

# Community action for health in India: evolution, lessons learnt and ways forward to achieve universal health coverage

Chandrakant Lahariya<sup>1</sup>, Bijit Roy<sup>2</sup>, Abhay Shukla<sup>3</sup>, Mirai Chatterjee<sup>4</sup>, Hilde De Graeve<sup>1</sup>, Manoj Jhalani<sup>5</sup>, Henk Bekedam<sup>1</sup>

<sup>1</sup>World Health Organization Country Office for India, New Delhi, India, <sup>2</sup>Population Foundation of India, New Delhi, India,

<sup>3</sup>Support for Advocacy and Training to Health Initiatives, Pune, Maharashtra, India, <sup>4</sup>Self-Employed Women's Association Trust, Ahmedabad, Gujarat, India, <sup>5</sup>Ministry of Health and Family Welfare, Government of India, New Delhi, India

**Correspondence to:** Dr Chandrakant Lahariya ([lahariyac@who.int](mailto:lahariyac@who.int))

## Abstract

The role of civil society and community-based organizations in advancing universal health coverage and meeting the targets of the 2030 Agenda for Sustainable Development has received renewed recognition from major global initiatives. This article documents the evolution and lessons learnt through two decades of experience in India at national, state and district levels. Community and civil society engagement in health services in India began with semi-institutional mechanisms under programmes focused on, for example, HIV/AIDS, tuberculosis, polio and immunization. A formal system of community action for health (CAH) started with the launch of the National Rural Health Mission in 2005. By December 2018, CAH processes were being implemented in 22 states, 353 districts and more than 200 000 villages in India. Successive evaluations have indicated improved performance on various service delivery parameters. One example of CAH is community-based monitoring and planning, which has been continuously expanded and strengthened in Maharashtra since 2007. This involves regular, participatory auditing of public health services, which facilitates the involvement of people in assessing the public health system and demanding improvements. At district level, CAH initiatives are successfully reaching “last-mile” communities. The Self-Employed Women's Association, a cooperative-based organization of women working in the informal sector in Gujarat, has developed community information hubs that empower clients to access government social and health sector services. CAH initiatives in India are now being augmented by regular activities led and/or participated in by civil society organizations. This is contributing to the democratization of community and civil society engagement in health. Additional documentation on CAH and the further formalization of civil society engagement are needed. These developments provide a valuable opportunity both to improve governance and accountability in the health sector and to accelerate progress towards universal health coverage. Lessons learnt may be applicable to other countries in South-East Asia, as well as to most low- and middle-income countries.

**Keywords:** civil society organizations, health for all, India, South-East Asia, universal health coverage

## Background

In recent years, there has been increasing recognition of the role of civil society organizations (CSOs) and community-based organizations (CBOs) in improving overall governance and accountability in the health sector. This recognition is reflected in major global initiatives relevant to health and well-being. For example, target 16.7 of the Sustainable Development Goals (SDGs) under the 2030 Agenda for Sustainable Development underscores the importance of “responsive, inclusive, participatory and representative decision-making at all levels”.<sup>1</sup> The Global Action Plan for

Healthy Lives and Well-Being for All, which brought together 12 multilateral health, development and humanitarian agencies to better support countries in accelerating progress towards the health-related SDGs, named “community and civil society engagement” as one of seven areas that merit a distinct focus given their potential to significantly accelerate progress towards the health-related SDG targets.<sup>2</sup> There has been global discourse on coordinated actions to engage civil society on health by (i) expanding the political space through joint advocacy; (ii) increasing resources for civil society capacity-building; and (iii) increasing meaningful CSO engagement to improve institutional governance.<sup>3</sup> The Global Conference on

Primary Health Care in Astana, Kazakhstan, in October 2018 endorsed a new declaration that includes a commitment to empowering individuals and communities and to supporting “the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health”.<sup>4</sup> There also is renewed global recognition that CSOs and CBOs can accelerate a country’s journey to achieving target 3.8 of the Sustainable Development Goals, to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”.<sup>1</sup>

In India, a number of mechanisms for community engagement on health were initiated from 2005 onwards, with the launch of the National Rural Health Mission (NRHM). In 2017, India’s most recent national health policy was launched, with the goal of full alignment with the concept of universal health coverage (UHC).<sup>5</sup> In the following year, the Government of India announced and launched the Ayushman Bharat programme<sup>6</sup> as a vehicle for advancing UHC, over and above ongoing initiatives such as the National Health Mission (NHM).<sup>7</sup> This article aims to provide an overview of CBO and CSO participation and engagement in policy formulation and implementation in India in the past two decades. Three major initiatives – one each at national, state and sub-state/district levels – to strengthen civil society engagement and participation in health services in India are described. This overview reflects the global discourse on civil society engagement for health through joint advocacy, capacity-building and improving institutional governance.

### Evolution of civil society engagement in health services in India

The mechanisms for the engagement of community members, civil society and nongovernmental organizations (NGOs) in the health sector in India were initiated with the launch of the second phase of the National AIDS Control Programme in 1999. A wide range of NGOs were engaged in the delivery of targeted interventions, preventive services, and programme monitoring and evaluation, and this engagement has continued and matured.<sup>8</sup> Other initiatives, such as tackling the challenges India faced in polio elimination, especially vaccination hesitancy, were effectively addressed through increased participation on the part of faith-based organizations, professional associations, CSO, CBOs and NGOs.<sup>9</sup> These efforts were supported by formal mechanisms such as the Social Mobilization Network of the United Nations Children’s Fund (UNICEF)<sup>10</sup> and other similar mechanisms, such as the CORE group.<sup>11</sup> However, most of these initiatives for CSO and CBO engagement in health services were programme specific, focused on limited geographical areas and had a narrow scope of implementation.

Arguably, the first systematic and health sector-wide institutional mechanism for civil society engagement in health services started during 2004, when CSO members were actively involved in the design and implementation of India’s flagship NRHM, which was launched in April 2005.<sup>12</sup> Communitization or community action for health (CAH) was recognized as one of the five pillars for health systems strengthening under the NRHM, and this continued when

the NHM was launched in 2013, subsuming the NRHM and the National Urban Health Mission.<sup>13</sup> This has been further formalized through representatives of some community and civil society groups being members of the Mission Steering Group, the highest decision-making body of the NHM, chaired by the Union Minister for Health and Family Welfare.<sup>14</sup> The process has continued to evolve, with increasing CSO and CBO engagement in health service delivery at national, state, district, block and village levels in India, as illustrated by the examples below.

### National level: community action for health and the Advisory Group on Community Action

Communitization was one of the components of the NRHM and included the creation of a new cadre of female community health workers – accredited social health activists,<sup>12,15</sup> the formation of village health, sanitation and nutrition committees<sup>16</sup> and the creation of “rogi kalyan samitis” (patient welfare committees).<sup>17</sup> These initiatives resulted from the recommendations and advice of the various task forces that had been set up in 2004–2005 to design the architecture of the NRHM in India. The task forces included representatives of civil society, public health activists and community representatives.<sup>18</sup> The term “community action for health (CAH)”, was subsequently coined to denote communitization at the operational level. To provide guidance on the roll-out of communitization and CAH processes, in 2005 the Ministry of Health and Family Welfare constituted the Advisory Group on Community Action, comprising eminent public health experts and practitioners with experience in community engagement and empowerment.<sup>19</sup>

Institutional mechanisms such as rogi kalyan samitis and village health, sanitation and nutrition committees ensured wide and inclusive representation of the population served. The CSOs and CBOs represented in these committees at district, block, facility and village levels ensured local-level planning, intersectoral coordination and accountability on the part of service providers.

CAH processes, under the guidance of the Advisory Group on Community Action, focused on (i) increasing community awareness of NHM entitlements, and the roles and responsibilities of service providers; (ii) training of members of rogi kalyan samitis and village health, sanitation and nutrition committees to collect data and provide feedback on health services; and (iii) use of “jan samvads”, or public hearings, to increase accountability on the part of and advocate to key stakeholders, with the aim of highlighting gaps in health services and finding solutions.<sup>12</sup> CAH developed and evolved as a strategy to improve health outcomes by strengthening community participation, as well as ensuring empowerment by making communities more accountable for their health needs (see Box 1).

The Advisory Group on Community Action, supported by the Ministry of Health and Family Welfare, guided the implementation of a pilot of CAH in 1620 villages in 36 districts across 9 Indian states (Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Rajasthan and Tamil Nadu) between 2007 and 2009.<sup>20</sup> An evaluation

**Box 1. Community actions for health in India<sup>12,19</sup>**

CAH processes are organized at the levels of villages, health subcentres, primary health-care centres and community health centres, and at block and district levels. The key steps/processes of CAH include the following.

- **Creating community awareness** on health entitlements and the roles and responsibilities of service providers.
- **Training and mentoring** of the members of the village health, sanitation and nutrition committees and rogi kalyan samitis on their roles and responsibilities and to undertake the community monitoring of health services. Constituted under the NHM, rogi kalyan samitis have a mandate to ensure compliance with minimum standards for facility-level care, adherence to treatment protocols and accountability on the part of health providers to the community. Rogi kalyan samiti members include elected representatives – members of Parliament, legislative assemblies and panchayati raj institutions (the system of rural, local self-government in India) – CSO and CBO representatives and officials from government departments and organizations covering health, women and child development, education, social welfare, public health engineering, public works, electricity, etc.
- **Facilitating the formation of planning and monitoring committees** at state, district and block levels and training the members to discuss and take action on the issues that emerge from the monitoring process.
- **Undertaking data collection** using monitoring tools such as village and health facility report cards, expenditure reviews, etc.
- **Compilation and analysis of data** using a scoring system to categorize good, average and poor services.
- **Sharing results** with key stakeholders at health facility, block and district levels.
- **Developing solutions to problems** that incorporate local inputs into planning processes.
- **Organizing jan samvads** to provide a forum for community engagement with health providers and managers, to share the key findings from the community monitoring processes and to discuss proposed solutions.
- **Taking corrective action** by engaging with health officials to address key issues and concerns.
- **Using the media as an ally** to increase pressure on stakeholders and keep them accountable.

of this pilot reported that implementation of CAH processes had resulted in greater awareness in the community with regard to health entitlements; improvements in the coverage of immunization and antenatal care services; increased availability of medicines and laboratory services in health facilities; and reductions in prescribing medicines that need to be purchased from private shops and demands for informal payments by health providers.<sup>20</sup> It was found that the CAH processes empowered the community, especially marginalized groups, to engage with health facilities and providers. An

affirmative approach had been taken to ensure that people from marginalized and disempowered communities (e.g. Dalit and Scheduled Tribe) and women were involved, in many cases by heading village health, sanitation and nutrition committees. CAH also strengthened service delivery and helped communities to take advantage of their health entitlements; enabled planning and corrective action; and created greater accountability on the part of service providers.

The evaluation also noted lessons learnt that could be used to make future improvements. For example, it was observed that the engagement of the district- and block-level planning and monitoring committees was weak because of inadequate training and lack of participation by health officials and members of panchayati raj institutions in the meetings. Similarly, while the process of sharing village report cards helped increased community awareness of services, this did not always translate into the changes for the better that might be expected as a result of the monitoring process. Jan samvads also caused upset to a few service providers and led to conflicts in some districts. This led to the suggestion that it would be helpful to discuss gaps with providers and officials prior to an event.

The evaluation recommended the creation of an institutional support mechanism at state level and below to guide the scaling up of community action processes, together with continued technical and financial support from the Ministry of Health and Family Welfare. CAH activities were subsequently expanded to additional states, with the Advisory Group on Community Action guiding and leading initiatives (see Box 2).

Since 2009, CAH activities in India have been scaled up, and by the end of December 2018, CAH was being implemented in 22 states (around 202 162 villages across 353 districts), covering 32% of villages and 54% of the districts in India, covering an estimated population of 450 million. CAH is an integral component of the NHM and is funded by the Ministry of Health and Family Welfare. CAH processes are managed through one of two mechanisms, depending on the state. In a few states, a state-level nodal NGO manages implementation and works in close collaboration with the state health

**Box 2. Activities of the Advisory Group on Community Action<sup>12,19</sup>**

- Developing the capacities of state-level institutions and organizations to strengthen and scale up implementation of CAH processes.
- Facilitating state-level vision and planning exercises, including the development of state NHM programme implementation plans.
- Developing and adapting guidelines, manuals and communication materials.
- Strengthening accountability mechanisms such as grievance redressal, public display of health service guarantees and citizens' health rights charters.
- Undertaking programme implementation reviews, including participation in the NHM's annual common review missions<sup>21</sup> and carrying out fact-finding missions on important issues.
- Providing regular mentoring and guidance to states on programme implementation.



department. Under this approach, the processes in the field are implemented by district- and block-level NGOs. In the other states, CAH is implemented through community processes support units, functioning under state health missions.

Despite these efforts, CAH processes had been introduced in only 22 of 36 states and union territories in India by the end of 2018. Even in states where CAH activities are being implemented, only three – Chhattisgarh, Meghalaya and Uttarakhand – have full coverage of all districts. There have been challenges, such as an insufficient presence of civil society and NGOs in many places. However, in many places, CAH has raised the interest and participation of non-health sector officials, such as the state social audit units set up under the Ministry of Rural Development, as well as that of elected representatives involved in health planning and implementation.

### State level: community-based monitoring and planning in Maharashtra

Community-based monitoring and planning (CBMP) is the regular, participatory audit of public health services, which facilitates the involvement of people in assessing the public health system and demanding improvements. CBMP processes provide officials in the public health system with an important, autonomous channel of information about the real functioning of health services at the ground level, enabling corrective measures to be taken. CBMP enables the capture of information on aspects often missed by routine reporting, such as the actual presence and availability of doctors in health centres, the conduct of outreach visits, the behaviour of health staff towards patients and if staff practise illegal charging or writing prescriptions for purchase.<sup>22</sup>

CBMP processes were implemented on a pilot basis in the nine states listed above. Among those, Maharashtra is one of the states where CBMP processes, led by a state-level nodal NGO, have been sustained, continuously expanded without interruption and diversified.<sup>23</sup> By the end of December 2018, CBMP was occurring in more than 1200 villages across 19 of the total 36 districts in the state. CBMP activities are implemented at village, primary health-care, block, district and state levels. Stakeholders, including health officials and staff, elected local panchayat representatives, CSO representatives and community members, come together in multistakeholder monitoring and planning committees at each of these levels. More detail on CBMP activities is provided in Box 3.

The data generated through successive rounds of CBMP have demonstrated substantial improvements in services being delivered at village level and at primary health-care centre level. There have been major improvements in immunization coverage and antenatal care at village level, and there is greater availability of ambulance services and medical officers staying on the premises of primary health-care centres (PHCs). An assessment of key health services was carried out by the state-level nodal CSO, Support for Advocacy and Training to Health Initiatives, in 2014. A set of 40 PHCs from various areas of Maharashtra where CBMP processes were active was compared with a set of 40 PHCs in areas not covered by CBMP. The two sets of PHCs were matched to ensure that they had similar basic infrastructures and levels

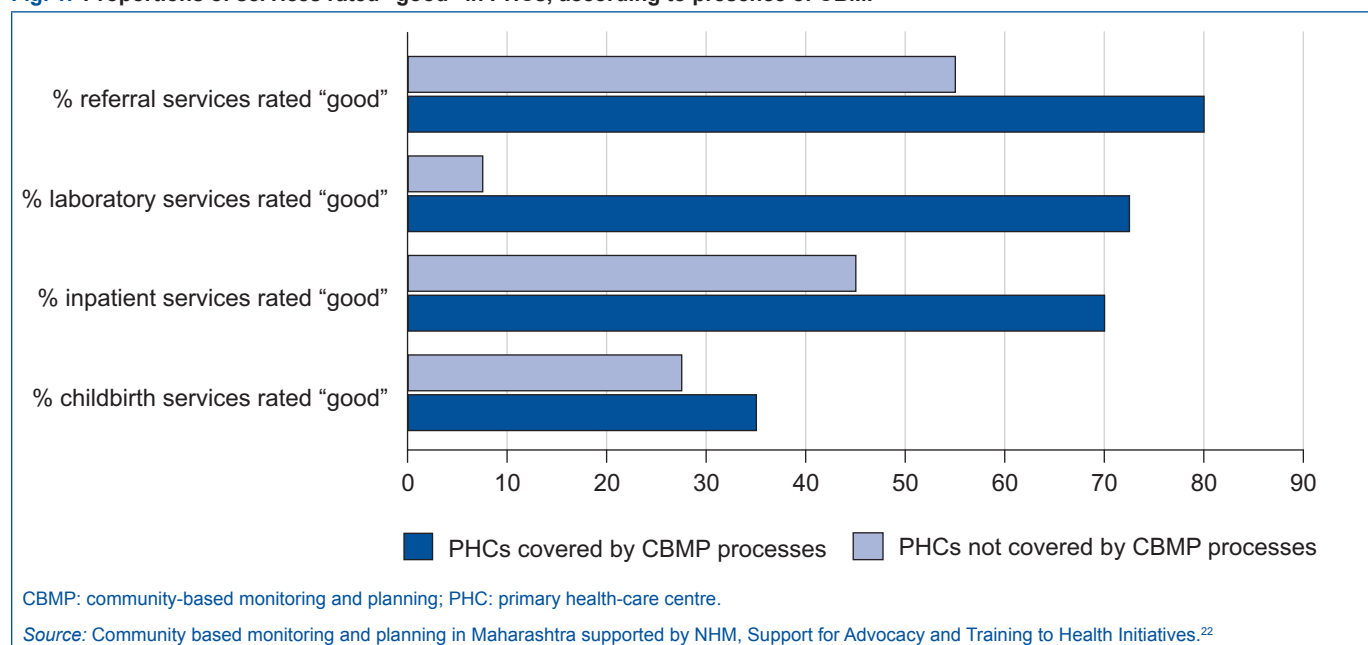
#### Box 3. CBMP activities and processes

**CBMP activities** Implementation of CBMP includes awareness-raising and preparatory activities; capacity-building and training of participants; formation and functioning of monitoring and planning committees at various levels; community-based assessment of health services; display of community report cards; and organization of public dialogues and state-level dialogue events. One of the core strategies of CBMP is the *jan samvad*, each of which is attended by community members and diverse stakeholders. In these public dialogues, citizens and grassroots activists and representatives report on their experiences of health services in the presence of health officials to inspire corrective actions. Village meetings (*gram sabhas*) are sometimes used for these activities, allowing anyone from the community to attend, which contributes to making the dialogue inclusive and participatory. The gathering of hundreds of community members enables a degree of equalization of power with officials and reduced threat of retribution. In addition, the formal provision of space and technical support also helps the hitherto voiceless speak out.

**CBMP processes** CBMP uses interactive methods to ensure and increase community participation; pictorial user-friendly tools to gather community feedback; digital methods for rapid feedback, such as SMS surveys; regular multistakeholder dialogue in participatory committees; periodic mass accountability events; chains of reinforcing actions across health system levels; a system of entitlements, with official sanctions to create community accountability; positive engagement and orientation of health-care providers; and facilitation by a coalition of CSOs. Organizations with a demonstrable track record of rights-based activities in the health sector have been selected as nodal CSOs in all areas. The state-level nodal CSO is selected by scrutiny through an officially nominated committee following an open advertisement for candidates. District- and block-level nodal CSOs are selected by the state-level nodal CSO through nomination and based on a track record of rights-based work in the health sector in each area.

of availability of medical officers, to ensure comparability.<sup>22</sup> Similar community monitoring data on the status of delivery of key health services were available for both sets of PHCs. The evaluation found that PHCs in areas where CBMP was operational had markedly better service performance than PHCs in non-CBMP areas (see Fig. 1).

There is documented evidence that CBMP activities at state level have improved the performance and outcomes of health programmes and improved services.<sup>24</sup> In Maharashtra state, the approach has been extended to nutrition services for children, as community action for nutrition (CAN).<sup>25</sup> CAN is based on community monitoring of child-care and nutrition centres, which has been being implemented in over 400 tribal villages across Maharashtra since 2018. CBMP in Maharashtra

**Fig. 1. Proportions of services rated “good” in PHCs, according to presence of CBMP**

state has contributed to deepening democracy in the context of the health system by creating forums for direct democracy such as jan samvads; expanding representative democracy through multistakeholder monitoring and planning committees with substantial community participation; reclaiming representative democracy by means of activation and orientation of elected local (panchayat) representatives; and strengthening internal accountability mechanisms by promoting external accountability processes. Maharashtra's CBMP experience can inform communization of health services in diverse contexts, by showing a path towards making health services genuinely effective and responsive to people's needs, thus paving the way for UHC.

### District level: “last-mile” cooperatives for accessing social services in Gujarat

“Last-mile” or “difficult-to-reach” communities typically lack infrastructure and have limited access to relevant information. Lack of information is a well-documented barrier to people accessing social services, including health services.<sup>26,27</sup> This challenge was recognized by the Self-Employed Women's Association (SEWA), a cooperative-based organization of women working in the informal sector, and resulted in the launch of the SEWA shakti kendras (SSKs) initiative in Ahmedabad, Gujarat, India, in 2015. An SSK is a centre located within a community – a village, urban ward or low-income neighbourhood – that enables women working in the informal sector and their families to exercise their rights to access public services and programmes, while ensuring that entitlements reach them in a simple, timely and transparent manner. The SSKs are run by local women leaders called “aagevans”, who are trained by SEWA, belong to the same community as the people they help, and have the leadership skills and motivation to serve. They themselves are all workers

in the informal economy, including street vendors; home-based workers such as garment workers and kite-makers; farmers; and domestic help. The SSKs become social service providers cum health hubs in their communities.

The SSKs are run, managed and used by local women, and their existence has triggered a process of exercising democratic rights and of active participation in and engagement with the public health system. The SSKs provide information on health and nutrition, serve as centres for health education and awareness, link local people with the many government schemes meant for them, and help them through the maze of procedures and the collection of required documents. They support and stand with the intended beneficiary until she gets the services that she is entitled to. At the SSKs, the women interact with the local authorities to obtain their entitlements and services and to address grievances. At the local level, the panchayati raj institutions support the running of such centres and provide space and other help. The SSKs organize women in relation to their health rights and entitlement issues. Once they are organized, they attend gram sabhas together and raise their voices for constructive action at the local level. The SSKs also work closely with local governance forums such as health, vigilance, school management and other committees for women; this develops their leadership skills and, with proper support, these committees become truly active and laboratories for democracy and good governance.

In December 2018, there were 18 SSKs in Gujarat, managed by the aagevans, who empower their clients with new knowledge, skills and linkages, and the confidence to speak out to the local health committees. The engagement of aagevans beyond the health sector provides them, and the communities they serve, with information and access to other entitlements, for example in relation to nutrition, pensions and insurance, that are part of the current social security net in India. Aagevans proactively reach out to the poorest and most vulnerable communities, such as Adivasis, Dalits and

minorities, to empower them through information on their rights and entitlements, offering easy and timely access to services and programmes and providing them with a space where they can discuss issues of local concern. In addition, the SSKs have also become hubs for building the capacity of the members of the various local committees (e.g. by providing up-to-date information on the structure and functions of local committees and on untied funds and their usage, and by developing members' managerial and leadership skills), thus increasing accountability and transparency and strengthening democratic governance in public health programmes.

A baseline survey of 400 households in areas covered by four SSKs, two rural and two urban, was done in 2016 and then repeated in 2018 to assess the impact of the intervention.<sup>28</sup> The survey was designed to measure the target population's knowledge about, and utilization of, various health and nutrition schemes, services and facilities. The evaluation found that the SSK intervention had increased awareness of government initiatives among the target community members across locations. Specifically, the SSKs had improved the proportion of respondents who were "fully aware" of a range of government interventions, where full awareness was defined as knowing about three predetermined entitlements to use a service, facility or scheme. For example, very high improvement in awareness was reported for government schemes meant for all household members, such as one providing cash benefits for the construction of toilets, and also for facilities meant for all or most members of household, such as PHCs. Fig. 2 shows increases in the proportions of women and men who demonstrated full awareness of three government services: family planning services, village health and nutrition days, and adolescent health days. In addition, among those who demonstrated full or partial awareness of the services, uptake generally increased. By contrast, no improvement was found in awareness and uptake of some

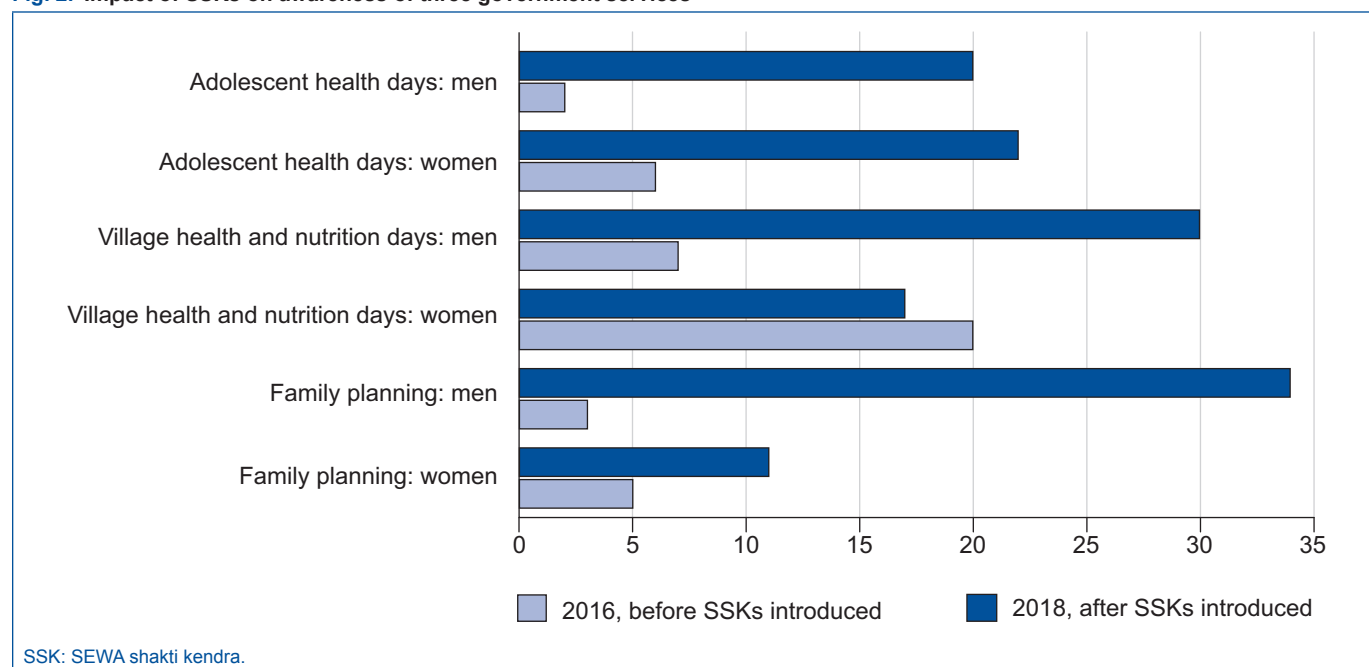
initiatives, such as two schemes focusing largely on nutrition and development in young children, and these results may inform future interventions.

## Discussion

### Global evidence on the role of civil society organizations in health

There is emerging evidence from various parts of the world on CSOs and CBOs playing an important role in health. The South African experience, where CSO engagement and advocacy ensured access to HIV/AIDS medicines, is widely recognized.<sup>29</sup> In Thailand, for more than a decade the National Health Assemblies have been a key enabling factor for building civil society's capacity to engage with the policy-making process and for bringing evidence more strongly into policy discussions.<sup>30</sup> Global experiences suggest that focusing on community participation yields several benefits: wider dissemination of knowledge on health schemes and programmes; better organization of services, keeping attention on the community's needs; and increased responsibility on the part of communities for their own health.<sup>31</sup> People are more likely to use and respond positively to health services if they are involved in the planning and decision-making processes.<sup>32</sup> In a community monitoring intervention in Uganda, quantitative survey data were used to construct a unique report card for each of a group of health-care facilities covering a population of 55 000 households. At community meetings, participatory methods were then used to disseminate the information in the report cards and encourage community members to develop a shared view on how to improve service delivery and monitor the provider. The authors reported that the intervention resulted in improved health outcomes, including reduced child mortality and increased child weight.<sup>33</sup> Although reanalysis of

**Fig. 2. Impact of SSKs on awareness of three government services**



the data suggested that the effects on health outcomes may be less robust than initially thought, it nevertheless supported the finding that the intervention modified health-care providers' behaviour and communities' utilization of services.<sup>34</sup>

### Civil society organizations and universal health coverage in India

CAH is arguably the largest community-led accountability initiative in India and possibly in the world, and it is being implemented with a mandate and financial support from the government. CSOs, at both national and state levels, have played a key role in the process. Efforts made as part of CAH have been contributing to health systems strengthening by improving health governance in India. CAH is giving voice to citizens and communities, creating accountability, helping to improve communication and increase transparency among a broader network of stakeholders, and providing an independent perspective on progress. CAH plays a critical role as India accelerates its journey towards UHC. CAH in India has been strengthened and developed considerably in the past decade and a half. The mechanisms have matured, with some states doing better than others. As noted earlier, CBOs and CSOs in India have gained extensive experience through playing an active role in the prevention and control of HIV/AIDS, polio elimination and increasing coverage of routine immunization vaccines over nearly two decades. Increasingly, these organizations are being engaged to work on tuberculosis elimination and related efforts in India.

In the past few years, following the release of the report of the high-level expert group on UHC in India in 2011,<sup>35</sup> there has been an increasingly vibrant policy dialogue and greater engagement on and around UHC in India, at both national and state levels. An example of the formal engagement of CSOs and CBOs in policy and implementation processes in India was the public consultation on the draft of the national health policy in 2015, which resulted in the Ministry of Health and Family Welfare receiving nearly 5000 responses from the public and CSOs. These responses were reviewed and considered during the final revision of the policy in 2017.<sup>5</sup> Thereafter, since the announcement of the Ayushman Bharat programme<sup>6</sup> in early 2018, several national consultations and policy dialogues on UHC with wider engagement of CSOs and CBOs have taken place. These have included consultations on UHC and CSOs (New Delhi, August 2018; Kolkata, March 2019; Shillong, July 2019; and Chennai, September 2019), the 3rd National Health Assembly in Raipur (September 2018) and a national meeting of the Advisory Group on Community Action in March 2019. In addition, there have been state-level workshops in Madhya Pradesh and Rajasthan on UHC, and discourses on the right to health in three Indian states.<sup>36</sup> These activities, discourses and consultations involved several representatives from CSOs and CBOs, and focused on various aspects of UHC, such as addressing inequities, the right to health and explaining the concept of UHC to people in non-technical, simple language.

CSO and community engagement has arguably facilitated an increase in the attention paid by elected leaders and politicians to health, which had a significantly higher profile in the run-up to India's general election in May 2019,<sup>37</sup> and a few state elections, than in previous years. Although it is not possible to identify a cause and effect relationship, these frequent and visible civil society engagements and activities

are likely to have contributed to health becoming a prominent issue in the election manifestos of several parties at both national and state levels in India. Health is a state subject in India, and the concept of access to health care as a right to be inscribed in law is gaining traction.

A series of consultations and public dialogues were held around the UN high-level meeting on UHC in September 2019,<sup>38</sup> which included the Community of Practitioners on Accountability and Social Action in Health Global Symposium 2019 on Citizenship, Governance and Accountability in Health, held in New Delhi,<sup>39</sup> a follow-up consultation on UHC and CSOs in New Delhi in November 2019, a workshop on ensuring the social accountability and responsiveness of the private health-care sector to help in moving towards UHC<sup>40</sup> and a state government-led national consultation on the right to health in Bhopal, Madhya Pradesh.<sup>36</sup>

Several initiatives have been led and coordinated by the government. As part of the expansion of health and wellness centres under the Ayushman Bharat programme, the Ministry of Health and Family Welfare constituted a working group with extensive representation of civil society members to focus on issues such as strengthening primary health care, communitization, ensuring referral linkage in health services, and convergence in health services at various levels. These initiatives have contributed to further formalization of CSO and CBO participation and sustaining momentum on accelerating UHC in the country. The Central Council of Health and Family Welfare (CCHFW) is one of the highest advisory bodies to provide support and advice to the Ministry of Health and Family Welfare on health policy formulation and implementation in India. The CCHFW was set up under Article 263 of the Constitution of India,<sup>41</sup> and is chaired by the Union Minister for Health and Family Welfare. The state governments are represented by their health ministers; other council members include public health experts and civil society representatives. In 2019, CCHFW was reconstituted with wider CSO and CBO representation, and the 13th meeting of the CCHFW was held in October 2019.<sup>42</sup> In December 2019, the Ministry of Health and Family Welfare collaborated with WHO and other partners and conducted policy dialogue sessions (called "policy labs") on three broad themes including "communitization and wellness" as part of a consultation to coincide with International Universal Health Coverage Day 2019.<sup>43</sup>

### Accountability and governance in mixed health-care systems

Community and social accountability and participatory governance of health systems are among the key elements for UHC.<sup>44</sup> There is a crucial role for CSOs and CBOs to play in developing accountability mechanisms in countries with mixed health-care systems (i.e. those in which out-of-pocket payments and market provision of services predominate as a means of financing and providing services in an environment where publicly financed government health delivery coexists with privately financed market delivery). Community and social accountability and participatory governance are needed to ensure regulation of the private medical sector and to protect patients' interests and rights. A mixed health-care system with private sector predominance is a major challenge to efforts to move towards UHC in low- and middle-income countries such as India, where regulations are poorly enforced and there



are deficits in accountability mechanisms and participatory governance in both the public and private health sectors. CAH, with CBO and CSO engagement, can work as an effective tool to strengthen accountability and governance in health-care systems in most settings and is especially desirable in health systems with private sector predominance. The presence of the panchayati raj institutions has contributed to the effective implementation of CAH in India. Members of these institutions are part of various bodies at the local level, such as village health sanitation and nutrition committees and rogi kalyan samitis, which give them a mandate as well as sense of responsibility. There are examples, documented through annual joint monitoring missions and common review missions, of communitization being better implemented when the participation of panchayati raj institutions was proactive and inclusive.<sup>21</sup>

### Need for more synthesis and dissemination of evidence on CAH in India

While CAH has been going on for more than a decade, there is an acknowledged need for documentation of experiences and evidence relating to a few relevant aspects. Have CAH and communitization in the NHM resulted in reduced corruption and improved transparency and accountability in health services in India? Are there broader and generalizable lessons on challenges and difficulties in community participation in health services, applicable to all settings? Has CAH helped to address gender issues relating to the provision of and access to health services? Clearly, there is a need for an in-depth, systematic and nuanced examination and documentation of CAH experiences in India, looking at some of these key questions. There are emerging discourses and dialogues on strengthening health systems and policy research and on setting up a national knowledge platform in India. To tackle the widely acknowledged shortfall in research on topics of relevance for health system improvements in India, the Ministry of Health and Family Welfare and other stakeholders have proposed setting up the National Knowledge Platform for health systems and public health policy research.<sup>45</sup> The generation of evidence on the impact of CSO and CBO engagement and CAH could be linked to this initiative.

## Conclusion and the way forward

There is a global consensus on engaging communities, CBOs and CSOs for better delivery of health services, which is supported by emerging evidence. CAH in India has developed and matured in the past decade and a half, and is rightly being supplemented and strengthened by regular consultations, workshops and public policy dialogues led and/or participated in by representatives of CBOs and CSOs. This is contributing to the democratization of community and civil society engagement in health in India. However, to make accelerated progress on UHC and scale up CSO and CBO engagement in health across the country, there is a need to sustain this momentum, building on the lessons learnt, generating additional evidence, strengthening institutional mechanisms and supporting activities through sustainable financing. There is also a need to create a broad base for participation of CSOs and CBOs beyond the Advisory Group on Community

Action and national consultations and workshops. These developments provide important lessons and opportunities, both to improve governance and accountability in the health sector and to accelerate progress towards UHC. Lessons learnt from the implementation of CAH in India may be applicable to other countries in South-East Asia, as well as to most low- and middle-income countries, as they make progress towards UHC and meeting the targets of the 2030 Agenda for Sustainable Development.

**Acknowledgements:** The authors would like to thank officials in the Ministry of Health and Family Welfare, Government of India, as well as in the Department of Public Health, Government of Maharashtra, for their engagement in community action for health activities. The inputs provided by government officials in both formal and informal interactions with authors of this manuscript are acknowledged.

**Disclaimer:** The affiliations in this article reflect the institutions at the time of finalization of the first draft of the manuscript. At the time of first submission, one of the authors (MJ) was with the Ministry of Health and Family Welfare, Government of India, and he is currently with the WHO Regional Office for South-East Asia, New Delhi. BR has been working with the Secretariat of the Advisory Group on Community Action based at the Population Foundation of India. CL, HDG, MJ, and HB are WHO staff members. The views expressed in this article are those of the authors and do not reflect the views and opinions of the institutions/organizations they are or have been associated with in the past or at present.

**Author contributions:** CL, HDG and MJ conceptualized the paper and developed the outline and content for the first draft. The related sections on national, state and district levels were drafted by BR, AS and MC, respectively. MJ and HB provided critical insights and inputs for the revision of the draft manuscript, prior to finalization. All authors approved the final draft.

**Source of funding:** None.

**Conflict of interest:** None.

**How to cite this paper:** Lahariya C, Roy B, Shukla A, Chatterjee M, De Graeve H, Jhalani M, Bekedam H. Community action for health in India: evolution, lessons learnt and ways forward to achieve universal health coverage. WHO South-East Asia J Public Health. 2020;9(1):82–91. doi:10.4103/2224-3151.283002.

## References

1. Transforming our world: the 2030 Agenda for Sustainable Development. New York (NY): United Nations; 2015 (A/RES/70/1; <https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf>, accessed 4 March 2020).
2. Towards a Global Action Plan for Healthy Lives and Well-Being for All: uniting to accelerate progress towards the health-related SDGs. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/311667>, accessed 4 March 2020).
3. Health systems governance for universal health coverage. Geneva: World Health Organization; 2010 ([https://www.who.int/universal\\_health\\_coverage/plan\\_action-hsgov\\_uhc.pdf](https://www.who.int/universal_health_coverage/plan_action-hsgov_uhc.pdf), accessed 4 March 2020).



4. Declaration of Astana. Global Conference on Primary Health Care. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF); 2018 (<https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>, accessed 1 March 2020).
5. National health policy 2017. New Delhi: Ministry of Health and Family Welfare, Government of India; 2017 ([https://www.nhp.gov.in/NHPfiles/national\\_health\\_policy\\_2017.pdf](https://www.nhp.gov.in/NHPfiles/national_health_policy_2017.pdf), accessed 31 March 2020).
6. Government of India. National Health Portal. Ayushman Bharat Yojana ([https://www.nhp.gov.in/ayushman-bharat-yojana\\_pg](https://www.nhp.gov.in/ayushman-bharat-yojana_pg), accessed 1 March 2020).
7. National Health Mission, Ministry of Health and Family Welfare, Government of India (<https://nhm.gov.in/>, accessed 1 March 2020).
8. National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India. Civil Society (<http://naco.gov.in/civil-society-0>, accessed 4 March 2020).
9. Thacker N, Vashishtha VM, Awunyo-Akaba J, Mistry RF. Civil society organizations, the implementing partners of the Global Vaccine Action Plan. *Vaccine*. 2013 Apr;31 Suppl 2:B97–102. <https://doi.org/10.1016/j.vaccine.2012.12.040> PMID:23598497
10. Siddique AR, Singh P, Trivedi G. Role of Social Mobilization (Network) in polio eradication in India. *Indian Pediatr*. 2016 Aug;53 Suppl 1:S50–6. PMID:27771640
11. CORE Group. Polio eradication toolkit (<http://coregroup.org/polio-eradication-toolkit/>, accessed 4 March 2020).
12. National Rural Health Mission: meeting people's health needs in rural areas – framework for Implementation 2005–2012. New Delhi: Government of India, Ministry of Health and Family Welfare; 2005 (<http://www.nipccd-earchive.wcd.nic.in/sites/default/files/PDF/NRHM%20-%20Framework%20for%20Implementation%20-%20%202005-MOHFW.pdf>, accessed 4 March 2020).
13. Gaitonde R, San Sebastian M, Muralleedharan VR, Hurtig AK. Community action for health in India's National Rural Health Mission: one policy, many paths. *Soc Sci Med*. 2017 Sep;188:82–90. <https://doi.org/10.1016/j.socscimed.2017.06.043> PMID:28732238
14. National Health Mission, Ministry of Health and Family Welfare, Government of India. Mission Steering Group (<https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=1293&lid=193>, accessed 4 March 2020).
15. Scott K, George AS, Ved RR. Taking stock of 10 years of published research on the ASHA programme: examining India's national community health worker programme from a health systems perspective. *Health Res Policy Syst*. 2019 Mar;17(1):29. <https://doi.org/10.1186/s12961-019-0427-0> PMID:30909926
16. Ved R, Sheikh K, George AS, Raman VR. Village health sanitation and nutrition committees: reflections on strengthening community health governance at scale in India. *BMJ Glob Health*. 2018 Oct;3 Suppl 3:e000681. <https://doi.org/10.1136/bmjgh-2017-000681> PMID:30364368
17. Ragi kalyan samiti. New Delhi: Government of India, Ministry of Health and Family Welfare, Press Information Bureau; 2013 (<http://pib.nic.in/newsite/PrintRelease.aspx?relid=98919>, accessed 4 March 2020).
18. Rao KS. Do we care? India's health system. New Delhi: Oxford University Press; 2018.
19. National Health Mission. Community action for health (<https://nrhmcommunityaction.org/agca/>, accessed 4 March 2020).
20. Singh S, Das A, Sharma S. Reviving hopes, realizing rights: a report on the first phase of community monitoring under NRHM. New Delhi: National Secretariat on Community Action, National Rural Health Mission; 2010 ([https://nrhmcommunityaction.org/wp-content/uploads/2017/06/A\\_report\\_on\\_the\\_First\\_phase\\_of\\_Community\\_Monitoring.pdf](https://nrhmcommunityaction.org/wp-content/uploads/2017/06/A_report_on_the_First_phase_of_Community_Monitoring.pdf), accessed 4 March 2020).
21. National Health Mission, Ministry of Health and Family Welfare, Government of India. Common review mission (<https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=795&lid=195>, accessed 4 March 2020).
22. Community based monitoring and planning in Maharashtra supported by NHM. Kothrud, Pune: Support for Advocacy and Training to Health Initiatives; 2015 (<http://www.cbmpmaharashtra.org/documents/book/Community%20Based%20Monitoring%20and%20Planning%20in%20Maharashtra%20Supported%20by%20National%20Health%20Mission-%20policy%20brief.pdf>, accessed 4 March 2020).
23. Shukla A, Khanna R, Jadhav N. Using community-based evidence for decentralized health planning: insights from Maharashtra, India. *Health Policy Plan*. 2014 Sep;33(1):e34–e45. <http://doi.org/10.1093/heapol/czu099> PMID:29304253
24. Khanna R. Developing capacities for using community oriented evidence towards strengthening health planning in Maharashtra state, India: an evaluation report. Kothrud, Pune: Support for Advocacy and Training to Health Initiatives; 2013 ([http://www.cbmpmaharashtra.org/study\\_reports/An%20Evaluation%20Report\\_Developing%20Capacities%20for%20Using%20Community%20Oriented%20Evidence%20Towards%20Strengthening%20Health%20Planning%20in%20Maharashtra%20State,%20India.pdf](http://www.cbmpmaharashtra.org/study_reports/An%20Evaluation%20Report_Developing%20Capacities%20for%20Using%20Community%20Oriented%20Evidence%20Towards%20Strengthening%20Health%20Planning%20in%20Maharashtra%20State,%20India.pdf), accessed 1 March 2020).
25. Support for Advocacy and Training to Health Initiatives. Community action for nutrition (<http://sathicehat.org/community-action-for-nutrition/>, accessed 4 March 2020).
26. Ensor T, Cooper S. Overcoming barriers to health service access: influencing the demand side. *Health Policy Plan*. 2004 Mar;19(2):69–79. <https://doi.org/10.1093/heapol/czh009> PMID:14982885
27. Eng TR, Maxfield A, Patrick K, Deering MJ, Ratzan SC, Gustafson DH. Access to health information and support: a public highway or a private road? *JAMA*. 1998 Oct;280(15):1371–5. <https://doi.org/10.1001/jama.280.15.1371> PMID:9794322
28. Trivedi M, Sharma B. Evaluation of Gujarat SEWA Shakti Kendras for good governance in selected rural and urban areas. Gandhinagar: Indian Institute of Public Health Gandhinagar; 2019.
29. Olesen T. 'In the court of public opinion': transnational problem construction in the HIV/AIDS medicine access campaign, 1998–2001. *Int Sociol*. 2006;21(1):5–30. <https://doi.org/10.1177/0268580906059288>
30. Rasanathan K, Posayanonda T, Birmingham M, Tangcharoensathien V. Innovation and participation for healthy public policy: the first National Health Assembly in Thailand. *Health Expect*. 2012 Mar;15(1):87–96. <https://doi.org/10.1111/j.1369-7625.2010.00656.x> PMID:21281413
31. Rifkin SB. Examining the links between community participation and health outcomes: a review of the literature. *Health Policy Plan*. 2014 Sep;29 Suppl 2:ii98–106. <https://doi.org/10.1093/heapol/czu076> PMID:25274645
32. Rosenstock IM. Why people use health services. *Milbank Q*. 2005;83(4). <https://doi.org/10.1111/j.1468-0009.2005.00425.x> PMID:5967464
33. Björkman M, Svensson J. Power to the people: evidence from a randomized field experiment on community-based monitoring in Uganda. *Q J Econ*. 2009 May;124(2):735–69. <https://doi.org/10.1162/qjec.2009.124.2.735>
34. Donato K, Mosqueira AG. Power to people? A replication study of a community-based monitoring programme in Uganda. 3ie Replication Paper 11. Washington (DC): International Initiative for Impact Evaluation; 2016 (<https://www.3ieimpact.org/sites/default/files/2017-11/rps11-power-to-people-uganda.pdf>, accessed 11 March 2020).
35. Planning Commission of India. High-level expert group report on universal health coverage for India. New Delhi: Planning Commission of India; 2011. <https://doi.org/10.13140/RG.2.2.12162.27843>
36. Government of Madhya Pradesh. Right to Health Conclave 2019 (<http://ayushmanbharat.mp.gov.in/conclave>, accessed 10 March 2020).
37. Rao P. Put health on the political agenda in an election year. *Hindu Business Line* (<https://www.thehindubusinessline.com/specials/pulse/put-health-on-the-political-agenda-in-an-election-year/article25913891.ece>, accessed 20 March 2020).
38. UHC2030. The UN High-Level Meeting (UN HLM) on Universal Health Coverage, 23 September 2019, New York (<https://www.uhc2030.org/un-hlm-2019/>, accessed 10 March 2020).
39. Community of Practitioners on Accountability and Social Action in Health. COPASAH Global Symposium 2019: Citizenship, Governance and Accountability in Health (<https://www.copasah.net/copasah-global-symposium-2019.html>, accessed 10 March 2020).
40. Support for Advocacy and Training to Health Initiatives (SATHI). Report: Workshop on ensuring social accountability and responsiveness of the private healthcare sector for moving towards UHC. Kothrud, Pune, and New Delhi: SATHI and Jan Swasthya Abhiyan; November 2019.

41. National Health Mission. Proceeding of the Central Council of Health and Family Welfare (<https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1255&lid=274>, accessed 10 March 2020).
42. Dr. Harsh Vardhan inaugurates 13th Conference of Central Council of Health and Family Welfare (CCHFW). New Delhi: Government of India, Ministry of Health and Family Welfare, Press Information Bureau; 2019 (<https://pib.gov.in/Pressreleaseshare.aspx?PRID=1587700>, accessed on 10 March 2020).
43. Lahariya C, Sundararaman T, Ved RR, Adithyan GS, De Graeve H, Jhalani M, et al. What makes primary healthcare facilities functional, and increases the utilization? Learnings from 12 case studies. J Family Med Prim Care. 2020;9(2):539–46. [https://doi.org/10.4103/jfmpc.jfmpc\\_1240\\_19](https://doi.org/10.4103/jfmpc.jfmpc_1240_19)
44. Primary Health Care Performance Initiative. Social accountability (<https://improvingphc.org/social-accountability>, accessed 10 March 2020).
45. Sheikh K, Kumar S, Ved R, Kumar S, Raman VR, Ghaffar A, et al. India's new health systems knowledge platform-making research matter. Lancet. 2016 Dec;388(10061):2724–5. [https://doi.org/10.1016/S0140-6736\(16\)32391-1](https://doi.org/10.1016/S0140-6736(16)32391-1) PMID:27924765