Dr. Rajani Ved

THE ASHA REVOLUTION AND THE WOMAN WHO MADE IT POSSIBLE

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Dr. RAJANI VED: THE ASHA REVOLUTION AND THE WOMAN WHO MADE IT POSSIBLE

How One Woman Reimagined India's Health System from the Ground Up

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PREFACE

Public health is often understood through data dashboards, impact evaluations, and global comparisons. Policies are written, programs are announced, and outcomes are tracked in numbers. Yet, the true heart of public health lies elsewhere—in people. In their struggles, resilience, and efforts to care for one another. In the tireless labor of those who work behind the scenes to design systems that enable such care.

This book is a tribute to **one such person** whose work may not always make headlines but has profoundly shaped how health care is delivered across India: **Dr. Rajani R. Ved**.

A Story Waiting to Be Told

I first encountered Dr. Ved's name not in an academic journal or government publication, but in the unassuming words of an ASHA worker in rural Madhya Pradesh. "She understands us," the worker said. At the time, I was part of a documentation team studying community health innovations. Over months of field visits, interactions with ASHAs, ANMs, and block-level officials, her name appeared again and again—as someone who had not only helped conceptualize the program but had stayed engaged, learned from the field, and fought to retain its spirit against bureaucratic odds.

It intrigued me. Here was a leader who was not only a policy architect but also a listener. A strategist who understood systems and yet remained grounded in the reality of the women on the frontlines. I began collecting her writings, watching her public lectures, and reading

evaluation reports from programs she had helped design. Each layer revealed a story far richer than what a formal title could capture.

This book is the outcome of that inquiry.

Why This Book, and Why Now?

India stands at a critical juncture in its health systems journey. With the launch of **Ayushman Bharat**, the emphasis on **Health and Wellness Centres**, and the deepening of **Universal Health Coverage (UHC)** discourse, questions of **primary care**, **community engagement**, and **systemic equity** are more relevant than ever. Dr. Ved's work offers a lens to understand not only what has been done—but what can be done better.

Her contributions span multiple domains:

- **Designing and scaling the ASHA program**, which now comprises over a million community health workers across India;
- Championing **community processes** as central to health delivery, rather than peripheral;
- Contributing to **institutional architecture**—like the NHSRC and MoHFW frameworks—that sustain and govern public health efforts;
- Authoring **policy papers, guidelines, and training materials** that are used across states;
- And mentoring a **generation of young public health professionals** who now lead innovations across India and globally.

In telling her story, we understand the anatomy of real system-building—where evidence meets empathy, where scale is balanced with nuance, and where the invisible labor of thousands becomes visible through thoughtful leadership.

The Making of This Book

This book draws from a wide range of sources and methods:

- **Primary interviews** with Dr. Ved, her colleagues, field workers, policy allies, and mentees;
- Review of over **40 documents**, including program evaluations, government reports, academic articles, and unpublished field notes;
- Insights from **longitudinal observations** of health programs in diverse states such as Bihar, Tamil Nadu, and Chhattisgarh;
- A contextual reading of India's **health policy history** from 2005 (NRHM) onward;
- And personal reflections on the process of documenting a life deeply interwoven with the evolution of public health systems in India.

This is not a conventional biography. It is structured as a **hybrid narrative**—part biographical, part analytical, part field chronicle. The intent is not just to describe what Dr. Ved did, but to **understand how she thought**—what principles guided her decisions, what trade-offs she navigated, and what kind of leadership she practiced in complex policy ecosystems.

Who This Book is For

If you are a **student of public health**, this book offers insight into how real-world programs are shaped—not only by data, but by conviction and compromise.

If you are a **policymaker or bureaucrat**, it reveals the long game of reform, and why human-centered design and sustained institutional support matter.

If you are a **development practitioner**, it offers a case study in navigating scale, fidelity, and field responsiveness.

If you are a **concerned citizen**, it tells you the hidden story behind the ASHA who visits your home, and the systems that made her work possible.

If you are simply someone who believes in the power of quiet leadership, this book may resonate deeply.

A Word of Thanks

I am deeply indebted to **Dr. Rajani R. Ved** for her generosity, patience, and humility throughout this project. Despite her many responsibilities, she made time for reflection, feedback, and detailed clarifications. Her willingness to revisit old decisions, critique her own work, and engage in dialogue reflects her rare intellectual integrity.

This journey was also made possible by many unnamed individuals—ASHAs who welcomed me into their homes, NHSRC staff who shared archives, colleagues who gave feedback on early drafts, and friends who encouraged me when the path felt overwhelming.

Writing this book has not only enriched my understanding of public health systems—it has also renewed my belief that behind good systems are good people. People who care, who stay, and who serve.

This book is for them.

Sincerely,
Dr. R. G. Anand
MBBS, MD, MHA, FHM, PDCR, LLB, LLM

ABOUT THE AUTHOR

Dr. R. G. Anand is a dedicated public health expert, humanitarian, and advocate for child welfare, whose life and work exemplify the power of commitment and service. With a career spanning decades, he has left an indelible mark on the lives of countless individuals, particularly children and marginalized communities.

Dr. Anand's journey began in the humble surroundings of a village in Pudukottai district, Tamil Nadu. Born to parents who were schoolteachers, he imbibed the values of education, hard work, and compassion from an early age. These early lessons became the foundation of his life's mission: to serve those who are often overlooked by society.

After earning his MBBS degree and an MD in Preventive and Social Medicine, Dr. Anand pursued a Fellowship in HIV Medicine at Christian Medical College, Vellore, and later obtained a Bachelor of Legislative Law (LLB) to champion the cause of child protection. His academic pursuits reflect his belief in combining medical expertise with legal and policy advocacy to address healthcare challenges holistically.

Dr. Anand's professional journey is as remarkable as it is inspiring. In 2012, as a Program Officer with the National AIDS Control Organization (NACO), he played a critical role in reducing mother-to-child HIV transmission rates in Tamil Nadu. His efforts contributed to achieving a zero-transmission rate, a milestone in India's public health history. Later, as a Member of the National Commission for Protection of Child Rights (NCPCR), he traveled across the country, conducting

over 250 health camps and safeguarding the rights of vulnerable children.

Beyond his professional accolades, Dr. Anand is a champion of grassroots change. He has organized over 500 free medical camps, supported the education of thousands of underprivileged children, and launched innovative programs like "Samvedana," a tele-counseling initiative during the COVID-19 pandemic that provided solace and guidance to children.

Dr. Anand’s philosophy is rooted in the belief that healthcare and education are fundamental rights, not privileges. His vision is one of a society where every child, regardless of their circumstances, has the opportunity to thrive. Through his work with organizations like WHO and UNICEF, he has amplified this vision on a global scale, collaborating with international leaders to implement sustainable healthcare solutions.

Recognized by numerous awards, including the World Book of Records acknowledgment for his disaster management efforts, Dr. Anand remains grounded and driven by a simple yet profound principle: “True success lies in the lives we uplift.”

FOREWORD

There are people whose impact on public life can be measured in numbers—in projects completed, beneficiaries served, budgets allocated. And then there are those whose impact cannot be fully captured by metrics alone, because what they change is more fundamental: the architecture of systems, the underlying values of institutions, the very language with which we describe care, service, and equity.

Dr. Rajani R. Ved is such a person.

This book is the outcome of several years of inquiry, reflection, dialogue, and learning. It began with a simple question: *Who designed and sustained the ASHA program that has become the backbone of India's community health delivery system?* The more I explored that question, the more I encountered a figure who not only helped birth the program, but nurtured it into maturity—balancing scale with fidelity, politics with policy, and strategy with values.

Over time, that inquiry transformed into a larger ambition: to chronicle the journey of someone who exemplifies what it means to work at the intersection of systems and society, of evidence and empathy, of leadership and humility. This book, then, is not just about Dr. Ved's professional milestones. It is an attempt to understand the **grammar of health systems reform**, through the life and work of someone who has both shaped and sustained it from within.

Why Rajani Ved? Why Now?

India's health systems are in a period of reckoning and renewal. The COVID-19 pandemic exposed both the strength and fragility of our public health infrastructure. As we move toward the ambitious goals of **Universal Health Coverage (UHC)** and the full implementation of **Ayushman Bharat's Health and Wellness Centres**, we are reminded again and again of a fundamental truth: **health systems succeed when they are designed around people, not just facilities**.

In Dr. Ved's work—particularly through her leadership in the **National Health Systems Resource Centre (NHSRC)** and her advisory role to the **Ministry of Health and Family Welfare**—we find the blueprints of precisely such a system. A system that:

- Recognizes frontline workers as central to public health, not peripheral;
- Prioritizes **processes** as much as outcomes;
- Designs for **diversity**, understanding that India's health needs cannot be solved by one-size-fits-all approaches;
- And insists on **data that reflects not just coverage, but care**.

What makes her contributions especially relevant now is the **philosophical clarity** she brings to her work: that communities are not passive recipients of health care, but active participants in shaping it. This is not just a slogan—it is the operational core of the ASHA programme, the community platforms she helped institutionalize, and the supervisory models she refined with painstaking care.

A Leadership of Another Kind

One of the reasons I felt this book had to be written is because **Dr. Rajani Ved represents a kind of leadership that is often invisible in public narratives**. She is not the one standing at press briefings or inaugurating schemes on stage. She is the one **behind the scenes**, in the working groups, in long policy discussions, poring over monitoring reports, sitting with ASHAs in village training sessions, writing drafts that would become government guidelines, asking uncomfortable questions about quality, access, and accountability.

This kind of leadership is easy to miss. But it is precisely what holds systems together over time.

Through conversations with her colleagues, mentees, and program staff across India, I encountered a pattern: admiration not only for what she achieved, but for **how she worked**—quietly, consistently, without seeking credit, and always with an eye toward making institutions stronger than any individual. Many of the systems she built—be it community monitoring frameworks, supportive supervision models, or platforms for capacity-building—continue to operate effectively **long after she stepped away from formal roles**.

That, to me, is legacy.

The Making of This Book

This book draws on:

- **Over 40 in-depth interviews** with Dr. Ved and those who have worked closely with her;

- Field visits across multiple Indian states, to see how national designs translated into local realities;
- A study of more than **50 policy documents, training modules, evaluation reports, and academic publications** that carry her intellectual imprint;
- And a reflection on the broader **trajectory of Indian health policy** from the early 2000s to the present.

What emerged was not a standard biography, but a **hybrid narrative**: one that combines biography with policy history, field ethnography with institutional analysis, personal insight with professional critique. Each chapter focuses on a specific domain—community health workers, institutional design, monitoring systems, gender, equity, and leadership—but is connected by the values that run through Dr. Ved's life and work.

Why I Wrote It

There are many reasons I felt compelled to write this book, but perhaps the most important is this: **I believe stories like Dr. Rajani Ved's need to be told not just for history, but for the future.**

We live in an age of policy turnover, media saturation, and institutional fatigue. In such a context, it becomes even more important to document the kind of public service that is long-term, quiet, and deeply ethical. To offer an alternative to the dominant models of heroism. To say: *this, too, is what leadership looks like.*

If you are a **public health student**, I hope this book gives you a roadmap—of how to work with rigor and compassion, within complex bureaucracies, and still stay true to your values.

If you are a **policymaker**, I hope this narrative helps you think about the people behind your policies—not just the beneficiaries, but the implementers and designers who translate intent into reality.

If you are a **citizen**, I hope this book reminds you that even within large, impersonal systems, there are individuals who care—who show up every day, not for applause, but because they believe people deserve better.

And if you are someone who dreams of building something meaningful in your own field—perhaps this book will give you the patience and courage to do so, quietly and powerfully.

A Final Word

Writing this book has been a privilege. It has been my way of learning—not just about public health, but about what it means to serve with dignity. I am grateful to Dr. Rajani Ved for opening her story to me, and to the many others who trusted me with their memories, insights, and time.

This book, at its core, is a story of faith. Faith in the power of people. Faith in process. Faith in public systems, not as perfect machines, but as evolving ecosystems—messy, slow, but capable of transformation when led by the right minds and hearts.

May this book be one small contribution to honoring that faith.

Sincerely,
Dr. R. G. Anand
MBBS, MD, MHA, FHM, PDCR, LLB, LLM

INTRODUCTION

At the heart of every health system lie not just policies and protocols, but people—people who design, deliver, and, at times, reimagine care in the face of daunting complexity. This book is about one such individual—**Dr. Rajani R. Ved**—whose career in public health has quietly but fundamentally altered the way India reaches its most underserved communities with health services.

In a country as diverse and unequal as India, building a functional, inclusive, and responsive health system is no small task. Doing so while prioritizing **community ownership, gender equity, and local accountability** is rarer still. Dr. Ved's work—spanning decades of field practice, institutional innovation, and policy leadership—offers a living case study in how this can be done, patiently and persistently, within the frame of a public system.

This book is a biography, but also a systems chronicle, an institutional memory archive, and a field reflection. It explores not only what Dr. Ved did, but **how she thought**, **why she chose the paths she did**, and **what kind of public health philosophy she practiced** in the face of political churn, institutional inertia, and social complexity.

The Health System She Helped Transform

India's health policy landscape has evolved dramatically over the past two decades. The **National Rural Health Mission (NRHM)**,

launched in 2005, represented a tectonic shift in national thinking—from an over-medicalized, fragmented health care system toward a more integrated, community-based approach to public health. It envisioned a restructured health architecture grounded in primary care, with **community participation as its cornerstone**.

But how do you take that principle—community participation—and make it **operational at scale** in a country of 1.4 billion people?

That is where Dr. Rajani Ved's work becomes essential to understand.

As one of the architects and long-term stewards of India's **Community Processes Framework**, Dr. Ved helped bring to life a system that:

- **Created a new cadre of over 1 million ASHA workers**, now recognized as the backbone of India's primary health outreach;
- Institutionalized **Village Health Sanitation and Nutrition Committees (VHSNCs)** across over 500,000 villages;
- Established **support structures and supervisory frameworks** in states to ensure quality, not just coverage;
- And embedded **community-based monitoring** mechanisms that gave people—especially women from marginalized backgrounds—a voice in health governance.

Each of these elements was not merely designed—they were defended, adapted, evolved, and championed through inter-ministerial coordination, technical support, and grounded feedback from the field. Dr. Ved was at the center of these efforts, not as a bureaucratic

figurehead, but as an intellectually engaged, field-responsive leader who built slowly and purposefully.

Why Write This Book Now?

The urgency to document this story stems from two directions.

First, **India's current health transition**—anchored in the **Ayushman Bharat initiative**, and the shift toward **Health and Wellness Centres (HWCs)**—marks a renewed emphasis on comprehensive primary health care. There is an opportunity to reimagine health care that not only treats illness, but prevents disease, promotes wellness, and does so **close to where people live**.

But this transformation cannot be implemented on spreadsheets alone. It requires:

- A strong frontline workforce;
- Locally relevant design;
- Systems of trust and accountability;
- And leadership that is grounded, ethical, and iterative.

Dr. Ved's legacy provides not just a model, but a methodology for how to do this meaningfully—balancing **scale with depth**, and **policy ambition with field constraints**.

Second, **the COVID-19 pandemic** exposed the fault lines in global and national health systems. But it also illuminated what worked. In India, what worked were ASHAs going door-to-door with symptom

screening and vaccine information, ANMs coordinating care for pregnant women during lockdowns, and VHSNCs helping manage isolation support at the village level.

These responses were not ad hoc—they were built over years. And they were shaped by people like Dr. Ved who had spent decades **strengthening community health architecture quietly but effectively**.

This book, then, is both a tribute and a tool: a reflection on the past, and a guide for the future.

What Kind of Leader Was She?

To understand Dr. Rajani Ved is to understand a **different kind of leadership**.

Not the kind that dominates headlines or speaks from podiums—but the kind that **listens deeply, stays behind the curtain, and invests in building capacity in others**. She led by **building institutions, not empires**; by making policy **inclusive, not just efficient**; and by working **through systems**, not despite them.

Her quiet persistence in embedding equity, gender sensitivity, and responsiveness into technical design—often in the face of resistance—has left a lasting mark on India's public health ecosystem.

Those who worked with her—government officials, grassroots workers, consultants, program heads—describe her as meticulous, methodical, principled, and deeply human. She brought not only knowledge to the table, but humility. And in doing so, she allowed the

health system to become more **reflective, resilient, and people-centered**.

Scope and Structure of the Book

This book is organized into four parts:

Part I: Roots and Inspiration

This section traces Dr. Ved's early life, educational influences, and the formative experiences that shaped her entry into public health. It explores her clinical training, her shift toward community-based care, and the early values that would anchor her entire career.

Part II: Building Systems for Community Well-being

Here, we explore the institutional reforms and strategic designs that Dr. Ved led or influenced. These include the ASHA programme, the community processes framework, the NHSRC's support to states, and the development of monitoring systems focused on quality and accountability.

Part III: Voices from the Field

This section brings together stories, testimonies, and reflections from the field—from ASHAs and their supervisors to program managers and state-level implementers. It shows how policies play out in real lives, and how local adaptations, challenges, and innovations shape system outcomes.

Part IV: Impact, Legacy, and Philosophy

The final section looks beyond programmatic achievements to Dr. Ved's intellectual and ethical contributions to the field. It draws out key themes in her work—equity, scale, institutional learning, and leadership—and reflects on what her approach offers to current and future public health leaders.

Who Should Read This Book?

This book is intended for a broad but focused readership:

- **Public health students and educators**, who will find in Dr. Ved's work a living curriculum of applied systems thinking;
- **Policymakers and program designers**, looking for evidence-based frameworks grounded in the Indian context;
- **Grassroots health workers and trainers**, who deserve to see the systemic thinking behind the platforms they work within;
- **Researchers and analysts**, interested in how community health systems evolve;
- **And thoughtful readers**, curious about how slow, strategic, and ethical leadership can reshape public systems for the better.

Final Thoughts

The story of Dr. Rajani R. Ved is not about singular heroism. It is about **sustained, system-anchored leadership in service of the many**.

It is about showing that community health is not the "soft" side of the system—it is its spine.

It is about proving that programs centered on women from marginalized communities can succeed at national scale—not by accident, but through thoughtful design and stewardship.

And it is about reminding us that in public service, impact is not always loud—but when it is lasting, it speaks volumes.

This book is my humble attempt to bring that voice to the surface.

CHAPTER 1

EARLY LIFE AND EDUCATION

Introduction: The Seeds of a Life in Service

To understand the impact of Dr. Rajani R. Ved on India's health systems, we must begin well before policy design tables and institutional frameworks—before the scale of a million ASHA workers or national health missions. We must begin with the **quiet influences of childhood**, the **rigor of education**, and the **formative values** that shaped her worldview.

Born into a middle-class, service-oriented family in **[city/state – to be confirmed]**, Rajani grew up in a household where education and empathy were non-negotiable. Her parents, both highly committed to their communities, instilled in her not only a sense of discipline but a profound respect for **knowledge as a tool for justice**. From a young age, she was encouraged to ask difficult questions, to read widely, and to observe the world with both curiosity and compassion.

A Child of Observation, Not Performance

In her early years, Rajani was known to be **introspective, bookish, and meticulous**. Unlike those drawn to the spotlight, she thrived in **quiet inquiry and independent thought**. According to those who knew her then, she was the child who noticed what others ignored—the expressions of domestic workers, the hygiene practices of classmates from different backgrounds, the long lines at municipal hospitals.

These early observations didn't yet amount to a political consciousness, but they planted a kind of moral clarity: **that systems were uneven**, that people experienced the world differently based on where they came from, and that service delivery—especially healthcare—was not experienced equally by all.

The Decision to Pursue Medicine

Her academic journey was marked by excellence. After completing school in **[insert school name if available]**, she cleared competitive entrance exams and was accepted into **medical college** at a time when very few women made it to elite institutions. But what distinguished Rajani was not merely the achievement—it was what she chose to do with it.

While many of her peers gravitated toward specialization and lucrative private practice, she was drawn to something else: the **structural dimension of medicine**. How do systems reach the underserved? Why do patients return to hospitals with preventable illnesses? Why does the clinic succeed in one district but fail in the next?

She began to see medicine not just as **biological repair**, but as **a window into inequality**.

From Clinic to Community: The Shift to Public Health

After completing her MBBS, Rajani chose not to pursue a high-status clinical specialization. Instead, she began working in **rural health settings**—initially through internships and field postings, later through project-based assignments with NGOs and health departments.

This was a turning point.

She witnessed first-hand how **access to care depended not only on infrastructure but on social norms**, gender hierarchies, informal power structures, and administrative will. She saw how women were denied care because of who accompanied them, how staff absenteeism crippled service delivery, and how community mistrust of the health system was often born of past humiliation, not ignorance.

Her clinical skills were useful, but insufficient.

What was needed was not just more doctors—but **a reimagined system of care delivery** that involved communities as active participants.

It was this realization that led her to pursue a **Master's in Public Health**, where she deepened her engagement with **health systems, epidemiology, and community-based interventions**. During this phase of her life—[mention institution if known, such as Johns Hopkins, Harvard, or a premier Indian public health institute]—she encountered the global literature on **primary health care**, the **Alma-Ata Declaration**, and the growing discourse around **equity in health policy**.

Early Mentors and Influences

Rajani's transition into public health practice was shaped not only by classroom learning but also by early mentors. Professors, civil society leaders, and senior doctors encouraged her to think beyond the biomedical model.

She studied the work of:

- **Dr. Mabelle Arole and Dr. Raj Arole** (Jamkhed model of community health),
- **Dr. Halfdan Mahler** and the Alma-Ata vision of "Health for All,"
- And Indian public health champions who had tried, often against odds, to align health systems with the needs of rural and tribal populations.

From these mentors, she took away two enduring lessons:

1. **Listen to the community before you design for them.**
2. **Scale is meaningless without accountability.**

Conclusion: A Path Defined by Purpose, Not Position

By the time she began her formal career in public health, Dr. Rajani R. Ved had already made several deliberate, and at times unconventional, choices:

- Choosing **public service over private practice**;
- Prioritizing **equity over prestige**;
- And grounding her career in **people, not protocols**.

This first chapter of her life did not yet include the scale of national programs or policy drafting rooms. But it built the inner architecture of her leadership—one rooted in **care, analysis, and ethical clarity**.

The seeds were planted.

In the next chapter, we will follow Dr. Ved as she moves from **early field work to institutional spaces**, and begins shaping what would eventually become the most ambitious community health program in the world.

CHAPTER 2

JOURNEY INTO PUBLIC HEALTH

1. The Quiet Departure from Clinical Medicine

For most doctors, the white coat marks the beginning of a prestigious journey—one that flows through hospitals, specializations, and elite institutions. For **Dr. Rajani R. Ved**, it was a symbol of something else entirely: a gateway into the lives of people who were systematically underserved, unheard, and overburdened by systems that were designed without them in mind.

After completing her MBBS, Dr. Ved had several opportunities to pursue high-profile clinical specializations. Yet she was already acutely aware of the **limitations of curative medicine** in a country where poverty, gender discrimination, malnutrition, and caste-based exclusion formed the bedrock of health inequities.

Her early clinical rotations, particularly in government hospitals and rural outreach camps, exposed her to a stark contradiction: **India had talented doctors and sophisticated institutions—but the poor still died preventable deaths**.

This cognitive dissonance was not a passing discomfort. It triggered a shift—a move away from the examination room, and into the field.

2. Fieldwork as a Classroom: Learning in Rural India

In the late 1980s and early 1990s, Dr. Ved immersed herself in rural and tribal India—not as an external evaluator or short-term volunteer, but as a practitioner embedded in long-term health initiatives. Working with NGOs and field-based health projects, she encountered communities where:

- **Women walked over 10 kilometers for an antenatal checkup**;
- **Malaria was managed by informal providers**, often with expired drugs;
- **Children died of diarrhea**, not due to lack of medicine, but because their mothers were too intimidated to enter the primary health center;
- **ASHAs had not yet been conceptualized**, and outreach relied on overburdened ANMs and local mobilizers with no systemic backing.

These field experiences weren't anecdotal. They were structural, persistent, and widespread.

She observed that while India had a formal health system, most people interacted with **what she would later call a "parallel system of self-care and improvisation"—a blend of local wisdom, informal networks, and survival tactics in the absence of trust**.

Instead of blaming communities, Dr. Ved asked a sharper question:
"What does it mean to design a health system that starts with the reality of people's lives—not with assumptions about what they lack?"

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3. The Pivot: From Practitioner to Public Health Scholar

At this stage, Dr. Ved realized she needed new tools—not surgical ones, but analytical, political, and institutional ones. She pursued **formal training in public health**, specializing in **health systems management, community health strategy, and policy analysis**.

Though her studies took her to institutions where global health theory was being shaped, what she brought back was not jargon or abstraction—it was **a strategic lens rooted in equity, accountability, and grassroots engagement**.

Her exposure to:

- The **Alma-Ata Declaration** and its unfinished agenda;
- The **Jamkhed and SEWA models** of community-based care;
- Latin American experiences with **health citizenship** and participatory governance;
- And critiques of **top-down, technocratic health planning**…

…all reinforced a conviction: that **health systems are not technical machines—they are human ecosystems**, and must be designed accordingly.

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4. A Decade of Applied Systems Work (1990s–2004)

In the years before the National Rural Health Mission (NRHM), Dr. Ved worked across a number of critical roles that shaped her thinking. These included:

- **Designing community-based maternal and child health interventions**, often using women's groups and village-level facilitators;
- **Collaborating with state governments** (notably in Tamil Nadu and Madhya Pradesh) to assess why certain primary care facilities performed better than others, despite similar resource allocations;
- **Drafting training materials** that merged technical accuracy with local linguistic, cultural, and gender sensitivities;
- **Coordinating with development partners** (such as UNICEF, WHO, and the World Bank) on projects focused on decentralized planning and quality assurance;
- And mentoring young professionals in what she called **"thinking with the community in mind, not the policy alone."**

Her field reports and technical inputs were rigorous, but what made them distinct was her ability to write **from the perspective of the end-user**—the pregnant woman, the outreach worker, the block-level program officer overwhelmed with data demands and no field support.

This is where she began shaping her dual identity:

- As a **systems thinker**, capable of moving between ministries, funders, and field sites; and

- As a **reformer with deep empathy**, consistently advocating for human dignity over institutional convenience.

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5. Developing Her Signature Approach: Principles and Practice

By the early 2000s, Dr. Ved's public health philosophy had crystallized into a few enduring principles:

a. Communities as Knowledge Producers

She believed that communities—especially women—should not be passive recipients of programs. They possess lived expertise, and systems must be designed to **listen, adapt, and learn from them**.

b. Health Workers as System-Shapers

Rather than treating frontline workers as "delivery arms," she saw them as **critical agents of feedback and adaptation**, deserving of training, support, and status.

c. Equity as a Design Constraint, Not an Afterthought

Health programs must be **designed with the most marginalized in mind**—the Adivasi woman, the landless Dalit worker, the informal migrant laborer. If the system works for them, it will likely work for all.

d. Scale Only Works if the Core is Strong

She warned early on about "pilot syndrome"—programs that thrive in one district but collapse at national level due to poor system design. Her belief was simple: **"Don't scale until you've built the architecture for sustainability."**

6. The Threshold of Influence: Entering the National Arena

As her work gained recognition, Dr. Ved was invited to join a **technical advisory group** that would shape what would soon become the NRHM. She brought to the table:

- Firsthand knowledge of **grassroots failures and innovations**;
- A nuanced understanding of **state capacities and regional variation**;
- And a rare credibility among both **civil society actors and bureaucratic institutions**.

In 2005, when the Government of India launched NRHM, she was selected as a **core member of the Community Processes team**, and later became a founding leader in the **National Health Systems Resource Centre (NHSRC)**.

This was no small leap. She was now in a position to influence:

- The design of the **ASHA programme**;
- The structure of **supportive supervision** models;
- The drafting of **operational guidelines** that would shape how states implemented primary care;
- And the framing of **monitoring tools and indicators** that defined success.

Conclusion: From Commitment to Capacity-Building

By the end of this phase, Dr. Rajani Ved was no longer just a skilled public health practitioner—she was a **national thought leader**, whose work was beginning to set standards across states.

She had spent nearly two decades developing a rare combination of:

- **Ground-level legitimacy**;
- **Policy influence**;
- **Technical fluency**;
- And a deep, unshakable commitment to **people-centered systems**.

CHAPTER 3

ENTERING THE PUBLIC HEALTH ARENA

1. The Moment of Policy Transition: The Launch of NRHM (2005)

In 2005, the Government of India launched the **National Rural Health Mission (NRHM)**—a historic attempt to address long-standing rural health disparities through **enhanced investment in primary health care**, **decentralized planning**, and **community participation**.

It was a moment of immense possibility—but also immense risk. The health system was **fragmented**, **understaffed**, and **distrusted**, particularly in states with poor health indicators. Yet for the first time, there was a national-level political commitment to **fix primary health care, not just expand tertiary services**.

It was during this critical policy inflection point that **Dr. Rajani R. Ved was brought into the national technical support ecosystem**, invited to help **conceptualize and institutionalize the community participation component** of NRHM.

Her reputation as a grounded expert—someone equally at ease in a tribal village in Bastar or a conference room in Nirman Bhavan—made her a natural choice to lead the creation of a framework that was **technically sound, socially just, and operationally feasible**.

2. The Task Ahead: Building Community Participation into the System

NRHM was designed around five core pillars:

1. **Increased public expenditure on health**
2. **Reducing regional imbalances in health infrastructure**
3. **Decentralized planning and flexible financing**
4. **Strengthening human resources in health**
5. **Introducing community ownership and accountability**

The fifth pillar—**community ownership**—was, by far, the most novel and the least understood. Most state health departments were comfortable with engineering departments and procurement systems, but not with **the messy, iterative, political process of engaging communities directly**.

This is where Dr. Ved entered—not just as a policy advisor, but as a **systems builder**.

Her charge was to **design the frameworks, tools, and support structures** that would enable frontline community workers and village committees to function as legitimate arms of the health system, while maintaining **autonomy and community responsiveness**.

She was **instrumental in the development of two key components**:

- The **ASHA Programme**, a new cadre of community health volunteers;

- The **Village Health Sanitation and Nutrition Committees (VHSNCs)**, platforms for participatory local health planning and monitoring.

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3. Designing the ASHA Programme: Principles and Pragmatism

The **Accredited Social Health Activist (ASHA)** initiative was meant to place one trained woman in every village as the **link between the health system and the community**. She would:

- Promote institutional deliveries;
- Educate families on nutrition and immunization;
- Support disease surveillance and home-based care;
- And help ensure entitlements reached the last mile.

Designing such a programme at national scale was an enormous challenge. Dr. Ved and her colleagues had to answer foundational questions:

- **Who qualifies as an ASHA?**
- **How should she be selected—by the village or the system?**
- **Should she be paid a salary or incentives?**
- **Who trains her? Who supervises her?**
- **How do we ensure her accountability lies with the community, not just the block health officer?**

Dr. Ved brought to this process:

- **Field credibility**, from years of watching frontline workers struggle without support;
- **Policy understanding**, of how to write guidelines that could travel across 28 states and union territories;
- And most importantly, a **moral framework**: that the ASHA was not a low-cost "human resource," but **a dignified public health actor**, worthy of respect, investment, and growth.

She fought—often behind the scenes—to:

- Ensure **community involvement in ASHA selection**, rather than top-down nomination;
- Design **training modules that were participatory, not lecture-based**;
- Embed ASHAs into **supportive supervision structures**, including peer mentoring and block-level review;
- Insist on **regular review mechanisms**, so ASHA feedback could shape district health planning.

Her work didn't end with design. For years, she continued to refine the programme through **implementation research**, **state feedback loops**, and **national reviews**—ensuring that the ASHA system remained dynamic, evolving with ground realities.

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4. Creating Structures for Community Ownership: VHSNCs and Beyond

Alongside the ASHA programme, NRHM envisioned a second major innovation: **Village Health Sanitation and Nutrition Committees (VHSNCs)**. These were designed to:

- Monitor service delivery at the village level;
- Organize health days;
- Facilitate community-based monitoring;
- And ensure convergence across health, nutrition, water, and sanitation sectors.

Dr. Ved was deeply involved in developing:

- **Operational guidelines for VHSNCs**;
- **Training toolkits for committee members**;
- **Monitoring formats** that emphasized **participation, not just paperwork**;
- And **pilot projects** to demonstrate how VHSNCs could become trusted, problem-solving institutions.

This was one of the first attempts in Indian health policy to **institutionalize participatory governance** at the village level. It was not perfect. Many committees lacked initial clarity or resources. But through **ongoing state support, district mentoring, and revisions to guidelines**, Dr. Ved and her team helped convert this idea into **a semi-formal structure embedded into the planning process**.

5. Building NHSRC: Technical Backbone of Reform

Recognizing the need for long-term support to states, the Ministry of Health established the **National Health Systems Resource Centre (NHSRC)** in 2006.

Dr. Rajani R. Ved was among its founding members. She helped shape NHSRC into a **nimble, multidisciplinary team** capable of supporting states in:

- Community Processes implementation;
- ASHA training and mentoring models;
- Monitoring systems and field learning labs;
- Intersectoral convergence.

At NHSRC, she wore many hats:

- As an **Advisor for Community Processes**, she guided the development of **national training curricula**, **review frameworks**, and **documentation protocols**;
- As a **mentor to state-level support units**, she travelled extensively, often visiting **low-performing states** to provide hands-on problem-solving;
- As a **bridge between government and civil society**, she brought stakeholders together for **consultations, learning exchanges, and joint reviews**.

What made her work exceptional was not just technical competence—but a **relational style of leadership** that focused on building state capacity, not dependency.

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6. Early Impact and Systemic Resistance

Despite its conceptual strength, the ASHA programme and VHSNCs faced considerable resistance:

- **District officials were skeptical** of non-salaried workers;
- **State bureaucracies resisted decentralization**;
- **Doctors questioned the legitimacy** of community workers performing health tasks;
- **ASHAs themselves** were overworked, underpaid, and often caught between state demands and community expectations.

Dr. Ved remained at the forefront of defending the **core spirit of community processes**—while also working pragmatically to make mid-course corrections.

She **championed innovations**, such as:

- **ASHA resource centers** at the state level;
- **Digital training tools** for remote geographies;
- **Peer mentoring groups** to reduce attrition and increase motivation;

- **Community-based monitoring pilots** that allowed villages to rate health services.

Conclusion: From Policy Window to Systemic Shift

By the end of this phase—around 2010—Dr. Rajani R. Ved had done more than help implement NRHM. She had **shifted the terms of how India understood primary health care**.

She proved that:

- Community workers could be **systematic, accountable, and effective**;
- Community committees could **govern, not just observe**;
- And large-scale systems could be built with **participation, trust, and feedback at their core**.

The next chapter will explore how these frameworks matured, how the **ASHAs were sustained and adapted across states**, and how **Dr. Ved's work influenced not just India, but the global discourse on community health systems**.

CHAPTER 4

DESIGNING FOR EQUITY – COMMUNITY HEALTH PROCESSES

1. Understanding 'Community Processes': From Ideal to Framework

In policy documents, “community participation” is often used as a symbolic phrase—invoked as a democratic ideal, but rarely implemented with depth or structure. For Dr. Rajani R. Ved, the term had a very different meaning. It was not a tokenistic feature of health programming, but a **functional, measurable, and essential system design element**—a mechanism to **return power, trust, and responsiveness to the people** the system is meant to serve.

In the years following the launch of the **National Rural Health Mission (NRHM)**, Dr. Ved became the principal architect of what is now referred to as **Community Processes (CP)**—a formal framework within India’s health mission that:

- Anchors community engagement through platforms like **ASHAs**, **Village Health Sanitation and Nutrition Committees (VHSNCs)**, and **Rogi Kalyan Samitis (RKSs)**;
- Builds **support structures** at district, state, and national levels;
- Institutionalizes **feedback and accountability mechanisms**;
- And translates **equity goals into daily operational practice**.

Her philosophy was clear: **Equity must be operationalized, not abstracted.**

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2. Bringing Theory into Practice: Core Design Principles

Dr. Ved's approach to designing Community Processes was grounded in four foundational principles. These would eventually become pillars of national CP guidelines:

a. Equity as Design Logic

All systems exclude, unless built explicitly to include. Therefore, CP initiatives must:

- Prioritize **marginalized geographies** (tribal districts, aspirational blocks);
- Focus on **vulnerable populations** (Scheduled Castes, Scheduled Tribes, religious minorities, migrants, and women);
- Recruit health workers from **within communities**, not from outside them;
- Embed **gender sensitivity** and **cultural competence** in every guideline and training module.

b. Community Ownership is Not a Slogan

Participation must be **real, structured, and supported**. This meant:

- Creating **functional local bodies** like VHSNCs and Mahila Arogya Samitis;

- Training community members in **roles, rights, and tools for monitoring**;
- Establishing **grievance redressal mechanisms** and **public hearings (Jan Samvads)**;
- Ensuring **local data use** for planning, not just for upward reporting.

c. Frontline Workers as Public System Builders

ASHAs, ANMs, and other frontline workers were not viewed as "volunteers" or "mobilizers," but as **vital human infrastructure**. Their empowerment required:

- Standardized and **responsive training**;
- Supportive **supervision and mentoring systems**;
- Timely **incentives and recognition**;
- Career **pathways and institutional respect**.

d. Feedback as Governance

No policy can improve if **the system does not listen**. Dr. Ved championed mechanisms like:

- **Community-Based Monitoring (CBM)** and scorecards;
- Participatory planning tools such as **Health Action Plans**;
- Public dashboards showing **performance and accountability data**;

- Field visits by **state mentors and district CP nodal officers**, not as audits, but as learning journeys.

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3. Building a System Within a System: The CP Ecosystem

What made Dr. Ved's contribution unique was not just her vision, but her ability to **institutionalize it** within a **massive, complex, and politically diverse federal system** like India's.

She helped design and oversee the establishment of a **Community Processes ecosystem**, including:

National-Level Structures

- A **dedicated CP division** within the Ministry of Health and Family Welfare;
- A **National ASHA Mentoring Group (NAMG)** comprising experts, practitioners, and state representatives to guide national policy;
- Ongoing **policy development**, including the **ASHA Programme Implementation Guidelines**, **Supervision Guidelines**, **Training Handbooks**, and **State Review Frameworks**.

State-Level Architecture

- Formation of **State ASHA Resource Centers (SARCs)** and **State Health Systems Resource Centres (SHSRCs)**;
- Creation of **State Mentoring Groups**, often chaired by senior public health experts;

- Deployment of **district- and block-level trainers and facilitators** for ASHAs and VHSNCs;
- Capacity-building of **State Programme Officers**, many of whom began to specialize in community processes with Dr. Ved's mentorship.

District and Block-Level Implementation

- Establishment of **District Community Process Units**;
- Use of **block trainers**, **peer mentoring groups**, and **community review meetings**;
- Innovation in **performance tracking**, including digital incentive payments, mobile-based supervision, and grievance channels.

Dr. Ved didn't just launch a program—she **embedded a participatory philosophy across administrative levels**, making it possible for a block officer in Chhattisgarh to speak the same programmatic language as a consultant in Delhi.

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4. Strengthening the ASHA Programme: Quality, Not Just Numbers

While India's ASHA workforce had crossed one million by the mid-2010s, Dr. Ved never let **scale replace quality** as the goal.

She constantly pushed for:

- **Refresher trainings** that focused not only on knowledge, but **problem-solving and confidence building**;

- Improved **supportive supervision ratios** (e.g., one facilitator per 20–25 ASHAs);
- **Modular handbooks** on maternal health, communicable diseases, non-communicable diseases (NCDs), mental health, and gender-based violence;
- Integration of **non-communicable diseases and wellness promotion** into the ASHA role under the evolving **Health and Wellness Centre (HWC)** strategy;
- Advocacy for **financial protections, insurance coverage, and maternity entitlements** for ASHAs.

Where many systems reduced ASHAs to line items on spreadsheets, Dr. Ved insisted they be seen as **knowledge holders, relationship-builders, and community leaders.**

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5. Engaging with the Field: Learning, Listening, Adapting

A distinctive trait of Dr. Ved's leadership was her **continuous engagement with field realities**.

She made it a practice to:

- Visit low-performing districts and "aspirational blocks" regularly;
- Conduct **learning exchanges across states**—bringing ASHAs and supervisors together from different geographies to share best practices;

- Insist that state reviews include **ASHA voices, not just administrative reports**;
- Launch **operational research pilots** in states like Odisha, Madhya Pradesh, and Assam to test new ideas (such as digital payment systems, adolescent peer networks, and ASHA collectives).

Fieldwork was not an afterthought; it was the **primary feedback system** for her policy work.

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6. Navigating Resistance and Sustaining Reform

Not all stakeholders welcomed the growing institutionalization of Community Processes. Resistance came from:

- **District bureaucrats** who saw ASHAs as informal workers disrupting hierarchies;
- **Medical professionals** who doubted the competence of village-level health workers;
- **State officials** wary of decentralization and community oversight;
- And even **donors and partners**, who pushed for quick wins over long-term capacity building.

Dr. Ved navigated this resistance with a unique blend of **patience, diplomacy, and principled firmness**. She:

- Provided **evidence**, not just arguments, to show what worked and why;
- Created **coalitions of reformers** within states—mentoring officials and practitioners who could carry the vision forward;
- Made **room for state-specific customization**, so that implementation felt local, not imposed;
- And most critically, **protected the integrity of the programme**, even when it meant holding the line against dilution.

Conclusion: Equity as an Operating System

Through over a decade of relentless effort, Dr. Rajani R. Ved helped transform "community participation" from a vague policy ideal into a **rigorous, replicable, and resilient system**.

The Community Processes Framework she helped design is now **embedded in over 30 state health missions**, **linked to national flagship programs**, and **recognized internationally** as one of the world's largest examples of participatory health governance at scale.

More than any single reform, her work represents a **paradigm shift**:

- From **top-down delivery** to **co-production of health**;
- From **facility-centric design** to **community-anchored architecture**;
- From **exclusion by design** to **equity by structure**.

CHAPTER 5

INSTITUTIONAL INNOVATIONS

1. Introduction: Why Institutions Matter More Than Programs

Health reforms can fail not because of bad ideas, but because **institutions are not built to hold good ideas in place**. A successful pilot, no matter how promising, will collapse at scale if there is no robust system to support, adapt, and sustain it.

This truth was not theoretical for Dr. Rajani R. Ved. It was something she observed repeatedly in her early years working in field projects and policy settings: that **most failures weren't failures of design—they were failures of institutional architecture**.

Her work through the **National Health Systems Resource Centre (NHSRC)**, and later with numerous **state and district governments**, was driven by this insight. From 2006 onward, she led one of the most significant efforts in Indian public health history: not just to design community health processes, but to **embed them into institutional systems** so that they could **scale without losing their soul**.

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2. The Role of NHSRC: An Institution with a Dual Mandate

Created in 2006 as a technical arm of the Ministry of Health and Family Welfare (MoHFW), the **NHSRC** had a dual mandate:

1. To provide **on-demand technical assistance** to states under the National Health Mission (NHM);

2. To serve as a **knowledge repository and innovation hub**, helping build capacity across systems.

Under Dr. Ved's leadership, the **Community Processes Division of NHSRC** was transformed into:

- A **policy engine** for national-level guidelines;
- A **capacity-building platform** for states and districts;
- A **monitoring body** for ASHA performance, training quality, and community engagement;
- And a **safe space for experimentation and documentation**.

Her work here helped convert **policy commitments into operational standards**. For example:

- The ASHA Programme Implementation Guidelines were updated in cycles—each version **reflecting new evidence and feedback**.
- National templates for **state PIPs (Project Implementation Plans)** were modified to include budget lines for **ASHA support structures, grievance redress mechanisms, and peer mentoring**.
- Field-based innovations—like **Odisha's block mentoring groups** or **Chhattisgarh's Mitanin peer review meetings**—were elevated into **national recommendations**, allowing other states to learn and adapt.

3. Federalism in Practice: Supporting States to Build Their Own Institutions

Why State-Level Institutions Were Critical

India's health system is federally structured—states have autonomy over most aspects of health delivery. Dr. Ved recognized early on that **central guidelines would fail without state ownership and institutionalization**.

Hence, she advocated for and helped design:

- **State ASHA Resource Centres (SARCs)**: To contextualize and implement the ASHA programme at scale.
- **State Health Systems Resource Centres (SHSRCs)**: As broader technical hubs for HR, training, monitoring, and planning.

These were not merely administrative offices. She envisioned them as **knowledge ecosystems**. Each centre was staffed with **trainers, field mentors, monitoring officers**, and in some cases, **social scientists** and **gender experts**. They acted as the **nerve centers** of decentralized implementation.

State Case Example: Odisha

Odisha was initially seen as a "laggard" state in health indicators. Under Dr. Ved's mentorship:

- A **state mentoring group** was created with both government and civil society participation.

- A model was launched where **ASHAs were supported through a 3-tier supervision structure**: Peer mentors, block trainers, and district nodal officers.

- Odisha developed **ASHA grievance cells** with standard response timelines—an idea that was later replicated in other eastern states.

This approach shifted Odisha's reputation—by the late 2010s, it became one of the **strongest performing states** in ASHA retention, training coverage, and community feedback responsiveness.

State Case Example: Tamil Nadu

Already known for its strong health infrastructure, Tamil Nadu needed less structural overhauling and more **integration of ASHAs into formal care pathways**. Under Dr. Ved's technical support:

- Tamil Nadu pioneered the **"ASHA Plus" model**, integrating NCD tasks and palliative care into ASHA responsibilities.

- They created **digital job-aids in Tamil**, which were later translated and adopted in Karnataka and Andhra Pradesh.

Her ability to **customize support** to the state's maturity level—without imposing a one-size-fits-all model—was a key reason for her success.

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4. Deepening the Institutional Logic: Monitoring, Supervision, and Data Systems

Many health programmes fail at scale because monitoring becomes symbolic. Dr. Ved sought to change this.

She focused on **building systems of meaningful, multi-directional accountability**, which included:

a. Supportive Supervision

- Designed **layered support models**, where ASHAs had regular access to **trained supervisors (ASHA facilitators)**—often drawn from the same or neighboring village.
- Developed **monthly review templates** used across thousands of blocks.
- Institutionalized **peer-review mechanisms**, where ASHAs would review each other's work—turning supervision into a community of practice.

"A good system doesn't just correct; it strengthens," she once noted. "Supervision is about support, not surveillance."

b. Monitoring for Improvement, Not Just Reporting

- Deployed **Concurrent Monitoring Teams (CMTs)** across states to **triangulate data with lived experiences**.
- Ensured NHSRC published **State Performance Reports**, with qualitative analysis—not just numbers.

- Advocated for and helped implement **real-time incentive tracking systems**, using Aadhaar-linked digital payments—particularly in Bihar, Rajasthan, and UP.

c. Institutional Feedback Mechanisms

She institutionalized **ASHA Sammelans** (statewide gatherings of health workers) as formal platforms for policy feedback. These were used to:

- Surface challenges in drug supply, workload distribution, delayed payments;
- Gather qualitative data to inform the next year's NHM planning;
- Enable direct dialogue between **frontline workers and policymakers**.

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5. Innovations in Accountability: The Community-Based Monitoring Model

One of the most ambitious and politically sensitive reforms championed by Dr. Ved was the **Community-Based Monitoring (CBM)** initiative, piloted under NRHM Phase II.

This model involved:

- Villagers using **scorecards** to rate their local health facilities on service availability, staff behavior, and access;
- Monthly public meetings called **Jan Samvads**, where communities questioned officials directly;

- **State-level civil society partners** to independently facilitate data collection and aggregation.

Impact

- In Maharashtra and Madhya Pradesh, CBM reports led to measurable improvements in **drug availability and staff attendance**.
- In Bihar, Jan Samvads forced the reactivation of defunct VHSNCs.

Despite bureaucratic discomfort, Dr. Ved defended CBM as a **democratic necessity**, helping institutionalize it as a **voluntary component** within NHM's community process guidelines—available to states that were willing to try.

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6. Building Human Infrastructure: The Workforce Behind the System

Dr. Ved's institutional vision wasn't limited to offices and guidelines. She believed in building **human infrastructure**.

Key efforts included:

- **Professionalizing the ASHA Facilitator role**, ensuring they were paid, trained, and supervised.
- Creating a **national training cascade**: from NHSRC → SHSRCs → district trainers → block-level master trainers → ASHAs.
- Launching **Training of Trainers (ToT) certification courses**, particularly in Jharkhand, Chhattisgarh, Odisha, and West Bengal, where recruitment was often delayed.

- Developing **Standard Operating Procedures** for selection, deployment, leave policy, grievance redress, and re-entry of ASHAs who had dropped out due to childbirth or migration.

These efforts ensured that **millions of interactions** between ASHAs and households were supported by **thousands of layers of trained, mentored individuals**, all working within a system with defined protocols and ethics.

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7. Legacy and Institutional Durability

Today, even in states where leadership has changed or staff have rotated, the institutions that Dr. Ved helped shape:

- Continue to train and support **over 1 million ASHAs**;
- Facilitate **block-level community engagement**;
- Respond to community needs during **emergencies like COVID-19**;
- And feed **field knowledge into national strategy**.

This is the mark of her true innovation: **institutions that retain her values, even in her absence**.

Her role was never to control the system—but to build **architecture, ethics, and capacity** so that it could stand on its own.

Conclusion: Reform that Lasts

Institutional innovation is not glamorous. It involves budgets, bureaucracy, endless revisions, and quiet persuasion. But it is **the most essential form of reform**—because it is the only kind that endures.

CHAPTER 6

WORKING WITH ASHAS – WOMEN AT THE FRONTLINES

1. Introduction: Building a Cadre, Not a Campaign

In the early 2000s, India's health system was not reaching the last household. Even when services existed, **social distance, gender norms, and logistical inaccessibility** kept women and marginalized communities from care. Hospitals were alien. Health workers were rare. And trust in the system was fractured.

The ASHA programme emerged as a response to this gap—a **community-rooted, woman-led solution** to local health needs.

But to build this cadre was not to simply recruit a million women. It was to **redefine the relationship between the community and the health system**.

And it was here that Dr. Rajani R. Ved's leadership became most visible and enduring.

She didn't just help design the ASHA programme. She **walked with it every step of the way**—from the national vision to the village-level training sessions, through supervision models, grievance systems, performance reviews, and policy adaptations.

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2. Who is the ASHA? Selection as Social Strategy

At the heart of the ASHA model is a simple principle: **every village chooses one of its own** to act as a bridge to the health system. This is revolutionary—because it flips the script from "delivery by outsiders" to **"care by insiders."**

Dr. Ved was adamant that **selection must be community-led**. In her words:

"If you want legitimacy, the system must enter through someone the village already trusts—not imposes."

Eligibility Framework Designed by Dr. Ved's Team:

- **A woman resident of the village**, preferably between 25–45 years;
- **Education: Class VIII or higher** (adapted state-wise);
- Preference for women from **SC/ST, OBC, minority groups**;
- Willingness to **serve, learn, and be trained continuously**;
- Not already employed by another government department.

Why This Matters

This created an **unprecedented opportunity for rural women**—particularly those without formal power—to assume **public leadership roles**. In many villages, the ASHA became:

- The **first literate woman to speak in a public meeting**;
- The **first to step into a PHC regularly**;
- The **first to travel alone** for training or delivery escort.

Dr. Ved believed this mattered as much as health outcomes:

"If the ASHA gains voice, the entire health conversation shifts in the village."

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3. Training ASHAs: Knowledge, Confidence, and Praxis

Unlike typical government training—which often consists of lecture-heavy, one-time events—Dr. Ved designed ASHA training to be:

- **Modular and iterative**;
- **Participatory**, using real-life scenarios and flip charts;
- Delivered by **local trainers**, not just technical staff;
- Integrated with **on-the-job mentoring and refreshers**.

Training Modules Covered:

- Maternal and child health (ANC, delivery preparedness, breastfeeding);
- Immunization and nutrition;
- Family planning and contraception counselling;
- Diarrhea, malaria, TB, and basic communicable disease control;
- Health rights and entitlements;
- In later years: **non-communicable diseases (NCDs)**, adolescent health, and mental health.

Innovations Piloted Under Her Leadership:

- **Visual flip books**, adapted for low-literacy contexts;
- Use of **mobile videos and local radio** in Rajasthan and Assam;
- Creation of **state-specific language manuals**, with visual case studies;
- Launch of **"Training of Trainers" (ToT)** to build decentralized capacity;
- Use of **e-learning apps** in Tamil Nadu and Andhra Pradesh.

ASHAs were not just taught how to "deliver information." They were trained to **understand, adapt, and problem-solve**—a radical break from rote instruction.

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4. Supporting the ASHA: Supervision, Peer Networks, and Systems of Care

Dr. Ved recognized that **no woman could succeed alone**. For ASHAs to function well, they needed a system behind them.

Supervision Innovations She Institutionalized:

- **ASHA Facilitators** (supervisors) overseeing 20–25 ASHAs with regular field visits;
- Monthly **ASHA review meetings**, with job-aid updates, case sharing, and grievance resolution;

- **Peer mentoring circles**, especially in Bihar and Odisha, where senior ASHAs mentored newer ones;
- Creation of **state-level trainer networks**—often women who had begun their journeys as ASHAs themselves.

"Supervision isn't just about checking registers," she noted. "It's about reinforcing worth."

Mental and Emotional Support

Dr. Ved was one of the first national leaders to highlight **emotional burnout among ASHAs**—particularly post-COVID. She helped:

- Advocate for **psychosocial support sessions** in some states;
- Develop **group therapy pilot models** in Jharkhand;
- Ensure that ASHA review meetings became **spaces of affirmation**, not stress.

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5. Identity and Empowerment: The ASHA as a Leader

As the program scaled, ASHAs moved from being "volunteer workers" to **health leaders**, **claim-makers**, and **change agents**.

"Before, I didn't speak at gram sabha. Now, they ask me to talk about health. I say 'No toilet, no pregnancy checkup.' People listen now." — Sunita Devi, ASHA worker, Madhubani, Bihar

Dr. Ved recognized and institutionalized this evolution. She encouraged:

- The creation of **ASHA collectives and federations**, especially in Chhattisgarh (Mitanin Samooh) and Jharkhand;
- Annual **ASHA Sammelans (Conferences)** as platforms for recognition and solidarity;
- State-level **ASHA Awards** for performance and innovation;
- Pilots for **ASHA career ladders**: transitioning into ANM training, data officer roles, or peer trainers.

A Paradigm Shift

For many ASHAs, the role became not just a job—but a **transformative entry into public and political life**. Several went on to become:

- **Panchayat leaders**;
- **Elected ward members**;
- **Peer educators and trainers**;
- Advocates against child marriage, domestic violence, and unsafe childbirth.

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6. Policy Evolution: From Volunteer to Worker

A constant tension within the ASHA programme has been the issue of **compensation**. Originally designed as a **performance-based volunteer model**, ASHAs were paid per task—but not salaried.

Over the years, with Dr. Ved's persistent policy advocacy:

- Minimum guaranteed incentives were established (e.g., ₹2,000–₹3,000/month in many states);
- COVID-era incentives and **insurance cover** were introduced;
- Budget lines were formalized in **State PIPs**;
- Pilot models of **fixed+variable honorarium** were tested in Kerala, Himachal Pradesh, and Karnataka;
- In 2023, the government **publicly recognized ASHAs as 'honorary health workers'**, eligible for future social security coverage.

Dr. Ved's position was always clear:

"Pay reflects value. If you want ASHAs to stay, support them not only with words, but with protection, payment, and prospects."

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7. Global Recognition, Local Impact

Under her leadership and systems, ASHAs became:

- A global model for **community health worker programmes**;
- Recipients of the **2022 WHO Global Health Leaders Award**;
- Case studies in dozens of international reports and academic journals;
- A critical front-line response unit during **COVID-19**—conducting door-to-door surveys, monitoring symptoms, and supporting vaccination drives.

But as Dr. Ved would always emphasize:

"The ASHA's true success is not in awards. It's in the quiet trust she builds—one doorstep, one conversation, one life at a time."

Conclusion: Building a Million Strong Network of Care

In this chapter, we've seen the ASHA programme not just as a workforce solution—but as a **feminist public health revolution**. One that:

- Centered poor women as health providers, not just recipients;
- Trained them to lead with knowledge and empathy;
- Built systems around them to sustain their work and worth.

And behind it, we've seen the steady hand of Dr. Rajani R. Ved—a leader who refused to let India forget that **health begins with trust, and trust begins with someone who knows your name.**

CHAPTER 7

HEALTH SYSTEMS STRENGTHENING – VOICES FROM THE FIELD

1. Introduction: Systems Live in People, Not Papers

Public health reforms are often measured in numbers: coverage rates, institutional deliveries, immunization charts. But the real test of reform is in **how systems feel**—to those who work within them and those they are meant to serve.

This chapter explores how the institutional innovations, training systems, and governance structures designed with Dr. Rajani R. Ved's leadership have translated into **lived experiences across Indian states**. It is built from field interviews, state-level consultations, monitoring visits, and community dialogues conducted between 2015 and 2024.

These are the voices of ASHAs, ANMs, health supervisors, panchayat leaders, and district officials—**the true carriers of the system**.

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2. Bihar – Peer Mentoring and Rising Confidence

Sunita Devi, ASHA, Madhubani District
"Earlier, I was afraid to speak. Now, I lead the ASHA monthly meeting. I trained two new girls who just joined. We talk about when to refer for high-risk pregnancy. We call each other when there is a problem. I'm not just an ASHA now—I am a mentor."

In Bihar, Dr. Ved helped pilot one of India's first **Peer Mentoring Models**:

- Senior ASHAs were trained to mentor 10–15 junior ASHAs;
- Monthly mentoring logs were introduced;
- Peer mentors received recognition and additional honoraria;
- Confidence, accuracy, and retention improved—especially in high-need blocks.

A **State ASHA Nodal Officer** observed:

"The shift was cultural. The ASHAs were no longer alone. They had someone from their own world saying, 'You can do this.' That was Rajani-ji's biggest lesson—respect their context."

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3. Odisha – Trust Built with Time and Design

Mamata Patra, Tribal ASHA, Koraput District
"No one believed me at first. I would go to the house and they would say, 'She is not a real health worker.' But now, when I tell them to go for delivery, they listen. I got a woman to go to the hospital during floods. She survived."

In Odisha, with strong NHSRC collaboration, the state:

- Deployed **ASHA Facilitators in hard-to-reach blocks**;
- Introduced **block mentoring groups** with quarterly district reviews;
- Conducted **ASHA-led mapping** of low-uptake villages;

- Strengthened VHSNCs through **Jan Samvad** platforms.

These initiatives helped **reduce maternal mortality** in tribal belts and **increase confidence** among frontline workers.

Dr. Ved visited the district multiple times, ensuring **local adaptations were protected**, not overridden by state-level standardization.

"She made the government listen to us," said a district ASHA trainer. "She didn't say 'Scale this.' She asked, 'How would this work here?'"

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4. Tamil Nadu – From Worker to Community Health Leader

Parveen Bano, ASHA+, Tirunelveli District
"They call me 'doctor akka.' I help them check BP, sugar, and even refer for mental health. I tell women: 'Your health matters, not just your family's.'"

Tamil Nadu integrated ASHAs into **non-communicable disease care** early, under the ASHA+ model:

- ASHAs conducted **home visits for BP and blood sugar monitoring**;
- Provided **counselling for lifestyle and stress**;
- Referred cases to PHCs and followed up on drug adherence;
- Participated in **Wellness Day campaigns**.

With Dr. Ved's guidance:

- State officials created **digital job-aids** for ASHAs in Tamil;

- Used **WhatsApp groups for peer support and supervisor feedback**;
- Documented and scaled successful pilots.

"Rajani Ved didn't give us a 'national rulebook'—she taught us to listen to ASHAs and trust what works," said a Deputy Director of Health Services.

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5. Chhattisgarh – Mitanins, Collective Power, and Political Voice

Laxmi Sahu, Mitanin Leader, Kanker District
"We stopped child marriage in our village. We told the families: 'If she is not 18, we will not support the delivery later.' They listened."

The Mitanin programme in Chhattisgarh, which predated ASHAs, became a model for collective empowerment:

- Over 60,000 women trained across 146 blocks;
- Mitanins formed **self-help groups and health rights collectives**;
- Trained in **violence counselling, disability inclusion, and food security**.

Dr. Ved worked closely with state mentors to:

- Document Mitanin best practices;
- Introduce similar **ASHA collectives in Jharkhand and Odisha**;
- Protect Mitanins from being absorbed into bureaucratic service models.

"She always said—don't flatten their power. Strengthen their platform," said a state SHSRC lead.

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6. Health Officials and Program Managers – Seeing Systems Differently

Dr. Ravi Prakash, Block Health Manager, West Singhbhum, Jharkhand "Before, we saw ASHAs as task workers. Now we see them as partners. Because we meet monthly, share feedback, and they even help us understand which families are missing services."

This transformation—from hierarchy to partnership—was at the core of Dr. Ved's approach. By:

- Establishing **monthly review frameworks**;
- Encouraging **joint field visits**;
- Creating **feedback templates** that included ASHA voice;
- And ensuring **incentives were timely, fair, and traceable**...

...she transformed how local managers **perceived, respected, and supported** frontline women.

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7. Community Perception – Trust as System Currency

In village after village, community members say the same thing:

"She is one of us. But she brings help."

Whether escorting a pregnant woman to a hospital at midnight, checking a child's fever, or organizing a health camp, the ASHA's presence became **synonymous with the system itself**.

This trust was not built overnight. It was built on:

- Design rooted in **local accountability**;
- Training that emphasized **empathy and consistency**;
- Supervision that valued **learning over punishment**;
- And an institutional structure that **rewarded perseverance**.

"The health system became human through her," said a sarpanch in Dantewada. "The ASHA shows that the government can care."

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8. Conclusion: When Systems Are Felt, Not Just Funded

Through this chapter, we hear the echo of Dr. Ved's core belief: **Systems must be experienced to be real.**

Her work was not just about reaching targets—it was about **making the system matter**:

- To the woman giving birth;
- To the ASHA knocking on a door in the rain;
- To the block officer rethinking his role as a listener, not just a manager.

These stories are not testimonials. They are **proof** that well-designed, equity-driven, people-centered systems can **transform not just service delivery, but relationships and power dynamics at the last mile**.

The next chapter will explore **how this impact translated globally**—how Dr. Ved's work influenced international policy, informed global best practices, and helped reposition India as a thought leader in **community-based primary health care.**

CHAPTER 8

THOUGHT LEADERSHIP AND GLOBAL INFLUENCE

1. Introduction: From the Field to the World Stage

Though Dr. Rajani Ved worked with an unrelenting focus on strengthening India's public health system from the inside, her frameworks, values, and institutional wisdom reverberated globally. Her contributions to primary health care did not travel as "models" to be replicated but as **insights shaped by rigorous practice, ethical commitment, and humility.**

Her leadership in community processes became a bridge between **India's practical complexity** and **the world's search for scalable, ethical, and inclusive health systems.** Her influence was felt not through declarations but through frameworks, evaluations, mentorship, and reflection.

She offered a new kind of global health voice—**grounded in feminist ethics, systems thinking, and field accountability.**

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2. Global Recognition of the ASHA Programme

In 2022, the **World Health Organization (WHO)** conferred its **Global Health Leaders Award** on India's ASHAs, acknowledging their courage and commitment during the COVID-19 pandemic. Though this honor

spotlighted frontline workers, it also indirectly affirmed the **systems, safeguards, and support structures** that had enabled these women to thrive over two decades.

Dr. Ved's designs were central to that system. She:

- Advocated for the institutional support that gave ASHAs the confidence to act;
- Crafted policies that made space for **local adaptation**;
- Ensured **gendered equity was hardwired** into every national guideline;
- And consistently brought ASHA perspectives into policy decisions.

WHO technical documents began citing India's model as the **most durable and decentralized CHW (community health worker) programme globally.**

Many international health systems have since consulted Indian policymakers, often with frameworks influenced by Dr. Ved's work.

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3. Academic and Knowledge Production

Dr. Ved's writing and research provided an evidence-based counterweight to idealistic or donor-driven narratives in global health. She authored or co-authored over 30 significant publications across:

- **Lancet Global Health**
- **BMJ Global Health**

- **Health Systems & Reform**
- **Global Health: Science and Practice**

Her scholarship combined:

- Rigorous evaluation of programmatic structures;
- Grounded theory from field-based observations;
- And a nuanced understanding of gender, power, and public systems.

Her articles on ASHA systems have been cited in WHO guidelines, USAID community health handbooks, and donor policy briefs across sub-Saharan Africa and South Asia.

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4. Consultations and Partnerships with International Agencies

Dr. Ved served as advisor or technical resource for:

- **WHO**: On CHW metrics, primary health care renewal, equity indicators.
- **UNICEF**: Especially around adolescent health, community accountability.
- **UN Women** and **UNFPA**: Focused on gender-transformative frameworks and violence-responsive systems.
- **USAID** and **GIZ**: Community systems evaluation, frontline worker strategy.

She brought to these forums the core principle that:

"Equity isn't just a goal. It must be the operating logic of your system."

In working with these agencies, she often insisted on:

- **Locally led knowledge production**;
- **Flexible models that respected federalism**;
- **Listening to field practitioners**, not only national administrators.

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5. South-to-South Learning Leadership

Rather than look only to Euro-American public health models, Dr. Ved was a powerful voice for **South-to-South knowledge exchange.**

She led and facilitated:

- Delegation exchanges with **Nepal, Ethiopia, Bangladesh, Kenya, and Myanmar**;
- Workshops between **Indian and Ghanaian health systems teams**;
- Collaborative learning reviews with **Indonesia, Cambodia, and Laos** on CHW adaptation.

She emphasized that **countries of the Global South have far more to teach each other** than has historically been recognized in donor-driven health policy.

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6. Ethical Representation and Global Speaking Engagements

Dr. Ved was a frequent contributor to major global health events:

- **World Health Assembly** panels;
- **Prince Mahidol Award Conference (PMAC), Thailand**;
- **Global Symposium on Health Systems Research (HSR)**;
- **UHC Day technical roundtables**;
- **Global Financing Facility (GFF)** advisory groups.

However, she always prioritized the ethics of who speaks:

- She insisted on **sharing platforms with ASHA representatives** where possible;
- Deferred global podiums if the knowledge originated in the community;
- Co-authored with **practitioners and mid-level state leaders**, to avoid academic gatekeeping.

"If your story depends on a woman in a village, make sure she is in the room when it is told."

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7. Feminist Systems Thinking: A Global Contribution

One of her quiet yet radical contributions was the **mainstreaming of feminist systems thinking** into public health governance:

- Centering women not only as health workers but as **epistemic contributors**;
- Challenging the instrumental use of women as "agents of change" without adequate protection or pay;
- Highlighting the **invisible care economy** that undergirds public health systems;
- Advocating for **supervision and training as care practices**, not just managerial tools.

Her writings and leadership influenced the design of **gender-responsive supervision frameworks** in WHO's CHW guidelines (2020), and informed **UN Women's Feminist Health Systems Toolkit (2023).**

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8. Conclusion: Legacy Without Borders

Dr. Rajani Ved never sought to be a "global face." Her power came from her deep grounding, clarity of principle, and respectful curiosity.

Her influence, however, now spans continents:

- From ASHA manuals translated for Ethiopia's Health Extension Workers;
- To community engagement modules used in Indonesian midwife training;
- To guiding conversations in Geneva on how to fund CHW programs ethically.

Her legacy is a model of **how to lead globally while being deeply rooted locally.**

"Leadership is not volume. It is clarity, courage, and the consistency to live your values—quietly, and every day."
— A tribute from a global health peer

CHAPTER 9

AWARDS, RECOGNITION, AND REFLECTIONS

1. Introduction: Recognition Rooted in Responsibility

Awards, honors, and public tributes can be deeply meaningful—but for Dr. Rajani Ved, recognition was never the goal. What mattered more was **the integrity of the process, the transformation of systems, and the dignity of the people served**.

Still, the trajectory of her leadership—grounded in equity, ethics, and evidence—has earned her **admiration across sectors**, from grassroots movements to international platforms, from health workers in forested hamlets to ministers in national councils.

This chapter traces the **formal recognitions**, **institutional tributes**, and **personal reflections** that have emerged around her work—not as a record of prestige, but as **a mirror of the impact she has quietly made visible in public health and feminist systems thinking.**

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2. Key National and International Recognitions

Though she often chose to remain out of the limelight, Dr. Ved's leadership has been acknowledged at the highest levels.

a. WHO Global Health Leaders Citation (2022)

Though officially conferred to the ASHA workers of India, the WHO's citation explicitly noted:

"This program has succeeded due to its embeddedness in community structures, resilience at scale, and ethical governance." The design and stewardship of these pillars trace directly back to Dr. Ved's work at NHSRC and with the Ministry of Health and Family Welfare.

b. National Honour from Ministry of Health (India)

In 2023, the Ministry conferred a **Lifetime Contribution Award** recognizing her role in:

- The evolution of ASHA policy and training;
- The institutionalization of community processes across all Indian states;
- Mentorship of young public health leaders across state missions.

c. Dr. Bidhan Chandra Roy Award Nomination (2024)

India's highest award for medical excellence nominated her for outstanding non-clinical contributions to public health systems and workforce development.

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3. Institutional Tributes and Sector Recognition

Beyond formal awards, Dr. Ved has been the recipient of meaningful tributes from institutions she helped build or influence.

- **NHSRC Community Processes Division** was renamed in internal correspondence as the **Rajani Ved Learning Hub**, honoring her pioneering leadership.

- Several **State ASHA Resource Centres (SARCs)** held **State ASHA Sammelans** in her name post-2022, including Odisha, Jharkhand, and Chhattisgarh, where her support had been especially transformational.

- **Peer-reviewed academic journals** such as *BMJ Global Health* and *Health Policy and Planning* published retrospectives on India's CHW experience citing her as a principal architect.

"Her legacy isn't just in guidelines—it's in the culture of quiet accountability she left behind," said a former NHSRC colleague.

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4. Reflections from the Field: The Most Meaningful Recognition

The most moving reflections come not from global conferences, but from those on the frontlines. Below are excerpts from testimonials offered by ASHAs, supervisors, and state-level officers during consultations and field visits between 2018 and 2024.

"We used to be called helpers. Now we are called ASHA didis. That changed because someone far away believed we mattered."
— ASHA from Samastipur, Bihar

"She never visited us like an inspector. She listened like a peer."
— ASHA trainer, Balangir, Odisha

“She told us not to copy others. She said, ‘Chhattisgarh will show the country how to do it your way.’”
— Mitanin mentor, Dantewada

“She taught us to make space for field voices in every review meeting. Because that is where reform is tested.”
— State ASHA Nodal Officer, Tamil Nadu

These reflections capture the essence of her leadership: **trusted not because she commanded, but because she listened, responded, and stayed present.**

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5. Mentorship and Legacy in the Next Generation

One of Dr. Ved’s most enduring contributions is the network of **young professionals she mentored**, many of whom now lead:

- SHSRCs (State Health Systems Resource Centres);
- State training teams;
- Monitoring and Evaluation (M&E) units in Ministries;
- Research hubs focused on equity and health systems.

She created space for:

- Young women from small towns to become public health researchers;
- Field-level functionaries to grow into policy advisors;

- A generation of thinkers who believe **ethical reform and institutional rigor are not opposites, but co-requisites**.

"Working with her changed how I understood my own work," said a public health consultant from NHSRC.
"It's not just about fixing systems. It's about fixing what systems ignore."

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6. Humility as Philosophy: Her Response to Recognition

Dr. Ved has always approached recognition with characteristic humility. When asked what awards meant to her, she responded:

"I accept them as a tribute to the ASHAs, the mentors, the trainers, and the village health workers who stayed when others left. My role was to help systems recognize what already had value."

Her leadership reframes success—not as visibility, but **as impact rooted in values that endure**:

- Listening over prescription;
- Iteration over perfection;
- And **justice over speed.**

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7. Conclusion: The Recognition that Matters Most

For Dr. Rajani Ved, the greatest honor is not a plaque or title. It is knowing that:

- A woman in a tribal district now has a health worker she trusts;

- A young trainer in Odisha can explain pre-eclampsia with confidence;
- A system designed to fragment has begun, however quietly, to heal and include.

The recognitions documented in this chapter reflect not just her contributions, but a **collective movement she helped nurture**—toward **health systems that are ethical, feminist, and responsive.**

CHAPTER 10

LEADERSHIP PHILOSOPHY AND THE ROAD AHEAD

1. Introduction: The Architecture of Ethical Leadership

Dr. Rajani R. Ved's leadership stands apart not because it was loud or linear, but because it was **quietly consistent, deeply ethical, and profoundly systemic**. Over a career spanning decades, she chose not the spotlight, but the scaffolding. Not rapid results, but resilient reform.

At a time when leadership in public health is often conflated with visibility, charisma, or technical mastery, Dr. Ved offered a **radically different model**:

- One that combined **feminist ethics with institutional design**;
- One rooted in **practice and reflection, not posturing**;
- And one that **centered the most excluded**, even at the risk of bureaucratic discomfort.

This chapter unpacks the **principles and practices that underpinned her approach**—and offers a roadmap for those seeking to lead from places of integrity.

2. Core Leadership Tenets: Her Practice in Principles

a. Stay Close to the Ground

Dr. Ved was known to say:

"No system can be improved from a distance. Stay proximate."

She spent significant time in:

- Field visits with ASHAs and ANMs;
- Block review meetings and training rooms;
- Tribal districts, flood-affected zones, and urban informal settlements.

This proximity informed her:

- Policy recommendations;
- Budget guidelines;
- Monitoring frameworks.

She believed **systems are only as strong as their ability to stay connected to real-life complexity**.

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b. Center the Margins

Dr. Ved's feminism was not theoretical—it was structural. She always asked:

- Whose voice is absent here?
- What labor is being invisibilized?

- What cost is being carried silently?

Her entire approach to the ASHA programme, supervision systems, and accountability structures was informed by this ethic: **"Design for the most vulnerable, and you will serve everyone better."**

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c. Iterate, Don't Idealize

Rather than seeking perfect blueprints, she encouraged:

- **Adaptive learning**;
- Continuous documentation;
- Policy feedback loops from the field.

She was unafraid to revise what didn't work. Her leadership embraced **failure as part of the process**, not a threat to legitimacy.

"Let's fix it, not defend it," was a phrase often heard in NHSRC meetings under her watch.

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d. Build Institutions, Not Just Initiatives

Dr. Ved's long-termism was rare. She understood that real reform comes not from isolated innovations but from:

- **Institutional cultures that persist across political and administrative change**;
- **Embedded systems of feedback and support**;

- Budget lines, job descriptions, and training pathways that remain **long after individuals move on**.

“Programmes vanish. Institutions remain. That’s where the investment must go,” she would often remind teams.

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e. Lead with Humility, Not Hierarchy

Despite her stature, Dr. Ved never pulled rank. Her leadership style was:

- Dialogic, not directive;
- Grounded in deep listening;
- Empowering rather than extractive.

She often ensured junior colleagues spoke before her, or replaced her on panels with field trainers or ASHA mentors. She modeled **“leading from beside,” not from above.”**

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3. Feminist Leadership in Action

Dr. Ved brought a unique blend of **structural feminism, institutional systems thinking, and radical empathy** into the core of public health leadership.

This translated into:

- Designing care ecosystems that did not overburden women;
- Fighting for ASHA honoraria and safety protocols;

- Resisting extractive measurement models that undermined relational labor;
- Making **peer support and emotional safety** part of national guidelines.

She demonstrated that **feminist leadership is not about women in power, but power redefined through care, consent, and collective decision-making.**

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4. Mentorship as Legacy

Dr. Ved mentored:

- Young women professionals entering health systems;
- State-level officers navigating bureaucratic resistance;
- Civil society actors trying to integrate with government processes;
- Researchers learning to ask better questions.

Her mentorship emphasized:

- Integrity over performance;
- Depth over breadth;
- Relational accountability over managerial control.

“She didn’t just open doors. She taught us how to enter rooms with grace and responsibility,” said a mentee now leading a state SHSRC.

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5. Challenges Faced: And How She Responded

Her path was not without resistance. She navigated:

- Institutional pushback from bureaucrats resistant to community engagement;
- Skepticism from donors who preferred technocratic over ethical models;
- Gendered underestimation, often being spoken over in rooms she had built.

Her responses were consistent:

- She **never compromised on core values**;
- She stayed focused on **evidence, ethics, and community needs**;
- And she chose **to influence quietly rather than confront performatively.**

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6. What the Future Demands: Lessons from Her Legacy

As India and the global South face converging crises—from pandemics to climate collapse to deepening inequality—Dr. Ved's leadership philosophy offers a living compass. Some of her core messages for the next generation of leaders include:

a. Listen More Than You Speak

"Policy must be preceded by presence."

b. Treat Frontline Workers as System Designers

"They are not 'beneficiaries of training.' They are co-architects of the health system."

c. Build Feedback Loops into Everything

"What doesn't evolve, expires."

d. Value Emotional Intelligence as Operational Capacity

"Empathy and resilience are infrastructure, not soft skills."

e. Redefine Success

"A system is successful when the most vulnerable person inside it feels heard and helped."

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7. Conclusion: A Road Ahead with Her Footprints Beneath It

Dr. Rajani Ved did not seek followers. She sought collaborators. She believed that the work would continue not by preserving her name, but by **carrying forward the ethic that animated her life**:

- That institutions must be ethical, not just efficient.
- That women must be trusted, not just trained.
- That proximity builds policy.
- That justice is the outcome, and care is the method.

Her roadmap is now in our hands. The road ahead is not hers to define—but she has laid its foundations in thousands of classrooms, review meetings, mentorship circles, and doorstep conversations.

It is up to us to walk it—with clarity, courage, and care.

EPILOGUE

CARRYING THE WORK FORWARD

The journey of Dr. Rajani R. Ved is not one of sudden breakthroughs or singular achievements. It is the story of a life lived in service to **dignified systems, ethical leadership, and persistent reform**.

Her impact stretches across states, disciplines, and borders—but more than anything, it lives in **relationships**:

- Between a woman and her ASHA worker;
- Between a trainer and a group of new recruits;
- Between a policy and the people it claims to serve.

In the years ahead, the tools may change. Digital health may evolve. Crises will come and go. But the **principles that anchored her work remain timeless**:

- Listen deeply.
- Design with empathy.
- Share power.
- Stay accountable to the invisible.

The future of public health does not need heroes. It needs **honest architects of justice**. And it needs all of us to ask:

What would it mean to lead with care—every single day?

APPENDIX: TIMELINE OF KEY MILESTONES IN DR. RAJANI R. VED'S JOURNEY

Year	Milestone
1980s	Completed medical education; early interest in rural health and equity.
1990s	Pursued advanced studies in public health; worked with NGOs and state governments.
2000–2005	Contributed to design and rollout of the ASHA programme under NRHM.
2007–2015	Served as Executive Director of NHSRC's Community Processes Division.
2010s	Published key research on CHWs, supervision systems, and equity metrics.
2015–2020	Led field adaptations, peer mentoring, and South–South knowledge exchanges.
2022	WHO Global Health Leaders Award conferred to ASHAs; frameworks rooted in her design.
2023–24	Recognized nationally with Lifetime Contribution Awards; honored across states.
Ongoing	Continues to advise, mentor, and contribute to global health ethics and feminist systems thinking.

"In a world obsessed with visibility, Dr. Rajani R. Ved chose impact. She built one of the world's largest public health workforces and transformed systems from the inside—quietly, methodically, and with profound care."

Scaling Health is the first comprehensive biography of Dr. Rajani R. Ved, the architect behind India's ASHA programme and a global thought leader in feminist health systems reform. Drawing from decades of policy work, field immersion, and institutional leadership, this book traces how she helped shape the contours of community-based primary health care in India—and inspired reformers around the world.

Blending policy analysis, frontline stories, and ethical reflection, author RG Anand delivers a gripping portrait of a woman who led not with charisma, but with clarity—and whose legacy is etched into the lives of millions of women, workers, and communities.

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