Task Force 6
Accelerating SDGs: Exploring New Pathways to the 2030 Agenda

USING THE PARTICIPATORY LEARNING AND ACTION APPROACH TO IMPROVE COMMUNITY ENGAGEMENT: LEARNINGS FROM INDIA

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Hemang Shah, Director, Children's Investment Fund Foundation
Shachi Adyanthaya, Portfolio Manager, Children's Investment Fund Foundation
Raj Kumar Gope, Team Lead, Ekjut, India
Amit Kumar, Program Coordinator, Ekjut, India

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Abstract

Over one million women and 3.5 million newborn infants could be saved if the targets of goal 3 of the Sustainable Development Goals (SDGs) are met by 2030. But 42 of 181 countries remain off track to achieving SDG-3. There is evidence to support effective community-based health interventions in achieving this target. Participatory learning and action (PLA), as an evidence-based approach, has the potential to reduce the incidence of death among newborns and mothers. Its efficacy and cost effectiveness are already well established. Recent evidence of PLA scaled up by public health systems makes a compelling case for its integration within national programmes in India and beyond. For the success of large government programmes, community engagement is essential, for which the PLA approach offers a unique operational framework. The impact on the global policy formulations by G20 nations can play a key role in scaling up this community-led approach.

The Challenge

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Over one million women and 3.5 million newborn infants' deaths could be averted if the Sustainable Development Goals (SDGs) are met by 2030. Presently, 42 of 181 countries are not on track to meet the SDG targets for maternal and child survival. There is evidence to suggest that these targets could be met through effective community-based health interventions.[1] The World Health Organization (WHO) defines a health system as "all the activities whose primary purpose is to promote, restore or maintain health". Community engagement aimed at improving health should be a part of the health system. However, the WHO framework comprising six "building blocks" of health systems—service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance—does not include community participation. Community participation and mobilisation can be advantageous for demand generation and increased accountability in the health sector and should, therefore, be a key focus area of health systems.

Community engagement through Participatory Learning and Action (PLA) meetings reduced neonatal mortality by 24 percent and 26 percent amongst the most marginalised communities in Jharkhand, a state in eastern India.[2] This initiative was led by the Indian government's health department and the meetings were facilitated by frontline workers called Accredited Social Health Activists (ASHA).

PLA as an intervention to improve community engagement has been evaluated through a series of scientific studies which have shown that a health system can be strengthened through community participation, ultimately improving demand and accountability. The approach has potential to be scaled further and can effectively address the challenges faced in improving maternal and infant survival rates.

Newborn mortality in India

While India's average neonatal mortality rate (NMR) has declined from 29.5 to 24.9 between the National Family Health Survey 4 and 5 (one newborn death for every 1,000 live births within the first 28 days of life), it remains high nationally and in several Indian states.[3] Despite average NMR reductions, Uttar Pradesh

has the greatest number of neonatal deaths per 1,000 births at 35.7, followed by Bihar (34.5), Chhattisgarh (32.4) and Uttarakhand (32.4).[4] A study by The Lancet from 2020 reveals that India has achieved progress in child survival, although there are significant differences in the amount and rate of reduction in mortality between states, and even greater differences between Indian districts.[5]

In rural India, there are considerable pockets of deprivation in terms of demography, levels of poverty, presence of tribal and other marginalised populations. Such groups are particularly vulnerable to high mortality and morbidity because of their difficult geographical locations and lack of access to health services, among several others causes. A recent study from Jharkhand, covering a sample of 48,589 births, reports an NMR of 39, which is much higher than the national and state average.[6] A sub sample study with 1024 cases of mothers belonging to Particularly Vulnerable Tribal Groups shows that the NMR in this population is much higher at 59/1000 live births.[7]

Despite significant progress, the massive disparities that continue within and between districts, states and nations highlight the urgent need to refocus on equity. The improvements in mortality and morbidity rates and other health indicators have been slow and at this rate, NMRs 12 or below will not be achieved. There is also a need to collect real-time data to track the progress of key mortality indicators through improved measurement and monitoring.[8]

The WHO has routinely encouraged community participation in health development, maintaining that "Community involvement in health development is central to WHO's strategy for health for all and needs to be considered by all health professionals and administrators in devising programmes for health promotion."[9] Consequently, community participation in health as a strategy is now well known. However, its implementation on the ground needs further investigation and contexualisation.[10]

The PLA approach

The WHO's individuals, families, and communities' framework, aiming to improve maternal and newborn health, outlines that maternal newborn health

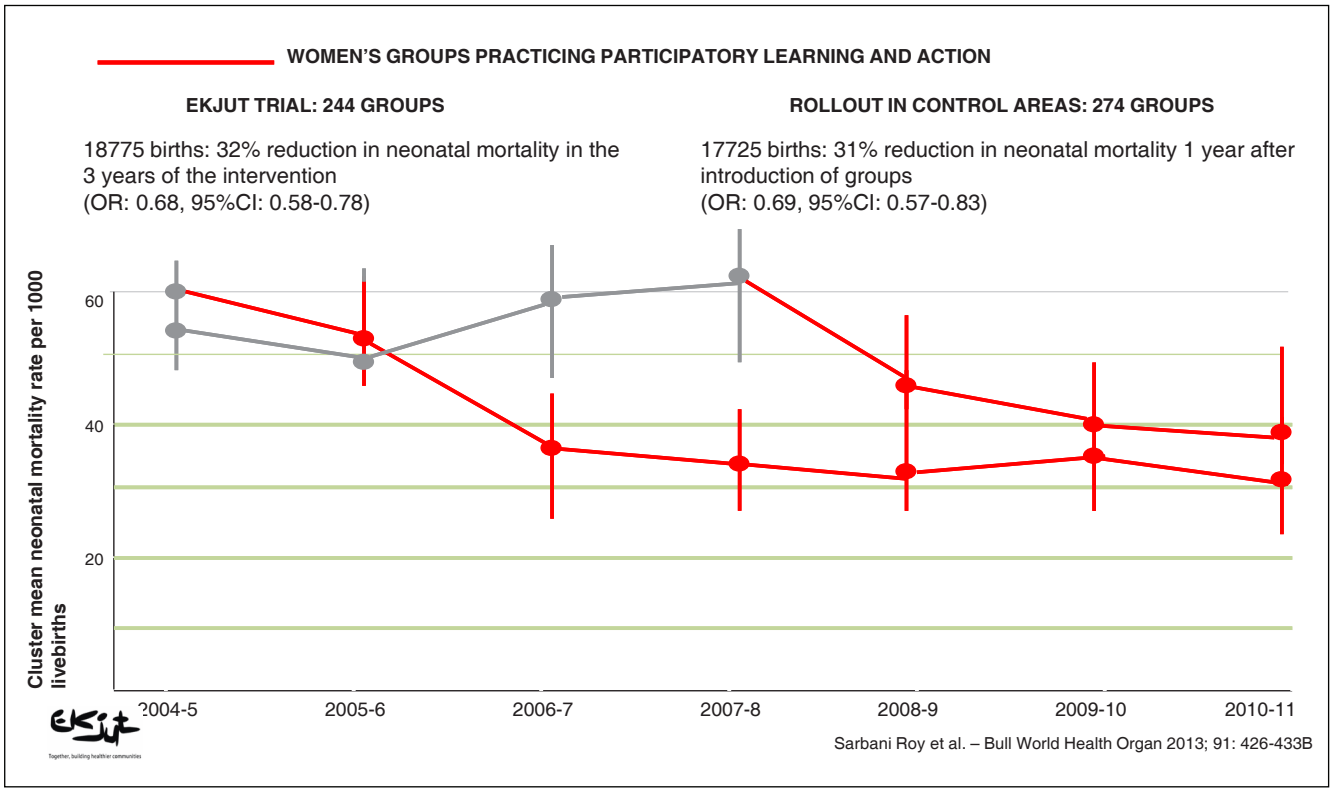
strategies need to improve the capacity of individuals, families, and communities to provide appropriate care to pregnant women, mothers, and newborns at home. It also addresses the reasons, despite clinical services provided, as to why women have challenges accessing good quality, skilled care during pregnancy, childbirth, and the postnatal period. Most importantly, the framework recommends community and intersectoral participation.[11] Community engagement is one of the key strategies emphasised under India's National Health Mission (NHM). Various platforms have been created to enable the active participation of the community and its representatives, especially the elected representatives of Panchayati Raj institutions[a] and urban local bodies. Their participation boosts the role they play in health promotion and action, particularly with regard to the social determinants of health.[12]

Unfortunately, there has been a paucity of evidence-based models that demonstrate the impact of effective community engagement on NMR. The PLA process is an exception and has been proven to successfully reduce NMR equitably and sustainably while being replicable and cost-effective. For these reasons, the PLA approach has been scaled up by the state government of Jharkhand and some other states in India.

PLA is a unique approach that builds the capacity of communities and enables them to work together to visualise health problems and prioritise them. They, then, collectively strategise, implement actions, and evaluate outcomes at a local level. The effectiveness and efficacy of the PLA approach has been established through different studies. From 2005 to 2008, a cluster-randomised controlled trial showed that PLA reduced neonatal mortality by 45 percent in 200 villages of Jharkhand and Odisha (see Figure 1-See ref 13). There was also a 57 percent reduction in moderate depression among mothers (see Figure 1).[13] The impact was also found to be equitable and the reduction in neonatal mortality was 71 percent among the most marginalised groups.[14] Between 2008 and2011, the replication of intervention using the PLA approach also resulted in the reduction of neonatal mortality by 31 percent in 200 additional

a These are local self-governance institutions in India mandated by Indian constitution.

Figure 1: Sustainability and Replicability of Participatory Learning and Action



Source: Roy et.al.[16]

villages and hamlets (see Figure 1).[15]

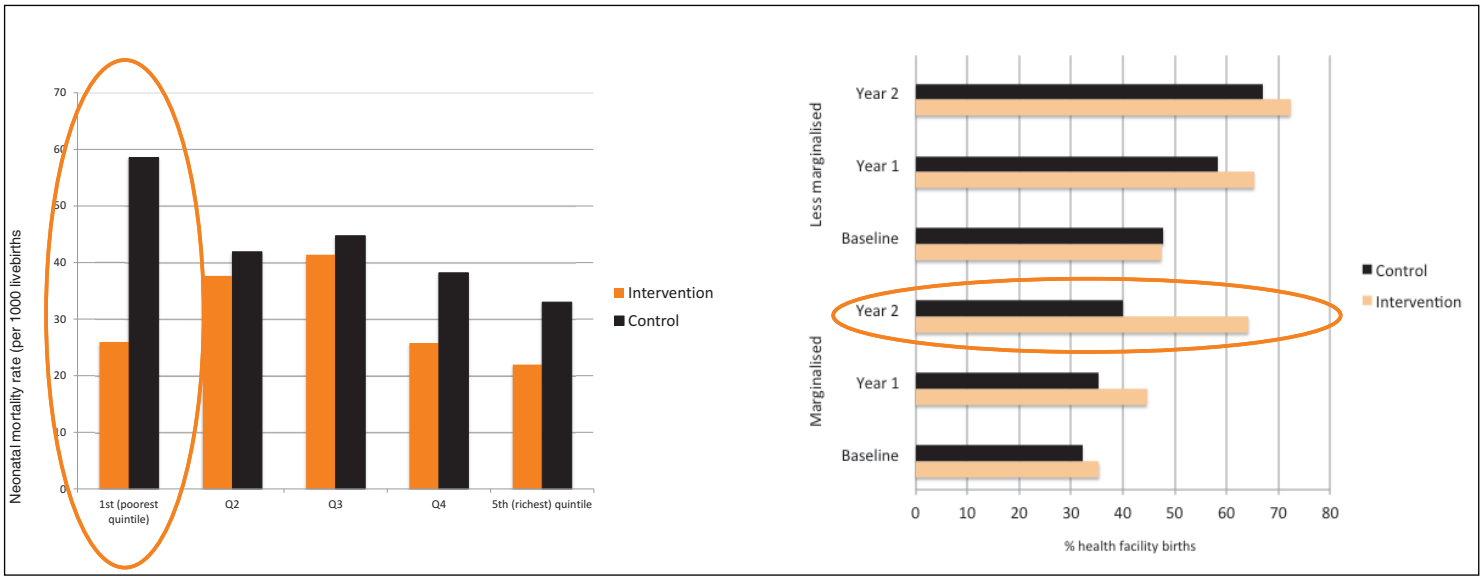
PLA intervention through ASHAs

ASHAs are frontline healthcare workers who are residents of the same villages where they work and are incentivised for their services. ASHAs are driven by values like independence, self-empowerment, community service, social recognition, feedback, and accountability.[17] Many ASHAs in Jharkhand, who have been facilitating PLA meetings, have shared their stories about how these meetings have helped them gain confidence and social recognition and improved their ability to connect with their communities. Over 800,000 ASHAs are employed in India and one of their key roles is mobilising community support for good health and well-being.

PLA meetings can be scaled up easily through trained facilitators and community mobilisers like ASHAs. In addition to the studies discussed above, there are two more studies indicative of

the effectiveness of the PLA approach. From 2009 to 2011 (JOHAR trial), in 179 villages in five districts of Jharkhand and Odisha, ASHAs were trained on PLA methods, They facilitated structured meetings which resulted in the reduction of neonatal mortality by 32 percent, with the most marginalised benefitting the most.[18] The impact in the poorest quintile was significantly higher than the overall impact and health facility births increased significantly among the marginalised sections of the study area (see Figure2). Following WHO's recommendation (the PLA process was recommended by the WHO in 2014)[19] and guidelines issued by the Indian government on the PLA, community meetings were scaled up statewide by the NHM, Jharkhand. This was evaluated in six districts (three early interventions and three delayed districts selected by NHM) and showed a 24 percent reduction in neonatal mortality

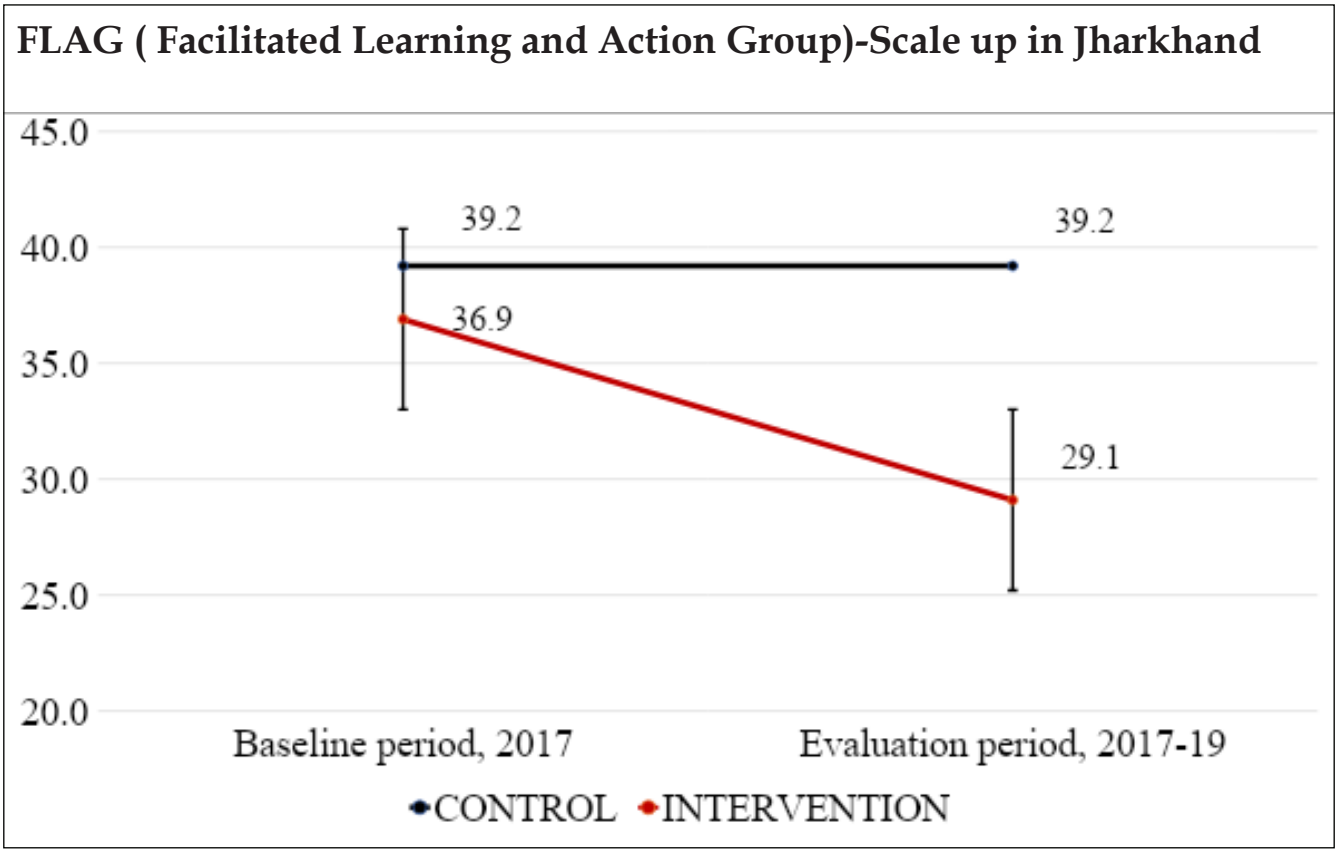
Figure 2: Equity Impact of Participatory Learning and Action



Source: Tripathy et al.[20]

Note: The JOHAR trial (2009-11) reported a 61 percent reduction in NMR among the poorest wealth quintile (left) and an increase in the proportion of institutional births (right).

Figure 3: Facilitated Learning and Action Groups scaled through National Health Mission, Jharkhand (2017-19)



Source: Nair et al.[21]

rate (see Figure3).

At the baseline, NMR were 36.9 per 1000 live births in the intervention arm and 39.2 in the delayed arm. Over 24 months of intervention, the NMR was 29.1 in the early arm and 39.2 in the delayed arm, corresponding to a 24 percent reduction in neonatal mortality including 26 percent among the most deprived.

There were specific challenges faced by the ASHAs while implementing PLA vis-à-vis capacitating a large workforce of ASHAs without compromising on the quality of training and provision of support in the field. This was resolved through innovative approaches like "on job trainings" (OJT) by ASHA facilitators (cluster leader of 15-20 ASHAs). ASHA facilitators received intensive training to become master trainers and they in turn trained other ASHAs in their

clusters, on the job, while conducting PLA meetings in their villages. Using the OJT approach, the task of training around 40,000 ASHAs from 32,000 villages of Jharkhand became time and cost-effective by reducing the training person-days by 90 percent. They additionally saved on training costs and increased the speed of the PLA roll out. Thus, community-based workers like ASHAs were successful in facilitating monthly PLA meetings in

The G20's Role

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their catchment areas.

The G20 can weigh the benefits of the PLA and recommend it for government programmes on health for equitable outcomes. The G20 can play a significant role in addressing neonatal mortality through the PLA approach by:

1. Investing in PLA initiatives that support community engagement and empowerment, leading to improved recognition and resolution of health and nutrition challenges, hence reducing neonatal mortality. PLA initiatives would inform people about best practises and the significance of accessing appropriate healthcare during the pregnancy, birth, and postnatal period.

2. Collaborating with local authorities and organisations to create a community-based healthcare infrastructure that meets the needs of expectant mothers, new parents, and families. To provide mothers and families with essential support and guidance, this could entail educating medical professionals and midwives.

3. Supporting research and ideas that may result in the creation of new knowledge and technology-based interventions that are accessible, useful, and capable of lowering neonatal death rates. These technologies can make it easier for mothers and newborns to get essential treatment, improving health outcomes.

4. Supporting cross-country partnerships and collaborations that can enable learning and sharing of knowledge, expertise, and solutions to improve maternal and newborn care. The G20 can also advocate for increased funding and resources for healthcare. Promoting international policies that prioritise investments in maternal and newborn health could go a long way in making positive change.

5. Engaging with civil society organisations, local communities, and other stakeholder groups on the PLA approach which can address systemic concerns that affect marginalised and vulnerable people in policies and programmes linked to maternal and neonatal health. Stakeholder engagement in PLA programmes will help tackle the underlying and immediate causes of neonatal

deaths at local level.

Overall, by investing, promoting, and supporting participatory community interventions through policy level integration, fostering cross-country collaborations and innovations, and promoting education and community engagement at local levels, the G20 can support the attainment of the UN's SDG of reducing neonatal mortality to 12 or

Recommendations to the G20

3

below by 2030.

Because of their impact on the world economy, the G20 nations can jointly address basic health challenges like unacceptably high neonatal mortality rates in low- and middle-income countries (LMICs) across the globe. Collaboration between players in various disciplines is undeniably paramount in the effort to improve global health outcomes and achieve the SDGs by 2030.

The PLA approach is an evidence-based process of engaging with communities that promotes active community participation in identifying, prioritising, and addressing health and other intractable issues in a sustained manner. PLA empowers communities and allows them to initiate feasible strategies for better health outcomes.

Monthly PLA meetings with women's groups, facilitated by frontline workers like ASHAs, has the potential to improve neonatal survival significantly at scale, while also reducing health inequities in high mortality settings.

A large, pragmatic effectiveness trial conducted in Jharkhand found that ASHAs practicing the PLA approach reduced neonatal mortality by 24 percent, with an even greater impact on the most marginalised. It was also found to be highly cost-effective, with an estimated 11803 new-born lives saved over 42 months at a cost of US$ 41 per life year saved.[22] A meta-analysis that included seven cross-country studies also found equitable impact on neonatal mortality.[23] This process was globally recommended by WHO in 2014.

The PLA approach allows communities to become active agents of change in identifying and addressing their health and nutrition-related concerns. It nurtures a sense of ownership, responsibility, and accountability in community members and frontline workers, leading to increased engagement and participation. This involvement helps improve nutrition and health outcomes. The process also increases the agency of women and builds their problem-solving capabilities. PLA meetings act as platforms that allow the community to come together to identify and implement locally appropriate, sustainable solutions that pertain to their identified health and nutrition needs. At the same time, they can better their

socio-cultural and economic contexts through improved practices related to home care and early identification of problems, while demanding access to healthcare services. PLA meetings help to promote equity and inclusion by providing a space for vulnerable and marginalised groups to express their concerns and needs. These meetings also allow them to participate in decision-making processes that affect their health and well-being.

Data collected over a decade makes a compelling case for the PLA approach's integration within national programmes in India and other countries.

Similarly, community based frontline health workers in various LMICs can implement the PLA approach to reduce the prevalence of neonatal mortality.

Policy recommendation

- Finding an equitable solution to the high burden of neonatal mortality must be an urgent priority for all nations. The G20 could add the PLA approach to reduce neonatal mortality in LMICs to its agenda. A formalised commitment would be helpful in constructing roadmaps for LMICs.
- The individual governments of the G20 member states could incorporate this participatory and sustained evidence-based approach into their national health plans and policies. This could be demonstrated by the national level allocation of sufficient resources and funding that could cover the cost of frontline workers' honoraria and incentives, training, documentation and printing costs, and other relevant costs. These actions can provide sustainability to the intervention.
- For real-time monitoring, IT-based platforms can be included in national surveillance frameworks. For the same, resources and financial allowances will need to be set up. Real-time monitoring is helpful in tracking progress and allows for course corrections and data backed decision-making.
- Plans and roadmaps for the program's phase-wise roll out could be provided through a close coordination with global health organisations, development partners, civil society, and academia with an experience of implementing PLA initiatives.
- Collaborations with stakeholders at international, national, and local

levels could foster cross-learning and an effective partnership ecosystem. It could also facilitate a prompt roll-out of the PLA approach and enable progress monitoring at multiple levels.

Attribution: Hemang Shah et al., "Using the Participatory Learning and Action Approach to Improve Community Engagement: Learnings from India," *T20 Policy Brief*, July 2023.

Endnotes

1 John W McArthur, Krista Rasmussen, and Gavin Yamey, "How many lives are at stake? Assessing 2030 sustainable development goal trajectories for maternal and child health," *BMJ,* 360, 2018, https://doi.org/10.1136/bmj.k373

2 Nirmala Nair et al., "Effectiveness of Participatory Women's Groups Scaled up by the Public Health System to Improve Birth Outcomes in Jharkhand, Eastern India: A Pragmatic Cluster Non-Randomised Controlled Trial," *BMJ Global Health* 6, no. 11 (November 1, 2021), https://doi.org/10.1136/bmjgh-2021-005066

3 Ministry of Health and Family Welfare, Government of India, *National Family Health Survey (NFHS-4) 2015-16*, 2016, http://rchiips.org/nfhs/pdf/NFHS4/India.pdf

4 Ministry of Health and Family Welfare, Government of India, *National Family Health Survey -5 (2019-20) India Fact Sheet*, 2021, http://rchiips.org/nfhs/NFHS-5_FCTS/India.pdf

5 Rakhi Dandona et al., "Subnational Mapping of Under-5 and Neonatal Mortality Trends in India: The Global Burden of Disease Study 2000–17," *The Lancet* 395, no. 10237 (May 23, 2020): 1640–58, https://doi.org/10.1016/s0140-6736(20)30471-2

6 Nair et al., "Effectiveness of Participatory Women's Groups"

7 Sophie L.P. Busch et al., "Socioeconomic Inequalities in Stillbirth and Neonatal Mortality Rates: Evidence on Particularly Vulnerable Tribal Groups in Eastern India," *International Journal for Equity in Health* 21, no. 1 (May 6, 2022), https://doi.org/10.1186/s12939-022-01655-y

8 Ann-Beth Moller et al., "Monitoring Maternal and Newborn Health Outcomes Globally: A Brief History of Key Events and Initiatives." *Tropical Medicine & International Health* 24, no. 12 (December 1, 2019): 1342–68. https://doi.org/10.1111/tmi.13313

9 Peter Oakley, *Community involvement in health development An examination of the critical issues,* Geneva, World Health Organisation, 1989, https://apps.who.int/iris/bitstream/handle/10665/39856/9241561262.pdf

10 Busch et al., "Socioeconomic Inequalities in Stillbirth and Neonatal Mortality Rates"

11 World Health Organization, *WHO Recommendations on Health Promotion*

Interventions for Maternal and Newborn Health, Geneva, WHO, 2015, https://www.ncbi.nlm.nih.gov/books/NBK304991/#ch3.s43

12 "Community Processes- Community Platforms," National Health Systems Resource Centre, last accessed 2023, https://nhsrcindia.org/practice-areas/cpc-phc/community-processes-community-platforms

13 Prasanta Tripathy et al., "Effect of a Participatory Intervention with Women's Groups on Birth Outcomes and Maternal Depression in Jharkhand and Orissa, India: A Cluster-Randomised Controlled Trial," *The Lancet* 375, no. 9721 (April 3, 2010): 1182–92, https://doi.org/10.1016/s0140-6736(09)62042-0

14 Tanja AJ Houweling et al., "The Equity Impact of Participatory Women's Groups to Reduce Neonatal Mortality in India: Secondary Analysis of a Cluster-Randomised Trial," *International Journal of Epidemiology* 42, no. 2 (April 1, 2013): 520–32, https://doi.org/10.1093/ije/dyt012

15 Swati Sarbani Roy et al., "Improved Neonatal Survival after Participatory Learning and Action with Women's Groups: A Prospective Study in Rural Eastern India," Bulletin of the World Health Organization 91, no. 6 (June 1, 2013): 426-433B, https://doi.org/10.2471/blt.12.105171

16 Roy et al., "Improved Neonatal Survival"

17 Syed Shabab Wahid, Wolfgang Munar, Sharmila Das, Mahima Gupta, and Gary L. Darmstadt, "'Our Village Is Dependent on Us. That's Why We Can't Leave Our Work'. Characterizing Mechanisms of Motivation to Perform among Accredited Social Health Activists (ASHA) in Bihar," *Health Policy and Planning*, (October 31, 2019), https://doi.org/10.1093/heapol/czz131

18 Tripathy et al., "Effect of Participatory Women's Groups"

19 World Health Organisation, *WHO Recommendation on Community Mobilization through Facilitated Participatory Learning and Action Cycles with Women's Groups for Maternal and Newborn Health*, Geneva, WHO, 2014, https://apps.who.int/iris/handle/10665/127939

20 Tripathy et al., "Effect of Participatory Women's Groups"

21 Nair et al., "Effectiveness of Participatory Women's Groups"

22 Tripathy et al., “Effect of Participatory Women’s Groups”

23 Audrey Prost et al., “Women’s Groups Practising Participatory Learning and Action to Improve Maternal and Newborn Health in Low-Resource Settings: A Systematic Review and Meta-Analysis,” *The Lancet* 381, no. 9879 (May 18, 2013): 1736–46, https://doi.org/10.1016/s0140-6736(13)60685-6

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