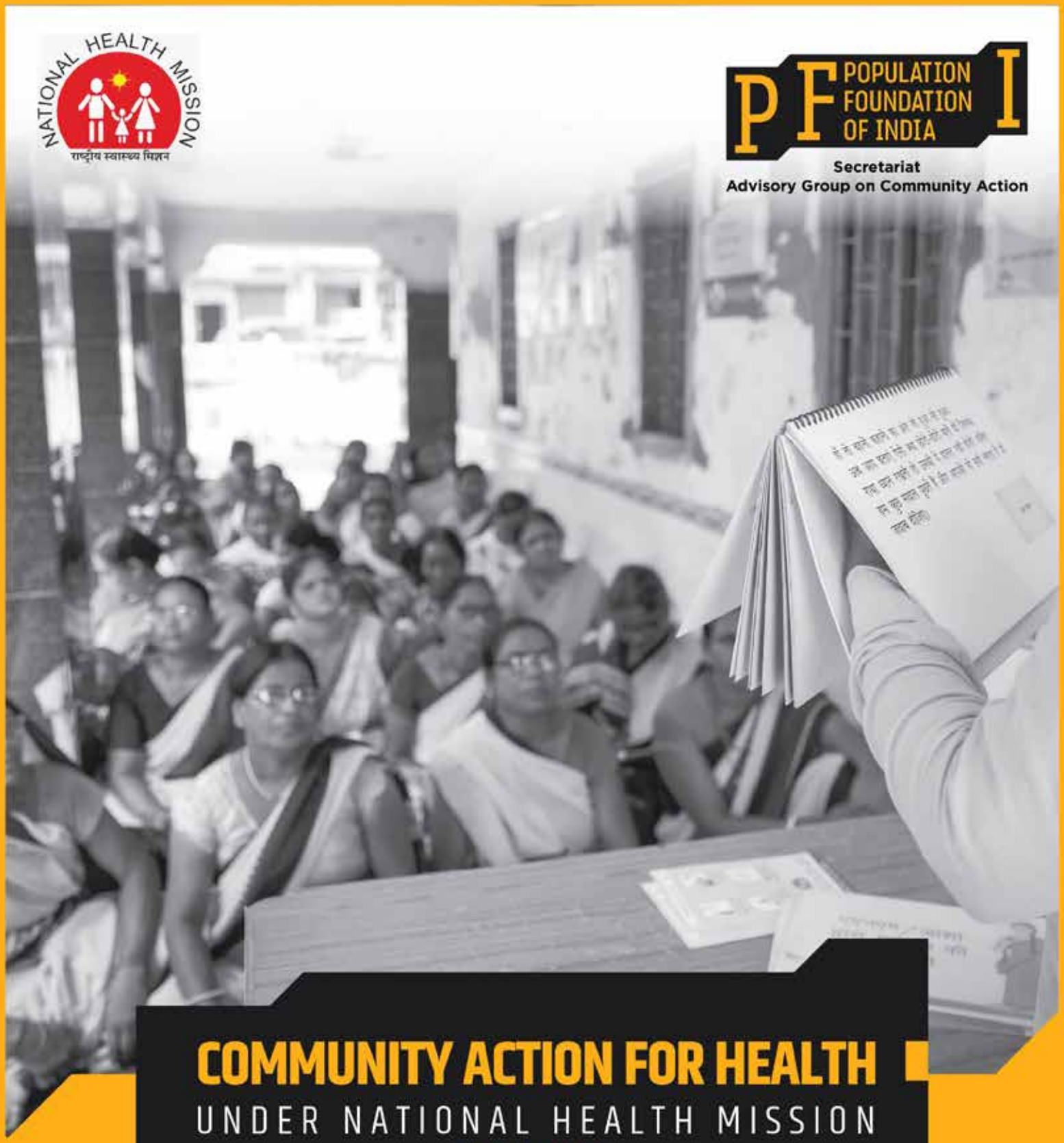
NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

POPULATION FOUNDATION OF INDIA

Secretariat
Advisory Group on Community Action



COMMUNITY ACTION FOR HEALTH

UNDER NATIONAL HEALTH MISSION

2005-2023

CONTENTS

FOREWORD

I am both proud and honoured to introduce this report, encapsulating 18 years of dedicated support by the Advisory Group on Community Action (AGCA) to fortify community action for health (CAH)—a key pillar of the National Health Mission (NHM). Comprising eminent public health experts, AGCA has continually guided state governments in fostering community engagement and accountability, in the planning, provisioning, and monitoring of public health services.

Since 2005, Population Foundation of India has had the distinct privilege of hosting the AGCA secretariat, as mandated by a government order. Under the guidance of several Ministry of Health and Family Welfare (MoHFW) officials, the National Health Systems Resource Center (NHSRC), the state NHM leadership, and CSOs, we have ardently strived to "bring the public into public health."

This document stands as a testament to the unwavering dedication of countless individuals and groups who champion community-driven initiatives, thereby paving the way for universal health coverage in India. The pages that follow spotlight AGCA's remarkable achievements, underscoring the pivotal role of community action in transforming the health landscape.

From its inception during the pilot phase, AGCA has embarked on a groundbreaking journey. It has pioneered innovative approaches, facilitating the adoption and expansion of CAH processes across over 2,30,000 villages, 145 cities, and 450 districts in 25 states, making CAH perhaps the biggest community action programme in the world. Over the years, the AGCA secretariat has successfully trained over 50,000 health officials as master trainers and facilitators. Throughout this journey, in collaboration with the NHSRC, the secretariat has crafted extensive resources for states, streamlined implementation, and fortified capacities within states and districts to navigate the intricate processes of community engagement. An evaluation of the CAH pilot showed the following outcomes: greater awareness in the community on 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 outside prescriptions and demands for informal payments by the health providers

Amidst shifting policy environments and the diverse needs of individual states, AGCA has consistently displayed adaptability and resilience. Our knack for blending technical support to local contexts and evolving demands underscores our dedication to the health and well-being of communities.

Field testimonials and case studies provide an insightful look into the tangible impact of CAH, enlivening statistics with faces and narratives. These accounts echo sentiments of change, hope, and progress.

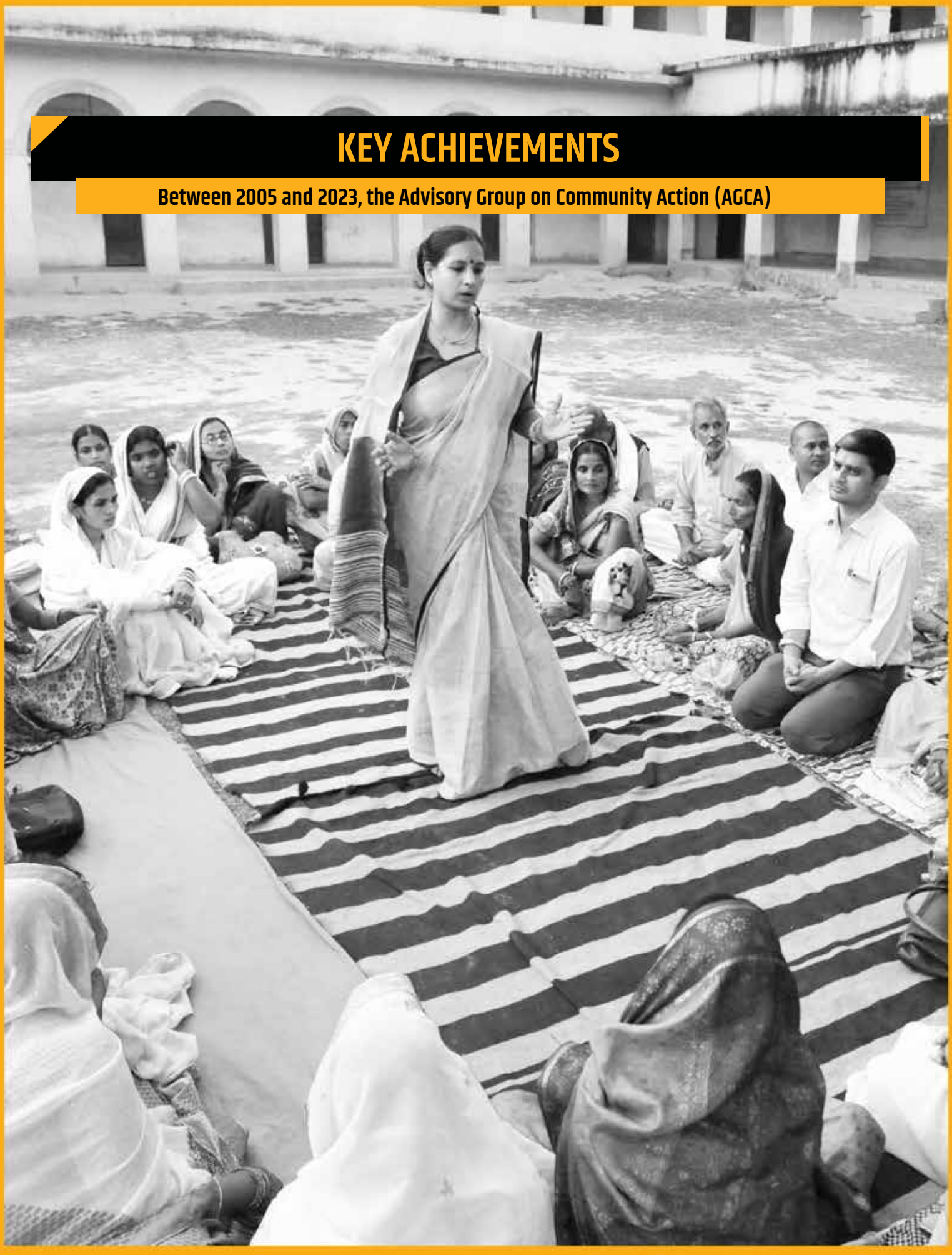
My profound gratitude to all AGCA members, who were extremely generous with their time and provided valuable guidance. I also want to thank the Secretariat team, Principal Secretary- Health, State NHM Mission Directors, state and district nodal officers, our partners, community leaders, and every stakeholder involved. Your steadfast commitment and relentless efforts are at the root of a brighter and healthier future for all.

As we continue this journey, let's renew our commitment to ensuring that community action remains at the forefront of health transformation, particularly under the ambitious Ayushman Bharat programme, spearheaded by the Government of India.

Poonam Muttreja
Executive Director, Population Foundation of India

KEY ACHIEVEMENTS

Between 2005 and 2023, the Advisory Group on Community Action (AGCA)



1

Provided technical support to 25 state governments to implement Community Action for Health (CAH) processes in **2,30,000 villages across, 450 districts and 145 cities.**

2

Supported the National Health Systems Resource Centre (NHSRC) in **developing national guidelines, training manuals and resource materials** for community action

3

Supported 31 state governments in developing the National Health Mission (NHM) **Programme Implementation Plan (PIPs)** for community action

4

Provided **regular feedback on issues from the ground** which required policy level attention, including participation in the Common Review Mission (CRM)

5

Oriented **4000 Community Health Officers (CHOs), Medical Officers (MOs)** on communitisation processes and rolling out Jan Arogya Samitis (JASs)

6

Organised over **3000 Jan Samwads** to find joint solutions between community and health officials to improve delivery of public health services

7

Organised **annual national and regional consultations, webinars, cross visits** to promote cross learning and adoption of good practices among state governments.

8

Trained a **pool of over 50,000 state, district and block NHM staff**

EXECUTIVE SUMMARY

The **Ministry of Health and Family Welfare (MoHFW) established the** Advisory Group on Community Action (AGCA), in 2005. It had eminent and experienced public health experts to guide state governments to ensure accountability in the health system and to make communities aware of their healthcare entitlements and take active part in the monitoring and planning of health services. The **AGCA Secretariat was hosted at the Population Foundation of India through a government order**. The Secretariat works under the guidance of the AGCA members. Quarterly meetings of the AGCA were organised with participation from the MOHFW and the National Health Systems Resource Centre (NHSRC). Regular interactions are also organized to review and plan out technical support to the state governments.

The AGCA has been providing technical support to state governments for the past 18 years to strengthen community action in the healthcare sector. It has been a vital cog in the country's public health system, enabling public participation and ensuring health services are need-based through a **blueprint that effectively implements community-action processes under the NRHM**. The AGCA has supported the NHSRC in **developing guidelines, training manuals, community monitoring tools and communication material.**

Between 2007 and 2009, the AGCA guided a **pilot in nine states** (Assam, Jharkhand, Odisha, Chhattisgarh, Madhya Pradesh, Rajasthan, Maharashtra, Tamil Nadu, Karnataka) covering 36 districts and 1,620 villages. The project was externally evaluated and showed very **positive outcomes** around **building trust between communities and health systems, improved coverage of health service and**, **support to frontline health workers** to overcome service delivery constraints. The project also effectively implemented local and **need-based planning** for special groups/remote areas, appropriate planning and **utilisation of untied funds** through Village Health Sanitation and Nutrition Committees (VHSNC), Sub Health Centers (SHC), Primary Health Centres (PHC) and Community Health Centres (CHC). The pilot resulted in the **deputation of doctors at PHCs, reduced demands for informal payments, timely and full payments of Janani Suraksha Yojana (JSY) incentives and a significant reduction in outside prescriptions.** The evaluation team recommended state governments **develop plans to initiate and scale up community-action processes**, along with simplifying the processes and community monitoring tools.

Continuing its support, the AGCA helped these nine states sustain and scale up their interventions while expanding the processes to five additional states—Gujarat, Bihar, Uttarakhand, Sikkim, and Manipur. Efforts were made to expand the state community-process teams **leading to the development of over 50,000 trainers and facilitators at the state, district, and block levels**. As a result, the community-action processes were **expanded from the initial pilot in nine states to 25 states, 452 districts, and 2,30,000 villages by 2023.**

In 2013, when the National Urban Health Mission (NUHM) was launched, the AGCA supported the activation of Mahila Arogya Samitis (MASs) in selected cities of Odisha. The success of these processes led to the scaling up of their implementation across **seven states and 145 cities.**

Since 2007, more than **3,000, Jan Samwads (Public Dialogues)** have been organised to enhance community engagement with health systems. These forums **facilitated the public voicing of issues and fostered a greater understanding of community healthcare challenges among administrators and policymakers. More importantly, solutions were sought jointly by 'Bringing the Public into Public Health'**.

Measures were taken to improve healthcare facilities, service provision, staff responsiveness, and fund utilization.
At the national level, the AGCA worked closely and supported the **National Health Systems Resource Center (NHSRC)** to develop national guidelines and resource materials. Additional **resources developed by the AGCA include guidelines for community-based monitoring**, **animation videos, and documentary films.**

In line with the MoHFW's focus on Comprehensive Primary Health Care (CPHC), the AGCA submitted a proposal on social accountability at Health and Wellness Centres (HWCs). It has been **working closely with the NHSRC to support state governments in rolling out Jan Arogya Samitis (JASs)**. This includes facilitating **training and orientation for over 3,700 Medical Officers (MOs) and Community Health Officers (CHOs).**

The AGCA has kept experimenting and nurturing **innovative approaches to community action** with state governments, including:

- Strengthening grievance redressal and local planning through Rogi Kalyan Samitis (RKSs) in 119 districts across five states—Bihar, Jharkhand, Uttar Pradesh, Manipur, and Goa

- Partnership between State Social Audit Units (SAUs) and NHM to conduct social audit of health services in 35 districts across 4 states: Jharkhand, Meghalaya, Uttarakhand, and Kerala

- Community-based monitoring of Health Wellness Centres (HWC) by the Village Health Sanitation and Nutrition Committees (VHSNCs) in 9 districts across Assam and Bihar

- Community-based monitoring through MASs in 145 cities across 7 states- Odisha, Bihar, Chhattisgarh, Gujarat, Delhi, Uttarakhand and Kerala

- People's Health Assemblies in 24 districts of Tamil Nadu

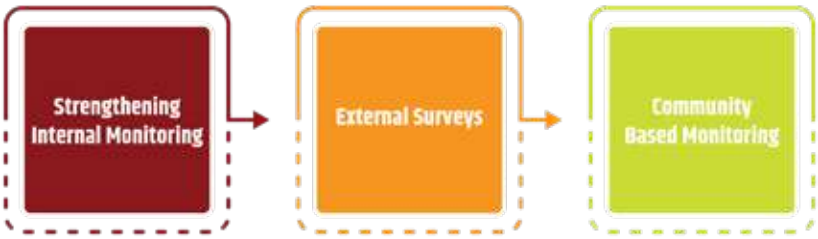
In 2023, AGCA launched the 'Samwad (Dialogue)' webinar series to **share best practices on community-action processes with the** state and district nodal officers to learn from these webinars and adopt effective practices in their own contexts. The AGCA has also been providing **regular feedback to the MoHFW, NHSRC and state governments** on ground-level issues that need policy-level attention. This is being done through **field visits** to states, participation in the **CRM** and **fact-finding missions** following a series of maternal deaths in Barwani, Madhya Pradesh, and sterilisation deaths in Bilaspur, Chhattisgarh.

Thus, the AGCA has contributed significantly to the success of NHM. Its approach of 'Bringing the Public into Public Health' provides a blueprint for making healthcare services transparent, accountable, and inclusive. The AGCA has championed a systemic shift from a passive receipt of services to an active community-engagement model, fostering trust and empowerment. By providing a platform for community voices, the AGCA has ensured that the Indian public health system is shaped '**of the people, by the people, and for the people**.' This robustly designed, implemented and evaluated has the potential to drive substantial improvements in the overall health status of the country.

During a global WHO meeting at Johannesburg, South Africa, senior officials from the international organisation **praised the community action model**, which has been led by the MoHFW and taken to scale across the country. At WHO's request, the AGCA submitted a case study to the organisation.

OVERVIEW OF COMMUNITY ACTION FOR HEALTH (CAH)

The National Rural Health Mission (NRHM) was launched in 2005 by the Government of India to provide equitable, affordable, and quality health services through an accountable framework. Communities were empowered to monitor and provide feedback on the functioning of health facilities in their areas. The AGCA was formed in 2005 by the MoHFW to guide community action under the NRHM. The AGCA Secretariat was hosted at Population Foundation of India through a government order.



Accountability Framework under NHM

COMMUNITY ACTION FOR HEALTH

Community Action for Health (CAH), previously known as Community Based Monitoring and Planning (CBMP), is a strategy of the National Health Mission (NHM). It places community members, organisations, and elected representatives at the centre of the health system to ensure their health needs and rights are met. It empowers communities to participate in monitoring health schemes, promoting equitable, accessible, and quality health services.

MANDATE OF AGCA

The AGCA comprises eminent and experienced public health experts from across the country. Its mandate is to

- Advise on developing community partnership and ownership for the NHM
- Provide feedback on ground realities to inform policy decisions
- Develop new models of community action and recommend further adoption/ extension to the national and state governments

AGCA MEMBERS

- Mr A.R. Nanda, Former Secretary, MoHFW
- Dr Abhay Shukla, SATHI-CEHAT
- Dr Abhijit Das, Centre for Health and Social Justice
- Mr Alok Mukhopadhyay, Voluntary Health Association of India (VHAI)

• Mr Gopi Gopalakrishnan, World Health Partners

• Dr H. Sudarshan, Karuna Trust

• Ms Indu Capoor, Chetna

• Ms Mirai Chatterjee, Self Employed Women's' Association

• Dr Narendra Gupta, Prayas

• Dr M. Prakasamma, Answers

• Ms Poonam Muttreja, Population Foundation of India

• Dr Sharad Iyengar, Action Research and Training for Health

• Dr Thelma Narayan, Sochara

• Dr Vijay Aruldas, Christian Medical College, Vellore

PILOT PHASE COMMUNITY ACTION FOR HEALTH (CAH)

In 2007-09 the AGCA guided the implementation of a pilot on community action for health in 1,620 villages across 36 districts in nine states.

Key results and findings from the pilot:

1. Village Health Sanitation and Nutrition Committees (VHSNCs) provided a voice to the community, especially from the excluded and marginalised groups

2. Increased knowledge of health entitlements in the community

3. Health department more responsive in providing services to the community

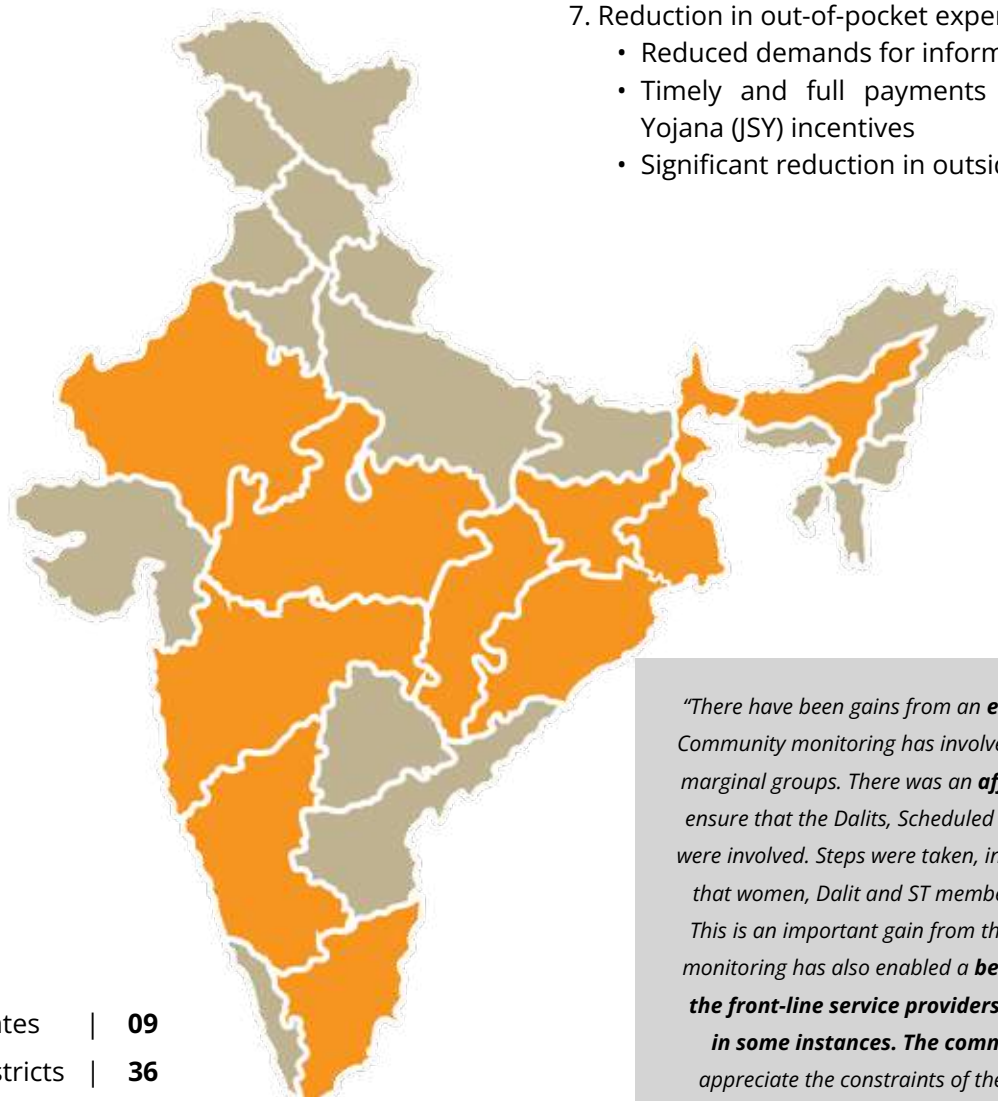
4. Greater community involvement and support to frontline health workers helped overcome service delivery constraints, supporting more effective local planning.

5. Enhanced trust and improved interaction between the provider and the community
   - Improvements in service delivery –ante natal and post-natal care, immunisation. Provider became more responsive to community needs.

6. Community-based inputs in planning and action
   - Active involvement of panchayat members in planning and functioning of health facilities

- Local and needs-based planning for special groups/remote areas
- Appropriate planning and utilisation of untied funds at VHSNCs, Primary Health Centres (PHCs), and Community Health Centres (CHCs)

7. Reduction in out-of-pocket expenditure
   - Reduced demands for informal payments
   - Timely and full payments of Janani Suraksha Yojana (JSY) incentives
   - Significant reduction in outside prescriptions



States | **09**
Districts | **36**
Villages | **1620**

Map not to scale

*"There have been gains from an **equity perspective** too. Community monitoring has involved the excluded and the marginal groups. There was an **affirmative approach** to ensure that the Dalits, Scheduled Tribes (ST) and women were involved. Steps were taken, in many states, to ensure that women, Dalit and ST members headed the VHSCs. This is an important gain from the process. Community monitoring has also enabled a **better connect between the front-line service providers and the community, in some instances. The community** has begun to appreciate the constraints of the front-line providers"*
Excerpts from evaluation report of pilot

EXTERNAL EVALUATION TEAM:

- Maharashtra and Rajasthan: Dr Ashok Dyalchand
- Karnataka: Dr Rajani Ved
- Odisha and Tamil Nadu: Mr S Ramanathan
- Madhya Pradesh: Dr/Ms Renu Khanna
- Assam, Chhattisgarh and Jharkhand: Dr Rajani Ved, NHSRC

SCALING UP COMMUNITY ACTION FOR HEALTH (CAH)

After the completion of the pilot phase, PFI provided support to state governments to scale up CAH, using its own resources. Over the next three years, **21 state governments/Union Territories included CAH as part of their Programme Implementation Plan (PIP)**. In consultation with the MoHFW, a two-day workshop was organised in 2012 with all the state nodal officers to develop a detailed plan of action for scaling up CAH. The plan was presented and approved by Mr Manoj Jhalani, Joint Secretary-Policy, MoHFW.

AGCA Secretariat Staff

- Mr Bijit Boy
- Ms Seema Upadhyay
- Dr Smarajit Chakraborty
- Dr Daman Ahuja
- Mr Saurabh Raj
- Ms Jolly Jose

STRENGTHENING OF THE AGCA SECRETARIAT

In 2014, the MoHFW approved AGCA's proposal to provide technical support to state governments to strengthen the CAH processes. Six experienced staffers were recruited and placed at the Secretariat. The Secretariat team works in close collaboration with NHSRC and functions under the guidance of the AGCA members to perform the following:

- Provide technical support to the state governments on community action processes
- Develop and disseminate training material, guidelines, checklists, tools, and communication material
- Feedback to national and state governments on community processes and ground realities

The community action processes are currently being implemented in over 2,30,000 villages, 452 districts and 145 cities across 24 states/UTs[1].

Testimony

As a result of the community action for health, institutional deliveries have increased from 50% to 80% and PHC OPDs have increased by over 20%.

Dr. Rajendra Pindarkar
Taluka Health Officer-Shahada
Nandurbar district of Maharashtra (2015)

[1]Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Delhi, Goa, Gujarat, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Nagaland, Odisha, Puducherry, Rajasthan, Sikkim, Tamil Nadu, Tripura, Uttar Pradesh, Uttarakhand.

SECTION 2: OUTCOMES

In this section the outcomes related to our mandate from the MoHFW are detailed.

MANDATE 1: ADVICE ON COMMUNITY PARTNERSHIP AND OWNERSHIP UNDER NATIONAL HEALTH MISSION (NHM)

The AGCA worked closely with the National NHSRC to provide technical support to state governments to strengthen community action. This included:

- Co- facilitating development of PIPs
- Support for upscale CAH processes
- Building capacities and guiding a pool of state and district level mentors and trainers
- Organisation of Jan Samwads (Public Dialogues)
- Supporting allied departments and stakeholders

OUTCOME 1.1. ALLOCATION OF RESOURCES IN PIPS BY THE STATE GOVERNMENTS (HSS)

The AGCA has worked closely with state NHM teams to co- facilitate development of PIPs for community action processes. Beginning with 9 states (2007-09), the community action processes were adopted by 31 states and Union Territories. The details are mentioned in the table below. The AGCA team engaged with the following states to institutionalise processes- Bihar (VHSNC), Gujarat (VHSNC), Karnataka (VHSNC), Maharashtra (Community Based Monitoring), Odisha (MAS), Sikkim (VHSNC), Uttarakhand (VHSNC) and Uttar Pradesh (RKS).

Number of years of approval since 2012	Number of states	States
11	6	Chhattisgarh*, Gujarat, Jharkhand*, Madhya Pradesh*, Maharashtra*, Odisha*
10	6	Arunachal Pradesh, Bihar, Kerala, Meghalaya, Sikkim, Uttarakhand
7,8,9	8	Assam*, Uttar Pradesh, Delhi, Himachal Pradesh, Karnataka*, Mizoram, Nagaland, Rajasthan*
4,5,6	4	Punjab, Goa, Tripura, Manipur
3,2,1	7	Tamil Nadu*, Chandigarh, Jammu & Kashmir, Puducherry, Telangana, Daman & Diu, West Bengal
Total	31	

*Pilot states @ States where processes are saturated.

OUTCOME 1.2: SUPPORT TO STATE GOVERNMENTS FOR SCALING UP IMPLEMENTATION OF CAH

The pilot phase of CAH engaged civil society organisations (CSO) to support capacity building of VHSNCs and other community-based monitoring structures till the state level. The external evaluation of the pilot phase suggested that community monitoring must be **anchored as a part of the larger communitisation effort of NRHM**. Based on the feedback, concerted efforts were made to **transition the implementation of CAH processes to state level institutions**, including Community Processes Resource Center, ASHA Resource Center, State Health System Resource Center (Chhattisgarh, Maharashtra, and Karnataka), State Social Audit Units (Jharkhand, Kerala, Meghalaya and Uttarakhand). This helped increase state ownership and rationalized costs for scaling up.

"States should adopt and scale up community action for health. There is need to have an effective grievance redressal mechanism in the context of community action as well as the upcoming National Health Assurance Mission."

Mr C K Mishra,
then Additional Secretary and Mission Director (NHM), MoHFW, National CAH Consultation Report, 2014

S.No	States	Facilitation mechanism
1.	Assam, Delhi, Goa, Gujarat, Himachal Pradesh, Jharkhand, Kerala, Madhya Pradesh, Odisha, Puduchery, Rajasthan, Sikkim, Uttar Pradesh, Uttarakhand (14)	Community Processes Support Structure-Rural and Urban (CPSC)
2.	Chhattisgarh, Karnataka (2)	State Health System Resource Centre (SHSRC)
3.	Meghalaya, Kerala (2)	Social Audit Unit (SAU)
4.	Maharashtra (1)	Civil Society Organisation (CSO)
5.	Bihar (1)	CSO+CPSC
6.	Manipur, Tamil Nadu, Nagaland (3)	Others

The AGCA has adapted its approach based on the policy priorities of NHM. With the launch of the National Urban Health Mission (NUHM), **community monitoring of services through the MASs** were piloted in Bhubaneshwar and Puri cities of Odisha. Subsequently, these processes were **scaled up in 145 cities across 7 states** (Bihar, Chhattisgarh, Delhi, Gujarat, Kerala, Odisha and Uttarakhand).

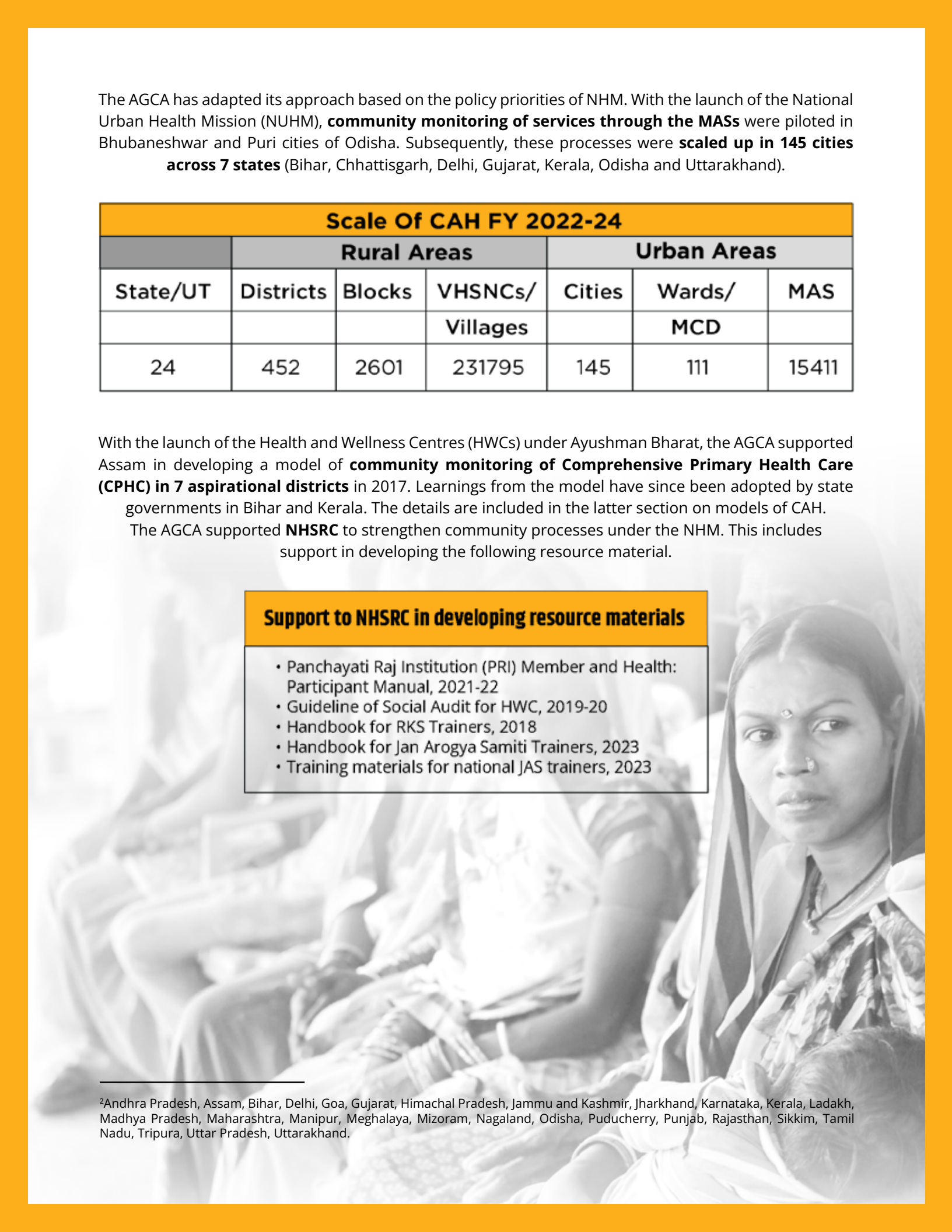
Scale Of CAH FY 2022-24						
	Rural Areas			Urban Areas		
State/UT	Districts	Blocks	VHSNCs/ Villages	Cities	Wards/ MCD	MAS
24	452	2601	231795	145	111	15411

With the launch of the Health and Wellness Centres (HWCs) under Ayushman Bharat, the AGCA supported Assam in developing a model of **community monitoring of Comprehensive Primary Health Care (CPHC) in 7 aspirational districts** in 2017. Learnings from the model have since been adopted by state governments in Bihar and Kerala. The details are included in the latter section on models of CAH.

The AGCA supported **NHSRC** to strengthen community processes under the NHM. This includes support in developing the following resource material.

Support to NHSRC in developing resource materials

- Panchayati Raj Institution (PRI) Member and Health: Participant Manual, 2021-22
- Guideline of Social Audit for HWC, 2019-20
- Handbook for RKS Trainers, 2018
- Handbook for Jan Arogya Samiti Trainers, 2023
- Training materials for national JAS trainers, 2023



[2]Andhra Pradesh, Assam, Bihar, Delhi, Goa, Gujarat, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Karnataka, Kerala, Ladakh, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Puducherry, Punjab, Rajasthan, Sikkim, Tamil Nadu, Tripura, Uttar Pradesh, Uttarakhand.

OUTCOME 1.3: CREATING AND MENTORING A POOL OF STATE AND DISTRICT LEVEL TRAINERS AND MENTORS

In 2014-2023 (upto May 2023), AGCA team **directly built the capacities of over 50,000 NHM staff and trainers across 27 states[2]**. The significant areas of capacity building included:

- Community action for health through VHSNCs, MASs and JASs
- Strengthening of RKSs
- Social audit of health services
- Community level initiatives to mitigate COVID-19

"I feel empowered with training I received and now I'm not afraid to ask questions or speak to health functionaries in our village."

Munwa Devi,
VHSNC member Pakadih village, Gaya district of Bihar She accompanied and helped a woman to access institutional delivery services in a timely manner

Since COVID-19 we have initiated online trainings and mentoring sessions with state NHM teams.
To support the trainers and the programme managers, **AGCA developed and disseminated a range of resource material among state governments** for VHSNCs, MASs, RKSs and JASs. The material **include posters, handouts, brochures and videos (detailed in Annexure 4)**. During COVID-19, the AGCA developed and circulated guidance notes for VHSNCs, RKSs, MASs and Resident Welfare Associations (RWAs) on their roles and responsibilities for COVID-19 mitigation.

In addition, AGCA **developed and customised training resource material** for each state. Assam, Bihar, Goa, Gujarat, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Meghalaya, Nagaland, Odisha, Punjab, Rajasthan, Sikkim, Uttarakhand, and Uttar Pradesh have adapted these materials.

OUTCOME 1.4: ORGANISATION OF JAN SAMWADS (PUBLIC DIALOGUES)

S.No	Year	TOTAL
1	2022-23	183
2	2021-22	286
3	2020-21	14
4	2019-20	2153
5	2018-19	89
6	2017-18	212
7	2016-17	71
8	2015-16	30
9	2014-15	3
	Total	3041

The process of community monitoring is followed by compilation of data as score cards at the village and facility levels. These depict the performance and gaps. Based on this, Jan Samwads (Public Dialogues) are organised at the SHC-HWC, PHC, block, district, and state levels for the community to amicably voice their issues and seek redressal. Involving the community, PRIs, VHSNC members, ASHAs and health officials, the forum also provides an opportunity to publicly appreciate the efforts and concerns of the frontline health workers and staff. These events helped administrators and policymakers understand the challenges faced by the community in accessing health care and take necessary policy decisions which were relevant for the entire state. Some of the indicative outcomes are detailed below as a case in point:

Gaps	Actions Taken
Policy issues	
• Ambulances (108) were not providing a drop back (Punjab 2015-16) • Dilapidated Sub Health Centres (SHCs) and PHCs buildings (Jharkhand, 2019-20)	• State level directive was issued to all health facilities to streamline drop back. • Allocation in the State PIP for construction and repair of SHCs and PHCs, including staff quarters
Accessibility issues	
• Expectant mothers had to be brought to the main road as ambulance drivers were reluctant to pick up in the interior areas (Madhya Pradesh 2017) • Demand for initiation of c-section delivery and x-ray services at the CHC Pakribarawan, Nawada (Bihar 2022)	• Agency was instructed to go to interiors on motorable roads. • RKS untied funds were used to set up operation theatre and the electricity department installed a high voltage connection to operate the X machine

Gaps	Actions Taken
• Demand for antenatal and postnatal care services in remote areas of Rajauli block, Nawada (Bihar- 2022)	• ANMs were deputed to provide services in Jamundaha, Chordiha, Marmo and Suerleti in a camp mode. Women were mobilised by the VHSNCs
• Demand for construction of Anganwadi Centre (AWC) and initiation on UHND outreach at new slum, Ward No. 48, Cuttack (Odisha 2022)	• Corporator facilitated construction of AWC facilitated. UHND services were initiated.
• Demand from adolescents to initiate Adolescent Friendly Health Clinic (AFHC) at Bahadrabad Community Health Center (CHC), Haridwar district (Uttarakhand 2023)	• AFHC was operationalised by Medical Officer in-Charge (MOI/C) in two months.
• Non-availability of ambulance services during emergencies. (Uttarakhand 2023)	• MOI/C and Block Development Officer (BDO) shared their contact details with people to inform them on instances of non-availability of ambulances
Quality of care issues	
• Patients and caretakers at Civil Hospital reported on (i) misbehavior by staff (ii) dirty toilets (iii) lack of signages to guide patients (iv) nonpayment under Balika Samridhi Yojana (Gujarat 2019)	• Medical Superintendent of Civil Hospital assured resolution of all issues.
• Non-availability of IFA tablets and sanitary napkins for adolescent girls (Gujarat, 2017-19)	• MOI/C communicated with the senior health officials to get supplies.
• Unaware of family planning methods and treatment of tuberculosis (Gujarat 2017-19)	• Teams of ANMs were formed to generate awareness of family planning methods and for TB treatment
Infrastructure issues	
• No restrooms for ASHAs at CHCs (Punjab 2015-16 and Uttarakhand 2022-23)	• Space provided at Manupur CHC, Punjab; state directives issued to allocate space for ASHA rest rooms in Uttarakhand
• Demand for construction of separate toilet for visitors and attendants near Urban PHC Jagatpur (Odisha 2022)	• Public toilet constructed with support from the Corporator

Gaps	Actions Taken
Intersectoral issues	
• Due to poor electricity supply the laboratory services were not being provided at Mangalbaria PHC resulting in out-of-pocket expenses (Sikkim 2022) • Poor water supply at Mangalbaria PHC Mabong-Segeng HWC and Kamling HWC (Sikkim 2022) • Unsafe drinking water and choked gutters (Gujarat- 2017-19) • No AWC buildings (Punjab 2015-16) • Lack of space for screening of pregnant women at VHSND sessions (Sikkim 2022) • Difficulties in reaching Gulni HWC which remained inundated with water during monsoons	• RKS members coordinated with electricity department to streamline supply. MOI/C lab equipped adequately with support from district health officials • Support sought from Department of Public Health Engineering (PHE) to rectify water supply issues • Corporator took responsibility of providing safe drinking water through water tankers and cleaning choked gutters. • Resources for construction of AWCs included in the District Annual Plan. • Block Development Officer (BDO) and Child Development Project Officer (CDPO) identified room. • Small bridge and approach road constructed through Gram Panchayat Development Fund

Initiation of x-ray service at a Community Health Center (CHC) Pakribarawan, Nawada district, Bihar

An issue was raised during the Jan Samvaad in December 2021 to initiate x-ray services for patients, visiting the Community Health Centre (CHC) Pakribarawan. Apparently the High -Tension (HT) line was not connected to the transformer and the earthing was not proper. The Electricity Department was directed to provide the necessary support to restore the HT line of the transformer. Ms. Aruna Devi, the local Member of Legislative Assembly (MLA) played a significant role in getting this done. The earthing was repaired by RKS fund and finally the X-Ray machine was inaugurated by the Civil Surgeon, Nawada on October 13th, 2022. The x ray machine is being operated regularly since then. Approximately 30-40 x-rays are done each day. The patients are saving INR 300 to 400, per x-ray. This results in a cumulative annual saving of Rs 200,000. This cost includes x-ray as well as transportation cost of going to Nawada.

Reflection from clients

When this X-Ray service was not available, we had to pay a lot of money (Rs. 300 -400/-) but now that the X-Ray service is available at CHC Pakribarawan, we can use the service free of cost.

Sarita Devi, Dola Pakribarawan

I am very impressed with the x-ray service being started at CHC as we now don't have to use private x-ray services.

S.Nawab, Pakribarawan

Grievance Redressal: Experiences from Melghat, Maharashtra

The community action process is being implemented in Maharashtra since 2007. The need to institutionalise a redressal mechanism to resolve public grievances became obvious with growing awareness of rights. Block and district level Grievance Redressal Committees were duly formed. The Takrar Nivaran Samiti (TNS) or Grievance Redressal Committee in Dharani block, a tribal dominated area in Amravati district, is one such committee. The block has been in the news for high infant and child mortality. The TNS members include: the Taluk Health Officer, the Medical Superintendent of the Sub-district Hospital, a representative from the Integrated Child Development Scheme (ICDS), the Sabhapati of the Panchayat Samiti, representatives from civil society and the media. The committee meets every 3 months to discuss and address grievances. The TNS receives grievances from both the community and the health care providers, and takes cognisance of issues arising from community monitoring. When a pregnant woman attending the sub-district hospital was found to have a very low haemoglobin level, the doctors referred her to the Amravati District Hospital, which was about four hours away from her residence. However, the woman and her husband refused to go there, as there was no one to take care of their children at home. The doctors sought help from the committee members. The members convinced the couple to go to the district hospital and arranged to take care of their children. One of the members regularly followed up with the Civil Surgeon at the District Hospital. This highlights how a committee can foster community action far beyond mere redressal of grievances, and ensure better health outcomes.

OUTCOMES CAPTURED THROUGH COMMON REVIEW MISSION (CRMs)

- Community action through Arogya Keralam Puraskaram awards has led to competition among panchayats to perform better in Kerala (10th CRM, 2016)
- Based on decisions at the Jan Samwads, immunization sites were moved towards remote areas, thus improving coverage in Uttarakhand (12th CRM, 2018)
- Decisions are being taken at the Jan Samwads on issues related to maternal deaths, denial of health services, and basic amenities in Meghalaya (13th CRM, 2019)
- Based on feedback by VHSNCs, urine tests, pregnancy testing kits and rapid diagnostic test kits for malaria were made available at HWCs in Hailakandi district in Assam. VHSNCs have also led community action on child marriage and addressing COVID-19 vaccine hesitancy leading to over 95% coverage in Assam (14th CRM, 2021)

OUTCOME 1.5: CONTRIBUTIONS TO OTHER STAKEHOLDERS AND DEVELOPMENT PARTNERS

AGCA over the years has worked with different stakeholders to strengthen community action strategies in health which include:

Stakeholder	Year	Contribution
Strengthening Capacities of PRIs under MoPR&RD (SCPRI) and UNDP	2015-17	Helped develop the 'Handbook for PRIs on Health'. Drafted the Chapter on 'Role of Gram Panchayat in Coordination and Monitoring'
Meghalaya Society for Social Audit and Transparency	2017 onwards	Tools and rules for social audit on health
eGov Foundation	2022 onward	Strengthening of Rogi Kalyan Samitis (RKSs) in the hospitals where 10 bedded ICU was supported by the eGov Foundation

SUPPORT DURING COVID-19

Based on the feedback from Mr Vikas Sheel, then Joint Secretary- Policy, MoHFW at the 41st AGCA meeting on May 7, 2020, the AGCA directed its technical support to state governments focusing on COVID-19. This included:

- Development and dissemination of **guidance notes** for PRIs, Village Health Sanitation and Nutrition Committees (VHSNCs), Rogi Kalyan Samitis (RKSs), Mahila Arogya Samitis (MASs), and Resident Welfare Associations (RWAs); standard operating procedures (SOPs) for organisation of Village Health Sanitation and Nutrition Days (VHSNDs) and Urban Health and Nutrition Days (UHNDs).

- **Social and behaviour change communication (SBCC) material** around COVID-19 such as videos, audio clips and posters.

- Undertook a **dipstick study to understand the issues around COVID-19 vaccine hesitancy** in 37 districts across seven states. A note including findings and recommendations was developed and shared with MoHFW and the NHSRC. Key communication messages that were identified from the study were converted into **reference book and SBCC materials** for frontline health workers in Hindi, English, Marathi and Oriya.
https://drive.google.com/drive/folders/1e6iC3zaIuJDpuvATJACl-N lPlXIjRdE?usp=sharing

- Facilitated over **100 online training sessions** on COVID-19 mitigation for engagement of VHSNCs, MASs and RKSs in which 5,642 block, district, and state nodal officers participated.

- Facilitated **11 virtual Jan Samwads** in Bihar and Rajasthan to enable community interactions and feedback to health officials during COVID-19

- Documented and disseminated **30 good practices** to state governments on community engagement initiatives during COVID-19.

Mahila Arogya Samities stitch and distribute masks to slum dwellers in Odisha

Members of Mahila Arogya Samities (MASs) came forward to support the community during the Covid- 19 pandemic. Among these was the initiative to distribute face masks to slum dwellers free of cost to those who could not afford them. MAS members of 4 cities: Cuttack, Berhampur, Koraput and Bhubaneswar in Odisha stitched and distributed face to the needy people in slums. MAS members purchased cloth for masks from three sources: (i) MAS untied funds, (ii) award money from the National Urban Health Mission (NUHM) on the best performing MAS based on their previous year work, and (iii) personal contributions.

MANDATE 2: DEVELOP MODELS ON COMMUNITY ACTION AND PROVIDE TECHNICAL ASSISTANCE TO STATE GOVERNMENTS FOR SCALING UP

The AGCA worked closely with the state governments to incubate models of community action and supported their scaling up. The models include:

1. Strengthening grievance redressal and local planning through Rogi Kalyan Samitis (RKSs) in 75 districts of Uttar Pradesh

2. Partnership between State Social Audit Units (SAUs) and NHM to conduct social audit of health services in the states of Jharkhand, Meghalaya, Uttarakhand and Kerala

3. Community based monitoring of HWC services by the VHSNCs and community members in Assam

4. Community based monitoring through Mahila Arogya Samiti (MASs) in Odisha People's Health Assemblies in Tamil Nadu

"Comprehensive primary healthcare is not possible minus active community involvement. The government is very keen on establishing a Jan Andolan, where people feel the need to participate in the entire processes of continuum of care and have their grievances heard."

Dr Manohar Agnani,
then Joint Secretary, Policy, MoHFW,
Report on the national consultation on CAH,
New Delhi, 2018

MODEL 1	INTERVENTION
Strengthening grievance redressal and local planning through Rogi Kalyan Samitis	• *Customized resource material- reference manual, frequently asked questions for RKS members, posters, documentary film* • *Create a pool of regional and district master trainers to strengthen RKSs.* • *Orientation and mentoring of the RKS members on governance, roles and responsibilities, planning and utilization of untied funds.* • *Seek client feedback on services.* • *Strengthen facility-based grievance redressal*
scale	UP - 75 districts (2016-23) Jharkhand - 24 districts (2018-2023) Bihar - 2 districts (2020) Goa- 2 districts (2018-23) Manipur - Piloted in 16 district hospitals in 2023
OUTCOMES	
Health System Strengthening	• Improved governance with regular meetings and patient centric utilization of funds in 11 districts of UP • Operationalisation of grievance redressal in 27 hospitals of Lucknow district. • Regular mentoring of hospital staff by trained regional and divisional programme managers in streamlining functioning of RKS across Uttar Pradesh. • Collaboration with State Quality Assurance Cell to ensure and address quality issues at the public health facilities through RKSs
Health Facility	• Operationalisation of blood storage units at 3 Urban CHCs, Lucknow • Mobilised additional resources to improve hospital facilities, including wheel chairs, seating arrangements at IPDs and OPDs, shades for parking areas, privacy arrangements, handwashing and sanitisation during COVID 19 in District hospitals and Urban/Rural Community Health Centres (CHC) in 6 Districts (Lucknow. Agra, Aligarh, Ghaziabad, Kanpur, Jhansi) • Infection control measures in labour rooms, regular swab tests, monitoring adherence to protocols in 3 districts- Lucknow, Aligarh and Ghaziabad • Disciplinary actions against errant staff in CHC, Itaunja in Lucknow district.
Clients and care givers	• Adequate seating arrangement for pregnant women at OPD in Lok Bandhu Raj Narain (LBRN) and UCHC Indiranagar, Lucknow and CHC, Loni, Ghaziabad

	• Privacy arrangements at the delivery rooms and wards in 6 districts (Kanpur, Ghaziabad, Aligarh, Agra, Jhansi, and Lucknow) • Installation of air coolers, air conditioners and heaters in the wards in above 6 districts • Arrangements of hot water and sanitizer for patients during COVID-19 in above 6 districts • Based on feedback from clients and caregivers, facilities improved quality of food, illuminated the dark spots in hospital and toilets for male caregivers, District hospitals- Verangana Jhalkari Bai and LBRN; UCHC Indiranagar, Lucknow district

MODEL 2	INTERVENTION
Partnership between State Social Audit Units (SAU) and NHM to conduct social audit of health services in Jharkhand, Meghalaya, Uttarakhand, and Kerala	• Convergence with Social Audit Unit (SAU) under Department of Rural Development and Panchayati Raj and National Health Mission (NHM) • Training of Village Resource Persons (VRPs) and Block Resource Persons (BRPs) from SAU and NHM teams • Focus on increasing community awareness on health entitlements and community feedback perceptions • Community based monitoring of services at VHSNDs, SHCs, PHCs and CHCs • Organisation of Jan Samwads: Brings people's voice into health service delivery and planning through policy decisions • Incorporation of community demands into PIPs
scale	• Meghalaya (2017-2021) – Piloted 6 districts covering 80 villages, scaled up to 1777 villages in 11 districts (2018-19); Current scale 80 villages in 6 districts (2022-23) • Uttarakhand (2017-22). Piloted in 3 blocks of Uttarkashi and scaled up to 30 blocks across all the 13 districts. • Jharkhand (2018-19)- 20 blocks across 5 districts • Kerala– Pilot in 6 districts from 2023

[3]Agra, Aligarh, Allahabad, Bareilly, Ghaziabad, Gorakhpur, Jhansi, Kanpur Nagar, Lucknow, Moradabad and Varanasi

OUTCOMES	
Health System Strengthening	• Allocation of budget in the state PIP for construction and renovation of PHCs and SHCs across five districts in Jharkhand. • Directives issued by Mission Director, NHM Jharkhand on zero tolerance against money being taken in lieu of services provided at the public health facilities. • Untied funds were released to VHSNCs in Meghalaya • Funds were raised from PRI members for construction of approach roads to Sub Health Centre (SHCs) and PHCs, boundary wall at HWCs and PHCs, water supply in Kerala and Meghalaya • Pregnancy test kit, calcium and iron folic acid tablets were promptly made available to all the ANMs in Jharkhand
Health Facility	• Display of citizen charter and updating of essential drug list at the health facilities • Water supply SHC at the level in Meghalaya
Community	• Provision of haemoglobin, urine test and counselling on family planning as an essential package of services during Village Health and Nutrition Days (VHNDs) • Release of Janani Suraksha Yojana (JSY) incentives to women and ASHAs which were pending for more than two years in some districts of Jharkhand

MODEL 3	INTERVENTION
Community based monitoring of HWC services through VHSNCs and community members	• Capacity building of VHSNC members • Tools developed for VHSNC members to generate awareness on HWC services, collect feedback on the functioning of HWCs, issues faced by patients and its resolution. • Regular dialogue with district and state officials to address gaps and take necessary policy decisions
scale	Assam- 7 aspirational districts (2018-23) Bihar- 2 districts (2022 onwards)
OUTCOMES	
Health System Strengthening	• Directives issued by the Mission Director NHM to the Joint Director, Medical Services /District Chief Medical Officers, to address gaps related to human resources, infrastructure and supply of medicines at HWCs • Letter issued by the Joint Director of Health Services, NHM Goalpara district to drug management personnel to ensure proper flow of essential drugs to HWCs. • Continuous engagement and mentoring built mutual trust between the health functionaries and the community
Health Facility	• Office of the Joint Director of Health Services, NHM Udalguri district, ensured repair of the generator and setting up of waiting area and drinking water facilities at HWCs. • Arrangements made for shed in waiting area, drinking water and construction of boundary walls
Community	• User-friendly and illustrated toolkit with community members motivated to provide relevant feedback • Prompt redressal of issues helped raise motivation and interest of the community to participate and contribute. • VHSNC members mobilised community for COVID-19 voluntary testing and vaccination. The 14th CRM (2021) noted that mobilisation by VHSNCs helped achieve 95% vaccination coverage. • VHSNCs led efforts to reduce incidences of child marriages

MODEL 4	INTERVENTION	
Community based monitoring through Mahila Arogya Samitis (MASs)	• Build capacities of members of MASs and RKSs of UPHCs • Monitoring of UHNDs and UPHCs services by MAS • Organisation of Jan Samwads for corrective actions on identified issues	
scale	• Odisha – 47 cities (2016) • Gujarat – 60 cities and 8 municipalities (2019) • Bihar – 3 cities (2022)	• Kerala – 10 cities (2019) • Uttarakhand – 5 Cities (2020)
	OUTCOMES	
Health System Strengthening	• Allocation of budget of ₹ 5000 to each UPHC for conducting community monitoring and Jan Samwad (Odisha) • Urban local bodies (ULBs) identified and addressed multi-sectoral issues such as nutrition, water and sanitation. • Basis feedback from MAS members, sensitisation meetings organised for district hospital staff on empathy, behaviour and support to clients, especially the elderly (Odisha) • Instructions issued to ASHAs who were not undertaking outreach in the slums of Berhampur (Odisha) • Community also appreciated regular services being provided by the UPHCs and good behaviour of the MOIC and staff of UPHC-Chandanhajuri (Puri, Odisha) • Community demand to initiate screening and services for Non-Communicable Diseases (NCDs) at UPHCs in Puri (Odisha) • State level directives issued to organise evening OPDs at UPHCs from 5.00 pm to 8.00 pm (Odisha)	
Health Facility	• Supply of IFA tablets, sanitary napkins, proper check-ups of the patients at district hospitals (Gujarat) • Signages installed at district hospitals based on community feedback (Gujarat) • Repair of drainage system at UPHCs, Cuttack (Odisha) • Construction of public toilets in UPHCs by ULBs, Cuttack (Odisha)	

	• Based on feedback from MASs, UPHC MOI/C premises and garden cleaned, Cuttack (Odisha)
Health System Strengthening	• Participation of MAS members in COVID 19 mitigation and community monitoring of health services (Odisha) • MASs collected and donated money to the district administration for COVID-19 relief work in Koraput (Odisha) • Continuous engagement with the MAS built mutual trust between the health functionaries and the community. • Recognition of MAS members as change agents of the community • Drinking water quality and sewage problems resolved by local councilor (Gujarat) • MAS members initiative to organise cleanliness drives for open area of the ward and at hospital (Odisha)

MODEL 5	INTERVENTION
People's Health Assemblies in Tamil Nadu	• Process steered by State Working Group (SWG) chaired by Project Director, amil Nadu Health System Reform Programme and District Working Group (DWG) chaired by District Collector. Members from Departments of Health, Women and Child Development, Public Health Engineering and selected CSOs. The SWG nominated the AGCA Secretariat to plan and guide the process. • Orientation of District Collectors, Dean of Medical Colleges and Chief Medical Officers (CMOs) to roll out the initiative in the districts • Organisation of district and block sensitisation workshops • Collecting community feedback, and aspirations by PRI members, ANMs, AWWs and supervisors • Dialogue between community representatives and health officials to improve healthcare services at village, block, and district assemblies. • Organisation of state assembly to decide on systemic issues. Event chaired by the Chief Minister and the Health Minister. • Allocation of budgets and directives to address needs of the community

scale	• Piloted in 14 districts (2021-22) • Scaled up in 16 districts (2022-23) • 24 districts including Chennai Corporation (2023-24)
OUTCOMES	
Health System Strengthening	• State allocated INR 23.50 crores to resolve issues to Phase 1 districts (2021-23) and INR 194.70 crores was allocated to the Phase-2 districts (2022-23) • Resources used for recruitment of human resources, blood storage units, installation of solar water heaters, upgradation of dental departments, construction of mortuary, postmortem unit, compound wall at PHCs and stafff quarters and public toilets
Health Facility	• Availability of equipment • Human resources gaps addressed. • Improved availability of medicines

MODEL 5	INTERVENTION
M-Shakti Interactive Voice Response System (IVRS) for real time community feedback to enhance health system responsiveness and accountability	Community monitoring in Bihar was earlier done manually through community level interviews and interactions, and the data was subsequently compiled to generate village and facility level reports cards. The process of collection, collation and analysis of data and generating reports cards took around three months. To simplify the process, Population Foundation of India partnered with Onion Dev (earlier known as Gram Vaani) to initiate community monitoring through a mobile-based **Interactive Voice Response System (IVRS), "m-Shakti"** in Bihar since 2016. The IVRS provides an interface to the community to (i) **know about key heath entitlements** and service, especially family planning, reproductive, maternal and child health and nutrition services provided at the Village Health Sanitation and Nutrition Days (VHSNDs), functioning and user experiences at Sub Health Centres (SHC), Health and Wellness Centers (HWCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs); (ii) **rate health services** (iii) **share specific qualitative feedback** on services. Users can share their responses on a designated number, which is automatically transferred to a server and analysed. An online dashboard displays indicator-wise details of the community enquiry process at the village, block and district levels. The compiled inputs and feedback are **presented at the Jan Samwads.** Population Foundation of India has trained Panchayat Raj Institution (PRI) and Village Health Sanitation and Nutrition Committee (VHSNC) members to create awareness in the communities to register and provide feedback on the IVRS. A total of **56,000 unique callers** have registered and used the IVRS till date.

scale	• 1000 villages in Darbhanga and Nawada districts of Bihar
OUTCOMES	
Key outcomes	The IVRS has resulted in quick and accurate collation and analysis of data, with report cards now auto-generated. The **dashboard** enables tracking of progress in overall services and specific indicators over a period of time, especially block and district health managers and as well as state officials to assess performance and take timely corrective actions on gaps. It can be operated from any **basic mobile phone** and does not require internet connectivity. Services are free with a call back facility. It is a cost-effective intervention, with each call **costing around 50 paise.** IVRS has led to specific outcomes including • Improved availability and range of ante-natal care at the Village Health Sanitation and Nutrition Days (VHSNDs) and health facilities. • Timely disbursement of monthly incentives to ASHAs, for family planning and J anani Suraksha Yojana. • Improved access to ambulance services for institutional deliveries. • Reduced demand for informal payments by health providers in lieu of services.

'Samwad': Webinar series to enable cross learning and scaling up of good practices on community action

The AGCA Secretariat organised 'Samwad (Dialogue)' to disseminate good practices on community action. Through these webinars, state and district nodal officers can learn from each other's experiences and adopt good practices within the state.

- The AGCA Secretariat co-facilitated the first webinar with the Odisha NHM team on '**Formation of JASs at PHCs in Odisha**' on February 3, 2023. Mr Sukanta Mishra, State Manager Urban Health and Dr Sushanta Kumar Naik, State Consultant Community Processes made presentations and interacted with the participants. Over 900 participants (state and district nodal officers and community health officers from 20+ states) attended the webinar.

- The second Samwad on **ArdraKeralam Puraskaram: Mobilising Panchayats for Health** was organised on June 6, 2023. Ms K M Seena, Head Social Development, National Health Mission-Kerala presented the initiative. Over 100 participants from the state NHMs attended the webinar and viewed it on YouTube.

MANDATE 3: PROVIDE FEEDBACK BASED ON GROUND REALITIES TO INFORM POLICY DECISIONS

The AGCA has regularly provided feedback to the MoHFW, National Health Systems Resource Centre (NHSRC), and state governments on ground-level issues needing attention. This has been done through field visits to states, interactions with state and district nodal officers, ASHAs, VHSNCs, MASs, JASs, RKSs and Panchayati Raj Institutions (PRI), as well as by participating in the Common Review Mission (CRM).

Here are a few examples of the feedback that has been provided:

Jan Arogya Samitis (JASs):

- Roll out of JASs: Many states faced challenges in constituting JASs at the PHC level. This was mainly due to the functioning of existing RKSs. The Odisha NHM issued detailed guidelines on converting the existing RKSs into JASs. The AGCA identified this initiative and shared the details with other states. A specific webinar was organised on this initiative in February 2023, wherein nodal officers from 20 states participated and learned.

- Sikkim constituted JASs in PHCs where RKSs still existed. The AGCA advised state officials to retain only one committee by dissolving the existing RKSs.

- The Medical Officers (MOs) and Community Health Officers (CHOs) could not form and lead meetings of the JASs. For this, the AGCA requested states to organise specific orientation sessions on the constitution of the committee, steps and preparations for organising initial meetings involving VHSNCs and community outreach, etc. The Secretariat facilitated physical and online training for CHOs in Bihar, Goa, Gujarat, Jharkhand, Karnataka, and Sikkim.

ASHAs:

- Fixed incentives for ASHAs were increased based on feedback to the Chief Minister of Puducherry during the 14th CRM, 2021.

- Timely release of ASHAs incentives in Bihar, Jharkhand, Gujarat, Madhya Pradesh, and Rajasthan (CRM and field visits).

- Space was allocated for ASHA restrooms in Jharkhand, Punjab, and Uttarakhand (CRM and Jan Samwads).

- Briefing of ASHAs on incentive structure and payments in Uttar Pradesh during the 14th CRM, 2021.

- ASHAs to be compensated for accompanying clients to the health facilities for follow-ups and treatment of NCDs, Uttar Pradesh 13th CRM, 2019.

- Provide warm jackets and boots for ASHAs in Ladakh for field outreach. This could not be included in the PIP.

Others:

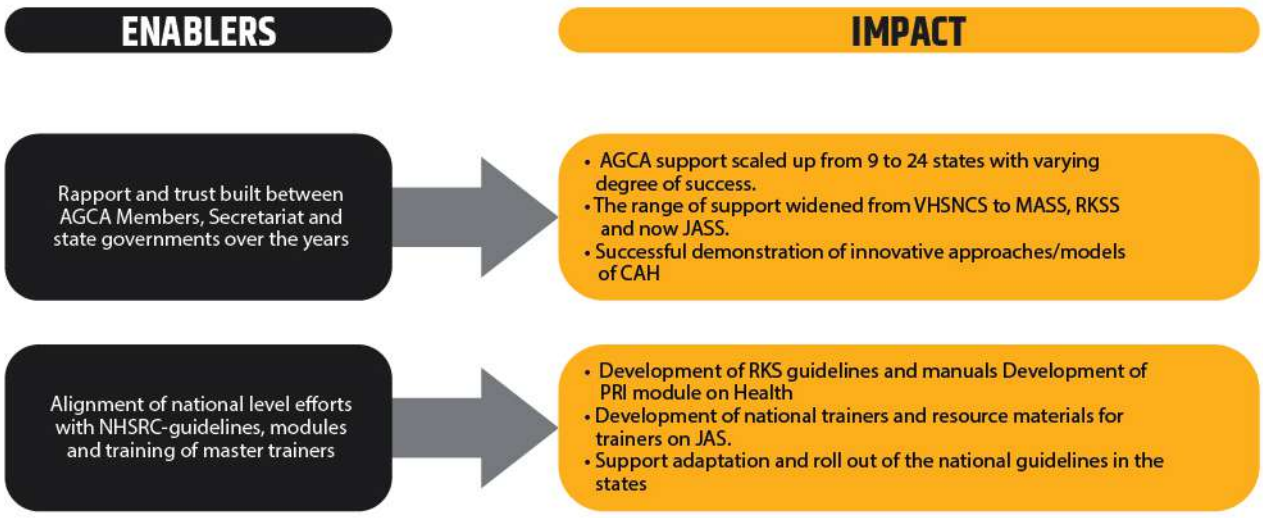
- Fixed day family planning services initiated at PHCs and HWCs in Darbhanga and Nawada districts in Bihar, 2022.
- Deputation of female doctors for OPD at PHCs twice a week in Nawada district of Bihar, 2021.
- ASHA Mentoring Group and State Advisory Group on Community Action in Assam were merged in Sikkim based on feedback from AGCA in 2015.
- In Gujarat, activities CAH approved under the PIP were not being implemented. This was streamlined based on feedback from AGCA during the 10th CRM, 2016.
- Patient feedback form to be made simple and illustrated for people with low literacy, Bahraich district, 13th CRM, 2019.
- Submitted plans to the MoHFW on:
  - Community-Based Health Planning, 2023
  - Social Accountability for HWCs, 2021
  - Feedback on Mera Aspatal, 2019
  - Inclusion of indicators to monitor the functioning of VHSNCs and RKSs as part of the Health Management Information System (HMIS), 2018

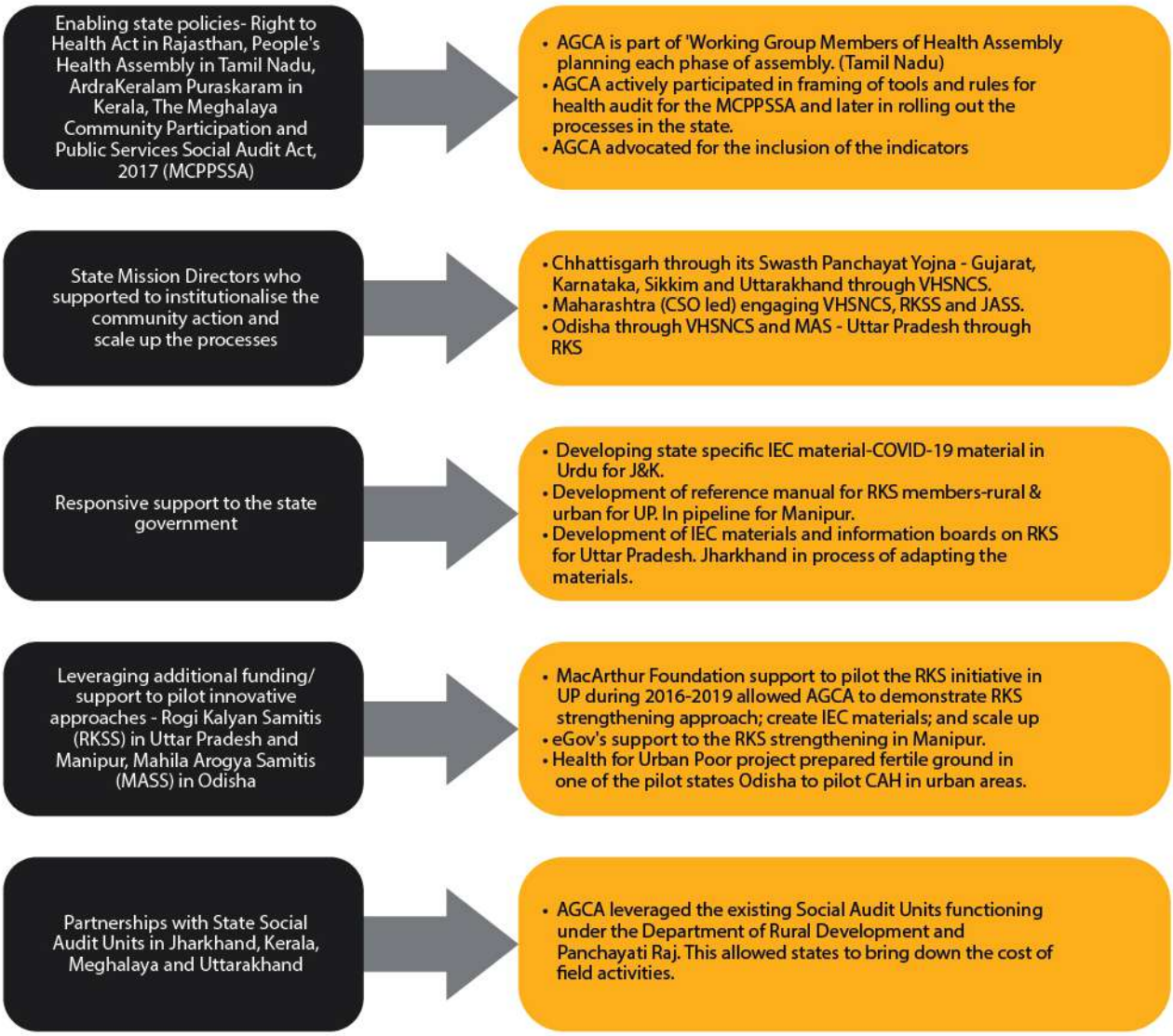
The AGCA is committed to providing timely and effective feedback on ground-level issues that need attention. This feedback is essential to ensuring that the health system is responsive to the needs of the people.

Enabling factors and challenges: Impact on the accountability processes

In pursuing its mandate, AGCA has been able to achieve many milestones in partnership with the state governments as listed in sections above. Based on our experience, an environment has been created that encouraged us to surge ahead and innovate. On the other hand, we have been beset by numerous challenges some of which AGCA was able to overcome but some persisted despite all our efforts.

ENABLING FACTORS IN COMMUNITY ENGAGEMENT




Enabling state policies- Right to Health Act in Rajasthan, People's Health Assembly in Tamil Nadu, ArdraKeralam Puraskaram in Kerala, The Meghalaya Community Participation and Public Services Social Audit Act, 2017 (MCPPSSA)
• AGCA is part of 'Working Group Members of Health Assembly planning each phase of assembly. (Tamil Nadu)
• AGCA actively participated in framing of tools and rules for health audit for the MCPPSSA and later in rolling out the processes in the state.
• AGCA advocated for the inclusion of the indicators
State Mission Directors who supported to institutionalise the community action and scale up the processes
• Chhattisgarh through its Swasth Panchayat Yojna - Gujarat, Karnataka, Sikkim and Uttarakhand through VHSNCS.
• Maharashtra (CSO led) engaging VHSNCS, RKSS and JASS.
• Odisha through VHSNCS and MAS - Uttar Pradesh through RKS
Responsive support to the state government
• Developing state specific IEC material-COVID-19 material in Urdu for J&K.
• Development of reference manual for RKS members-rural & urban for UP. In pipeline for Manipur.
• Development of IEC materials and information boards on RKS for Uttar Pradesh. Jharkhand in process of adapting the materials.
Leveraging additional funding/ support to pilot innovative approaches - Rogi Kalyan Samitis (RKSS) in Uttar Pradesh and Manipur, Mahila Arogya Samitis (MASS) in Odisha
• MacArthur Foundation support to pilot the RKS initiative in UP during 2016-2019 allowed AGCA to demonstrate RKS strengthening approach; create IEC materials; and scale up
• eGov's support to the RKS strengthening in Manipur.
• Health for Urban Poor project prepared fertile ground in one of the pilot states Odisha to pilot CAH in urban areas.
Partnerships with State Social Audit Units in Jharkhand, Kerala, Meghalaya and Uttarakhand
• AGCA leveraged the existing Social Audit Units functioning under the Department of Rural Development and Panchayati Raj. This allowed states to bring down the cost of field activities.

CHALLENGES AND ADAPTATIONS

CHALLENGES	IMPACT ON PROGRAMME	ADAPTATION
Lack of structured reporting and review mechanism in states on progress	Results in lack of data for necessary programmatic corrections and also showcasing the progress	AGCA undertakes review visits with the state NHM teams and collect information on impact in field and feedback.
Multiple nodal officers handling VHSNCS, MASS, RKSS, JAS and CAH leading to challenges incoordination	Leads to difficulty in making comprehensive approach to community participation in health system as these are linked to one another	AGCA forge relationship with each nodal officer and tries to bring some synergy in planning and implementation.
Some states do not implement processes approved in the state PIP	Lost opportunity, state do not A get the community feedback to address the ground issue and informed policy decision	Despite persistent efforts of the AGCA, this remains a challenge.
Prolonged delays in extension of MoUs and release of funds to NGOS facilitating CAH	The capacity building of the community based structures, identification of issues for resolution and improvement of services gets adversely impacted	Administrative delays remains a challenge
Only 70% salaries of Secretariat staff is covered through MOHFW	Difficult to recruit experienced staff on salaries allowed by GoI	Population Foundation of India uses its resources to fill the gap.
Participation of AGCA in Common Review Mission (CRM). national review and planning meetings gaps since 2022	This is lost opportunity and AGCA remains unawares of the national level discussions and reviews generating some learningl	AGCA engages with state nodal officers and visits states to understand the ground realities and accordingly plan the future course of action. Have meetings with officials in MoHFW and NHSRC to understand the national priorities.
Participation of AGCA in Common Review Mission (CRM). national review and planning meetings gaps since 2022	People's feedback if not considered in time bound manner, they tend to be disinterested in any initiative with the health system.	The facilitating agency/NHM officials try their best to resolve the issues. But the challenge remains.

Support and work with NHSRC in making JASs functional and effective

- Provide hands on support to select states where formation of JASs is slow. This can include brain storming on operational issues related to formation/ re-constitution of JASs, adaptation of guidelines and drafting of advisories for the districts

- Support development of a capacity building and mentoring plan, including selection and training of district trainers, development of resources, training of trainers and feedback

- Develop resources and an orientation plan for Medical Officers and Community Health Officers (CHOs) to operationalise JASs- reorganising the committee, organising meetings, planning health promotion and outreach

- Co-facilitate state review and reflective exercises to gauge functioning of JASs and provide necessary support

Facilitate cross learning and scaling of good practices

- Continue to organise webinar series Samwad (Dialogue) to facilitate cross learning and scaling of good practices among state governments

- Document and disseminate good practices

- Facilitate exposure for state and district officials

Re-initiate community-based health planning (CBHP)

- Develop tools including digital tools and user manuals along with NHSRC and select state officers.

- Pilot the intervention in selected geographies beginning with two states

Continue support to state governments on strengthening functioning of VHSNCs, MASs, RKSs

REFLECTIONS FROM ADVISORY GROUP ON COMMUNITY ACTION (AGCA) MEMBERS

The constitution of AGCA to promote communisation and community action in health was a novel thought taken under the National Rural Health Mission (NRHM) launched in 2005 throughout the country. Its members were representatives of the voluntary organisations with long experience of working directly with communities in different parts of the country and also some superannuated medical experts from different disciplines. The AGCA in its initial years did substantive work and created a framework of how the public health system could be rooted in the community to get better results from the health interventions. I became its members from its second meeting wherein I was initially called to discuss a proposal submitted by Prayas for undertaking a project of community monitoring of health services in one of the districts of Rajasthan. Though the AGCA resolved not to review and recommend individual proposals sent to it by the ministry but decided to undertake some pilot projects in different regions of the country on similar lines. I anchored one such project implemented in four districts of Rajasthan and demonstrated that it is possible to get a very active community engagement in health promotion through effective demand and supply of preventive and curative services. What made AGCA distinct was that though it was a body created by the government, its secretariat was located in a civil society organisation. This arrangement ensured that meetings held regularly, agenda planned, in-depth discussions take place in the meetings and provided input to the health ministry based on the discussions. The AGCA was a platform which provided me the opportunity to dynamically interact with the public health functionaries from apex to periphery in most parts of the country. In this process while I provided my insight, I gained a lot. It was a very pleasant experience. The Secretariat of the AGCA based at Population Foundation of India did a commendable job in keeping the momentum of AGCA even till the end.

Dr Narendra Gupta
Member, AGCA

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The origins and journey of the AGCA, I believe, date back to the years before the International Conference on Population and Development (ICPD) at Cairo in 1994. In the early 1980's when I started working in public health, there was not much public health to speak of and only family planning programmes. Whenever people spoke to us at SEWA on health, knowing we are a women's organisation, they would say: "Tell them to stop having so many children." Meanwhile, our SEWA members would say: "We need to have four to six children so that two or three survive." There was a wide mismatch in views between the grassroots and middle-class policy-makers, leave alone community action for health being mainstreamed in ministries of health in the states and in the centre. The ICPD conference changed all of that and after the excitement of change that it brought in, we began dialogue and consultations with our Ministry of Health and Family Welfare (MoHFW). Our officers had played a key role at Cairo and we were eager to see that the recommendations which India signed on to were implemented at home.

I think working together with the government in the years before and after Cairo led us to the National Rural Health Mission, along with the political will of the government of the day. This then led to an understanding that without community action for health, not much change in people's health status could be achieved. My recollections are that the AGCA was born out of the "manthan" or churning of those times, with responsive officers in the MoHFW and a government willing to take some conceptual leaps and put some faith in the people of our country.

We started out in 2005, ably led by Mr Amulya Ratna Nanda of Population Foundation of India and former Health Secretary, MoHFW, with community-based monitoring of NRHM's programmes and services. We collectively developed templates and then tested them out in several states. It was not easy---there was resistance from local officials and others. People in the villages we worked in and in the urban mohallas did not at first understand how they could play a role, being the recipient of services where no one asked them anything---from planning to implementation, leave alone monitoring. But we persisted and were patient and kept keeping on. The evaluation of the pilot phase showed that we had made headway but had far to go.

Fortunately, the MoHFW was also committed to the AGCA and our team---its members and the Secretariat at Population Foundation of India, kept going and adding to our knowledge and praxis. We also moved from monitoring only to several community-based actions including decentralised planning, capacity-building of local health committees like the VHSNCs and MASs and deeper dialogue with the state and national health officials. We were invited to participate in the Common Review Missions, train trainers in state government on community action or what began to be called community action for health. States engaged actively with our secretariat team and we did much to build capacity wherever and whenever required. Finally, there were the national level consultations which brought out several strong examples of community action by the states and by civil society.

What did we learn and what did we contribute? First, in several states, we were able to create awareness that people are and should be active participants in their own health, by participating in health planning at the local level, their health committees and in conducting Jan Samwads (Public Dialogues) with local public health authorities. They learned to ask questions about the government's services and entitlements without any fear and hesitation. They learned that health is a right and that they could be active in demanding, providing and monitoring health services, rather than being passive recipients. Many of them in several states were not only active on the VHSNCs and MASs but also acted on the social determinants of health---preventing early marriages, on water and sanitation, ensuring their Aaganwadis were functioning and providing quality food and more.

Second, there was much mutual learning between the government officials and us. We may not have always agreed on issues or ways of going about community action, but an open dialogue and discussion was initiated and continued for fifteen years! The dialogue also led to ear-marked funds for community action---maybe less than we needed, but a good start in any case.

Third, community action for health is now mainstreamed in government policy documents. While people's action for health at the grassroots will take some more time, it is enshrined in the health policies in many states and at the national level. That is certainly a big step forward. In addition, community action or citizens' action is now seen as a core aspect of the long journey towards universal health care.

Fourth, many ideas and workable examples from civil society like methods for social accountability, more active participation in Gram Sabhas (Village Assemblies) and even running low-cost pharmacies have been mainstreamed in the government programmes across many states.

Fifth, I believe that AGCA and our action in several states at the grassroots and with policy makers contributed in some measure, albeit modest, to the deepening of democracy in our country, as people found voice and representation---especially women, Adivasis, Dalits, informal workers and others who were central to our efforts. Their agency developed as they took collective action to

safeguard their own health and obtain the services that are their due. These are but a few of what we learned in what has been a rich harvest.

Forty years ago, or before, who would have thought that community action for health would be mainstreamed as much as it has? Many of us are pushing for more, but let us remember where we were and where we have reached. No doubt we have far to go and we will not rest till universal health care, its complete and comprehensive architecture, reaches every corner of our land. The AGCA has shown us that it is the people of our country, especially those who are most vulnerable like women, who will get us there one day.

Ms Mirai Chatterjee
Member AGCA

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After 17 years the curtains have come down on the AGCA Secretariat. The AGCA was constituted to support community participation within the NRHM. One of the first tasks assigned by the then Mission Director (MD), MoHFW to the AGCA was to draw up the outlines of Community Monitoring, a component that had been introduced as a vital part of NRHM. The MD NRHM had felt that the AGCA with its membership drawn from community health practitioners was best suited for this task. Once the outline was ready the MD asked the members of AGCA whether they would be able to guide the process of implementation at least in the initial phases, and the AGCA Secretariat was established in the Population Foundation of India. Since then, the Secretariat has been involved in devising mechanisms and tools for Community based Planning and Monitoring and supporting different state governments to strengthen community engagement and participatory planning and monitoring across the country. It has been a task that has been welcomed enthusiastically by the states, and in these many years, various states have developed their own capacities to do so. The NRHM and subsequently National Health Mission (NHM) have been acknowledged as one of the largest initiatives in the world towards achieving Universal Health Coverage, and the AGCA Secretariat has been a keen partner in strengthening community participation. It's experiences over the years forms a treasure trove of valuable lessons, not only for state governments and Health Departments in India, but in all low resource community settings across the world. It has been a matter of pride to have been associated with these efforts in a small way, but the lessons remain, and the practices will also remain forever grounded in the thousands of villages, blocks and districts across India.

Dr Abhijit Das
Member AGCA

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The AGCA journey has been enriching in every way. We came together with a passion to serve the nation country when the NRHM was conceptualised and rolled out. It has been an unusual, one-of-a-kind collaboration between the government and civil society, characterized by mutual regard, respect and encouragement. The NRHM provided the vehicle for change, which the government staff at different levels have taken advantage of.

In Community Action for Health which has been the core of our work, our understanding

has evolved, become richer and more robust because of the scale of implementation, and the diverse contexts, socio-political realities and variations in political and other enablers. The consistent focus at the national level on "communitisation" has provided states the nudge and the AGCA the encouragement to work on strengthening community processes. That this focus has remained through the changes in the NHM leadership is a testament to its relevance at the grassroots and to the understanding of the NHM leadership.

The annual Common Review Missions (CRM) have been a great learning – I have visited Odisha, West Bengal, Tripura and Mizoram. The enormous efforts put in by the state governments before and after each CRM is to be complimented. "Communitisation" would not have been possible without the support of the state functionaries at the grassroots. It has worked well where they encouraged it. Appropriate local facilitation by civil society has often made a crucial difference. I have been inspired by how communities have learnt to utilise the space provided to them and have admired the spirit and persistence of the facilitating civil society groups.

The AGCA secretariat team at Population Foundation of India has been outstanding. It has done an excellent task of facilitating, working with states, converting ideas to reality, structuring interventions and persisting in their efforts. Population Foundation of India's leadership has been crucial. We also owe a lot to the MoHFW, which enabled the formation and functioning of the AGCA and its work and has encouraged it through the many changes. The AGCA journey will always remain close to my heart. I hope that Population Foundation of India will continue to be available as a nodal point for the group to continue to dialogue. Thank you to my AGCA colleagues too, for your passion, encouragement and inspiration. May you continue to be blessed in all that you do.

Dr Vijay Aruldas
Member AGCA

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Community Action for Health, through its institutional mechanisms, facilitated by the public health system has created practical opportunities to bring in peoples' voice and participation to improve access to health care in 2.3 lakh villages across 25 states of India. This intense process includes ASHAs, VHSNCs now appropriately called Jan Arogya Samiti's (JAS), people's charters for health, PRIs, facility level committees etc. Studies show positive impacts on the functioning and accountability of the health system. Through a process of constructive engagement by several individuals through the AGCA; a competent Secretariat; several organisations and networks, community action for health was scaled up, with able leadership by the MoHFW, consistently over the years. This is a unique effort from a global perspective, and one hopes that it will continue to grow from strength to strength. Society for Community Health Awareness Research and Action (SOCHARA) and its predecessor the Community Health Cell has promoted and adopted a community health approach since 1984, along with many other organisations.

Dr Thelma Narayan
Member AGCA

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I have had the privilege of being a member of AGCA from its establishment in 2005 by the National (Rural) Health Mission, till 2023. I saw the key role of the advisory group comprising senior members of civil society engaged in the field of health, along with a compact Secretariat hosted by Population Foundation of India, as facilitating the NHM initiatives to bring about communitization of its key activities, to strengthen the system's accountability to the community and in enabling community members to adopt a role as active participants rather than as mere recipients of health services.

I travelled to support AGCA facilitated activities in the states Himachal Pradesh and Rajasthan and have taken part in NHM Common Review Missions (CRMs) to Mizoram, Bihar, Punjab and Uttar Pradesh, focusing on community action for health, among other areas. I found that the AGCA added significant value to those undertaking NHM activities mainly in the way it encouraged state and district officers to look at interventions and its impact from the community standpoint, and to consider the possibility that common people might view health needs and care very differently from planners and implementers. It achieved this change in perspective by encouraging a collaborative rather than adversarial relationship with active community voices. The delivery mechanism was necessarily large scale -- through community institutions like VHSNCs, MASs, Rogi Kalyan Samitis, etc. but it was evident all along, that there was an effective blend of state health system approaches and a feedback collection and redressal mechanism. I found the AGCA Secretariat team to have exercised enormous perseverance and creativity in interacting with a range of state health officials, respecting their competing priorities, while enabling their teams to reach out to the community. This was especially in evidence during the difficult Covid 19 pandemic times, when online platforms were utilized on a large scale. With the AGCA Secretariat having been disbanded, I fervently hope that activities for community action for health continue in spirit and on the ground. The 18-year legacy of partnership between civil society and government would thereby endure and hopefully seed new initiatives.

Dr Sharad Iyengar
Member AGCA

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ANNEXURE 1

STATUS OF APPROVALS FOR CAH IN NHM PROGRAMME IMPLEMENTATION PLANS

SN	State/UT	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-24
1	Chhattisgarh	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	Gujarat	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3	Jharkhand	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4	Madhya Pradesh	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
5	Maharashtra	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6	Odisha	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
7	Arunachal Pradesh	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y
8	Bihar	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
9	Kerala		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Meghalaya	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	1
11	Sikkim	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y
12	Uttarakhand	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Assam	Y	Y	Y	Y	Y		Y	Y	Y	Y	2
14	Uttar Pradesh		Y	Y	Y	Y	Y	Y	Y		Y	Y
15	Delhi				Y	Y	Y	Y	Y	Y	Y	Y
16	Himachal Pradesh	Y			Y	Y	Y	Y	Y	Y		Y
17	Rajasthan		Y			Y	Y	Y	Y	Y	Y	Y
18	Karnataka	Y	Y		Y	Y	Y	Y				Y
19	Mizoram		Y	Y	Y	Y	Y	Y				Y
20	Nagaland	Y				Y	Y	Y	Y		Y	Y
21	Punjab	Y	Y	Y	Y	Y			Y			
22	Goa		Y					Y	Y	Y	Y	3
23	Tripura		Y		Y	Y						Y
24	Manipur	Y	Y	Y		Y						4
25	Tamil Nadu		Y		Y	Y						Y
26	Chandigarh	Y	Y	Y		Y						5
27	**J&K**		Y									
28	**Pondicherry**	Y										6
29	**Telangana**							Y				
30	**Daman & Diu**	Y										
31	**West Bengal**				Y							
	TOTAL	**21**	**22**	**16**	**20**	**23**	**18**	**23**	**21**	**17**	**19**	**19**

NUMBERS OF YEARS RESOURCE ALLOCATED

11 | 10 | 09 | 08 | 07 | 06 | 4-5 YRS | 1-3 YRS

OTHER SOURCES 11 25

ANNEXURE 2

SUPPORT PROVIDED TO THE STATE GOVERNMENTS

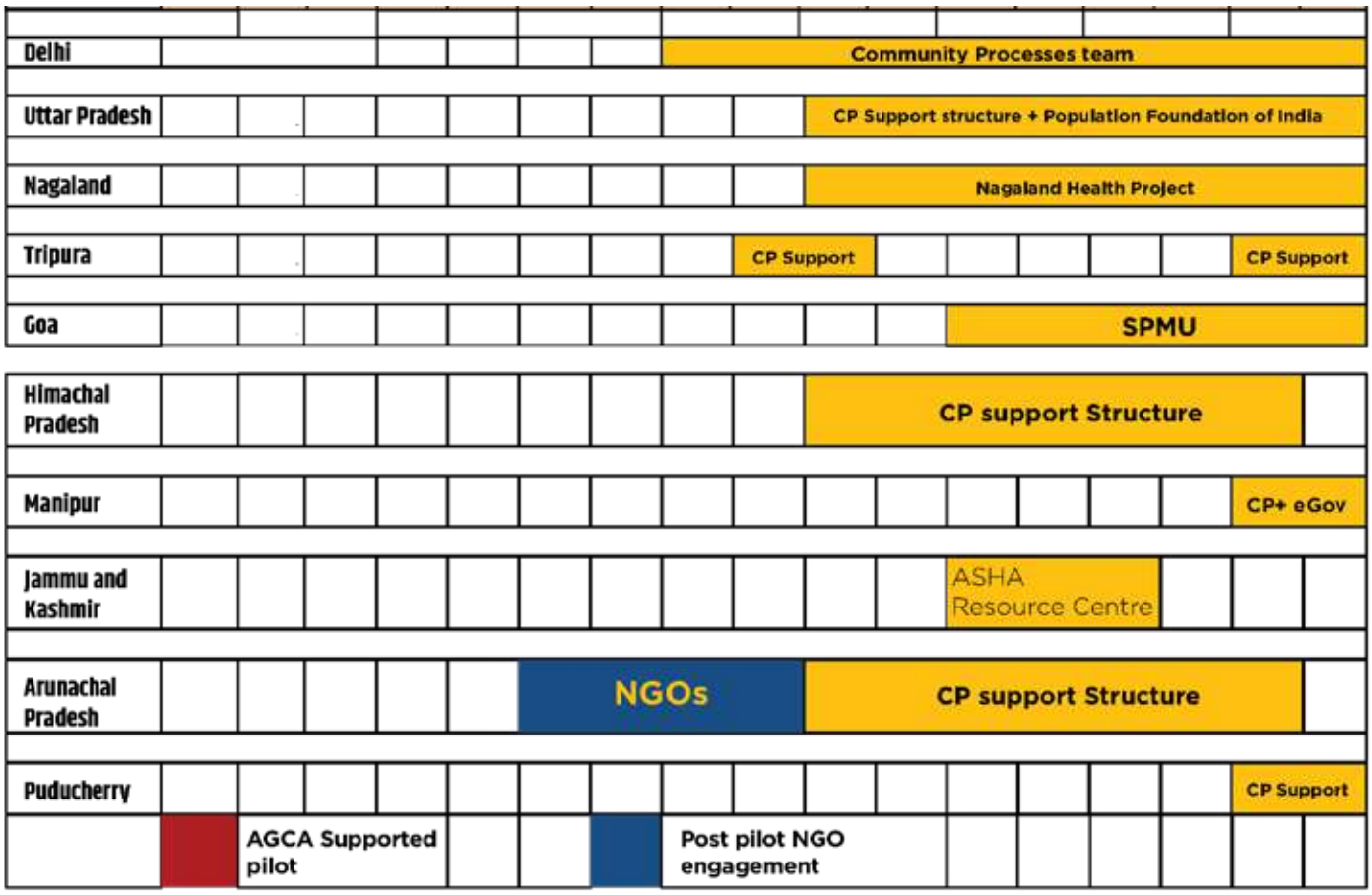
SNO.	STATE/UT	CAH through VHSNCs	CAH through MAS	RKS	JAS	Social Audit
	Active states					
1.	Bihar	Y	Y	Y	Y	
2.	Chhattisgarh*	Y				
3.	Delhi		Y			
4.	Goa	Y		Y	Y	
5.	Gujarat	Y	Y			
6.	Jharkhand*	Y	Y	Y	Y	Y
7.	Karnataka*	Y				
8.	Kerala	Y				Y
9.	Madhya Pradesh*	Y	Y			
10.	Maharashtra*	Y		Y	Y	
11.	Manipur	Y (In past)		Y		
12.	Odisha*	Y	Y	Y	Y	
13.	Rajasthan*	Y				
14.	Sikkim	Y		Y	Y	
15.	Tamil Nadu*	Y (In past)				Health Assemblies
16.	Uttar Pradesh	Y		Y	Y	
17.	Uttarakhand	Y	Y		Y	Y
18.	Assam*	Y			Y	
19.	Arunachal Pradesh	Y				
20.	Himachal Pradesh	Y				
21.	Meghalaya	Y (In past)				Y
22.	Mizoram	Y				
23.	Nagaland	Y				
24.	Pondicherry				Y	
25.	Tripura	Y				
26.	Punjab	Y				
27.	Jammu and Kashmir	Y				
	Engagements in past but no processes undertaken recently					
28.	Haryana					
29.	Telangana					
30.	West Bengal					
31.	Ladakh					

*** Pilot states (2007-09**

ANNEXURE 3

FACILITATION STRUCTURES FOR CAH IMPLEMENTATION

	States	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Pilot states	Assam						NGOs				NGOs		Community Processes support structure					
	Chhattisgarh				State Health Resource Centre													
	Jharkhand				Sahiyya Resource Centre								SAU					
	Karnataka				NGOs						KHSRC							
	Madhya Pradesh				Mentoring Group on Community Action													
	Maharashtra				NGOs													
	Odisha (R)				NGOs						National Urban Health Mission-CP support structure							
	Rajasthan				NGOs						Community Processes support structure							
	Tamil Nadu															Health Assembly		
Scale up	Bihar					NGOs				CP support structure + Population Foundation of India								
	Punjab							NGOs										
	Meghalaya					NGOs						Social Audit Unit					SAU	
	Mizoram								NGOs								CP support	
	Gujarat				NGOs							Urban+Rural CP Support Structure						
	Uttarakhand									NGOs		ASHA Resource Centre and 2019 onwards Social Audit Unit (USAATA)						
	Kerala									Social Development Cell (Urban + Rural)								
	Sikkim								Community Processes Support									


Delhi
Community Processes team
Uttar Pradesh
CP Support structure + Population Foundation of India
Nagaland
Nagaland Health Project
Tripura
CP Support
CP Support
Goa
SPMU
Himachal Pradesh
CP support Structure
Manipur
CP+ eGov
Jammu and Kashmir
ASHA Resource Centre
Arunachal Pradesh
NGOs
CP support Structure
Puducherry
CP Support
AGCA Supported pilot
Post pilot NGO engagement

ANNEXURE 4

LIST OF RESOURCE MATERIALS DEVELOPED BY THE AGCA SECRETARIAT

SNo	Particulars	Language	Description
	I.Pilot Phase		
1.	Community Entitlement (2007-2009)	English Hindi	Introduction to NRHM, service guarantees scheme and provision under NRHM, community participation in NRHM, and Framework for community monitoring. https://nrhmcommunityaction.org/pilot-phase/
2.	• Managers' Manual	English	Introduction of NRHM, Community Monitoring under NRHM, first phase of community monitoring, implementation of first phase of community monitoring, organizational responsibility https://nrhmcommunityaction.org/pilot-phase/
3.	• Training Manual	English	How to conduct state managers' orientation, and block providers' workshop at the state and district level and how to train different levels committees https://nrhmcommunityaction.org/pilot-phase/
4.	• Monitoring Manual	English	What are health rights, health systems in India, communitization of health services, what is community monitoring, introduction to NRHM, frameworks for community monitoring in NRHM, mobilizing community and formation of VHSCs, conducting community monitoring at the village and facility level, compiling village and facility level score card, sharing the results and conducting Jan Samwad https://nrhmcommunityaction.org/pilot-phase/
5.	A Report on the First Phase of Community Monitoring under NRHM (2010)	English	Introduction to NRHM, the process, national preparatory phase, state implementation phase, immediate outcomes, review of community monitoring. https://nrhmcommunityaction.org/pilot-phase/
6.	A documentary film on pilot phase **Reviewing Hopes: Realizing Rights** (2010)	Hindi with subtitles in English	The film highlights the potential of Community Monitoring as a community empowerment tool and democratization process in the context of people's right to health. The film contains the experiences and opinions of various stakeholders associated with the process at the national, state and grassroots levels. It also captures the processes, immediate impact of the process at the field level, lessons learned and challenges faced. https://www.youtube.com/watch?v=0D_jZH0uIps

	II.Scale-up Phase		
	Poster		
7.	Strengthening Community Action for Health (2014-2019)	English Hindi	CAH process, accountability framework of NHM, pilot phase, external evaluation and scale-up phase. https://nrhmcommunityaction.org/resource-materials/
	Guidelines and Manuals		
8.	User manual on CAH (2014)	English Hindi	Detailing how to conduct community level enquiry using a set of formats, and in compiling village level report card and facility report cards. https://nrhmcommunityaction.org/resource-materials/
9.	Guidelines for Programme Managers' on CAH (2014)	English Hindi	The guideline was developed based on the cumulative experience and understanding of the pilot phase, which include a comprehensive set of principles of establishing and strengthening CAH, institutional mechanisms and processes required for implementation. https://nrhmcommunityaction.org/resource-materials/
10.	Monograph on CAH (2014)	English	It is a review on CAH undertaken from field visits to five different projects implementing community action programmes /projects in health across the country. https://nrhmcommunityaction.org/resource-materials/
	Posters		
11.	Primary Health Centre (2015)	English Hindi	Services available at the PHC https://nrhmcommunityaction.org/resource-materials/
12.	Sub-Health Centre (2015)	English Hindi	Services available at the SHC https://nrhmcommunityaction.org/resource-materials/
13.	Village Health Sanitation and Nutrition Committee (2015)	English Hindi	About the committee and its main activities https://nrhmcommunityaction.org/resource-materials/
14.	Village Health Nutrition Day (2015)	English Hindi	Available services for women, children and adolescents https://nrhmcommunityaction.org/resource-materials/

15.	Community action for health (2015)	English Hindi	Detailing its six processes https://nrhmcommunityaction.org/resource-materials/
16	Leaflet on CAH (2015)	English Hindi	Brief on CAH and its six steps https://nrhmcommunityaction.org/resource-materials/
	Newsletter on CAH/ Publication		
17.	Newsletter on CAH (2015)	English	Detailing messages from the MoHFW and AGCA, updates from the state and national level, case stories, etc. https://nrhmcommunityaction.org/resource-materials/
18.	Grievance Redressal Mechanisms for the health sector in India – Experiences, learnings and challenges (2018)	English	It captures experiences, learnings and challenges on grievance redressal mechanisms across India and South East Asia. It details 6 models from six states including Tamil Nadu, Andhra Pradesh, Maharashtra, Odisha, Madhya Pradesh and Rajasthan. https://nrhmcommunityaction.org/resource-materials/
	Rogi Kalyan Samiti		
	Posters		
19.	Role and Responsibilities (2019)	English & Hindi	Key roles of RKS members https://drive.google.com/drive/folders/1v9YbGtVqRaQO3NTC5Ks65kK1POFP9Cbd
20.	Grievance Redressal Mechanisms (2019)	English & Hindi	Explains various forums/platforms available for patient grievance redressal. https://drive.google.com/drive folders/1v9YbGtVqRaQO3NTC5Ks65kK1POFP9Cbd
21.	Information Boards (2019)	English & Hindi	Display of information on RKS for public: (i) composition of RKS, (ii) works undertaken by RKS, (iii) meetings of the RKS, (iv) details of grievance redressal committees, (v) details on income and expenditure, etc. https://drive.google.com/drive/folders/1v9YbGtVqRaQO3NTC5Ks65kK1POFP9Cbd

	Reference Manuals/FAQ on RKS		
22.	Frequent Answered Questions (FAQ) on RKS, UP (2019)	Hindi	It details the frequent questions on RKS process including its objectives, members, role and responsibilities, untied fund, etc. based on the experience and lessons learnt from RKS implementation and scale-up in Uttar Pradesh during 2016-19. https://drive.google.com/drive/folders/1v9YbGtVqRaQO3NTC5Ks65kK1POFP9Cbd
23.	User Manual on Rogi Kalyan Samiti (RKS) for Urban Primary Health Centres, UP (2021)	Hindi	The manual comprises an introduction about RKS, organisation of its committee meetings, registration/ renewal process, format for writing minutes of meetings, etc. The purpose behind to develop this document was to orient the role of NUHM officials at the state and divisional levels in strengthening RKS at the Urban PHC level, and share the soft copy of the document with them for their easy reference and understanding. https://nrhmcommunityaction.org/resource-materials/
24.	User Manual on Rogi Kalyan Samiti (RKS) for district hospitals and community health centres, UP (2023)	Hindi	The manual comprises an introduction about RKS, organisation of its committee meetings, registration/ renewal process, format for writing minutes of meetings, etc. The document is developed for orienting the government officials at the state and divisional levels to strengthen the functioning of RKS at the district hospitals and the community health centres. https://drive.google.com/drive/folders/1v9YbGtVqRaQO3NTC5Ks65kK1POFP9Cbd
	Innovation Briefs on CAH		
25.	Monitoring health services at the Health and Wellness Centres in Assam (2020)	English and Hindi	Processes adopted to strengthen community mobilization and monitoring of HWCs and how the community's feedback led to corrective actions on the ground. https://nrhmcommunityaction.org/resource-materials/
26.	Social audits of health services in Jharkhand, Meghalaya and Uttarakhand (2020)	English and Hindi	Describes how the pilots on social audit increased community awareness and participation in monitoring local health services. https://nrhmcommunityaction.org/resource-materials/

27.	Rogi Kalyan Samitis in Uttar Pradesh (2020)	English and Hindi	Summarizes the processes adopted to strengthen RKS functioning in Uttar Pradesh, and the impact that has had on the quality of services clients received at public health facilities. https://nrhmcommunityaction.org/resource-materials/
28.	Briefer on Community Action for Health (2020)	English and Hindi	Brief on CAH, processes, brief on AGCA and its members, coverage and innovations emerged from the states. https://nrhmcommunityaction.org/resource-materials/
	Resource Materials on Jan Arogya Samiti		
29.	Brochure (2022	English and Hindi	Details about JAS, Ayushman Bharat, its office bearers, members, and its services. https://drive.google.com/drive/folders/1v__Je2a-nK7KxJd0FN7GYBKUFPcdZMDf
30.	Posters (2022)	English and Hindi	(i) JAS at PHC level; (ii) JAS at SHC level (iii) Roles and Responsibilities; (iv) Utilization of funds https://drive.google.com/drive/folders/1v__Je2a-nK7KxJd0FN7GYBKUFPcdZMDf
31.	Animation video (2022)	English and Hindi	Detailing about JAS including its members, composition, role and responsibilities of each member, JAS at the PHC and at SHC. https://drive.google.com/drive/folders/1v__Je2a-nK7KxJd0FN7GYBKUFPcdZMDf?usp=drive_link
32.	Guidance note on Jan Samwad (2022)	English	Detailing about the processes for organising Jan Samwads https://drive.google.com/file/d/1J7v6ev_mUgfETS5kf7zeKJ9N9T7pLTni/view?usp=drive_link
33.	Reference Manual for JAS trainers, Assam (2022)	English	It details about organising meetings, establishing grievance redressal including simplified and illustrated patient feedback forms, and social accountability processes https://drive.google.com/file/d/19Z0-z4on6ERM2vyqg12YpLse_B0P96Xz/view?usp=drive_link
	Films/Animation videos		
34.	Pag Pag Aage (2009)	Hindi	The film 'Pag pag aage' focuses on health entitlements and services under the National Health Mission (NHM). The story

			revolves around a ward member, who has received training on health entitlements under NHM, and uses the platform of the Gram Sabha to generate awareness on their rights and motivate people to access and demand the services. https://www.youtube.com/watch?v=KnjNTUkzTfA&t=19s
35.	Community Action for Health (2013)	Hindi	The documentary depicts the changes brought about by the programme – Community Action for Health (CAH) under the National Rural Health Mission in selected districts of Bihar. Health sub-centres, which were shut for years were made functional, service providers stopped asking for informal payments for medicine and care, and there were marked improvements in quality of services. https://www.youtube.com/watch?v=lETsAn7VpIo&t=7s
36.	Bringing Public into Public Health (2015) Jan Swasthya ke Badhte Kadam	Hindi English	The documentary film Bringing Public into Public Health (Jan Swasthya Ke Badhte Kadam) showcases the models of Community Action for Health (CAH) in various states. It summarizes key experiences, challenges and lessons learnt from various community action processes being implemented across the country. The film captures the experiences from the urban areas of Bhubaneswar and Delhi too. https://www.youtube.com/watch?v=GFmzyaHkT50 (English) https://www.youtube.com/watch?v=dNkUUnuNfWY&t=4s (Hindi)
37.	We must change this story (maternal death review) (2016)	Hindi and English	The film We Must Change this Story – Yah Kahani Hamien Badalni Hi Hogi, developed by the AGCA Secretariat with support from the State Health Mission – Madhya Pradesh, illustrates real life case stories of maternal deaths and near miss cases, which occurred while seeking treatment from public health facilities in Madhya Pradesh. The primary objective of the film is to evoke an emotional response among health service providers and health managers to make them think, internalize, reflect and take preventive actions for averting maternal deaths. https://www.youtube.com/watch?v=roMehZVbmR0&feature=youtu.be (Hindi) https://www.youtube.com/watch?v=z7qkh0_sRm8&feature=youtu.be (English)
38.	Rogi Kalyan Samiti (2019)	Hindi	The documentary film on Rogi Kalyan Samiti (RKS) showcases the processes, outcomes and learnings of RKS strengthening initiative in Uttar Pradesh. The film is used as resource material for state, regional and district level master trainers. https://www.youtube.com/watch?v=bFcvCSYRE5I

39.	Animation film on Village Health Sanitation and Nutrition	Hindi and English	The film briefs on the functioning of Village Health Sanitation and Nutrition Committee (VHSNC). It summarizes key steps and stages of VHSNC formation in detail; members of the committee; and the roles and responsibilities of each VHSNC member towards its strengthening.
	Committees (2019)		https://youtu.be/6bxqMxxbFys (English) https://youtu.be/Q6V8ombCoVw (Hindi)
40.	Community Action for Health: Innovative Approaches (2021)		The film showcases the new approaches/innovations undertaken to deepen the CAH processes in some selected states, which include: community mobilization and monitoring of Health and Wellness Centres (HWCs) in Assam; monitoring and auditing through State Audit Units (SAUs) in Jharkhand, Meghalaya, and Uttarakhand; and strengthening Rogi Kalyan Samitis (RKSs) to improve quality of health services in Uttar Pradesh. Also, film covers monitoring of Adolescent Reproductive and Sexual Health (ARSH) services in Bihar; and CAH in urban cities of Gujarat. https://www.youtube.com/watch?v=y1u06t4BBG0&t=6s