Author's response to reviews

Title: Empowering health personnel for decentralized health planning in India: the Public Health Resource Network

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Empowering health personnel for decentralized health planning in India:

The Public Health Resource Network

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A mission needs missionaries and it needs them where the needs are the most…

The rationale and scope

The question confronting health systems in India is how best to reform, revitalize and resource primary health systems to deliver different levels of service aligned to local realities, ensuring universal coverage, equitable access, efficiency and effectiveness, through an empowered cadre of health personnel. One of the important pre-requisites to achieve these outcomes is decentralized health planning to include conceptualization and operationalization of health programs at local levels, as well as decentralized governance of systems of planning and delivery, at least at the level of the district [1].

The district is the smallest administrative unit in India, and is considered as the most appropriate level for operationalizing primary health. It is the basic unit of development where agencies of various social development sectors, including health, plan and implement their programmes, thus providing a unique opportunity for integration and inter-sectoral coordination. The district provides an opportunity for interface between policy and implementation of health programmes at the level of the community, in addition to being a composite unit of health system with a clearly defined administrative and geographic area – including the health sub-centre (at 3000-5000 population), the primary health centre (at 30000-50000 population), the community health centre (at 80000-100,000 population), and the district hospital (catering to a population of about 1,000,000).

Districts vary widely according to the specific needs of their population, and even more so in terms of existing interventions and available resources. Strategies, therefore, have to be district-specific, not only because health needs vary, but also because people's perceptions and capacities to intervene and implement programmes vary. In centrally designed plans there is little scope for such adaptation and contextualization, and hence, decentralized planning becomes critical [2].

District health plans have also assumed a new centrality and urgency in the current context of the National Rural Health Mission (NRHM) [3], which includes decentralization of health planning to empower local governments to manage, control and be accountable for public health services as a core strategy [4].

The challenges
For such planning to take place effectively, there is a strong need for trained, motivated, empowered and networked health personnel. However, it is at this level that a lack of technical knowledge and skills, and the absence of a supportive network or adequate educational opportunities impede personnel from making improvements. The limited nature of in-service training and of training curriculum that reflect field realities add to this, discouraging health workers from pursuing effective strategies. There is also the need to evolve from a more ‘command and control’ orientation of public health functionaries towards the community, to an attitude of participation, openness and accountability, recognizing the rights of the poor and the vulnerable. Capacity building is also needed in civil society groups, for members who are active in forums like District Health Societies, district planning teams, in hospital management committees, and in the implementation of community health programmes.

One of the major gaps that has been repeatedly identified by public health experts in the capacity of public health functionaries is the lack of experience and perspectives on the socio economic, cultural and political aspects of health and poverty [5]. Lack of capacity to analyze and interpret ‘what is really going on’ in their area, has led to an absence of district health planning, and consequent ‘out sourcing’ of this exercise to international technical assistance groups. This only propagates the situation of apathy and non-ownership on part of the health functionaries.

These gaps need to be addressed systematically in order to bring about the desired achievements in decentralized planning. The Public Health Resource Network is an effort towards this end.

The Public Health Resource Network

Started in 2005, the Public Health Resource Network (PHRN) is an innovative distance learning course in training, motivating, empowering and building a network of existing health personnel from government and civil society groups. Its aim is to build human resource capacities for strengthening decentralized health planning and reach out to motivated, though often isolated, health workers. Thus, PHRN’s objectives are as follows:

- Reaching out to dedicated individuals to whom health equity is a major concern, and providing them access to essential information and opportunities to contribute to this goal.
- Sharing public health technical resources with existing and potential district health programme managers towards strengthening the public health system in their districts, and assisting in the emergence of state and district resource groups for this purpose.
- Empowering civil society to create spaces, and utilizing the spaces being created under the NRHM, for improving and increasing public participation in health planning and management.
- Promoting decentralisation and horizontal integration at district, block and village levels by building capacity on technical, programmatic, epidemiological and social understandings of health.
- Strengthening the resource base needed for informed advocacy within the government and civil society.
- Facilitating networking and mutual support among public health practitioners.

Structured as an innovative distance-learning course spread over 12 to 18 months of course work and contact programs, the PHRN comprises of 14 core modules and 5 optional courses. The technical content and contact programs 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 roles. The thematic areas of the course range from technical knowledge related to maternal and child health, communicable and non-communicable diseases; programmatic and systemic knowledge related to health planning, convergence, health management, and public-private partnerships; and perspective building knowledge related to mainstreaming gender issues, and community participation [6].

Currently, the PHRN runs in the states of Chhattisgarh, Jharkhand, Bihar and Orissa, with over 500 participants. Initially supported by the State Health Resource Centre Chhattisgarh (SHRC), the PHRN is currently coordinated by the Public Health Resource Centre (PHRC), which provides continuous support to the four state offices. The initiative has received valuable support from the NRHM at both central and state levels, state training institutes, the National Health Systems Resource Centre (NHSRC), and leading civil society organizations including, the Child In Need Institute (CINI), Population Foundation of India (PFI), the ICICI Centre for Child Health and Nutrition (ICCHN).

Besides the regular course, one other strategy of the PHRN is the fast track capacity building program [7] that is organized in collaboration with state governments willing to invest in its human resources.
Constructed as three rounds of a six day long training workshop held three to four months apart, this is focused on capacity building of government personnel working with NRHM for district level planning. The goal is to build adequate skills in a team of 5 resource persons per district for the next five years – to create a pool of 25 public health functionaries – from amongst motivated individuals from the government – from which a district resource unit could be made functional, to facilitate quality district health plans based on situational analyses, and to develop capacity to train panchayat (lowest unit of decentralized governance) functionaries and civil-society groups in effective outcome-oriented village health planning [8].

The experience of implementing the PHRN has contributed to valuable learnings for establishing and sustaining a people’s network, with close collaborations with the government, for the end objective of building capacity to improve decentralized planning and programming. In terms of course participants, while the response to enrolment, contact sessions, and the use of course material have been very encouraging, the challenge has been in motivating participants to undertake projects and assignments, especially due to the absence of any current formal accreditation. The collaboration of the government in organizing the fast-track capacity building programs, and participation of the health system personnel have been a positive experience, although follow-up of these concentrated sessions for translation into policy and practice needs to be strengthened. The cooperation of individual resource persons in volunteering for contact sessions and fast-track capacity building programs has the decentralized operationalization of the PHRN possible.

The road ahead

PHRN, independent of its capacity building role, also has a role of promoting all interventions that would improve NRHM outcomes. Keeping with these larger goals, the PHRN has expanded its scope. Two new initiatives of the PHRN are 1) accreditation through Indira Gandhi National Open University (IGNOU) for a Post Graduate Diploma in District Health Management. Participants, who enroll into the course through IGNOU, and fulfill the stipulated credits on the basis on course assignments and evaluations, would be awarded the diploma; 2) to create and support a Fellowship Programme. The fellows supported through this program would be placed in District Health Societies and local civil society groups, with strong and continuous mentoring support from a network of resource individuals and organizations from across the
country. The envisaged role of these fellows are to support all community level processes in the districts through advocacy, appraisal of training and community processes, formative studies for designing community programs and improve training curriculum, and documentation of ongoing processes.

An effort towards improving the PHRN has been an exchange of experiential learning with the distance learning course on Diploma/Masters in Public Health offered by the School of Public Health (SOPH) at the University of Western Cape in South Africa. Sharing of course material between the two programs, interaction with the SOPH to share opportunities and challenges of implementation and future directions, and conceptualizing partnerships in research, have been valuable in strengthening the PHRN, and planning for its future trajectory.

The PHRN thus, is a network that responds to the unique needs of changing realities. It is an effort to build capacity, and to empower the participants to translate knowledge into action, and to bring about positive, equitable and sustainable change.

**Competing Interests**

The authors declare that they have no competing interests.

**Authors' Contributions**

AK conceptualised the structure of the manuscript; AK, VP, SZ and VRR worked on the manuscript. All the authors read and approved the final manuscript.

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**Endnotes**

1. In India, a district is the smallest administrative unit. The country has 604 districts across its 28 states and 7 Union Territories.

3. The National Rural Health Mission (NRHM), 2005 – 2012, was announced in April 2005 by the Government of India with the stated goal “to promote equity, efficiency, quality and accountability of public health services through community driven approaches, decentralisation and improving local governance”. Its focus is on 18 states – Assam, Arunachal Pradesh, Bihar, Chhattisgarh, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand, Uttar Pradesh – where the challenge of strengthening the weak public health system and improving key health indicators is the greatest.


6. The course covers the following main themes:Quarter 1 - Introduction to Public Health Systems; Reduction of Maternal Mortality; Accelerating Child Survival; Community Participation and Community Health Workers; Behaviour Change Communication and Training. Quarter 2 - Mainstreaming Women’s Health Concerns; Community Participation; Disease Control Programmes; Convergence; District Health Planning. Quarter 3 - District Health Management; Public-Private Partnership; Legal Framework of Health Care; Issues of Governance and Health Sector Reform. Quarter 4 (Optional Courses) - Tribal Health; Urban Health; Hospital Administration; Non-Communicable Diseases and Mental Health; Disaster and Epidemic Management.

7. Such fast track programmes have been organized in collaboration with the state government in Arunachal Pradesh, Assam, Chhattisgarh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, and Tripura.
