Government of Tamil Nadu

Health & Family Welfare Department

Health Assembly

TNHSRP
Access, Equity, Quality

Tamil Nadu Health System Reform Program
(Program for Results supported by World Bank)

WORLD BANK

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HEALTH ASSEMBLY

Contents

1. Introduction

Right to health is integral to the right to life and the Government has a constitutional obligation to provide healthcare to all citizens of the country. The Universal Health Care (UHC) envisages ensuring health and healthcare for all, regardless of caste, creed, gender, race or sexual orientation.

It is essential for the Government to establish a system to engage with the public, enabling people from the community themselves to be responsible to take care of their individual health and also to promote and sustain the health of the community as a whole.

The concept is that in order to achieve UHC, we need a process and platform for developing participatory public policy such that it facilitates organized community effort and systematic social action based on collective wisdom not only in the planning process but also in implementation, not only in the health sector but in collaboration across sectors.

The utilization of health services can be achieved only when improved access and quality of services synergizes with the community becoming an active participant in the production of health rather than being a passive beneficiary.

The presence of a robust and reliable public health delivery system works as one of the best regulators of private service provision and cost containment. One of the philosophical foundations of this approach is that healthcare is not seen as a commodity that lends itself to packaging and purchase mechanisms but rather as a relationship of trust, that has to be established between a health team and the community it serves.

The role of the Government is to build linkage between the systems and to have effective measures to enable such a trust-based relationship between providers and

the community and the co-production of health achieved by them acting together. The central issues in most discourses on strengthening health care systems are accountability, transparency and community participation.

Hence, public health sector service delivery will be effective only if the community actively participates in the whole process of planning and service delivery.

The existing mechanisms in this regard are specially designed institutions that facilitate participation such as State and district and local levelhealth societies, patient welfare societies and Village Health, Water Sanitation and Nutrition Committee (VHWSNC) along with general populations from community.

Recognizing that health is a product of processes, which are largely located at the intersection of the community- any program for universal health care must aim to involve communities as active participants, or co-producers of health rather than merely as passive beneficiaries or consumers of health care.

2. Government of India Initiative

Based on the WHO Inter-Governmental Alma ATA Declaration of 1978 (of which India was a signatory) and several experiences in the voluntary sector within the country which showed an improvement in health indicators, the Govt. of India enhanced its commitment to community participation in health. The Panchayat Raj Act was an important step in this direction.

The National Rural Health Mission (NRHM) in the 'Framework for Implementation' document, adopted by the Cabinet in 2006 had five core components, one of which was 'communitization'.

The High-Level Expert Group on Universal Health Coverage for India also has a chapter on community involvement in monitoring and planning of the health system and the 12th Plan Approach Paper (draft) underlies the importance of involving communities in the health system.

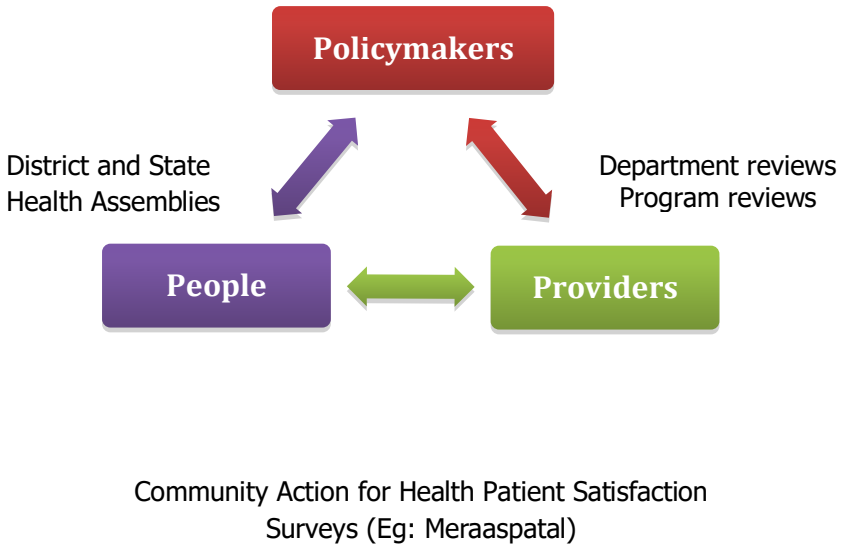
The recent National Health Policy 2017 has mention of community accountability as one of the key strategies to achieve health outcome.

The Community Action for Health (CAH) project has been implemented in depth with support from the State Health Society (SHS) in Tamil Nadu from 2010 to 2012 and subsequently state level catalyst activities were carried out till 2014. Currently, in 2020, the State is reviving the program under the ambit of NHM with multi stakeholder participation.

The major objectives of CAH is to set up a mechanism for community led monitoring and planning of health system in the entire state, to strengthen the supportive structures, to handhold the community monitoring process in Tamil Nadu and to develop a tool for community led monitoring and feedback loops of both upwards and downwards.

The World Development Report, 2004 developed a framework of accountability relationships (Fig 1) for improving service outcomes for poor people, which requires strengthening the three relationships in the chain-between provider, citizen and policymaker.

Fig 1: Framework of Accountability Relationships



In the earlier period there have been efforts made to improve the interaction between policymakers and providers (systems of reviews and supportive monitoring) and between people and providers (village committees, hospital societies etc.). But the direct linkage between community and policymakers seems to have received less attention.

3. Health Assemblies – Collective Wisdom

To increase citizen empowerment and social accountability of the health sector to its citizens, the Government of Tamil Nadu is proposing to convene district and state health assemblies. These are envisaged to improve voice of the public and agency of citizens through collective action while also raising the visibility of the health concerns and needs of communities.

Health assembly can be defined as an event in which representative of citizens directly or indirectly related to health (users, public) and key stakeholders (both public and private service providers, policymakers and other Government officials, academician, civil society, CBOs, NGOs, etc.) come together to have a dialogue on health issues, brainstorm solutions and come up with resolutions to further the health of the people in a jurisdiction and make health as a major part of political discourse.

It is a process and platform for developing participatory public policy based on collective wisdom. This event has to be embedded in a social process akin to a movement for greater effectiveness with the objective being to improve the interactions between all the stakeholders involved so that healthcare become more universal and community centric.

Most of the health programme and polices are only driven by Government and policymakers. But these programmes and interventions may be ignored to political regime change, whereas health assemblies ensure blessings of the public over the policies and program to increase the likelihood of continuity of policies and programs despite political changes.

4. National Health Assembly:

Thailand Model

One good practice example of a participatory health governance platform is the National Health Assembly (NHA) in Thailand, which has been established by local research and experimentation. Thailand is a nation with about the same population size as Tamil Nadu. The first NHA of Thailand was held in December 2008 in Bangkok, and it brought together over 1500 people from Government agencies, academia, civil society, health professionals and the private sector to discuss key health issues and produce resolutions to guide policymaking.

It adapted the approach used at the World Health Assembly of the World Health Organization. Fourteen agenda items were discussed, and resolutions passed. Potential early impacts on policymaking have included an increase in the 2010 public budget for Thailand's universal health coverage scheme. The cabinet endorsement of proposed Strategies for Universal Access to Medicines for Thai People, establishment of National Commissions on Health Impact Assessment and Trade and Health were few early outcomes as part of NHA.

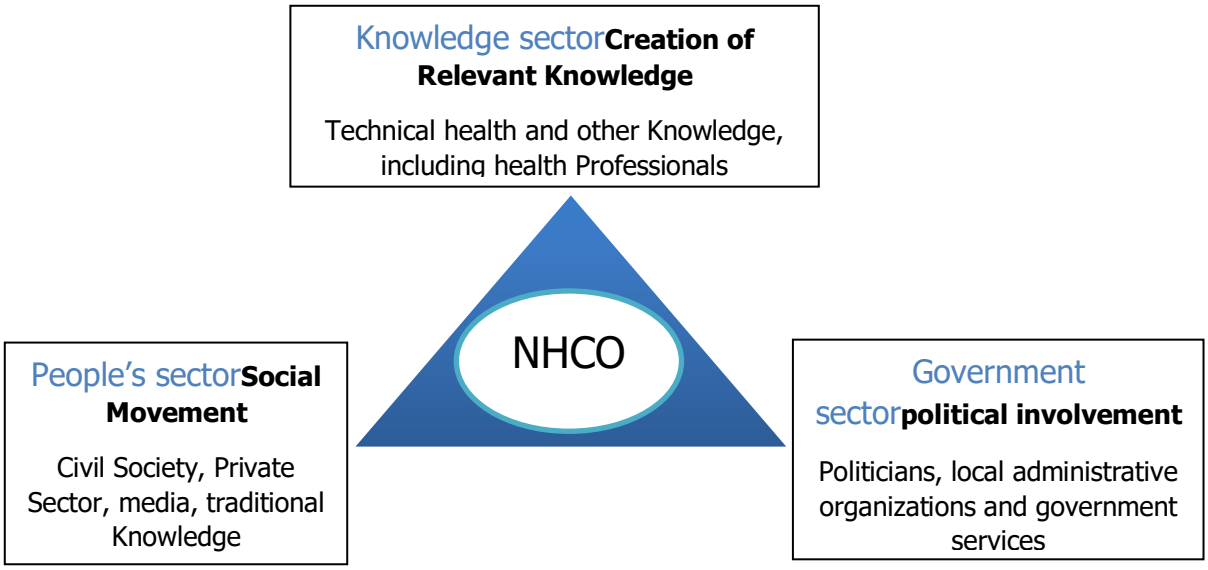
Over the years, Thailand Health Assemblies have evolved and now comprises three components

1) Area Assemblies: The assemblies include a provincial and regional level. The area-based health assembly is set up to raise local concern and solves problems. Furthermore, Area-based Health Assembly is another tool to disseminate and receive comments to the draft NHA resolutions. They are one of driving forces to put the NHA resolution in action in their provinces

2) National Assemblies: After Area Assemblies have been conducted, representatives from the provinces/regions will convene at the national level for the NHA. Representatives of all provinces attend NHA to express their final feedback before adoption.

3) Issues Assemblies: In addition to annual assembles and national health assembles, special issue-based Health Assembly is convened based on a specific issue to seek the consensus or to develop specific public policies. The 7 issues include development of national health information system, draft bill on reproductive health protection, traditional medicine strategy, nanotech strategy on safety and ethics, health workforce educational reform, national strategic plan on health promotion at the end of life (2014-2016).

Figure 2: The triangle that moves the mountain, National Health Commission Office (NHCO)



Evidence support and inclusive participation are incorporate throughout the process starting from agenda setting, resolution drafting, stakeholder and public consultation, resolution adoption, implementation, monitoring and evaluation. The Thai NHA process enables us to have an in-depth look at its strengths and weaknesses and the lessons learnt from this participatory governance model can be relevant for other settings like Tamil Nadu.

5. Health Assemblies: Other Examples

In addition to Thailand Health assembly, there are other examples of health assemblies conducted around the world. Among them, a few of this have been at the global level like in Savar, Bangladesh during December 2000, Cuenca, Ecuador in July 2005 and Cape Town (South Africa) in July 2012. These 3 global health assemblies were organized and conducted by People Health Movement (PHM)[1].

The health assembly in Savar, Bangladesh during December 2000 has participation of 1,453 participants form 92 countries, which was the culmination of eighteen months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross-section of people who have been involved in thousands of village meetings, district level workshops and national gatherings.

The assembly brought together grassroots health activists, civil society organizations and academics from around the world. The major stakeholders include Medicine pour le Tiers Monde, Belgium, Medicus Mundi International, Switzerland, Health Poverty Action, United Kingdom, Latin American Association of Social Medicine, Gonoshasthaya Kendra – People's Health Centre, Bangladesh, Health Action International, Third World Network, International Baby Food Network etc.

The assembly have formulated and finally endorsed the People's Charter for Health. The charter is seen as a common tool of worldwide citizens' movement committed to make the ALMA ATA dream reality.

Another global health assembly was conducted in Cuenca, Ecuador in July 2005 and attended by 1492 people from 92 countries. This health assembly was also

[1] PHM is a global network of grassroots health activists, civil society organizations and academic institutions particularly from developing countries

organized by PHM broadly across nine thematic areas- issues in equity and people's healthcare, intercultural encounters on health, trade and health, health & environment, gender, women and health sector reform, training & communicating for health, right to health for all in an inclusive society, health in people's hands.

A similar third global Assembly was conducted by PHM in Cape Town (South Africa) in July 2012 and attended by about 1000 people from over 90 countries. The major outcome of this assembly was the 'Cape Town Call to Action'- a final document for building alliances with other stakeholders who seek progressive and transformative changes in health sector.

In addition, a National Health Assembly was recently conducted by Jan Swasthya Abhiyan (JSA)[2] in Raipur, Chhattisgarh during 22nd and 23rd September 2018. The discussions were based on gender dimensions of health of women and transgender, different health insurance policies, inefficient implementation of existing provisions and laws, innovations required to strengthen public service delivery and experiences with community engagement. The event concluded with a formulation of a charter on better health provisions for all, which was later submitted to the Ministry of Health and Family Welfare and few State Governments.

[2] Jan Swasthya Abhiyan (JSA), the India chapter of the People's Health Movement, formed in 2001, working towards health and equitable development

6. Health Assembly in Tamil Nadu

Integrated people-centered health services mean putting people and communities, not diseases and providers, at the centre of health systems, and empowering people to take charge of their own health rather than being passive recipients of services.

Evidence shows that health systems oriented around the needs of people and communities are more effective, cost less, improve health literacy and patient engagement, and are better prepared to respond to health crises.

At the initial stage, the community needs encouragement and support from health care providers, knowledge sector and people sectors. They will make use of this ample opportunity to establish their central role in improving the delivery and utilization of healthcare service.

They must be addressing the people from marginalized group, and therefore improving the health seeking behaviour and fight for them as well, as a responsive citizen to have access to health care. A conscious effort will be required to build their expertise and experience, including mentoring, to make this transition happen.

Global experience has shown that community processes are most effectively mediated through organizations- elected local bodies, self-help groups and other community-based organizations, and official committees set up by the health department where public participation is provided for. In addition, Non-Government Organizations (NGO) also play a major role in supporting communities to articulate some specific concerns of the community.

The proposed State and District Health Assemblies in Tamil Nadu are envisaged with the aim to invite people from multiple sectors ranging from community to district and state authorities from health and non-health background, academics, civil society etc. to take combined and strategic decisions.

6.1 Vision

To actively involve communities, civil society, academia and other partners in making informed, participatory and strategic decisions to promote health and well-being through an integrated, people-centered health system in Tamil Nadu.

6.2 Goals and Objectives

- ✓ To establish a dialogue between different stakeholders- particularly communities including the marginalized, health care providers in both public and private sector, and mid and top-level management of health care systems and policymakers.

- ✓ To discuss health challenges faced by communities and advocate for health rights

- ✓ To raise the profile of health among communities and policymakers (i.e. emphasize importance of health)

- ✓ To develop, formulate, and implement health-related policies, through multi-sectoral collaboration and stakeholder's participation.

- ✓ To create a sense of ownership of communities over their health and healthcare system- leading to better utilization of health services, optimal adoption of healthy behaviours and eventually better health outcomes

- ✓ To empower the community with knowledge of their rights on health and healthcare and make healthcare delivery systems people-centric

- ✓ To build ownership over public and private health services and also develop their role as active co-producers rather than mere consumers of healthcare.

- ✓ To build understanding and networking among partners through capacity building for promoting health

- ✓ To strengthen the inter-sectoral collaboration for improving the health of population

- ✓ To improve strategic decision-making capacity of the health department and shape the public health systems into an adaptive system that is continually learning from systematic community feedbacks

- ✓ To bring changes in, practice, behaviour, power relations and policy at local, district and state level

6.3 Multi stakeholder's involvement: A Key to Success

The National Health Assembly (NHA) in Thailand model as well as other examples of community involvement in health show that participatory policymaking models are more successful than non-participatory models. The NHA's approach derives from the concept of the triangle that moves the mountain- where policymakers, providers and the people interact to achieve progress towards improved health and health equity. The approach aims for less bureaucracy, more flexibility and greater inclusiveness.

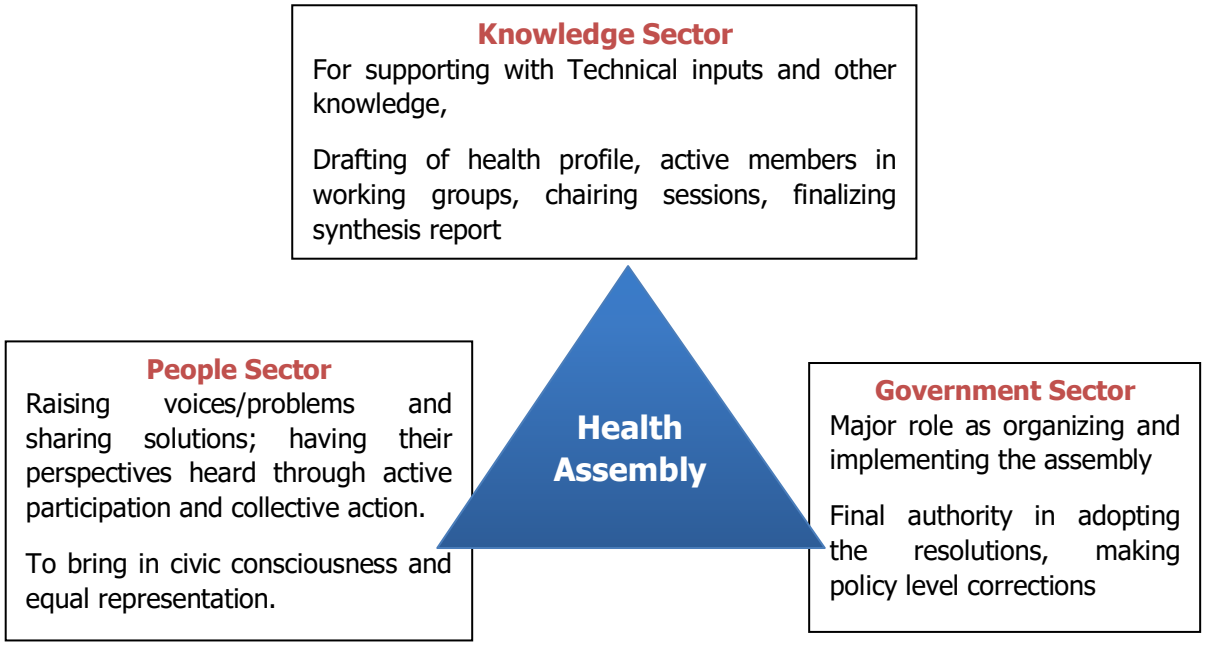
On similar lines with Thailand's NHA, Tamil Nadu also values the interaction of different groups of stakeholders and aims to bring together those in the People's sector, Knowledge sector and Government sector with varied roles and responsibilities (fig 3).

The People's sector that forms the foundation of the health assembly raises their felt health needs, complaints and concerns and also suggests solutions suitable for them.

The Knowledge sector is critical in supporting with technical inputs and evidences. They can also support in documentation including final synthesis report and will be active members in working groups during agenda discussions, chairing sessions etc.

The Government Sector plays the major role in organizing, financing and conducting the health assembly through setting up three important committees/groups- Health Assembly Steering committee, Organizing Committees and working Groups. Importantly, the Government sector will likely play a major role in implementing or supporting implementation of resolutions coming out of the assemblies.

Fig 3: Roles of Major Sectors involved in conducting Health Assemblies



The underlying principle is to bring together these three sectors together under one umbrella to review the existing policies on health, inform new policies on health, to raise/prioritize issues on the health agenda that may not yet be on the radar, focus on specific health agendas proposed by the organizing committees and to pass resolutions to address the issues.

The policy makers (Government Sector) will further take up the resolutions passed in the assembly for policy level and programmatic changes and depending upon the nature of the resolutions, stakeholders from the other sectors may also be involved in implementation.

The way in which different stakeholders discuss and debate with each other in a real attempt at consensus thus represents a reformed model in policy dialogue. Hence, ultimately the assembly will create a sense of 'inclusive ownership of policies' among all three sectors and thereby also improving implementation follow-up.

Both for District Health Assembly (DHA) and State Health Assembly (SHA) bring together these different sectors at district and State level. The various stakeholders proposed for participating in the District Health Assembly (DHA) includes

1) **People Sector:** Persons involved with respect and standing in local community, representative of peoples health organizations and movements which have a presence in the district, Village Health, Water, Sanitation and Nutrition Committee (VHWSNC) members, representatives of women's associations, self-help groups and community-based organizations; patient support groups, people science forum, representatives of the marginalized groups (LGBTQ, Differently abled) and the institutions such as members of tribal groups and their networks in particular district, leaders of women's organizations, representatives from Media, private health sector and representatives from Indian Medical Association (IMA).

2) **Knowledge Sector:** Non-Government organizations active in science communication or health advocacy, state and central universities, Academicians who have worked on health or related issues, health research organizations, representatives from the preventive and social medicine departments of Government and private Medical colleges and from faculty in medical colleges with public interest, Representatives from Veterinary unit, entomological department, WASH committee, Swatch Bharat Abhiyan etc., civil society organizations active in working for health rights and health education.

3) **Government Sector:** Health Staff (Medical Officers, Staff Nurses, Lab technician, Pharmacist, ANM, GNM, SHN, CHN, WHV etc.). Representatives of local self-Government bodies- both elected and executives,Politicians, District Magistrate/collector, District Health Society Members, District Management authorities (Commissioner, Tahsildar, City Welfare Officer), Representatives from State health authorities like National health mission, and officials from line departments like Directorate of Medical health and Rural health services, Directorate of Public health and preventive medicine, Tamil Nadu Health System Reforms Project, State level public health institutions

The State Health assembly also will bring in National (NHSRC, MoHFW, AGCA etc.) and International partners (WHO, UNICEF, UNDP, World Bank, etc.) to bring in more dialogues and take up the important policy level matters to national level.

6.4 Committees for supporting District and State Health Assembly

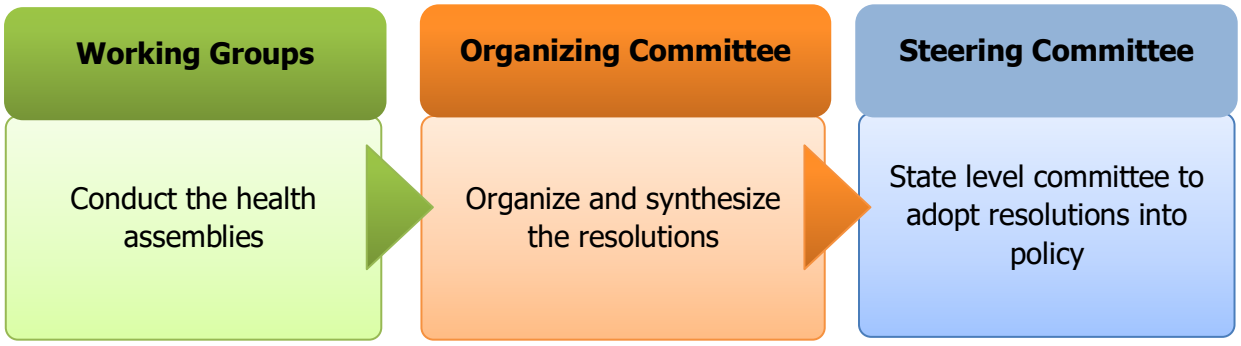
Health Assembly involves a larger effort to bring people together, moderate the sessions, persuade the importance of resolutions to policymakers. The following three committees are involved in the process of health assemblies (Fig 4).

1) **Health Assembly Steering committee:** Functions at the State level to take final calls on implementation of Health assembly, mobilize resources, supports in preparation of health profile and other technical papers for the assembly, take up resolutions to state assembly for ratification etc. Resolutions of both DHA and SHA will be submitted to the steering committee. It is a Government body having members from civil society and from public. Existing TNHSRP Steering Committee will function as the Health Assembly Steering Committee with co-opted members as needed.

2) **Organizing Committees:** Organizing committees will be established for each district and state health assembly. This committee will coordinate with District Health Societies and other stakeholders at district and State level for successfully organizing the committee. Committee responsible for organizing the health assemblies at district and state level, largely members from civil society and community but also have few representations from the Government. This function may be handed over to NGO/CSO at the district level.

3) **Working Groups:** Working groups will be created for each district health assembly and state health assembly by the organizing committee. Includes partners from State and national level responsible for agenda setting, organizing and carrying out discussions based on agendas set. They will be chairing/moderating each session of the assembly based on the agendas set. Each working group shall collate the important discussion points and shall present during the concluding session of the assembly. These groups report to the organizing committee throughout the process.

Fig 4: Committees for supporting Health Assemblies



6.5 Framework for implementation of District Health Assembly (DHA)

District Health Assembly (DHA) will be built on foundation of community linkages and conducted by collaborative activities of three committees in the following steps (Fig 5).

A) Creating foundation for District Health Assembly

Strengthening the community linkages by expanding the scope of VHSNC and VHND, encouraging community participation at local level in healthcare delivery and Involving PRIs in health delivery is the base of DHA framework. Organizing committee will be established for each DHA. Organizing committee will identify partners & stakeholders for conducting the health assembly. Organizing committee for conducting the DHAs will form the working group. The nodal function of the working group can be entrusted to civil society organization, which has experience in working for health rights and people's participation. Working group will facilitate meetings at district level, conduct consultative meetings with stakeholders, local level consultations with community with special focus on reaching the marginalized sections and IEC necessary for a sufficient build up to Health assembly. The District Health Assembly shall be seen as a culmination of a process of interaction with communities, and not as a standalone event. The District Health Assembly is when empowered members of the community come face to face with other stake-holders- providers, mangers, policymakers, professional associations etc. who would be more influential, articulate and powerful. This is the rationale for prior information and facilitated interactions with the communities.

B) Agenda setting for District Health assembly

Based on demographic and epidemiological profile of the district, social determinants of health, public health issues of the district, possibility for policy level changes and felt needs of the community agenda for DHA will be drafted by the working group. Once the Organizing Committee has finalized the themes/agendas for discussion, it commissions a technical background paper. These papers are made available to all the stakeholders, to inform discussions before and during the assembly.

C) Organizing the District Health assembly

Organizing committee will finalize date, venue, participant list and structure for conducting one day assembly at the district level. All participants at the DHA have equal speaking rights. First half of the assembly will be on discussion of themes, health priorities, district health profile and major health issues of the district. Second half of Assembly will be group discussions based on framed agendas by the Moderator(s). Concluding Session with rapporteurs presenting major discussion points of each group. These agendas transformed into draft resolutions and accepted resolutions will be drafted as Final Synthesis Report with an executive summary.

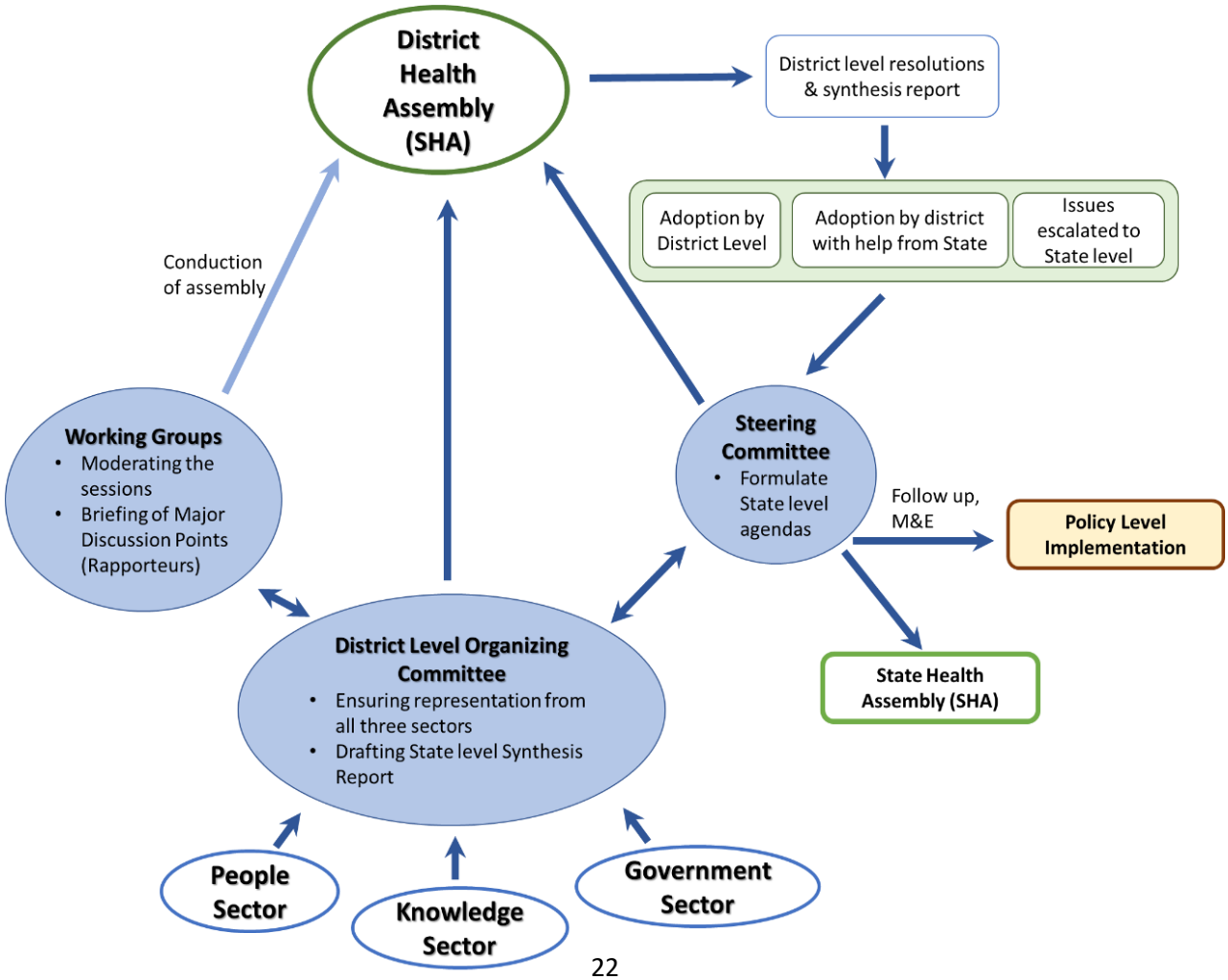
D) Dissemination and Follow-up of reports

Final Synthesis Report with resolutions shall be submitted to District Health Officials by organizing committee. Based on the feedback during consultative meeting with district officials, all the resolutions will be categorized and submitted to Steering Committee with recommendations. The issues may be of three natures as follows some are resolved at district level, some are resolved at district level with help from state level and some are escalated to state level for policy changes.

The District health authorities and the District Administration after consideration of all the issues that were highlighted in the assembly, would

also give a direct feedback to the participants of the assembly and the public in the form of a communication/resolution that is placed on the district website and disseminated through media and available in a printed form on request. This would be done within one month of the district health assembly. It could also include a plan of action for the issues that can be resolved at the district level. The nodal civil society organization of the working group and the working group members themselves would also be informed, and they too would disseminate the district administration response. Later when a similar feedback occurs at the state level, that too would be disseminated through these same district level mechanisms. Many issues can be addressed at the district level and do not require state level policy changes. The immediate response of the district administration within a month, need not wait for the state health assembly and its conclusions and follow-up actions.

Fig 5: District Health Assembly (DHA) and its linkage with State Health Assembly (SHA) and committees



6.6 Framework for implementation of State Health Assembly (SHA)

State Health Assembly (SHA) will be built on recommendations from DHAs and conducted by collaborative activities of three committees in following steps (Fig 6).

A) Creating foundation for State Health Assembly

Conducting District Health Assemblies (DHA) with representation for people, knowledge and Government sector is the base of SHA framework. State level Organizing committee will be established for SHA. Organizing committee will identify partners & stakeholders for conducting the state health assembly. Working group will be formed by Organizing committee for conducting the SHA. Working group will facilitate meetings at state level, conduct consultative meetings with stakeholders and IEC prior to Health assembly.

B) Agenda setting for State Health assembly

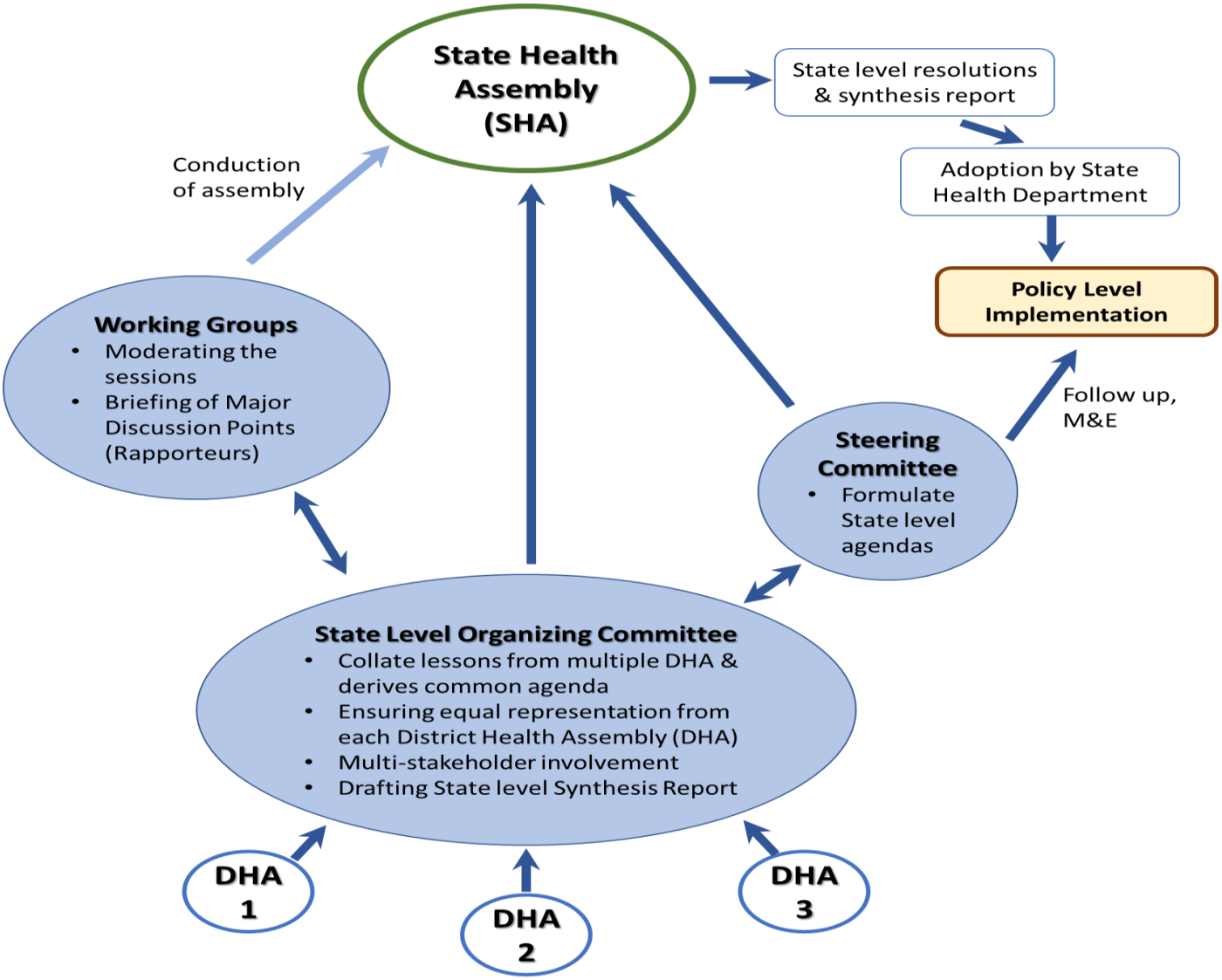
The Agenda for the SHA will be primarily determined by the common agenda items/resolutions arising from the DHAs. In addition, there will also be provision for agenda items which may be selected based on criteria's such as any emerging health emergencies or evidence-based health issues of importance. The Tamil Nadu Health Profile and its Social and Environment Determinants, Gender and Health, / Women's Health Issues or Health issues of the marginalized, Public Health Service Delivery- special reference to the UHC and action on NCDs/Chronic Illness, Public Health programs- with emphasis on communicable disease epidemics and their prevention, Private sector engagement and regulation are a few of the broader themes which may be discussed at the SHA.

Once the Organizing Committee has finalized the themes/agendas for discussion, it commissions a technical background paper which shall include State level policy issues and common discussion points/themes identified at the DHA. These papers are made available to all the stakeholders, to inform discussions before and during the assembly.

C) Organizing the State Health Assembly

The Organizing Committee (State level NGO) shall be responsible for organizing the health assemblies at state level. This committee will coordinate with State health department and other stakeholders at district and State level for successfully organizing the committee. They will facilitate bringing representatives from DHA to SHA. The representation at SHA shall be finally decided by the steering committee in consultation with Organizing Committee. The organizing committee will also ensure that equal participation from all stakeholders involved in multiple DHAs are represented at the SHA. There will also be Working Groups responsible for agenda setting, organizing and carrying out discussions based on the agendas set. They will also be chairing/moderating each session of the assembly based on the agendas set. Organizing committee will finalize date, venue, participant list and structure for conducting one day assembly at the state level similar to district health assembly. All participants at the SHA have equal speaking rights. Presentations made during the concluding sessions will be discussed and accepted resolutions will be drafted as Final Synthesis Report with an executive summary.

Fig 6: State Health Assembly (SHA) and its linkage with District Health Assembly (DHA) and committees



A) Dissemination of reports

The state health assembly reports will be submitted to Steering committee which takes final calls on implementation of Health assembly, mobilize resources, supports in preparation of health profile and other technical papers for the assembly. Organizing committee will follow up the policy changes proposed to State Officials. A feedback would be provided to the working groups of the district level within a month, and after six months and after one year.

6.7 Implementation Plan for District and State Health Assemblies

Health Assemblies in Tamil Nadu will be implemented in multiple Phases. The first phase will be from the year 2020–21 by organizing 4 District Health Assemblies.

The selection of the district shall be made at the State level through a consultative process. The next phase will be scaled up based on the gained experience of the initial phase, which will be slowly incorporated in all other districts with specified duration of time.

State Health assemblies will be conducted annually and after completion of district health assemblies. The broader framework and plan of action remains the same as the district health assembly.

The State Health assembly will garner experiences from the district health assemblies and take up specific agendas common to the districts and other themes/agendas important at the State level through a consultative process by multi-stakeholder engagement.

6.8 Future Implications

The Health Assemblies will improve civic consciousness and amplify citizen’s voice. The improved quality of dialogue and consultations in a periodical run, will give an insight to shifts in mind-set of officials and citizens which led to an increased understanding and respect for each other’s views and a more balanced perspective reflected in consensus-based resolutions for better health outcome of the State.

Health Assembly

Major Sectors involved in conducting Health Assemblies

Knowledge Sector

- ✓ For supporting with Technical inputs and other knowledge,
- ✓ Drafting of health profile, active members in working groups, chairing sessions, finalizing synthesis report

People Sector

- ✓ Raising voices/problems and sharing solutions; having their perspectives heard through active participation and collective action.
- ✓ To bring in civic consciousness and equal representation.

Health Assembly

Government Sector

- ✓ Major role as organizing and implementing the assembly
- ✓ Final authority in adopting the resolutions, making policy level corrections

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