Chapter 10
Chhattisgarh Swasth Panchayat Yojana: Convergent Community Action for Health and Its Determinants in Rural India

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Abstract This chapter provides the implementer's perspective on the Chhattisgarh Swasth Panchayat Yojana as an example of convergence on a single, decentralized action platform for health and its determinants. The rationale for this initiative was the wide-ranging participation of community institutions like the Panchayat (an elected Village Council) in coordination with the Village Health, Sanitation, and Nutrition Committees (VHSNC), and Mitanins (Community Health Workers or CHW), stewarded by the State Health Resource Centre of Chhattisgarh in collaboration with the state Government. From 2006 onwards, there has been active community engagement in the collection of data on indicators of health status, access to health services, and determinants of health (nutrition, water, gender, employment). Indicators have been designed so that the community can record, understand and make use of the data to advocate for and monitor improvements in public service delivery. The challenges and lessons are many, including the fact that poor progress on indicators can sometimes reflect the severity of social determinants and not merely the lack of progress or success of any action. The process has seen several iterations and revisions, and the addition of new components to compile and use the data at levels beyond the village. This chapter attempts to describe how multiple interventions were brought in at various stages. The impact is a result of the mutually-reinforcing, interlinked and therefore integrated set of interventions, with some interventions being seen as more successful than others. The community platform was strengthened at each stage, where further components were added based on a periodic analysis of what worked and what did not. The process of analysis and the adding of components was also guided by a vision of community empowerment and a holistic definition of health that specifically included SDH. The complex and interlinked nature of interventions were crucial to achieving convergent action on health and Social Determinant of Health (SDH) and its scaling-up. Chhattisgarh has scaled-up the Swasth Panchayat program across the state and has institutionalized its implementation and facilitation arrangements. The National Health Mission has included the essential components in its guidelines.

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The adequacy of arrangements for the facilitation of community-level structures and the autonomy of key actors will be crucial to the success of its replication.

Keywords Rural health · Village health · Sanitation and nutrition committees Healthy panchayat · Chhattisgarh

Introduction

Chhattisgarh state was formed in 2000 when it was carved out of the state of Madhya Pradesh. The state had a population of around 21 million, with nearly 80% being in rural areas. The state also had a substantial population of indigenous tribes forming 32% of its population, most of which were distributed in forested areas away from the centre of the state. The state had inherited a health system severely deficient in health human resources and was at the bottom in terms of indicators of health status and health care services. For example, its rural Infant Mortality Rate (IMR) in 2000 was 95 per 1000 live births, and the full immunization rate measured in 1998 was 21%. In this context, the state was willing to try out new initiatives to improve health. One such key intervention was the Mitanin Program, a CHW program initiated by the Government of Chhattisgarh state in 2002.

The Mitanin Program currently has nearly 70,000 CHWs (called Mitanins) covering almost all of the rural habitations and urban slums of the state. The word Mitanin literally means a friend in the local dialect of Chhattisgarh. The Mitanin program was unique as it was initiated by government but its design consciously included the essential features drawn from earlier successful models of NGO-run CHW programs in India [1]. It was further significant as it had mechanisms for a fast scale-up and it actually spread to all rural areas of the state within two years of its beginning in 2002. It has been credited with the unprecedented decline achieved by the state in its rural IMR [2, 3]. The national policy environment on health in India underwent a similar change in 2005 with the launch of National Rural Health Mission (NRHM). The NRHM initiated a national CHW program called ASHA (Accredited Social Health Activist) and further interventions for community participation in health along with the strengthening of health care services. The Mitanin initiative of Chhattisgarh, being an up-scaled CHW model promoted by government, served as an important reference for ASHA. Mitanins were recognized as ASHA by the NRHM.

The Foundation Laid by the Mitanin Program for Convergent Action on Social Determinants of Health

The Government of Chhattisgarh state launched the Swasth Panchayat Yojana in 2006. The literal translation of the phrase is the healthy village scheme. This scheme was built upon the foundations laid by the Mitanin Program.

The role defined for the CHWs in the Mitanin Program laid down the path, which led to emergence of the Swasth Panchayat or the Healthy Panchayat scheme. The concept of health as taught to Mitanins in their curriculum, included an emphasis on the Social Determinants of Health (SDH). There was a definition of health prominently stated in the Mitanin Program's first training module [4]. Health was defined as the physical, mental and social well-being of a person. 'Good Health' includes the following:

- Adequate food
- Secure and equitable work environment
- Safe drinking water, sanitation, housing, clean environment
- Access to preventive and curative health care services
- Well-being: rest, entertainment and human relations
- Gender equity

The role of Mitanins therefore extended far beyond health education and the curative elements. The stated objectives of the Mitanin Program also included (a) Organizing women and weaker groups to secure their rights related to health and (b) Promoting involvement of locally elected bodies (Panchayats) in the health sector and facilitating systematic local health planning and action [4].

Experiments in the Koriya district of the state had shown the success achieved by Mitanins in organizing a community watch on nutrition programs through neighborhood committees [5]. This experience was expanded into other parts of the state through the design of a nutrition security initiative in 2006 with two main components (a) Direct counseling or Behavior-Change-Communication on nutrition, and action on the prevention and control of infections amongst young children, and (b) promoting community awareness and action to access food and nutrition entitlements from government programs. Quantitative evaluations have shown that the above Mitanin-led interventions were effective in achieving a very significant state-wide reduction in child malnutrition rates [6]. More recently, the Mitanin program has been playing a key role in the implementation of the Fulwari Scheme—a program for community-managed child crèches and spot-feeding centers under the ownership of local elected Panchayats [7]. There have been efforts to carry out an in-depth analysis of action by Mitanins on SDH and to understand the factors contributing to its efficacy. They show that the way objectives were stated, along with the way that the selection was done, the training curriculum was designed and how supportive supervision was provided in the Mitanin program, led to the activeness of Mitanin CHWs on SDH issues [8]. The seeds of an initiative like Swasth Panchayat were always there in the way wider community involvement in action on health and SDH was emphasized in the design and the processes of the Mitanin program.

In terms of the involvement of local elected bodies called Panchayats, there were significant attempts right from the start of the program. When the program was launched, a large social mobilization campaign was taken up across the state through cultural troupes to convey the message of the need for community

participation in health. This campaign was facilitated in most places by Panchayats. The selection of Mitanins was based on consensus decisions taken by meetings of citizens at habitation level, which was ratified by a Gram Sabha—the general body of the village recognized by the Constitution of India. Beyond selection, Panchayats were also involved in local planning for vector control in the prevention of malaria, and received joint-training with Mitanins on this in 2004.

Another feature of the program that strengthened the possibility of facilitating a community platform and action on SDH, was the Mitanin support system built into the program right from its beginning. Each cluster of 20–25 Mitanins is supported by a nearly full-time Mitanin Trainer. Thus, an average block has around 450 Mitanins supported by around 20 Mitanin Trainers who in turn receive supportive supervision from two block coordinators. The above teams are guided by the State Health Resource Centre (SHRC) through its District Coordinators. The SHRC is an autonomous organization created through collaboration between the state and civil society. It has been facilitating the Department of Health and Family Welfare in implementing the program and other initiatives aimed at strengthening health systems.

The Start of Swasth Panchayat Yojana

With the aim of strengthening the involvement of Panchayats in the health sector, the Swasth Panchayat scheme was launched by the state Government in 2006. The objectives were to enable local communities and elected Panchayats to assess the situation of their health and SDH, and identify gaps, and then to plan and execute multisectoral collective action to address those gaps. One of the mechanisms to build the involvement of Panchayats in the health sector was to institute awards for those Panchayats showing a better performance of health and SDH. It required the ranking of Panchayats in each administrative block. A Panchayat-level Health and Human Development Index (Panchayat-HHDI) was conceptualized to measure performance and rank Panchayats based on objective indicators. The Swasth Panchayat indicators and HHDI was thus meant to serve twin purposes: to (a) encourage Panchayats through awards based on objective health performance and (b) involve communities in collecting information on SDH for assessing health performance—including any gaps—thus putting into motion a process of dialogue, understanding and action on SDH.

In order to start implementation of the intervention, a dedicated training module was designed as training had been the preferred strategy and practice for introducing anything new in the Mitanin Program. In order to give a boost to this message, another strategy adopted was to organize large gatherings at district level of Panchayat representatives in 2006–07. The training module conceptualized what constitutes a ‘healthy village’ and the role that elected Panchayats had in achieving it. It questioned the conventional narrow understanding of the role of Panchayats as implementation agencies for construction-based rural development schemes.

It attempted to convey the message that a Panchayat addressing the gaps in SDH is a 'Healthy Panchayat' [9]. Mitanins and members of Panchayats across the state were trained together on this module, which also included critical aspects of community health and the collection of data on those aspects. The involvement of the local community in data collection was aimed at creating an opportunity for them to assess their health situation.

It included the collection of data on 26 Indicators covering SDH, such as access to the local public health care services, status of nutrition and sanitation, and access to food and nutrition programs.

The Evolution of Swasth Panchayat

Beginning in 2007, disaggregated data were collected annually from each habitation on the above indicators and recorded on a Panchayat scorecard. The data set was computerized to allow the calculation of Panchayat-level composite scores. Awards were given to the top ranking Panchayats in each block. The scheme covered all 146 rural blocks of the state and Swasth Panchayat data collection took place in nearly 80% of the 70,000-odd rural habitations in the state. Four rounds of the Swasth Panchayat survey and HHDI were carried out between 2007 and 2011.

One of the strengths of the methodology was that for the first time, it enabled comparison across habitations on objective health indicators. It brought out the sharp inequalities that existed between habitations in terms of their access to health, nutrition, drinking water and education services. Habitations with poorer communities often had lower access to services. Inter-Panchayat comparisons were also very instructive with Panchayats located in more remote locations and having a predominantly tribal population usually got very low scores. The scores therefore did not realistically reflect a Panchayat's performance in acting on health issues. The score was much more a reflection of the severity of the inequity faced by a Panchayat in comparison to others. Thus, it was always debatable whether the award-winning Panchayat was actually making a greater effort to improve SDH or whether it had benefited from being more favorably located with respect to available services.

Nevertheless, the Swasth Panchayat scheme was able to collect and compile data to highlight local inequities in health. The next and more difficult challenge for the scheme was to enable the local communities to understand and make use of the information. While implementation mechanisms were available for collecting data and computing Panchayat-wise HHDI, the mechanism for creating a community dialogue through which to make use of the information had yet to evolve. It also required ways of communicating the quantitative information to Panchayats and other stakeholders in community, including Mitanins. The attempts to communicate in form of Panchayat scorecards or through creating grades of performance with an associated color-coding did not bear the desired fruit. The intended practice of assessing situations based on quantitative data seems to have remained alien to the

rural stakeholders. The strategy of giving awards also seemed ineffective in making a serious impact on the involvement of Panchayats in health. It did, however, contribute to keeping the issue alive in discussions and in the minds of Mitanins and Panchayats at the local level, and policymakers and planners at state level.

Village Health, Sanitation and Nutrition Committees (VHSNCs)

There were other changes happening in that period which guided the evolution of Swasth Panchayat. In 2008, the state constituted Village Health, Sanitation and Nutrition Committees (VHSNCs) as a key intervention promoted through the National Rural Health Mission (NRHM). VHSNCs provided the ideal platform for promoting action on SDH as the name itself conveyed that its role was in multiple sectors. It showed the potential to be able to fill the gap in Swasth Panchayat on a community-level platform, which focused on health and encouraged the participation of Panchayats in it. VHSNCs could carry out a 'Community Watch and Action' on health and social determinants. In 2008, the NRHM introduced another component called 'Community Based Monitoring' (CBM) which brought in civil society groups with the primary objective of organizing a community watch on health services.

Chhattisgarh had begun an intervention on Nutrition Security in 2006 through Mitanins, which by 2009 had created an implementation structure capable of facilitating local health monitoring, planning and action. Realizing the complementarities and overlaps in the Swasth Panchayat HHDI and ranking, VHSNC-based action and CBM, and the Nutrition Security initiative, it was decided to integrate all of them under the umbrella of the Swasth Panchayat scheme from 2009 onwards. The constitution process of VHSNCs was built on the participation of Gram Sabhas and Gram Panchayats (village general assemblies and elected councils) and it helped to eliit their involvement in VHSNCs right from the beginning.

For two years, VHSNCs tried to utilize the information available through Swasth Panchayat indicators to identifying local health gaps and plan collective action to address them. Based on that experience, the indicators used in the Swasth Panchayat survey were simplified and the number of indicators was reduced so that rural stakeholders had a better chance to understand them. In 2011, the annual Swasth Panchayat survey was transformed into a Village Monitoring Register (VRM) that was updated monthly in VHSNC meetings. It allowed communities to have more continuous monitoring on key issues.

These VRMs monitored health status, service access and determinants using basic counts in the previous month of the following:

(1) Health status (comprising mortality—infant mortality, maternal mortality, and by common causes like malaria, diarrhea, TB, pneumonia etc.; morbidity—due to common causes; malnutrition; and violence against women);
(2) Access to local health services (including immunization, free drug provision, referral transport, and use of bed nets); and
(3) Access to underlying determinants of health including food, water, sanitation and education, again linked to government schemes and entitlements (including functionality of hand pumps, toilets, out-of-school girls, midday meals, rural employment guarantee wage payment, and provision of food under the Integrated Child Development Scheme).

The VRM data were connected to Village Health Action plans in a stepwise process of identifying a gap and its cause, along with the response and responsibilities of different stakeholders and a timeline for joint action. Studies have shown that by 2012, around two-thirds of the villages in the state had started using this methodology [10].

It was a challenge to sustain the link between monitoring and planning. The assumption was that the monitoring register would lead to the identification of gaps to address which the VHSNC would then plan to act on. In actual practice, it was found that around one-third of the problems were identified through registers. Other ways of deciding the topics of action were spontaneously expressed problems by a community-participant in a VHSNC meeting, topics decided by the support-structure at state level from time to time and topics that were more convenient for the facilitator to incorporate. The last method produced the least value-addition but was common enough to be a concern.

It was seen that the majority of monitoring registers tended to under-report the gaps across sectors. Facilitators found it difficult to have an adequate discussion on 29 indicators in every meeting. The presence of a service-provider in the meeting e.g. an Anganwadi worker also reduced the chances of recording her performance negatively, but did result in the development of an unrecorded understanding with her to address gaps to the extent that she was able. Despite the under-recording of problems, the monitoring registers still led to the identification of more issues than the VHSNC or its facilitators could take-up.

The tools given to enable the community showed some drawbacks. In some situations they tended to be used mechanically by the facilitators. Recording is useful but it runs the danger of becoming the central feature of VHSNC facilitation rather than ‘action’. In order to overcome this, periodic issue-based campaigns involving action on a specific SDH were introduced. It helped to rejuvenate community involvement in VHSNCs to some extent though carried the risk of being seen as imposed from the top at the cost of local priorities. In order to reinforce the idea that ‘action’ is the essential purpose of VHSNC meetings, it was decided to try to mobilize the community in the course of a VHSNC meeting itself to initiate their action there and then.

The VHSNCs enjoyed leadership from Mitanins and elected women representatives. The attendance of workers representing Integrated Child Development Services (ICDS) in VHSNC meetings was also found to be good. The ward Panchs, the lowest level of elected representatives (elected from a population of around 200) contributed significantly to VHSNCs. In 2014, a drive was taken up to increase membership of VHSNCs, as a result of which it went up from 11 members per committee to 20 [11]. However, there are variations across villages in the level of active participation of local communities in VHSNCs. In some committees, Mitanins end up doing all the work due to the limited attendance of others in VHSNC meetings. This has been a persistent challenge for the facilitation process. Another attempt was therefore made in 2015 to expand the membership of VHSNCs and to improve their representation of all habitations in a village. Further measures to improve attendance included: (a) using more formal ways of reminding VHSNC members of upcoming meetings by circulating a register, (b) conducting meetings in the open so as to attract attendance, and (c) shifting the meeting to days other than the immunization day in order to allow greater time for Mitanins to mobilize attendance and for the VHSNC to discuss and act on issues.

Building Further on the Swasth Panchayat and VHSNC Program—Community Monitoring of Mortality and Facility Level Health Care Services

The monitoring data available from VRMs of VHSNCs presented an opportunity for extending the feedback to government beyond local (village and block) to state level. Further, this data has also been combined with community feedback data gathered on health care expenditure and facility level care. The first state report on community monitoring was produced in 2011. The state level sharing of reports strengthened the legitimacy of the community monitoring process and helped in articulating some gaps at the program planning and policy levels. Feedback on the services of Health Sub Centers and Primary Health Centers (PHCs) was gathered from concerned VHSNCs. Exit interviews of outpatients and inpatients were performed to get feedback on services of CHCs and District hospitals. In terms of eliciting action from government on the gaps, feedback taken on specific services such as the availability of anti-snake venom, anti-rabies vaccine, emergency obstetric care and referral transport was more effective than feedback on health facilities covering a large number of aspects. Thus, the government response was more forthcoming when one problem was taken at a time. The structure of the community monitoring reports evolved according to such experiences.

The mortality data from death registers kept by VHSNCs is being compiled at state level. This process began in 2012. It is used to triangulate government data of both all-cause and specific-cause mortality. It thus creates an alternative evidence of inequity especially where governments often grossly under-report cause-specific mortality e.g. for malaria or diarrheal diseases. It has helped in bringing back the

focus to key health problems that the poor face. E.g., state action has become stronger in order to ensure essential health care services for malaria, one of the biggest public health issues in the state [14]. A total of 40,000 deaths were covered in 2012 and the coverage of deaths has been improving each year. In 2016, around 100,000 deaths were covered, thus capturing information on more than two-thirds of the total expected rural deaths in the state.

While the Government has a process of auditing maternal deaths and child deaths through Medical Officers, followed by a review involving a committee of senior district officials, in 2013 a need was felt to augment it through community audits of deaths as the child death audits by medical officers had not taken off as expected. Apart from the implementation gaps in medical officer-led audits, the key reason for instituting community audits was to involve the voice of community or families through verbal autopsies. It was felt that biases in the medical officer-led audits were inevitable as the medical officers would avoid recognizing the gaps in facilities as contributors to preventable mortality. Also, audits done by the officers were good at finding the clinical causes of deaths but often missed the systemic causes. After the state Government asked the SHRC to initiate community audits, a social autopsy tool was created. Block coordinators of the Mitanin program were trained to collect further information on gaps leading to maternal or child deaths using the social autopsy tool. They present the information back to the VHSNC in the following monthly meeting and a common understanding is arrived at regarding what gaps led to the death and how such gaps can be prevented in future. From 2014 onwards, around 400 maternal deaths and 3000 child deaths (0–5 years) have been audited by communities through this process. This has now emerged as a system of community audits, providing valuable feedback on gaps in health care.

In order to ensure inputs to more VHSNCs and to create a sense of solidarity amongst them, VHSNCs were federated into clusters with monthly meetings introduced in 2011. This created a supportive network around VHSNCs and their action on SDH. It helped VHSNCs to escalate the complaints to higher levels and to look at issues which were common across villages.

By 2015, it had become a regular practice in more than 15,000 of the state's villages to monitor using the register, to record and discuss deaths and their probable causes, and to plan and act on two or three problems identified each month. Assessments showed that around 50% of the collective action undertaken resulted in success [10].

It has now become difficult to draw a line between action on SDH by Mitanins and by VHSNCs. Each month they monitor more than 100,000 service providing institutions at village level including ICDS centers, government schools, 'fair price' shops, immunization sessions and health centers. They played a successful role in promoting access to the Public Distribution System (PDS) [6]. Getting access to safe drinking water by ensuring the repair of hand pumps has been another very common feature of action. Mitanins and VHSNCs together account for opposing domestic violence in around 25,000 to 40,000 cases annually [12]. They took up a campaign on the rights of disabled people in 2014, which resulted in more than 15,000 disabled people being able to demand and secure their entitlements from the Government.

In terms of addressing gaps through local collective action, a need was felt for a block-level platform where any unresolved issues could be raised to demand accountability from higher officials (block/district level). To this end, public dialogue events known as Jan Samwads were initiated at block level. Though this component had been in practice in some blocks since 2007, it was institutionalized in 2013 when more than 100 blocks held such events. Elected representatives of state legislature and even the national Parliament supported many such events by attending them and creating pressure on government service provider departments to address public complaints. Public dialogue events have been documented and it has been shown that each of them attracted 500–1000 people, mostly VHSNC members attending voluntarily and presenting 100–1000 complaints each covering a variety of issues involving access to health, safe drinking water and food and social security entitlements [15]. These gatherings strengthened the network and solidarity amongst Mitanins, VHSNC members, Panchayat representatives and individuals. By 2015, 137 of the 146 blocks in the state had started organizing annual public dialogues. Mitanins and their local facilitators gained significant capacity to gather and present evidence and to articulate demands along with the organizational skills needed for the public dialogues. These gatherings continued to attract the participation of elected representatives. As these dialogues became a regular annual feature, they gained acceptance with government officers at the local level and they started responding better to collective demands.

An innovation was introduced in 2016, as a strategy cutting across many of the above activities. It was the use of street theatre to train Mitanins to articulate certain issues in public dialogues and to communicate them to the wider community through VHSNCs. It also shows promise as another tool to rejuvenate community engagement. Mitanins and community committees as the support structure, tried street theatre and were soon taken in by its power to communicate and engage.

The program ensured that underprivileged areas were included in the facilitation process and got equal attention compared to other areas. Mechanisms like the Swasth Panchayat facilitators, VHSNC cluster meetings and block-level public hearings were first introduced in tribal blocks. The program, however, is yet to evolve mechanisms to provide additional inputs and priority to such areas in terms of ensuring actual improvements in services. It has mobilized communities in underprivileged areas to air their grievances and demands collectively. There is some movement in recognizing the needs of such areas and not considering all of their problems as given constraints.

Institutional Arrangements for Implementation

Mitanins and the Mitanin support system played a central role in facilitating each phase of implementation. The Swasth Panchayat survey was led by Mitanin trainers. It was compiled by the SHRC, with the help of block coordinators of the

Mitanin program. SHRC conceptualized the HHDI methodology and implemented it directly with funding from the state health department.

VHSNCs were formed by mobilizing local communities and their elected bodies. Mitanins and their support system carried out the mobilization and formation of VHSNCs. The SHRC helped the state Government in formulating the structure and function of VHSNCs in the form of guidelines and it also implemented a round of training Mitanins and VHSNC members on those guidelines. The capacity-building strategy borrowed heavily from the large-scale multilevel training cascade used in the Mitanin program. However, with the number of VHSNC members being around 4 times the number of Mitanins, it posed a daunting challenge in terms of funding as well as for creating an adequate number of trainers. It was resolved by deciding to train around one-third of the membership of VHSNCs in formal training workshops and leaving the rest to be oriented through monthly meetings of VHSNCs facilitated by Mitanin trainers.

It was realized that VHSNCs require active facilitation by trained facilitators in order to be able to monitor and plan action on SDH in a systematic manner. It was felt that VHSNCs relied heavily on inputs from Mitanins and therefore should share the support structure of Mitanins instead of having their own. Therefore, from 2011 onwards, the role of the support structure of the Mitanin program explicitly included the facilitation of VHSNCs and was institutionalized though guidelines issued by the Government. Systems were created for the allocation of adequate time for facilitation, training of facilitators and their monitoring through a block-level coordinator focusing on VHSNCs. The job charts of Mitanin trainers were tweaked so as to have a fixed schedule of monthly VHSNC meetings. Their job charts allocated around 35% of their time to VHSNCs. The Mitanin program monitoring system was also altered to cover the essential processes in VHSNCs as well as the role of Mitanins and trainers in them. The involvement of Mitanin trainers in facilitating VHSNCs definitely improved the regularity of meetings and the completion of monitoring registers and the recording of action plans. It did, however, in some VHSNCs create a problem of dependence on the Mitanin trainer and stifled the 'natural' community process. Another related critique of the strategy was that Mitanin trainers tended to impose the priorities given from the top. On the other hand, there were some areas where the VHSNCs did not receive the required attention from the Mitanin support system. Ensuring the quality of facilitation was a challenge for the up-scaled program. Continued emphasis on the facilitation of village monitoring and planning for more than three years helped in improving the capacity of facilitators and the monitoring of its quality.

The State Health Resource Centre (SHRC) has played a key role in designing the Swasth Panchayat initiative and the various iterations and additions in its evolution. Its unique governance structure and its role as an innovative institution improving the effectiveness of community-based interventions on SDH have been documented by researchers [16]. The SHRC conceptualized the interventions and created a composite approach by synthesizing elements from the National Rural Health Mission (NRHM), views of the state health department and experiences of civil

Table 10.1 Cost estimates and source of funds for Swasth Panchayat

Year	Annual direct cost (rupees million)		Annual indirect cost (rupees million)		Total annual cost (rupees million)
	State share	Central share (NRHM)	State share	Central share (NRHM)	
2007	8	0	0	0	8
2014	16	6	15	45	82

society initiatives and tuning them to the context of Chhattisgarh. The SHRC designed and implemented all the capacity-building required. It compiled and shared data at state level and it helped in getting the state on board.

Financing of Swasth Panchayat

The Swasth Panchayat Yojana was fully funded by the state Government at the outset. The direct costs of the program in 2014 was 22 million Indian Rupees (Rs.). The indirect annual costs in terms of time allocated to the Mitanin support structure on facilitating its various interventions described here were close to Rs. 60 million in 2014. The intervention covered a population of around 20 million across 19,000 villages. Thus, the total estimated annual cost per capita is around Rs. 4 and per village covered is Rs. 4200. It is around five times more economical when compared with costs to the NRHM for community monitoring and action in some states [17]. What helps it to be cost-effective, is the integration of its activities with the processes of Mitanin program. As a result, the requirement of additional human resources is limited to one facilitator per block. The table shows the costs at different stages of the initiative (Table 10.1).

Conclusion

Swasth Panchayat Yojana has evolved into a program which enables citizen involvement in activism on entitlements. Activism, even though funded by the state in this case, can still be resented by many government officials when they have to face questions, and when CHWs and VHSNCs supported by the health department are raising those questions. But in actual experience, the process has not been stifled. It has been able to grow and the articulation of issues in public dialogue events has been gradually becoming sharper as the teams gain more experience and confidence. The factors that enable it seem to be:

(a) In Chhattisgarh, the process being led by the SHRC has been a key factor. The SHRC has a civil society character as well as that of a parastatal. It has a governing board with a majority of members and a chair drawn from civil

society. The structural autonomy that the SHRC enjoys has enabled its work on SDH and entitlements. The SHRC has characteristics of a boundary organization that bridges the gap between government and community and between design and implementation.

(b) The articulation of Mitanins' role as activists in government guidelines has been strong and consistent for more than a decade. Mitanins have also enjoyed a fair bit of autonomy as volunteers.

(c) Involvement of Panchayats and other elected representatives has won it the space for raising grievances and demanding accountability from officials.

That the SHRC is providing leadership, however, results in it remaining the prime mover and the ownership of the overall initiative by government is limited as a result. However, despite this limitation, the state has managed to arrange adequate facilitation to community-based structures on a long-term basis to undertake action on SDH. The program involved periodic creation of some buy-in from government, followed by its scale-up and gradual acceptance by the Government. The process was aided by the continued political support given to Mitanins through elected representatives, irrespective of their political party affiliations.

In 2013, the state transferred the responsibility of paying Mitanin incentives to Gram Panchayats. This move had the potential to improve the autonomy of Mitanins further and is likely to strengthen the Mitanin-Panchayat relationship that is critical to the Swasth Panchayat program. However, it was perceived by the health department as a loss of control over payments to Mitanins. The decision was rolled back and block officials of the health department are now responsible for paying Mitanins. The implications of the rollback on the autonomy of Mitanins is yet to be fully understood, but the early indications show that Mitanins are still able to maintain autonomy to a great extent.

In terms of achieving involvement of Panchayats in the health sector, VHSNCs seem to be relatively more successful compared to other attempts. The VHSNC-based processes have allowed representatives from most of the Panchayats to participate and contribute to action on SDH. Their involvement has been more noticeable in addressing issues such as drinking water, the functioning of nutrition programs, and domestic violence. The involvement of Panchayats in paying incentives to Mitanins and in the implementation of Fulwari crèches has provided them with a well-defined role in continuous work on health and nutrition. Thus while traditional roles still dominate the agenda of Panchayats, they have begun to engage with SDH issues. This has allowed Panchayats to realize some of their role in the social sector and to exercise a limited accountability over local service providers from government departments. A quantum jump is possible in this aspect if the state guidelines and actions encourage genuine decentralization and actually allow Panchayats to assert their control over the decision-making of most departments. The implementation of the 73rd amendment of the constitution in spirit, can thus take the convergent action on SDH far beyond where it stands today.

The impact achieved on SDH in the form of action and improvements in the PDS, ICDS, school meals program, domestic violence, and drinking water etc.

is a result of a combination of approaches tried out over a decade. This impact was initiated by the Mitanin program and built on by Swasth Panchayat and its various interventions at different stages. The factors that were crucial for the impact achieved on SDH and its scaling-up seem to be:

- The interventions were complex, interlinked and mutually reinforcing.
- The approach was to integrate each new intervention with the existing platform.
- The integrated set of interventions evolved through field experience and reflection. Some interventions were assessed as more effective than others. Such interventions were given more attention and they were scaled-up across the system. This led to the periodic strengthening of the community platform.
- The process of analysis and adding of new interventions and components was also guided by a vision of community empowerment and a holistic definition of health that specifically included SDH.

Frequent reflection on field experience, based on dialogues with local facilitators and visits to VHSNCs has been a feature of this effort. Innovation while being a force taking the program forward, has almost been a necessity in Swasth Panchayat. Sustaining the active participation of rural communities required reflection and innovation.

There have been efforts to replicate the Swasth Panchayat experience in other states and domains. Mitanins and VHSNCs from Chhattisgarh continue to be seen as national best practices [18]. In Chhattisgarh, similar processes have been introduced in urban slum communities through organizing Women's Health Committees called Mahila Arogaya Samitis (MAS) and getting them facilitated through urban Mitanins. Though urban areas do not have mechanisms like the Gram Sabha (general assembly) and Panchayats, they have elected councilors for urban wards. MAS fill these gaps to some extent and show potential to emerge as a platform for promoting participatory democracy in urban slums. They have started maintaining monitoring registers and death registers and have begun to undertake action on SDH. Chhattisgarh started it in urban areas in 2012, a couple of years earlier than the effective launch of the NUHM. Currently, there are around 3700 such committees actively engaged in SDH across 19 cities in the state. The replication in urban areas involved some modifications to the VHSNC-based design, but it benefited a great deal from the experience of Swasth Panchayat. Urban slum communities as represented through MAS show a faster trajectory to achieving significance in their work on SDH issues such as violence against women, and drinking water. They seem to fill a big vacuum in community participation in urban areas. They also seem to be facing far fewer challenges in staying relevant and energetic when compared to VHSNCs in rural areas, though the reasons for this crucial difference are yet to be understood.

Most of the components of the Swasth Panchayat program including the facilitation process and the tools used have been included the national guidelines of NRHM and NUHM on Community Processes [19, 20]. The training modules designed at the national level have also been guided by the experience [21].

It remains to be seen how other states respond to the opportunity. The lessons that the Swasth Panchayat experience offers will be critical while replicating and adapting the initiative in other states. It also offers a fertile ground on which to explore the complex issues of promoting community participation and the role of government in SDH, issues of autonomy, and the accountability and governance of community programs.

Commentary—Swasth Panchayat Yojana

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In India, where decentralization to local government up to the *Gram* (village or cluster of villages) level is a constitutional mandate, other than in a few states there is a paucity of evidence to demonstrate the processes by which such decentralization can be effected for improved health care and action on Social Determinants of Health (SDH). The implementation framework of the National Rural Health Mission (NRHM), launched in 2005, envisioned the Communitization component as a key part of the health systems reform process, creating a Community Health Worker—the Accredited Social Health Activist (ASHA), rooted in the community, supported and strengthened by a Village Health Sanitation and Nutrition Committee (VHSNC) to undertake community monitoring as a way of improved accountability and village-level planning and implementation. The document also envisaged the creation of planning and monitoring committees at various levels of the health system to enable people's participation in health and health care [1].

The chapter on convergent community action for health and its determinants in Chhattisgarh state throws up several useful lessons for other states in the country and indeed globally. This article provides a historical trajectory of the intervention, commencing with the Mitanin or Community Health Worker to the establishment of Village Health, Sanitation and Nutrition Committees involving broader community participation including members of local government and implementation at scale. Including SDH, equity and the involvement of local self-government as an inherent part of the model design and ensuring that this vision was an integral part of all processes—creation of institutional structures, development of training modules and the very orientation of the stakeholders involved demonstrates that this factor, notwithstanding the intensity of process, has made scaling-up possible. The model, in fact, demonstrates a promising alternative to engaging elected representatives in addressing issues of SDH, through action on health and its determinants as a way of promoting local action and accountability, on a basket of determinants ranging from food security to the maintenance of hand pumps.

There are two noteworthy aspects of the intervention that attest to the particular strength of the model in addressing SDH and the capacity for decentralized action.

The first is the discussion on the ability of the VHSNC to address issues of disability and domestic violence which are both completely bypassed by the public health system. The model demonstrates that the VHSNC is an effective platform with the potential to identify cases of disability and domestic violence and demand action. Thus it becomes an important first step in formulating a strategy for the health system to mount a comprehensive response in both areas.

The second appealing facet of the model is the use of village monitoring registers by the VHSNC to record deaths and undertake community audits of maternal and child deaths. The focus on collection of mortality data enables a form of step by step approach to community monitoring, and allows for a causal analysis that is linked to the specific event of death, but which could be attributed to the health system response, to social or environmental determinants or a mix of all three. This component of the model enables a focus on largely preventable deaths and builds the VHSNC's perspective on causes of mortality and the accountability of the health system and their own responsibility. The article is an important contribution to understanding the value of mortality audits as an early step in village health planning.

The role of village health committees in promoting the accountability of service providers and the health system while increasing community capacity to take action on SDH, is an area of considerable study. The article adds to this body of literature and the focus on process provides insights for policymakers and programs on implementation and scaling-up. Two aspects of this intervention need further investigation. One is the understanding of service provider perspectives and responses to community demand for action, which is key to creating a broader and sustained health system response. The second is the nature of power relationships between members of the VHSNC and the extent to which this affects participation and action.

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