Community Participation and UHC

Reflections from implementing the Community Action for Health process in Tamilnadu

Rakhal Gaitonde
Society for Community Health Awareness Research and Action (SOCHARA)
Plan of Presentation

- Key recommendations of the HLEG report.
- Key messages.
- The context of the presentation - The CAH process.
- Questions emerging from practice.
- Reality check.
KEY RECOMMENDATIONS OF THE HLEG REGARDING COMMUNITY PARTICIPATION

• Strengthening institutional mechanisms for community participation in health governance and oversight at multiple levels (rural and urban).
  – Transformation of existing Health Committees into health councils.
  – Organizing periodic health assemblies.
  – Participatory governance, review and oversight will be supported by legal, adequate finances and capacity building.
KEY RECOMMENDATIONS contd.

- Increasing the number of community health workers to two workers per village and equivalent urban administrative unit.
- Enhancing role of PRI and elected representatives in health governance and community oversight.
- Enhancing the role of CSOs in delivering information, enabling participation, community mobilization, capacity building.
Instituting a formal grievance redressal mechanism.
The life of the concept

- Alma Ata – Comprehensive Primary Health Care - “an approach not just a set of services”
- Health and Human Rights – Special Rapporteur's delineation of participation as part of the Right to Health.
- Democracy – moving from representative to deliberative democracy.
- Warmi, Manandhar, EKJUT, IMAGE, CLICS.
- Elinor Ostrom – polycentric governance
Competing meanings...

- Different groups of people interpret / give different meanings to the concept.
- Giving rise to differing motivations.
- Leading to implementation diversity.
- *This can lead to differences in evaluating effectiveness and impact.....*
Multiple perspectives...

**NGO / Civil Society Perspectives**

Rights / accountability

**Health System**
- Lower level Staff
- Reaching targets
- Ensuring people Access Government services

**Health System / higher levels**
- Control over lower level staff

**Communities**
- Grievance Redressal
- Access to resources
The CAH process
Community based monitoring and planning – an emerging approach for accountability

- Community members and local activists identify gaps, issues, priorities for change
- Perspective of people’s health rights and accountability of public services is at the core
- Challenging the hierarchy of power and moving towards certain kind of equalization of power
Committee formation and information flow – pilot process

- State Planning & Monitoring Committee
- District Planning & Monitoring Committee
- Block Planning & Monitoring Committee
- PHC Planning & Monitoring Committee
- Village Health and Sanitation Committee

Appropriate Action & Intervention

Feedback & Reports
Purpose
↑ To close gap.

Current Status

Desired Status

Gap

Feedback

Monitoring

Corrective Action

↑ Power to act will ↑ ownership

Baseline

Consumption Specifications

Power To Act District

Power To Act Panchayat

Power To Act Village
The Tool
## Sample Village Health Report Card

<table>
<thead>
<tr>
<th>District</th>
<th>Village</th>
<th>GHWB</th>
<th>Total</th>
<th>Health Category</th>
<th>Health Indicators</th>
<th>Health Score</th>
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<tbody>
<tr>
<td>3</td>
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<td>6</td>
<td>2</td>
<td>Health Category</td>
<td>Health Indicators</td>
<td>Health Score</td>
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<td>Health Category</td>
<td>Health Indicators</td>
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<tr>
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<td>3</td>
<td>1</td>
<td>Health Category</td>
<td>Health Indicators</td>
<td>Health Score</td>
</tr>
</tbody>
</table>
Case studies of CAH

- Ownership of government services increased.
  - Also a functionality of increase investment in infrastructure during the NRHM period.
  - Kanniyakumari – shift to Governement PHC, Thiruvallur – shift away from Satyavedu,
  - Invitations for meetings from Panchayat not NGO any more.
Case Studies of CAH

- Discussion on route of the Mobile Medical Unit, where it stops in a given village etc. Information regarding its regular program.

- Involvement of a number of people from outside the Health department – BDOs, MLAs, Panchayat district chairpersons, Collectors
‘Good’ ratings for village level Health services across 220 villages in Maharashtra over 3 phases

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
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<tbody>
<tr>
<td>48%</td>
<td>61%</td>
<td>66%</td>
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</table>
Higher increase in people’s OPD utilisation in PHCs covered by CBM

<table>
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<th></th>
<th>07-08</th>
<th>08-09</th>
<th>09-10</th>
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<tbody>
<tr>
<td>Thane district</td>
<td>741</td>
<td>679</td>
<td>869</td>
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<tr>
<td>OPD per PHC</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>per month</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Thane CBM</td>
<td>767</td>
<td></td>
<td></td>
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<tr>
<td>OPD per PHC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>per month</td>
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</tr>
</tbody>
</table>

Increase in Thane district PHCs OPD: 17%
Increase in Thane CBM PHCs OPD: 34%
Increase in deliveries in PHCs covered by CBM

<table>
<thead>
<tr>
<th>Thane district deliveries per PHC annual</th>
<th>07-08</th>
<th>08-09</th>
<th>09-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thane CBM deliveries per PHC annual</td>
<td>104</td>
<td>172</td>
<td>209</td>
</tr>
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</table>

Increase in Thane district PHC deliveries: 48%

Increase in Thane CBM PHCs deliveries: 101%
CAH gains at different levels

- Panchayat level – increased awareness, increased involvement of the PRI, increased ownership among community.
- PHC level – increased awareness, increased utilization, feedback regarding various aspects including quality of field programs.
- Block level – bringing various departments together around health – the seeds of a system for intersectoral coordination and work on the social determinants of health.
CAH ...challenges wrt action for health

- Changes still is a top – down process – more based on higher officials diktat - the difference between people's democracy and administrative democracy – Collector.

- What type of changes are happening – an extra ambulance being posted is easier than getting the timings of the PHC, ICDS on a board.

- Very little freedom to “respond” at lower levels.

- Untied funds were still not brought under the control of the committees.
Process level challenges....

- Community monitoring sensitive vs community monitoring resistant services.
- How long will communities be motivated if system does not respond?
- How will lower level staff respond without system level constraints in their activity being removed.
- Political commitment to system level changes – the so called architectural corrections and redressal of power imbalance.
CONCEPT OF COMMITTEE / COUNCIL

- Reality of NRHM and NREGA – time to take stock.
- Who are the people in the committee?
- Who are they holding accountable?
- How does the system see the people?
- Governance in general.
Who are the people in the committee?

- Ultimately the onus for change and leadership fall on the most marginalized and usually those that can least afford such “indirect costs” to demanding their rights.
- How do we facilitate capacity building and enabling them to talk to power – in a system that systematically dis-empowers them?
Who are they holding accountable?

• What ever the systemic issues – what is visible and measurable by the community are gaps in the performance of the lowest / most peripheral staff – who usually also bear the brunt of being at the lowest level of a stiflingly hierarchical system.

• Unrealistic and competing demands from the system and from such processes like CAH.
  – Doctor and data.
  – VHN posting and ATP.
How does the system see the people?

- The socialization of the system – how do they see people?
  - Ignorant
  - Irrational
- What will it take for them to see people as equal partners?
ROLE OF THE PRI

• The Committees fully integrated into the Panchayat system.
• The Gram Sabha as the basic forum for reporting and accountability of the committee.
ROLE OF CIVIL SOCIETY

NGOs / People's movements – schools of citizenships, creating spaces, enabling the occupation of spaces.

Academics and intellectuals – research and documentation of topics critical in advancing the people's agenda.

How much do you critique? Towards further weakening, further strengthening, Moving beyond confrontation to co-production.
Borrowing from Thailand...

1. Creation of relevant knowledge

2. Social movement

3. Political involvement

Figure 1. Triangle that Moves the Mountain
Brazil - Health councils

A landmark of the Brazilian UHC is community participation, guaranteed by a network of over 5,000 Municipal Health Councils, 27 State Health Councils, and the National Health Council, involving some 100,000 individuals in this voluntary work. Most of the decisions on healthcare such as budget, construction of health facilities, implementation of health programs, etc., must be approved by health councils.
Brazil - Health councils

All social sectors are represented in these councils:

- clientele or community representatives (50%)
- health providers plus health managers / officials (25%)
- healthcare workers (25%)
Community Participation, the way forward

- Community Participation is a fundamental right.
- There is enough evidence that participation leads to tangible changes.
- There is enough evidence that participation leads to system strengthening.
- There is a number of international examples to learn from.
- We have a home grown experience of community monitoring and planning / Community Action for health, over the last 4 years that needs to be studied and discussed.
Community participation...Being realistic.....

- There are no magic bullets.....
- Neither ASHA nor Community participation are stand alone interventions.
- Expecting them to produce results in a context of Social Economic Political Cultural Environmental in-equities and without clear and realistic steps to tackle these is un-ethical.
- Participation means redistribution of power – is the system really ready for it?
Thank You!