Taking RSBY to the Socially Excluded: Learning from the PACS Programme
Table of Contents

1. Executive Summary 6
2. Introduction 7
   2.1. Health and Consequences of Diseases 9
   2.2. Health Insurance in India 10
   2.3. Rashtriya Swasthya Bima Yojana 12
   2.4. Poorest Areas Civil Society Programme & RSBY 16
3. PACS Intervention 20
   3.1. Phase 1: Creating Enabling Environment 20
       3.1.1. Advocacy with the Government 20
       3.1.2. Selection of CSOs 21
       3.1.3. Orientation and Training of CSOs 22
   3.2. Phase 2: Implementation 23
       3.2.1. Pre-Enrolment Stage 25
       3.2.2. Enrolment Stage 36
       3.2.3. Post-Enrolment Stage 39
4. Conclusion and Lessons Learnt 44
5. Annexures 47
   Annexure 1: About PACS 47
   Annexure 2: List of CSOs Working on RSBY under PACS 48

List of Figures
Figure 1: Timeline of health insurance in India 11
Figure 2: RSBY stakeholders 13
Figure 3: The eight sub-processes of RSBY 15
Figure 4: Supply side and demand side interventions 19
Figure 5: PACS implementation structure 22
Figure 6: Activities under RSBY 24
Figure 7: PACS intervention under RSBY 44

List of Tables
Table 1: Percentage distribution of persons by coverage of health expenditure support for each quintile class of UMPCE 12
Table 2: Stakeholders and their roles 14
Foreword

I am happy to present this document ‘Taking RSBY to the Socially Excluded: Learning from the PACS Programme’ which captures the key learnings, details of the approaches and strategies adopted, their efficacy from the eyes of multiple stakeholders, including the communities involved in the implementation of the programme.

World’s largest health insurance programme, Rashtriya Swasthya Bima Yojna (RSBY) was launched by the Government of India in 2008 and gained momentum in the years that followed. Coinciding with the period of the initiation of the PACS Programme it presented an opportunity to take the benefits of the health insurance to the socially excluded households with whom the PACS Programme worked. In RSBY, PACS saw a potential of providing security from the sudden financial liabilities arising out of health shocks as well as facilitating access to quality health care in case of hospitalisation needs for the socially excluded communities and the most needy.

PACS Programme, during its implementation period of 2011-2016, worked on addressing critical gaps of awareness, enrolment, barriers and discrimination free access and grievance redressal in RSBY. It did so by bringing multiple stakeholders including the communities, insurance providers, government and hospitals, together to work towards reaching the benefits of the scheme to the socially excluded communities.

Working in collaboration with the biggest stakeholders, particularly the Government was the hallmark of the approach which the PACS Programme adopted and demonstrated its efficacy at scale. It enabled the programme and its partners to take up innovative interventions, work on addressing specific bottlenecks and barriers and try out strategies which brought about awareness and change at scale. PACS programme established a space for civil society facilitation and intermediation which otherwise was not a part of the design of a seemingly straightforward scheme like RSBY.

I hope that this document is able to further strengthen the discourse on looking at the issue of social exclusion and access to services in multiple dimensions and how they impact each other. This document also presents the efficacy of a constructive approach of working closely with the state and how changes brought about by influencing the system are more sustained and lasting.

Due to the diversity and scale of experiences of the PACS Programme I am sure this document will find value in the eyes of multiple stakeholders, key among them being the development practitioners, implementers and others who have a responsibility of working on various flagship programmes of the Government.

Anand Kumar Bolimera
Director, PACS Programme
Executive Summary

The figure highlights the typical journey and challenges faced by eligible beneficiaries under RSBY through each of its stages before and after PACS intervention.

As shown in the figure, often SEGs had no clue about the smart cards and were left uncovered during the enrolment stage. PACS intervened to ensure that all eligible beneficiaries were aware of when the enrolment camps are scheduled and that they were present for enrolment. Even when PACS ensured holding of enrolment camps there were recurring forms of glitches and wrong doings during the process. For instance the insurance companies and TPAs would fill erroneous data in the SMART Card, retain SMART cards even after registration or not complete enrolment due to large number of enrolees. There were also cases when intimidating villagers oppose enrolment of certain groups that discourage enrolment of SEGs in RSBY. Besides, even if smartcards were issued, but no IEC material was distributed with the card, beneficiaries remained largely unaware about the entitlements or did not know how to use it. In order to manage these difficulties, PACS undertook the responsibility of monitoring, supervising and facilitating the process of enrolment. PACS ensured that the enrolment team issued smartcards to all beneficiary families on the spot, along with a list of empaneled hospitals and detailed information on treatment package. To educate the community regarding the proper utilisation of smartcards, relevant IEC material in the form of contextual pictorial booklets was also made available in the enrolment camps.

Although smart cards were issued with IEC material, it did not necessarily assure discrimination free access to quality health services in empaneled hospitals. Often beneficiaries were denied treatment because of faulty credentials in their cards or nonfunctioning card machines in the hospitals. Even if some beneficiaries managed to avail treatment under the RSBY package, they would be charged for it or hospital authorities would retain their cards. To mitigate these issues PACS had to develop community based monitoring systems to ensure quality health delivery by the service providers as described in RSBY guidelines. PACS also collected feedback from the community regarding their experiences of using the smart cards. The same was shared directly with the SNAs and other relevant stakeholders to improve uptake of entitlements.
The World’s largest open health insurance programme Rashtriya Swasthya Bima Yojna (RSBY) was launched by the Ministry of Labour and Employment (MoLE), Government of India (GoI) on 1st April 2008. The beneficiaries under RSBY are entitled to hospitalisation coverage up to Rs. 30,000/- and the coverage extends to five members of the family. The major objective of this health insurance scheme is to provide financial safety net to the BPL households in the event of expenditures arising out of medical treatment involving hospitalisation.

Though RSBY offered many benefits and protection to lakhs of poor families from financial liabilities arising out of health shocks; the programme faces severe issues in implementation and delivery of benefits. It was found that eligible beneficiaries particularly persons from socially excluded groups (SEGs) were unclear about the processes of availing benefits and remained largely unaware about the various entitlements and services under the scheme. Subsequently, it was realised that removing financial barriers does not necessarily guarantee equitable access to health care. Often there are underlying social, political and cultural factors and processes that exclude certain social groups and result in their differential access and inability to utilise health care provisions.

This prompted UK Government’s Department for International Development (DFID) under its Poorest Areas Civil Society (PACS) programme in 2009 to engage actively in the implementation and monitoring of RSBY to ensure equitable and discrimination free access to quality health services by the SEGs.

While the ‘lack of demand awareness’ for the scheme was the primary motivating factor for PACS to intervene in the scheme, it was realised that the scheme suffered from various other shortcomings. It was understood that solely increasing the demand would not prove to be an effective strategy if there are gaps in the supply side. As a result of which it was crucial to address these challenges in a holistic manner. Thus, a decision was taken to strengthen the supply side and demand side interventions and support the programme through each of its stages:

1. **Pre enrolment stage**
2. **Enrolment stage**
3. **Post enrolment stage**

With the conviction that peoples’ organisation can play a significant role in facilitating access to the entitlements under the scheme, PACS intended to leverage the support of its wide network of civil society partners spread across the five states of Bihar, Uttar Pradesh, Jharkhand, West Bengal and Orissa. PACS believed that community engagement and ownership would not only lead to increased access, but also strengthen the accountability mechanism inbuilt in the health insurance scheme. However, since PACS and its partner civil society organisations (CSOs) were not inherent stakeholders in the scheme, they could not have intervened directly in the programme. Therefore, PACS initiated the first step to create an enabling environment to set a strong foundation for its intervention. In this context institutionalising the process of engagement through formal agreements and MoUs with the government was a key milestone, as it allowed for smooth introduction of the CSOs in the scheme. This gave them the credibility to work within the ambit of the scheme and also the required acknowledgement by other stakeholders.

This was followed by the second phase, namely, the implementation phase, wherein structured approach was adopted by PACS and its partners that covered the three major activities, namely

1. **RSBY Awareness**
2. **RSBY Enrolment and Access**
3. **RSBY Service Delivery**

Greater demand for uptake of entitlements under the scheme was generated by creating awareness about the scheme through a variety of communication platforms such as miking, street plays, nukkad natak, magic and puppet shows among others. Additionally capacities of CSO were also built on the main features of the scheme to reduce the information asymmetry. Likewise in order to enhance the enrolment and access to RSBY, PACS undertook the responsibility of monitoring, supervising and facilitating the process of enrolment. The role played by PACS ensured that the enrolment process occurs systematically and without any malfunctioning. Similarly to improve the service delivery under the scheme PACS built awareness among the smart card holders regarding its utilisation by organising rallies, street plays and film shows. Local folk art was also used widely as people could relate to them instantly. Secondly in order to enable utilisation exposure visits to the hospital were organised to familiarise the community members with the process of admittance in the hospital. Correspondingly sensitisation workshops were organised with empanelled hospital authorities to change their behaviour and attitude towards the patients from SEGs.

However, it is important to note that during the PACS programme, the interventions faced various challenges. Some of the critical challenges faced during the implementation include lack of coordination among stakeholders, improper distribution of name slips before enrolment camps, discrepancies in BPL list for enrolment, inefficient deployment of IEC activities by the insurance companies and TPAs, input of inaccurate data in the RSBY card, non-distribution and retention of SMART cards even after enrolment by POKs, exclusion of remote areas from enrolment, poor quality services provided by empanelled hospitals under RSBY package and delay and rejection of claims by insurance companies.

As a response to some of these challenges PACS and its partners employed a range of interventions such as building capacities of CSO on monitoring the standards of quality health delivery by the empanelled hospitals, awareness generation in the communities by adopting targeted intervention approach and developing appropriate IEC materials in the local context, facilitating state, district and block level consultative multi-stakeholder meetings, institutionalisation of Grievance Redressal Cell at district level and working in close coordination with State Nodal Agency (SNA) for generating the common action plans and strengthening the implementation of the agreed activities under the scheme.

In order to further enhance community participation and ownership towards this scheme a new cadre of human resource called the RSBY Mitras was created. The concept of RSBY Mitras was envisioned to facilitate and help the community to use their cards in times of hospitalisation. They had full information and knowledge about the provisions of RSBY and were equipped with the required information, including the list of hospitals and services the beneficiaries are entitled to. However it was observed that while their role of hand holding the community was beneficial, communities were developing high dependence on them which may not prove to be very viable for the long run.

An important aspect of the intervention was how it led to convergence of different stakeholders involved in the scheme. The strategy under RSBY intervention focused on supporting the government and all the PACS partners were oriented to work in convergence with the government departments. Similarly, to develop a collaborative approach for better implementation of the scheme a twin-pronged approach was adopted; wherein on one hand PACS partners focussed on extensively mobilising the communities for enrolment and uptake of entitlements under RSBY, while on the other hand, the district labour department focussed on strengthening monitoring systems to make service providers more responsive and accountable. Succinctly, PACS intervened at various levels to ensure that the scheme is successful in reaching the communities which were otherwise left uncovered or were not aware of the existence of the scheme. It was also seen that the intervention on RSBY led to increase in uptake of rights under other schemes as well. Awareness generation in the community under the RSBY scheme led to community empowerment making them conscious of their rights, in general.
PACS engaged actively in the implementation and monitoring of RSBY to ensure equitable and discrimination free access to quality health services by the socially excluded groups.
2 Introduction

2.1 Health and Consequences of Diseases

World Health Organisation (WHO) has defined health as ‘the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. However, despite of taking measures and precautions to remain healthy and free from diseases, incidences of diseases or subsequent need for medical care and hospitalisation arise in the life of every person.

The incidences of diseases have multifarious impacts on the life of a person. In epidemiological parlance, the collective consequences of a defined disease or a range of harmful diseases with respect to disabilities in a community is expressed as the burden of disease. It can be measured using several indicators such as mortality, morbidity, or financial cost.

The 71st round survey conducted by the National Sample Survey Office (NSSO) revealed that the Proportion (per 1000) of Ailing Persons (PAP), measured as the number of living persons reporting ailments (per 1000 persons) during 15-day reference period, was 89 persons in rural India and 118 persons in urban India.

While measurement of morbidity and mortality enable the estimation of the burden of disease in populations, it is also important to gauge the economic consequences of ill health in order to gain a complete understanding of the impact of diseases. Both macro and microeconomic consequences result from the occurrence of disease in a person. The major macroeconomic impacts include increased health expenditures, labor productivity losses and reduced investment in human and physical capital formation. At a microeconomic level, diseases lead to an increase in household expenditures on health services and goods and reduction in time spent on generating income.

The 71st round survey conducted by NSSO found that the average medical expenditure per case of hospitalisation in the public hospitals was Indian Rupee (INR) 6,120. This expenditure was almost four times higher in the case of hospitalisation in private hospitals (estimated INR 25,850). The average medical expenditure per non-hospitalisation case was INR 509 in rural India and INR 639 in urban India.

The cost of medical treatment in India witnessed a double-digit pace of growth and it has outpaced the average inflation in both rural and urban areas over the past decade. A major factor causing this rise in medical expenditure in India is the increase in the number of cases of hospitalisations taking place in private-sector hospitals due to a combination of poor quality of services offered by public-sector hospitals and their geographic inaccessibility.

Ghosh (2011) points out that the principal means of healthcare financing in India is through out of pocket payments (OOPs). These expenditures are also the leading cause of household debt which forces people to sell assets or borrow money. The draft National Health Policy for India also highlights the growing incidence of catastrophic expenditure due to health care costs (18% of all households in 2011-12 as compared to 15% in 2004-05). With over 63 million persons facing poverty every year due to health care costs alone, it is estimated that catastrophic health expenditures will be a major cause of poverty in the years to come.

Medical expenditures will have the potential to negate the gains of increased household income. While escalating medical costs are likely to push many households into poverty, Ghosh in his study has highlighted that it is again the poorer households who are making more catastrophic health payments. In addition to bearing the high health costs disproportionately, the poorer households are also severely impacted by the escalating health cost. Most persons from these poorer households work in the unorganised sector. The uncertain nature of job in the unorganised sector, coupled with the associated low income, and lack of savings to fall back upon after incurring medical expenditure, adds to the burden of these poor households and lead them into the ‘medical poverty trap’.

The Indian health insurance sector comprises of Governmental insurance schemes, Social Health

Insurance (SHI), Voluntary Private Health Insurance and Community-Based Health Insurance (CBHI). The major milestones of health insurance in India are presented in Figure 1. There has been an increase in the population coverage under the publicly financed health insurance schemes from almost 55 million people in 2003-04 to about 370 million in 2014. Nearly two thirds (180 million) of the population covered under these schemes are from Below Poverty Line (BPL) category.

The 71st round survey conducted by NSSO showed that 12 per cent urban and 13 per cent rural population was brought under Government health protection coverage through schemes like RSBY. The data on the coverage of health expenditure support for each quintile class of usual monthly per capita consumption expenditure (UMPCE) in rural and urban India is shown in Table 1.

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<th>Urban India</th>
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Table 1: Percentage distribution of persons by coverage of health expenditure support for each quintile class of UMPCE. (Source: NSSO, 2014)

2.3 Rashtriya Swasthaya Bima Yojana

RSBY was launched by MoLE, GoI from 1st April 2008. The major objective of this health insurance scheme is to provide a financial safety net to the BPL households in the event of sudden expenditures due to medical treatment involving hospitalisation.

The origin of RSBY can be traced to the enactment of the Unorganised Workers Social Security Act (2008). Based on the recommendations of this Act, a number of Central Government schemes were launched to provide social security to workers in the unorganised sector. RSBY was one of the policy initiatives in the health insurance arena.

RSBY responded to the long term demand for health insurance models to prevent further impoverishment of BPL families due to burgeoning costs of hospitalisation. The scheme provided financial protection to the BPL families in the event of hospitalisation of a family member. The scheme intended to mitigate the combined impact of health care cost and loss of wages during the period of hospitalisation on BPL families. It aimed to prevent most of these families from being pushed further into the poverty trap due to medical expenditure.
Health insurance cover under this scheme was initially provided only to BPL households. In the recent years, several categories of workers from unorganised sectors like street vendors, domestic workers, beedi workers, building and construction workers, and workers who have worked for more than 15 days under Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) can avail of the benefits under this scheme.

There are six primary stakeholders involved in the implementation of the scheme: The Central Government, State Government, SNA, Insurance Company/Third Party Administrators (TPA), Hospitals and CSOs. The roles of each of these stakeholders are clearly defined in the scheme and represented in the following table.

The beneficiaries under this scheme are required to pay INR 30 as registration fee and they are entitled to hospitalisation coverage up to INR 30,000 for a specified set of diseases that require hospitalisation. The coverage can be extended to five members of the family which includes the head of household, spouse and up to three dependents. In the event of hospitalisation, RSBY beneficiaries enjoy the triple benefits of:

1. **Cashless Insurance**
2. **Paperless Insurance**
3. **Portability**

Under this scheme, a smart card is issued to the beneficiary family and the empaneled hospitals are IT-enabled. The beneficiary can go to any of the empaneled public and private hospitals for cashless treatment.

The following 8 sub processes (on the next page) represents the process and work flow under RSBY. Each process comprises of process objective, process name, key stakeholders, pre-requisites, process and responsibilities, training, capacity building and information, education & communication (IEC) activities required as specified by the guidelines.
• The smart card and key management process is also important. It involves the creation of a secure and convenient environment for beneficiaries through IEC activities to ensure that data arising out of procurement and personalisation of all master keys matches the Field Key Officer (FKO) card data.

• Hospital management is one of the key processes within RSBY. Hospitals, Primary Health Centre (PHC) /Community Health Centre (CHC), SNA, District Key Manager (DKM), FKO, insurance company among others. Complaints received from various stakeholders including beneficiaries can also be logged at the call centre and the call centre then directs these complaints to the intended authorities. Each complaint/grievance received is closely monitored by a dedicated team at MoLE to check resolution times and to intervene if unresolved. The major purpose of this process is to set a strong mechanism for redressal of complaints and grievances to ensure efficient delivery of services under RSBY.

Kiosks are the front end service delivery channels for RSBY services to the beneficiaries. Insurance company sets up and maintains kiosks that provide services such as updation/modification/lost card replacement and issuance of split card to the beneficiaries. This process helps to provide RSBY administrative services to the beneficiary at the district level for enhanced beneficiary access and provides convenience of member addition/data updation/lost card replacement/split card issuance to the RSBY beneficiary. Additionally it also registers complains or grievances and acts as a window for addition of new beneficiaries under RSBY after proper verification from respective department.

• A key process within RSBY that remains constant throughout the life cycle is the claim management process. Claims raised by both public and private hospitals to insurance company are also monitored through the claim flow application by MoLE, SNA and insurance company. Claim management process intends to ensure settlement of claims within mutually agreed timelines with least number of disputes. It also tries to ensure seamless settlement of claims by clearly defining the criteria for automatic approval and conditions under which claims can be rejected and to reduce number of fraud claims.

• The most important link to all processes in RSBY is the complaints and grievance redressal process. Complaints are generally received from beneficiaries, hospitals, Primary Health Centre (PHC) /Community Health Centre (CHC), SNA, District Key Manager (DKM), FKO, insurance company among others. Complaints received from various stakeholders including beneficiaries can also be logged at the call centre and the call centre then directs these complaints to the intended authorities. Each complaint/grievance received is closely monitored by a dedicated team at MoLE to check resolution times and to intervene if unresolved. The major purpose of this process is to set a strong mechanism for redressal of complaints and grievances to ensure efficient delivery of services under RSBY.

• Hospital management is one of the key processes within RSBY that remains constant throughout the life cycle of RSBY. One month prior to the enrolment processes, both public and private hospitals are empaneled by the insurance company and empaneled hospitals are provided with the latest package rates through the transaction management software installed at each hospital. Once hospitals have treated a beneficiary and discharged him, claims can be raised to the insurance company, while the process of empanelment and de-empanelment continues round the year for each insurance company.

- Data preparation and pre-enrolment is the first step in implementation of RSBY. Beneficiaries who are eligible to avail the services under RSBY are identified during this process and provided with the RSBY card at the time of enrolment. The main objectives of this process is to ensure creation of de-duplicated enrolment list for RSBY by collecting beneficiary data from departments and ensuring accuracy and consistency of data collected, both from a structural and template perspective.

- Enrolment is the most important process of RSBY scheme. It entails setting up of enrolment stations up to the village level by the insurance company/ smart card service provider for enrolling the beneficiaries under the scheme at the respective districts. The primary objectives of this process are, firstly to reach out to maximum number of targeted beneficiaries in the enrolment list; secondly, to educate and empower beneficiaries through IEC activities to utilise the RSBY services using the RSBY card; thirdly, to ensure that only intended beneficiaries get enrolled; and lastly to ensure that data arising out of this process is accurate, clean and re usable.

- The smart card and key management process deals with master card key generation at MoLE, procurement and personalisation of all master key cards as well as beneficiary cards issued during enrolment. The major purpose of this process is to create a secure and convenient environment for beneficiary transactions using RSBY smart card. It also tries to ensure security of transaction data from unauthorised read or write access and to ascertain that all beneficiary cards are personalised through authorised and authentic personnel, master cards and equipment. Lastly, it aims to maintain an inventory of master cards that have been issued.

- The premium payment activity is done after all the beneficiaries from the enrolment list have been issued RSBY cards. The premium amount for the insurance company is divided between the state and central governments based on the regions and also calculated on the condition that beneficiary post enrolment data matches the Field Key Officer (FKO) card data.

- The enrolment process of all the eligible beneficiaries could not be achieved unless enrolment of all the eligible beneficiaries could be achieved:

- Low enrolment rate of the families from SEGs
- Lack of awareness regarding the schemes among a large section of eligible beneficiaries
- Demotivation due to unsuccessful utilisation of smart cards
- Low utilisation rate
- Delay in issue of smart cards
- Inadequate number of empaneled hospitals in the catchment area
- Delay in installation of IT facilities in empaneled hospitals
- Denial of services by private hospitals for many categories of illnesses
- Problems for migrants to use the card in areas other than hometown
- Delay in payment of premium to the insurance company by the Government
- Decreasing Premium
- Charging of informal payments
- Lack of efficient mechanism of dispute resolution

14 Wu, Q. (2012). What cause the low enrolment rate and utilisation of Rashtriya Swasthya Bima Yojana: a qualitative study in two poor communities in India. A dissertation submitted to the Liverpool School of Tropical Medicine impartial fulfillment of the requirements for the award of Master of Science in International Public Health (MPH) degree
PACS & RSBY

PACS Programme is an initiative of the UK government’s DFID. Under PACS, DFID partnered with Indian civil society to help SEGs claim their rights and entitlements more effectively, so they receive a fairer share of India’s development gains. A detailed description on PACS has been attached in Annexure 1.

There is ample evidence confirming that many people in India, particularly the poorest and most vulnerable, go without effective health care. This is mainly because access to and utilisation of effective health care interventions in our country continue to be a major problem for the underprivileged. Most commonly, insufficient resources, inappropriate allocation, inadequate quality are cited as major impediments to the delivery of effective health care that reaches the poor. However, it is important to understand that access in consonance with a multitude of factors, leads to utilisation.

Factors such as awareness, information, knowledge, sensitivity of the care providers and a conducive environment to enable utilisation of medical services and resources strongly determine access and utilisation, thus highlighting that merely removing financial barriers does not necessarily guarantee equitable access to health care. This is mainly because there are underlying social, political, geographical and cultural factors and processes that exclude certain social groups and result in their differential access and inability to utilise information, bureaucratic processes and health care provisions. Moreover, perception of self and the capability of care seekers to overcome inhibitions and obstructions in interactions with providers and institutions can also majorly affect utilisation among SEGs. For instance, social exclusion in health care provisions may be due to disrespectful, discriminatory or culturally inappropriate practices of medical professionals and their organisations. Therefore, identifying and addressing access barriers that remove the fear and intimidation that the SEGs face when confronted with hospitalisation is crucial.

PACS realised that while RSBY was conceptualised and implemented to offer support to the ones who need it the most (RSBY beneficiary), the community members were largely unaware of the scheme and its benefits. During the initial planning phase, RSBY was not identified as one of the intervention areas for PACS and the focus was on other health, nutrition and livelihood, related entitlements as part of the strategy to bridge the gap between schemes such as Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), National Rural Livelihood Mission (NRLM) and the poorest in the PACS state. However, looking at the wide gap that existed between service provision and its actual utilisation, alongwith the potential of the existing PACS network to curb this gap, PACS took on the opportunity to work on RSBY across five out of seven of its intervention states.

The prospect of the National Health insurance scheme to reduce out of pocket costs and catastrophic health expenditures, particularly for the SEGs, was the primary motivation for the PACS Programme to support the government for championing the interests of SEG in the context of this scheme. PACS efforts in supporting RSBY also emanated from the understanding that most households from SEGs lacked financial protection. In the event of occurrence of any disease or injury leading to hospitalisation, people from these groups are forced to make catastrophic out of pocket health payments resulting in their sinking further into the poverty trap. The enrolment of persons from SEGs in RSBY will prevent them from falling in the hands of unscrupulous money lenders to pay the cost of medical treatment, implying that these persons will not be forced to sell their assets, including land, to meet health care costs. The reduction in out of pocket medical expenditure may allow for more investment in other areas like education, leading to empowerment of these groups.

Understanding the gap in access to the entitlements under RSBY, with special focus on the challenges faced by the SEGs, PACS took on the task of facilitating community engagement under RSBY. PACS believed that community engagement and ownership would not only lead to increased access, but also strengthen the accountability mechanism built in the health insurance scheme.

With the belief that peoples’ organisation can play a significant role in facilitating access to the entitlements under the scheme, PACS intended to leverage the support of its wide network of civil society partners spread across the five states of Bihar, Uttar Pradesh, Jharkhand, West Bengal and Orissa.

2.4

PACS had been working with the marginalised communities on various issues other than RSBY. While working towards helping the socially excluded communities get better access to their rights, we understood that the government had initiated a health insurance scheme for the benefit of the community. Under this scheme, BPL families and members of the marginalised communities could access free health care services. “

“However, people had no information about the existence of such a scheme. It was unfortunate that people continued to suffer even when there were provisions by the government to access healthcare services. In spite of there being a health scheme for the marginalised groups, they had no access to it due to lack of awareness”

“We decided to take it upon ourselves to bridge this gap, so the scheme could reach the audience it was intended for and the benefits could be enjoyed by those who need it the most – and thus the PACS RSBY intervention was born.”

- Raj Kumar Bidla, Head of Programmes PACS

What PACS brings to RSBY

- Strong and vibrant network of civil society groups working directly with communities
- Deeper and wider reach to communities through civil society networks
- Range of innovative community participation strategies for increasing uptake of services under RSBY
- A perspective from ground giving a realistic assessment of scheme implementation

PACS worked towards creation of space for the community organisations to engage actively in the implementation and monitoring of RSBY scheme by following a twin-pronged approach focusing on supply side as well as demand side interventions.
While the ‘lack of demand/awareness’ for the scheme was the primary motivating factor for PACS to intervene in the scheme, it was realised that the scheme suffered from various other shortcomings. It was understood that solely increasing the demand would not prove to be an effective strategy if there are gaps in the supply side. It was imperative to address these challenges in a holistic manner. Thus, a decision was taken to strengthen the supply side and demand side interventions.

The PACS intervention under RSBY focused on addressing the gaps throughout the lifecycle of the programme in order to strengthen the supply and demand. However, since PACS and its partner CSOs were not inherent stakeholders in the scheme, they could not have intervened directly in the programme. Thus, the first step for PACS was to create an enabling environment to allow PACS to undertake this journey of bridging the gap between the scheme and its utilisation. Thus, creating enabling environment was a crucial step to set the strong foundation for the intervention and was prerequisite for its success. This was followed by the second phase, namely, the implementation phase, wherein PACS supported the programme through each of its stages.

The following sections throw light on each phase detailing various steps, processes involved, innovations adopted and the challenges faced.

### Phase 1: Creating Enabling Environment

In order to address the identified gaps in access of services under RSBY, PACS worked towards introducing CSO and defining their role in the scheme. However, in a scheme that already had a defined structure with specific roles and responsibilities outlined for each stakeholder, incorporation of an additional structure or any change was not going to be an easy task. In order to create an enabling environment for the introduction of this new cadre of resources to work under the ambit of the scheme, PACS undertook the following key activities.

#### 2.1.1 Advocacy with the Government

Experience suggests that even the most carefully designed programmes encounter difficulties when implemented. Invariably there are situations or interplay of unexpected forces which may hinder the roll-out of any programme. And especially with a scheme on the scale and ambition of RSBY, translation of objectives into tangible outcomes was not going to be a path without many hurdles. For instance, it was thought that the provision of smartcard and digitisation will provide for a seamless and convenient option to ensure that the benefits were reaching the poor and socially excluded. But in reality, there was a considerable shortfall between the registered beneficiaries and actual hospitalisation because of limited awareness amongst the communities and gaps in coordination among the implementing stakeholders. In this context, the success of RSBY was largely dependent on building community awareness and ownership, in addition to ensuring that service providers were more responsive and accountable.

In order to support the scheme, the first step for the PACS was to convince the government to allow participation of the CSOs. They approached the government with

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**ACTIVITIES UNDER RSBY**

**Supply**
- Sensitisation of service providers - SNA, Hospitals, Insurance companies
- Capacity building of government frontline workers on RSBY
- Facilitating interfaces with beneficiaries through consultation/workshops
- Support to run RSBY helpdesks in hospitals
- Motivate hospitals to get empaneled and ensure empaneled hospitals stay motivated to continue RSBY
- Supporting Insurance companies - programme support, claim settlement, organising health camps, provide IEC material
- Strengthening grievance redressal cell

**Demand**
- Building capacities of civil society organisations on RSBY
- Creating awareness among the community members on RSBY through media and door to door counselling
- Exposure visit to the hospital
- Interface with the service providers
- Community monitoring to ensure quality of health services

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Figure 4: Supply side and demand side interventions
a conceptual note on the identified need to create awareness among the communities and the possible role of CSOs in supporting the same.

Various meetings were conducted to explain the need to establish a mechanism to increase the utilisation of the cards among the communities. The evidence from the field was suggestive of the fact that the mere possession of an RSBY card did not translate into overcoming socio-cultural barriers or the barrier of ignorance among the community members. Various instances from the field were shared with the government stakeholders to support the PACS argument.

PACS consistently advocated the need to support the SEG to uptake the services offered under RSBY. PACS offered to work closely with the MoLE to support them in the implementation of services. At this point the Ministry agreed to use the support from the PACS network to strengthen the existing scheme.

PACS signed a formal tripartite Memorandum of Understanding (MoU) with five state governments, namely, West Bengal, Odisha, Bihar, Jharkhand and Uttar Pradesh to ensure effective community engagement in the implementation of the scheme. This formalisation of PACS role in RSBY through signing of an MoU was a key milestone for the intervention. It laid the foundation for the beginning of the second phase to bridge the gaps in the existing system to ensure that communities, especially SE groups, could now avail the benefits of the scheme.

As of 2015, PACS worked through a wide network of 225 civil society partners in 90 districts, touching 8 million people’s lives across five states under the RSBY intervention.

2.1.2 Selection of CSOs

Along with advocating their case with the government, it was extremely critical that PACS identified the local CSOs who were willing to take up the task of strengthening RSBY. While PACS leveraged its existing network, a participatory and consultative approach was followed to get inputs from the CSOs to gauge their willingness and intent to participate in the intervention. The existing networks of CSOs were consulted in a state level workshop to understand their perspective. PACS team discussed the various existing gaps under the scheme and the possible roles the CSOs could play to bridge this gap.

After the selection of partner organisations for each intervention district, a state level consultation was organised in each of the five states to discuss the roles and responsibilities of CSOs. The state level consultation saw extensive deliberations and participation from the CSO partners. This platform was also used to develop a roadmap for the intervention areas in RSBY in each state.

PACS state level offices supported the partner CSOs in implementation of the intervention. The partner CSOs worked with the Community Based Organisations (CBO) at the Gram Panchayat and village level. The following figure details the implementation structure under the intervention.

As of 2015, PACS worked through a wide network of 225 civil society partners in 90 districts, touching 8 million people’s lives across five states under the RSBY intervention.

2.1.3 Orientation and Training of CSOs

It was clear from the state level workshop that while the CSOs in the five states saw this as a potential opportunity to serve the community, especially the socially excluded groups, they themselves had very little awareness about the scheme. The next important step after the selection of CSOs was to orient them about the RSBY programme. It was critical for the CSOs have an in-depth understanding of the programme and its various components. To train the CSO members on the nuances and provisions of the programme, training sessions were organised. A substantial component of the training was on the role of the CSOs in the programme which focused on their responsibilities and detailed activities to be undertaken by them.

CSOs play an important role in any intervention at the community level as they have greater reach and credibility within the community. Therefore, it was important that CSOs were fully informed about the RSBY scheme and its details so they could encourage the community to reap full benefits of the RSBY scheme. A cascade model was used to disseminate the trainings. A group of master trainers were trained in each district with 3 day Training for Trainers (ToT) and a follow up refreshers ToT for one day was organised. The capacity building of CBOs was then organised by CSO partners at the block/ gram panchayat (GP) level. Apart from the master trainers, 10 specialised CBOs per district were trained on RSBY. These specialised groups were entrusted with the role of mobilising the community, tracking drop outs from enrolment and facilitating the listing process.

3.2 Phase 2: Implementation

Once the foundation for the intervention was laid, the second phase included the rolling out of the intervention with CSOs ready to take on the responsibility of supporting the communities, creating awareness and ensuring that the benefits reach the ones who need it the most. PACS and its partners used a structured approach and covered the three major activities, namely...
Identified challenges under the scheme

- **Lack of awareness:** While people were aware of the scheme; they lacked the understanding of how to use it and were uninformed about the details of the scheme. Most card holders were unclear about the processes of availing benefits and unaware about the various entitlements and services under the scheme as none of this was shared with them by any one.

- **Lack of coordination among stakeholders:** Before PACS intervention, there was limited coordination and synergies between the insurer, hospitals and government actors at the central, state and district levels. This resulted in fragmented ownership with neneficiary suffering in the process.

- **Improper distribution of name slips:** The names slips of the target families for enrolment in RSBY were often found to be not distributed accurately in the villages, as a result of which, many families were left out or missed during enrolled under the scheme.

- **Discrepancies in BPL list for enrolment:** Errors and variances in the names of eligible families in BPL lists, often lead to missing out of those BPL families who need the scheme the most. This commonly instigated eligible families to question authorities and create chaos and confusion during enrolment.

- **Inefficient deployment of IEC activities:** IEC activities were not carried by the insurance companies/TPAs resulting in lower no awareness about the scheme utilisation. Poor communication about the enrolment schedules led to low turnout for enrolment under RSBY defeating the purpose of the scheme. Moreover fluctuations in dates announced for enrolment camps and lack of communication from the insurance companies/TPAs to intended beneficiaries led to low participation and dampened interest among communities.

- **Erroneous data in the RSBY Card:** Inaccurate details such as errors in names of beneficiaries, missing or incorrectly matched finger print on the RSBY Card entered by TPAs and verified by the FKO’s during enrolment process often forced computer operators and doctors in the hospitals to turn down the patients in case of such errors found in the SMART cards.

- **SMART cards availability at the time of enrolment:** Despite the RSBY guidelines clearly stating that the SMART cards should be immediately handed over to the beneficiaries just after enrolment, there were numerous cases of non-distribution and retention of SMART cards even after enrolment by FKOs.

- **Exclusion of remote areas from enrolment:** Going deeper into the remotest areas and setting up for enrolment in such areas is often very difficult and expensive for insurance companies and TPAs. As a result of which enrolment camps were not conducted in many geographically excluded areas actually comprising of the neediest population.

- **Poor quality services provided under RSBY package:** In some cases, it was seen that the services provided to the beneficiaries under RSBY were substandard. It was found that empanelled hospitals were not providing food, medicines, pre-hospitalisation costs and transport allowance to the RSBY patients, though included in the package. Often patients were also misguided about the provisions under the scheme and hospitals/doctors claimed extra money over and above their claims from the insurance companies.

- **Delay and rejection of claim:** Delay in payments and rejection of claims was reported to by the hospitals. This delay led to growing sings of demotivation and dissatisfaction amongst hospitals.

Some of the challenges identified under the scheme have been detailed below:

With the aim to increase uptake in non-discriminatory access to RSBY by the SEGs and BPL households, PACS intervened at all stages of the scheme. The entire lifecycle of the RSBY programme, from its conception to its termination, can be broadly classified into three stages, namely

The involvement and support provided by PACS under each stage has been detailed in the section below.

Figure 6: Activities under RSBY
2.2.1 Pre-Enrolment Stage

PACS has been striving to ensure access to quality health care services and infrastructure for socially excluded communities. It works within a strong rights and entitlements framework. The RSBY intervention by PACS has been undertaken as a step towards fulfilling this goal. The intervention aims to empower socially excluded communities by making them aware of their rights and building their capacities to leverage the benefits of the scheme.

The first level of intervention to improve the uptake of entitlements under the scheme was at the pre-enrolment phase. It was based on the understanding that the first hurdle in the path of effective utilisation of RSBY was the lack of awareness and coordination among stakeholders and lack of knowledge about the RSBY scheme within the local communities.

As the first step towards addressing this gap, PACS partners conducted evaluation survey/assessment in the target areas to understand the access, quality and utilisation patterns of RSBY services by the community. The findings from the survey helped to identify the overall difficulties faced in accessing the scheme as well as the area-specific problems. A detailed analysis of the outcomes of these surveys helped design strategies to improve awareness in low enrolment areas and to promote utilisation in high enrolment areas. Based on the findings of the surveys, PACS intervened in the pre-enrolment phase in a three-pronged manner.

a. Coordination and convergence in planning

RSBY scheme was launched by the MoLE, GoI in 2008. For the effective implementation at the state level, State Nodal Agencies (SNA) were formed. A number of other stakeholders, besides SNA, were also involved in the implementation of RSBY scheme at the state and district levels. Primary among them were the insurance companies, TPAs and other government departments like Health, WCD and P&RD. There was limited coordination between these agencies as well as between the insurer, hospitals, government agencies and the beneficiaries. Such limited coordination amongst stakeholders, particularly at the district and block level, was believed to have majorly hindered awareness generation and resulted in fragmented ownership of RSBY.

PACS believed that developing stronger linkages with and between these stakeholders was imperative to ensure that the outreach of the RSBY is increased for the benefit of the marginalised community. Towards this end, PACS held discussions with all the stakeholders to ensure that RSBY was given due prioritisation at the government level. As a first step towards formalising the collaboration between SNA and PACS, a detailed MOU, with special focus to state specific concerns, was developed and signed. The MOU served as a legitimate basis for PACS intervention in RSBY and was used as an important tool by the PACS partner to establish a link with the district administration. Since the systems were already established in the district under RSBY, PACS partners struggled initially to make their place in the district. They had to work hard to develop rapport with the key stakeholders so that they are not seen as duplicating anyone’s role. The initial months went in winning the trust of the stakeholders so that CSOs are viewed as entities to support the effective implementation of the programme. Once the CSOs made their place in the district, they participated in the planning meetings with the key stakeholders including district administration, insurance companies and hospitals. These meetings were the platforms where the planning for the implementation of the scheme along with discussion on its progress was done. It is in these sessions that the route maps for holding camps were planned for the district. Formal sharing of the route maps with the PACS CSOs was the second key milestone achieved under the intervention, after the signing of MOU. Village wise enrolment schedules, including identification of enrolment stations were drawn up in consultation with the insurance company and the district administration so that the insurer and smart card vendors can complete the preparatory tasks in time and PACS partners can mobilise the community to be present for the sessions. This provided CSOs the information on how and when to plan the mobilisation activities in accordance with the enrolment camps.

PACS also liaised with all the key stakeholders involved at the district level like the SNA, other government bodies, TPAs, Insurance companies, among others. To bring about the required convergence at the state and district levels, periodic meetings with these stakeholders was conducted. PACS was involved in all relevant stakeholder meetings during the entire process of implementation.

b. System strengthening

While getting involved in the planning phase, PACS partner also focussed on strengthening the existing systems and processes. PACS identified two major gaps that needed to be addressed urgently. Firstly, it was found that a major factor affecting the uptake of entitlements under RSBY was the limited availability of quality healthcare services in intervention areas. There were limited numbers of empanelled hospitals in these areas and often the beneficiaries had to travel long distances to reach the empanelled hospitals. It was found that sometimes, in spite of having a smart card and being aware of its use, beneficiaries were unable to make use of it because there were no empanelled hospitals in the vicinity. This was a major hurdle in increasing the uptake of entitlements. PACS took up the big challenge of increasing the number of hospitals available to the beneficiaries by motivating and convincing hospitals to get empanelled.

Secondly, it was realised that the already empanelled hospitals did not have the prescribed RSBY provisions at the hospital. Getting hospitals empanelled was a challenge in itself. But, an equally challenging task was to make sure that these hospitals, including the ones already empanelled, were well informed about the services the beneficiaries were entitled to and were sensitive to their needs. Awareness campaigns for doctors and hospitals were conducted by PACS towards this end. To enable discrimination-free access to entitled health care services for all smart card holders, it was also crucial to conduct sensitisation drives in the empanelled hospitals. Sensitisation meetings were held with doctors, nursing staff and hospital management authorities on social exclusion and discrimination issues. In the words of the Programme Manager in Uttar Pradesh, “it is not only accessing the services but also doing it with dignity”.

IEC materials were also made available at the hospitals for the community. PACS ensured that the RSBY desk in the empanelled hospitals was functional and responded promptly to the needs of the beneficiaries. PACS conducted a total of 37 trainings for help desk operators in Bihar, Uttar Pradesh and Jharkhand. PACS conducted a total number of 32 district level programmes in the
states of Bihar, Jharkhand and Uttar Pradesh for the capacity building of hospital authorities, strengthening the capacities of more than 539 care providers.

The objective of these trainings/drives was to ensure that hospitals were motivated to comply by the RSBY capacity building of hospital authorities, strengthening at the block level and below, Panchayati Raj Institutions stakeholders.

c. Supporting the government stakeholders

At the block level and below, Panchayati Raj Institutions (PRI) members along with government frontline workers were expected to play an important role for the effective implementation of the scheme and in ensuring greater utilisation of entitlements by the community. But for this, it was crucial that these stakeholders were themselves fully aware of the schemes and its nuances. PACS found this important link to be missing and intervened at this level to spread awareness among the PRI members about the scheme and how it would benefit the local community. Awareness campaigns were conducted and trainings were held, wherever possible, to educate these government frontline functionaries about the scheme and empower them.

It is these workers who interacted directly with the community and were the actual implementors at the community level. So, by involving them directly in the scheme, PACS ensured greater outreach among the community. PACS conducted 74 capacity building programmes for PRI members and frontline workers with the total population coverage of 3453 in the states of Uttar Pradesh, Jharkhand and Bihar.

In spite of extensive training, implementing the scheme at the community level was riddled with many challenges. One of the major one being inability of the functionaries to notify eligible families about enrolment camps well in time. The insurance companies collaborate with a technology partner for the enrolment of beneficiaries. It is the responsibility of the technology partner to display the beneficiary household list at prominent locations in the village (gram panchayat office, library, school etc.) before the enrolment. They also announce the dates of the enrolment camps in the village using loudspeakers. The technology partner, along with the FKO from the village distributes chits containing beneficiary names to the eligible households two days before the enrolment camps. It is on the basis of these chits that the beneficiaries are enrolled in the camps. However, in most places, the chits are handed over to the Anganwadi Workers (AWW) or Accredited Social Health Activist (ASHAs), a day prior to the camp. This did not give enough time to the government functionary to reach out to the community members and often some of them would be left out.

This was another crucial area of PACS intervention. PACS helped to ensure that the chits were distributed in time so that the eligible families could reach the enrolment stations on the scheduled day. At many places, PACS supported the government functionaries by undertaking the chit distribution with them. Evidence from the field suggests that there have been instances when ASHA reached out to the PACS partners for support in this process.

For instance, in Majhgaon block in Jharkhand, when the ASHA got the chits late at night, she called the RSBY Mitra, Sumitra Hembrom, for help as it would not have been possible for her to distribute all the chits single-handedly overnight. Together, the two strived to reach all areas that had to be covered in the limited time frame and made sure that all eligible families got the chits in time. This could otherwise not have been possible because an ASHA alone could not have covered all the houses at such a short notice at night, particularly in a naxal affected area. The help of the RSBY Mitra was crucial as the Mitras maintained a list of eligible households and thus, it was easy to reach out to the household without cards.

Another example from Sevapuri block in Uttar Pradesh highlights how the two stakeholders, the ASHA and the CBO worked closely to reach out to the community. The RSBY Mitras – Nirja Devi, Sita Devi and Saroj Devi - together with the ASHA, went around on cycles from door-to-door and delivered chits to all the eligible families to ensure that all beneficiaries reach the enrolment camp. The area facilitator of Gramya, Anjum Siddique and Poonam Gupta, as well as the CSO block coordinator Ashish Kumar Singh, came together to facilitate the chit distribution process. They would all get together at the Sevapuri Samudayik Bhawan every
morning and then disperse from there to reach every household in the area. Their sense of responsibility, ownership and determination took them beyond the call of duty and helped reach out to all the beneficiaries. In their own words, “Ek gehra bhawntatmak rishta ban gaya tha ASHA aur hum sab RSBY Mitra ke beech” (A deep emotional bond has formed between the ASHA and RSBY Mitras.)

While some of these examples highlight the coordination and partnership established for the chit distribution process, PACS stressed on this process because in most cases, this step was often ignored. Once the intimation was given to the ASHA, there was no one to follow up if the beneficiary got the information or not. Thus, it was imperative to mobilise the service providers to focus on this step.

Another fundamental problem in deserving beneficiaries being left out of enrolment was that there were discrepancies in the BPL list itself, which formed the basis of enrolment. This was primarily because the BPL lists updated in 2003 and 2005 was used as the basis of the identification process for enrolment in 2012-2015. The lag resulted in many transformations in the actual list, which were not reflected in the official lists.

Another factor responsible for actual beneficiaries being left was the role of some of the influential people in the village. Often, they would ensure that their friends and families enrolled for the cards in the name of other deserving candidates. PACS and its partners were determined to address this challenge to ensure that the deserving candidates were enrolled during the camps. This was achieved by addressing gaps at three levels – one, timely distribution of chits to all eligible families, as mentioned above; two, awareness generation at the community level; and three, close monitoring and supervision in the enrolment camps, and support to the enrolment team.

d. Mobilising the community

The biggest impediment in the success of RSBY was limited awareness among the targeted community regarding the scheme and its provisions. While people in general might have been aware of the scheme, they lacked complete understanding and were uninformed about the details of the scheme. It was commonly found that many eligible beneficiaries were not fully aware of the scheme and most card holders were unclear about the processes of availing benefits and unaware about the various entitlements and services under the scheme. So, in spite of them holding RSBY smart cards, they did not know how to use it. This created a major gap between the number of registered beneficiaries and cases of actual hospitalisation, thus rendering the scheme ineffective. It was, therefore, essential to not only increase the number of beneficiaries, but also to spread awareness among the existing ones. This thought echoes in the words of Manju Devi from Varanasi, who said, “Garibo ke saath bohut anyay hata hai agar jankari na ho toh” which translates into, “In the absence of the right information, the poor often have to suffer grave injustice”

Sushila Devi, RSBY Mitra from Pratapgarh, highlighted that the BPL lists were erroneous and generally Pradhans and other influential people discriminated against excluded groups and ensured that their relatives were enrolled, so that they may reap the benefits under the scheme.

She specifically pointed out how in some cases the disadvantaged households were deliberately excluded from participating in the RSBY enrolment camps. The village heads would dupe the unaware community members into believing they were not eligible. In her own words, “Often Pradhans chase us away saying our names are not there in the BPL lists and instead make cards for their relatives on our names”.

She narrates how she went to every single BPL household in her village to ensure that they are not excluded and others people do not get cards made in their names.”

Involving religious leaders in community mobilisation

Religious leaders were also roped in the process of mobilising the community wherever possible. In West Bengal, Mohammad Kamaluddin, a Maulvi in the Mosque in Murshidabad district was sensitised about the use of the card. Once he understood the importance of creating awareness among the community members, he took on the task of spreading the message. He used the Masjid mike pre and post Azan (the Muslim Call for Prayer) to talk about the RSBY scheme and its benefits. He also conducted sessions on RSBY in the village Madrasa to spread awareness among the youth.

An active and wide spread awareness campaign was launched at the community level. This was undertaken to inform the beneficiaries as well as the general community about RSBY and its provisions. In this exercise, CBOs played a major role in awareness generation among the community.

There were many ways in which this was achieved. Along with door to door communication, awareness campaigns were held in which different forms of media were used to promote messages regarding RSBY in the community. Awareness generation rallies were organised in association with the CBOs in which maximum participation by the community was encouraged. Streetplays and nukkad natakas were held on this theme as this was one form of media to which the people connected instantly. Puppet shows and magic shows were organised with special focus on RSBY enrolment and utilisation of benefits. A total of 29 puppet shows, 153 street plays were conducted at the gram panchayat level in the states of Bihar, Jharkhand and Uttar Pradesh. The RSBY video van also held 1550 screenings reaching a population of 1,09,200 in the same states.
Often, it was seen that once the community understood the message, they became the agents of change themselves and would spread the message across the community. When Cheddi Sharma attended the puppet show on RSBY in the village, he learnt about the benefits of the scheme. Understanding the scheme, he realised how this could help his relative Munni Devi who was suffering from uterus related issues but had not been able to get treatment due to financial constraints.

He immediately informed his relatives and connected them to the CSO programme manager, Binduji. Upon connecting with the family, Binduji explained to them the details of the scheme and ensured that Munni Devi, who had complaint of severe stomach ache, was taken to the hospital and treated under the scheme. While the family had a smart card, the patient, who was the wife of the card holder, did not have her name on the card. The programme manager supported the family in getting the patients name included in the RSBY card through district kiosk at the Chief Medical Officer’s (CMO) office which made it possible for Munni to be taken to the hospital, properly diagnosed and treated for her ailment.

The story of Munni highlights how the spread of information was not limited merely to people attending the awareness generation sessions, but traveled across the community through word of mouth, benefitting many in the process. Once Munni was treated, she was inspired to create awareness in her own village so that many others like her could reap the benefits of the scheme.
Local media, art and culture were weaved carefully into these campaigns and efforts were made to ensure that the campaigns were contextually relevant so that the local community could easily understand and relate to it. IEC materials were developed and distributed among the community. These materials were designed in an innovative manner and comprised of pictographic representation of steps in enrolment and in utilisation of smart cards. The mode of communication was area specific and varied from state to state. For e.g. in West Bengal, the local mosques were also involved in reaching out to the community in a bid to create greater awareness.

At the community level, CBOs form the pillars supporting the RSBY intervention by PACS. They are the most important player in awareness generation at the community level Recognising this important role, PACS organised training programmes for the CBOs at regular intervals to inform and update them about the key provisions of the RSBY as well as the procedures involved in availing benefits under the scheme. This enabled the CBOs to reach out to the community more effectively in terms of awareness generation and thus helped the community to avail maximum benefits from the scheme.

A very important step taken by PACS towards community mobilisation and awareness generation was introducing the concept of RSBY Mitras, who became the front runners in the implementation of the scheme at the community level.

Community awareness building programmes, Uttar Pradesh

RSBY MITRA - The community RSBY health worker

Community involvement in the delivery of health services to RSBY beneficiaries is the most important initiative towards enhancing community participation and ownership towards this scheme. The concept of RSBY Mitras was envisioned to fulfil this urgent need of the scheme as well as the community. These well informed friends of the community acted as the bridge between the service providers and the beneficiaries in the RSBY scheme. These Mitras were volunteers from the CBOs of a village (as institutionalised by the CSO partners of PACS). One RSBY Mitra is responsible for every 50 families enrolled in the scheme with possession of a smart card. Since they belonged to the community itself, they were considered to be the ‘go to persons’ by the community members in case of need. They would facilitate and help the community to use their cards in times of hospitalisation. They had full information and knowledge about the provisions of RSBY and were equipped with the required information, including the list of hospitals and services the beneficiaries are entitled to. They were the first contact point for the card holders, where complaints and grievances were first registered.

Capacity building programme for CBO members, Uttar Pradesh
Since these Mitras were from the community itself, they had a sense of ownership and the community also could easily relate to them. This increased their credibility. With the help of RSBY Mitras, the outreach of the scheme extended to hitherto unreached areas. Like, for example, in the nasal infested areas of Jharkhand, where the scheme was practically non-existent because no CSOs or government functionaries were active in those areas. The creation of RSBY Mitras led to positive change in the intervention areas leading to increased enrolment and utilisation of benefits.

In the words of a community member Tinku Kumar Mandal from Deogarh, Karon Block “Mitra is kshetra mein ek vardin hai. Mitra ke aane ke baad is programme mein jaan dal diya gaya tha” (Mitras are a boon in this area. The Mitras have made this programme alive and vibrant).

PACS Mitras successfully reached the areas seldom covered before. The hard to reach areas were mostly left uncovered and the community had no clue about the smart card. However, with the PACS intervention, things have drastically improved. As the Programme Manager from Jharkhand said “No ICICI Lombard would have gone to Palamu, the tribal district to enrol the community for smart cards. Our presence made it possible to reach the population where access was a huge challenge”.

It also surfaced during discussions with different stakeholders that PACS intervention in terms of awareness generation among the stakeholders created a ripple effect. The CSOs had to intervene in the non-intervention districts due to demand from beneficiaries and authorities to help in implementation of programme. Often people from the other communities heard about the concept of Mitra from their relatives in the intervention district and would enquire about their presence in their respective district.

Other than that, it was seen that once the capacity of the CSO was built, they did not limit themselves to the PACS intervention district. In places, awareness sessions were also organised in non PACS districts under the purview of the local CSOs.

Sumitra Hembrom’s journey as a Mitra

Sumitra Hembrom (28 years) lives in Damodarsai village in Jharkhand, which is one of the tribal populated village in the Nayagaon panchayat. The village severely lacked health care facilities and nobody in the village knew about the RSBY scheme. People had never heard of it before the intervention by SHARE (a CSO in the area) under PACS programme. Villagers were deprived of their rights and entitlements under RSBY due to lack of awareness.

SHARE worked towards the formation of a Gram Sansathan under PACS with the objective to support the socially excluded communities. Sumitra was selected as a Vice President of the committee and also the RSBY Mitra of the community. She worked tirelessly to create awareness among the community members after receiving trainings under PACS programme. She accompanied 17 families to the hospital to avail benefits at Gayetri Seva Sadan hospital at Chaibasa. She describes how her journey as a Mitra not only transformed the village but also her life. In her words, “I started working in the village in the year 2013. During the training I realised how my village has been deprived of this scheme which can save so many of us. I took on the task of ensuring that everybody in my community knew about it and ensuring that the community members get the correct treatment under the scheme. It brings me immense satisfaction to say that each and every villager knows about the scheme today. In case anyone faces any challenge, they approach me without any hesitation.”
2.2.2 Enrolment Stage
The pre-enrolment activities undertaken to improve linkages between the stakeholders, promote empanelment and sensitisation of hospitals, create awareness among the community and build capacities of the stakeholders at different levels laid the foundation for the next stage of intervention. This was the enrolment stage. ‘Enrolment’ is the process during which the identity of the beneficiary is authenticated and they are registered and provided with biometric enabled smartcard. Enrolment is undertaken by the insurance companies in every village with beneficiary households. This is done at the beginning of each policy year. The enrolment of beneficiaries is primarily the responsibility of the insurance company, supported by the RSBY SNA. An enrolment centre is set up at every village to register the beneficiaries on a pre-scheduled day. During enrolment, the smart cards are issued to the beneficiaries on the spot, the same day during registration. To instil a sense of ownership in the beneficiaries, a token registration fee of INR 30 per annum is charged per household. The entire process has been designed to be very compact and quick, taking normally less than 10 minutes per household.

Three simple steps occur during the enrolment:
1 Based on the BPL household list finalised by the respective State Government and MoLE, Gol, beneficiary households are identified in each village.
2 The beneficiaries, which include the head of household, spouse and up to three dependents per BPL family, provide their fingerprints and photographs at the enrolment station.
3 A registration fee of INR 30 per household is paid at the centre and each household is issued a biometric enabled smartcard. The card is issued in the name of the head of the household and contains details of all the enrolled members. Keeping in mind the special case of migrant worker and to ease their access to the benefits, the cards are split for separate use in any RSBY empaneled hospital across India.

These smart cards can then be used by the beneficiary household members at any health facility empaneled under RSBY. Since the smart cards are biometric enabled, it ensures that only the authentic beneficiaries use it, thus preventing misuse.

While the above mentioned process of enrolment indicates how it should have happened in an ideal scenario, the situation on the field was quite different and faced with several challenges. One of the major concerns was the absence of camps in the remote location, and consequently, absence of smart cards with the eligible beneficiaries. In general, it was seen that insurance companies would not hold enrolment camps in rural areas. The situation changed when PACS partners intervened as they ensured that remote locations were factored in at the time of making route maps itself. Apart from this, Mitras ensured that the camps were organised on the mentioned dates. Thus, the role of PACS was not only to support different stakeholders but also to monitor the work in the district.

Other than that, in areas where camps were held, there were many cases of malfunctioning of the smartcards in terms of thumbprints mismatch. Sometimes, the insurance companies refused to cover old people or people with chronic diseases. Incorrect information was being filled during the registration, adversely affecting hospitalisation. There were problems in adding beneficiaries to the existing cards and in renewal of cards. Often, cards were never handed over during the camps - the beneficiaries were registered but not issued instantly with smartcards on the pretext of malfunctioning machines. At times, the insurance companies refused to work till late and left even though some of the families were left to be enrolled in the area. In many cases, though smartcards were issued, no IEC material was distributed with the smart card, resulting in lack of awareness about the entitlements under the scheme.

It was these gaps which had surfaced during implementation that PACS, together with its CSO partners, sought to address. At this stage, PACS and the RSBY Mitras played a crucial role in ensuring that the enrolment process occurs systematically and without any malfunctioning. Their role was mainly monitoring, supervising and facilitating the process of enrolment.

**Being a RSBY Mitra changed her life**

Shanti Mahto, 52 year old Mitra lives in Sathahaka village in West Singhbhum district of Jharkhand with her four daughters. Shanti has been a widow for the last 18 years and faced severe hardship coping with the stigma attached to being a widow. While she struggled to single handedly bring up her four daughters, her husband’s family continued to harass her by accusing her of being responsible for her husband’s death and threatening to take her property. She was not only looked down upon in the family but was also socially excluded by the community. The customs and traditions would often be invoked to marginalise and isolate her. She would often be labelled as a witch or treated as an untouchable. She was condemned to live her life as a second class citizen. She lived in the margins of society for 18 years and was brought back to mainstream societal narrative as a RSBY Mitra.

Her life completely changed when she took on the role of Mitra in 2013 under the support of the CSO Ekal Nari Shashakt Sangathan, a platform to empower single women in Jharkhand. While in the beginning, villagers were hesitant to come to her for help, things began to change gradually. Learning how the RSBY card could help them, the community started to see her in a new light. Slowly, her position in the society changed from being a bad luck to that of a saviour. In the process, she has now become a more empowered individual. She said “Mera koi wajood nahi tha, na ghar mein na samaj mein. Kabhi daayan karar diya jati thi ya kabhi chiwa chat sehne, ek Dwyom darj ka zindagi jee rahe thi.” In other words, ‘Today as a Mitra she has overcome and coped with the tragedy of facing years of oppression and emerged a more independent and stronger person with her own identity’.

She now cycles freely through the village assisting those in need and fulfilling her duties. She is not only well accepted in her society but her service as Mitra is well acknowledged and admired by one and all.
Madkhamhatu, Loharda Panchayat, some enrolment camps were scheduled and that they were present for enrolment. They helped with crowd management, thus making the process quicker and easier for the insurance companies. The Mitras made sure that the names and details of each beneficiary were correctly entered on the card and that their photographs and fingerprints were correctly taken. They took care that no member of eligible beneficiary families is excluded during RSBY enrolment. PACS ensured that the enrolment team issued biometric smartcards to all beneficiary families on the spot, along with a list of empaneled hospitals and detailed information on treatment package. In case of genuine inability to do so due to malfunctioning of machines, the RSBY Mitras proactively ensured that follow up visits were made as soon as possible and cards given to the deserving beneficiaries. They made sure that each household is charged with only INR 30 as registration fee. In almost all states, as a result of the monitoring and supervision of the partners, the camps continued till late at night and full enrolment was achieved.

In Argundi, Loharda Panchayat, enrolment was done in the first phase, but since then, no teams have turned up. In Banamguttu, Badachiri Panchayat, many families were still left to be enrolled.

Madkhamhatu, Loharda Panchayat, many families were included in BPL lists in the previous year but no slips for them in the current year.

Madkhamhatu, Loharda Panchayat, some beneficiaries received cards with no information on them.

Miras played a pivotal role in ensuring that the government takes notice of these issues. The State Labour Institute took immediate action to resolve the issues and re-organised the camps wherever required. The government also acknowledged the Mitras for sharing their insights from the field and their support to the programme.

In this context, PACs assumed the responsibility of ensuring that all eligible beneficiaries were aware of when the enrolment camps are scheduled and that they were present for enrolment. They helped with crowd management, thus making the process quicker and easier for the insurance companies. The Mitras made sure that the names and details of each beneficiary were correctly entered on the card and that their photographs and fingerprints were correctly taken. They took care that no member of eligible beneficiary families is excluded during RSBY enrolment. PACS ensured that the enrolment team issued biometric smartcards to all beneficiary families on the spot, along with a list of empaneled hospitals and detailed information on treatment package. In case of genuine inability to do so due to malfunctioning of machines, the RSBY Mitras proactively ensured that follow up visits were made as soon as possible and cards given to the deserving beneficiaries. They made sure that each household is charged with only INR 30 as registration fee. In almost all states, as a result of the monitoring and supervision of the partners, the camps continued till late at night and full enrolment was achieved.

"Cards were being issued to the well-off families by taking INR 100 as bribe while the deserving BPL families were left out. We confiscated the register and other items of the organisers and demanded that they stop "selling" the smart cards for money. Some of the members of the organising committee and other powerful people picked up stones and slippers to throw at us. However, the members of the women’s group unified and did not let them continue with their malpractices. As a result, a camp was organised the next day in which the eligible beneficiaries and their families were enrolled". - Shabnam Bano, Hungama Womens’ Group, village Pure Devajani

The responsibility at the enrolment camps did not end with the issuance of smart cards. It was imperative to educate the community regarding the benefits of smartcard and its proper utilisation. Towards this end, PACS ensured that all relevant IEC material was available in the enrolment camps. To facilitate easy understanding of the process, the IEC materials were primarily in the form of contextual pictorial booklets. They also encouraged the migrant families to demand for split cards, so that they could avail of the benefits that they were entitled to.

Some big changes have small and simple beginnings

A very common problem that arose frequently was that of fingerprint mismatch of the farmers. This caused problems in issuing cards to them. This primarily happened due to their nature of work, which caused dirt particles to accumulate in their hands, thereby smudging and camouflaging their fingerprints. PACS came up with a simple solution to this problem. The Mitras encouraged the farmers to wash their hands properly before giving their biometrics, thus making sure that no eligible beneficiary is deprived of their rights.

PACS and RSBY Mitras ensured that the stipulated number of FKOs accompany the enrolment teams in the camps (for every 300 beneficiaries expected at the enrolment camp, at least one FKO is appointed. In case the BPL list for a location is more than 300, more than one FKO should be present in the camp). The Mitras also liaised with the FKOs and ensured that all non-negotiables like banners, equipment and human resource are present in the enrolment station. They also assisted the beneficiaries in case they faced any confusion. In case of any problems, they assisted the FKOs to take immediate action and also liaised with the district RSBY cell, if necessary.

2.2.3 Post-Enrolment Stage

During the enrolment process, the RSBY beneficiaries are issued biometric enabled smart cards. These smart cards can be used by the holders to avail medical and health services, including hospitalisation, in any hospital empaneled under the RSBY scheme. The scheme also seeks to reduce any out of pocket expenses by providing a stipulated travel allowance, free food and medicines. The smart card holder has to go to the nearest empaneled hospital, and the smart cards are swiped, biometrics confirmed and services are provided free of cost. This seemingly simple step was riddled with many challenges.

The first and biggest hurdle was that the smart card holders were not aware of the benefits they were entitled to and how to use the smart cards. There was a significant gap in the number of smart cards issued and the actual utilisation of benefits. There were cases reported where many smartcard holders believed it to be an Automated Teller Machine (ATM) card and tried to use it to get cash.

"When people were not aware of the purpose of the card, they made their own presumptions on how to use it. Some people went to the ATM machine to withdraw cash from the card. While some people stored it at a secure place thinking it is some form of identification card."

- Anand Shankar Pandey, Project Coordinator, Purvanchal Gramin Seva Samiti

Even when the beneficiaries were aware of the benefits, they sometimes were reluctant to go to the hospital as they felt intimidated by the surroundings. The behaviour and attitude of the hospital staff towards the SEGs and their lack of knowledge proved detrimental for the scheme. This was another crucial stage at which PACS intervened to address these challenges and improve the utilisation of smart cards. For this, PACS undertook the following activities:

Conducting awareness sessions: The first and foremost step in the post enrolment stage was to create awareness among the smart card holders regarding its utilisation. The beneficiary community, in spite of being enrolled, did not have sufficient knowledge about the smart card, its provision and processes, thus limiting its utilisation. Towards this end, awareness sessions were organised by PACS and partner CBOs informing them about the entitlements, benefits and processes related to the smart card provided to them under the RSBY scheme. Information regarding the list of empaneled hospitals, facilities and treatments available, procedure to be followed was disseminated to the beneficiaries to enhance utilisation under the scheme.
The card that saved my son

Mahmud Alam’s wife Rukhsana Begum had no clue about the scheme, although she had a card. When she went to her maiden village, she learnt about its use from a Mitra. She realised her family could use the card to get her son’s liver surgery done. In her words, “I had kept this card safely for over a year now. While the government provided us the card, no one told us about its use until the Mitra who worked in my parents village told me about it.”

Once they used the card, they took on the task of making people aware about its use in their village. Mahmud Alam says, “People did not know about the purpose of the card, once we used it for the operation of our child, they understood its importance. We have reached out to most people in our village and almost everyone knows about its benefits now”.

His successful utilisation of the smart card encouraged many more people from the village to use their cards. He ensured uptake of entitlements by 14 cards holders in 2012-2014. Given his commitment, Mahmud Alam was encouraged to become a Mitra to support the community and spread awareness.

To motivate the people to utilise the benefits available under RSBY, PACS organised rallies, street plays, film shows within the community. Local folk art was used widely as people could relate to them instantly. IEC materials like brochures and pamphlets in local languages were distributed. PACS conceptualised and developed pictorial tools which clearly depicted the entire process of using a smart card in a systematic manner. Posters and banners were put up in villages to encourage and motivate people to use their smart cards and avail the benefits that they are entitled to. Some of these were specially developed by PACS keeping in mind the contextual realities of the marginalised communities. These contained messages on where the smart cards could be used, how to use them, health services and facilities the beneficiaries are entitled to, list of service delivery points and, most importantly, where to go if they face any problems or discrimination. A pivotal role was played by the RSBY Mitras and CSOs in this process.

Enabling utilisation: Apart from organising awareness sessions, PACS partners also worked towards ensuring that beneficiaries get the services they are seeking. It was often found that the beneficiaries from the community felt intimidated with the idea of visiting the hospitals and asking them from medical treatment even though they had access to the smart card. To help community overcome this apprehension, Mitras organised exposure visits to the hospital to familiarise the community members with the process of admittance in the hospital. This acquainted them with the utilisation process of the smart cards as well as with the formalities involved in the process. These visits helped in familiarising the communities with the processes involved in using the smart card at the hospital and gave them the confidence to operate the card whenever required.

In Bihar, Jharkhand and Uttar Pradesh 707 weekly visits to RSBY empanelled hospitals were conducted at the block level. Apart from the hospital visits, a crucial role was played by the RSBY Mitras in bringing the people needing treatment to hospitals. Managing transport costs was a huge challenge, as the actual cost for travelling would usually be much more than the prescribed transportation allowance of INR 100. But so strong was their sense of responsibility towards the community that this did not deter them from doing their duties. They found a solution to this problem and would gather a few patients together and take them to the hospital in a group, thus managing transport costs. The same process was followed during discharge. In the words of an RSBY Mitra from Jharkhand, Chaima, “I contact the other Mitras on phone to check if they have any patients. Then we take all the patients together, seven-eight of them. Again on the day of discharge, one person goes to get them discharged. That’s how we manage transport costs”.

The Mitras were constantly faced with the new challenges during the process. Often it was found that hospitals rejected hospitalisation due to identity or information mismatch. In such a case, Mitras were often the ‘go to person’ for the beneficiary. They had to facilitate the process of fixing the card by either getting in touch with district kiosks or by getting a verification done by the Pradahan/Munda. Mitras, thus, became champions of the community resolving any issue that the community may face in accessing the services.

Sometimes, the beneficiaries could not avail the benefits as machines used to swipe the cards was not functional like at the district hospital in Sidharth Nagar, Uttar Pradesh. As per a card holder from Bhima Parik village, Uttar Pradesh, the cards was swiped, but money was also taken from the holder.

Another practice being adopted by the hospitals to avoid RSBY patients was delay in first diagnosis. The doctors would withhold the diagnosis for more than two days after the initial tests, by which time the eligibility under RSBY would be over. PACS ensured that such practices are stopped and also ensured that other facilities available under the scheme such as free food and medicines were also made available to the smart card holders.

To promote utilisation of smart cards, CSOs organised health camps in villages to screen patients on the day of enrolment. In 2015, Sanjeev Nachalaya organised three eye check-up camps, one each in Naya Goan Panchayat, Adhikar Panchayat and Tantaria Panchayat in Jharkhand at the day of enrolment camps. Villagers were encouraged to come to the camp for a health screening. Around 60 cases were identified and treated with the use of smartcard.
then accompanied Gulab to an empaneled hospital in Varanasi. In the hospital, Gulab was given a drip, this stomach assured Gulab that he could get proper treatment at a RSBY empaneled hospital as he was a smartcard holder. He was bandaged and he was told that he had an abdominal surgery by the doctor in charge. A very perplexed the role of PACS was significant to strengthen services through constant monitoring and providing support to the various private and government hospitals. During this process, he met a suspected middleman, Pappu, who assured Gulab that he could get proper treatment at a RSBY empaneled hospital as he was a smartcard holder. He then accompanied Gulab to an empaneled hospital in Varanasi. In the hospital, Gulab was given a drip, his stomach was bandaged and he was told that he has had an abdominal surgery by the doctor in charge. A very perplexed and still untreated Gulab was discharged in two days, after which he handed over a “commission” to Pappu.

The disappointed and confused Gulab requested for help from a medical student in reading his discharge papers. The papers revealed that he had undergone a surgery for gallstones as per the papers given to him. This shocking revelation led Gulab to contact the only trustworthy source he could think of – the RSBY Mitras. The Mitras immediately came to his help and intervened. They confronted the hospital and ensured that Gulab got proper treatment.

It was clear that ignorance of the community, as in this case Gulab, was exploited under the scheme. This is where the role of PACS was significant to strengthen services through constant monitoring and providing support to the community.

Dispute management/resolving conflict: To ensure effective utilisation of the scheme, community based monitoring systems were developed to collect feedback from the community regarding their experiences of using the smart cards. This feedback from the community was then shared directly with the SNAs and other relevant stakeholders.

A very important step towards resolving conflicts was participation in the GRCs. The GRCs are the key institutions responsible for resolving problems and differences that may arise among stakeholders, thus minimising conflict and aiding in smooth functioning of the RSBY scheme. The GRC has a panel of prescribed members which also included PACS in the intervention states. PACS liaised with the GRCs and attended monthly meetings at the state and district levels to ensure that the benefits of RSBY reach the beneficiaries in a fair and equitable manner and that any problems faced during the process are effectively resolved.

RSBY smart card users group

In most intervention areas, groups of RSBY card users were formed at gram panchayat level. The group members select a president and a secretary from each group and are supposed to conduct meetings every month to discuss issues related to smart card and its utilisation.

A very important step taken by PACS in this respect was the setting up of a toll free number in Jharkhand to provide information related to the scheme and register any complaints/grievances faced during the process. This was done in collaboration with Gramvaani Community Media in Jharkhand who would connect the beneficiary to the nearest Mitra for effective and immediate redressal of the problem. If the Mitra was unable to resolve the issue, it was then escalated to the PACS coordinator at the district level, and then on to the state level.

Often when the community is unaware, others take advantage of the situation”, said Majida Begum, chairperson of the block advocacy group. Her role includes supporting the community deal with challenges faced during the use of smart card under the scheme. She says, “I support the community members when they are faced with fraudulent acts while using the smart cards. I use the GRCs and follow up the cases with the district administration”. She recollects one such case when her neighbour’s son was taken to the empaneled hospital and charged fee for the blood tests in spite being a smart card holder. She says, “when I got to know about the problem, I called on the toll free number and registered a complaint. After the complaint, an immediate action was taken and the money was reimbursed to the patient’s family”.

The GRCs acts as platforms through which the common man can express the injustice being done to them and also gives him/her a confidence to speak up against the wrong being done in the community.

The story of Gulab, aged 30 years, from village Domela, block Sevapuri, Varanasi highlights the effective role played by the Mitras in immediate grievance redressal.

Gulab was an asthmatic patient who had been unsuccessful in trying to get his condition treated for years in various private and government hospitals. During this process, he met a suspected middleman, Pappu, who assured Gulab that he could get proper treatment at a RSBY empaneled hospital as he was a smartcard holder. He then accompanied Gulab to an empaneled hospital in Varanasi. In the hospital, Gulab was given a drip, his stomach was bandaged and he was told that he has had an abdominal surgery by the doctor in charge. A very perplexed and still untreated Gulab was discharged in two days, after which he handed over a “commission” to Pappu.

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It was clear that ignorance of the community, as in this case Gulab, was exploited under the scheme. This is where the role of PACS was significant to strengthen services through constant monitoring and providing support to the community.
PACS intervention in RSBY was based on a strong rights based framework and aimed at improving utilisation and uptake of benefits under the scheme.
A glance at RSBY helpline, Jharkhand
During the first quarter of 2015, there were a total of 2372 incoming calls on the Helpline;
- There were 711 calls by RSBY Mitras on Grievance Status Update, i.e. to listen to recorded grievances and give voice updates on status of the grievances
- Thirty-five per cent (35%) of recorded grievances were pre-enrolment complaints, which included problems like names not appearing in the BPL list, wrong name in the BPL list, no information about enrolment dates and venues, camp not held on correct date/time, no camps held, no Pragya Kendra or Unrecognised Workers Identification Number (UWIN) card registration centre and/or advice and information on RSBY scheme.
- Fifty per cent (50%) of recorded grievances were post-enrolment complaints related to the problems faced by the community on non-issuance of card after enrolment, information errors on the card, issues on renewal of card, false card issued in someone else’s name, adding names or family members to the card, non-operational RSBY district kiosk.
- Fifteen per cent (15%) of recorded grievances were hospitalisation complaints such as refusal of treatment at empaneled hospital, lack of desired services at empaneled hospital, extra money taken by hospital staff, provisions of RSBY not met by hospital, inability to read card/thumb impressions at hospital, lack of IT facilities to process card at the hospital.

Source: RSBY Helpline Seva - Governance Intervention, First Quarterly report 2015

PACS Intervention under RSBY was based on a strong rights based framework and aimed at improving utilisation and uptake of benefits under the scheme. PACS, in collaboration with other stakeholders, strengthened certain existing practices and introduced innovative ways of reaching the marginalised communities. It can be said...
that PACS intervened at various levels to ensure that the scheme is successful in reaching the communities which were otherwise left uncovered or were not aware of the existence of the scheme.

It can be surmised that PACS played a key role in ensuring effective implementation of the RSBY scheme by strengthening both the supply and demand through a range of activities. PACS ensured that they focus on strengthening the supply side by closely working with a range of service providers including the government, hospitals and insurance companies. Along with that, the prime focus was to create demand among the community members by creating awareness about the scheme through a variety of communication platforms.

An important aspect of the intervention was how it led to convergence of different stakeholders involved in the scheme. The strategy under RSBY intervention focused on supporting the government and not working in isolation. All the PACS partners were oriented to work in convergence with the government during the intervention. Convergence with existing departments was seen as the core strategy of this intervention. As Nasim Ansari from PACS partner Tarun Chetna, said, “Working with government has always been a huge challenge for us, primarily because there was no common platform for us. We had our expectations and they had their own opinion. While working with the state government on RSBY, we realise how important it is to work in coordination with the government.”

Effective liasoning with the district labour department particularly with the District Superintendent, Labour Department/ DKM was done to develop a collaborative approach for better implementation of the scheme. A twin-pronged approach was adopted wherein on one hand, PACS partners focussed on extensively mobilising the communities for enrolment and uptake of entitlements under RSBY, while on the other hand, the district labour department focussed on strengthening monitoring systems to make service providers more responsive and accountable. Simple yet effective ways for the intervention were explored and implemented for these purposes.

### Collective monitoring of hospitals

For instance, in Jharkhand, collective monitoring visits to the hospitals were planned with the DKM and PACS partners. The strategy for conducting surprise visits to the hospitals and following up with cases to ensure proper redressal of identified issues proved to be very effective. Between 2013-2015, frequent visits were made to hospitals like Gayatri hospital, Swastik Hospital, Medha Sewa Sadan, Bednath in the district. As a result of these visits, hospitals started ensuring that a doctor was available 24 hours, medicines were available, patients were not over charged and other entitlements under RSBY were given to the patients. The main objective of these visits, as put by the DKM, was to reduce the opportunities of errors and ensure increased benefits for beneficiaries.

Due to the partnership developed under the RSBY scheme, the labour department in Jharkhand now works closely with PACS Jharkhand office on various issues other than RSBY.

It was seen that the intervention on RSBY led to increase in uptake of rights under other schemes as well. Awareness generation in the community under the RSBY scheme led to community empowerment making them conscious of their rights, in general. As the community became more aware and accessed the provisions under the scheme, they were seen to be more confident about their rights. The interventions nurtured their capacity to be aware of their surroundings and other schemes implemented their states. In this manner, the community became more aware of its rights and the uptake of entitlements under other schemes also increased.

It is noteworthy to mention that institutionalising the process through formal agreements and MoUs with the government play a crucial role in allowing smooth introduction of the CSOs in the scheme. This gives them the credibility to work within the ambit of the scheme and also the required acknowledgement by other stakeholders.

The programme also saw the emergence of a new cadre of human resource called the RSBY Mitras in Jharkhand.

The concept of RSBY Mitras was a step towards enhancing community partnership for participation and ownership. The concept rose from the need to bridge the gap between the service providers and the smart card holders accessing the benefits of the scheme. Initiated by PACS and approved by the government of Jharkhand, the concept was successful in creating community mobilisation and increasing demand of health services under RSBY. Other than that, it is important to note that having a grievance redressal system in place and making it work effectively encourages two way communication ensuring that the rights of the community are protected.

It was noted from the intervention that Civil Society Participation has a potential to provided visible impetus to the scheme. Community based approaches and capacity building provides sustainable local solutions to strengthen the programme. The involvement of civil society providers assisted the service providers in ensuring last mile connectivity. CSO with strong local mobilisation have a potential to make the services reach to some of the most difficult areas and excluded communities.

While PACS was successful in creating its intended change, some of the challenges faced by them have been detailed below.

- A fundamental challenge faced across the states was the discrepancies in the BPL lists. Since the lists that were used for the enrolment were updated in 2003 and 2005, they were partially redundant with many gaps.
- While Mitras have emerged as the torch bearers of the scheme at the grass root level and their crucial role has helped tremendously in enhancing the uptake of benefits, it was observed that communities were developing high dependence on them. While their role of hand holding the community has been observed to be beneficial, over dependence may not prove to be an effective strategy. For instance, the community members got so habitual to go to the hospital with the Mitra, they did not have the confidence to go on their own. When asked if they could go to the hospital by themselves after the first visit with the Mitra, they insisted on being accompanied by them.

It is essential to define Mitras’ role as that of a facilitator. Their role should demand that they empower the community and build their capacity to access rights on their own. Mitra’s should thus be seen as a support mechanism for the community.

- It was found that there were state-wise discrepancies in issuance of ID cards to the Mitras. In Jharkhand this had proven to be an effective strategy as this gave an identity to the Mitras and made it easier for them to interact with the district officials. This provided them with a legitimate basis for intervention. Having an official identity and recognition instils a greater sense of responsibility and ownership in the Mitras.

- The success of pre-enrolment and enrolment activities depends on the ability to mobilise the community. But another major factor affecting the success of the enrolment camp is the location. In case of marginalised communities, long distance translates into loss of livelihood for the day, which becomes a strong demotivating factor for them. A greater distance may also be a problem in difficult terrains. Therefore, while preparing a route map for the intervention, the government officials need to consider these factors as well.

- It is important to comment that while PACS role was limited to strengthening the systems and processes of the existing schemes, it was observed that many hospitals had not been paid their dues for the cases. This was either due to their conflict with the insurance companies or district administration. The reasons for the conflict were unclear and debatable as each party have their own story. It can be said that this issue would require further investigation before concluding or assuming what were the gaps.

While PACS was not directly involved in the process, this had a direct impact on the service delivery of the programme.
Annexure 1

About PACS

Poorest Areas Civil Society Programme (PACS) is an initiative of the UK government’s Department for International Development (DFID). Under PACS, DFID partnered with Indian civil society to help socially excluded groups claim their rights and entitlements more effectively, so they receive a fairer share of India’s development gains.

PACS, in its second phase of implementation (2009-2016), had been supporting the work of CSOs to promote inclusive policies, programmes and institutions at local, district and state levels in the areas of livelihoods and basic services. The programme was initiated by DFID in 2001 to support and strengthen civil society to help the poorest and most vulnerable in deprived districts in India to claim their rights.

Its first phase, which ended in 2008, focused on reaching all poor groups and tackling the general causes of poverty. Experience gained during the first phase of PACS showed clearly that the poor in India are not homogenous: certain categories of people are particularly marginalised. While the persistent poverty of these groups can be partly attributed to general causes that create deprivation among all poor people in India, there are specific factors that aggravate hardship among the socially excluded and make it harder for them to escape poverty.

The second phase of the PACS Programme was implemented across seven Indian states- Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Uttar Pradesh and West Bengal covering 90 of the poorest districts across these states. These are the districts identified as those having poverty levels higher than the average for rural India. In addition a substantial proportion of these district’s total population belonged to socially excluded groups.

PACS worked with 225 CSOs during its implementation. The CSO projects supported by PACS were initiated in September 2011 and concluded by December 2015. This period also witnessed a number of thematic campaigns and other interventions carried out by PACS in collaboration with multiple stakeholders including the government.

PACS aimed at reducing the welfare gap between socially excluded groups and the rest of the population and achieving gender equality. The heterogeneity of the nature of social exclusion rendered the implementation of PACS to be specific and people centred. Driving on a CSOs and community based approach, PACS stressed on empowering the socially excluded groups towards greater awareness and access to key government schemes. The selection of schemes have been such that PACS targets three major facets of human development: Livelihoods, Health and Nutrition and Education. Strengthening upon discriminatory access of the socially excluded groups to the rights and entitlements enshrined in these government schemes on these three areas, PACS had strived towards bridging the welfare gap between them and rest of the population.

PACS Programme was managed by a consortium of organisations led by Christian Aid UK along with Caritas India, Access Development Services, Indian Institute of Dalit Studies and Financial Management Service Foundation.

Annexure 2

List of CSOs Working on RSBY under PACS

<table>
<thead>
<tr>
<th>State</th>
<th>CSOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bihar</td>
<td>• Centre for Health and Resource Management</td>
</tr>
<tr>
<td></td>
<td>• Bihar Viklang Kalyan Parishad</td>
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<tr>
<td></td>
<td>• Muzaffarpur Vikar Mandal</td>
</tr>
<tr>
<td></td>
<td>• Prayas Grameen Vikas Sansthan</td>
</tr>
<tr>
<td></td>
<td>• Pragati Grameen Vikas Sansthan</td>
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<tr>
<td></td>
<td>• Nidan</td>
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<tr>
<td></td>
<td>• Yatharth</td>
</tr>
<tr>
<td></td>
<td>• Samagra Shiksha Evam Vikas Sansthan</td>
</tr>
<tr>
<td></td>
<td>• IZAD</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>• Chetna Vikas</td>
</tr>
<tr>
<td></td>
<td>• Badlao Foundation</td>
</tr>
<tr>
<td></td>
<td>• Society for Reformation and Advancement of Adivasis (ASRA)</td>
</tr>
<tr>
<td></td>
<td>• Naya Saveri Vikas Kendra</td>
</tr>
<tr>
<td></td>
<td>• Shramjeeti Mahila Samiti</td>
</tr>
<tr>
<td></td>
<td>• Society for Human Assistance and Rural Empowerment (SHARE)</td>
</tr>
<tr>
<td></td>
<td>• Prerana Bharati</td>
</tr>
<tr>
<td></td>
<td>• Lok Chirag Sewa Sansthan</td>
</tr>
<tr>
<td></td>
<td>• Ekjut</td>
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<tr>
<td></td>
<td>• Gramodaya Chetna Kendra</td>
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<tr>
<td></td>
<td>• Jharkhand Vikas Parishard</td>
</tr>
<tr>
<td></td>
<td>• Evangelical Fellowship of India Commission on Relief (EFICOR)</td>
</tr>
<tr>
<td>Odisha</td>
<td>• Development Institute for Scientific Research, Health and Agriculture (DISHA)</td>
</tr>
<tr>
<td></td>
<td>• Visionaries of Creative Action for Liberation and Progress (VICALP)</td>
</tr>
<tr>
<td></td>
<td>• Society for Welfare, Animation and Development (SWAD)</td>
</tr>
<tr>
<td></td>
<td>• AAINA</td>
</tr>
<tr>
<td></td>
<td>• Centre for World Solidarity</td>
</tr>
<tr>
<td></td>
<td>• Janasahajya</td>
</tr>
<tr>
<td></td>
<td>• Society for Promoting Rural Education and Development (SPREAD)</td>
</tr>
<tr>
<td>State</td>
<td>CSOs</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Uttar Pradesh | • Purvanchal Grameen Seva Samiti  
               • Sahbhagi Shikshan Kendra  
               • Tarun Chetna  
               • PARTICIPATORY ACTION FOR COMMUNITY EMPOWERMENT (PACE)  
               • Samudayik Kalyan Evam Vikas Sansthan (SKEVS)  
               • Gram Niyojan Kendra  
               • Panchsheel Development Trust  
               • Grameen Vikas Sansthan  
               • Aadharshila  
               • School for Potential Advancement and Restoration of Confidence (SPARC)  
               • Gramya Sansthan  
               • Shramik Seva Kendra (SSK)  
               • People for Peace Service Society (PPSS)  
               • Purvanchal Rural Development and Training Institute (PRDTI)  
               • Nav Bharati Nari Vikas Sansthan |
| West Bengal | • Child in Need Institute  
               • Nari O Shishu Kalyan Kendra  
               • Shripur Mahila-o-Khadi Unnayan Samity (SMOKUS)  
               • Jalpaiguri Seva Sadan |
The Poorest Areas Civil Society (PACS) programme is an initiative of the UK government’s Department for International Development (DFID). Under PACS, DFID partnered with Indian civil society to help socially excluded groups claim their rights and entitlements more effectively, so they receive a fairer share of India’s development gains. PACS, in its second phase of implementation (2009-2016), had been supporting the work of CSOs to promote inclusive policies, programmes and institutions at local, district and state levels in the areas of livelihoods and basic services.

RSBY is one of the flagship programmes of the Government on which PACS Programme worked from 2011 to 2015 across its intervention states. This document presents the approaches, strategies, results, achievements and key learning from the intervention along with the stories of change from the intervention area.