Fostering community engagement in health services

OP-19 GENERATING MOMENTUM TOWARDS COMMUNITY ROLES IN UNIVERSAL HEALTH COVERAGE: KEY OUTCOMES OF A SERIES OF STATE-CIVIL SOCIETY CONSULTATIVE PROCESSES

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Background Community participation can be considered the backbone of universal health coverage (UHC). This has been extensively demonstrated through the successful experiences of Thailand and Brazil, among others. Optimised roles and effective performance of local or grassroots organisations are essential to the integration of community participation for delivering UHC. In India, grassroots organisations supporting community participation in health include the village *Panchayats* (local governance bodies), the health administration at sub-district level and below, local civil society represented by community-based organisations (CBOs) and community engagement processes. While the 2011 report of the High Level Expert Group on UHC highlighted importance of engaging citizens in UHC processes, a majority of discussions post this report focused mainly on financing and service provision aspects of the UHC. In this context, a series of activities were undertaken to elicit the enhanced role for grassroots organisations in UHC and related health initiatives.

Methods Noted civil society leaders prepared concept papers on critical themes, which included the role of civil society organisations (CSOs), *Panchayati Raj* institutions (PRIs) and other CBOs. A national consultation and two state-level consultations were held, involving critical civil society players and state actors. Reports of the consultations were prepared, with inputs from coordinating civil society agencies and individuals. A qualitative analysis was conducted to elicit the reflections of key participants about these processes.

Findings The concept papers prepared as part of the initiative focused on the historical evolution and theoretical and practical issues around community participation in health. They also identified important contributions of different types of civil society organisations to the health sector, at national and international levels. Contentious issues needing further analysis were also highlighted.

Both the national and the state-level consultations elicited the importance of defining and promoting community roles as an integral part of policies and programmes. Need for expanding the role of the community actors to areas such as policymaking, planning, oversight, regulation, grievance redressal and local resource generation, in addition to the conventional role of support in service provision, was also identified. Orientation and sensitisation of both civil society and government actors at state, district and community level were also suggested as critical measures.

Involving PRIs with improved role clarity, capacities and leadership space was suggested as an important step to move the UHC agenda forward. Abilities of PRIs in forefronting and addressing people's priorities for health was highlighted based on the Kerala experience. Focusing on organisations of marginalised and vulnerable groups was seen as an essential

strategy to ensure inclusion of such populations. The need for differentiating between 'civil society' and 'private players' was also highlighted. The role of political society in addition to civil society was seen as an area that needs better understanding. Investing in institutional mechanisms to ensure, support and sustain community engagement was listed as a key requirement.

Discussion The principles of equity, social justice and participation are fundamental to the spirit of universal health *coverage* – and they pose a challenge to the standard nomenclature of 'coverage', because this alone does not ensure equitable access, participation and utilisation. An alternative vision of UHC is premised on the integral role of citizen engagement in all elements of health policy and programme formulation. What these roles are and how they can be integrated into the health sector needs to be re-examined. Important roles that different kind of CSOs have played for enhancing quality of health services and for ensuring equitable access need to be acknowledged. These include actual service provision, health education and entitlements awareness, monitoring of health services, research and advocacy for inclusion of the most marginalised groups and their health needs, facilitation of dialogue between communities and the health system, and engagement with the health system for health sector reforms.

The experience of several countries indicates that the central forces that brought about UHC were social movements and community action. In India too, CSOs working on health have been discussing and debating the details of UHC. Many civil society actors in India also believe that UHC should democratise the health system, reducing the power balances both within the health systems and between healthcare providers and people.

Conclusion UHC plans and debates should move beyond the discourse on financial protection and insurance to one that acknowledges and accommodates the central role that people and their organisations can play in facilitating universal access to health. Such larger vision for change should actively include people and community-based organisations in defining, detailing, demanding and imparting health, in their specific contexts. Establishing and supporting institutional arrangements to create, expand and sustain such participation should be a state priority.

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