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Dialogue

Moving Towards the 'Centre': Reproductive health and rights in Tanzania and Kerala, India

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ABSTRACT *Priya Nanda argues that the distance of local health care providers from decision making mean that reforms fail to ensure that local care givers can be effective agents of change. Decentralization has failed to move power from the centre to community representatives, especially women, and health care workers. She argues that core health needs, particularly of women should be visualized at the centre of concentric circles of power in order for decentralization to transfer power to community health care workers.*

KEYWORDS *gender equity; local health care; health reforms; health care systems; Tanzania; Kerala*

Introduction

Throughout the last decade the conventional wisdom has been that reforms in the health sector are necessary for overall improvement in health care systems and that the implementation of the sexual and reproductive health and rights (SRHR) agenda is partly conditional on these reforms (Yazbeck, 2004). Health sector reforms for gender and rights issues, However, seem to have little to do with improving women's access to SRHR services and addressing gender inequities in health. The main problem has been that the implementation of the SRHR agenda not only requires fundamental shifts in organization of the health care delivery system, but also what services are prioritized and the ability of women to seek those services, issues that have been neglected in the etiology of reforms. The lack of SRHR within the Millennium Development Goals is also indicative that this agenda cannot be reduced to a few technocratic solutions and measurable indicators.[2] It is not only a conglomeration of services but it is also a paradigmatic shift in how we conceptualize health care. Beyond the concern that market-based health sectors reforms at odds with the SRHR agenda,[3] how far we are from our goals of reproductive health and rights is also directly proportional to the distance 'reforms' are from the health centres, communities and homes where the bulk of health care takes place for the poor. I reflect on findings from our research on health sector reforms[4] carried out in Tanzania and Kerala, India to demonstrate the 'distance' of a reform effort, namely decentralization, from the local producers of health care. The papers highlights this 'distance' through the fact that reforms have bypassed the core by giving inadequate attention to health care providers and community leaders as key agents of change. The

analysis presented here is from a larger study on how reforms have impacted women's access to reproductive health care in Tanzania and India.

Decentralization devolves power away from the centre

Decentralization of the health sector has occurred within the context of Local Government Reforms in Tanzania and the *Panchayati Raj* Act in Kerala. (Makundi *et al.*, 2005, www.genderhealth.org; Ramanathan *et al.*, 2005, www.genderhealth.org) Decentralization has involved devolution of power from the central level (Ministry of Health) to the district and village levels in both settings. The intention has been to decentralize power and authority to the local levels, by shifting basic health management responsibilities and decision-making about health resources and health services held at the central and regional levels to the local governments at the districts level. The health care system has been decentralized to correspond with the administrative structure of the local government councils in both settings. Significant efforts have been made to transfer both authority and responsibilities to district authorities. District councils have both political and administrative authority to determine district health budgets. It is expected that through this process the needs of the community will be reflected in the local priority setting.

In theory, decentralization seems to be an efficient way to ensure that health plans reflect the needs of communities through providing power to the districts to allocate resources based on perceived local priorities and ensure community participation. Currently in both settings, decentralization has focused on transfer of authority, functions and resources from national to district levels. The current capacity of local institutions to participate in the decision-making process is, however, still limited. It is evident from our research findings that in order to have health interventions that are truly responsive to the needs of the communities, local communities should be able to express their health needs, lobby for them and hold their leaders responsible for meeting them. This is especially true in settings where we want those affected by HIV/AIDS to be part of the community-based response to treatment for HIV/AIDS.

Much remains to be done in both settings before decentralization and health planning can achieve their potential, especially with regard to representation of reproductive health and rights in the health care system. Local leaders and health care workers (even women leaders as is the case in Kerala) have limited understanding of reproductive health and rights issues, are unfamiliar with the reform process, and of their own rights and responsibilities. The findings show that the decentralization process needs to build greater technical and management capacity at all levels of the health system. Local leaders must be prepared to take up their new responsibilities, as currently in both settings local leaders at village levels lack a clear understanding of decentralization and their role in the process.

Decentralization and empowerment of health workers

What is the potential for decentralization to empower health care workers and communities? Several parameters constrain health workers such as lack of autonomy, ability to organize services according to local priorities and level of interaction with the decentralized structures of power.

In Tanzania (based on a study of four facilities in a district in northern Tanzania) district health boards (DHB) have been formed, which comprise of elected councilors representing the local communities. These boards have been entrusted with responsibility to make overall policy decisions for district health services. The District Medical Officer (DMO) is accountable to the DHB with full responsibility and control of funds and resources to run the district health services, working with the assistance of the new Community Health Management Teams (CHMT). Linking the district with communities is done through village committees. In each village there is a health committee (VHC), and village health workers (VHW) are members of the committees. VHCs are expected to work closely with health facilities in the provision

of health services. To further strengthen the involvement of communities in the provision of health services, for each health facility, a facility health board is formed (members coming from communities surrounding the facility) to oversee the implementation and management of funds collected through cost sharing. The local government has been entrusted with the administration of health facilities that are below the hospital level, that is, dispensaries and health centres.

Decentralization in the study district is noted to have facilitated the efficiency of use of available resources and reduced bureaucracy in implementing activities. Decentralization has made it easier to implement a set of plans and objectives, because health managers at the district level now make decisions; they do not have to go through the bureaucracy of the MOH and at the regional level.

> In the past planning for an activity did not guarantee that you will be able to execute that activity, funds would somehow be diverted to other activities like education and there was very little you could do about it … at least now we have some assurance that we can achieve our plans (CHMT member, Bukoba rural district).

A major challenge facing the district is one that affects its reproductive health indicators, through its inability to hire qualified staff. Members of the community health teams (CHMT) complained that on paper, the local Government is the employer of health workers, however, in practice all health workers must be selected and approved centrally by the Ministry of Health. The local government and the community health teams have no power to hire or fire health workers. One of the health managers noted that the district was facing a shortage of health staff in recent years since the AIDS pandemic, but there have been few replacements so far. The district did not have a gynecologist for almost two years when this interview took place in August 2003.

One of the key questions for this research was whether health workers in a decentralized structure had more autonomy than before. In all facilities, the facility in-charge at the health centres and dispensaries stated that they did not have any decision-making about the utilization of funds collected at the facility level. They did not have the power to utilize the revenue collected from user fees and allocate it towards what they considered as priority needs for the facility. The revenue instead was sent to the district headquarters and potentially ploughed back to address facility problems. They felt discouraged by this as is captured in an interview by a heath worker from a PHC in the district:

> For us (the staff working at the facility level), this is something we are not satisfied with … it happens that when you go to submit the monthly reports sometimes they give you the drugs that you are supposed to come with, at the facility, however, all the costs from transport to accommodation falls to you. Worse still, when you step in the office nobody cares for you. We are not even supposed to decide how to use the money we collect from fees, while we are not compensated for even the fares we use to go to collect medical supplies from district headquarters (Health Worker – PHC in Bukoba district).

Although in theory decentralization is geared towards empowering health providers, the reality seems less than positive. The health staff at the health centre level felt that much of the power has been concentrated at the district level, with very little of it trickling down to the lower levels. Health workers in the four facilities visited (two dispensaries and two health centres) expressed discontent with the slow pace or in some instances utter lack of responsiveness from the health managers at the district level about routine issues, for example, affecting the acquisition and timely arrival of drugs.

> The issue of taking power to health facilities is still theoretical, how can we decide while we collect all the money to the district and in return we get nothing, we have only one delivery bed and the maternity room is so small with just a few beds, we have complained several times, but no one would listen to us (Health worker, K Health center).

> It is almost three weeks since the day I ordered for the supplementary kit, but to date no drugs have been supplied to the facility. This is a pattern and as a result we have started to face drug shortages (Health worker, L Health center).

Findings from interviews with health providers at the four selected facilities also indicate that there

is lack of clear understanding of what role they are expected to play in the reform process, especially with regard to resource allocation and priority setting. For example, the data collected through the HMIS has been used more as a procedure to prepare monthly reports for the district rather than as a tool for priority setting for the facilities. Health workers seemed to have limited information of the reform process, and some complained that they have not received any training since reforms have been introduced. As a result, there were no significant changes in the ability of health staff in organizing services based on local needs and priorities.

Generally, community representatives of the village health committees have limited information about decentralization, with very few community leaders able to identify processes and structures that would ensure community participation. Village health workers are nominated by their respective village government and receive some basic training on health service delivery from nearby health facilities. The working arrangement is on a voluntary basis, and they are only paid a small allowance when they participate in national immunization campaigns. It is the responsibility of the village health workers, who are also members of village health committees, to set health priorities based on their experience of working in the communities. The term 'community participation' is, however, understood in a limited way mostly as providing information to the community members about the decisions reached by the village government. There is no mechanism in place at the moment that can enable communities to actually participate in the management of their health care facility. Health workers are invited to village meetings when health matters are reported, but because of heavy workload health workers reported that they were often unable to attend these meetings. This contributes to poor relations between health facilities and their surrounding communities.

It is the medical attendants and MCH assistants who are inadequately trained to deliver reproductive health services that manage health facilities. It is obviously not considered a priority position since the staffing is inadequate and poor. Because of the inability of districts to recruit, the MCH coordinator, a co-opted member of the CHMT, usually assumes the responsibility.

> In many districts MCH coordinators have low levels of education, that are normally MCH assistants who have promoted to that position … now coming in with a reproductive health package one has to be more qualified than that (Stakeholder at district council).

Like in Tanzania, decentralization in Kerala has done little to enable health care workers to be empowered as agents of change. The whole point of decentralizing services is that those who are at the crux of service delivery can be a more effective part of decision-making around service delivery and local priority setting for health. Much has been written about the theoretical benefits of decentralization as a core strategy of reforms. In Kerala the model has been innovative, as resources have been devolved to the local district and village councils known as *panchayats*, with a small share of their budget earmarked to women's needs noted as women's component plan. People's planning campaign or a process of local participatory priority setting has been undertaken as a part of decentralization.

However, our research findings suggest that health care workers are not a critical part of this process and in fact the process of decentralization has done little to change their knowledge and awareness of women's reproductive health needs or change their attitudes towards a participatory client-centred approach. Decentralization in Kerala effectively can be viewed as greater access to slush funds to take care of physical improvements of the PHC as well as taking care of routine expenses of the PHC. There is no real planning at the community level to help strategize what are people's health needs, how best the primary health care system can address these and to use the limited though committed resources towards those needs.

A positive working relation between the two institutions – panchayats and PHCs – is essential for the successful implementation of decentralization. However, there is no real mandate to help strengthen the relationship between panchayats and PHCs. This did not even seem to have been a priority of the decentralization process at the

outset. In its absence, most panchayat/community members we interviewed stated that their relationship with the health care system is restricted to basic issues such as printing of information leaflets and outpatient tickets, conducting awareness and health camps, immunization, and chlorination of wells. In addition, panchayat members participate in the health campaigns but their involvement is limited. The panchayats have the flexibility to make special sanctions in terms of resources to the PHCs in case of emergencies such as cholera epidemics or floods. However, there is no overall organic process of identifying local priorities and using collective resources of panchayats and PHCs (material, financial, and human) in an optimal manner.

Medical officers are supposed to participate in planning meetings that draw up proposals for health projects and project review meetings. However, the medical officers often send junior level health care delivery staff to participate in these meetings. According to a key stakeholder and senior bureaucrat from Kerala, medical officers do not like to acknowledge the authority of the panchayats. Based on reports from the community leaders, medical officers are also reluctant to participate in village level meetings, and even when they do participate they tend not to communicate. The common perception is that the medical officers think they are 'superior' in qualification and ranks compared to panchayat members and therefore refuse to cooperate with them. At the same time, panchayat members we interviewed about this issue stated they were infact 'superior' to medical officers since 'we control' PHCs'. This perceptual clash of ego basically acts as an impediment to any effective communication, coordination, or cooperation between the government health care system and panchayats.

According to interviews with medical officers, the most important and visible change at the level of the PHC was in the infrastructure facilities of the health centres. These included improvement and construction of outpatient and in-patient buildings, operation theatres and laboratory facilities, toilets, prompt repair of water and sanitation facilities and minor repair works. Health centres have been starved of funds for a long period of time spanning almost 20 years. So, even a small addition of resources for non-salary expenditure has made a significant impact on the health care provision and through that on health. As against a centralized approach, decentralized approach has the potential to facilitate quicker disposal of funds during emergency situations and funds can reach the beneficiaries immediately.

However, the existence of positive relationships between the individuals heading the panchayats and PHCs is extremely important because the funds are controlled by the panchayats while the medical personnel have the technical know-how. Local priorities cannot optimally be addressed without complete cooperation between them. Even though medical officers are aware that the relationship between the PHC and the panchayat members determine the allocation made to the PHCs, they are still reluctant to acknowledge this operationally.

Although decentralization has a huge potential to solve health problems of the community, and some potential benefits have already been realized in terms of physical improvements, the unrealized potential seems to be large. Part of the problem lies in the process itself. For instance, health has suddenly become a 'panchayat subject' and there does not exist any clear understanding between the state government and panchayats regarding their respective domains and expertise with respect to the health sector. As a result, health has found itself in 'no man's land'. This is reflected in the decline in resource allocation to health and larger neglect of government health care system including the PHCs. Moreover, decentralization itself is partial since there are several issues that are left unresolved. Health was transferred to panchayats but the resource control of the panchayats was restricted to roughly about 10 per cent of state resources. It means that 90 per cent of resources flowing into health are out of bounds of the panchayats. This has already resulted in some duplication of efforts by state government and panchayats. Moreover, even the 10 per cent resources flowing into the panchayats carry restrictions, which ultimately limit the panchayats' role in health. Moreover, there is no technical support to the panchayats from the PHCs. Health is one sector where technical support plays a large role in

allocation of resources. The health system still follows a hierarchical structure of management, which is in direct contradiction to decentralization and the participatory management through the panchayats.

Moving towards the centre

A key finding from these studies is that there is limited capacity of districts health councils to address reproductive health priorities at the facility and community levels. The village and district council members also need training on community participatory approaches so as to be able to adequately address local community priority issues. District or local councilors are the main decision makers representing the interest of communities. In order to ensure that reproductive health issues are a priority in council meetings, councilors have to be sensitized on the importance of reproductive health issues so as to allocate adequate resources, since it is possible to neglect reproductive health in the face of other pressing health care issues. There is a need to intensify training on reproductive health and, where there is shortage, to recruit medically trained personnel.

In both settings there was limited community involvement in addressing priority health problems. Communities need to know their own rights, responsibilities, and obligations in the ongoing reform process and be equipped with skills and knowledge necessary to participate in the decentralization process. Women should be empowered in decision-making based on reproductive health needs. Deliberate efforts should be made to integrate gender empowerment at the community level that goes hand in hand with the health reforms.

A critique of a complex process like decentralization may be simpler than offering constructive solutions. What kind of decentralized health care system do we need to move power to the centre and through that to improve quality sexual reproductive health services? I look at this through a three-dimensional lens – in order to create a solid health system we need changes along all three of the dimensions. Consider these changes as those that are Critical, those that are Contextual, and those that are Comprehensive. And a decentralized health care system should strive to accomplish these changes:

Critical changes: These are changes that are essential and cannot be foregone. These would include updated and essential training of all health staff; privacy in clinics and well-managed supply of commodities and drugs; health workers who do not foster cultural biases and negative towards women and the poor; health workers are empowered in their jobs and get timely and adequate compensation. Health workers at any level of the health care system be it doctors, nurses or frontline outreach workers have a critical role to play in bringing the supply side of the health system closer to the articulated and unarticulated health needs of people that constitute the demand side of the health system. And within the demand side a need to recognize and empower the emerging agents of change, such as the panchayats or village health workers, who can play a critical roles in breaking barriers or resistance to seek health care. Such changes would enable a better feedback to the health system, greater involvement of the community, better outreach for the health centres and better surveillance and information systems.

Contextual changes These are changes that are based in on-the ground realities of why services are poor and how poor services make its people poorer. This would include that providers need to understand who is being affected by specific morbidities and why. Women who are young are increasingly adding to the HIV prevalence at a disproportionately high rate. Our research in Uganda, Kenya, and Tanzania reveals that poverty and violence is a part of these women's reality. Services and systems need to be designed to offer women comprehensive prevention technology, ability to protect themselves against coercive sex, incentives to stay in school, employment opportunities, and so on. The health system is minimally responsible for information and tools for comprehensive prevention for men and women, outreach to men especially, early testing and counseling for HIV, strategies for disclosure, and unbiased care for those affected. Decentralization is only an aspect of the changes that need to be brought about. It is necessary but not sufficient. What decentralization can enable is a better understand

of the contextual factors that put young girls more at risk to HIV, or why men reluctant to use condoms or women more likely to deliver at home despite seeking formal prenatal care.

Comprehensive: These changes are those that do not de-link proximate determinants of health but view health services within the composite set of factors that determinant ill health. This would imply recognition that poverty is a root cause of ill health and a poor health care system contributes to greater poverty. Decentralization can enable and build upon these changes by giving power and voice to those who are poor and most affected by poor health care systems.

We do not need necessarily another international call for action nor a time bound and discrete measurable goal but a fundamental understanding and commitment to reduce social and gender inequities in health care through these changes. Working upwards from a model of critical, contextual, and comprehensive changes, reforms would look totally different even if the mechanisms were similar such as decentralization of health care resources or reorganization of different departments of health care. Rights would become an essential aspect of health care reforms. Gender equity would not have to be integrated into an existing health care system. Rather a health care system would have to be reformed or 'mainstreamed' into a framework of rights and equity, including gender equity and SRHR. Lest these are viewed as rhetorical ideas, we know that many successful efforts in primary health care, participatory models of advocacy such as the treatment access movement, have been made in the past and ideas such as these emerge from those experiences.

Notes

1 The author is the Director of Research at The Center for Health and Gender Equity (CHANGE), Takoma Park, MD, 20912. CHANGE is a donor accountability organization that seeks to ensure that US international policies and programs promote sexual and reproductive rights and health through effective, evidence-based approaches to prevention and treatment of critical reproductive and sexual health concerns, and through increased funding for critical programs.
2 She argues that MDGs should be premised on health systems that are conceptualized as core social institutions that help define the experience of poverty and citizenship (Freedman, 2005).
3 Nanda, P. Forthcoming, 2006.
4 The Center for Health and Gender Equity has recently concluded a multi-dimensional research project set in India and Tanzania on the implications of health sector reforms for reproductive health and rights from 2002–2004. The author was the Principle Investigator of the research project that included three sites – Kerala and Tamil Nadu in India and Tanzania. These analysis data presented here is from two of the three studies, conducted in Kerala and Tanzania. These studies were conducted in collaboration with Achuta Menon Center for Health Sciences and Sakhi in Kerala, India and National Institute of Medical Research and University of Dar es Salaam in Tanzania. The author would like to acknowledge the study partners and coauthors. Dr. D.V. Varathrajan, Dr. Mala Ramanathan, Ms. Aleyamma Vijayan and Dr. R. Sukanya from Kerala; and Emanuel Makundi and Joyee Nyoni from Tanzania. For detailed country analysis from these studies please download the reports from www.genderhealth.org.

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