Question 2: *What are effective and sustainable mechanisms or processes to integrate local, community, sub-national, national, and regional voices, priorities, and contributions into health system strengthening efforts?*

Empowering Communities to take action for their health through social accountability and community monitoring mechanisms at primary healthcare centers in Jharkhand, India

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Context

The Government of India launched the Ayushman Bharat Health and Wellness Centers (HWCs) initiative to provide comprehensive, equitable and quality primary healthcare closer to the communities. Under this initiative existing primary healthcare centers were revamped to provide an expanded package of services through a continuum of care approach. A total of 150,000 HWCs were operationalized by December 2022. USAID-supported NISHTHA project, implemented by Jhpiego is supporting 12 state governments in strengthening the delivery of comprehensive primary healthcare. Following the operationalization, key challenges identified were community engagement, limited community ownership and participation in decision-making processes, inadequate monitoring mechanisms, and a lack of social accountability. These challenges hinder the delivery of quality healthcare services at the primary care level. The Government of India launched guidelines on establishing Jan Arogya Samitis (people's health committee) at primary health centres to increase community engagement and accountability,

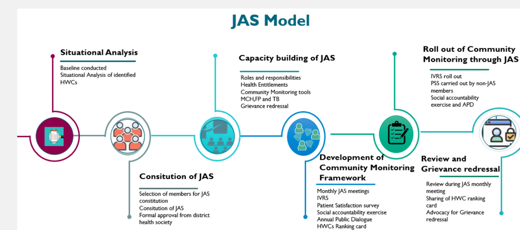
In view of this, USAID-NISHTHA piloted a learning lab on establishing Jan Arogya Samitis (people's health committee) in the state of Jharkhand, India, specifically in the districts of West Singhbhum and Khunti. The aim is to address health system challenges and behavioral factors contributing to the delivery of primary healthcare services.

Actors within and outside the health system contribute to the problem. Within the health system, there was limited awareness and skills in community engagement and monitoring. Outside the health system, communities faced challenges in actively participating in their healthcare decisions, and there were gaps in social accountability and non-existent grievance redressal mechanisms.

The learning lab implemented in Jharkhand aimed to engage communities and make them active participants in seeking primary healthcare. This included empowering communities by giving them a voice and active participation through the establishment of Jan Arogya Samitis (JAS), training and building the capacities of JAS members, and establishing community monitoring and social accountability mechanisms. The desired outcomes included increased community ownership, improved decision-making processes, enhanced monitoring mechanisms, and greater social accountability for primary healthcare services.

The absence of community members and beneficiaries from the initial discussions may have limited the understanding of the healthcare system's real challenges and potential solutions. Their firsthand experiences and perspectives are crucial in identifying gaps, addressing community-specific needs, and fostering a sense of ownership and accountability. Without their inclusion, the proposed solutions might have been disconnected from the ground reality, potentially leading to ineffective interventions and limited community engagement. By empowering communities and fostering a sense of ownership, the approach aims to promote active engagement, collaborative decision-making, and accountability. The model recognizes that addressing health challenges requires not only structural changes but also shifts in behaviors, attitudes, and social dynamics within and outside the health system.

Activity Description



Taking a systems-thinking approach, USAID-NISHTHA's intervention focuses on community empowerment, building sustainable health facilities, and fostering intersectoral collaboration. The intervention was co-designed by USAID-NISHTHA/Jhpiego team, state community mobilization cell, Health and Wellness Center (HWC) state department and a local NGO GRAAM was also engaged in this intervention. To ensure local and stakeholder engagement, a state district-level sensitization meeting was organized, inviting representatives from health and non-health sectors such as Panchayat Raj Institution (PRI), community members and local community leaders.

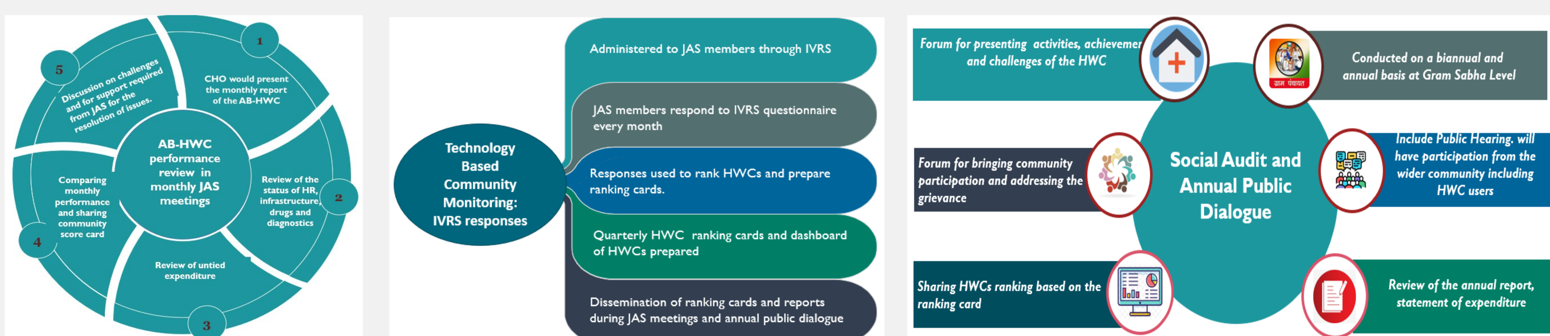
As a first step, a health plan was developed, a visioning exercise was conducted involving all the local stakeholders. Following this, interventional HWCs were identified for the constitution of JAS, and its functionality was defined. This collaborative approach aimed to foster a sense of ownership and joint responsibility among stakeholders, ensuring their active involvement and investment in the success of the intervention. The intervention emphasized community participation in decision-making processes. With the support from the local NGO GRAAM, the selection of JAS members (which included community members, community influencers and the community health officer from HWC) was conducted, resulting in the constitution of JAS committees in 35 HWCs. Capacity building sessions for JAS members were initiated by trained field coordinators of GRAAM using learning resource packages developed by Jhpiego. The topics for capacity building were determined based on community interests, and these sessions were conducted during monthly JAS meetings.

To facilitate community monitoring, USAID-NISHTHA/Jhpiego developed a framework that incorporated various monitoring mechanisms. These mechanisms included HWC performance review in monthly JAS meetings, IVRS responses (technology-based community monitoring), patient satisfaction surveys (exit surveys/feedback forms), social accountability exercises (social audits), and an Annual Public Dialogue involving the entire population which the Health and Wellness Centre caters to.

In the monthly JAS meetings, the Community Health Officer (CHO) presented the performance report of the HWC, and collective decisions were made by JAS members to address gaps and improve the functioning of their respective HWCs. IVRS calling was administered to JAS members, who responded to a questionnaire assessing service delivery, human resource behavior, infrastructure, and more. The data from IVRS calling was used to rank the HWCs and generate ranking cards to identify gaps and poor-performing indicators.

Patient satisfaction surveys were conducted by non-health JAS members, selecting beneficiaries from HWC Out-Patient registers. The face-to-face surveys, conducted outside of HWCs, collected feedback from 10 randomly selected beneficiaries regarding promptness, service availability, waiting time, cleanliness, and staff behavior at HWCs.

Social audit exercises took place biannually and annually at the Gram Sabha level, involving participation from PRI, Livelihood Mission, and the education department across all 35 HWCs. During these exercises, the community reviewed annual reports, statements of expenditure of SHC-HWC, untied fund utilization, and HWC-related issues. Social audits established mutual accountability between the HWC (health system) and the community (represented by the JAS). To ensure public participation and engagement from multisector stakeholders and vulnerable communities, an Annual Public Dialogue (APD) was conducted. The APD provided an opportunity to share the activities, successes, and challenges of HWCs, focusing on its roles in healthcare service delivery and community-level interventions.



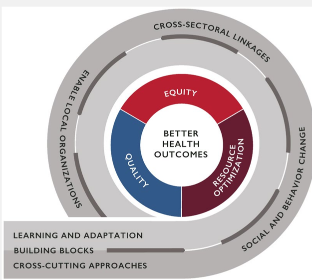
Activity Impact

The impact of the Jan Arogya Samitis (JAS) intervention is evident in several key areas, demonstrating the effectiveness of the systems-thinking approach:

Inclusivity and Community Understanding: JAS facilitated regular meetings, allowing community members and stakeholders to come together, identify gaps, and collaboratively develop action plans. This inclusive approach ensured that community needs were understood and addressed effectively.

- **Co-creation and Ownership**: By actively involving the community and key stakeholders in decision-making processes, JAS promoted co-creation and ownership. The utilization of untied funds, procurement of essential drugs and test kits, and prioritization of resources were driven by the collective efforts of JAS, Village Health Sanitation and Nutrition Committees (VHSNCs), and Panchayats.
- **Accessibility and Utilization of Healthcare Services**: Through JAS initiatives, healthcare services became more accessible and utilized. The JAS committees advocated for themselves, leveraging resources and addressing issues directly through representation. This empowered the community to navigate the healthcare system, ensuring that patient concerns were addressed and systemic improvements were made.
- **Sustainable Community Empowerment**: JAS fostered sustainable community empowerment by strengthening partnerships between the community and healthcare providers. The standardized grievance redressal mechanism ensured patient-centered care, quality improvement, and trust-building. JAS members actively tracked grievances and escalated them when necessary, leading to responsive actions and systemic improvements.
- **Data-Driven Decision Making**: The collection of over 350 patient satisfaction feedback through surveys conducted by JAS members provided invaluable insights for identifying areas of strength and areas needing improvement. This data-driven approach supported evidence-based decision making for quality improvement, service delivery, and addressing health worker behavior.

Additionally, capacity building efforts focused on climate resilience, gender and social inclusion, utilization of untied funds, and grievance tracking mechanisms, further enhancing the effectiveness of the intervention.

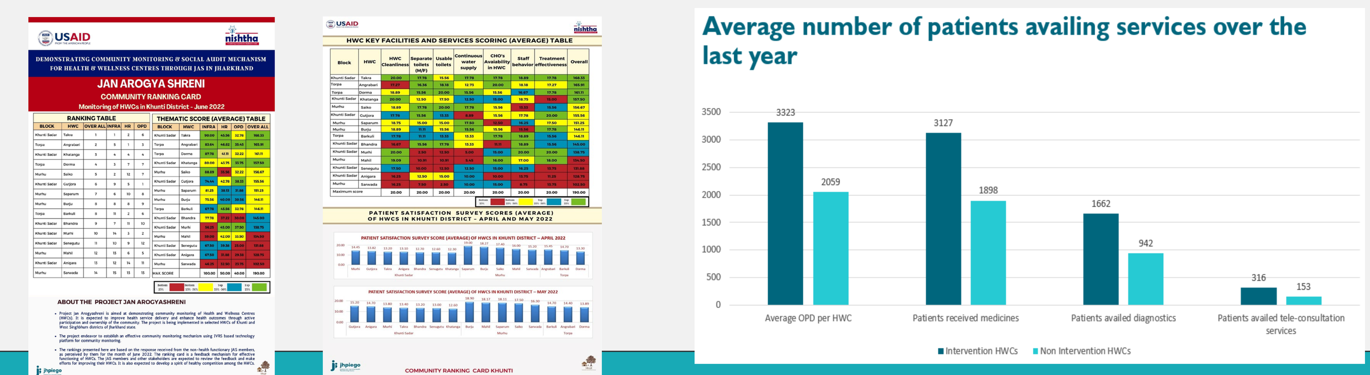


Evidence

Overall, the JAS activity strengthened the health system by promoting inclusivity, community understanding, co-creation, ownership, accessibility, utilization of healthcare services, and sustainable community empowerment. Through engagement with new voices, such as JAS members and community representatives, this activity contributed to health equity, quality improvement, and optimized resource allocation, resulting in a more responsive and effective health system.

The successful integration of local, community, sub-national, national, and regional voices, priorities, and contributions in this approach is supported by the following evidence:

- IVRS-Based Community Monitoring: The enrollment of 370 non-health functionaries for IVRS-based community monitoring indicates the active involvement of diverse stakeholders in the monitoring process. The completion of one quarterly cycle and the generation of three community ranking cards demonstrate the successful engagement of these voices in assessing and improving the health facilities.
- Increased OPD Footfall: The higher OPD footfall of interventional HWCs compared to non-interventional HWCs, with an average of 3323 per HWC, indicates improved community ownership and efforts to enhance the quality of healthcare services. This data shows that the community is actively utilizing and benefiting from the services provided.
- Increased Service Uptake: The constant increase in service uptake for maternal and child health (MCH), family planning (FP), tuberculosis (TB), and non-communicable diseases (NCDs) at the interventional HWCs demonstrates the impact of community-led initiatives in promoting health-seeking behaviors. Specifically, the screening, diagnosis, and provision of hypertension medication to 150 more hypertensive patients in interventional HWCs highlight the successful integration of community voices in addressing specific health conditions.
- Social Audits: The participation of over 1100 community members, block officials, and JAS members in two rounds of social audits across all 35 facilities indicates the active engagement of stakeholders in reviewing and improving the functioning of the health facilities. This process fosters transparency, accountability, and collective decision-making.
- Baseline and End Line Study: The conducted baseline and end line study in 1311 households provides measurable evidence of the impact of the intervention. The observed average change of 10% in service utilization, patient/beneficiary satisfaction, and facility readiness demonstrates the effectiveness of the community-led approach in improving health system performance.
- HWC Ranking Card: The utilization of the HWC ranking card as an effective monitoring tool highlights the integration of local, community, and sub-national voices. It promotes competition among HWCs and motivates them to excel and continuously improve their performance.



Facilitators

USAID Support: USAID played a crucial role as a funding agency, providing financial support that allowed for the implementation of the JAS intervention. This support facilitated the execution of activities, capacity-building efforts, and the development of monitoring tools such as the IVRS system.

Existing Coordination Mechanisms and Government of India guidelines: The intervention capitalized on the presence of working groups and coordination mechanisms within the health system. The state community mobilization cell, Non-communicable Diseases – AB-HWC department, and Women and Child Health department served as established platforms for stakeholder coordination. Leveraging these existing structures ensured efficient collaboration and effective utilization of resources.

Contextual Relevance and Local Partnerships: The JAS intervention was co-designed with key stakeholders, including the state community mobilization cell, Non-communicable diseases – AB HWC department, and local NGO partner GRAAM. This participatory approach ensured that the intervention was tailored to the specific needs and priorities of the local context. The formal approval obtained from the District Health Societies of West Singhbhum and Khunti districts further solidified the partnership with the government, establishing a strong foundation for the intervention's integration within the existing health system.

By leveraging USAID support, existing coordination mechanisms, and establishing local partnerships, the JAS intervention was able to navigate the health system effectively and ensure its contextual relevance. These factors contributed to the successful implementation of the intervention, fostering collaboration, resource optimization, and alignment with the local health system priorities.

Challenges

- Limited community awareness and participation: Initially, there was a lack of awareness and understanding of the JAS concept among community members. To address this challenge, training and capacity building sessions were conducted during monthly JAS meetings to enhance community members' knowledge and engagement.
- Lack of sense of ownership and accountability: Initially, community members perceived that the responsibility for the functioning of the HWCs solely rested with the health system. To overcome this challenge, tools for community-led monitoring and social accountability exercises were introduced. This helped community members realize their active participation and responsibilities in improving the HWCs.
- Unawareness about the status of HWCs: Community members had limited knowledge about the performance and status of their HWCs at the district and state levels. The introduction of HWC ranking cards proved beneficial in addressing this challenge. The ranking cards provided information about the gaps and indicators that required improvement, enabling community members to understand the areas that needed attention.
- Lack of advocacy for grievance redressal: JAS members were initially unaware of the mechanisms available to address their local issues and how to escalate problems to the relevant authorities. To tackle this challenge, a JAS Grievance Redressal system was developed. This system empowered JAS members by providing them with the knowledge and channels to effectively address their concerns and achieve prompt action.

Overall, these challenges were addressed through targeted training, awareness-building initiatives, and the introduction of supportive tools and systems. The aim was to empower community members, enhance their understanding of their role and responsibilities, and foster active participation in improving the health system.

Lessons Learned

Lessons learned during the implementation of this activity have significant implications for future activities and approaches:

- Streamlining community monitoring and social accountability: Implementers should prioritize the establishment of effective community monitoring and social accountability mechanisms. This includes engaging JAS members and other community representatives in monitoring activities to empower them and foster transparency in the functioning of healthcare facilities.
- Engage stakeholders and build partnerships: Collaborating with a wide range of stakeholders, including government departments, NGOs, and community-based organizations, is crucial for successful implementation. Involving these stakeholders in the design and planning process ensures ownership, collaboration, and sustainability of the approach.
- Contextual adaptation: Understanding the local context is essential before implementing the JAS model or any similar approach. This involves considering the existing health system, community dynamics, cultural norms, and political environment. Adapting the approach to address specific requirements and obstacles enhances its effectiveness and relevance.
- Capacity building and empowerment: Building the capacity of communities on health topics and empowering them with knowledge about their rights and responsibilities is vital. This enables them to actively participate in decision-making, monitor service delivery, and advocate for improved healthcare services.

Advice for other implementers and health system actors in other countries:

- Prioritize community engagement and ownership: Actively involve community members throughout the intervention process. Encourage their participation, seek their input, and ensure their ownership of the approach. This creates a sense of responsibility and enhances the sustainability of the intervention.
- Foster collaboration and coordination: Establish effective coordination mechanisms among stakeholders, including government agencies, NGOs, and community representatives. Promote collaboration, information sharing, and joint decision-making to optimize resources and improve health outcomes.
- Promote transparency and accountability: Develop robust monitoring and feedback mechanisms that promote transparency in service delivery. Involve communities in monitoring activities and provide platforms for them to voice their concerns and demand accountability.
- Continuously learn and adapt: Embrace a learning mindset and be open to feedback and adaptation. Regularly evaluate the intervention's progress, collect data, analyze results, and make necessary adjustments based on lessons learned.

By incorporating these lessons, implementers and health system actors in other countries can adapt and implement similar approaches that effectively engage communities, improve health system performance, and empower individuals to take an active role in their own healthcare.