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Community Participation for Health Systems Strengthening" - A Decade of Experience in Sustaining Community Interventions in NHM, Odisha

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Abstract

This paper presents a framework to explore the decadal experience of community participation for health system strengthening using Primary Health Care Approach in National Health Mission (NHM), Odisha. It traces the concept of community participation, its various facets, dimensions and application in the context of health system strengthening using Primary Health Care Approach. The paper tries to ascertain the scope of the community participation in National Health Mission (NHM), identify and highlight measures adopted for improving community participation leading to improvement in health system and health outcomes. Further it tries to critically understand how the decadal experience community participation efforts have been sustained in NHM, its challenges and way forward.

Keywords: *Community participation; Health system strengthening; Primary health care; Community interventions; National Health Mission.*

1. Introduction

Community participation as a development strategy has a long history. WHO and UNICEF sponsored conference on Primary Health Care (PHC) at Alma Ata in 1978 was one of the most defining events in the global public health arena that gave community participation a prominent place in public health. The Alma Ata Declaration defined Primary Health Care (PHC) as "Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (WHO, Alma Ata Declaration VI, 1978, p.1). World Health Organization (WHO, 1991) defines participation in health as a process that involves groups and individuals exercising their rights by playing a direct and active role in the development of the needed health services and in ensuring the sustainability of better health. It states that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care." The term 'community participation' is commonly understood as the collective involvement of local people in assessing their needs and organising strategies to meet those needs (Zakus and Lysack 1998). The rural health policy framework Healthy Horizons Outlook (National Rural Health Alliance 2000) includes the principle, 'participation by individuals, communities and special groups in determining their health priorities should be pursued as a basis for successful programs and services to maintain and improve their health'.

The direct involvement and engagement of ordinary people in the design, implementation and evaluation of planning, governance and overall development programs at local or grassroots levels has become an integral part of democratic practice in recent years (John

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Friedmann, 1992). In large part, this is due to the benefits it brings to health programs and interventions. Baum FE (1998) notes that participation is highly beneficial to health; it ensures effectiveness and sustainability of interventions ensuring that internalization, trust and support of the people are gained. Community participation in primary health care and rural health service development has been argued to result in more accessible, relevant and acceptable services (National Rural Health Alliance 2002; Taylor et al.2008). In addition, it is often implied that community participation results in higher community satisfaction with health services, and indeed better health outcomes, even though evidence to support this assertion is limited (Kilpatrick 2009).

One practical way is to look at community and participation separately and then applying that understanding in defining the concept as 'a process by which people are enabled to become actively and genuinely involved in the defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change' (WHO, 2002, p.10). An essential understanding is that effective community participation in health entails a side-by-side involvement of community members with health care professionals and a responsible sharing of both power and responsibility.

Community participation in National Health Mission (NHM)

"The community should emerge as active subjects rather than passive objects in the context of the public health system" - NRHM Framework for Implementation, MoHFW, GoI, 2005-2012

Drawing its notion from Alma Ata Declaration and Primary Health Care Approach, the framework of National Rural Health Mission (NRHM) and subsequently NHM has emphasized on the involvement and participation of the community in the management of their health related affairs. Realising the importance of community participation in health, NRHM framework of implementation focused on the communitization process as one of the five main approaches of NHM. The key aspects of communitization process in NHM are Positioning of Community Health Worker, Hospital management committee/PRI at all levels, Untied grant to community/PRI bodies, Funds, functions and functionaries to community organizations, Decentralised planning, Village, Health and Sanitation Committee. Starting from the framework of NHM, it designed a system to promote and strengthen processes of community engagement, empowerment process. The process of communitization has emphasised the role of the community in shaping their future in issues related to health and social determinants of health. So the strategy of NHM intended to create and establish the platform to promote and strengthen community participation. This has been subsequently incorporated as an inherent part of the Programme Implementation Plan (PIP) of NHM which is prepared and implemented on annual basis. The Communitization process in NHM is build around both individual and collective approach, platforms and frameworks.

Objectives

This paper intends to

- Find out the decadal experience in implementation of various community process activities under NHM, Odisha using primary health care approach.
- Understand the nature and extend of community participation initiatives in health system strengthening.

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- Analyse the strength and weakness of the efforts to sustain community intervention for NHM and its way forward.

ASHA, the pivot of communitization process

The most important intervention of NHM is to position a Community Health Worker called as Accredited Social Health Activist (ASHA) at the village level. ASHA as the Community Health Volunteer promotes the process of communitization in health. Being embedded in the community and supported by the community, she is the pivot of the community process and as the torch bearer at the community level she facilitates the community level action. Being a part of the community, she mobilises the community around health issues, promotes right health seeking behaviour and facilitates maximum utilization of health services. The State of Odisha is having the presence on 47147 ASHAs both in rural areas and in urban slums catering to the needs of the community. The average population served by one ASHA in rural areas is 777 and in urban slums its 1300.

Ever since the inception of ASHA in health system, her involvement in the health related activities has gone many folds. With the increasing need of the health system, health related activities performed by her at the community level have been widened. Number of activities ASHA involved has gone upto 53 during the year 2019-20 which included activities related to RMNCH+A, Disease Control Programme (DCP) and Non Communicable Disease (NCD) Control Programme. She receives performance based incentives for the tasks performed by her along with the non monetary incentives and career path initiatives. State of Odisha provides assured incentive (regular and recurring) of Rs. 3500/- per month including State matching contribution of Rs.1000/- per month. Besides, ASHAs get other incentives based on their activity performance. An average performing functional ASHA would get an amount of Rs. 5000/- per month including assured amount plus performance based incentives. Besides the State of Odisha has made non monetary incentive provisions of award for best performing ASHA, Accidental and death benefits, educational enhancement programme, Maternity benefit schemes, one time retirement benefit scheme, preference in admission and placement of ANM in order to sustain the motivation of ASHA and contribute further.

A strong supportive work force of ASHA has immensely helped the State of Odisha in achieving many health indicators. ASHAs have contributed significantly in this regard. As leant from the data, some of the notable contributions of ASHA includes mobilising 4.9 lakh pregnant women for intuitional delivery, providing home based new born care to 5.4 lakh babies, promoting 1.5 lakh eligible couple for adopting FP measures or spacing, facilitating 4.11 lakh VHND sessions, mobilising 5.56 lakh children for complete immunization upto one year, conducting malaria testing through RDK, identification and ensure completion of leprosy cases, supporting ANM for the screening of the population on Non Communicable

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Diseases, facilitating functioning of Village Health Sanitation and Nutrition Committee (VHSNC) during the year 2018-19.

ASHA Programme: Areas of improvement

Despite ASHA being the front runner of the communitization process in health and has contributed significantly, there a number of areas which could be critically looked in ASHA programme implementation. Since the induction of ASHA, each year with the introduction of new programmes the pressure on ASHA is increasing in many folds. A time performance ratio suggests that an ASHA has to spend at around 4 hours a day. This adds pressures to her day to day life along with other family and social commitments. With the increasing number of health programme is bestowed upon ASHA, it is imperative that her capacity is adequately built in order to manage those programmes at the community level. Further, continuous capacity building with addressing the variations in the capacity to absorb the training content is an important area. ASHA reaching to the unreached population and to cater to their health needs remains an area of concern for the health system. "Reaching to the last mile" for health service delivery through ASHA is a concern looking at the physical inaccessibility, geographical difficulties etc. Strong supportive supervision mechanism is the key to success of a bottom heavy programme like ASHA which needs a dedicated HR support at the Block level. The role of ASHA "whether she is s part of the community or a part of Health System" is a debate. Though she maintained a balance between her role as a community person and an interface with the health system, but still her identity as a community person is gradually weakening. This needs to be sustained along with her voluntary sprit. The most important question before us is who is empowered as a result of the communitization process in health, ASHA or Community. In the present arrangement ASHA is more empowered than the community. Because ASHA goes to the community for her task accomplishment. But the community approaching to ASHA is minimal. ASHA meeting the community aspirations and representing the same is an area of concern. She moves around conducting activities at the community level and thereby getting her incentives. Sometimes it is said that ASHA is working as the additional ANM of health system. There are certain areas in which ASHA could not contribute as per expectations are RMNCH indicators, Early registration, Complete ANC, Full immunization, FP measures, Nutrition, Haemoglobin level of PW, Birth weight, HBNC, Adolescent care, Sanitation, HBYC, Reaching to unreached, Equity perspective.

Community level platform in NHM

The communitization process in NHM is spearheaded by the community level platform called as Village Health and Sanitation Committee (VHSNC). In Odisha it is formed at the Revenue village level and known as Gaon Kalyan Samiti (GKS). It provides a wonderful opportunity for inetrsectoral convergence, community level action to address health issues. It

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initiates action to address health issues, promote inter sectoral convergence, facilitate referral and maximum service utilization. Ward member act as the President, AWW is the Convener, ASHA is the facilitator. Annual untied fund of Rs.10000/- is being placed to GKS in order to undertake various need based activities for addressing issues related to health and other social determinants of health. Each GKS prepares need based Village Health Plan (VHP) in a consultative manner at the community level incorporating the local issues and concerns of the villages and hamlets which becomes the basis of untied fund expenditure.

In order to augment the effective functioning of GKS contributing to the health outcomes, NHM has taken up capacity building of the GKS members on health issues, participation, roles and responsibilities, management of GKS, Village Health Plan (VHP) preparation, implementation and monitoring. Training on financial literacy to the GKS Convener conducted in order to manage the untied fund expenditure. The health system personnel were trained to provide handholding support to GKS. Further, capacity development of Panchayati Raj members like GP Sarapanch for GKS management and mobilise resources for health activities, inter sectoral convergence, integration with service delivery mechanisms was conducted. Each of the Gaon Kalyan Samiti prepares a Village Health Plan involving the community members which becomes the basis of undertaking different activities by GKS and utilization of untied fund. The VHP includes activities related to health and other social determinants of health.

As a community level platform, GKS has utilised the annual untied fund by developing the Village Health Plan (VHP) which is prepared at the village level with the participation of the people. GKS has taken up exemplary activities at the community level in addressing issues related to health and other social determinants of health. They have played an important role in Malaria eradication programme called Daman (State initiative), management of Stretcher in the inaccessible areas in order to facilitate transportation of the pregnant women to the hospital for delivery, facilitated organising VHND in hard to reach habitations. GKS has been integrated with the Panchayati Raj system. The GP Sarapanch reviews the GKS activities, prepared GP Health plan by combining VHP, facilitate support for the mobilization of resources and review of the GKS untied fund expenditure.

GKS as a Community level platform: Areas of improvement

GKS has established itself as a community level platform. However, a critical analysis reflects that there are a number of key areas that needs to be further improved. GKS delivering as a team is missing and has become subject to factionalism among the office bearers. Lack of adequate supportive supervision mechanism at various levels has affected the overall functioning of the GKS. GKS mostly focused on the expenditure of the untied fund rather than acting as a community level facilitating platform to address issues related health and social determinants of health. It could not adequately address the equity issues at the community level. A critical analysis of VHP reflects that it does not ensure adequate representation of the interests of all categorise of people/hamlets coming under the GKS. Preparation of the Village Health Plan is often statutory and has not reflected the true aspiration of the community. In most of the cases it is criticised that the VHP is limited to only three office bearers of GKS i.e. ASHA, AWW and Ward Member and a few members of GKS. The issues and concerns raised at the community level in the VHP does not have the scope to be reflected in the PIP of NHM. So in true sense, reflecting the aspirations of the community in the NHM plan document needs improvement. Though the untied fund is utilized by the GKS, there are a number of issues and bottlenecks which are evident in the

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management of GKS untied fund. However, the expenditure on activities was limited to only spending the annual untied fund. Except a few placed no additional funds were mobilised to undertake activities at the community level.

Besides the above individual and community level platforms, there are a number of initiatives taken up and tried to enable the community in planning, implementation and monitoring of the health related activities at the community level.

Rogi Kalyan Samiti

As envisaged in the NRHM framework of implementation, Rogi Kalyan Samitis (RKS) are constituted as all the health facility level starting from the PHC, CHC, SDH and DHH. The RKS is a facilitating body to facilitate participation of the community in the management of the health facility activities as per the need. RKS bring in the community perspective, the needs and difficulties that people are facing while coming to the hospital and availing services at health facility. As a management body of the health institution, RKS incorporates the community concerns and se that those are addressed at the health facility level.

However, the effective role played by the RKS for the welfare of the patients need a critical look. The activities of RKS are often managed by the Health system personnel leaving not much for the community representatives to involve in the process. The RKS health plan needs to be prepared with due consultations. Capacity development, monitoring and evaluation of RKS activity is not taken up which has affected the efficacy of the programme. The role of the community and inclusion of the aspirations of the people in hospital improvement still needs to be addressed in order to make RKS more vibrant catering to the needs of the people.

Decentralised planning process

Every year a Health Action Plan namely Progamme Implementation Plan (PIP) is prepared for the NHM which is approved by the Govt. of India in a consultative manner. Preparation Health Action Plan provides a scope for the inclusion of the community needs and aspiration in the plans and it has a wide scope to make the health system include the needs of the community and deliver the health services accordingly. However, preparation of the Health Action Plan by involving the community and incorporating community needs and aspirations is an area of concern. Though tried in certain years, the Programme Implementation Plan (PIP) of NHM has incorporated mostly the requirements of the health facility. However, it has not created a proper scope to include the issues raised in the VHP prepared by the GKS and the decentralised planning process involving community is not materialised in its true sense reflecting true bottom up planning process.

Community monitoring

Monitoring of the health services by the community is a crucial step in not only makes the heath system responsive to the needs of the people also facilitate partnership of the community in health service delivery. Community monitoring was one of the important activities in promoting community participation is mentioned in the framework of implementation of NHM. The programme is implemented with the support of the volunteers with the involvement of Gaon Kalyan Samiti (GKS). However, community monitoring of the health activities delivered by the Govt. is a missing link. People being the owner of the health programmes needs to be actively involved in monitoring of the delivery of the health services in order to make it more effective and yielding the results.

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Involvement of other community level platforms, integration and convergence

The involvement of the other community based platforms like women Self Help Group (SHG), Community Based Organisatons (CBOs), Panchayati Raj functionaries needs further strengthening in order to address the issues relating to health and other social determinants of health. Integration and convergence still remains as an important area of concern while looking at the community empowerment in health.

SWOT analysis of communtizaton process in NHM

Strength ▪ Presence of 47000 ASHAs in each village/habitations of the State ▪ Strongly grounded Community Health Worker, ASHA programme ▪ Assured income (fixed plus performance based incentives(for ASHA that makes them motivated in work performance ▪ Community participation and mobilization by ASHA ▪ More than 46000 Gaon Kalyan Samiti (GKS) is in place at the community level ▪ Strong capacity development of GKS and exemplary activities performed by ASHA ▪ Rogi Kalyan Samitis are in place at the Health Facility level ▪ Community monitoring implemented to facilitate community involvement and partnership	**Opportunity** ▪ Established communitization process in health ▪ Presence of individual and community level platform ▪ Results of the effective community process is reflected in the indicators achieved for the State.
Weakness ▪ Voices of the people not reflected in village Health planning process ▪ Equity perspective in community process is missing ▪ Mentoring and civil society involvement is lacking in community process activity implementation ▪ Excessive focus on ASHA ▪ Reaching the unreached not adequately addressed ▪ Community is not the centre of the communitization process in health	**Threats** ▪ If not nurtured properly, the community process may die out ▪ If not strengthened well, community process may phase out

Summary and Conclusions

The State of Odisha has a structured community process implemented under NHM over the last decade has reflected in the achievement of indicators. The reduction in IMR, MMR, TFR and increase in institutional delivery and the coverage of immunization is to be attributed to the strengthened community process at the ground level. The highest reduction of IMR in the country by Odisha is attributed to a strong combination of community and facility interventions.

A critical analysis of ASHA programme reveals that the health system strengthening is not feasible without the presence of ASHA at the community level. The community benefits from ASHA, in the form of the services she renders at the community level by raising the awareness at the community level on right health practices, improving the linkages of the people with the health facility, provide basic health services at the community level. From the systemic point of view, she bridges the gap between the community and the health facility. She tries to bridge the gap between the community aspirations with the service delivery at the facility level. However, in the process of communitization, does the community participating in the affairs of the health and empowered enough to manage their health activities at the community level, is a question mark. Whether the community is empowered in the process. The system is more dependent upon ASHA to deliver the services at the community level rather than empowering the community to come forward to avail the health services and solve their problems.

The role of ASHA is to be augmented to perform the best at the community level. Role performance of ASHA is to be sharpened with the build in skill improvement. Community facets of ASHA are to be maintained along with the systemic requirements of health system. Focus is to be making GKS as a vibrant community level platform to address issues related to health and social determinants of health. Integration of GKS with the PR system is to be further strengthened, funds to be mobilised for addressing health issues from Panchayat funds. Community monitoring process is to be strengthened. People's aspirations to be

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reflected in the planning process and policy decisions. Integration and convergence is to be strengthened in order to make the community process further strengthened in order to achieve results.

There are a few pertinent questions which needs to be answered while looking at the community processes in health. Whether the present design of communitization process is sustainable. Can it be sustained without ASHA. The linkages between communitization process and health system strengthening needs to be strengthened. The more people are empowered in health activities, the better it is for the health system.

To conclude, it is to be mentioned that the decadal experience of NHM, Odisha in strengthening community participation processes in health is praiseworthy. However, scope for the people in the decision making process of how health services are delivered thus promoting sustainability is to be strengthened. People need to be empowered by gaining knowledge, skills and confidence and by being involved in community health. The choice is to be given to the beneficiaries in the delivery of the care they receive. The community participation or community engagement must focus on involving communities in order to change poor health behaviour and defining how government can support their choices. Community participation as a process rather than as an intervention is more useful. Intervention is an act or fact or a method of interfering with the outcome or course especially of condition or process, whereas process is an action or events leading to a result. In health improvements, an intervention is an act or method that seeks to encourage individuals and/or communities to accept a change in attitudes and behaviour to improve their health. A process is the action over time that allow acceptance of the intervention. Community participation has most often been seen as an intervention to improve health outcomes rather than a process to implement and support health programmes to sustain these outcomes.

References

1. "A new approach to community participation assessment" – Gunilla Bjaras, Bo J.A. Haglund and Susan B. Rifkin. Vol. 3, Health Promotional International, Oxford University, 1991.

2. "Improving Health Outcomes through Community Empowerment: Glenn Laverack, Department of Social and Community Health, School of Population Health, University of Auckland, Auckland, New Zealand. J HEALTH POPUL NUTR 2006 Mar;24(1):113-120.

3. "The benefits of community participation in rural health service development: where is the evidence" - Robyn Preston1, Hilary Waugh1, Judy Taylor2, Sarah Larkins1 1James Cook University, 2Spencer Gulf Rural Health School UniSA/University of Adelaide. 10th NATIONAL RURAL HEALTH CONFERENCE

4. Chesiyna, P. K., & Wanyoike, D. A. N. I. E. L. (2016). Determinants of effective implementation of constituency development fund projects in baringo central constituency, Kenya. International Journal of Research in Business Management, 4(4), 31-42.

5. Healthcare through Community Participation : Role of ASHAs. Sujay R Joshi, Mathew George. Sujay R Joshi (drsujayjoshi@gmail.com) is with the Foundation for Medical Research, Mumbai. Mathew George (mathewg@tiss.edu) is with the School of Health System Studies, Tata Institute of Social Sciences, Mumbai.March 10, 2012 vol xlviI no 70 10. Economic & Political Weekly.

ISSN: 1430-3663
Vol-15-Issue-1-January-2020

6. Al-Rimawi, R., Alshraideh, J., & Al-Hussami, M. (2018). Historical Development of Health Equity: Literature Review. International Journal of Applied and Natural Sciences (IJANS), 7(1).

7. Community participation in rural primary health care: intervention or approach? Robyn Preston A, Hilary Waugh A, Sarah LarkinsA,c and judy TaylorA,BASchool of Medicine and Dentistry, James Cook University, Douglas, Qld 4811, Australia. BSpencer Gulf Rural Health School, University of South Australia and University of Adelaide, Nicolson Avenue, Whyalla-Norrie, SA 5608, Australia. cCorresponding author. Email: sarah.larkins@jcu.edu.au.

8. Geetha, s., & Maniyosai, R. An Evaluation of Maternal Health Care Services in Primary Healthcare Centers (PHC) in Thanjavur District Tamil Nadu.

9. Improving health through community participation: Concepts to commitment. Proceedings of a Health Education Authority Workshop 9-10 December 1998, Leicester. edited by Alizon Draper and Diana Hawdon. Project Team - Joan Heuston, Tsegai Gezahegn, Dominic McVey, Hilary VVhent, Mary Hiclanan.

10. Kaphle, H. P., Gupta, N., & Shrestha, N. Policy Prospective, Service Provision and Gap in Maternal Health in Nepal.

11. What is participation – Susan B. Rifkin, Maria Kangere. Colorado School of Public Health, January, 2002.

12. Goswami, S., & Chouhan, V. Developing Community based Sustainable Electronic Waste Management Model.

13. A Framework Linking Community Empowerment and Health Equity: It Is a Matter of CHOICE. Rifkin, SB (2003). Journal of health, population, and nutrition, 21 (3). pp. 168-80. ISSN 1606-0997