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COMMUNITY PARTICIPATION IN HEALTH: THE NATIONAL LANDSCAPE¹

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TECHNICAL PAPER

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INTRODUCTION

In India, strengthening the institutions of democracy has remained a challenge. For this task, the involvement of people in the health system is influenced by a number of macro level factors. Prominent among these factors are the following:

- India, similar to a number of countries attaining independence after the Second World War, adopted the colonial state apparatus and much of its legal framework. Moreover, governments dominated by the western educated elite meant that the state/system's outlook towards people remained as in colonial times i.e., one of sympathy and paternalism. [Isaac and Frenk 2001; Hasan 2000].
- A series of social and economic crises in the immediate post-colonial period were a strong stimulus for centralization [Isaac and Frenk 2001; Hasan 2000].
- Political parties in the present scenario give more importance to staying in power than bringing about development. This leads to more and more patron-client relationships and decisions based on populism, rather than a deepening of democracy [Hasan 2000]. The fact that the influence of the political parties' power negotiations is reflected at all levels of governance, including at the *Panchayat* level, and interferes constantly in bureaucratic decision making means that direct people's participation and a deepening, deliberative type of democracy in spirit or practice is impossible.
- The upper caste class identities of those who get to medical school and occupy decision making positions and powers in the system, are in contrast to the majority of the people, leading to a relationship of paternalism or looking down on the 'ignorant people'. [Banerji 1985].
- Given the amount of rent seeking in which a ruling party is able to indulge, motivation for implementing programmes that will genuinely empower people gets lost. This is true not only for politicians, but also for bureaucrats and implementers in the line departments. The primary motivation seems to be following the diktats of superiors. [Das Gupta et al 2003].
- The community itself is deeply divided along lines of caste, class and religion, and in many places these have only deepened over the years. This breakdown of village communities, and simultaneous reinforcement of caste and religious identities by political parties, means that a feeling of community rarely exists.
- The practice of medicine and public health has also become more techno-managerial, with increasingly less importance being given to the involvement of people.

Increasingly people have come to be seen merely as consumers of health care interventions rather than as co-producers of health.

In their review of development and participation in India, Dreze and Sen note that, “The main limitations of Indian democracy do not, however, relate so much to democratic institutions (or democratic ideals) as to democratic practice. The performance of democratic institutions is contingent on a wide range of social conditions, from educational levels and political traditions to the nature of social inequalities and popular organizations” [Dreze and Sen 2005:350].

It is in this broader context that the ability of communities/civil society to meaningfully participate in the health system must be seen. To study the current community involvement this paper will follow the framework evolved during the discussions of the subgroup on Civil Society Involvement of the High Level Expert Group constituted by the Planning Commission of India.

While communities need to get involved in health systems at all levels and in all activities, experience over the past decades shows this has been done in the following six broad areas. We will be using these areas to structure the subsequent sections of the paper.

- **Community Health Workers:** Community members, after getting short-term training, provide a range of services including curative, preventive and promotive interventions. They are expected to act like bridges between the health system and the community.
- **Creation of models and other management inputs:** Communities have been involved in the health system through a number of civil society initiatives especially through NGOs. In these instances, the NGOs either put forth models providing a range of services, or the government contracts out various services that the NGOs provide on its behalf.
- **Community Health Insurance:** This includes a number of community based financial initiatives that have tried to improve access to, and ownership of the health system by prepayment mechanisms.
- **Community Monitoring:** This includes various examples of communities actually getting involved in monitoring activities and holding the health system accountable. Such monitoring may focus on availability of services, accessibility of services, quality and equity.

- Community Planning: Initiatives where communities are involved in the actual articulation and evolution of village level health plans.
- Inter-sectoral Convergence: While inter-sectoral convergence is recognized as a crucial aspect of the comprehensive Primary Health Centre (PHC) approach and essential for the success of any universal health care system, the exact mechanisms and structures need to be evolved based on complex local realities. While departmental differences may remain a factor for service providers and bureaucrats, for the people at the village level convergence is the rule. There is thus great potential both for non-health work benefitting the overall health of the community, and also for communities to recognize the importance of inter-sectoral activity and take the lead in making it happen.

Civil society groups see community involvement as a fundamental right, and civil society action/ interventions as means to facilitate the realization by the people of that right. The government, however, envisions participation merely as a form of extension services providing minimal contribution to a sanctioned programme. Thus, while the discourse on participation among civil society groups usually invokes the concept of rights, the discourse in the corridors of power is most likely to be around the concept of 'efficiency'.

Although initial innovations were carried out by the NGO sector in small geographical areas, over time, attempts were made to implement many of these at the state level, usually by state governments. In 2005, the central government rolled out the National Rural Health Mission (NRHM) on a national scale, including components such as the Associated Social Health Activist (ASHA) and other aspects of community involvement. [Ministry of Health and Family Welfare, 2005].

The following sections of the paper will review the various experiences of participation in India under the headings of the framework described above. First there is a scan of the policy scenario in the country followed by discussions on the individual topics.

PREVAILING POLICY FRAMEWORKS

National and provincial level policies and laws of the land, which pertain to the participation of communities in delivery, accountability and increased convergence of health care and related services.

	Relevant policy(ies)	Level ² and type ³ of policy	Salient points of policy
Patient Rights and Entitlements	United Nations Declaration of Human Rights Source: United Nations, (1948). '§ Article 25, Universal Declaration of Human Rights'.	International Level International Agreements	India is a signatory to this Declaration “Everyone has a right to a standard of living adequate for health and well-being of himself and of his family including food, clothing, housing and medical care and necessary social services”
	International Covenant on Economic, Social and Cultural Rights Source: United Nations, (1961). "§ 12, International Covenant on Economic, Social and Cultural Rights'	International Level International Covenants	India is a signatory to this International Covenant “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

² National or State

³ Act, Policy or Programme guideline

	Relevant policy(ies)	Level ² and type ³ of policy	Salient points of policy
	<p>Right to Life</p> <p>Source: Government of India, (1950). '§ 21, Constitution of India</p>	<p>National Level</p> <p>Act - Fundamental Right</p>	<p>Right to Life - “No person shall be deprived of his life or personal liberty except according to procedure established by law.”</p> <p>Various Supreme Court judgements have positioned Right to Health and Health Care under this fundamental Right</p>
	<p>Assam Public Health Act.</p> <p>Source: Ministry of Health and Family Welfare, Government of Assam, (2010). 'Assam Public Health Act'.</p>	<p>State Level</p> <p>Act of the Assembly</p>	<p>Recognizes the Right to Health as an inclusive right extending to socio-economic, cultural and environmental rights</p> <p>Shall make budgetary provisions for the realization of the Right to Health and avoid denial of right to healthcare services</p> <p>Defines collective and individual rights in relation to Health like right to appropriate health care, emergency health care, rational drugs, standard treatment and so on.</p> <p>Right to access medical records and data, voluntary informed consent.</p>
	<p>Draft National Public Health Bill</p> <p>Source: Department of Health and Family Welfare, Government of India (2009). 'National Health Bill'.</p>	<p>National Level</p> <p>Draft Bill</p>	<p>Recognizes the following Rights - Right to access, use and enjoy appropriate health care, food and nutrition, water, sanitation, housing, dignity, information, participation and Right to Justice</p> <p>Right to Health Care – Survival integrity and security, right to seek, right to receive, right to emergency treatment, right against coercion in family planning, right to rational health care and right to choice of treatment either in Allopathy or Ayurveda or any other recognized system of medicine.</p>

	Relevant policy(ies)	Level ² and type ³ of policy	Salient points of policy
	<p>Recommendations of the National Human Rights Commission.</p> <p>Source: National Human Rights Commission, Government of India, (2004).</p> <p>'Recommendations of the National Human Rights Commission, Southern Regional Hearing on Right to Health Care held on 29th August 2004 at Chennai'</p>	<p>National Level Recommendations</p>	<p>Right of Health Personnel to treat in a non-threatening environment.</p> <p>State and National Health Budgets shall be increased.</p> <p>Citizen's Charter shall be displayed prominently at PHCs</p> <p>The distribution and physical accessibility of PHCs shall be ensured. The PHCs shall provide good quality services during prescribed timings, indicators for the same need to be developed</p> <p>Staff vacancies shall be filled up immediately and adequate provision of medicines, equipment and consumables shall be ensured</p> <p>Urban poor must not only have access to family planning services but also to primary health care services</p> <p>Coercive, targeted approaches to family planning shall not be used.</p> <p>Rational Drug Policy, essential drug lists, standard treatment guidelines shall be adopted both in private and public facilities</p> <p>Treatment for mental illness shall be available in a decentralized manner</p>

	Relevant policy(ies)	Level ² and type ³ of policy	Salient points of policy
	<p>PHC Charter for Citizens, Karnataka</p> <p>Source: Department of Planning, Directorate of Health and Family welfare, Government of Karnataka (2002). 'PHC Charter for Citizen'</p>	<p>State Level</p> <p>Charter</p>	<p>Promise of priority and impartial care to severely ill patients, women, children and elderly citizens</p> <p>Provide medicines free of cost on doctor's advice</p> <p>No user charges other than the prescribed fees which shall be displayed prominently at the facility and receipt shall be duly provided for any fees collected</p> <p>Particular days in the week fixed for immunization and ante-natal care services</p> <p>A complaints box for the registration of complaints shall be provided and due action shall be taken</p> <p>In addition to the above, citizens have a duty to keep the facility premises clean and also not to bribe the facility workers.</p>
Community Health Worker	<p>Accredited Social Health Activist (ASHA) under National Rural Health Mission</p> <p>Source: Ministry of Health and Family Welfare, National Rural Health Mission, 2005. 'National Rural Health Mission – Mission Document'</p>	<p>National and State Level</p> <p>A National Mission</p>	<p>A community health activist provided for every village. A woman from the same village selected</p> <p>Bridge between Public Health system and the community. Accountable to the Panchayat.</p> <p>Referral and escort services, construction of household toilets</p> <p>Trained in pedagogy of public health</p> <p>Receives performance based incentives</p> <p>Secretary to the Village Health and Sanitation Committee and supports the preparation of village health plans</p>

	Relevant policy(ies)	Level ² and type ³ of policy	Salient points of policy
NGO Service Delivery	<p>Mother NGO, Field NGO</p> <p>Source: NGO Division, Department of Family Welfare, Ministry of Health and Family Welfare, Government of India, (2003). 'Guidelines for Department of Family Welfare supported schemes', http://mohfw.nic.in/NGO%20Guidelinesfinal%20Oct.03.pdf</p>	<p>National & State level</p> <p>Programme Guideline</p>	<p>Addressing the gaps in information of Reproductive and Child Health (RCH) services in the project area</p> <p>Building Strong institutional capacity at the state/district /field level</p> <p>Advocacy and awareness generation</p>
	<p>Service NGO Scheme</p> <p>Source: NGO Division, Department of Family Welfare, Ministry of Health and Family Welfare, Government of India, (2003). 'Guidelines for Department of Family Welfare supported schemes', http://mohfw.nic.in/NGO%20Guidelinesfinal%20Oct.03.pdf</p>	<p>National & State level</p> <p>Programme Guideline</p>	<p>Provide clinical services in the RCH sector complementary to the Public Health services in un-served and under served areas</p>
	<p>Management of Primary Health Centres by Non-Governmental Organizations</p> <p>Sources: Draft report on recommendation of task force on public private partnership for the 11th plan, 2009; Government of Odisha, National Rural Health Mission, 'A Conceptual Framework for Management of PHC,' (2007). Government Order (G.O. No. H&FW 106/95, Bangalore dated 11-3-1996) for Karnataka</p>	<p>State Level (including Karnataka, Arunachal Pradesh, Odisha, Gujarat, Madhya Pradesh).</p> <p>Government Orders</p>	<p>Running of the PHCs by the NGOs.</p> <p>Infrastructure by the government</p> <p>Money transferred to the NGOs by the government (either 75% or 90%) and the rest of the money to be raised by the NGO</p> <p>Management and service delivery by the NGO. Staff either recruited by the NGO or by government staff with mutual consent</p>
	<p>NACO–CBO/NGO</p>	<p>National and</p>	<p>Promote better governance and service delivery</p>

	Relevant policy(ies)	Level ² and type ³ of policy	Salient points of policy
	Source: National AIDS Control Organization, (2007). 'NGO/CBO Organizational Guidelines'.	State level Operational Guidelines	Behaviour Change Communication To increase STI/HIV/AIDS awareness Promote condom usage Running of Integrated Counselling and Testing Centres (ICTC) Targeted Interventions
Community Financing	No policies found as yet.		
Community monitoring and accountability	Community Monitoring and Planning under National Rural Health Mission Source: Department of Health and Family Welfare, Government of India, (2005). 'Framework for Implementation of National Rural Health Mission'	National Level Government Order – Framework Document	Involve local communities in assessing progress on the health action plans against agreed benchmarks. Public participation in monitoring shall be mediated through representatives of community based organizations Monitoring shall be from the village level up to the state level through appropriate institutional mechanisms like Village Health and Sanitation Committees, PHC Health Monitoring and Planning committees and so on. The monitoring system shall be directly linked to corrective decision making bodies at the appropriate levels. .Appropriate monitoring will change communities from passive beneficiaries to active participants Communities shall monitor demand/need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel. They shall also monitor denial of care and negligence. Few and simple indicators for

	Relevant policy(ies)	Level ² and type ³ of policy	Salient points of policy
			<p>monitoring shall be used.</p> <p>Public Dialogue/Public Hearing shall be held to involve and empower the general public.</p>
	<p>Advisory Group on Community Action (AGCA)</p> <p>Source: Department of Health and Family Welfare, Government of India, (2008). 'Constitution of Advisory Group on Community Action, G.O. no. N.14012/12/05-EAG/NRHM-II'</p>	<p>National Level</p> <p>Government Order</p>	<p>-Advise on the development of Community Partnership and Ownership for the Mission</p> <p>-Advise on Community Monitoring of the various schemes of the Mission</p>
	<p>Communitization of the Health Units in Nagaland</p> <p>Source: Government of Nagaland, Ministry of Health and Family Welfare, (2002). 'Guidelines on Communitisation of</p>	<p>State Level</p> <p>Act and Operational Guidelines</p>	<p>Formation of Village Health Councils (VHC)</p> <p>Supervise, direct, guide, and support the work of the Sub-Centre staff including that of Mahila Swasthya Sangh (Women Health Committee)</p> <p>Salaries of the health department transferred to the VHC</p>

	Relevant policy(ies)	Level ² and type ³ of policy	Salient points of policy
	Health Sub-Centre in Nagaland ¹ .		account and VHC shall disburse the salaries of the personnel on a 'No work, no pay' basis and monitor the attendance and performance of the health personnel before paying the salaries.
	Draft National Public Health Bill Source: Department of Health and Family Welfare, Government of India (2009). 'National Health Bill'.	National level Draft Bill	Communities, civil society shall be involved in setting health priorities Processes shall be initiated for implementing community planning, implementation and monitoring under Panchayats within two years of the Act coming into force - Community Monitoring and Planning processes similar to those under National Rural Health Mission Disputes Resolution through people's courts (Jan Sunwai) Grievance redressal mechanisms through in-house Complaints Forum
Participatory Planning	Community Monitoring and Planning under National Rural Health Mission Source: Ministry of Health and Family Welfare, Government of India, (2005). 'Framework for Implementation of National Rural Health Mission'	National and State Levels Government Orders and framework document	Village Health and Sanitation Committees comprising of Panchayat members, ASHA, Auxiliary Nurse Midwife (ANM), Anganwadi worker, local community based organization (CBO) and self help group (SHG) women representatives. Village Health Plans to be prepared at the Village level by the Village Health and Sanitation Committees and the Block and District plans would be an aggregation of the Village Health Plans. Similarly at PHC level, Block Level, District level, Health Monitoring and Planning Committees at the respective levels to prepare health plans Annual plans shall be based on resources and prioritization exercises at the various levels based on community needs

	Relevant policy(ies)	Level ² and type ³ of policy	Salient points of policy
			and socio-epidemiological situations. Untied funds at all the levels for facilitation of the processes
	<p>Communitization of the Health Units in Nagaland</p> <p>Source: Government of Nagaland, Ministry of Health and Family Welfare, (2002). 'Guidelines on Communitisation of Health Sub-Centre in Nagaland'</p>	<p>State Level</p> <p>Act and Operational Guidelines</p>	<p>Formation of Village Health Councils (VHC)</p> <p>Planning and implementation at the Village Health Council level</p> <p>Supervise, direct, guide, and support the work of the Sub-Centre staff including that of Mahila Swasthya Sangh (Women Health Committee)</p> <p>Salaries of the health department transferred to the VHC account and disbursement by the VHC based on the performance of the health personnel</p>
	<p>Swasth Panchayat Scheme, Chhattisgarh</p> <p>Source: Directorate of Health Services and State Health Resource Centre, Government of Chhattisgarh, (2008). 'Panchayat level Health and Human Developmental Index of Chhattisgarh'.</p>	<p>State Level</p> <p>Scheme</p>	<p>Health indicators to measure the performance of Panchayats</p> <p>32 health indicators developed</p> <p>Development of a Health and Human Development Index for the Panchayats.</p> <p>Ranking based on the Index</p> <p>Panchayats to improve their health performance based on the ranking.</p>
Convergence	<p>Madhya Pradesh Gram Sabha Ad hoc Health Committee</p> <p>Source: Government of Madhya Pradesh,</p>	<p>State Level</p> <p>An Act</p>	<p>Merging of the various village level committees into a single Gram Sabha Ad hoc Health Committee</p> <p>All the funds like the 'Water Sanitation Campaign Account',</p>

	Relevant policy(ies)	Level ² and type ³ of policy	Salient points of policy
	Ministry of Panchayat and Rural Development, Madhya Pradesh Gram Sabha Ad hoc Health Committee, (2010). (Constitution, Conduct of Business and Meeting) Rules		'Health Fund Account' and 'Nutrition Account' merged at committee level. Each of the accounts to be operated jointly by the Chairperson along with: secretary of the Panchayat for the Water Sanitation Campaign; along with the ASHA for the Health Fund account; and along with the Anganwadi worker for the Nutrition account. Any disbursement of any amount has to be compulsorily approved by the Committee in the meetings to be held once a month.
	[Tamil Nadu] Public Health Act, 1939 Source: Madras Presidency, (1939). 'Tamil Nadu Public Health Act'. http://www.tnhealth.org/epidemics.doc	State Level Act	Director of Public Health to direct local authority for improving water-supply Power of Health Officer to require drains to be constructed Obligation of local authority to provide public sanitary conveniences Power of Health Officer to abate nuisances like clogging of drainage and so on Prevention, notification and treatment of diseases
	Assam Public Health Act. Source: Ministry of Health and Family Welfare, Government of Assam, (2010). 'Assam Public Health Act'.	State Level Act of the Assembly	Recognizes the Right to Health as an inclusive right extending to the socio-economic, cultural and environmental rights
	Draft National Public Health Bill	National Level	Recognizes the following rights - Right to access, use and enjoy appropriate health care, food and nutrition, water,

	Relevant policy(ies)	Level ² and type ³ of policy	Salient points of policy
	Source: Department of Health and Family Welfare, Government of India (2009). 'National Health Bill'.	Draft Bill	sanitation, housing, dignity, information, participation and Right to Justice

THEME: COMMUNITY HEALTH WORKERS

The recruitment of community health workers was suggested a long time ago by the Bhole committee to ensure that services reach the people. Later projects in Jamkhed [R. Arole 2001; M. Arole 1988; M. Arole & R. Arole 1994] and Mandwa [Antia 1986; Antia 1988] saw training community health workers as a way of reaching services to marginalized communities, demystifying health and medicines, and making health care more accessible. Health workers were seen as bridges between the health system and the community. Many projects dealt with social issues such as caste and gender in the provision of services [Arole and Arole 1994]. The literature elsewhere in the world suggests, however, that as soon as community health worker programmes started to question the status quo (eg. in Nicaragua and Zimbabwe), they were dropped [Werner et al 1997]. Still, such programmes were key inspirations for the 1978 Alma Ata declaration, which defined health as human right and insisted upon community participation.

According to Murthy and Vasan (2003), India has had three well-known experiences of community involvement in health: the Community Based Distribution (CBD) project, the Community Health Volunteer (CHV) scheme, and the Link Worker scheme.

In the CBD project, Village Health and Sanitation Committees selected “*Sanyojak*” (organizers) received contraceptives gratis from the government, functioning as depot holders, receiving remuneration for the amount they sold. In the CHV scheme was introduced in 1977 and entailed village leaders selecting health volunteers who then received government training, medicine kits and a small monthly honorarium. CHVs provided treatment for minor health conditions and promoted family planning. In 1983, when CHVs started demanding integration into government service, the scheme was discontinued. Under the Link Worker scheme, volunteer couples appointed by the government were paid a small honorarium to hold and promote contraception in their village communities.

Under all three schemes, community involvement translated into the appointment of volunteers by village leaders or health officers, incentive compensation or honoraria based on performance of pre-determined tasks. Murthy and Vasan (2003) submit that many of them considered themselves village level government functionaries..

Later, with the increased development of the public health infrastructure, questions began to be asked about whether the role of NGOs and community health workers was to create an

alternative/parallel service. Soon training programmes for community health workers started to focus on how they should educate people, telling them about their rights and entitlements, orient them towards the public health system to increasingly demand their rights, and thereby strengthen the public health system through this increased demand. Programmes like the *Aarogya Iyakkam* project of the Tamil Nadu Science Forum in Tamil Nadu focused on developing a village level cadre that informed people about their rights and also had basic medical knowledge to demystify illnesses. This ensured that the Village Health Nurses (VHNs), the Tamil Nadu equivalent of ANMs, were held accountable to provide appropriate services at the village level. [Sampath 1997].

Another major innovation has been the *Jan Swasthya Rakshak* scheme introduced by the Government of Madhya Pradesh. This aimed at providing simple and basic therapeutics at the village level. In this programme, *Jan Swasthya Rakshaks* (JSR) were trained in public sector hospitals and then given permission to practice at the village level. This scheme got mired in controversies including irrational practices and the migration of these workers to more urbanized settings. It also faced a number of design, supervision and support challenges. [SOCHARA 1997].

Subsequently, the newly formed Government of Chattisgarh launched the Mitandin programme. Prior to its launch, the basic document of the programme reviewed all previous health worker schemes to derive lessons from them. [SHRC 2003]. The document contained a number of crucial issues, summarized below:

1. The main premise is that if every citizen has a fundamental right to health and health care, then community health programmes are essential to ensure that services reach those who need them.

Other factors which have to be taken into consideration to turn this right into a reality include

- Workload of Village Health Nurses (VHNs)
- Problems of geography
- Constraints to expanding multi-purpose worker workforces
- Health education within the community
- Community participation

- Increased utilization of health care services in the public health sector
- Linking with *Panchayats*

Thus, from the Mitanin programme onwards, large scale government programmes too accepted that to be effective, community health workers had to perform both the service provision (at least minimally depending on the quality of the public sector input) and 'activist' roles. The programme also tried to implement the concept of inter-sectoral coordination and linkages with local government structures like the *Panchayat*.

2. Women as health workers: This was a major shift in government programmes where earlier both in the CHV scheme of 1977 and in the JSR scheme in Madhya Pradesh, the government appointed men. However in almost all NGO programmes nationwide, the workers were mostly women.

3. Importance of the selection process: Given that health workers are expected to increase access to health care for marginalized communities, it is important that only those workers willing to work among these communities be chosen. Ideally we need to choose workers from the marginalized communities themselves. Selection processes are crucial to make sure that the community perceives their health worker as representing their interests, rather than working at the behest of the government or some funding agency.

4. What is to be provided is supplementary and not central to curative care.

5. Complexity about whether and how to compensate the worker monetarily: Appropriate compensation for wage loss and travel as well as for work performed needs to be determined scientifically.

6. Need for continuous training and support.

7. Government programmes merely saw the health workers as extensions of the department. Meanwhile NGOs many a time had very little direct interaction with the public health system and built up parallel systems of referral from their grass roots workers. However, a few

programmes like those of SATHI, BGVS, PRAYAS and others took a different approach, in which the community health worker was seen more as health activist or a mobilizer with roles in providing health education and organizing the community for self-help. There is the need for a state–civil society partnership.

While summarizing the experiences of nine of the most iconic community health worker programmes in India the author of a review notes [SHRC 2003]:

The importance of referral back to the community health workers.

- A longer duration of the process – given that these are process intensive and processes at the community level take time.
- High quality leadership and support and active support and training throughout the programme.
- Women as community health workers.

Cognizant of these various experiences, the Government has implemented a massive programme of appointing one ASHA in each hamlet under the National Rural Health Mission (NRHM). As of now there are estimated to be about seven lakh ASHA workers. However, while the ASHAs owe a debt to the Mitandin programme from Chattisgarh, nearly four years down the line, various concerns have been raised with regard to the ASHA programme (CRM 2009). These include the following:

- Given the difficulties of a proper selection process, workers are either chosen by the ANM (and thus anyone seen to be a good 'helper' will be chosen), or by the *Panchayat* president (the choice will usually be a relative, or used to confer patronage).
- The roll out of training and support to the ASHAs has been very difficult: after nearly three years of the programme's inception, only five rounds of training have occurred.
- Incentives and supplies do not reach the ASHAs on time/in sufficient quantity.
- Support and back-up by the higher levels of the system are still wanting.

THEME: NGO INVOLVEMENT IN HEALTH

There have been a number of ways in which NGOs have interacted with the health system. While early activities consisted primarily of the NGOs going to places where the government had not reached and where people could not access even basic services, gradually, with the expansion of the public health system, parallel streams of service provision emerged.

The National Health Policy of 1983 clearly spelled out the role of the non-state sector, particularly the NGO sector, in India's provision of health care. During the 1990s the involvement of NGOs in provision of health services gained momentum, more so as the focus on participatory approaches through public-private partnerships and ideas emanating from these experiences formed key strategies of health sector programmes. The experiences, ideas and practices in this area also started shaping and influencing the strategies of various development partners. The new economic policy of the Government of India allotted an expanded role for the non-state sector in the provision of development services. The Cairo Population Conference 1994 also reiterated the contribution of NGOs in helping achieve the goals of the global Reproductive and Child Health agenda. Over the years, national policy documents have recognized the need for partnership with NGOs to achieve targets in national health programmes. The Seventh and Eighth Five Year Plans envisaged a larger role for NGOs in advocacy and promotion of health programmes. During the Ninth Five-year Plan, the role of NGOs was broadened to act as pioneers of reform. Further, the National Health Policy 2003 and National Population Policy 2000 envisaged an increasing role for NGOs and civil society in building up awareness and improving community participation; this became part of the agenda of the Tenth Five-Year Plan, advocating for NGOs to have a major role in promoting community participation. The Tenth Plan also proposed to allow NGOs with adequate expertise and experience to participate in RCH service delivery. (Bhat 2007)

Following this phase of service provision in parallel streams, the government increasingly looks upon NGOs as being able to reach areas that the government has not reached, and as able to provide better quality in a number of areas of service provision. The latter is considered especially true in the areas of awareness building, health education and health information and training. The government has also handed over a number of service provision/service support functions to NGOs. Examples include contraceptive distribution, counselling and testing services in HIV, and microscopy and drug depots in the Revised National Tuberculosis Control Programme.

The government has also embarked upon the experiment of handing over a number of PHCs to various NGOs. A spate of such experiments occurred in the early and late 1980s in Gujarat (SEWA_RURAL) and Rajasthan (PRAYAS). All these groups, however, returned the PHCs due to a number of reasons. More recently, in the post 2000 period, Karuna Trust has taken on the running of a number of PHCs in Karnataka and Arunachal Pradesh. In these cases, while the NGOs actually run the programmes including the recruitment of staff, the money comes from the government. Interim reports suggest that all is not going smoothly due to the way the government runs/ administers the project. (Prashanth 2008).

In one instance the Government of Tamil Nadu introduced a scheme whereby industrial houses were given a list of PHCs that were in need of a 'facelift' and were requested to 'adopt' any of these institutions as per their convenience. Three models were offered, differing on total outlay and yearly recurring cost. A Government Order was also issued to facilitate the smooth functioning of this scheme. Nearly 90 PHCs in the state have been adopted under this scheme. While overall there is a very positive feeling about this programme and there have been some indications that the utilization of these institutions has increased after these measures, there is concern about the long term sustainability of the programme, especially due to the 'gentle coercion' initially used to recruit adopters. (Vartharajan 2006) More recently, governments have got NGOs to perform specific tasks like large-scale recruitment and training of staff.

Another way in which the NGOs engage with the government is by creating models and alternative discourses. For example, Rural Women's Social Education Centre (RUWSEC) in Kanchipuram has shown the feasibility of providing quality and gender sensitive delivery care to women at affordable costs, which pressured the public sector to improve its services (Murthy 2009). Similarly NGOs continue to innovate and provide models for a number of programmes that later go on to inform government policy – examples are in the field of mental health, domestic violence and de-addiction.

Recently the government has been innovating with newer spaces known as para-statal spaces and sometimes as 'hybrid spaces'. In these spaces the government sets up independent bodies that are integral to the health department but have staffing and management patterns provided by NGOs. These are bodies such as the State Health Resource Centre at Raipur, the National Health Systems Resource Centre at Delhi, the Advisory Group for Community Action, and the ASHA Mentoring Group, all of which are innovative ways of drawing on the expertise of the NGOs within the government, yet allowing the NGOs to retain their flexibility and creativity (that set them apart in the first place).

NGOs are also involved in a range of research and documentation projects that bring to the notice of government the various gaps in services. Such programmes include the Maternal Death follow up and tracking by SAHAYOG in Uttar Pradesh (Subha Sri 2009), The Denial of the Right to Health public hearing series of the Jan Swasthya Abhiyan (JSA 2004), and the immunization coverage study by the JSA chapter of Tamil Nadu. (Kannan 2011). These are just a few examples of research and documentation by NGOs that play an important role in policy making at the state and national levels.

THEME: COMMUNITY BASED FINANCING

Alternative financing mechanisms that have been used in community settings include micro-credit based schemes and the more recent micro-insurance based schemes.

In the micro-credit based model, an 'emergency fund' is provided. This fund is lent out to people for use in emergency health situations. While there are success stories in a few countries like Thailand, experiments in India (ARTH and RUWSEC) have shown mixed results. Problems include the use of money for very simple illness to the financing of unethical and irrational care.

There are a number of experiments of community based health insurance schemes that have been tried in India, most of which have been introduced around or after 1995. An NGO has been the intermediary in almost all such schemes. Broadly three mechanisms have been tried out:

1. The NGO is the insurer as well as the service provider. In this arrangement the NGO usually has its own hospital, to which the scheme is attached.
2. The NGO purchases care from independent private providers.
3. An increasingly common model; the NGO purchases insurance from a formal insurance company and acts as a partner-agent. This model is called the linked model.

The advantage of the third model which has itself spawned a number of other innovations is that the NGO intermediary/partner can negotiate deals with both insurers and providers on behalf of the communities that they serve. Karuna Trust, for example, negotiated with funding agencies to subsidize the premiums and with insurance companies to provide compensation for a number of need-based costs that came up during an illness. Similarly, SEWA was able to negotiate with providers for a Preferred Provider Service (PPS) through which basic levels of quality and a cashless transaction could be provided for its members (Soors 2010).

In the *Jowar* scheme of the Mahatma Gandhi Institute of Medical Sciences, an insurance scheme linked to the hospital was started. Unlike other schemes, it insisted on a number of innovative features such as the whole village needing to enroll (or a minimum of 75% of

households); the premium was accepted in kind (*jowar*); and there was a trained Village Health Worker who undertook a lot of basic diagnostic, therapeutic, preventive and promotive work. Moreover, the scheme required that the village adopt the agenda of installing one toilet for every house, and that the *Gram Sabha* actively participate. Thus, the *Jowar* scheme inspired by the ideals of Mahatma Gandhi, Vinoba Bhave and Jaiprakash Narayan tried to link the health insurance component to multiple dimensions of health and development. This model, though presently functioning only in about 40 villages, shows the potential of such schemes, especially for inter-sectoral activity (Jajoo and Bhan 2004).

THEME: COMMUNITY MONITORING, HEALTH RIGHTS AND ACCOUNTABILITY

There has been a number of experiments using a number of approaches that included a monitoring role by communities. In one set of projects like *Arogya Iyakkam*, the local groups trained hamlet/ village level volunteers in basic health care, both preventive and curative. However, while they had knowledge of basic therapeutics, they were not given any medicines and were expected to refer all patients they saw to the public health sector. Similarly, when someone was ill and went to the public sector for treatment, these workers could identify the cases where appropriate treatment was not provided. Both these functions acted as a form of monitoring and demystification of health services.

There were a number of initiatives in the SATHI/KS programme where villagers maintained a public calendar of the Village Health Nurse's (VHNs) activities, or health workers maintained a diary of the quality of the water (through simple water testing kits) and maintained the log in public. Similarly, there were a number of programmes where communities collected information regarding specific services/groups of services of interest to them. Public hearings have been used both as a tool for protest as well as a powerful documentation and monitoring exercise. They were widely used with great impact by the JSA during the Denial of the Right to Health hearings, in partnership with the National Human Rights Commission, at both the national and state levels. (JSA 2004).

Pre-NRHM, there was a number of experiments of community monitoring that used a roughly similar approach. The Institute of Public Health, Bangalore, did a review of five of these schemes (Bhojani U. and Devadasan N., 2007). The five projects included in the review and it's the broad findings are presented below.

- People's Health Management Information System (PHMIS), Odisha
- *Swasth Plus*-Community monitoring Project, Karnataka
- Citizen Record Card (CRC) study of public services, Bhubaneswar, Odisha
- "*Prayas*", Odisha
- Rural Poverty Reduction Project (RPRP) (Monitoring of Health Services), Andhra Pradesh

Some of the important lessons learnt by implementers are summarized below:

- The Health Management Information System (HMIS) works effectively only when the data collected is utilized at all levels and when it holds meaning for people at all levels.
- Community members/ citizens can effectively carry out monitoring. They can understand and interpret health information provided it is presented to them in a simple and demystified form. For example, spatial mapping of villages using stones and the presentation of data using seeds by the PHMIS project made the community understand and realize what each piece of data represents.
- The training of community workers to carry out effective monitoring should preferably be periodic, with the use of multiple strategies such as, individual and group training, role plays, use of traditional learning methods using songs, plays, etc.
- The community should be involved in the process of developing indicators, as the requirements of the community and those of service providers may vary. This difference needs to be considered and accommodated while designing tools for monitoring.
- The reporting system for the community also needs to be appropriate to the capabilities of the community involved. For example, WRCSP used verbal reporting to enable illiterate community workers to report weekly.
- Engagement of service providers in the process right from the early stages brings ownership and legitimacy to the process.
- Service providers need to be receptive and should extend their support and cooperation to the community in carrying out the monitoring process.
- Service providers often need training and actual handholding in effectively facilitating the Community based monitoring process.
- Service providers need to be responsive and should constitute and execute a time bound action plan to resolve identified issues.
- The monitoring tools and the data recording system should be made simple and self explanatory preferably with the use of pictures, diagrams etc.
- Successful local initiatives should be scaled up to make an impact at a block/district level.

A public hearing is a very empowering and powerful tool from the point of view of the people and the movement. Many people described the euphoria of being part of a large group, of seeing such a high official in the village for the first time, of being able to speak into a mike in front of such a large gathering and being able to speak to/against a high official. All these were very empowering. However a couple of negative issues also came up:

- One was the issue of follow up. While the various testimonies were very powerful and sometimes led to action being taken at the local level, when the dust settled after the public hearing, the complainant had to go back to the same scenario in which the person or system that he or she complained against remained as the only service provider. This leads to a potential back lash, and given that the NGO capacity to follow up every case is limited, a number of times such victims are left to defend themselves from the back lash on their own.
- Another issue is the way in which the public sector sees public hearings. Some of the major grievances shared by public sector employees like the Medical Officers and ANMs from the PHCs are as follow:
- The issues are not brought to the notice of the respondent (from the system) beforehand so there is a lot of tension from not knowing what to expect. Most of the issues come as a complete surprise to the respondents who may or may not have very good contact with the field.
- Many of the issues brought forward are not within the decision-making authority of the respondent, leading to a lot of frustration for both the respondent and the people.
- There does not seem to be any space for the various service providers to raise issues of their own, such as the problems they face while providing services. Thus, public hearings seem to devolve into one-way complaints with all parties becoming frustrated and demoralized.

In the more recent set of experiments with community monitoring and planning under NRHM, there have been some very innovative actions and positive results. These include the formation of the village level Village Health and Sanitation Committees, their orientation and training and the development of a specific set of tools to be used by them to come up with a village level report card, which can be fed back into and acted upon by the system. In nine states this programme is in the pilot stage of implementation, and in the four states which are in the post pilot phase, clear improvement can be seen in the health system performance where community monitoring takes place.

THEME: PARTICIPATORY PLANNING

While theoretically, village-level planning is the back-bone of the *Panchayati Raj* system, its actual realization is yet to happen. Despite this, there are a number of ways in which health planning/village level planning have been carried out.

- The Kerala model – this model tried out an ambitious exercise of inter-sectoral planning under the Panchayati Raj/decentralized planning concept. The planning process consisted of five basic steps. The first step consisted of convening a Gram Sabha and the discussion of 12 sectoral themes in small groups. The second step was creating the Panchayat development report using various techniques of Rapid Rural Appraisal. The third step entailed convening a development seminar where the Panchayat development report and issues raised by the Gram Sabha were reviewed. This led to the fourth step, the finalization of the local plan, followed by the fifth step, which was the development of the block and district level plans based on the Panchayat plans. Recording of the key facts included the information that nearly 40% of the budget was made available at the Panchayat level, and that massive amounts of trainings through training teams were developed. The planning process was conceptualized as an instrument of social mobilization and a campaign for the creation of a new civic culture. (Isaac and Franke 2001).
- Another model evolved as part of the Mitandin programme in Chattisgarh. First, a set of desirable indicators are evolved – in this case, the *Panchayat* Health Development Index. This Index consists of indicators drawn from various dimensions of overall development. Based on this, methodologies were provided to calculate the Health Development Index of a particular *Panchayat*. The aim of this exercise was to first find out the performance of a particular *Panchayat* on each of the dimensions, and then decide on how to improve performance in respect of the given indicators. (SHRC 2007).
- A further model was developed by Mahatma Gandhi Institute of Medical Science (MGIMS), Sewagram as part of their program called CLIC. In this model, called the social franchisee model, there is a village level survey done by the Department of Preventive and Social Medicine. This data/survey forms the basis of the planning exercise with the Department and the Village Health Committee, prioritizing the issues that emerge from the survey. The next step is for the Department and the people to define their respective contributions to the realization of the goal. In this way, not only do both parties commit to the process, but most importantly, there is automatic ownership of the process. These commitments are agreed upon in the form of a MOU with the *Panchayat* as a witness. [CLIC 2004].

- In other models that are being tried out in Jharkhand and Odisha, the HMIS is used as the basis of data for the village health planning exercise. In these processes the ANM and Multi-purpose Worker are the nodal persons for the planning exercise along with the Village Health and Sanitation Committee. (Rafay 2011 Personal Communication). In a slight but important variation from the above models, village health planning in Maharashtra and Tamil Nadu begins by using the village health report card as the starting point. The aim of the planning exercise is to work out how to change the 'red' color (denoting poor services) into 'green' (denoting good services).
- Foundation for Research in Health Systems (FRHS) model. In this committee model, persons from different localities in their respective villages were selected by community members. They were expected to organize activities to improve awareness and access to health services. But they had no financial or administrative power vis-à-vis the health staff, except for a start-up grant they received. They were expected to raise resources for their activities and carry out their task in collaboration with the health staff and *Panchayat* leaders, who had different expectations from them. (Murthy 2003). Though the idea of forming Village Health Committees was not new, this project tested a new model of health committee. In this model health committees were not expected to play a dependent role (i.e. government deciding what they would do and provide funds), or an adversarial role (i.e. acting as a pressure group) but a collaborative role (i.e. working with health staff and Community-Based Organisations (CBOs) as partners). Success of this model, therefore, depended on how well committees managed to play that role and resisted pressures to become either dependent or adversarial. (Murthy 2003). This model requires the independence of committees from the Health Department – avoiding co-optation, It also requires NGO support to function effectively. A challenge in this program was the failure of committees to contribute to needs assessment and the development of activity plans, because of incompatibilities in their view of (the utility of) needs assessments relative to health workers, and the latter's view of the technical competencies of committees. While levels of mutual trust and respect between committees and health workers were high and a certain level of social capital was built in communities, sustaining this model would require the government's acceptance of these health committees as a legitimate local institution, possibly with linkages to other existing committee structures in the state such as the *Rogi Kalyan Samithi* or Board of Health Visitors, that represent civil society and health officials and undertake the function of overseeing health institutions at district and block levels. This layered structure would be able to perform the tasks performed by Community Facilitators and FRHS, needed to sustain and upscale the model to district level. This idea however needs to be field-tested. (Murthy 2003).

In the aforementioned report of the Foundation for Research in Health Systems study in Husur, Karnataka, the following were the major factors that emerged as predictors of success/or that encouraged the functioning of the committee. (Murthy 2003).

Credibility: First and foremost, building the credibility of the committees was a very important factor that helped them to play the bridging role. Since the government had not formed these committees, the government health staff was not sure that they needed to cooperate with them. *Panchayat* members also wondered why these new committees were set up when health standing committees under the *Panchayat* system could, but hadn't yet been formed. Committee members themselves were not sure about the legitimacy of their role.

Organizing Capacity: Community Facilitators contributed a great deal towards building the organizational capacity of the committees. They contributed ideas about what programmes to organize and how and helped in identifying other NGOs and resource institutions to make programmes effective.

Motivation: Sustaining committee members' motivation over a two-year period was a major challenge, since all members were volunteers and received no money for their time and effort. Public appreciation was their only reward, which they received mainly through the newsletters and newspapers.

THEME: INTER-SECTORAL CONVERGENCE

It can be argued that departmental approaches and the division of a development project into a number of segments is only in the mind of the development worker or the government bureaucracy. In the minds of the people, all such acts naturally converge. At the village level, the links of various sectors with health and vice versa are obvious for all to see and experience. Similarly, while at the state and central levels there may be varying compulsions to see development department-wise, at the district level, and especially at the village level, the activities of various departments converge per force.

A number of programmes described here, like the Kerala *Panchayat* level planning exercise (Isaac and Franke 2001), the Mitandin programme (SHRC 2004), the *Jowar* Rural Health Insurance Programme (Jajoo and Bhan 2004), and others (Garg 2006) clearly show the immense potential for community level groups to get involved in facilitating inter-sectoral action for health, hindered only by miscommunication between the departments, and/or between the people and departments.

The illustrative (but not exhaustive) list of projects mentioned above clearly show that by empowering a group of people through involvement in one particular aspect of development like health or livelihood automatically leads that group to take an interest in and planning action with respect to a number of other dimensions. Both civil society and the government need to tap into this synergy. The Women's Development Programme of the Rajasthan Government is an instructive example of the potential for inter-sectoral action:

Village level volunteers known as SATHINS were used in Rajasthan. SATHINS were women volunteers appointed as part of a scheme of the Women's Development Programme of the Government of Rajasthan. The programme enabled the evolution of women's collectives under the leadership of the sathin, the grass roots worker at the village level. The strength of the sathins and these collectives was derived from the support structures provided by the partnership between the government and the voluntary agency arm of the programme -- IDARA (Information and Development and Resource Agency), with its primary role of training and providing creative and critical inputs. In its early years, the WDP mobilized women around several issues in feudal Rajasthan, from sati to rape and child marriage. Several successful struggles at the panchayat level against corruption in development programmes took place. A significant achievement was the entry of women in village forums such as the "hatai" or the Chaupal along with men. In addition, women's forums were initiated at the village level for presenting women's perspectives in taking up issues of justice and development,

governance and social issues, including participation in the Panchayati Raj institutions. Despite such success stories the Rajasthan government chose to discontinue the programme. (World Bank)

The above case shows the potential of simple inputs and support to community level groups. Equally instructive is the government's action of closing down this scheme despite it being evaluated and many positives being attributed to it.

NEWER SPACES

A number of newer spaces are being opened up to enable various kinds of civil society engagement. In these the engagement is neither one of creating parallel services, nor is it merely a watchdog or monitoring activity. Most of these spaces and programmes broadly fall under the category of co-production or co-governance.

At the policy level these spaces are reflected by organizations like the State Health Resource Centres (SHRC) at the state level, and the National Health Systems Resource Centre (NHSRC) at the national level. These also include a number of standing committees of the NRHM like the Advisory Group on Community Action and the ASHA Mentoring Group. In these spaces while the committee or the institution is clearly a government body, its constitution and management allow for considerable flexibility and for the incorporation of resource persons from civil society. This type of space has the legitimacy of a government body, at the same time retaining the flexibility and the critical dimension of civil society.

At another level are institutional bodies like the *Rogi Kalyan Samities* (RKS), 'management' committees with multi-stakeholder composition, complete ownership of the institution, and a commitment to improve it. This can lead to a number of positive outcomes, as confrontation and the demand for transparency become easier and more feasible from such spaces, notwithstanding challenges of implementation. (Murthy and Balasubramaniam 2008).

At the field level, there are two major innovations in civil society involvement in health system strengthening using these newer spaces. One such activity is characterized by the efforts of the Public Health Resource Network (PHRN) spread across a number of Empowered Action Group states and initiated by the SHRC in Raipur, currently run with support of the NHSRC. In this, a set of materials (at present 17 volumes; PHRN 2010) is made available to doctors in the public sector who are interested in learning the basics of public health and district health planning. There are also contact courses and mentoring of those who take the courses. This intervention uses the concept of distance education.

Apart from this there are a series of Fellowship programmes like the ones run by SEARCH in Rajasthan, by PHRN in Odisha, Bihar, Jharkhand and Chattisgarh and by the Centre for Public Health and Equity (CPHE) of the Society for Community Health Awareness Research and Action (SOCHARA) in Madhya Pradesh. In these programmes (each with its unique strengths), the common feature is intensive study of the public health system, the NRHM and its various

components, especially aspects of communitization and planning. Throughout the duration of their fellowship, fellows are placed at the district level either in the District Planning and Management Unit or in NGOs, but involve themselves almost completely in strengthening the implementation of the various aspects of the NRHM. (SOCHARA forthcoming).

CONCLUSIONS

The motivation for increasing the involvement of communities and civil society differs quite widely depending on the group of stakeholders. As noted earlier, civil society and CBOs often employ a rights based approach, International Financial Institutions invoke the efficiency model and that of the receding state, while national and state governments have to balance a number of these pressures, from international agencies, from its own citizens, from the demands and realities faced by frontline staff of the public health department, and politicians driven by the compulsions of election cycles.

Regardless of the model, there are some essential requirements to successfully implement any programme that hopes to involve communities or civil society on a sustained and effective basis. The requirements can be summarized under three broad headings:

- The necessity of a strong legal framework that defines rights unambiguously. The law needs to define a number of aspects like timeliness of implementation, feedback, institutionalization and redressal mechanisms. A review of the various policies in India today gives a fair idea of the diverse ways in which the state is trying to evolve this legal framework. Similarly, international examples like the People's Constitution of Brazil or the law of Popular Participation in Bolivia and the Constitution of South Africa point us in the right direction. Yet, law alone is not enough. Experience of implementation of a number of well-articulated laws is quite dismal. One of the crucial aspects of the legal and the policy framework is the involvement of the private sector. Another critical aspect is the regulation of the private sector. These and many other issues need to be well defined in the statutes for full enjoyment of their benefits.
- The second key aspect is of creating spaces and mechanisms for people/civil society to participate, like the formation of village level committees, institution level committees and a number of spaces where people and civil society can engage with the government, and mechanisms for this need to be evolved.
- Most important of all it seems is the development of the 'spirit' of participation in society: This involves not only the people, but also sensitization to, and orientation about people's participation for public health staff and officers. There is also clear need to include this and related issues into the medical curriculum.

Other crucial aspects of engagement that are frequently overlooked include:

1. Capacity within the government to engage with different partners. This is a crucial gap that is seldom recognized.
2. Capacity of peripheral health staff to engage, which is as important as training the people on how to engage with the system.
3. Training, not just a one time affair but a long drawn out process and includes constant follow up. This requires the creation of a number of training teams and evolution of a number of innovative methodologies.
4. Gradual expansion, with continuous documentation and monitoring and operations research to observe what is going on, and learn from the ongoing process to inform future expansion.
5. Respect for diversity and willingness to continue learning, given the various levels and dimensions involved in evolving a health system that will truly provide health for all.

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