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Supporting Community Health and District Planning Strategies in Bihar

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Contents

1 Introduction

Improving the health of its large population, especially among the most economically and socially vulnerable sections of society, is central to the achievement of human development in the state of Bihar. Child health and nutrition, in particular, is an area of urgent concern. While declines in infant mortality have been noteworthy, especially in the context of the extremely poor economic performance of the state relative to other regions in the country, the Infant Mortality Rate in Bihar reported in 2004 remains high at 61 deaths per 1000 live births, with the rural IMR at 63[1]. The most recently released indicators of child nutritional status reflect an even graver situation. The National Family Health Survey-III (2005-06) reports that 58 percent of children in Bihar (compared to an all-India average of 46 percent) are underweight and 42.3 percent of children under 3 are stunted, reflecting widespread and chronic under-nutrition during the critical first years of life. The incidence of anaemia among this age group is also very high at 87.6 percent. Not surprisingly, infection rates are high and health and nutrition practices poor. Breastfeeding practices, an essential aspect of childcare and nutrition, are particularly poor in the state, with an extremely low 4 percent of newborns breastfed within the first hour of birth and only 28 percent of infants in the 0-5 month age group exclusively breastfed, in contrast to an average of 46 percent across India. 2 out of every 3 children being raised in Bihar do not receive the recommended schedule of immunizations. Given the close linkages between women and children's health, predictably women's health is poor with 68.3 percent of ever married women anaemic and 43 percent in the 15-49 year age group with chronic energy deficiency[2].

In such a context, there is no doubt that there is an urgent need for investment and action to strengthen integrated primary health systems through a range of approaches and improvements at multiple levels. It is widely acknowledged, for instance, that Bihar suffers from a critical shortfall in health infrastructure. Around 40 percent of Sub Centres, the first level of outreach services do not exist in the state and only 11 percent of the designated numbers of Community Health Centres are in place[3]. Shortfalls in hu-

[1] Sample Registration Survey 2004, Registrar General of India
[2] National Family Health Survey (NFHS) - 3, 2005-06, http://www.nfhsindia.org
[3] RHS Bulletin (March 2006), Ministry of Health and Family Welfare, Government of India

man resources, both in terms of absolute numbers and the quality of their training and performance are also significant systemic problems.

Given the multidimensional scope and scale of the health systems challenge, there can be no substitute for a comprehensive series of reform measures to build and strengthen primary health systems and services across the state. Such a complex agenda, however, requires significant and catalytic starting points capable of achieving two interrelated impacts: 1) securing improvements in key health outcomes based on rigorous technical knowledge and 2) establishing central principles and processes for a long-term programme of deep and gradual reform and system strengthening. This brief paper suggests that two key components of the Government of India's National Rural Health Mission (NRHM)[4] - the Accredited Social Health Activist (ASHA) programme and District Health Planning - provide a unique and critical opportunity towards such change in Bihar, and indeed in the other priority states. Both initiatives capture the core objective of the NRHM to "*promote equity, efficiency, quality and accountability of public health services through community driven approaches, decentralization and improving local governance*[5]." Moreover and most importantly, they provide programmatic platforms to directly mobilize already existing and largely unharnessed resources - both within households and communities and within health systems - that have the greatest potential to immediately begin to translate knowledge into action and thereby significantly improve health outcomes where this is most needed.

The remaining sections of this paper outline in turn some of key directions for the conceptualization and implementation of the ASHA Programme and District Health Planning of relevance to Bihar and other priority NRHM states.

2 The Accredited Social Health Activist (ASHA) Programme

The Accredited Social Health Activist (ASHA) Programme is one of the cornerstones of the NRHM and aims to select, train and support a community-based change agent for at least every cluster of 1000 people in rural areas. This Community Health Volunteer

[4]For details on the NRHM, see Appendix I

[5]National Rural Health Mission (NRHM) 2005-2012, Ministry of Health and Family Welfare, Government of India

is expected to be a locally selected woman who will catalyse and a community-based process of behavioural change and facilitate better access to basic health services by poor households. She will disseminate knowledge and create awareness about health issues and their social determinants, engage closely with pregnant women, mothers and other household members to negotiate and adopt appropriate care practices, and mobilize her community to participate in local health planning and increase the utilization and accountability of existing health services. In addition to her primary role as a promoter of desired health practices, she could also provide a minimum package of curative care as appropriate and feasible for her profile and make timely referrals.

In recent times, Community Health Workers (CHWs) have received renewed attention, both nationally and internationally, as research has established and emphasized the effectiveness of community strategies and household-level practices in promoting child survival and development[6]. We know, for instance, that collectively, three largely preventable and treatable causes - diarrhoea, pneumonia and a limited set of neonatal conditions - account for 82 percent of all child deaths and that malnutrition is an underlying cause in around 52 percent of all cases. A number of household practices, such as improved nutrition and care during pregnancy, providing warmth and hygienic care to newborns, breastfeeding and complementary feeding, the use of Oral Rehydration Salts (ORS), hygiene practices during food preparation, and the use of insecticide treated bed nets for pregnant women and young children can have a significant impact on child mortality and malnutrition. As individual interventions, breastfeeding and ORS are especially effective: taken alone they are each capable of averting 16 percent and 14 percent respectively of all child deaths in India[7]. Most strikingly, analysis presented in *The Lancet* Child Survival Series, estimates that actions taken at the household and family level alone can prevent over 30 percent of child deaths and a similar proportion (up to 37 percent) of neonatal deaths[8]. Aware and vigilant families are also more likely to ensure that their

[6]See for instance, Haines, A., Sanders, D., et al, 'Achieving Child Survival Goals: Potential contribution of Community Health Workers', The Lancet, March 6, 2007. http://www.thelancet.com; Manandhar, D.S., Osrin, D., et al, 'Effect of a Participatory Intervention with Women's Groups on Birth Outcomes in Nepal: Cluster Randomised Controlled Trial.' The Lancet 364 (9438): 970-79. (2004); Bang AT, Bang RA, Baitule SB, Reddy MH, Deshmukh MD. 'Effect of home-based neonatal care and management of sepsis on neonatal mortality: field trial in rural India'. The Lancet 354: 1955-61. (1999).

[7]Jones, G., Schultink, W. & Babille, M. 'Child Survival in India' in Indian Journal of Pediatrics; 73 (6): 479 - 487, (2006)

[8]Bellagio Study Group on Child Survival, 'Knowledge into Action for Child Survival'. The Lancet, Vol. 362

children get prompt and appropriate facility-based clinical care, further contributing to declines in mortality. This is therefore clearly a priority area in high mortality resource-poor settings and requires investment in creative, contextual and decentralised strategies to work with families and communities. In this context, CHWs, such as those who are currently joining the ASHA Programme have a vital role to play. From a review of a range of past experiences, we have learned that wherever Community Health Workers have been appropriately identified, trained and supported health and nutrition indicators have dramatically improved[9].

In addition to drawing strength from the latest scientific research, the ASHA Programme also builds on a rich history of civil society innovation in community health in India and in many other developing countries and is an attempt to translate earlier experiences and insights, a majority of which have emerged from smaller field-level initiatives, into large-scale processes of community participation in and ownership of health knowledge and services[10]. Here, the critical challenge is to conceptualise and implement state-wide CHW programmes in regions with very weak health systems. Creating a space for such an activist - within the community, within the programme, and within the public health system - requires flexibility to both the community's and individual's needs, as well as commitment to providing continuous inputs and supportive structures. Most importantly, the health activist should occupy a unique position, one that is based in the community and yet has access to knowledge and resources from the larger programme. At this stage in particular, when states such as Bihar have already selected thousands of ASHAs across the districts, the quality of ASHA training and ongoing support must assume priority. This is also an area that lends itself to innovation and can benefit greatly from civil society expertise adapted to the challenges of large-scale programme management.

(9380), (2003), http://www.thelancet.com

[9]Haines, A., Sanders, D., et al, Achieving Child Survival Goals: Potential contribution of Community Health Workers, The Lancet, March 2007

[10]Mander, H., "People's Health in People's Hands?: A Review of Debates and Experiences of Community Health Workers in India", CEDPA: Delhi (2005)

2.1 ASHA (Community Health Workers) Training

Training is an important element of the ASHA programme since it goes a long way in determining its effectiveness. Training equips motivated but untrained ASHAs to undertake their wide and complex responsibilities for preventive, promotional and curative health, as well as their role in educating and planning with the community. A large body of work exists and has been undertaken, where Community Health Worker (CHW) training has been conceptualised as a form of education for participation, empowerment and action for change[11].

Informed by this experience, the following have emerged as important aspects of training:

- **Training Curriculum**: This defines the abilities, knowledge and perspectives that the ASHA needs to have, as well training methodology, which refers to the ways in which this knowledge will be acquired.

  Given the ASHA's role, it is important to plan and create training modules that address health, nutrition and social issues comprehensively. In the context of Bihar, where literacy levels, especially among rural women living in poverty are significantly low, majority of the ASHAs would be from non-literate and semi-literate backgrounds. In this situation, recognising the unique needs of this population, and addressing them in the conceptualisation and implementation of training programmes, by innovating on content and methodology, is imperative for the training to be meaningful and for the ASHA programme to be effective. It is therefore, important that the training methodology takes into account the existing learning levels and integrates significant scope for field- based training, to provide the ASHA with more confidence in her knowledge[12], through an ability to assess issues in reality rather than in a training centre, and act on them accordingly. Training techniques need

[11] Werner D., Communication as if People Mattered: Adapting health promotion and social action to the global imbalances of the 21st Century. Background Paper #5, for the People's Health Assembly, December, 2002.

[12] Such field -based training methodology has been included in the CHW training modules of The Ranchi Low Birth Weight Project - an action research project to evaluate the effectiveness of life cycle based community level interventions (which includes a hamlet level CHW and Village Health Committees) in reducing the incidence of low birth weight and improving maternal and child health in two blocks of Ranchi district in Jharkhand. This project has been undertaken by the Child in Need Institute, Krishi Gram Vikas Kendra and the Social Initiatives Group, ICICI Bank. CHW training undertaken by the Foundation for Research in Community Health (FRCH) has the primary aim of empowering the rural women to learn and inculcating the confidence to translate this into practice by applying the knowledge to their immediate environment and life situations.

to be innovative and be based on principles of adult learning, avoiding didactic presentations and information overload, and learning by drawing from life experiences instead. These could include elaborate explanation of the training modules using interactive techniques such as pictorial material, story telling, skits, role plays, folk media such as *Kalajathas*, mass media such as local radio programmes[13] to impart indepth understanding about social issues and technical health knowledge to the ASHAs[14,15].

- **Training Strategy**: Given the large number of ASHAs (approximately 50,000 or more) that every state is expected to have it is important to plan how the training of such large numbers is to be organized, not just once, but continuously over a number of years. This implies detailing out the block, district and state level training structures and strategies. Additionally, it includes determining whether the training will be modular or one time, camp or field-based, its duration as well as the site of training. Specifying the profile of trainers and their support systems would be important for ensuring the continuity of training. Other important aspects include costs, monitoring and use of training materials.

  Experience suggests that for effectiveness trainings should be conducted in different rounds, gradually introducing new knowledge and constantly reinforcing learnings. Such phased training ensures time for reflection on basic concepts and does not load the individual with too much information at the same time[16]. Importantly, the training should positively impact attitudes, build knowledge, skills and confidence. Thus, the training process should be conceptualised as part of a process of empowerment. A training strategy should aim to adapt itself to and emerge from the social and cultural context of different regions within the state.

[13]Kalajathas (folk plays performed by local artistes) and a local radio programme - 'Kahat hai Mitanin' were used for training and community mobilisation in the Swasthya Mitanin Programme in Chhattisgarh that has trained over 60,000 hamlet level women health volunteers performing the role of health change agents by providing preventive-promotive and basic curative care to the communities.

[14]State Health Resource Centre, Chhattisgarh. "Training Competencies" in The Mitanin Programme, Conceptual Issues and Operational Guidelines, SHRC: Raipur (2003)

[15]SATHI-CEHAT has developed pictorial material for training non-literate CHWs on basic clinical and diagnostic skills as a part of the Swasthya Sathi Programme in tribal Maharashtra.

[16]The strategy of phased training (with 7 training rounds phased across one year) was used in the Swasthya Mitanin Programme in Chhattisgarh to train its 60,000 hamlet level women health volunteers performing the role of health change agents by providing preventive-promotive and basic curative care to the communities.

In large scale programmes, where hierarchical 'training pyramids' (in the form of a cascade approach) have been created to train ASHAs, it is important to address the issue of 'transmission losses' and hold strong training sessions at the 'senior' levels[17]. Developing modules in the form of books has also been found to be useful for quality and standardised training in scaled programmes. At the same time there needs to be sufficient flexibility for district and block level trainers to innovate and include within their training sessions local health issues and practices and address them within the frames of regional variations of ethnicity, tribe, religion and caste that would arise in the context of Bihar.

There is therefore an important need to develop a contextualised training curriculum and strategy which is rooted in the socio-cultural milieu of any state.

3 District Health Planning

District Health Plans have assumed a new centrality and urgency in the current context of the National Rural Health Mission. The rationale for having District Health Plans comes from the concept of addressing local needs and local specificities of health and nutrition in a district. Districts vary widely in their specific population needs and even more in innovations for intervention. Thus, in one district, there may be a problem of drug resistance in malaria control programme, whereas in another district the need may be to integrate control of malaria with filarial control. In one district there may be an active private sector available even in smaller towns for proposing partnerships whereas in another there may not be. Strategies therefore have to be district specific, not only because health needs vary, but because perceptions of people and capacities to conduct programmes also vary. In a centrally designed and driven plan there is little room for such adaptation and contextualization, hence district planning becomes critical.

Other reasons for focusing on District Health Planning are:

[17]Sundararaman, T. Approaches to Achieving Scale: Missions and Movements - a key note presentation made at the National Workshop on Community Health Worker Training: Linking Pedagogy and Practice, organised on April 9-11, 2006 in Pune by the Social Initiatives Group, ICICI Bank in collaboration with the Foundation for Research in Community Health.

- **Enabling decentralisation and community participation**: Community participation needs to be seen as an important aspect for decision making in public health spheres. District Planning and even other more local levels of planning, such as village level planning and block level planning give the scope to do so.

- **Convergence**: One major area which requires reform and a critical thrust is the coordination between various departments contributing to health. Currently they operate as distinct vectoral programmes, delinked from each other, leading to wastage of resources, duplication and various inefficient and suboptimal outcomes. There is a need to have effective coordination between all health related sectors like water and sanitation, nutrition and food security, education, environment etc. to ensure health outcomes. There is also a need for coordination between different disease control programmes and Reproductive and Child Health programmes and for close integration between the management of different faciilties such as CHCs, PHCs and district hospitals. Planning at the district level makes uses of the resources made available from numerous "vertical" programmes into a single "horizontally integrated" district plan[18].

- **Improving Accountability of Health Systems**: By clearly stating what the problems and goals of the health sector are at the local level, the district plan brings the whole process of health sector functioning into public scrutiny.

Most importantly, it is at the district level that large numbers of individuals, both within government agencies and NGOs are currently working close to the ground and where individual initiative in planning, administration, supervision and service delivery can make significant impact even in a larger context of institutional constraint. It is also precisely at this level that a lack of technical knowledge and skills and a supportive network of similarly motivated in individuals impede functionaries from making improvements within their control and dishearten them from pursuing effective strategies. Developing ways to reach out to these motivated but often isolated individuals, whether they are district programme managers, medical officers, NGO workers, or ICDS Project Officers is a key challenge. This becomes especially complex when one considers the need

[18]Gopal, K.M. & Mondal, S. District Health Planning, Module 10. Public Health Resource Network, 2007

for strategies that are at once linguistically and analytically accessible, professionally actionable, and ultimately viable given the time constraints within which district and block level functionaries operate.

The Public Health Resource Network is an effort to interact with and empower district functionaries both from within the government health system and civil society to meaningfully participate in and strengthen district planning processes and outcomes[19]. Structured as an innovative distance-learning course aimed at building in-service and field-based capacity at the decentralized levels of districts and blocks in the area of public health planning, management and implementation, the PHRN aims to disseminate technical resources through modules and reference materials to district level functionaries proactively enrolled in the course at an affordable cost. The technical content and contact programmes have been specifically developed to build perspectives and technical knowledge of participants and provide them with a variety of options that can be immediately put into practice within their work environments and everyday roles. As importantly, the programme is concerned with building a vibrant network of district resource persons, with the hope of creating greater energy and multiple points from which to leverage change.

Bihar is one of the four states where the PHRN has been launched in its first phase and course enrolment and networking is underway in a number of districts. Most recently, District Programme Managers have begun participating in the programme. With active support, the PHRN and other district level capacity building efforts can be scaled and strengthened across the state.

[19]The PHRN is a civil society initiative, organised as a partnership programme of a number of government and non-governmental organisations, and resource centres. The partners are: The National Rural Health Mission, National Institute of Health and Family Welfare, Department of Health and Family Welfare (Government of Chhattisgarh), State Institute of Health and Family Welfare (Government of Chhattisgarh), Jharkhand Health Society, Institute of Public Health (Government of Jharkhand), State Institute of Health and Family Welfare (Government of Orissa), Population Foundation of India (Regional Resource Centre for RCH), Child In Need Institute, ICICI Centre for Child Health and Nutrition. The coordinating agency is the State Health Resource Centre, Chhattisgarh.

4 Conclusion

The National Rural Health Mission (NRHM)[20] has provided states with a comprehensive framework for policy reform, programmatic innovation and health systems strengthening over the next few years. For Bihar, as for other priority states, investment and action in this area is an urgent need and challenge, but also presents an important opportunity to improve health outcomes through a variety of new approaches. Undoubtedly, this will be a phased and gradual process, but the nature of initial programmes will set the tone for way in which the Mission is translated. This paper recommends that two critical aspects - the ASHA Programme and District Health Planning - be considered as early priorities for immediate attention.

First, ensuring effective, contextual and ongoing training of the thousands of ASHAs currently selected across Bihar will empower these local women to disseminate essential health knowledge among their communities and support household and community level changes in health behaviours and practices. This has the potentially to significantly reduce child mortality and malnutrition among the rural poor. Second, building the capacities of district health resource persons through innovative initiatives such as the PHRN will enable meaningful decentralised planning and generate contextual solutions designed to address diverse district-specific needs and utilise the varied resources available within different districts. Crucially, both initiatives seek to mobilise and activate already existing resources from within communities and health systems - individuals and networks that have the most potential and stake in improving health services and outcomes. Of course, further investments in infrastructure, personnel and structural change will be vital, but both these programmes will create a larger mobilisational context within which new investments and initiatives are likely to be much more responsive, contextual and publicly accountable. These efforts require strong support in conceptualisation and implementation and fresh approaches, but will they will provide the impetus and idiom necessary for much more community-based, participatory and effective health system reform and strengthening.

[20]National Rural Health Mission (2005- 2012), Ministry of Health and Family Welfare, Government of India.

5 Summary of Recommendations

The following is a summary of the recommendations for improving child health outcomes in Bihar, within the larger policy context of the National Rural Health Mission (NRHM), focusing on the two crucial areas of community health workers (the ASHA Programme) and decentralised health planning (District Health Planning):

- Government and civil society partnerships at each level of the decentralised structure of the NRHM - at the state, district, block and village levels - to facilitate training of the ASHAs, their trainers and the other personnel involved in this process.
- Integrating learnings from civil society innovations about community mobilisation and CHW training into the conceptualisation and implementation of, and support to the ASHA programme at the level of scale.
- Undertaking review and development of state training modules in a participatory manner by involving personnel from different levels, as well as seeking feedback from local and sectoral experts.
- Developing contextualised training content and methodologies, that can sensitively respond to the unique contextual realities in different geographies across the state of Bihar. Contextualisation can involve development of training modules in local dialects; designing content to address local problems, beliefs and practices; defining the roles and scope of the ASHA to best suit local needs; and adapting training to suit the profiles of the human resources available in different regions.
- Developing specific training content for non-literate ASHAs, keeping in mind the high prevalence of illiteracy in Bihar, especially among rural women.
- Capacity building and training of government personnel, especially at the district and block levels, on undertaking decentralised health planning to implement the NRHM. The Public Health Resource Network, which is already operational in Bihar, can provide useful resource material in this regard.
- Government and civil society partnerships at each level of the decentralised structure of the NRHM - at the state, district, block and village levels - to facilitate selec-

tion and training of the ASHAs, their trainers and the other personnel involved in this process.

- Capacity building and training of government personnel, especially at the district and block levels, on developing and implementing training for the ASHAs. At the state level, this can involve efforts such as workshops to orient the State Mission Directors / State Facilitators about the various innovations and best practices in CHW training in the sector.

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6 Appendix - 1

The National Rural Health Mission

The National Rural Health Mission (NRHM) was announced in September 2004 as a part of the Common Minimum Programme of the Government of India with the following goal "*to promote equity, efficiency, quality and accountability of public health services through community driven approaches, decentralization and improving local governance*[21]." The duration of the Mission is seven years (2005-2012) and its focus is on 18 states[22] where the challenge of strengthening the weak public health system and improving key health indicators is the greatest. Taking an 'omnibus approach' by integrating existing vertical health programmes[23], the NRHM seeks to provide effective health care to the rural population, especially the disadvantaged groups including women and children, by improving access, enabling community ownership and demand for services, strengthening public health systems for efficient service delivery, enhancing equity and accountability and promoting decentralisation[24].

The key components of the NRHM to achieve these objectives include the following[25]:

- Accredited Social Health Activist (ASHA) Programme: The core component of the NRHM is the Accredited Social Health Activist (ASHA) Programme, which involves placing a community based change agent at a 1000 population level, to catalyse a sustainable community-owned process for behavioural change and to facilitate access to basic health services by the poor. The primary role of the ASHA is to create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of desired health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

[21] Ibid.

[22] These include: Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa, Rajasthan, Himachal Pradesh, Jammu & Kashmir, Assam, Arunachal Pradesh, Manipur, Nagaland, Meghalaya, Mizoram, Sikkim and Tripura.

[23] The vertical health programmes converged under the NRHM include the Reproductive and Child Health II project (RCH II), the National Disease Control Programmes (NDCP) and the Integrated Disease Surveillance Project (IDSP).

[24] National Rural Health Mission (2005- 2012), Ministry of Health and Family Welfare, Government of India.

[25] Ibid.

- Strengthening public health infrastructure: The NRHM recognises that strong public health systems are imperative for achieving improved health outcomes. The Mission has allocated additional funds for strengthening the public health service delivery infrastructure, particularly the sub centres, the PHCs and the CHCs for the provision of primary and first contact curative care. This would be accompanied by improved management capacity to organise health systems and services in public health by emphasising evidence based planning and implementation.

- Fostering public-private partnerships: The NRHM will support civil society participation to increase social participation and community empowerment, promoting healthy behaviors at the community level, and improving intersectoral convergence. This component also includes the regulation of the private sector to improve equity, transparency and accountability and reduce out-of-pocket expenses.

- Decentralisation of health planning: One of the core strategies of the NRHM is to empower local governments to manage, control and be accountable for public health services. It envisions the setting up of the State Health Mission led by the State Departments of Health and Family Welfare, the District Health Mission led by the Zila Parishad and the Village Health Plan to be formulated by the Gram Panchayat. The NRHM has created structures at each of these levels for the planning and implementation of the initiatives to be undertaken within the Mission.