nutrition, safe drinking water, sanitation, shelter, preventive and curative health, is through empowerment, leadership and participation of communities in integrated, bottom-up, socioeconomic planning, supported through with the collaboration of all sectors involved in the development process.

Table No. 1.1.
Examples of the Determinants of Health

<table>
<thead>
<tr>
<th>Categories of Determinants of Health</th>
<th>Examples of Specific Health Determinants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual factors: Genetic, biological, lifestyle/behavioral and/or circumstantial. Some of these factors can be influenced by proposals and plans, others cannot.</td>
<td>Gender, age, dietary intake, level of physical activity, tobacco use, alcohol intake, personal safety, sense of control over own life, employment status, educational attainment, self esteem, life skills, stress levels, etc.</td>
</tr>
<tr>
<td>Social and environmental factors: Physical, community and/or economic/financial conditions</td>
<td>Access to services and community (health, shopping, support, etc.); social support or isolation; quality of air, water and soil; housing; income; distribution of wealth; access to safe drinking water and adequate sanitation; disease vector breeding places; sexual customs and tolerance; racism; attitudes to disability; trust; land use; urban design; sites of cultural and spiritual significance; local transport options available, etc.</td>
</tr>
<tr>
<td>Institutional factors: The capacity, capabilities and jurisdiction of public sector services.</td>
<td>Availability of services, including health, transport and communication networks; educational and employment; environmental and public health legislation; environmental and health monitoring systems; laboratory facilities, etc.</td>
</tr>
</tbody>
</table>

Source: Health Impact Assessment-International Best Practice Principles, Special Publication Series No. 5 September 2006, International Association for Impact Assessment (IAIA)
The primary health care approach lays emphasis on health care provision by the people. It centres on peoples’ participation in their own activities. Community based initiative encourages communities to identify local priorities and to build community capacity in order to meet their health needs. It motivates them to work together to improve their income, health, nutritional status and environment and enables them to undertake sustainable development activities to improve the quality of their own lives.

A rudimentary health system was inherited at the time of statehood in 1963. Over the years, the State Government established a network of health institutions throughout the state. Presently there are 11 District Hospitals, 21 Community Health Centres (CHCs), 86 Primary Health Centres (PHCs), 397 Sub-Centres (SCs), 2 Tuberculosis (TB) Hospitals, 1 Mental Hospital and Naga Hospital Authority Kohima (NHAK) –as the State Referral Hospital. Besides these are, 1 Nursing college, 2 General Nurse mid-wifery (GNM), 1 Auxiliary Mid-wifery (ANM) schools and 1 Paramedical Training Institute, which are producing the much needed human resources to man the public health institutions. For strengthening the public sector health system and meeting public health goals, the State Government is also developing partnership with the non-governmental sector. Considering the shortage of resources, the Referral Hospital conceived to provide tertiary care and a plan to incorporate a medical and nursing college, is now being managed by the Christian Institute of Health Sciences & Research. Through these health infrastructures, the State has registered significant health progress, improving life expectancy at birth, reducing morbidity and mortality, including infant and maternal mortality.

Table No. 1.2.
Health Status Trends, Nagaland

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Indicators</th>
<th>Nagaland NFHS-1 (1992-93)</th>
<th>NFHS-3 (2005-06)</th>
<th>India NFHS-3 (2005-06)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Crude Birth Rate</td>
<td>31.3</td>
<td>16.8*</td>
<td>23.8*</td>
</tr>
<tr>
<td>2</td>
<td>Crude Death Rate</td>
<td>NA</td>
<td>3.8*</td>
<td>7.6*</td>
</tr>
<tr>
<td>3</td>
<td>Infant Mortality Rate</td>
<td>17.2</td>
<td>18*</td>
<td>58*</td>
</tr>
<tr>
<td>4</td>
<td>Maternal Mortality Rate</td>
<td>NA</td>
<td>NA</td>
<td>301*</td>
</tr>
<tr>
<td>5</td>
<td>Total Fertility Rate</td>
<td>3.26</td>
<td>3.74</td>
<td>2.85</td>
</tr>
<tr>
<td>6</td>
<td>ANC 3 or more visits</td>
<td>39.3</td>
<td>31.6</td>
<td>44.2</td>
</tr>
<tr>
<td>7</td>
<td>Institutional Delivery</td>
<td>6.0</td>
<td>12.2</td>
<td>33.6</td>
</tr>
<tr>
<td>8</td>
<td>Skill Birth Attendance</td>
<td>22.2</td>
<td>25.9</td>
<td>42.4</td>
</tr>
<tr>
<td>9</td>
<td>Full Immunization</td>
<td>3.8</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>10</td>
<td>Use of any FP Method</td>
<td>13.0</td>
<td>29.7</td>
<td>48.2</td>
</tr>
</tbody>
</table>

Source: National Family Health Survey India (* Sample Registration System (SRS) 2006)
With the National Rural Health Mission (NRHM) supplementing the much needed resources, the health scenario has been drastically improved - e.g. the patients’ attendance in the Out Patient Departments (OPDs), Institutional deliveries.

**Figure 1.1.**

![Image of a graph showing the impact of NRHM on improved utilization of services.]

Yet, good health for all is far from reality. The health gains have been unevenly shared. Health gaps between regions and among social groups have widened. On one hand public health system utility and contributions were far below expectations (Figure 1.1). On the other hand, the unregulated private sector health care has pushed the cost of health care up, making it unaffordable for the rural poor.

There are many old unresolved problems. Many continue to suffer and die from preventable diseases, pregnancy and childbirth related complications and malnutrition. The increasing burden of the emerging threats and challenges like HIV and AIDS, lifestyle diseases, increasing age of the population and re-emergence of communicable diseases, has the potential to undermine the health and developmental gains made so far.

**Box 1.1**

*Impression of Common People on Public Health Institution Pre-Communitisation*

‘There is a Primary Health Center, but no doctors or medical staff. There are no medicines or any other amenities’. All the interviewees said that they are not at all satisfied with the medical facilities in their area.

(Individual interviews were conducted at Phek town and Losami village, while a group interview was conducted at Phek village in the Church premises. About a 100 people, comprising of both men and women were present at the time).

Some reasons for dysfunctional public health institutions and services are: - poor management (poor state of infrastructure), indifferent attitude of employees, high absenteeism from duty, decadent monitoring mechanisms, lack of accountability etc. Also, as the community was hardly consulted or taken into confidence, they remained passive spectators, often becoming victims of inefficiency and callousness. For instance, many health centres located at the outskirts of the village, caused many inconveniences to the service users and providers, as well as compromised accessibility. This is due to the failure to educate the villagers on the importance of easy accessibility and lack of proper consultation at the time of selection of the site for the health center.

Furthermore, people expected the Government alone to deliver quality services as these institutions and facilities were owned and managed by the Government. They had little or no sense of belonging or responsibility, to public institutions and services. People tended to disregard, mutilate or even destroy Government property. There was deep resentment and frustration at the perceived failure of Government.

*Box 1.2*
**Communitisation – The Genesis**

- “Imagine Nagaland” –
  An exercise was undertaken in the year 2002 by involving the young and old representatives of civil society and Government, to envisage Nagaland's vision and future at different levels. As a result several priorities emerged: Improving public service delivery at grassroots level was one among them.

- If the empowered are not motivated, why not empower the motivated ones (local communities)?

- Rich and dense social capital in Naga society:
  - strong tribal and village community bonds
  - effective Village Councils and Village Development Boards

The State Government, recognizing the need for community participation as a fundamental requirement to achieve health and sustainable development, initiated measures to harness its rich social capital to vitalize the public institutions by launching the “Communitisation Policy” with the enactment of Nagaland Communitisation of Public Institutions and Services Act in 2002. The venture paid off with Nagaland being selected for United Nations Public Service Awards in 2008 for communitisation programme in recognition of its innovative use of rich social capital.
Communitisation
2.1. COMMUNITISATION: THE CONCEPT

By tradition and culture, the Naga society has a rich social capital, community spirit, a sense of community based action and the unique absence of caste and social discrimination. Strong tribal and village community bonds exist in traditional institutions which are organized, effective and participatory. Traditional Village Councils have been the crux of grassroots administration in Nagaland.

At a time when privatization of public sector units has become the buzzword, the State Government has adopted openness and encouraged active participation of civil society, harnessing its rich social capital to revitalize and improve public services through the concept of Communitisation.

Box 2.1
The Concept- Good Health Is A Shared Responsibility

- Evolved out of a quest to improve public delivery systems providing mass scale services
- Involves partnership between Government and Community including:
  - Transfer of ownership of public resources and assets.
  - Control over service delivery.
  - Decentralization, delegation, empowerment and building capacity.
- Based on Triple ‘T’ approach
  - Trust the user community
  - Train them to discharge their newfound responsibilities
  - Transfer governmental powers and resources in respect of management

“In essence communitisation is half way to privatization in the able hands of the user community”

Unlike other forms of decentralization or privatization, communitisation develops partnership between Government and the people through delegation of powers and responsibilities to the community for the management of public institutions, so that the performance of the public utilities improve.

The communitisation of health sector means the community takes over ownership and management of health institutions and services. It also means active participation of community in preventive and promotive measures, contributing their share to make health a reality in their own community.
2.2. COMMUNITISATION: IMPLEMENTATION

(A) PREPARING THE GROUND

The State Government was committed to revitalize the ailing public institutions systems to enable every individual, family and community to attain self-sufficiency, self-reliance and good health. But development can only be sustainable if social and economic dimensions are considered at all levels that entail inter-sectoral efforts.

Launching an efficiency drive within the existing Government set up would be low-cost, but even in well governed areas the outcome is not satisfactory as the results are transient, localized and ephemeral. Another alternative is privatization, but the question of affordability by the general population and acceptability by the employees is not feasible on a mass scale where the supply of public good is essentially a welfare scheme.

After considering several options, the Government decided to adopt measures to revolutionize the practice of health care and health sustainable development, leading to health for all through meaningful involvement of community in the planning, implementation and maintenance, besides maximum reliance on local resources and capital.

Box 2.2 .
Advantages of Communitisation

- Privatize, but in the hands of the user community
- Leverage Government funds, expertise and regulatory powers with the ‘social capital’ of the user community
- If the empowered are not motivated, why not empower the motivated ones?
- Thus, combine the best of public and private sector worlds

* A democratic solution for Inefficiencies of democracy!!

Spurred by rich and dense social capital of Naga society, communitisation took off speedily. Following a series of meetings at various levels, the State Government decided to try it out initially in the Primary schools and Health Sub-Centres. As communitisation involves devolution of powers and responsibilities to the community, an ordinance was promulgated to provide legal support. In March 2002, the ‘Nagaland Communitisation of Public Institutions and Services Act’ was enacted by the State Assembly.
The Government, in phases, handed over ownership and management of education, health care, water supply, electricity, tourism and bio-diversity conservation to the communities, to be managed by committees/boards under the aegis of the Village Council as prescribed by the Act.

**Box 2.4. Nagaland Communitisation Act 2002- Salient Features**

- Boards or committees constituted under the aegis of Village Councils to own and manage the communitized institutions.
- A representative Committee of the community
  - Members are from the user community … the actual stakeholders.
- Assets, powers and management functions of the Government transferred to Committee through MOU.
- **Responsibility of the Committee:**
  - Disbursal of salary, grant of casual leave, control of employees including power to exercise ‘no work no pay’, maintenance of buildings and assets, purchase of essentials e.g. textbooks, medicines.
- **Responsibility of the Government:**
  - Ensure deployment of health workers, provision of funds for salaries and other grants, provision of technical guidance and support.

‘Government to be in assistive, monitoring and regulatory role - A paradigm change’.

This process required procedural changes, relaxation of provisions of Treasury Rules, an amendment to Financial and Cognate Power Rules (1964), and devising of new forms and formats. To implement communitisation of health sector, the Nagaland
Communitisation of Health Sub-Centres Rules, 2002 was formulated, laying down the framework for constitution and guidelines of various Health Committees. A series of intensive awareness campaigns, training and sensitization of Committee/Board members, teachers and department officials, preparation of hand books and setting up of Monitoring Committees at various levels were under taken to sensitize and build the capacity of the stakeholders.

The Village Councils (VCs) were empowered to constitute a Village Health Committee (VHC) in their respective villages and a Common Health Sub-Centre Committee (CHSCC) at the Sub Centre (SC) level, comprising of constituent Village Health Centres (VHCs) that comes under the jurisdiction of a SC. Wherever SCs have been established in the urban areas, respective Ward/Colony authority constituted an Urban Health Committee (UHCs).

At the level of Community Health Centres (CHCs) and Primary Health Centres (PHCs), the Village Councils/Town Committees of the constituent villages and towns constituted a Health Centre Management Committee (HCMC).

The State Government launched the Communitisation of Health Sector in 2002 by communitising 302 Sub Centres (SCs). The communitisation was extended in a phased manner to all rural based health facilities- SCs, PHCs and CHCs. So far, all the 397 SCs and 21 CHCs and 63 functional PHCs have been communitised while 1278 VHCs were formed.

**Table No. 2.1. Status of Communitisation of Health Units as on January 2009**

<table>
<thead>
<tr>
<th>Sl.No</th>
<th>Health Units</th>
<th>Total</th>
<th>Communitised</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Community Health Centres (CHCs)</td>
<td>21</td>
<td>21 (100%)</td>
</tr>
<tr>
<td>2</td>
<td>Primary Health Centres (PHC)</td>
<td>86</td>
<td>63 (73%)</td>
</tr>
<tr>
<td>3</td>
<td>Sub Centre (SC)</td>
<td>397</td>
<td>397 (100%)</td>
</tr>
<tr>
<td>4</td>
<td>Village Health Committees.</td>
<td>1278 Village Health Committees have been formed</td>
<td></td>
</tr>
</tbody>
</table>

2.3. COMMUNITISATION: THE ACTUAL EXPERIENCE

The question since the enactment of the Communitisation Bill in 2002 has been, ‘Has communitisation limited its effect to the village committees or has it, beyond rhetoric, been fully realized by the community itself?’ The discussion has often been tinted in the negative by many. For too long the Naga society, which for generations has been self-governed, has invariably become dependent on the goodwill of New Delhi. For the Government to hurl the responsibility of health on the community after 50 long years; to allow it to allow it to own the process and design its own course is taken as a misgiving by most, even within the Government let alone its people.

The challenges in understanding the intent of the ‘Communitisation Act’ and also to see its relevance, has not only led to the discovery of fissures in the process of the implementation but also realized the potential in the ‘act’ to usher sustainable change even in remote villages.

(A) MOPUNGCHUKET VILLAGE MEDICAL SUB-CENTRE: A SUCCESS STORY

Mopungchuket village is one case in point which has fascinated many with its story of how a progressive community can do so much for itself to uplift education and the health system within the limited resources at hand. Mopungchuket village in Mokokchung district is the ideal to aspire for.

The village of around 400 household is 15 kms from the District Head Quarters (HQs) and is located on a high-rise plateau surrounded by two parallel ranges of rolling hills. This village was also the Head Quarters (HQs) of the American Missionaries, who later moved on to establish Impur just next to the village as the Mission centre for the entire Eastern and Northern Naga Hills under the British administration prior to Independence.

With the introduction of the Communitisation Bill in 2002, the wisest decision resolved by the Mopungchuket Village Council was to engage a responsible and respectable member in the village to head the Village Health Committee. The unbiased decision by the council proved that for change to happen within a ‘community driven’ structure, the social values that govern a structure should become the essence of development. Rev. Puna Jamir, who formerly served as the Education Secretary of the Ao Baptist Church Council, has since inception been serving as the Chairperson of the Village Health Committee of the Sub-Centre. Besides being a respected community leader,
he is hard working and passionate about his vision. His primary mission and the first step in ushering community participation was to conscientize the entire village, re-ignite the principles of traditional ‘community building’, and the role each stakeholder had in the Health Sub-Centre. The church was the first to respond, followed by the Village Council and thereafter the student bodies in the village.

The centre produces a news bulletin twice every year; besides health related news, every bulletin carries information and names and donations received from both local and Government sources. It is very transparent in its management and this practice, according to the health committee, serves two purposes. First, it encourages people to donate towards the centre and second, it gains the trust of the community which in turn engages all in its noble pursuits. During the course of interview with villagers, one of the common key words expressed repeatedly by them was, “ya asen mozuki” which, translated, means, ‘This is our Hospital’.

**Table No. 2.2.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients Treated</th>
<th>No of ANC</th>
<th>No of SBA</th>
<th>No of Full Immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>1551</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>2004</td>
<td>2887</td>
<td>11</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>2005</td>
<td>1675</td>
<td>10</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>2006</td>
<td>1026 (Jan to June)</td>
<td>8</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>2007</td>
<td>1187 (Jan to June)</td>
<td>9</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>2008</td>
<td>3118</td>
<td>10</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>


**Observations**

i. One striking observation is, since the centre is now being fully run by the community, the staff has became answerable to the community and as a consequence there is consistent accountability by the medical staff. They do not only limit their service to the centre but even undertake outreach activities within the vicinity. In the records of the Sub-Centre, not a single paisa has been deducted by the committee from any staff member for negligence or absence from work.

ii. The other worth mentioning outcome of community ownership is their enthusiasm to develop the centre. They do not appear restricted by the ‘Sub-Centre’ profiles set by the Department of Health & Family Welfare but pursue to meet all health requirements of the village. In 2006, the committee decided to attach a six bedded unit to the Sub-Centre. The Church donated ₹ 2 lakhs and the Government through National Rural Health Mission (NRHM) contributed ₹ 3 lakhs. The community also
donated in cash and in kind. They abandoned the old Government building and shifted to the newly built RCC structure. Unlike the earlier remote location, the centre is now at the heart of the village and easily accessible by all.

iii. The third observation is that because of the quality service in terms of medicine and referral linkages, the contribution of the village towards the medicine fund has increased. What the Government provides is just one third of the people’s contribution.

Table No. 2.3. Local Contribution Towards Medicine Fund

<table>
<thead>
<tr>
<th>Sl No</th>
<th>Year</th>
<th>Amount (₹)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2003</td>
<td>14485.00</td>
</tr>
<tr>
<td>2</td>
<td>2004</td>
<td>21550.00</td>
</tr>
<tr>
<td>3</td>
<td>2005</td>
<td>29928.00</td>
</tr>
<tr>
<td>4</td>
<td>2006</td>
<td>25820.00</td>
</tr>
<tr>
<td>5</td>
<td>2007</td>
<td>29016.00</td>
</tr>
<tr>
<td>6</td>
<td>2008</td>
<td>37516.00</td>
</tr>
</tbody>
</table>

iv. Today every progressive manager speaks of convergence of services. The community comprises of people representing all constituencies within the village, and as such what is observed here is that when the centre was seen as a ‘community asset’, all stakeholders in the community began to participate in its growth. The Public Health Engineering Department built a water tank and set up a water filtering unit. The School contributed stretchers and beds. The Students Union helped in its up-keep by setting flower pots and by cleaning its surrounding. The church, both the women and the general, contribute each year toward maintenance of the Sub-Centre.

v. The potential of a dynamic and a living community knows no bounds. It strives to continuously re-invent itself and define unmarked roles and responsibility. In the last five years, the centre has organized exposure tours, health melas, seminars, trainings and even invited other centres to visit their set-up. The villagers assert that the Sub-Centre has become central to the core activities of village life.

vi. Unlike other medical set-ups in the State, the extension service of the centre is observed to be tailored according to the requirements of the community. In the discussion, the villagers expressed that greater care for women is required and for which the centre has been pressed to cater more to women in general and more-so for pregnant mothers and lactating mothers. Immunization of children at the school is done as a regular routine programme. Family Welfare and Reproductive Child Health (RCH), Antenatal check up, control of vector born control programme, blindness control and all other generalized diseases are taken care of in the extension service of the Sub-Centre.

vii. The centre has been awarded the prestigious Governor’s Commendation Award.
Every endeavor has both elements of the positive and the negative. However, the failure of governance is observed to be the underlying thread that runs through most of the projects which have failed. In most cases of the communitisation process, it has been observed that the people have failed and not necessarily the concept. As in all cases, the core underlying factor has been the ‘quality of the village leadership’ that has determined the impact of any programme. The following case studies will go on to show how outcomes are subject to the quality of the leadership in the community, which in turn establishes the norm for efficient outcome. The other overreaching and recurring themes are the tendency of the community to lay off and confer responsibility on significant players and to abstain from collective responsibility. In this case the dependency on Government continues to be the primary hurdle. The stories of Rüsoma and Merema go on to also show how ‘leader centered’ programmes can also go wrong and hence the need for responsibility sharing by both the management and the community to ensure sustainable change.

Rüsoma village is 10 kms from Kohima. The road leading to the village winds along a narrow ridge and is lined with trees all the way up to the village. The village has 419 houses, which are inhabited by farmers, with only a few of them serving in Government establishments in Kohima.

The Sub-Centre was established forty years ago and is one of the first centers to be communitised in 2002. The centre is headed by a pharmacist, two nurses and other attendants and helpers. In the course of the discussion, it was observed that in the first few years of communitisation of the centre, the health committee presumably was highly motivated because of the initial enthusiasm of the Government in having passed the celebrated ‘Communitisation Bill’. In their earnestness, there was some resemblance of community involvement in the form of participation by villagers. Between 2002 and 2005, devoid of any external assistance, the community had renovated the entire building, contributed in procuring basic amenities such as a fridge, proper lighting, gas connection and added many physical developments to the structure. During this period, the number of people accessing services was much higher as compared to the present and the people’s contribution was relatively significant. However, with the change in leadership, the role of the community since 2006 is at its minimum. The new members admitted that today they hardly meet to discuss issues relating to the centre and had no budgetary plans laid out for community contribution. The Pastor admitted...
that none of the five churches in the village support the centre, and at its worse the medical staff does odd jobs, like work in the kitchen and garden to raise support for the centre. Other social platforms like the students, the women’s groups and others, cared less for the Sub-Centre and this led to question the sudden shift in response to the communitisation initiative of the Government. The worst affected seemed to be the medical staff because they appear to be in dire dilemma. On the one hand the medical centre is under the charge of the community and on the other, the community seemed to bother less after the initial excitement had long died down. Those who can afford, now rush to Kohima since it is just 10 kms away but the poor are left to fend for themselves.

At Merema, the story was the same. One of the Health Committee members expressed that given the intensity of the visits by various officials in 2002, she was apprehensive that the communitisation process would entail much work. However, it was a brief episode and since then no one has really bothered even to speak to them on the process. Because the initiation was not qualitative, the villagers today are solely dependent on the Government to provide all support and services.

**Observations**

<table>
<thead>
<tr>
<th>i.</th>
<th>The process was Health Committee driven and not people engineered. The momentum shrunk once the committee members were replaced in 2006. Today the expectation is on the medical staff to perform and not the community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ii.</td>
<td>While the sensitization was being initiated, it was observed that the various constituents like the church, students etc. in the village have not been engaged in actualizing participation.</td>
</tr>
<tr>
<td>iii.</td>
<td>The women appeared ignorant when asked if they were aware of the various schemes meant for women like the Janani Soraksha Yojana (JSY), maternity benefit, etc. The committee appeared to be unmindful of their responsibility or it is felt that it was asking too much of them.</td>
</tr>
<tr>
<td>iv.</td>
<td>The issue of the lack of convergence of the various service providers in the village seemed to be the ‘one’ major gap. Everyone seemed to be doing their job but in isolation.</td>
</tr>
<tr>
<td>v.</td>
<td>The flip-side of the ‘communitisation’ mantra was that many in the village were given to understand that communitisation of the Sub-Centre would bring additional funds to the village. In fact there was a sense of camouflaged opinion that Government had failed them.</td>
</tr>
<tr>
<td>vi.</td>
<td>The only beacon of hope in the entire discussion was that the mothers felt the ‘medicine was much better’ as compared to the earlier ‘supply’ since they now bought it themselves.</td>
</tr>
</tbody>
</table>
(C) WEAVING A DREAM: A PEOPLE’S INITIATIVE FOR HEALTH CARE

The Communitisation Bill does not only limit its scope to the bill but has also created space for those desiring to re-ignite community creativity for positive action. The tribal community spirit has the potential to invent itself and this is observed in most village settings even today. A case in point is that of the villages of ‘Changsang Range’ that have come together with no Government intervention to align their collective energy to run a ten bedded hospital to cater to health concerns. The discussion first emerged in an annual conference when the need for health facility was being raised by almost all members at the gathering. The outcome was the eleven villages of the range would on their own devise a health facility, with the active engagement by the villagers.

The primeval Naga village setup was one, where the community defined its own course of collective action in response to the challenges faced by them as one entity. In days of epidemic the village would engage or hire witches, medicine man or a faith healer. Very often witchcraft was the only alternative through which the entire community would perform ‘ghenna’ and put up mementos at the gate of the village, assuming this act would bar diseases from entering the village.

The spirit with which a community thrived was in its ingenious response to the given environment and very often the time tested solutions have proven to be most effective.

Given the situation of services denied to people in this region, the citizen’s expectation of the Government to provide health has been subjected to critical debate by people of the eleven villages of the ‘Changsang Range’. As per the Department record, the villages lying in the lower ridges of the ‘Ngakuson range’ are infested by malaria and tuberculosis. As a response to the given scenario, the villages got together to define for themselves the issues associated to ill-health. The definition and the implications of the issue then led to a master plan, which if achieved would become a beacon of hope for many in regions which are poor and marginalized.

On the 23rd of April 2008, the citizen of the eleven village got together to devise a strategy to set up their own health unit. Waiting for the Government to provide them health services has proven to be futile. The discussion led to two pertinent issues. On one hand, the elders felt that if health had to be locally financed, the cost would mean contribution by all and procurement from internal resources. On the other, it meant that for sustained wealth to be generated, the people had to be gainfully engaged in the farms, the only source for resource mobilization.
Eleuthorus Christian Society (ECS), a local Non-Governmental Organization (NGO) which has for many years been engaged with the local community on livelihood and education has in the process facilitated the discussion. The reflection of it was formulated into designing a master plan to holistically converge various players to actualize the dream of a healthy community which would contribute to the larger vision.

The subsequent meetings provided greater clarity; and the emerging solutions go to show how when communities decide their futures, the results can be beyond the normal perception.
(I) A TEN BEDDED HEALTH CENTRE

The ten bedded health facility is being assisted in the initial years by the doctors and nurses of the hospice established by ECS. The centre is housed at the hospice itself and the villagers contribute in the construction of low cost houses. Hakchang village has built a nurse quarter and a two room shelter for the doctor. The Maksha village built one quarter for the nurse. Konya has contributed towards construction of the kitchen for the inmates. Sangsangyo has leveled two separate spaces measuring 100x35 ft for the constructions. The others will pitch in once the preliminary work is completed. The eleven village councils have resolved to contribute ₹ 500 each year and every family will contribute ₹ 10/- annually toward the upkeep of the centre.

The centre is fee based and medicine is being provided at subsidised rates. The management comprises of the members representing the Health Committees of the various villages. The finance committee members are from within the management and in this ECS have been assisting in computing and monitoring of the various activities. The other salient feature of this is that the churches play a major role in awareness creation, thereby enhancing health seeking behaviour in the project villages of the ‘Changsang Range’. The churches have also resolved to budget funds for the health project each year.

The Commissioner & Secretary of the Department of Health and Family Welfare visited the site on the 3rd of February 2009, and intense discussion has been initiated at all levels of the Department.
(II) HEALTH INSURANCE POLICY: INSURING HEALTH

The women in the project villages are formed by ECS into Self Help Groups (SHGs). In one village alone, the mothers have formed themselves into ‘Edou Banks’ and boast of a corpus of ₹ 16 lakhs. The mothers have devised a simple policy to raise finance for medicine by way of a ‘health insurance policy’ which would be fully managed by the SHG mothers.

(III) BIRLA SUNLIFE INSURANCE: INSURING A FUTURE

The ECS in 2008 has bargained a Memorandum of Understanding (MOU) with the Birla Sunlife Insurance, wherein the policy requires the farmer to invest a one-time deposit of ₹ 50/100 or 200 which would pay 100 times the amount deposited in case of death. On completion of three years, the policy holder may withdraw the money with an interest earned at 10 percent or re-invest thereafter. The Village Councils of the eleven villages have in a phased manner agreed to enroll all households for ₹ 200/- which would mean every member would be ensured for ₹ 20,000/- in the next few years.

(IV) NATIONAL BANK FOR AGRICULTURE AND RURAL DEVELOPMENT (NABARD)

For building a regular income base for each member, the villages on the 18th December resolved to work towards a massive inter cropping project for citrus and banana. Since then the jhum plots have been converted into permanent orchards and in this the council is in the process to identify those not owning plots and to negotiate with those having excess plots within the designated jhum area. Each family has contributed one acre for the said project. The General Manager of NABARD has visited the site and formally launched the project.

The 500 families of six villages are divided into farm groups of 10 farmers each. The management of the project is based on group pressure and by fully engaging the women SHG members. Marketing will be done at three levels and negotiation with the Government is on to link the project area by road to Assam. In the next five years, it is estimated that each family would earn a minimum of ₹ 5 lakhs each.
(V) EDUCATION: HEALTH THROUGH AWARENESS

Health and education are two interconnected issues. The effort is on to define education beyond conventional understanding. The process to make schools community centred is being pursued. All the eleven villages have revived the traditional ‘morung’ or ‘sochum’ in Chang, to define education as a ‘centre for learning skills for progressive living’. The learning method is Activity Based Learning (ABL) and values which are fast dying are being revived through the active participation of the entire community. Environmental education is one major aspect, and this is being done by teaching issues related to environment and farming. Most ‘sochums’ have their own farms, the idea being to make children become guardians of the soil and the forest. Through formal education, health is being taught more from a preventive standpoint. The Department of Education has approved a pilot project to take up the ‘morung/sochum’ concept implemented in the project area to be up scaled in the entire State. The community has appealed to the Government to ensure that the middle school at Sangsangyo is upgraded to a high school, so that migration of children from the project villages to the town for higher education is discouraged.

(VI) NAGALAND EMPOWERMENT OF PEOPLE THROUGH ECONOMIC DEVELOPMENT (NEPED) ENERGY TEAM: POWER FOR HEALTH

The NEPED energy team has already prepared a Detailed Project Report (DPR) for generating 700KW of hydro power from the River Yijung which runs through the eleven villages. The project will be channel based and the power generated will go to light seven of the eleven villages. Also, the proposal by NABARD is to fund a cold storage which will require 24x7 power supply. The project will be the first of its kind in the country, since the entire management will be by the community and the power generated will also be connected to the main power grid. A billing system will be formulated, whereby the community will tax the Department for power supplied to the main grid.

(VII) THE NATIONAL OLD AGE PENSION: SECURING THE FUTURE

All persons aged above 65 will be covered under the National Old Age Pension in the eleven villages. With the active involvement of the pastor and the village council, the process is on to list the aged people and discard and report death cases still found in the Departmental list. Many dubious practices are being identified by the villagers and this is being screened for correction. The Director has conceded to the proposition.
(VIII) FIRST PRIMARY HEALTH CENTRE (PHC) TO PROVIDE ANTI-RETRO VIRAL THERAPY (ART) TO HUMAN IMMUNODEFICIENCY VIRUS (HIV) POSITIVE PEOPLE

Since the community centre is in the proximity to the hospice for HIV affected people, the proposal is under consideration by the Nagaland State AIDS Control Society (NSACS) to have a link Anti Retro Viral Therapy (ART), or an extension ART centre at the Medical Centre. This will become the first PHC in the entire country to provide ART for people living with HIV in the district. Tuensang being the worst affected, the experience of the centre will go on to show how services can reach even remote settings, when undertaken by the community.

(IX) BAMBOO MISSION: A HEALTHY ALTERNATIVE

The project hopes to rope in the Bamboo Mission, so that dependency on wood products are minimized, thereby retaining the water level through forest coverage. Since conserving water is essential to the survival of the entire project, discussion has been initiated to focus on bamboo production and encourage bamboo fabrication for housing and other end usages. The region has one of the largest biodiversity reserves in Nagaland. It stretches all the way down into Myanmar and spreads along the Indo-Myanmar ridges.
(X) ICT CONNECTIVITY

The Department of Information Technology has in principle agreed on establishing a Community Information Centre (CIC) at the Medical Centre. This will aid in marketing and dissemination of information by linking to the World Wide Web. The access to the information grid will assist our doctors and nurses for referral linkages and update information to funders and people concerning the project. The relocation of the CIC from Tuensang to the project site is agreed upon and an early decision by the concerned Department is awaited.

The resources generated from the NABARD project and the sale of Hydro-Power will be the major resource facility. Along the lines of the Agriculture Production and Marketing Centres (APMCs), a revolving fund of ₹ 20 lakhs will be at the disposal of the marketing committee to ensure a ready market and to acquire the produce from the farmers in the project. Of the total income, 30 percent would go toward the project of which a major chunk would go towards the medical centre. The service tax levied on the farmers will also go for youth recreation and skill training programmes for underprivileged women. The project also has plans to establish senior citizen’s day-care in the hope to enhance the capacity to produce.
Challenges Ahead
3.1. IMPACT ASSESSMENT

The Ottawa Charter (World Health Organization, 1986) defines health promotion in terms of ‘enabling people to increase control over and to improve their health’. The communitisation policy is a self-sustaining, community-orientated strategy, which aims to address people’s basic development needs. The approach is dependent on the full involvement and participation of communities through the collaboration of all sectors involved in the development process.

The communitisation of health has improved the condition of public health system by harnessing the community spirit. Impact assessment of the project revealed dramatic all round improvements in service delivery outcomes.

Box 3.1
Highlights of Impact Assessment

- Staff attendance improved : 97%
- Staff attendance checked : 95%
- Registers/Records maintained by the Committee : 60%
- Community contributions : 42%
- Health awareness activities held : 53%
- Health Committee meeting held regularly : 62%


Like any new programme or concept, the much acclaimed communitisation policy in the course of implementation witnessed various problems- organizational, stakeholders or otherwise.
3.2. PROBLEMS RELATED TO THE COMMUNITY

i. People were unwilling and apprehensive to accept as they felt the Government is shirking its responsibility and passing the burden to the community.

ii. Most community participation is limited to infrastructure development such as constructing buildings; donations in cash and kind etc., but there is lack of capacity for organizational management including planning, monitoring and supervision, problem-solving capability and non-involvement of the users in decision making.

iii. Some members find the work demanding/taxing affecting their pursuit for livelihood. Too much is expected of the community while very little is provided to sustain creativity. Citizen participation is determined by the balance between benefits and costs. The more intense the activity, the higher the cost to participants in money and time -with the result that fewer people participate.

iv. There are also instances of poor transparency & accountability by the Health Committees. This is particularly prevalent where the Committee is run by influential people.

v. In some places the process of communitisation was Health Committee driven and not people engineered, the momentum slackened once the committee members were replaced.

vi. Some Village Councils were not aware of the rules and responsibilities All the communitisation committees are to be monitored and supervised by and function under the Village Councils.

vii. Despite best efforts, communitisation has not taken off in some places as the people do not have the capacity to shoulder the responsibility.
3.3. PROBLEMS RELATED TO THE SERVICE PROVIDERS

i. Resistance within the service providers towards change in the existing system such as devolution of power and accountability towards the community.

ii. The problem of absenteeism, low motivation and commitment among health personnel persist. Intellectual and social isolation that qualified health personnel experience in remote rural areas, lack of amenities such as electricity, telephone, proper accommodation and transportation, inadequate and high cost of commodities and lack of proper institutions for children’s education are some reasons cited for unwillingness to serve in remote areas and high absenteeism. The problem is further compounded by the absence of professional development, job satisfaction, by lack of incentive or compensation for serving in remote areas, and other factors like attractive private practice in urban areas etc.

iii. Due to resource constraints, the State Government is unable to provide adequate funds for infrastructure development, deployment of manpower, technical guidance, monitoring and supervision. The buildings of many health centres are dilapidated. Some even do not have a building. There is also acute shortage of equipment and instruments, staff quarters, mobility facilities, medicines and other consumables.

iv. The infrastructure of many health centres have been developed but the turnover of the health centre including quality of care, preventive and promotive services is still far from satisfactory.
Box 3.2
Challenges Faced In Communitisation Process

- Skepticism among Government officers about misuse of funds by local communities.
- Government employees reluctant to give away power.
- Skepticism amongst local communities about their capability to handle administration.
- Criticisms that Government is indulging in ‘load shedding’ and ‘passing the buck’.

OVERCOMING CHALLENGES

The programme started as a pilot to assure all the stakeholders that, if unsuccessful, it will be wound up.

- Apprehensions and misconceptions of all the stakeholders were addressed, by involving political leaders, influential members of bureaucracy, civil society and the church etc.
- All the stakeholders were sensitized about the meagre additional costs involved and the long term benefits of such an initiative.
Suggestions and Recommendations
4.1. RECOMMENDATIONS

The problems are mainly related to lack of capacity in terms of infrastructure and human development. These problems threaten to negate all the gains achieved so far in terms of the community’s goodwill, confidence and motivation.

Presently, community participation is limited to infrastructural development such as construction of buildings; donations in cash and kind etc. Community participation should not be limited to cost sharing alone but should also include other problems in the health systems.

Besides maintaining financial support, continuous capacity building and hand-holding of all the stakeholders is necessary to consolidate the gains towards meeting the expectations about health and health needs of the people. Concerted efforts should be directed towards fostering partnerships and creating a well-informed community, to enable the community to manage its health system that is more socially relevant and more responsive to the people’s needs, while producing better outcomes.

(A) DEVELOPING CAPABLE COMMUNITY AND EFFECTIVE LEADERSHIP

Capacity building can meet the changing demands by transferring knowledge, skills and technology to strengthen management, planning and monitoring of the health system, for effective delivery of quality health care. It also empowers individuals and families to make choices that are relevant to their health and help them to participate in decisions relating to their health.

Politically, the legitimacy of Governments and their popular support depends on their ability to protect their citizens and play a redistributive role. Governments are expected to protect health, to guarantee access to health care and to safeguard people from the impoverishment that illness can bring.

To bring about a sustainable health plan and social participation effective leadership is required. Instead of disproportionate reliance on command and control, community leaders should engage the community in developing a common vision, a shared ownership, and a sense of responsibility for the well-being of the community and its residents. Health authorities have to ensure that popular expectations and demands are balanced with need, technical priorities and anticipated future challenges.
(B) HEALTH ADMINISTRATIVE REFORM

By enacting the Communitisation of Public Institution Bill, the Government paved the way for empowering the community to ensure ownership and involvement for sustainability of the services. Administrative reforms too are required to enable service providers to do better and improve quality of services: For instance, the undermentioned measures can be taken up:

i. Salary compensation for serving in remote areas.
ii. Providing incentives for desirable behavior by constituting awards for excellence.
iii. Strengthening monitoring, supervision and evaluation mechanisms.
iv. Strengthening job-skill programmes for all categories of services providers.
v. Creation of adequate technical posts to address the paucity of service providers.
vi. Reviewing the career advancement policy.
vii. Restructuring the recruitment and placement policy.

(C) PROVISION OF ADEQUATE FUNDS FOR INFRASTRUCTURE DEVELOPMENT

Sufficient funds may not be available but by sharing the responsibilities through convergence and inter-sectoral collaboration, health infrastructure can be improved.
Conclusion
5.1. CONCLUSION

High investment does not always result in better delivery. Given the financial constraints and limited human resources, low cost but high impact programmes can bring solutions. Today we need to reorganize the health services around people’s needs and expectations, so as to make them more socially relevant and more responsive to the changing world.

As an innovative approach to strengthen the health systems, health institutions were communitised under the ‘Communitisation Act’ by fostering partnership with the community and transferring the ownership and management of health institutions and services to the community. In this way it paved the way for active participation of community in preventive and promotive measures, to make health a reality in their own area.

While communitisation policy has resulted in the revitalization of the dismal health system in the State, its rudimentary infrastructure and service is still unable to meet the expectations and needs of the people. The problem can be mainly related to lack of capacity in terms of infrastructure and human development.
Community participation is not a time bound project; rather it needs to be continuous, sustained and locally grounded. Communitisation can be sustainable only as long as the relevant actors remain committed and the sociopolitical and economic environments are conducive to the process.

Capacity building has to be ongoing and the Government has to invest its resources through all channels to capacitate all the stakeholders through exposures, trainings, documentation of best practices and follow-up monitoring & supervision. Creating an ‘aware community’ can become the nation’s greatest asset.

Change takes time and patience. To create a vision of a safe and healthy community in which the needs of all members are met may take only a day; to realize it, on the other hand, may take a generation. This process lasts a lifetime.