

# **Empowering health personnel for decentralized health planning in India: an experience of the Public Health Resource Network**

Anuska Kalita <sup>∞</sup> <sup>□</sup>, Dr. Vandana Prasad <sup>\*</sup>, Sarover Zaidi <sup>∞</sup>, V.R. Raman <sup>Δ</sup>

<sup>∞</sup> ICICI Centre for Child Health and Nutrition Centre, Pune

<sup>\*</sup> Public Health Resource Centre, Delhi

<sup>Δ</sup> State Health Resource Centre, Raipur

<sup>□</sup> Corresponding author

E-mail addresses:

Anuska Kalita – [anuska.kalita@gmail.com](mailto:anuska.kalita@gmail.com)

Sarover Zaidi – [sarover.zaidi@icchn.org](mailto:sarover.zaidi@icchn.org)

Vandana Prasad – [chauhath@yahoo.com](mailto:chauhath@yahoo.com)

V.R. Raman – [weareraman@gmail.com](mailto:weareraman@gmail.com)

*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 conceptualisation and operationalisation of health programmes at local levels, as well as decentralized governance of systems of planning and delivery, atleast at the level of the district [1] – the smallest administrative unit in India.

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 decentralisation 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 absence 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 comes forward 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 programmes, the PHRN comprises of 14 core modules and 5 optional courses. 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 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 programme* [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 persons 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 functionaries and civil-society groups in effective outcome- oriented village health planning [8].

### **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 is continuously expanding its scope by undertaking new initiatives. 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.
2. Gopal KM, Mondal S: **District health planning : an overview**. In *District Health Planning*. Edited by Sundararaman T, Prasad V. Raipur: Public Health Resource Network; 2007: 1-12. [*Public Health Resource Network*, book 10.]
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, Uttaranchal, Uttar Pradesh – where the challenge of strengthening the weak public health system and improving key health indicators is the greatest.

4. Krishnamurthy M, Zaidi S, Kalita A: **Supporting Community Health and District Planning Strategies in Bihar** . *Working Paper Series*. Chennai: Centre for Development Finance, Institute of Financial Management and Research; 2007.
5. Ministry of Health and Family Welfare, Government of India: *Task Force on Medical Education for the National Rural Health Mission*. New Delhi; 2005.
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.
8. Public Health Resource Network: *Brochure* . Raipur; 2007.