Engaging grassroots governance structures for community health and development through a whole-of-government approach in the south Indian state of Karnataka

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HEALTH SYSTEMS STRENGTHENING ACCELERATOR

Context

When the second wave of COVID-19 hit in 2020-21, the health system and infrastructure in the south Indian state of Karnataka came under tremendous pressure. Vulnerable populations for socio-economically disadvantaged communities had limited access to health facilities due to distance, the lack of transportation, or the cost of transportation. Many of them did not understand the importance of getting tested, treated and vaccinated against COVID-19, particularly due to rumours about the vaccine causing death and fertility problems. Many people who work for daily wages were unwilling to lose a full day's earnings to go get themselves vaccinated, and potentially lose further income due to the side- effects.

Gram Panchayats (GPs), which translate to 'village council', are rural grassroots self-governance bodies of elected representatives. The Department of Rural Development and Panchayat Raj of the Government of Karnataka leveraged their strengths and networks to address the pandemic by forming Gram Panchayat Task Forces (GPTFs) to spearhead the COVID-19 response in rural areas. GPTFs were envisioned to develop into Health Task Forces after the pandemic, and KHPT supported a convergence and decentralization initiative with a whole-of-government approach to engage and empower Gram Panchayats to bring healthcare to the communities and workplaces of the most vulnerable and isolated communities. The initiative, called the Graama Panchayat Arogya Amrutha Abhiyaana (GPAAA) has been implemented since September 2021 by the Departments of Rural Development and Panchayat Raj (RDPR), Health and Family Welfare (HFW), and Women and Child Development (WCD), with support from KHPT and funded by USAID.

Karnataka has made several strides in efforts to enhance community well-being and development across health, social, educational and nutrition indicators over past decade. However, health surveys such as the National Family Health Survey (NFHS- 5) reveals high rates of anaemia among men and women, and non-communicable diseases, as well as the prevalence of issues such as child marriage and school dropout among adolescent girls. Evidence shows that with a robust primary healthcare system, better health outcomes could be achieved . Currently, even a well-functioning primary health centre (PHC) caters to less than 15% of all morbidities for which people seek health care .

A critical analysis of the current data around health and development highlights the overall challenges that appear to delay the realization of holistic community-health and wellbeing. The communities are not aware of their health status and do not go for timely testing due to loss of pay, fear of being diagnosed with a disease and the stigma associated with it, high out-of-pocket expenditure, gender barriers to accessing services, lack of transport facilities, mistrust of government services. This leads to a delay in accessing care until health conditions become severe. From the supply side, a lack of perspectives among Government departments on systems, parallel implementation of programs leading to duplication of efforts by different functionaries of different departments, and the poor alignment of programs to the needs of marginalized populations lead to poor uptake of government services. Therefore, a response that considers the socio-economic barriers, as well as the need for integrated services at the lowest levels is essential, especially for the most vulnerable communities.

A critical analysis of the current data around health and development highlight some overall challenges that appear to delay the realization of holistic community-health and wellbeing. They are:

1. At a conceptual level, a lack of perspective among government departments on systems and social constructs like caste and gender propagate unequal distribution of power, opportunity and resources and alienate certain disadvantaged populations. Therefore, programs/schemes align poorly to the needs of these marginalized populations, affecting their access to services and further alienating them from benefits of the program.
2. At an execution level, parallel implementation of national programs both within and between departments leads to fragmented or isolated efforts, reach and service delivery. This is primarily due to the lack of convergence/synergy between government departments including health, education, livelihoods and women and child development.
3. At a sustainability level, there is an absence of spaces that nurture people's participation at the lowest levels leading to poor realization of local ownership of programs. In addition to the above communities do not have access to quality health services , the lack of resources, both financial and human, is an ongoing issue for health systems, leading to an inability to provide the necessary care to those in need at the right time.

Activity Description

- The primary approach taken up to address the health problems identified is convergence and decentralization through a whole-of-government approach. The GP represents India's decentralized local self-governing body that envisions people's rule at the village level. The configuration of panchayats, representing all genders and castes make them suitable centers of village administration and development, with potential to provide decentralized services to rural people at the lowest levels.
- Operationalizing convergence includes coordination between the various mandated committees, community structures and individual functionaries across all departments at the level of the village and GP. There are several mandated structures at the village, GP and Primary Health Centre (PHC) levels that can be leveraged to work together for supporting all health and development initiatives. These include the Village Health Sanitation and Nutrition Committee, the School Development and Management Committee (SDMC), women's Self-Help Groups (SHGs) and Bal Vikas Samitis (BVS) for child development, as well as informal groups like youth clubs, occupational groups and caste groups. There are also individual functionaries at the village level like the frontline health worker, the ASHA, the Anganwadi Worker (AWW) from the women and child care centre, and SHG members who can bridge gaps in health awareness and health service provision at the village level.
- By adopting a convergence and decentralized approach, a rich and diverse set of allied functionaries and structures that already exist at the village and GP levels can be made available as a supportive resource to reach vulnerable groups, increase awareness, deliver quality services and also create an overall enabling environment for development programs in the villages. This approach can empower Gram Panchayats make community health and well-being a people's mandate
- KHPT worked with the three government departments, the Departments of RDPR, WCD, and HFW, as well as with the concerned stakeholders such as frontline functionaries, committee members, department officials, and the structures of GP. We selected them because all the departments have cadres of frontline staff with overlapping roles and common grassroots priorities, which would help them engage in the joint planning and review mechanism, capacity building, and data reporting, to integrate services at the Gram Panchayat level.
- Various opportunities were created to engage these stakeholders throughout the planning and implementation process. At the state-level, consultation and planning meetings with representatives of all three departments were conducted, ensuring a common understanding. In these initial meetings, there were detailed discussions on the overall vision, objectives and intended impact of the program. These efforts of bringing together the stakeholders talking to each other and having sharing vision has laid the foundation for taking forward the convergence approach.
- The Departments shared official circulars/directives for the local governance bodies to attend trainings, organize health camps in a strategic manner and enter the data into the state's monitoring portal so that the program could be better planned and monitored on an ongoing basis. Hand-holding support was provided by a KHPT team of coordinators at the sub-district level
- Regular updates of progress shared with key stakeholders at various levels and through various channels. Weekly, bi monthly and quarterly updates were shared with stakeholders to keep them updated about the developments. Field-level challenges were shared with the stakeholders and joint meetings to trouble shoot the challenges took place on a period basis.
- GPAAA was closely aligned with the priorities of the Departments of RDPR, HFW and WCD, and representatives of these Department were involved from sub-districts to district and state levels to ensure that their concerns were addressed and local contexts were integrated into planning. Every activity was co-created with the consensus of representatives of all the Departments through a series of joint planning meetings. The government would then issue directives to authorities at the district and sub-district levels to undertake specific activities such as training, organizing health camps and monitoring performance.
- GPs were trained to be able to plan, implement and monitor the activities themselves, with the support of allied structures and frontline health workers. GPs consist of key community leaders who were able to bring the concerns of the community forward for discussion. For example, health camps conducted in the community were not always accessible to daily wage laborers who could not leave their work sites to receive health screening even within the villages. The program underwent numerous cycles of review and refinement to be able to address such concerns. For daily wage laborers, camps were organized at their worksites – construction sites and fields – so that that they could step away momentarily to be screened.
- Since the early stages of planning GPAAA's strategy, key officials in the three Government Departments were consulted to help shape the program with the existing human resources of the programs run by these departments. All activity plans, data monitoring formats, informational materials and training tools were developed during a consultative workshop chaired by a senior RDPR official to ensure that there was buy-in at all stages. Data was provided on a monthly basis to all key government officials and their feedback and suggestions sought.
- GPs went through an extensive training on not only the basics of community health, but also their specific roles in improving community health, which helped build their perspective on the importance of ensuring community well-being by tackling specific health issues. The handholding support provided by KHPT's field teams also ensured that they gradually took on ownership of the programs as they were leveraging their own community networks and resources. With the GP's activities around awareness and screening, and bring health services right to their doorsteps, the community was able to access services free-of-cost.

Activity Impact

GPAAA initially covered 14 districts with the aim of reducing the burden of Tuberculosis (TB) and Non-Communicable Diseases (NCDs); increasing vaccination rates among remote communities; addressing mental health issues, and preventing the incidence of child marriages. The key activities included:

- Distribution of health management kits for community-based health camps - KHPT distributed 2816 health management kits through USAID funding, comprised of nine devices for point-of-care testing for Non-Communicable Diseases such as diabetes and hypertension, anaemia, undernutrition, as well as for taking temperatures and blood oxygen saturation levels. The kit was designed to be portable, and taken into the communities for local health camps. KHPT's team of field staff supported the Gram Panchayat Task Force members to organize health camps to screen for NCDs and provide COVID-19 vaccinations free of cost, especially to women, the elderly, children, daily wage workers and persons with limited mobility who could not access health services.
- Capacity building of Gram Panchayats- 112,500 GPTF member across the state were trained in a phased manner through various modes, including satellite broadcast. Cascade trainings were also done with expert resource persons from the Departments of HFW, RDPR and WCD to train the GP members and constitute a resource pool at state and sub-district level. GPs were trained not only on community health concerns and their role in their mitigation but also to strategically allocate human and financial resources to plan, implement and monitor health activities, especially to reach the most vulnerable
- Providing mental health supp ort through the Careline tele counselling service: As part of GPAAA, Sahita Careline, a free-of-cost outbound tele counselling service supported by USAID was established in September 2021. The Careline is staffed by trained counsellors who provide counselling services and link persons in need of additional services to the district mental health program.
- Community awareness on health concerns- Community mobilization methods were such as conducting meetings with community leaders, door-to-door visits, display of posters in popular places where people congregate, local promotional and awareness camps etc, were conducted, with the support of local community structures. Efforts are being made to use community radio under GPAAA to create awareness about health issues in the community

The pilot phase of the project was successful in reviving the health mandate of the GPs and also in demonstrating the convergence at the lowest levels in 14 districts, 2816 GPs covering a rural population of 20.2 million population.

• PHASE 1

In light of the increased screening and testing for TB and NCDs, as well as vaccination uptake in the implementation districts, the Government of Karnataka made a provision in its annual budget in 2022-2023 to scale up GPAAA to all 31 districts in the state, with a financial allocation of INR 105 million. The RDPR Department took over the leadership of overall implementation of the program and KHPT continued to provide technical support to the state as the program expanded to 37.7 million people.

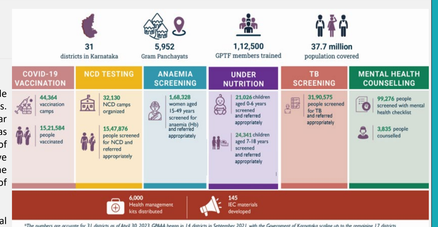
• PHASE 2

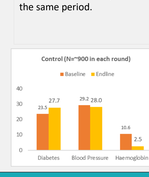
Evidence

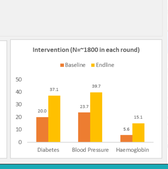
Evaluation of the program

In September 2021, KHPT conducted a cross-sectional sample survey among households in six of the 14 intervention districts. Also, to measure the effectiveness of the intervention, a similar study was conducted in three districts where the intervention was not implemented. The pandemic has led to improved awareness of co-morbidities like diabetes and hypertension. However, we have seen a significant difference between the intervention and the control districts in households accessing the services for testing of blood sugar, hypertension, and undernutrition.

The charts below show that among the households in rural intervention districts, the proportion of any member getting tested for diabetes increased from 20 to 37 percent from September 2021 to September 2022, as compared to 24 to 28 percent in the control districts in the same period. Similarly, in the same period, the levels of testing for hypertension changed from 25 to 40 percent in the intervention districts as compared to 29 to 28 percent in the control districts. The proportion of households where any member was tested for anaemia increased from 6 to 15 percent in the intervention districts, whereas it reduced from 11 to 3 percent in the same period.







Facilitators

The collaboration of GP functionaries, health facility staff and frontline workers have helped streamline the planning and implementation of health activities and prevented the duplication of efforts due to overlapping responsibilities

The leading role of the RDPR Department in anchoring the program and bringing together the HFW and WCD Department helped systematically structure and build out the program, resulting in its scale up across the state

KHPT's team, through USAID support, was able to provide technical and handholding support from the village, to sub-district and state levels, helping to streamline activities and pass on feedback to help shape the program

The existing community structures in the villages such as SHGs, youth associations, and associations of the Indian rural employment guarantee programme, were key stakeholders of this initiative in terms of mobilising people for the screening camps and spreading awareness.

KHPT and RDPR developed a complete resource toolkit, including an explainer on convergence, a training manual on health concerns and micro-planning for GPs, and data formats and for GPs to help them to streamline their efforts

Testimonials

"In Mandya district, Karnataka, 365 villages have been identified as fluorosis affected. We arrange medical screenings for fluorosis in certain villages. At those medical camps, urine tests, NCD screening for diabetics, hypertension, height and weight and nutritional status were also conducted. During the camp, it came to our attention that Gram panchayats received health kits from KHPT/ GPAAA in order to accomplish these kinds of activities. The kit was helpful at that time because it had all the equipment we required. I hope that the program will be successful in the future."

Dr. Diwakar, Fluorosis Counselor, Mandya District, Karnataka, India

Challenges

- One of the key factors which has been observed to hinder convergence initiatives and multi-sectoral collaborations across sectors is the absence of a mechanism to understand and devise strategies for effective collaboration. Lack of easy-to-understand guidelines and a detailed action plans has made it difficult for various actors to work together efficiently. Additionally, unclear definition of roles and responsibilities and conflicting priorities of each department and sectors hamper the effective coordination and implementation of various convergence initiatives.
- To address these issues, concerted efforts were made to bring all departments together and ensure a unified strategy and approach at various stages of the project including planning, implementation and monitoring. This included activities such as sharing resources and information among departments, establishing interdepartmental task forces, and setting common goals and objectives, issuing joint circulars (direction from the government), formation of committees etc. to ensure that all departments are working toward a common goal and are able to leverage each other's strengths to achieve the goals.
- There is a limited people's participation at the lowest levels, resulting in poor implementation of local ownership of programs. Without their support, the success of these projects is severely compromised. In addition, spaces for local people to voice their opinions and contribute ideas limit the potential for local growth and development. Without the necessary resources or well-functioning platforms for engagement, local people are unable to realize the potential of their own projects and initiatives emerging at the lowest level.
- The timely availability of consumables for the point-of-care testing devices at the GP level was key to conducting the screening as planned, without these supplies, it is impossible to provide sufficient testing and screening services to a larger population. A considerable number of GPs have started procuring consumables, and more GPs should follow suit. It is essential to budget adequate funding for blood strips and consumables in the 15th Commission Finance Budget.

Lessons Learned

- By providing direct access to primary care services, those living in poverty or in rural areas can receive the healthcare they need without having to travel far and wide. This approach through the GP helps to ensure that those with chronic health issues are seen and treated in a timely manner.
- Capacity building is also necessary to empower GPs to use available resources, and to make decisions that have the potential to benefit the local communities. Additionally, the capacity building needs to be tailored to the specific needs of the local communities, in order to ensure that the empowerment of the panchayats is effective and sustainable.
- Local governance engagement is a crucial tool for achieving large-scale community participation and reaching the most vulnerable, especially women, children, and the poor. It allows for inclusivity and facilitates a sense of ownership over the development process, leading to increased trust and improved outcomes. It also helps to ensure that the most vulnerable are not left behind and that their needs are taken into account when making decisions.

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