Leadership and Strategic Management in NRHM

Theme:1Communitization of Health Care Services – The New Paradigm

Theme:2 Community Monitoring and Accountability – Beyond Rhetorice

A Management development Programme of IHMR – Jaipur
In Bangalore on
23rd June 2011

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Centre for Public Health and Equity, Society for Community Health, Awareness, Research and Action, Bangalore, India

Themes

I - A New Paradigm of Health & Health Care

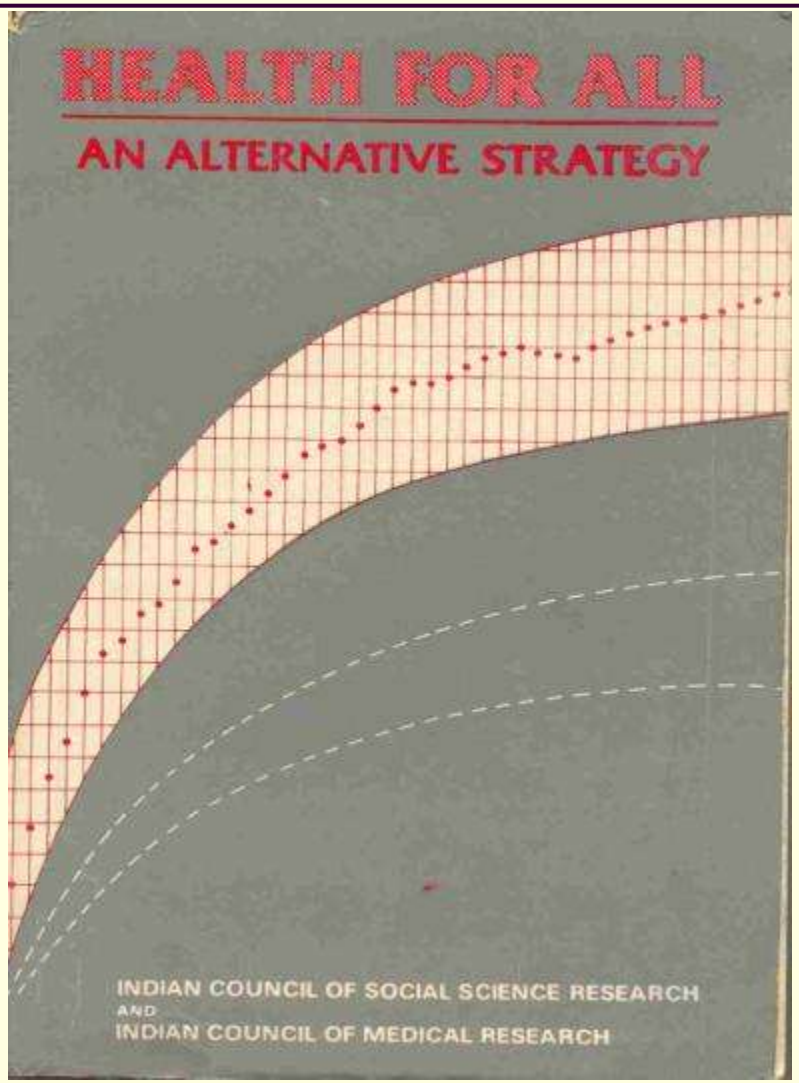
II - NRHM and Communitization of Health Care Services

III - Community Monitoring and Accountablity

I - A New Paradigm of Health & Health Care

Inspiration: 1

Health for All – The Prescription of ICMR and ICSSR

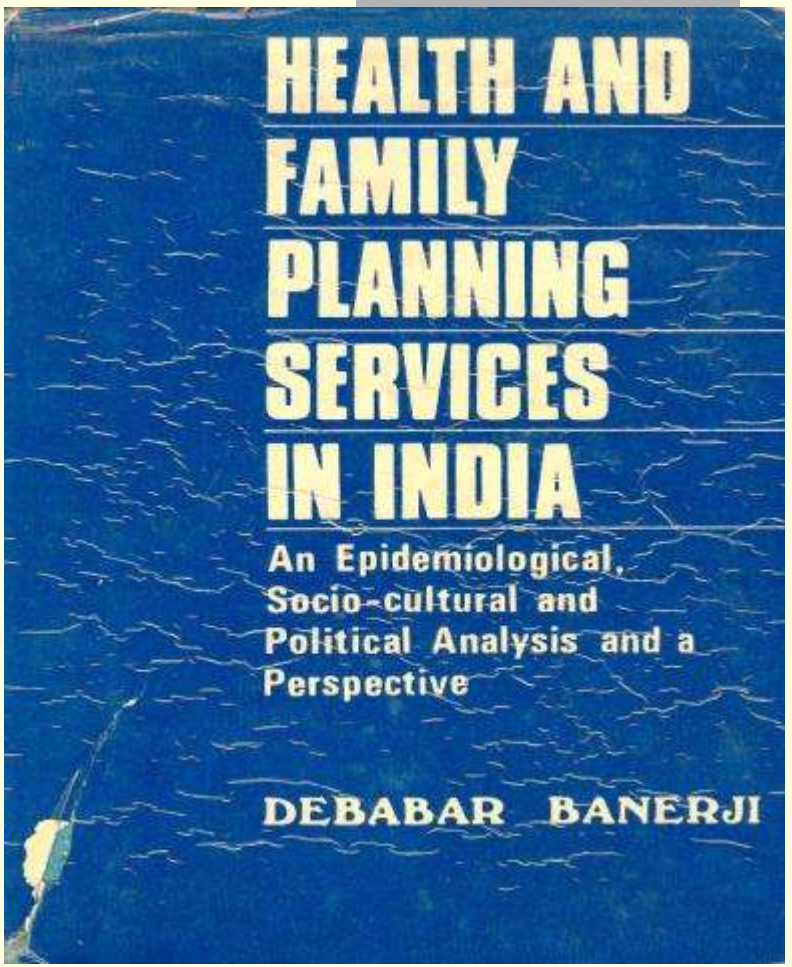


"A Mass movement to

- Reduce Poverty inequality and spread education.
- Organise poor and underprivileged to fight for their basic rights
- Move away from the counter productive Western model of health care and replace it by an alternative based in the community ....."

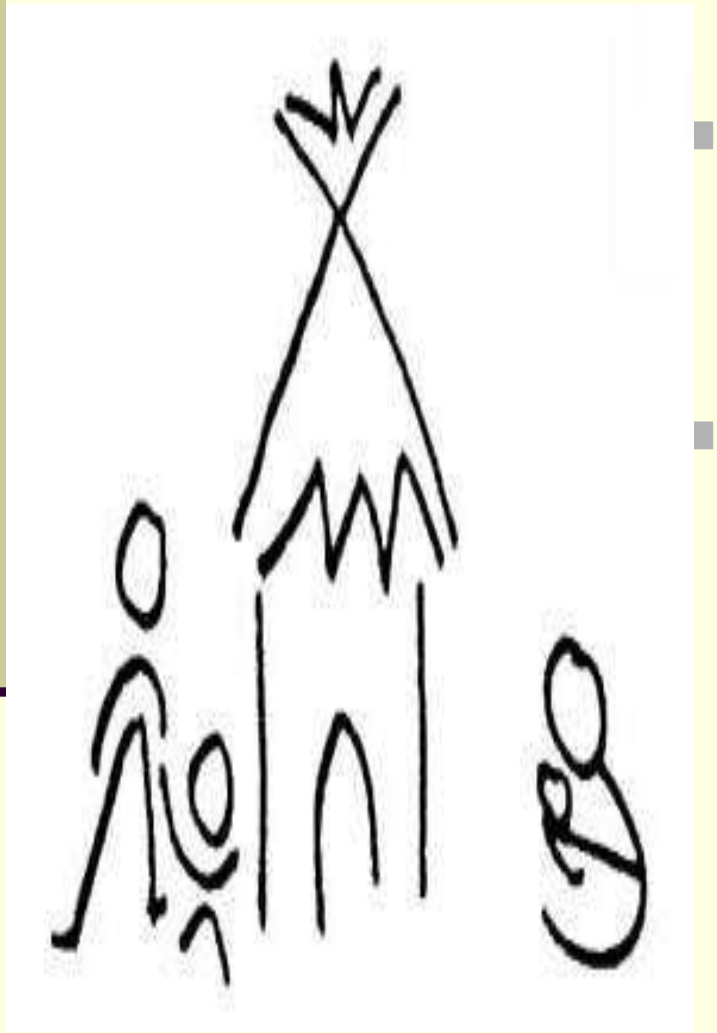
Inspiration -2
An Epidemiological, Socio- cultural and political analysis and a perspective

- ….Health service development is thus
  - A socio cultural process
  - A political process
  - A technology and managerial process, with epidemiological and sociological perspective”



Source: Banerji. D, 1985

1984- Initiation of Community Health Cell (CHC)



Goal

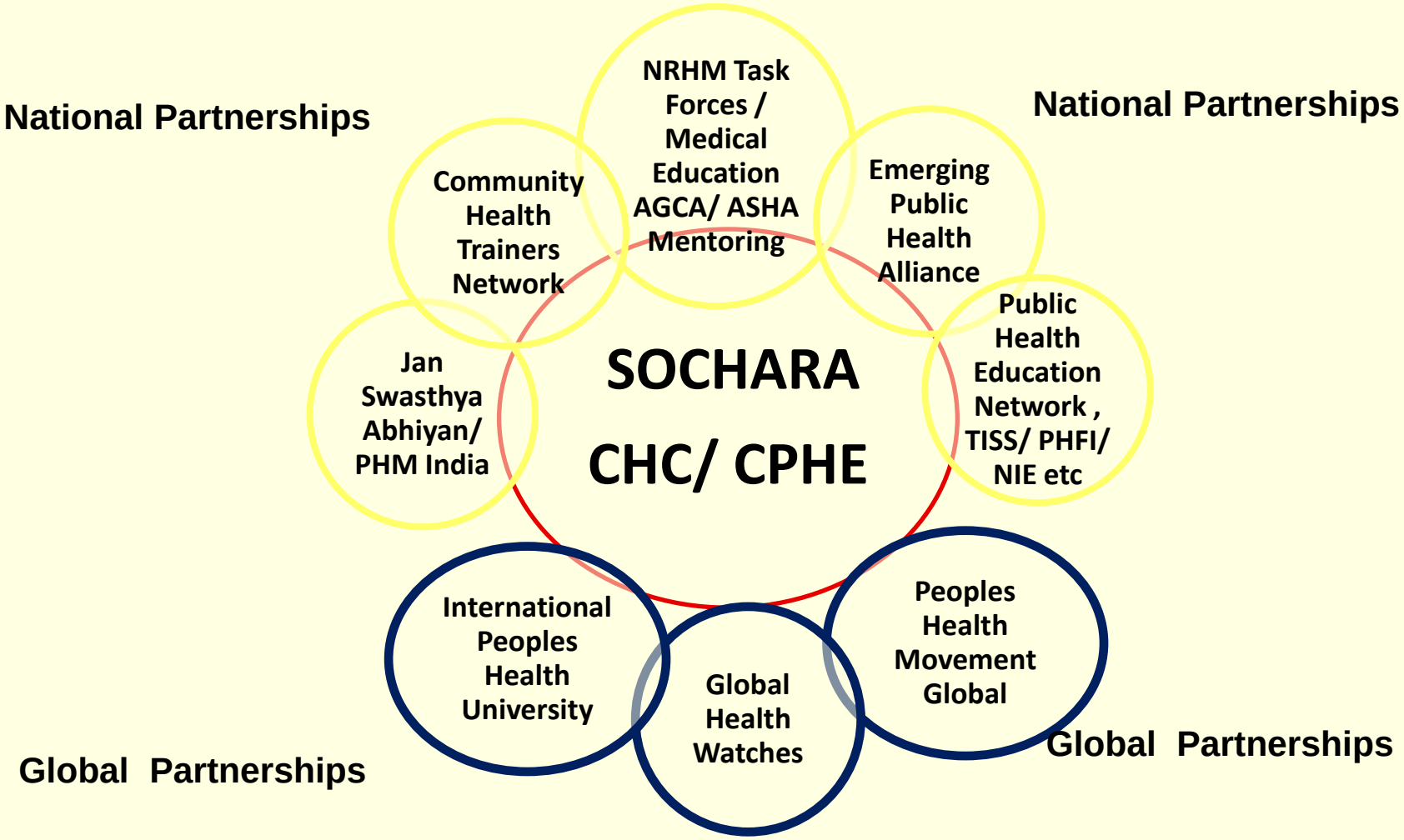
- "Community Health is a process of enabling people to exercise collectively their responsibility to their own health and to demand health as their right.
- Community health involves increasing of the individual family and community autonomy over health and over the organizations, the means, the opportunities, the knowledge and the supportive structure that makes health possible".

Society for Community Health Awareness, Research and Action (SOCHARA)

- Multidisciplinary professional resource network in Public Health/Community Health
- Objectives include awareness building, community action, educational strategies, research and policy advocacy
- Works with central and state governments; NGOs & CSOs; campaigns and people's movements and international health agencies

www.sochara.org

Alternative Sector Partnerships of SOCHARA, Bangalore.



Recognising the Alternative Sector- I

Partnerships:

"Many alternative institutions, both organized and informal have been actively involved in public health work, as well as public health capacity building. Sometimes they have been termed as alternative sectors…….
….A wave of community health NGO movements has taken place to try alternative experiments and actions, and to build capacity from communities and grass root workers. Unless the national apex institutions or schools of public health recognize these alternative sectors as strong resources and involve them in training and research , a large portion of creative energy in public health will remain untapped".

Source: South East Asia Public Health Initiative -2004-2008 – WHO – SEARO

Recognising the Alternative Sector-II

Partnerships:

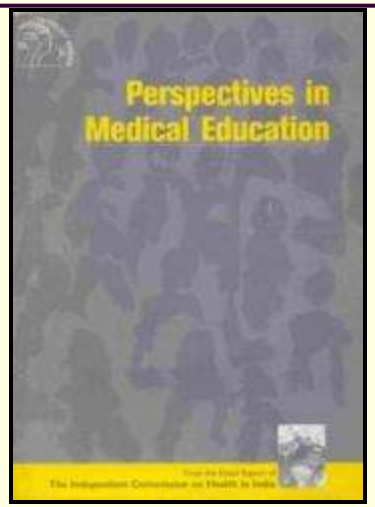
"For example, in India, the following organizations, among others have been active in public health education and training- some since the 1980's and others more recently:

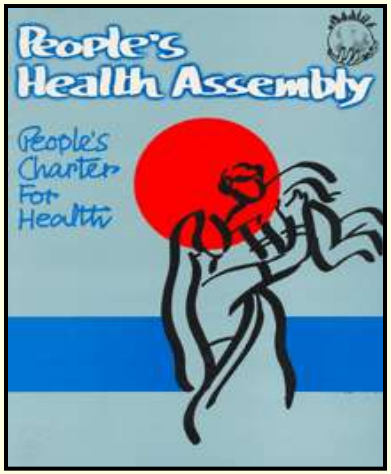
- **Network of Community Health trainers and voluntary organizations who conduct short courses in community health, development and management**
- **Peoples Health Movement**
- **Society for Community Health Awareness, Research and Action (CHC/ CPHE)**
- **Centre for Enquiry into Health and Allied Themes (CEHAT)**

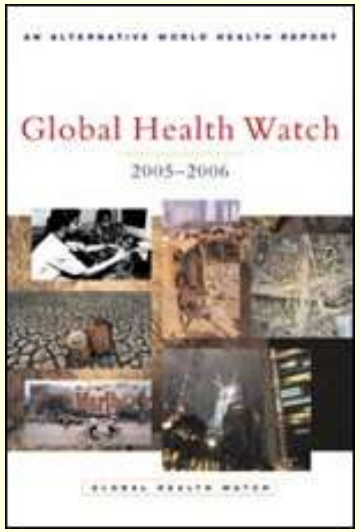
The list can be enriched by examples from other countries as well as with more examples from India. ……"

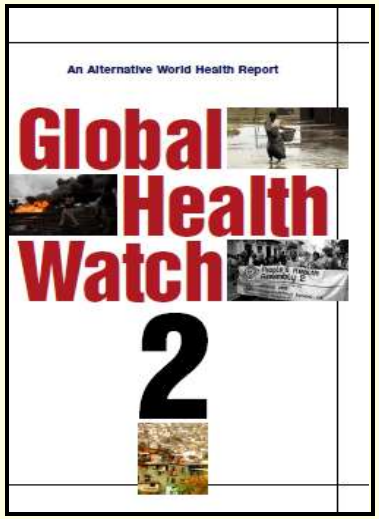
Source: South East Asia Public Health Initiative -2004-2008 – WHO – SEARO

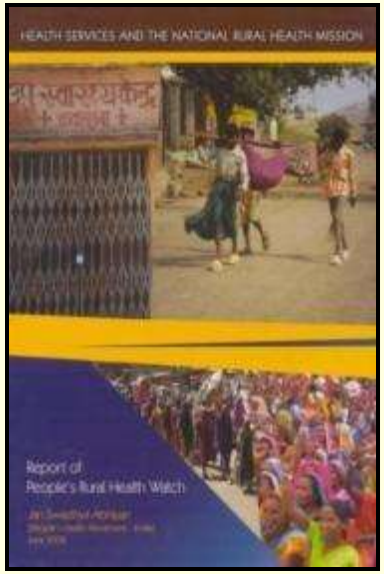
DEVELOPMENTS IN PUBLIC HEALTH POLICY and ACTION: ALTERNATIVE SECTOR:1998-2008

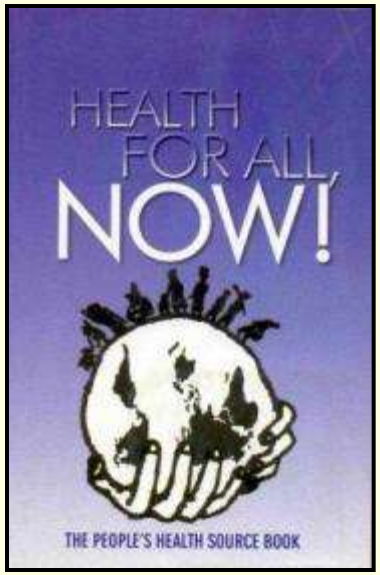




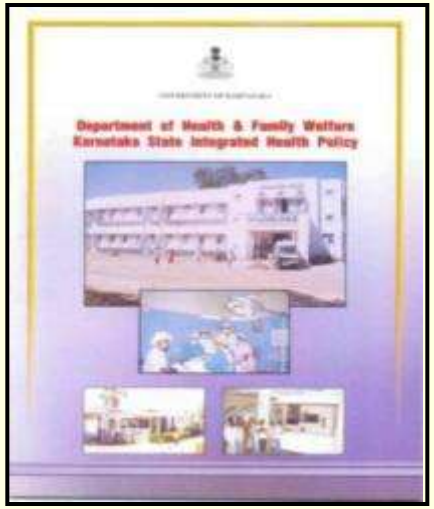


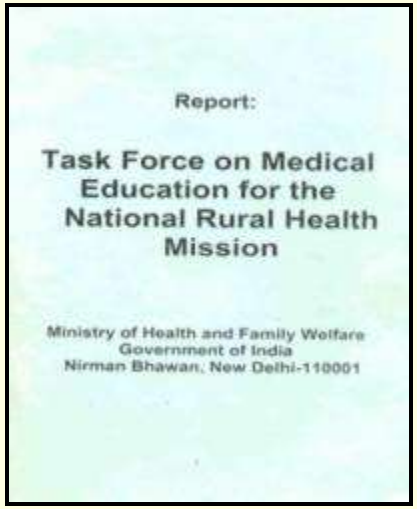


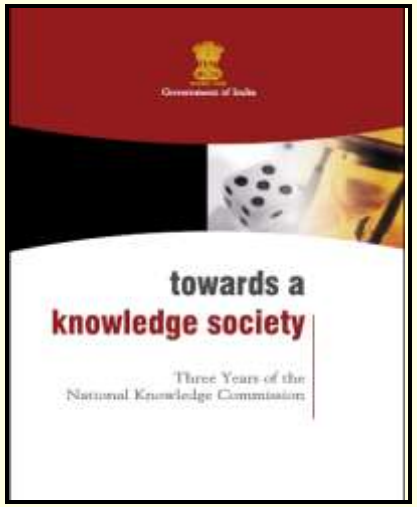




MAINSTREAM DEVELOPMENTS IN PUBLIC HEALTH WITH PARTNERSHIP OF ALTERNATIVE SECTOR – 1998-2008







The New Epidemiology

“ **The primary determinants of disease are mainly economic and social and therefore its remedies must also be economic and social …**

Medicine and politics cannot and should not be kept apart.”

- Prof. Geoffrey Rose, 1992

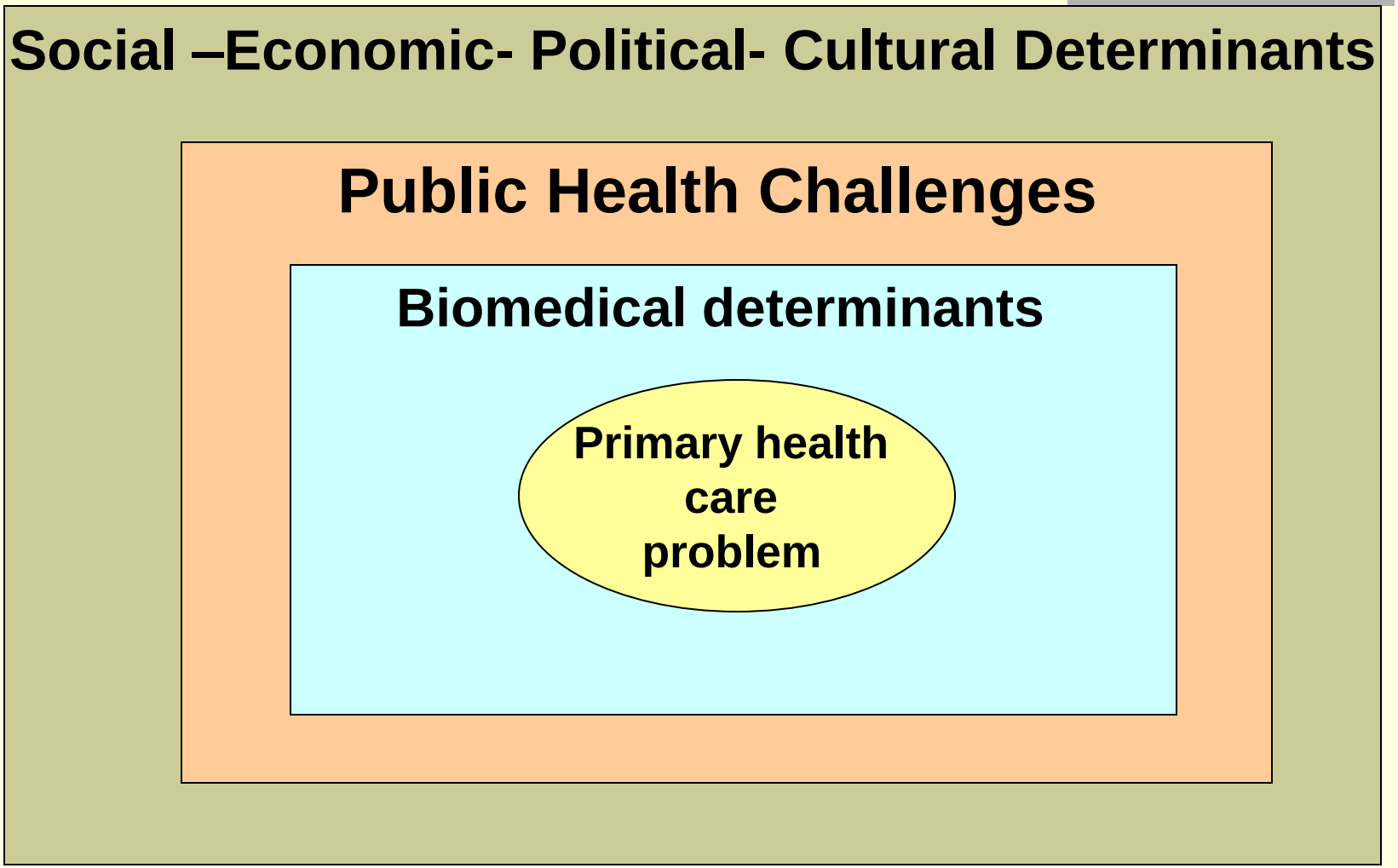
The Strategy of Preventive Medicine

Researching levels of analysis and solutions for TB: A common health problem

Levels of analysis of tuberculosis	Casual understanding of tuberculosis	Solutions / Control strategies for tuberculosis
Surface phenomenon (medical and public health problem)	Infectious disease / germ theory	BCG, case finding and domiciliary chemotherapy
Immediate cause	Under nutrition/ low resistance, poor housing, low income / poor purchasing capacity	Development and welfare – income generation / housing
Underlying cause (symptom of inequitable relations)	Poverty / deprivation, unequal access to resources	Land reforms, social movements towards a more egalitarian society
Basic cause (international problem)	Contraindications and inequalities in socio-economic and political systems at international, national and local levels	More just international relations, trade relations etc.

Source: Narayan T.,1998

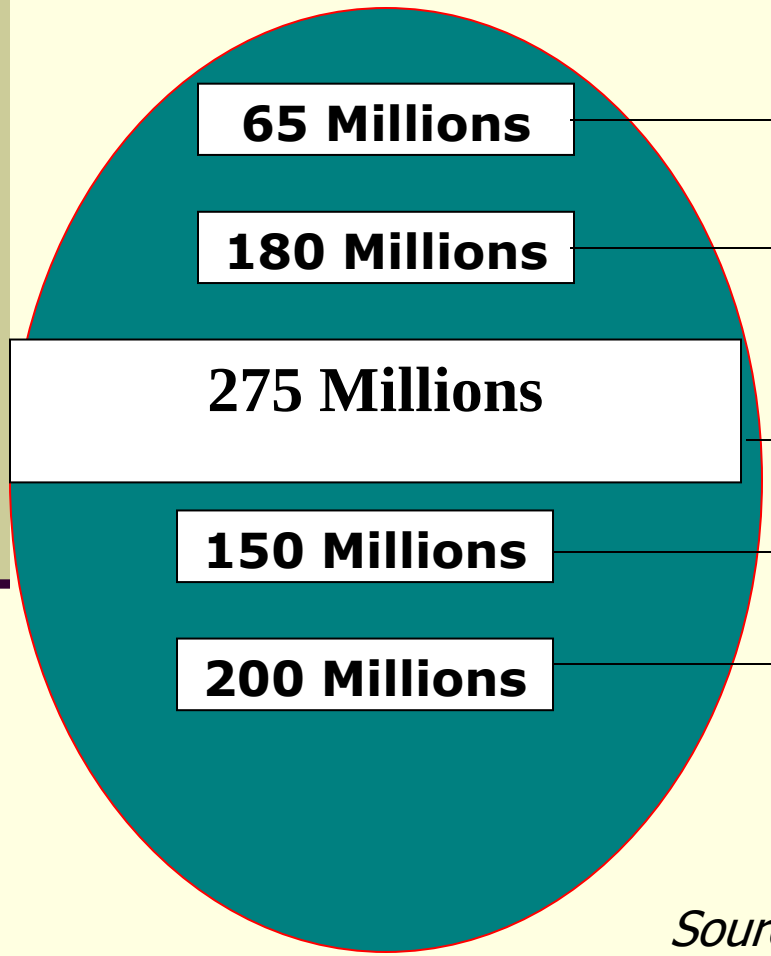
Towards a new epidemiological analysis for primary health care research



New Public Health/Epidemiology-I
The Paradigm Shift – (GFHR Forum 8 -Mexico)

Approach	Biomedical deterministic	Participatory social/ research
Focus	Individual	Community
Dimensions	Physical / pathological	Psycho- social, cultural, political, ecological
Technology	Drugs / vaccines	Education and social
Type of service	Providing/ Dependence Social marketing	Enabling / Empowering Autonomy Building
Link with	Patient as passive beneficiary	Community as active
Research	Molecular biology Pharmaco – therapeutics Clinical Epidemiology	Socio – epidemiology Social determinants Health Systems Social Policy

India's Population
Reflecting recent changes

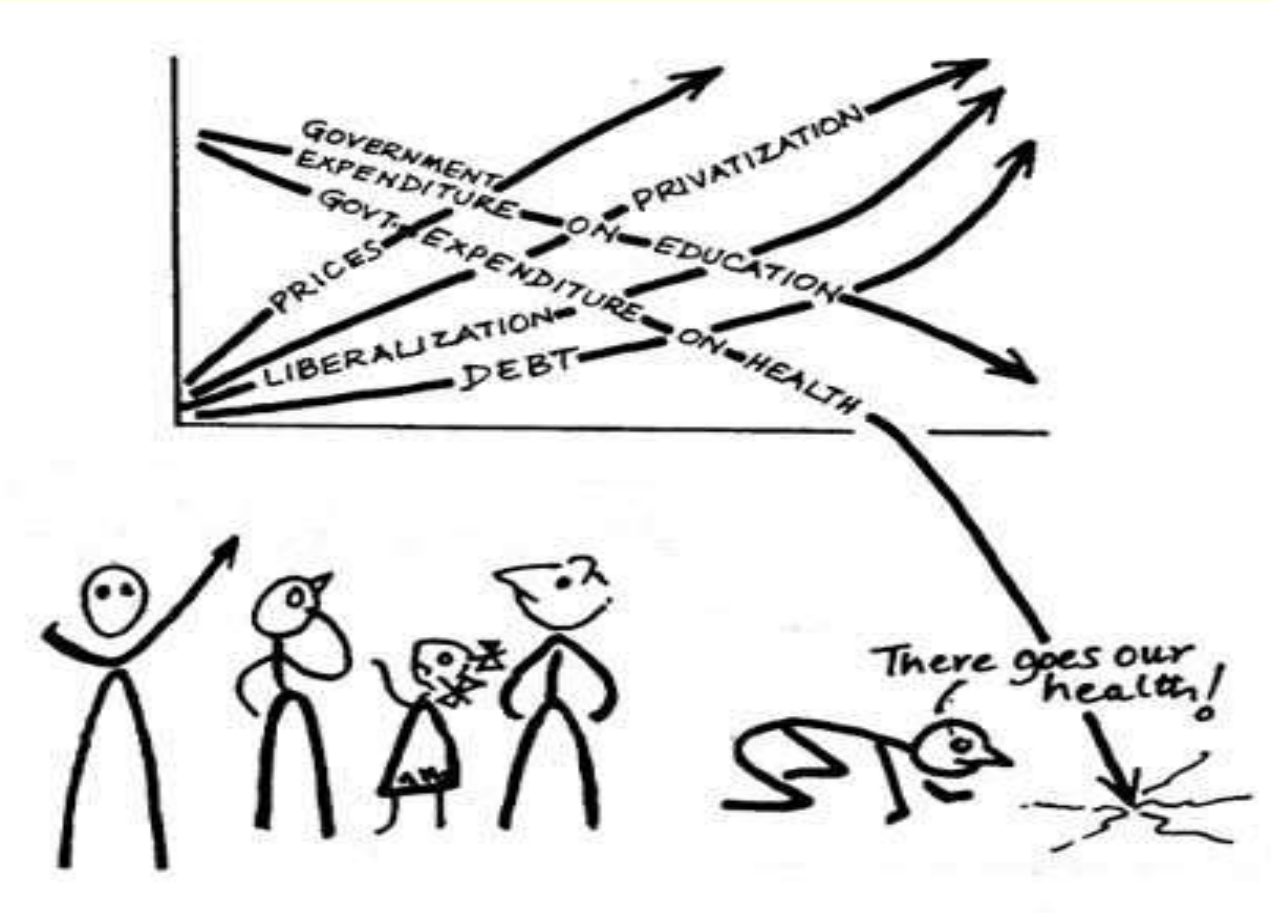


- The elite
- Consumers
- Climbers
- Poor (aspiring)
- Destitute

SourceL : India Today – MARG Poll, April, 1995

Development : A Right to Health Perspective

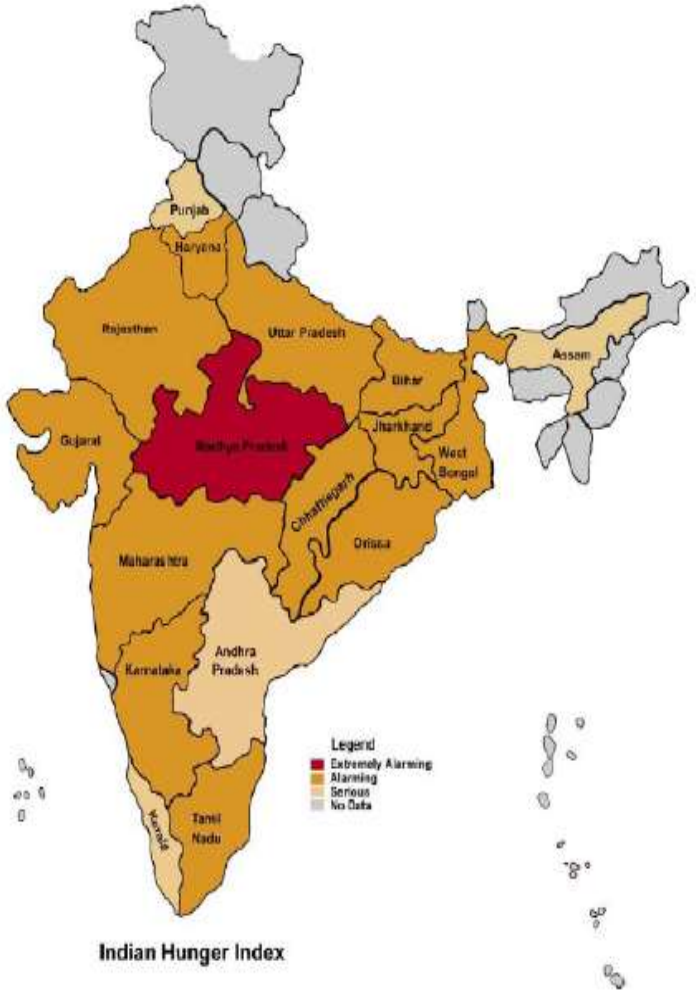
What are the people saying



HUNGER Index for India

Table 3. Severity of Indian State Hunger Index, by State.

<4.9 (low)		<5.0-9.9 (moderate)		10.0-19.9 (serious)		20.0-29.9 (alarming)		>30.0 (extremely alarming)	
State	ISHI	State	ISHI	State	ISHI	State	ISHI	State	ISHI
None		None		Punjab	13.6	Haryana	20.0	Madhya Pradesh	30.9
				Kerala	17.7	Uttar Pradesh	20.9		
				Andhra Pradesh	19.5	Tamil Nadu	21.0		
				Assam	19.8	Rajasthan	21.0		
						West Bengal	22.2		
						Karnataka	22.8		
						Orissa	23.7		
						Maharashtra	23.8		
						Gujarat	24.7		
						Chhattisgarh	26.6		
						Bihar	27.3		
						Jharkhand	28.7		

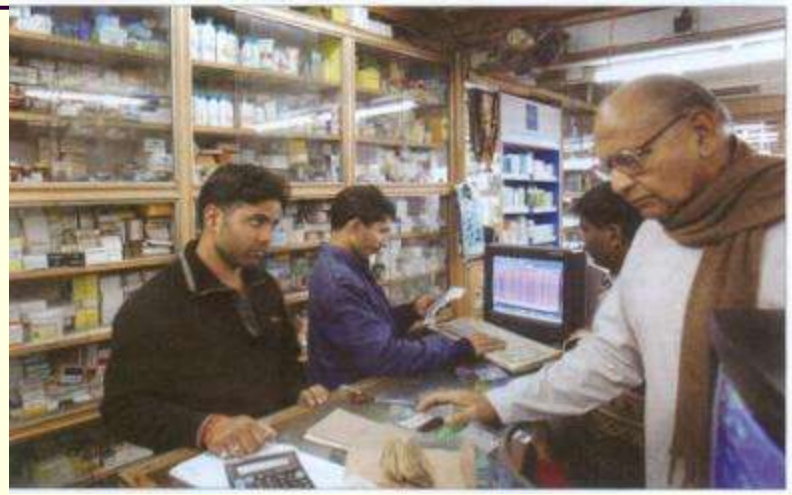


Indian Hunger Index

Basic Challenges – inadequately recognized

Equity

Access



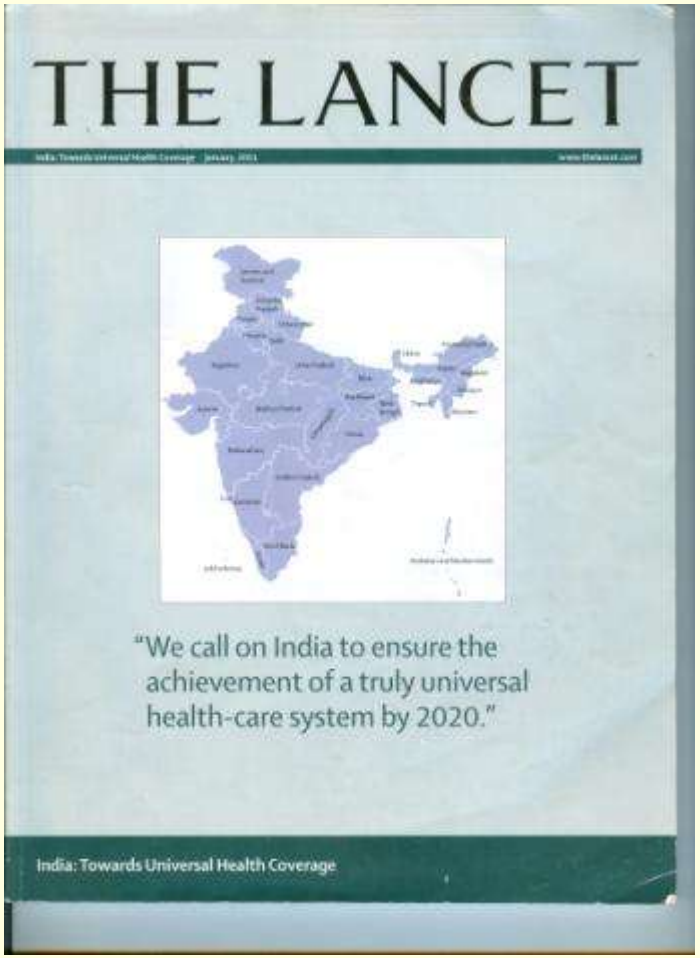
Corruption

Social Determinants

Themes and Challenges

THEMES

- **Infectious Diseases**
- **RCH and Nutrition**
- **Chronic Diseases/ injury**
- **Equity and Health Care**
- **Human Resources**
- **Financing Health Care**

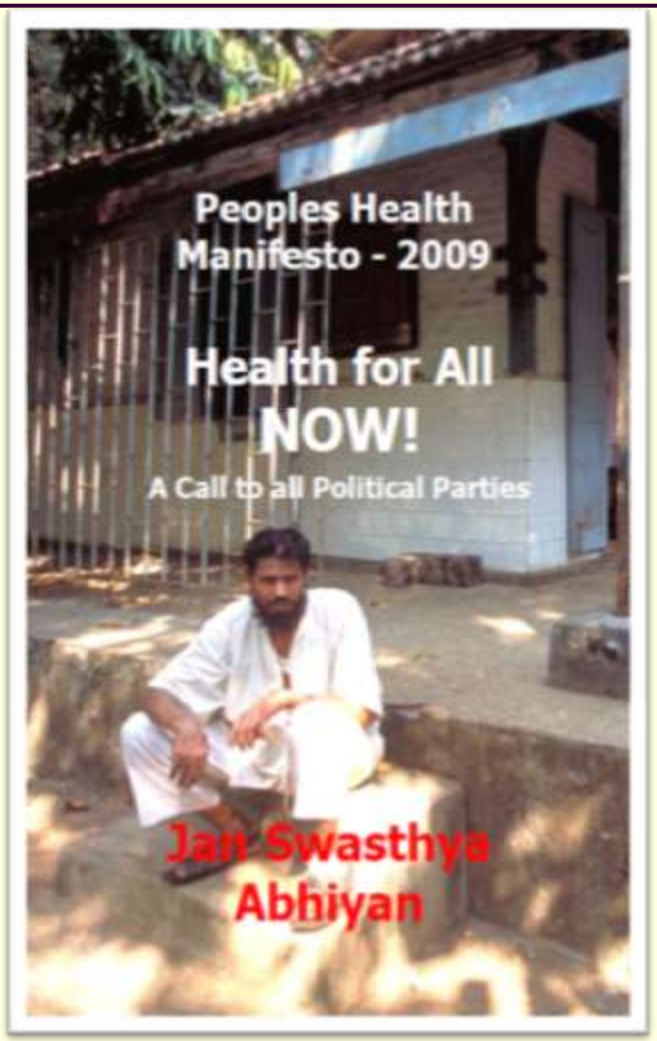


CHALLENGES

- **Health Rights**
- **Gender Equity**
- **Markets/ Access**
- **Governance**
- **Corruption**
- **Social Determinants**
- **PPP/ Economics**

Towards universal Health Care- A Call to Action

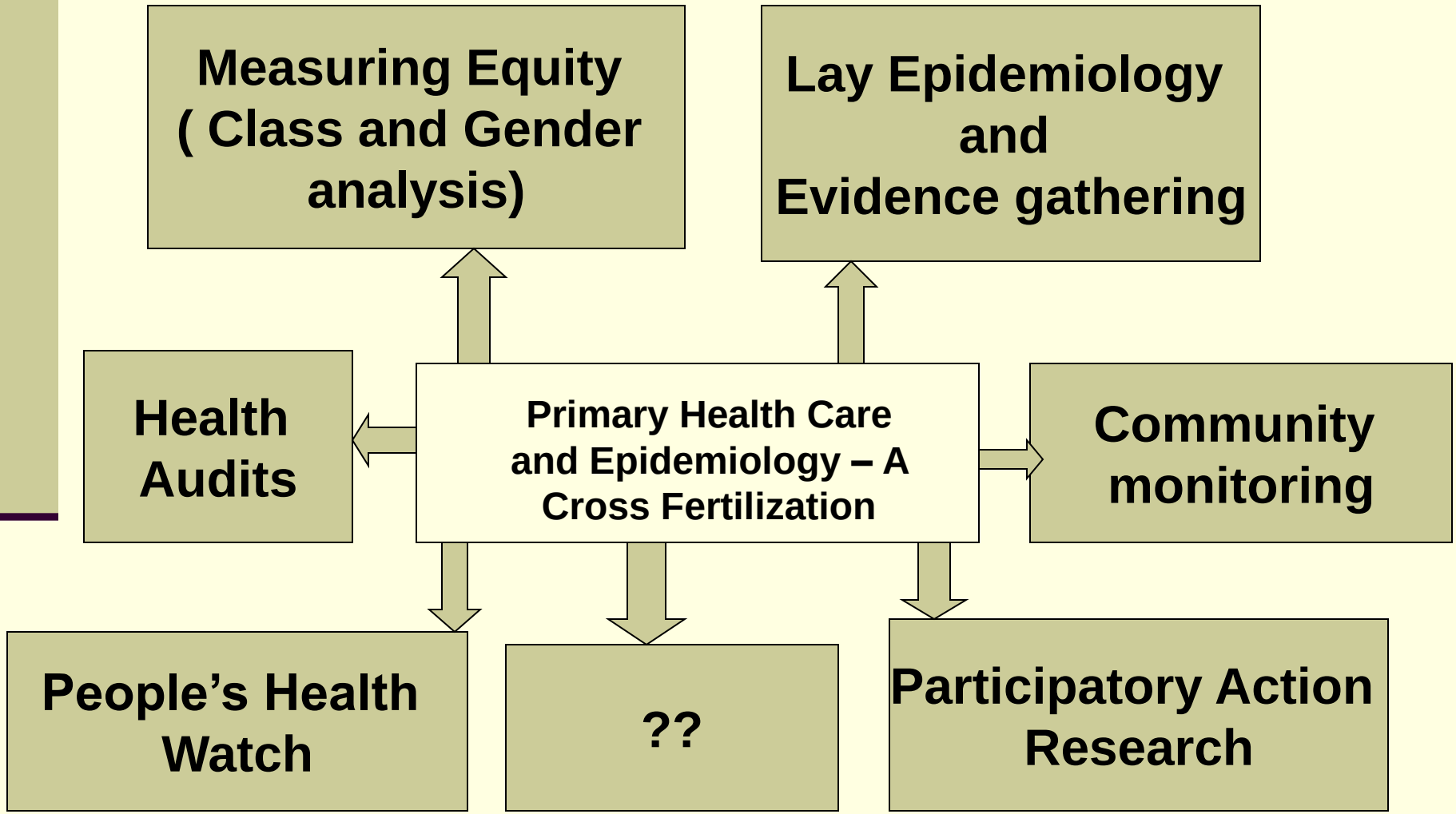
Peoples Health Manifesto- 2009



Suggested effective measures to achieve right to health

- **Enactment of National Health ACT-** to guarantee the basic affordable quality health care services in all clinical establishments including the private establishment
- **Rural Infrastructure and the National Rural Health Mission-** Increased allocation and effective utilization of Funds and strict action on corruption
- **Drug Medicines and Patents-** List of Essential and Consumable drug s by the state. Ethical code of marketing medicine and revival of public sector companies on medicine and vaccines
- **Gender and Health –** Abolish coercive laws on policies and practices that violate the reproductive and democratic rights of women and Assure women of gender-specific health entitlements
- **Child Health and Nutrition –** Urgency for a National policy on Child health and nutrition. Universalization with quality IDCS

Revitalizing Epidemiology through Primary Health Care.



COMMUNITY PARTICIPATION – RECOGNISING THE PARADIGM SHIFT – 2000AD and beyond

Approach	Biomedical, deterministic, managerial model	Participatory social/ model
Link with community	As passive client or	As active and empowered participant
Dimensions Explored	Physical and technical	Psycho- social, cultural, political, ecological
Focus of Participation	Resources, Time/ Skills	Leadership, Ownership, setting, Monitors.
CHW Role	Service provider, educator, data collector (lackey ?)	Mobilisor, activist, empowerer, social auditor, monitor. (Liberator)
Research	Community participation as	Community participation as

Source: CHC 2008

For further information visit

www.sochara.org

www.phm-india.org

www.phmovement.org

www.ghwatch.org

www.iphcglobal.org

II- NRHM and Communitization of Health Care Services

Meeting People's Health Needs

Health for All

Health Survey and Development Committee- India

Bhore Committee (1946)

- "No permanent improvement of public health can be achieved without the active participation of the people in the local health program….
- We consider that the development of local effort and the promotion of a spirit of self help in the community are as important to the success of the health programme as the specific services, which the health officials will be able to place at the disposal of the people
- Formation of village health committees and Voluntary health workers are needed who will need suitable training.."

Source : CBHI 1985

Mudaliar Committee (1961)

- "Unless the conscience of the citizens has a whole is stimulated to demand and accept better standards of health…..
- Unless the principles of sound hygiene are inculcated into the masses through health education and other efforts, and ….
- Unless government feels strengthened in taking positive measures to promote health, it will be difficult for health authorities alone to ensure that the measures contemplated are actually implemented…."

Source : CBHI 1985

National Health Policy (1983)

- **…..Largescale transfer of knowledge, simple skills and technologies to health volunteers, selected by the communities and enjoying their confidence.**

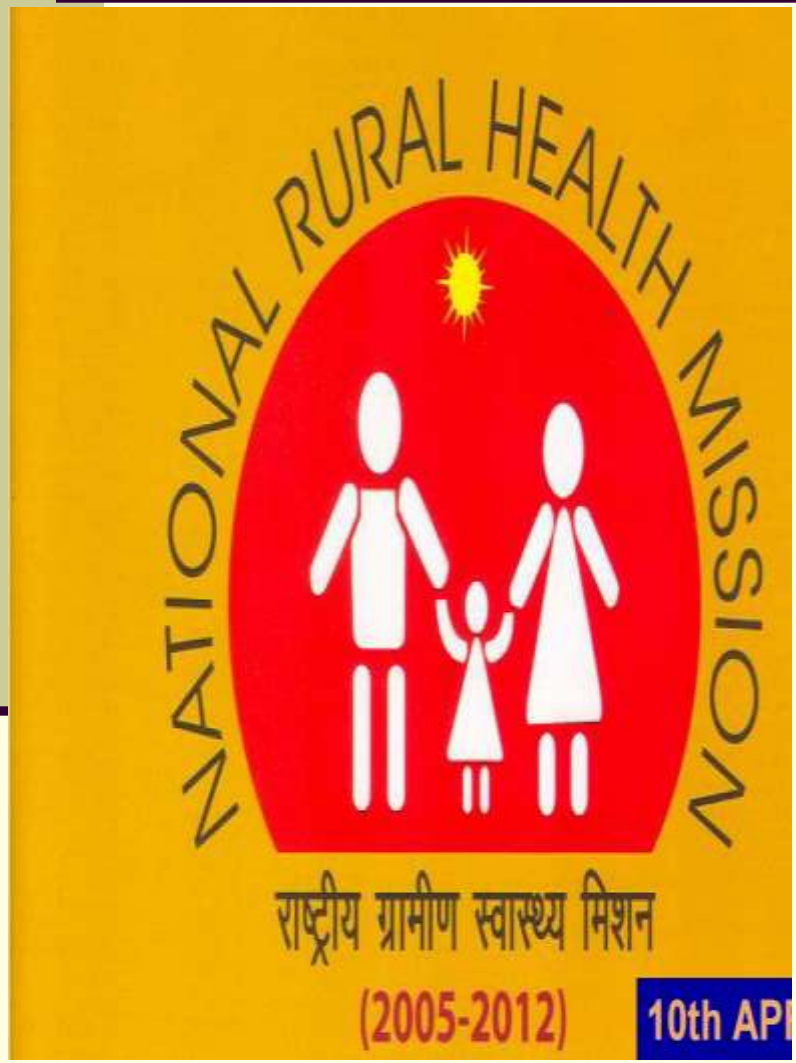
- **The Functioning of the front line of workers, selected by the community would require to be related to definitive action plans for the translation of medical and health knowledge into practical action,**

- **The quality of training of these health guides/workers …… crucial to the success of this approach.**

- **The success of the decentralized primary health care system would depend vitally on the organized building up of individual self reliance and effective community participation.**

National Rural Health Mission 2005-2012

- Evolving through the politics of engagement



Goal:

- To improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children

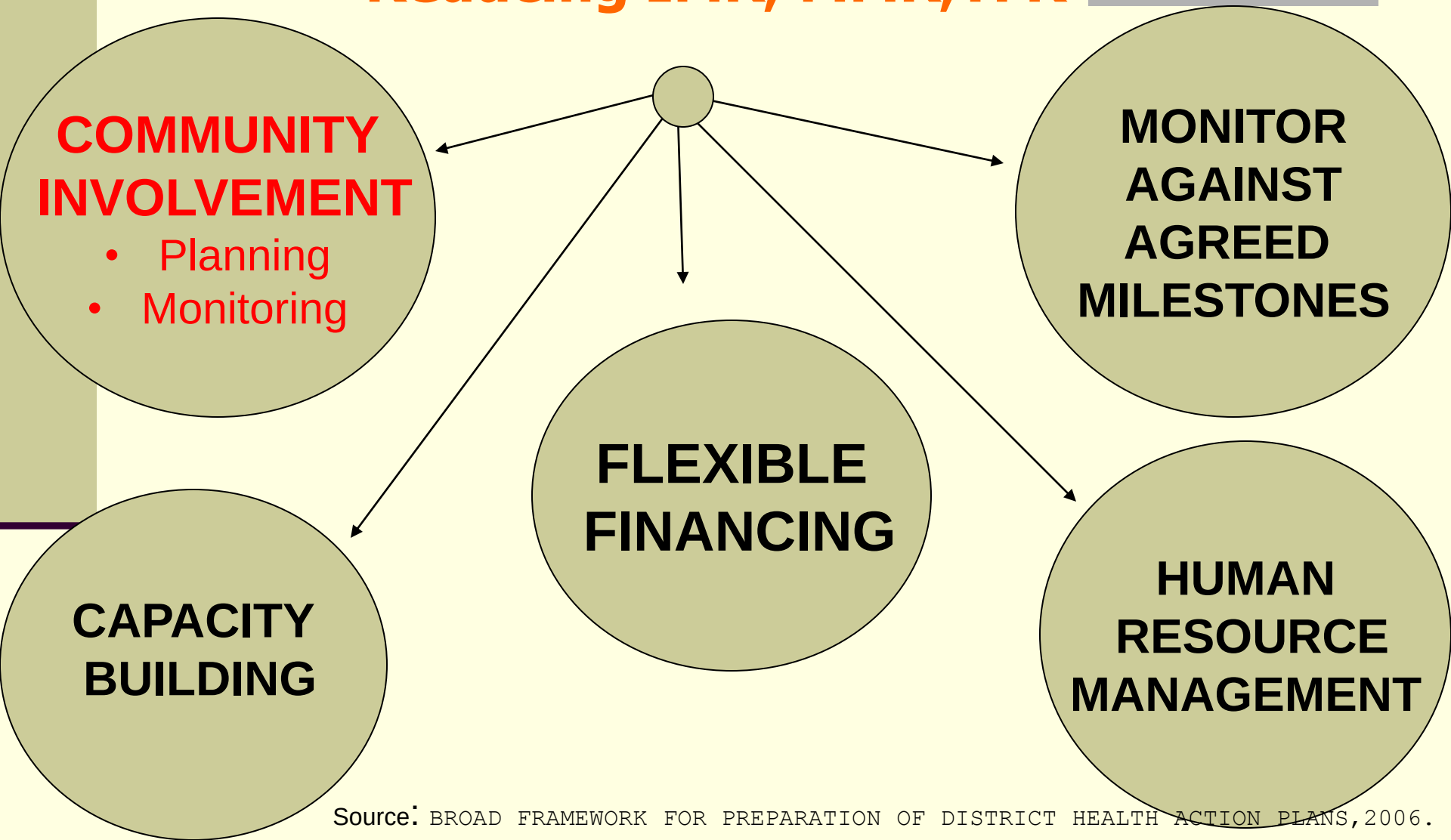
Principles:

- It seeks to improve access to equitable, affordable, accountable, and effective primary health care.
- It has as its they component provision of a female health activist in each village; a village health plan prepared through a local team headed by the village health and sanitation committee of the panchayath.
- Train and enhance capacity of panchayathraj institution to own, control and manage public health service.

NRHM GOALS & APPROACHES

Presentation by : CHC Team

Universal Health Care
Reducing IMR, MMR,TFR



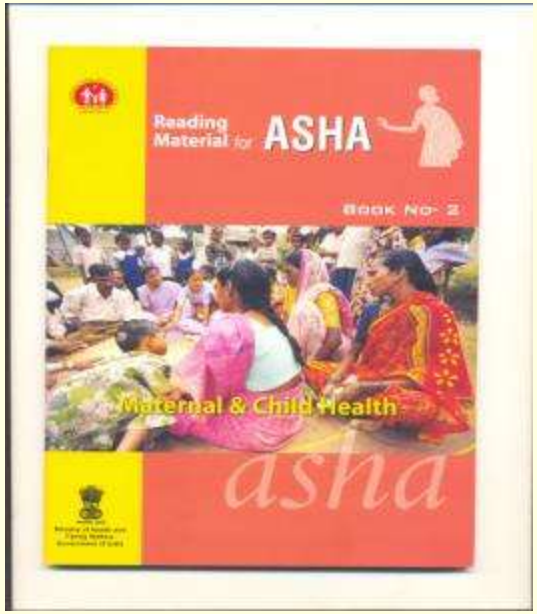
Source: BROAD FRAMEWORK FOR PREPARATION OF DISTRICT HEALTH ACTION PLANS,2006.

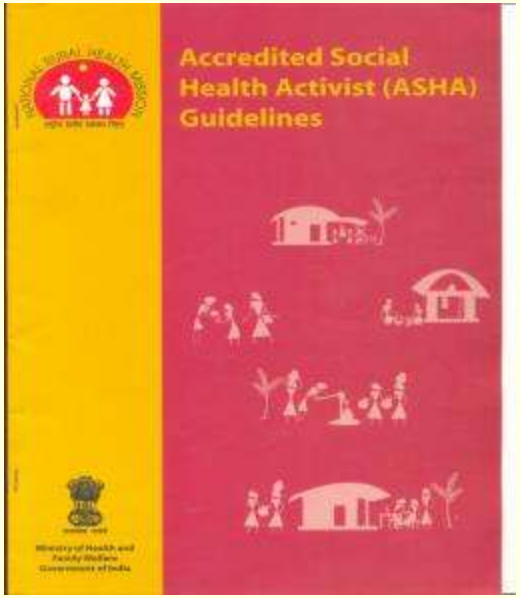
COMMUNITISATION COMPONENTS

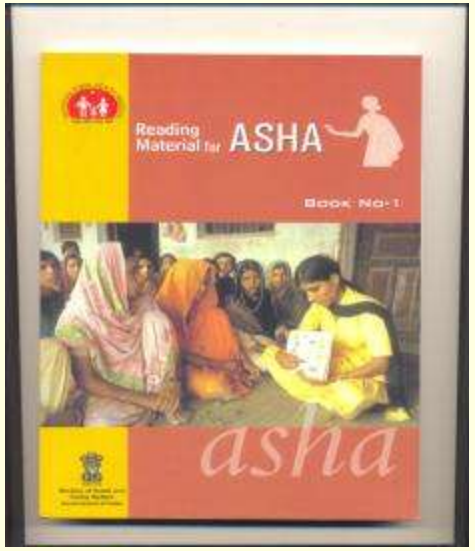
The new Health Worker as Health Activist
ASHA Training Programme of NRHM- India 2004

"A new band of community based functionaries named as **Accredited Social Health Activists (ASHA**) who would be a health activist and mobilize the community towards local health planning and increase utilization and accountability of existing health services".

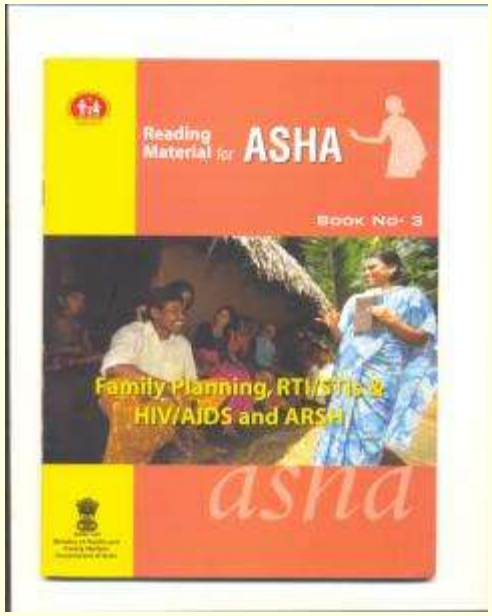
ASHA TRAINING MANUALS

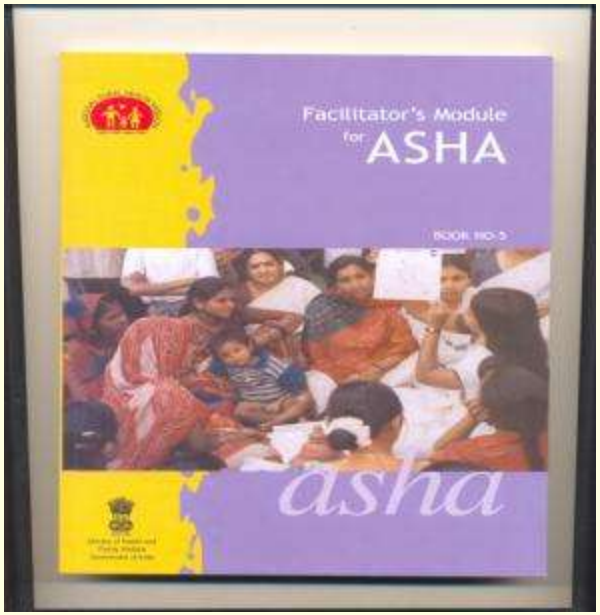


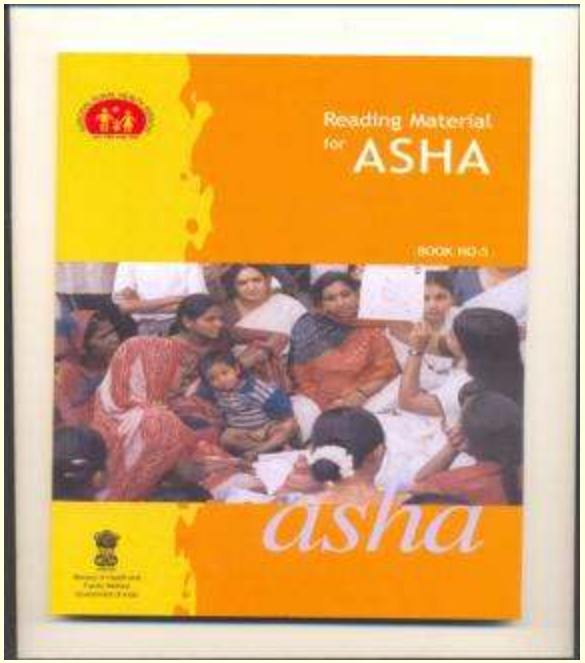




ASHA TRAINING MANUALS







Role of civil society organizations

- As members of monitoring committees
- As resource groups for capacity building and facilitation
- As agencies helping to carry out independent collection of information

Source: Manual on Community based Monitoring of Health Services under NRHM, 2007. AGCA.

Why civil society engagement?

- Why: Genuine engagement /community parrticipation
  Means to empower community/capacity development
- What: Skills to plan and assess and monitor health systems and give feedback
- Who: Range of representatives – Panchayat
  CBO's
  People's Organisations and movements
  Teachers / SHG's etc

III- Community Monitoring and Accountablity

Community Planning & Monitoring of Health Services

- Places people at the center of the process of regularly assessing the fulfillment of their health rights and needs
- Is one of the three proposed accountability frameworks of NRHM
- Seen as important to promote community led action in Health

Source: Manual on Community based Monitoring of Health Services under NRHM, 2007. AGCA.

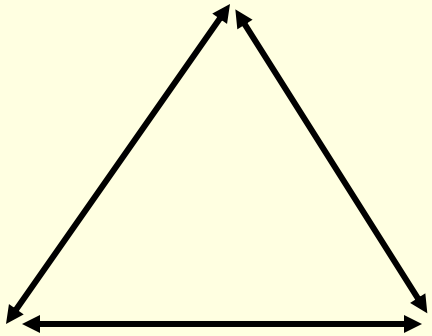
Objectives

- **To provide regular and systematic information about community needs to guide the planning process**
- **To provide feedback according to the locally developed yardsticks, as well as on some key indicators.**
- **To provide feedback on the status of fulfillment of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.**
- **To enable the community and community-based organisations to become equal partners in the planning process, to increase the community participation to improve responsive functioning of the public health system.**
- **To validate the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.**

Source: Manual on Community based Monitoring of Health Services under NRHM, 2007. AGCA.

Community Action
A three way partnership

Health System



Community, Community Based Organisations (CBOs) and NGOs

Panchayat Raj Institutions (PRI)

Source: Manual on Community based Monitoring of Health Services under NRHM, 2007. AGCA.

Why Community Monitoring?

- It is a community's Right to know how resources collected in its welfare's name is being used. Whether it is being used as per the policy? Whether it can be put to better use? Whether those who need it are getting it?
- Ensures Accountability.
- Promote decentralized inputs for planning and managing of health activities.
- Evidence has shown this works.

NRHM – Giving real "power" to the people

Planning, Management and Evaluation

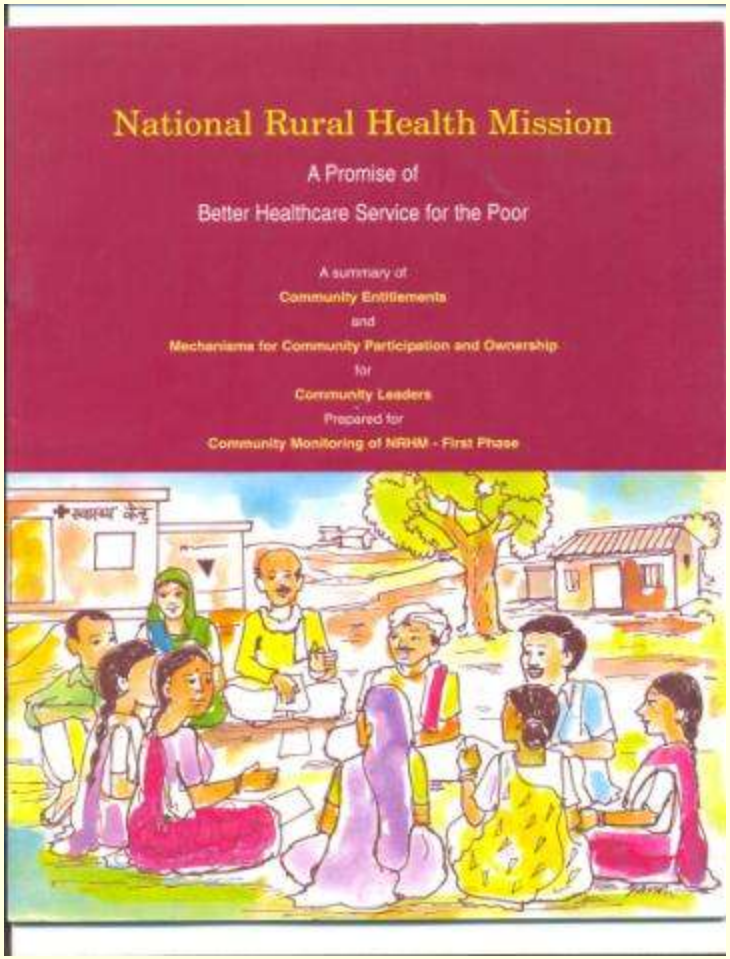
- Set up a platform for involving the Panchayati Raj institutions and community **own, control and manage** Public Health Services.
- To institutionalize community led action for health, NRHM has sought **amendments to acts and statutes in States to fully empower local bodies** in effective management of the health system.
- For the accountability framework to be truly community owned, the effort will be to **ensure that at least 70 percent of the total NRHM expenditures** are made by institutions and organizations that are being supervised by an institutional PRI/community group.

Village Health and Sanitation Committee (VHSC)

- **Members**: ASHA, Anganwadi Sevika, Gram /Ward Panchayat representatives, SHG leader, CBO representatives
- **Role:**
  - House hold Survey
  - Village Health Register
  - Village Health Plans
  - Community Action for Health
  - Community Monitoring
- **Training**
  - of VHSC members
  - Training modules prepared
  - already initiated in some states
- **Financing**
  - Bank accounts
  - Untied funds.

Community Monitoring & Planning

- Advisory Group on Community Action for the NRHM
- Pilot testing in 9 states
- Expansion through Project Implementation Plans/ Central fund
- Posters, pamphlets survey forms
- Media fellowships



NRHM Mission Document

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing PHCs and CHCs.

From Core Strategies

Pilot Phase - Community Monitoring and Planning

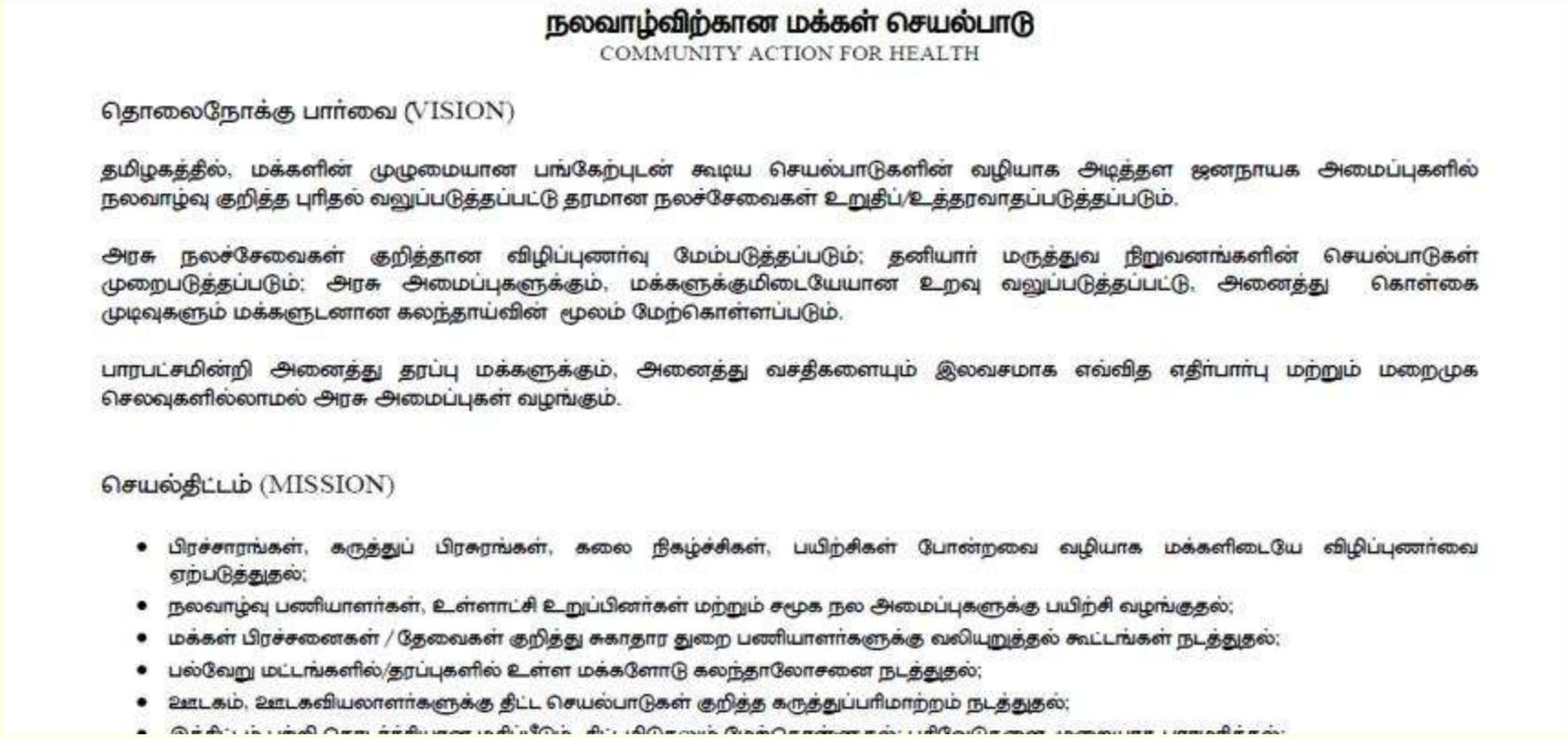
- 225 hamlets in Pilot phase
- 15 blocks in six districts
- One round of monitoring – modified the centrally developed tool
- External evaluation
- Joint workshop – In August 2009- Top bureaucrats from Health system, civil society – Background paper with joint authorship prepared

Project Area & Human Resources

- 446 Panchayats covers 3752 hamlets spread across in 14 development blocks of six districts
- One Panchayat level animator for five to six Panchayats, one coordinator for each block, one coordinator for each district, Consultant for each district and state unit team
- District & state level mentoring committee
- Project Governing body
- Government order G.O (M.s.) No. 411 issued

Developing shared understanding

- Used International Development Resource Centre's **OUTCOME mapping** tool
- Shared vision and mission for the project developed
- Boundary partners and the expected change on them were



நலவாழ்விற்கான மக்கள் செயல்பாடு

COMMUNITY ACTION FOR HEALTH

தொலைநோக்கு பார்வை (VISION)

தமிழகத்தில், மக்களின் முழுமையான பங்கேற்புடன் கூடிய செயல்பாடுகளின் வழியாக அடித்தள ஜனநாயக அமைப்புகளில் நலவாழ்வு குறித்த புரிதல் வலுப்படுத்தப்பட்டு தரமான நலச்சேவைகள் உறுதிப்/உத்தரவாதப்படுத்தப்படும்.

அரசு நலச்சேவைகள் குறித்தான விழிப்புணர்வு மேம்படுத்தப்படும்; தனியார் மருத்துவ நிறுவனங்களின் செயல்பாடுகள் முறைபடுத்தப்படும்; அரசு அமைப்புகளுக்கும், மக்களுக்குமிடையேயான உறவு வலுப்படுத்தப்பட்டு, அனைத்து கொள்கை முடிவுகளும் மக்களுடனான கலந்தாய்வின் மூலம் மேற்கொள்ளப்படும்.

பாரபட்சமின்றி அனைத்து தரப்பு மக்களுக்கும், அனைத்து வசதிகளையும் இலவசமாக எவ்வித எதிர்பார்பு மற்றும் மறைமுக செலவுகளில்லாமல் அரசு அமைப்புகள் வழங்கும்.

செயல்திட்டம் (MISSION)

- பிரச்சாரங்கள், கருத்துப் பிரசுரங்கள், கலை நிகழ்ச்சிகள், பயிற்சிகள் போன்றவை வழியாக மக்களிடையே விழிப்புணர்வை ஏற்படுத்துதல்;
- நலவாழ்வு பணியாளர்கள், உள்ளாட்சி உறுப்பினர்கள் மற்றும் சமூக நல அமைப்புகளுக்கு பயிற்சி வழங்குதல்;
- மக்கள் பிரச்சனைகள் / தேவைகள் குறித்து சுகாதார துறை பணியாளர்களுக்கு வலியுறுத்தல் கூட்டங்கள் நடத்துதல்;
- பல்வேறு மட்டங்களில்/தரப்புகளில் உள்ள மக்களோடு கலந்தாலோசனை நடத்துதல்;
- ஊடகம், ஊடகவியலாளர்களுக்கு திட்ட செயல்பாடுகள் குறித்த கருத்துப்பரிமாற்றம் நடத்துதல்;

Formation

- **People as Instrument for project activities Vs Change makers / power centers**
- **Participation as Value hence the process become important**

- This phase enabled the Involvement of a large number of people
- Democratizing participation – Expansion of Village Health Water and Sanitation committee (VHWSC)
- Open meetings at every village

Formation

- Community choose one or two members from each village – **voluntary, interested, interest in social issues and acceptable by community**

- Formed expanded VHWSC – members from community, Panchayat system and health and other government system – In total the number of VHWSC members are 5340
- VHWSCs are ratified in Gram Sabha

VHWSC orientation & Meetings

- **Participation & Citizenship**
- **Rights and responsibility / Practice**
- Involving the committee members in the process – Orientation on NRHM, importance & space for participation, entitlements of community, responsibility of members & community

- By getting to know the system and service providers' roles & responsibilities
- Recognizing their entitlement & identifying un met needs - **Peoples demand of accountability from the system will increase**

Cultural events

Monitoring

- **Participation as means to greater agency to people within the health system**
- Active participation of Community & VHWSC members
- Realising the gap in service & un met need
- Devloped a pictorial tool – through multiple steps – based on the feedback received from pilot phase

Tools development process

- Collected people's opinion through Participatory Rural Appraisal (PRA) methods
- Social mapping – Useful to know the pattern, layout, demography, different groups & etc.,

Focus group discussion (FGD) on the issues people want to monitor

Social mapping and FGD are conducted two per block, 28 in total project area

Tools development process cont…

- Two days workshop – dates ….
- Major services in respective to the age group was selected (service provider to age group based)
- Each question was analysed to ensure three aspects –Availability, Accessibility & Quality
- Traffic signal colour code was used – Red, Yellow & Green
- Completion of the circle to indicate comprehensiveness of the service
- Actual pictures of instruments were used - should I know technicality or restrict to my rights and services !

Sample page of Tool

Tools development process cont…

- First draft of the tool was discussed at various level – civil society, Deputy directors of health services, state bureaucrats, technocrats

- Piloted in six Panchayats of three districts
- Discussed in three days state level workshop in Kanniyakumari – Animators, block, district and state core team members

Published materials

Data collection

- Two to three members of

  each VHWSC members got trained on tools
- **Increasing accountability at various level (community & system) is the basis for act / active participation –** Led to include respondents basis of ***equity*** (disadvantage groups), ***increasing social capital*** (distant villages) & ***Inclusive citizenship*** (Higher caste groups)

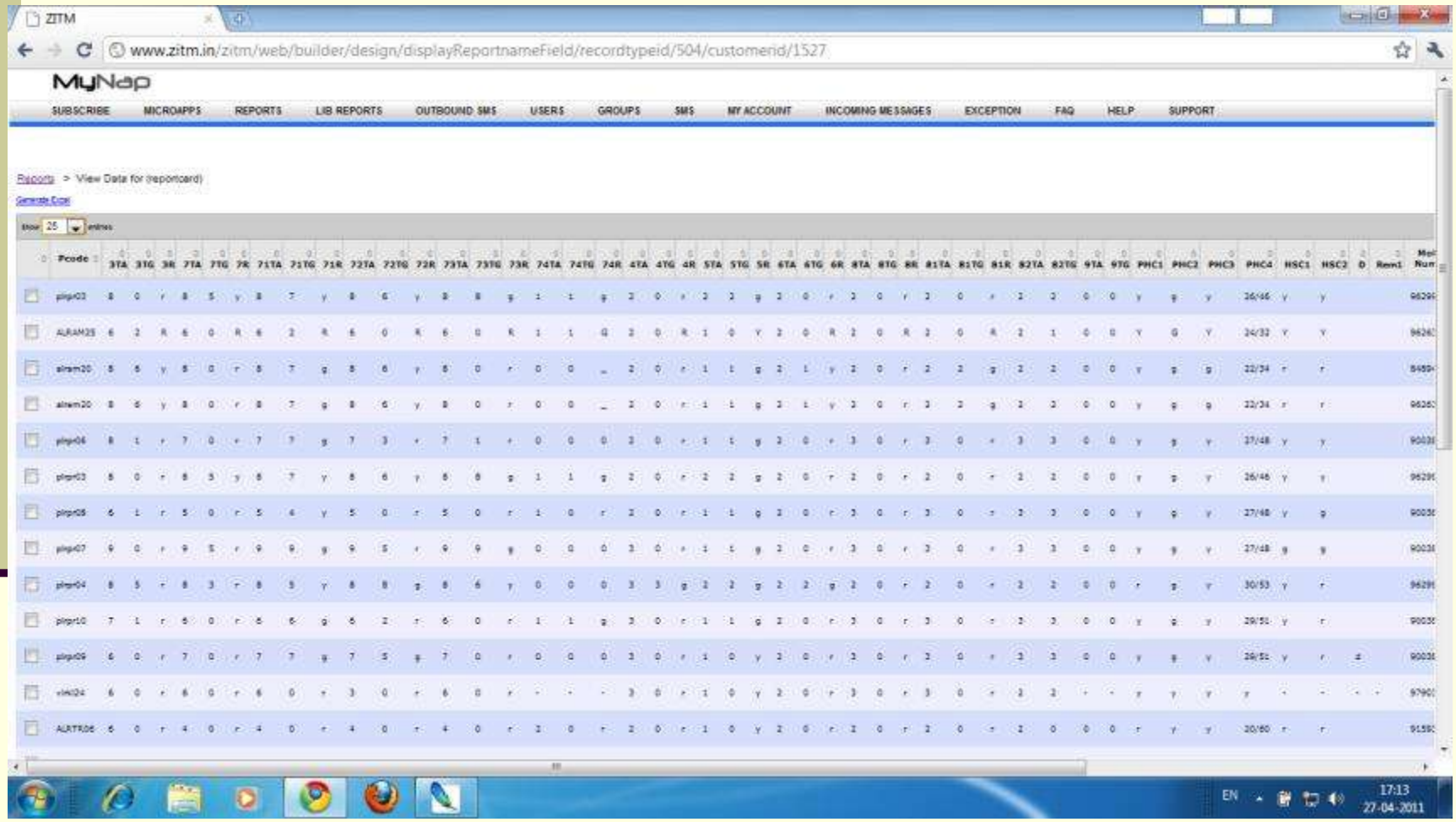
Data collection

- In total around 1,70,000 people contributed to the data
- VHWSC members, youth groups along with Panchayat animators collected data

Data collection

- Opinion were collected from services provider via PHC infrastructure, equipment, institution based services monitoring
- Peoples opinion on the institution was collected through voting
- Cell phone technology was used to digitalize the data – SMS based data entry system

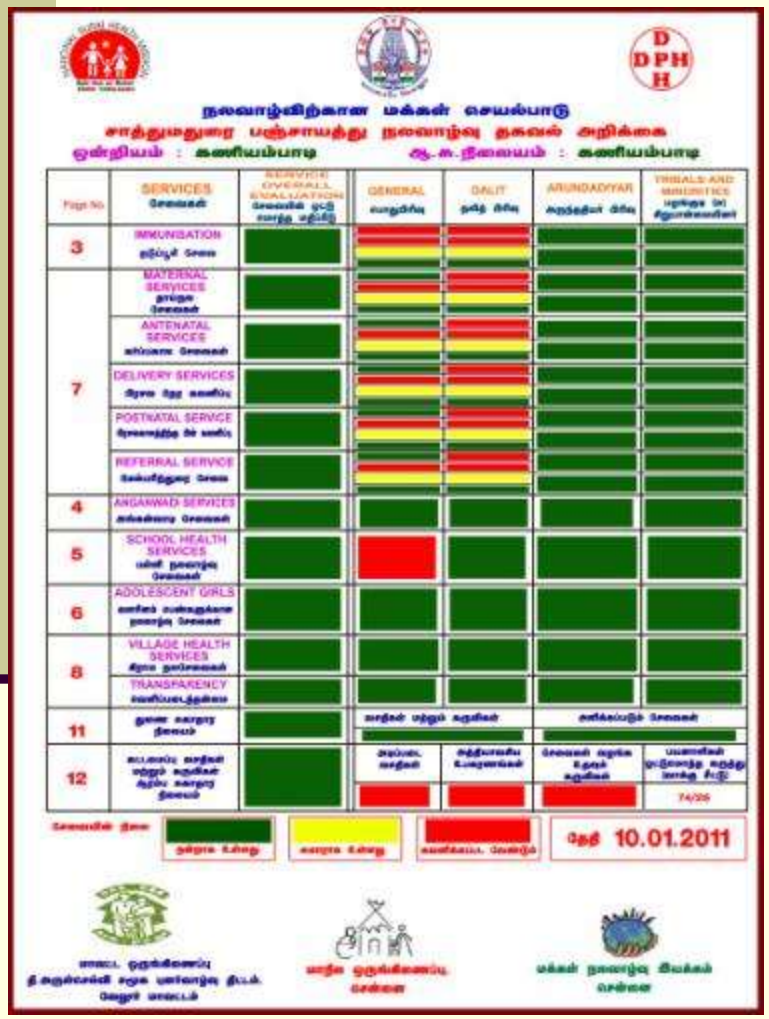
Data base of SMS server



Development of planning tool

Finalised sheet

Panchayat Health plan



- Panchayat report card was developed for 446 Panchayats
- Report card was disseminated to the entire community
- Report card was discussed in **non hierarchical** nature - People, VHWSC members, representatives of the system, elected leaders

Panchayat Health plan

- People are the important / equal stake holders of the discussion and planning
- By change in power dynamics peoples negotiation power increases
- Peoples felt need has become focus of the discussion

Panchayat Health plan cont…

- Non responsive nature of the system was questioned
- Plan for improvement of services and ways to reducing the gap between entitlement and actual position was identified
- Responsibilities shared among citizen and the service providers – Adaptation of social franchisee model of SEWA GRAM
- Multiple level responsibility / accountability was in demand

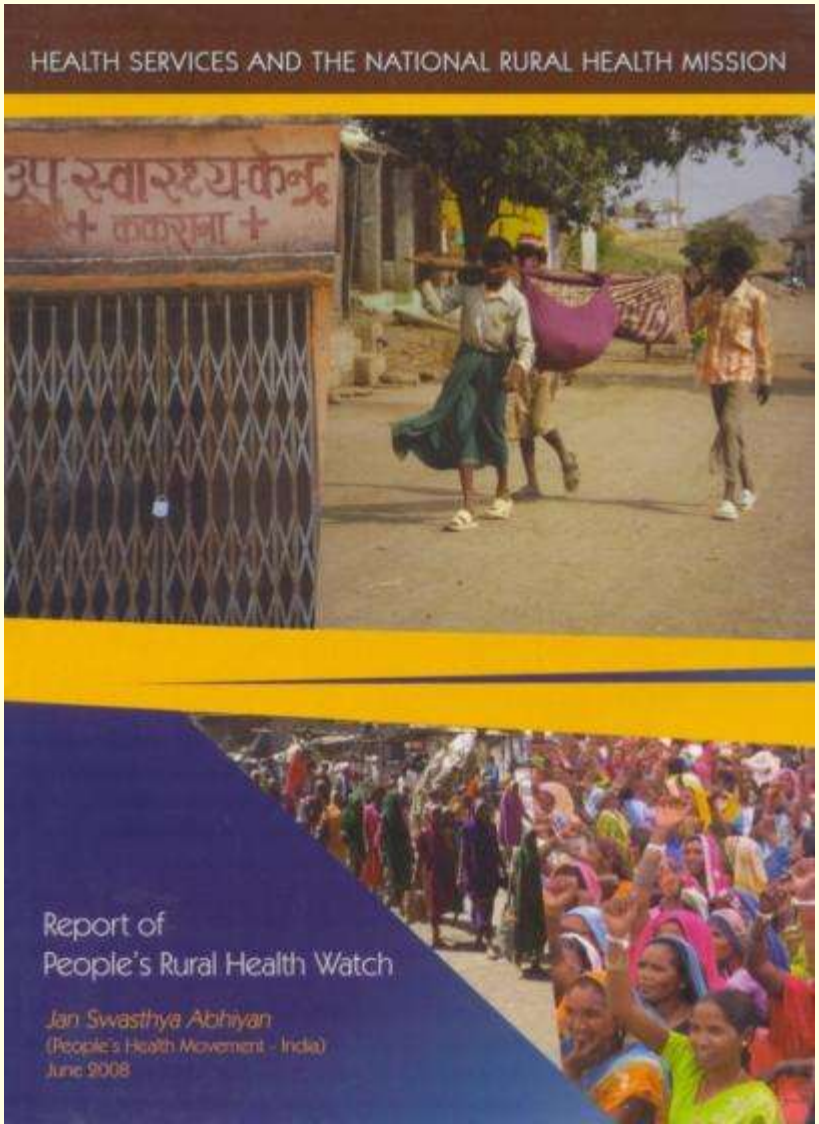
Active participation, transparency in discussion and in sharing information leads to sustenance of accountability

Peoples Rural Health Watch

State Health Assembly - 3
March 21st 2007, Bangalore

- JSA working from the ground up -8 states.
- State reports
- Annual reports
- Community monitoring in NRHM

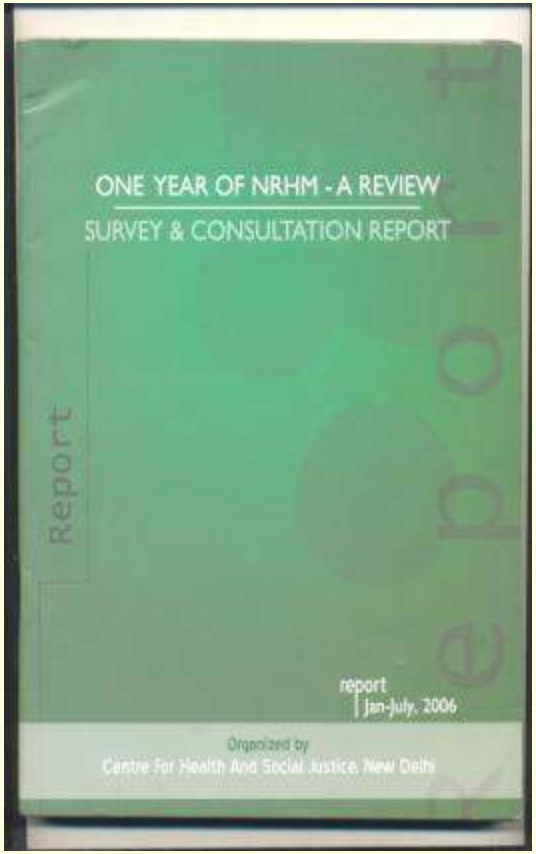
People's Rural Health Watch, 2008 Recommendations

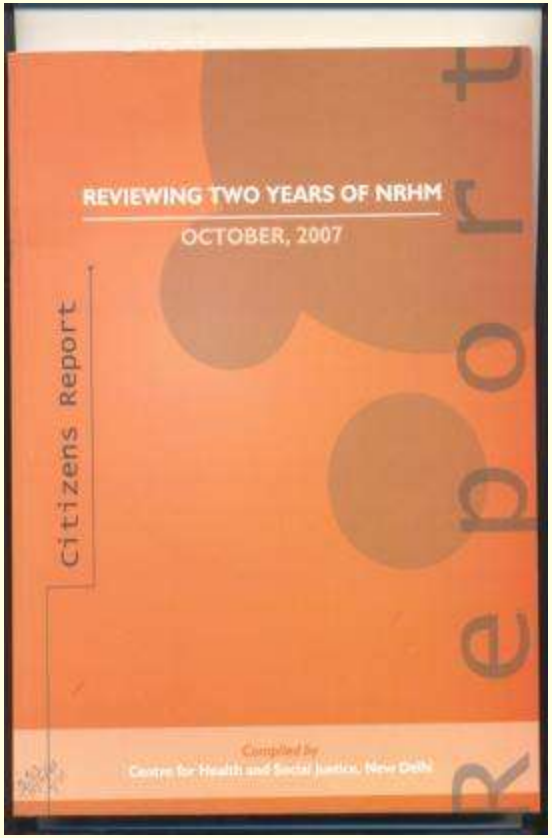


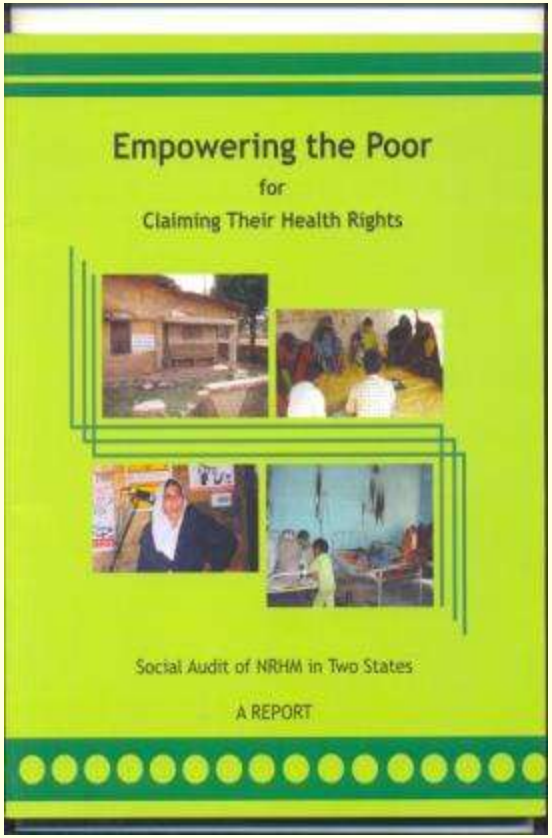
- ASHA's to be chosen through a consultative village process
- Constitution and training of village health and sanitation committees before preparation of village and district health plans
- Community based monitoring to be integral part of public health system and not a stand alone component
- The communitzation option, with public people partnerships to replace the privatization options….

Independent Reviews

JSA People's Rural Health Watch- two reports - 2007 – 2008, PLUS other reports







COMMUNITY PARTICIPATION – RECOGNISING THE PARADIGM SHIFT – 2000AD and beyond

Approach	Biomedical, deterministic, managerial model	Participatory social/ model
Link with community	As passive client or	As active and empowered participant
Dimensions Explored	Physical and technical	Psycho- social, cultural, political, ecological
Focus of Participation	Resources, Time/ Skills	Leadership, Ownership, setting, Monitors.
CHW Role	Service provider, educator, data collector (lackey ?)	Mobilisor, activist, empowerer, social auditor, monitor. (Liberator)
Research	Community participation as	Community participation as

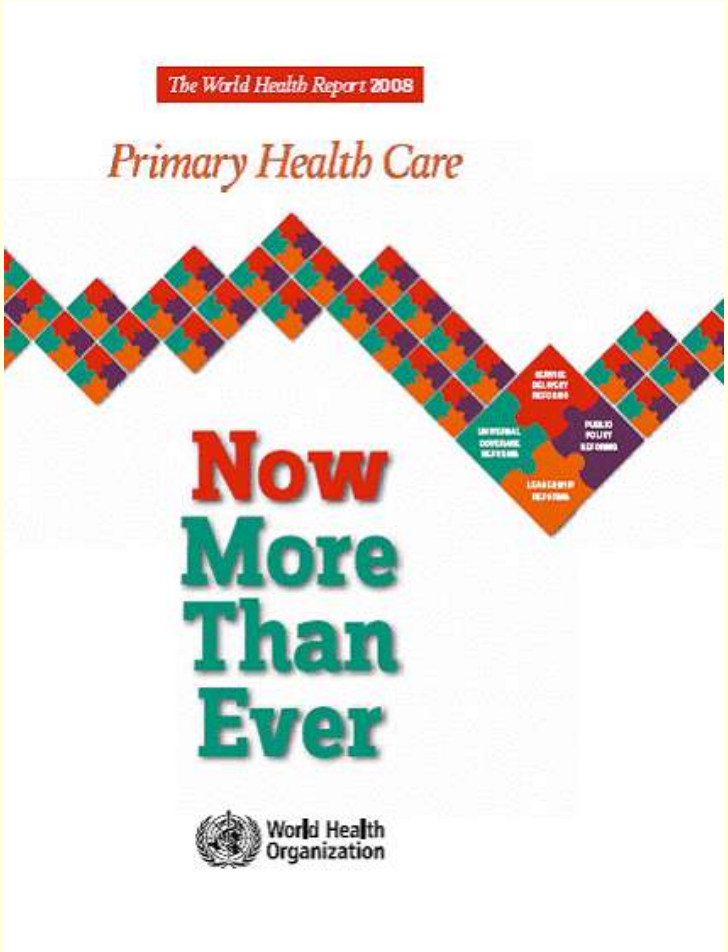
Source: CHC 2008

The Challenge for PHC in the new millennium

- The People back into the centre of primary health care
- The Public back into Public health systems
- The Community back into the health policy discourse.

(Reporting at Alma Aty – 2008 on People Centred Primary Health Care)

Towards a new paradigm of People - centered PHC :Mobilising the participation of the people (last page of the report?)



- **"Where reforms have been successful, the endorsement of PHC by the health sector and by the political world has invariably followed on rising demand and pressure expressed by civil society"**
- **Thailand –Thai reformers joined a surge in civil society pressure**
- **"Mali –sustained extension by local community health associations"**
- **"Chile - agenda of democratization"**
- **"India – Strong pressure from civil society and the political world"**
- **"Bangladesh - pressure for PHC from quasi public ngo's"**
- **"Countries need to demonstrate their ability to transform their health systems in line with changing challenging and rising popular expectations. That is why we need to mobilise for PHC now more than ever"**

Source: Page 110-111

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