



Promising Practices

Community Based Monitoring System (CBMS)

In the beginning of the project in 2006, this sample CBMS tool was initially developed and introduced with a few relevant malaria related indicators. This tool was developed with the participation of community people. In subsequent years the Gaon Kalyan Samittee (GKS) were formed and strengthened under the aegis of National Rural Health Mission (NRHM). The project also facilitated formation of Panchayat level Health Resource Centres (PHRCs) to support and hasten the grassroots developmental initiatives. When the GKS members got empowered and graduated to higher levels, and the PHRCs developed into vibrant institutions, the existing CBMS tool on malaria was revised/ modified jointly by incorporating relevant indicators which members thought were useful to them. The affected communities got involved in advocating for change as participants in the process, and not as objects.

The Mayurbhanj Integrated Community Health Project, LEPRA Society, Odisha, facilitated the use of this tool in 118 villages through GKS and PHRCs. Over a period of four years, the attendance and regularity of Anganwadi Workers (AWW), Accredited Social Health Activities (ASHAs) and health workers in the area has increased in 50% villages, dichlorodiphenyltrichloroethane (DDT) spray and use of mosquito nets have been regular, blood slide collection has also increased by 12%, and district authorities have opened 51 new Fever Treatment Depots for malaria. As an outcome of this community mobilisation process, as many as 431 issues were brought to the notice of health as well as other district level authorities out of which 285 issues were addressed. These outcomes could be directly attributed to the effective use of information emanated from the CBMS tools.

Malaria Samadhan Sibir (MSS)

Malaria Samadhan Sibir (Malaria Consultation Camp) is one of the unique initiatives of Mayurbhanj Integrated Community Health Project (MICHP) which was meant to reduce high prevalence of malaria in the district. MSS is generally a camp organised in remote and highly inaccessible areas highly endemic in malaria. Sibirs (camps) are organised in pre-decided venues and dates with the active involvement of all concerned in the district working in malaria control. This combines three elements: health education using IEC vans; provision of diagnostic and treatment services to those with fever; and joint meetings of health functionaries and key community members to organise communities for vector control and programme-related problem solving. Hence, all kinds of services/ benefits are made available at doorsteps of the people. Apart from receiving services people also share their health-related grievances which are either settled on spot or settled in later dates.

During the project period (2006-2010), project has organised 244 numbers of MSS in different remote pockets of 26 blocks of the district, where 38,268 villagers (18,205 male and 20,013 female) directly benefitted through the diagnosis and treatment services during the programmes. Nine thousand four hundred and fifty four (9,454) persons were suspected for malaria and their blood slides were examined; out of which 1,945 cases (21%) were found positive and received treatment. Nine thousand five hundred and two members (3,562 male & 5,940 female) from GPHRCs and GKSs participated in the interface workshop organised during the MSS to discuss issues and problems related to malaria. Six

hundred and seven issues were raised and discussed during MSS out of which 494 issues were addressed by Health Authorities during MSS and 113 issues were addressed in due process.

The MSS has been adopted by the Mayurbhanj District Health Department under the same name and strategy which organised 51 MSSs during 2009-10 in inaccessible pockets of the district in collaboration with LEPRAs Society and other Non-Government Organisation (NGOs). The most visible contribution towards the disease control has been the reduction of Annual Parasite Index (API) to 4.35 in 2009 from 8.5 at the beginning of the project in January 2006, and reduction of positive case load from 22,913 (January 2006) to 10,619 by December 2009.

Sputum Collection Centres (SCC)

A Tuberculosis (TB) suspect, is required to give sputum twice; once on spot and the second time on the next day for required testing to ascertain positivity. In remote and inaccessible tribal dominated areas people are required to travel even more than 40 to 50 kilometres to provide sputum at the Designated Microscopic centres (DMCs). Because of distance factor people are not usually encouraged to travel that far, to provide sputum twice. In order to bridge the gap between the TB suspect and the sputum testing Centre, this innovative model was introduced in the Koralep area. The project identified places close to villages (places not more than 5-6 kilometres away) where the sputum is collected by the volunteer. It is the responsibility of the volunteer to take the sputum samples to the DMCs for testing, ensure the test is done, collect the test report, and if any person is found TB positive then the volunteer ensures that the person is linked to Directly Observed Treatment Shortcourse (DOTS) treatment. This model was scaled up in the Sahyog project and subsequently in the Axshya India TB project between 2008 and 2012. As many as 300 SCCs were functional in the region. This helped TB detection to a great extent. The picture above depicts the model and explains the linkages.

Social Audit

During 2011, the blacklisting of a number of NGOs by CAPART (Council for Advancement of People's Action and Rural Technology) in the country, created a general suspicion towards the manner and functioning of NGO community as a whole. There was adverse reporting in different media across the country highlighting deficit of credibility of certain NGOs and demanding reinforcement of stringent control mechanisms. In this backdrop, LEPRAs Society decided to initiate Social Audits in the organisation as a proactive step towards transparency and accountability. As the first step, a concept note on Social Audit was developed in order to bring uniform understanding across the organisation and to follow common processes while implementing the same in projects. The organisation carved out following objectives for undertaking the Social Audits. They are; a) disclose the project performances to the stakeholders, b) enrich organisational learning through reflection and feedback, c) enhance public participation, strengthen relationships and partnerships among stakeholders, d) create a platform for wider public to raise issues about misappropriation of funds, unethical practices by the project (if any), e) reaffirm organisations accountability to its beneficiaries, f) share models for other development organisations to replicate, and g) demystify the general perception that NGOs, in general, are deficit in credibility. The first ever Social Audit started in the LF project Puri on August 5, 2011. Subsequently other projects of the organisation initiated this practice.

The Sreyassu-Community Based Organisation (CBO), Andhra Pradesh, the Technical Resource Unit (TRU)/Strengthening Referral System (SRS) project Odisha, the Munger Referral Centre, Bihar, the Targeted Intervention (IDU project) Bhagalpur, Bihar have conducted Social Audits in 2012. It was a unique experience and a source of inspiration for those who value openness and accountability.

Conducting Social Audit was an evolving process as well as a great learning exercise for the organisation. The feedback from the observers, remarks of auditors and the suggestions from the participants reported were used for reference and corrective actions. There was wide coverage of all events by media, both print and electronic, which was a step towards organisational visibility. Before organising the event, there was a bit of skepticism about the successful organisation of the event, fear about handling a large number of unknown audience, and a bit of uncertainty about attendance (too large or too low). The good work done in the area as well as organisational transparency stood behind us as strengths and encouraged us to go ahead with the event. Social Audit events brought lots of good will to the project as well as to the organisation. All sections of people acknowledged and appreciated the organisational disclosure process and encouraged to keep continuing the same.

Referral System and Integration of reconstructive surgery into general health care system

After successful completion of District Technical Support Team project (2004-2007), it was strongly felt to establish a good referral system in the general health care system, so that the leprosy patients can be diagnosed and managed at Primary Health Centres (PHCs) and referred to district hospitals, referral centres and RCS centres for difficult, complicated and RCS cases. The TRU & SRS project (2007) continue to build the capacity of PHC/Community Health Centre (CHC) and district staff for management of normal cases and organised special trainings for RCS surgeons, physio-technicians, shoe-technicians, District Leprosy Officers (DLOs), District Leprosy Centres (DLCs) for management of referral and RCS cases. Thus, LEPRO established 10 Referral Centres and supported 10 RCS centres at government institutions by strengthening the operation theatres, hands-on-training to government surgeons, extending its in-patient wards for hospitalisation of RCS cases and rigorous counselling of staff and monitoring the programme. Through the project, LEPRO reached 71,236 leprosy affected persons for care and services, provided 22,935 customised footwear, trained 4,103 government staff and facilitated 2,058 reconstructive surgeries. The model is very well appreciated and integrated in the National Leprosy Eradication Programme (NLEP) revised Disability Prevention and Medical Rehabilitation (DPMR) Guidelines.