Taking an Ecosystems Approach: Support for Advocacy Training Initiatives' (SATHI) Public Health Work in India

Brendan Halloran (adapted from a longer study by Padmaja Nair) | September 2016

Delivering accessible, inclusive and high-quality health services in India is both technically challenging and politically complex. India's public health services have been highly decentralized for more than a decade, though the central government still plays a critical role. Thus the management and accountability for health services are spread across multiple layers of institutions, from the village Gram Panchayat councils to state and central government ministries.

The state of Maharashta is one of India's most powerful economic engines. Yet many social groups in Maharashta lack access to quality healthcare. Despite India's commitment to the principle of universal access, the state government spends less than 4 percent of its budget on health, poor individuals are often little choice but to seek expensive private healthcare.[1]

There are, however, opportunities to improve health access and quality in Maharashta. The structure of the National Rural Health Mission (NRHM), a combined set of services to address rural health deficits in 18 Indian states, includes design features that provide formal spaces and processes for community engagement in health provision, including monitoring of services.

Support for Advocacy and Training to Health Initiatives (SATHI), a civil society organization (CSO), has been working to improve healthcare in Maharashta for almost 20 years. SATHI has worked within the context of limited resources, complex governance and delivery structures, and opportunities for community engagement with the objective of making the public health delivery system accessible and equitable to all, especially poor and marginalized people. SATHI's work takes place along three fronts: ensuring the accountability of the public health system, establishing social control over private health systems, and promoting universal access to quality health care.

[1] Low levels of public investment and the consequent poor quality of services has led to the establishment of a large and wide spread private sector that is flourishing with little or limited regulations.

SATHI has worked across different levels of government, and with both state and non-state actors, as it has sought to navigate, connect, and strengthen the elements of a complex ecosystem of healthcare delivery and accountability. It has focused on improving the implementation of the Community Based Monitoring and Planning (CBMP) component of NRHM in Maharashtra. This has provided SATHI with the opportunity to build and leverage relationships with civil society and government actors at the community, state, and national level to influence health policy and practice.

SATHI's collaboration with the International Budget Partnership (IBP) began in 2009. Over the course of this partnership, SATHI has expanded and deepened its approach to working within the health accountability ecosystem in Maharashtra. The organization has coordinated the involvement of more civic actors, both community groups and formal CSOs, in work that is increasingly vertically integrated across all levels of the health system.[2] In addition, SATHI and its partners have expanded their engagement to include both planning and monitoring of health budgets and services.

The partnership of SATHI and IBP has evolved under IBP's 2014 India strategy. Since 2014, IBP has supported SATHI to both deepen its vertical engagement across different levels of governance and to strengthen its engagement with coalitions and networks of communities, CSOs, and government actors. SATHI's work contributes directly to IBP's strategic goal of improving service delivery and strengthening accountability systems in India. Since 2009, IBP has provided funding for SATHI to use the CBMP space to track primary healthcare spending, financial flows to primary healthcare institutions, and the availability of medicines, as well as to audit the use of untied funds available with these institutions.

This work has deepened over the years. IBP has provided technical assistance and strategic accompaniment, including capacity building of SATHI staff to engage with budgets, social audits, and bottom up planning. This has helped SATHI to integrate its work with the CBMP process. SATHI's efforts to strengthen transparency, participation, and accountability in the NRHM have evolved along three lines: Participatory Audit and Planning (PAP) at the facility level for planning and tracking of untied funds; decentralized health planning under the NRHM Program Implementation Plan (PIP) framework; and social policies and budgets at the state level. In all three focus areas, SATHI works together with CSO networks and broader social movements to influence change.

[2] This includes the 22 CSOs implementing the CBMP, the more than 30 CSOs that constitute the Maharashtra State chapter of People's Health Movement, the Right to Live campaign for a range of accessible social services, including health. SATHI is one of the leading organizations in these networks, coordinating and facilitating some of accountability-related processes in the state of Maharashtra and, to some extent, at national level.

This case study documents the strategies and achievements of SATHI and its coalition partners, the impacts of CSO interventions on public health delivery and accountability, and challenges that have emerged.

STRATEGIES AND ACHIEVEMENTS

Three inter-related aspects of SATHI's strategy stand out as central to its work. First, from the very beginning SATHI adopted a deliberate policy of working with collectives and networks of CSOs to ensure local participation in planning and monitoring to improve government accountability and improve the delivery of health services. SATHI's strategy of collective action — partnerships and networks at the local, block, and district levels, and larger coalitions at the state and national levels — has contributed significantly to its impact. SATHI defines its relationship with the government as one of "critical engagement" rather than "partnership," and therefore claims to be able to play the role of a capacity building, monitoring, and mentoring agency for the state, as well as to challenge it from the outside.

Second, SATHI works at the community level to better understand the dynamics of the health system and assess its impact on the marginalized communities. But the hierarchical structure of the public health service in India requires SATHI to work at multiple levels of governance, including at the state and national level, to advocate for policy and institutional changes. Thus, SATHI adopts a vertically integrated strategy that engages with relevant actors, spaces, and mechanisms across different levels of health governance, as well as in a holistic manner at multiple points of the budget and service delivery cycle, from planning to monitoring.

The final and transversal aspect of SATHI approach is its dedication to evidence. This has led to a systematic embedding of action research into the organization's work in a way that generates continuous data to feed into iteratively refined strategies. SATHI continuously gathers evidence about bottlenecks and good practice in health planning and monitoring to pilot improvements, which can then be expanded to other communities or government agencies. This commitment to action research and evidence-based innovation is deeply embedded in the organization's learning culture, and is reflected throughout SATHI's work.

COMMUNITY BASED MONITORING

By 2007, NRHM had matured into a full-fledged program and encouraged the participation of the community as well as CSOs. "Communitization," one of the five key approaches adopted in NRHM,

meant developing decentralized planning, and setting up and funding hospital management committees, known as *Rogi Kalyan Samiti* (RKS), with representatives of the community at all levels.[3] SATHI, together with its network of CSO's and local partners, sought to use this opportunity to improve the delivery of healthcare, beginning with the monitoring aspect of the CBMP component.

Within NRHM, CBMP is a process that is responsible for determining whether budget allocations to public health are sufficient and whether the quality health services being delivered are up to scratch. CBMP encompasses three areas: the availability of health services guaranteed by the state; the availability of related resources like infrastructure, human resources, and medicines; and the effective and efficient utilization of funds. It is designed to provide regular and systematic feedback of community needs based on locally-developed indicators and to provide feedback on the functioning of the public health system and service providers.

SATHI was identified by the central government as the leading agency for managing and coordinating the implementation of CBMP in Maharashtra and entrusted with the task of supporting and coordinating the work of 45 Primary Health Centers (PHCs) in five districts and disbursing funds to CSOs. SATHI is also a member of several planning and monitoring committees under the CBMP, and has a representative in the Advisory Group for Community Action (AGCA) at the national level. Through the CBMP, SATHI was given formal institutional space to facilitate improvements in the healthcare system by adopting a community participation and feedback mechanism.

The structure and process of CBMP also provided SATHI with an opportunity to officially collaborate and link with a vertical chain of institutions stretching from the Village Health, Sanitation, and Nutrition Committees (VHSNCs), the *Gram Panchayats* at the village level, their counterparts at the block and district levels, to the state and national governments, including the AGCA. By 2014, the CBMP process in Maharashtra had expanded to 118 PHCs covering 815 villages.

The CBMP process is undertaken in well-defined stages that include: the formation of planning and monitoring committees with the involvement of all stakeholders at village, PHC, block, district and state levels; the collection and generation of feedback and relevant data from the community; the organization

[3] Evidence from health committees in other countries suggest that representativeness, institutional features, facilitation and connections to broader organizations and movements are all important factors in the inclusiveness and effectiveness of health councils in representing the interests of citizens, especially from more marginalized groups. For evidence from the Brazilian experience, see Coelho, V. S. P. (2006), Democratization of Brazilian Health Councils: The Paradox of Bringing the Other Side into the Tent. International Journal of Urban and Regional Research, 30: 656–671.

of *Jan Sunwais,* or public hearings; regular state level communications and dialogues for corrective actions; and constant engagement with the media to keep the public informed.

The *Jan Sunwais* were particularly effective in bringing together the community and local service providers, CSOs, and public health officials. *Jan Sunwais* provided a platform for the issues of the community to be heard collectively and resolved in public. The organization of the event itself and the follow up activities are carried out by the local NGO, closely supported by SATHI. SATHI reports that between 2007 and 2014 over 450 public hearings have been carried out.

The *Jan Sunwais* aim to improve accountability and facilitate a vertical integration process of promoting change and influencing the state and its agencies from the district to the state level. The process also puts pressure on the lower level officials to perform. This interactive process, SATHI claims, has led to more awareness amongst the people and has forced public health service providers to improve their performance.

Initially the *Jan Sunwais* were not well received, primarily because health workers and service providers felt that the process only served to highlight the gaps in the system and the failure of the public health system to deliver. Regular interactions by SATHI and its local partners with the service providers and constant efforts to improve the format of the *Jan Sunwais* convinced them about its benefits and the potential for also voicing their own concerns. Indeed, the realization that the issues and grievances of front-line health workers were equally important for improving the health system was a real turning point. Without the engagement of health workers, SATHI's work would have resulted in fewer meaningful improvements to the CBMP system.

In 2014 SATHI constituted a federation of community monitoring committees at the block level in the five pilot phase districts to help in the process of transition of CBMP from the CSOs to the community institutions. The strength of SATHI's inputs were in the collaborative mode that it adopted and the constant process of dialogue and consultations with various agencies that was maintained. To begin with SATHI ensured that the committees formed at various levels were well represented by government officials at all levels, as well as representation from the community. This represents the careful balance SATHI has sought to achieve to bring together actors from the state and civil society to address common challenges, while also ensuring that the focus is on accountability for health provision.

TABLE 1. HEALTH GOVERNANCE AND IMPLEMENTATION

	Government Institutions	**Panchayat Raj**
National	Ministry of Health and Family Welfare, National Rural Health Mission (NRHM), National Health Systems Resource Centres (NHSRC)	
State	Community Based Monitoring and Planning (CBMP) State Coordination Committee, participation of health officials, service providers, and health facilities committees	
District	CBMP participation of health officials, service providers, and health facilities committees; public hearings; public health officials oversee Program Implementation Plan (PIP) process	CBMP participation of Panchayat representatives and community members
Block	Participatory Audit and Planning through RKS at health facility level; CBMP participation of health officials, service providers and health facilities committees; public hearings; public health officials oversee PIP process	CBMP participation of Panchayat representatives and community members
Village	CBMP participation of health officials, service providers and health facilities committees	CBMP participation of Gram Sabha, Panchayat representatives and community members

TABLE 2. SATHI'S KEY ACTIVITIES

	State Institutions	Panchayat Raj
National	Advising on Community Based Monitoring and Planning (CBPM)	
State	Coordinating CBMP activities and engaging health officials on implementation challenges	
District	Facilitating CBMP for health centers	Facilitating development of community proposals for health issues in the PIP
Block	Facilitating CBMP of health centers; supporting CSOs to organize public hearings with community members and public officials	Facilitate development of community proposals for health issues in the Program Implementation Plan (PIP) process
Village	Facilitating Participatory Audit and Planning (PAP) at the facility level for planning and tracking of untied funds; documenting problems in health access and service quality	Building capacity of village health committees; facilitating and documenting citizen health priorities and complaints

Community based monitoring has been an important precondition for raising awareness of health issues, identifying community based priorities for planning, and creating pressure for change through community mobilization in events like public hearings. However, achieving real community influence through community based planning is by no means automatic or straightforward. There are several prerequisites for doing so: focused capacity strengthening, consensus building among stakeholders, and support to ensure opening up and democratization of local planning forums.

The existing process of nominally "bottom-up" PIP preparation is actually highly centrally controlled and defined. This allows very little space to incorporate suggestions from non-official, community-based stakeholders. There is an urgent need to reconfigure this entire process at various levels, which would involve widening the planning process with effective and substantial inclusion of relevant non-official stakeholders. The strength of community-based actors and CSOs lies in their ability to collect local evidence and articulate community based priorities, which may otherwise remain unrecognized.

Planning at the level of health facility committees is generally tightly controlled by local officials, though often with the formal assent of elected local representatives. However, with the identification of key

community concerns and the capacity building of main stakeholders, including elected representatives, facility-level planning with the use of flexible funds can be made to be more responsive to the needs of marginalized communities. CSOs can play an important catalytic role by orienting political representatives and enabling them to act on community-oriented priorities. However, to effectively exercise this catalytic role, civil society representatives need to be both capacitated and given some formal status in planning bodies.

In the course of their engagement in the monitoring process, SATHI and its coalition partners realized that many of the improvements required in health service delivery could be managed by the community's active involvement in the planning process. Engagement in the planning process would lead to better monitoring of community's expressed needs. As SATHI was part of multiple committees associated with CBMP, it could keep up a continuous process of advocacy regarding community participation in planning. SATHI successfully advocated for CBMP committees to be linked with facility-based RKSs to improve the decentralized planning process.

RKSs have been constituted in health facilities overseen by each level of government. These committees manage the affairs of the health facility or hospital, and decide how to spend funds (including grants from the NRHM transferred directly to primary healthcare centers) to treat patients and maintain the facilities; these funds are untied and the RKS has significant discretion over how they are spent. The RKS is also expected to ensure the availability of subsidized food, medicines, and drinking water for the patients; oversee the cleanliness of the facilities and premises; and facilitate the regular training and skills development of doctors and staff.

The RKSs, and the untied funds at their disposal, were seen as critical to the process of community level planning for delivering health services. Yet, while RKSs have been formed in most of the facilities in the state, not all of them function efficiently. Many are dominated by state officials, there is a lack of training and capacity development of RKS members, and there is little transparency in fund management.

Between 2010 and 2012 SATHI undertook several action research interventions to understand decentralized planning and advocate for improvements. This included a short study supported by IBP that sought to understand the pattern of utilization of RKS and untied funds. The findings were subsequently used to influence the state to improve NRHM interventions. Currently SATHI (under an IBP initiative) working to build the capacity of the RKS and CBMP committees to undertake planning and monitoring and to contribute towards the development of PIPs.

In order to address the range of issues related to the PIP preparation process, SATHI and its partners carried out a focused intervention related to decentralized health planning on a pilot basis in three blocks of Gadchiroli district during 2015/16. The main objective was to test and develop processes, tools, and mechanisms which could help incorporate community health issues into the District PIP and annual budget plans. A total of ten proposals were developed and submitted to several levels of government. Of these, two proposals were developed and submitted to District Planning and Development Committee, six proposals were submitted to Tribal development department for availing integrated action plan funds, and two proposals were submitted to the State National Health Mission for availing supplementary PIP funds. As a result, a district health officer has ordered medical officers to execute the decisions which have been taken during DHP process. For example, a new provision for supplementary nutrition to new mothers was included in the PIP.

PROCUREMENT AND DISTRIBUTION OF ESSENTIAL MEDICINES

Since 1998, SATHI has been examining the availability of essential medicines in public health facilities, as part of its efforts to improve accessibility and inclusiveness of healthcare. A household survey and a facility survey revealed problems related to the mismanagement of the system of medicine distribution, finding that some PHCs were overstocked with medicines while others were understocked. The surveys also uncovered evidence of corruption in drug procurement and distribution. Contending that the right to essential medicines is a critical part of the "right to health for all," SATHI began to examine the issue in depth.

In 2010 IBP supported SATHI to launch a project to study the budgetary allocations for drugs and their procurement and distribution in Maharashtra. SATHI began building coalitions at the local and national levels to advocate for the procurement system to be improved. Partners in these networks were trained to monitor the availability of essential medicines in their local areas and collect relevant data for further study and analysis using tracking tools that SATHI developed. The findings[4] from the studies undertaken in the project were shared at the district and state levels. The availability of medicines in PHCs was discussed during the *Jan Sunwais* as part of the CBMP process at the block and district levels, and subsequently at a meeting of the CBMP at the state level in which officials from the health department participated.

SATHI used a variety of strategies to influence the state. This included issuing a press statement demanding the provision of free health care, adequate medicines through PHCs and rural hospitals,

[4] Only 25 percent of essential medicines were available in adequate quantity; 40 percent of essential medicines were not available at all.

substantial increases in the budget for medicines, and for the community to be involved in monitoring the purchase and distribution of drugs. SATHI reports that the budget for medicines in the state increased by 60 percent between 2009 and 2011 and some modifications were made in the procurement policy. Generic drugs are now reportedly being procured at the state level and more effectively distributed.

In 2014, in the current phase of the IBP program, SATHI has extended this work to other districts, studying the impact of changes in the system of medicine distribution and its responsiveness to the needs at the facility level. The action research study is being implemented through local and national coalitions, including the CBMP network. SATHI's strategy involves building capacity amongst all the stakeholders to disseminate its research findings through various forms of media. SATHI's efforts, alongside state interventions to address corruption in the drug and equipment procurement systems, appear to have paid off. A new state level procurement policy to ensure transparency in the purchase of medicine and equipment was approved by the state government in October 2015.

IMPACTS AND CHALLENGES

SATHI states that the CBMP network has contributed to quantitative improvements in the health sector, reflected in improvements in the health indicators and the use of facilities and services over a period of time. Qualitatively, there have been operational improvements through the pressure created through the CBMP network and processes.

To examine the impacts of SATHI and its partners' health work in the CBMP, SATHI compared a set of 40 PHCs from 13 CBMP blocks in various regions of Maharashtra to a set of 40 PHCs with similar regional profile, but from 13 other blocks where no CBMP processes were underway prior to 2014. Comparable data was available for both sets of PHCs. Routine CBMP data was available for the first set of PHCs from early 2014, while a first round of data collection, using similar CBMP tools, had been carried out to create a baseline in the latter blocks, where CBMP activities on voluntary basis were initiated in the first quarter of 2014.

Comparing data on four key parameters related to the delivery of services, major differences can be seen. Overall with identical inputs, the outputs appear much better in CBMP areas as compared to non CBMP areas.

The most substantial difference can be seen in "PHC laboratory services" (a priority area for CBMP in Maharashtra). Almost ten times the number of PHCs in CMBP areas received a "good" rating than PHCs

in non-CBMP areas (72.5 percent versus 7.5 percent). This reflects the focused engagement of CSOs working through the CBMP process over the past several years.

The demand for adequate "referral services" is another parameter where CBMP areas have performed substantially better than non-CBMP areas, especially during *Jan sunwais* (80 percent of CBMP PHCs were rated "good" compared to 55 percent in non-CBMP PHCs). This difference could be attributed to concerted efforts to raise awareness of communities on the entitlement to free ambulance services and continuous follow-up with the health system on this issue.

Through the CBMP process, there has been an effort to advocate for full functionality of PHCs, including "admission facilities and 24-hour delivery services." Demands have been regularly raised in *Jan sunwais* and during monitoring and planning committee meetings in all CBMP blocks. This may have contributed to better services in CBMP PHCs, as compared to the non-CBMP PHCs. However, only about one-third of the PHCs in CBMP areas are rated "good," which is a matter of concern which needs further definitive action. Delivery services must be available 24 hours a day to be rated as "good."

According to SATHI, such progress was made possible through regular and systematic capacity building, raising awareness amongst community members and health workers, regularly collecting data and creating an evidence base, disseminating information through the media, and encouraging dialogue between the community and service providers. Such activities helped to apply pressure on, as well as jointly problem solve with, service providers and the government. This leveraging of multiple and complementary tools and approaches for advocacy and monitoring aligns with the experiences of other successful organizations and campaigns.[5]

SATHI's success in supporting and leveraging the CBMP mechanisms to improve health outcomes has led the government to expand the full implementation of the CBMP from five to 14 pilot districts, as well as additional districts where other CSOs are replicating some elements of the process. The number of CSOs has grown to about 40 partners located at the district or block level. Several CBOs have also been incorporated into the process, bringing more diverse organized social actors into the fold.

SATHI's contribution to vertical integration has led to an overall improvement in the delivery of health services. There are multiple advantage to the vertically integrated structure of the planning and monitoring committees that has been put in place under NRHM:

[5] See http://www.transparency-initiative.org/reports/connecting-the-dots-for-accountability

- It has helped SATHI and its partners to adopt a sequential approach to addressing each level of governance.
- It reaches down to the village level and provides every household with an opportunity to place its health services related needs and grievances before the mandated officials.
- It allows for the participation of a cross section of stakeholders from the community, the elected representatives from the community institutions, and government officials and service providers.
- The public nature of the *Jan Sunwais* leads to issues being discussed and grievances being addressed on the spot.

Evidence from India and elsewhere suggests that these participatory spaces would not be as inclusive and effective without the engagement of SATHI and its CSO partners.[6]

CBMP has provided SATHI and its local partners with a great opportunity to consolidate and establish more structured and effective vertical linkages for advocacy, problem analysis, and monitoring. It has also made SATHI more aware of the advantages of working on the planning side of the equation, not just monitoring, and thus address the full budget and service delivery cycle. Furthermore, SATHI has been able to leverage other spaces and mechanisms to pursue additional synergies, such as by successfully advocating for a formal link between CBMP committees and the RKSs, thus connecting elements of the health accountability ecosystem.

SATHI and its partners now face the challenge of maintaining momentum and ensuring tangible change. SATHI has worked at multiple levels. It has not been easy to convince government officials at the block, district, and state levels that the purpose of CBMP is not to criticize, and that it is a process that can benefit them.[7]

SATHI has been most effective at the village, block and district level PHCs, and less able to influence the district and state agencies. District and state level advocacy has been difficult as the broader policy changes sought often require approval from elected and appointed officials who are more difficult to access and influence. While CSOs are able to work individually with the community and influence local

[6] With respect to the MKSS and social audits in India, see: Lakha, S. (2011). *Accountability from below: The experience of MGNREGA in Rajasthan (India)*. Asia Research Institute, National University of Singapore. For wider evidence, see: Cornwall, A., & Coelho, V. S. (2007). *Spaces for change?: the politics of citizen participation in new democratic arenas* (Vol. 4). Zed Books.

[7] For instance, the CEO of Gadcharoli District and other senior officials of the health department were of the opinion that CBMP and the tools it used helped them to get live status of services and performance from the remote PHCs in their District.

agencies at the operational level, changes at the decision-making level of the district and state appear to require the combined strength and multiple strategies of influential civil society groups.

SATHI has also had to contend with new challenges and obstacles in the broader political context. The agenda and priorities of the ruling political party in the state have not been beneficial for more inclusive and quality health services. The actions of state politicians have recently delayed the implementation of CBMP, including SATHI's facilitation of this process. Although state officials claim procedural issues are behind the delay, questions have been raised about their commitment to the participatory CBMP process. SATHI is pushing the state government to expedite the process while keeping the CBMP process moving with its own funds. Thus, even as SATHI has proved its competence and built up a strong network across lower levels of government, the organization must still adapt to broader political dynamics that shape the context of its work.

ANNEX: INTERVIEW PARTICIPANTS

Name	Designation/ Organization
Dr. Abhay Shukla	SATHI
Dr. Nitin Jadev	State Coordinator, CBMP- Maharashtra SATHI
Shweta Marathe	SATHI, Office in Charge and Research Staff
Hemraj Patil	SATHI, Action Staff
Deepali Yakundi	SATHI, Research Staffs
Bhausaheb	SATHI, Action Staff
Indavi Tulpule	CEO of NGO Van Niketan, Thane
Organization members	Two CBOs from Thane (Van Niketan Sanghathan and Shramik Mukti Sangathan)
Panchayat Samiti and RKS members	Vasind PHC, Thane
Federation Committee Members	Narayan Gaon, Thane
Organization staff	NGO Chaitanya, Maharashtra
Appasaheb Aher	Facilitator, looking after PHCs with MASUM and Federation for Research in Community Health
Trupti Joshi	SATHI, Action Staff
Dr. Hemlata Pisal	District Co-ordinator, MASUM, Pune
Kajol	Project Co-ordinator, MASUM, Pune
Mangal Mangre	Facilitator, MASUM, Pune
Dr. Satish Gogulwar	Amhi Amachya Arogyasathi, Gadchiroli
Shubada Gogulwar	Amhi Amachya Arogyasathi, Gadchiroli
Amrit & Vijaylakshmi	Coordinators, Amhi Amachya Arogyasathi, Gadchiroli
Manisha	*Karyakarta* MGNREGA
Sangeeta	*Karyakarta* Community Based Rehabilitation
Pratima	*Karyakarta* Sangathans, KishoriSanghs, SHGs (all CBOs)
Sampada Mehta	CEO , Gadchiroli
Dr. Suresh Kandale	Civil Surgeon, Gadchiroli
Dr. Mote	THO in charge of PHCs at Block level, Gadchiroli

Dr Jhotkar	Directorate NRHM
Dr. Sonkar	Project Officer for CBMP, Directorate NRHM
Ravindra Sawant	Joint Director, Finance and Accounts, NRHM, Mumbai
Executive Director and Resource Team	State Health Systems Resource Center, Pune