

CAHI

Community Action for Health

Experiences, Learnings and Challenges



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ACKNOWLEDGEMENTS

This monograph is a resource, which we hope will be useful for policy makers, implementing agencies, researchers and academics. It captures the collective work of many individuals and organisations.

First, we sincerely thank Mr C K Mishra, Additional Secretary and Mission Director, National Health Mission, Mr Manoj Jhalani, Joint Secretary, Policy, and Ms Limatula Yaden, Director, National Health Mission, Ministry of Health and Family Welfare, for their continued support and guidance on the implementation of Community Action for Health. A special thanks to the AGCA members for leading the processes to strengthen community action implementation under the National Health Mission.

We thank Dr B Subha Sri for the extensive field visits and research she undertook to put together the monograph.

We acknowledge the contributions of Dr Rajani Ved, Advisor, Community Processes, National Health Systems Resource Centre in guiding the study. We are grateful to Dr J P Mishra and Mr Sameer Garg, State Health Resource Centre, Chhattisgarh, Dr Renu Khanna, SAHAJ, Dr Thelma Narayan and Dr Rakhal Gaitonde, SOCHARA, and Dr Meena Nair, Public Affairs Centre for contributing to the understanding of the different models and facilitating Dr Subha Sri's field visits.

Many officials of the health department, health care providers, project implementers, Panchayati Raj representatives and community members shared their experiences of community participation and action and our thanks to all of them.

We are grateful to the John D and Catherine T MacArthur Foundation, and its Deputy Director-India, Ms Dipa Nag Chowdhury, for funding the study.



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LIST OF ACRONYMS

AGCA	Advisory Group on Community Action	NGO	Non Government Organization
ASHA	Accredited Social Health Activist	NHM	National Health Mission
ANM	Auxiliary Nurse Midwife	NRHM	National Rural Health Mission
BBMP	Bruhat Bengaluru Mahanagara Palike	NMR	Neonatal Mortality Rate
BPMC	Block Planning and Monitoring Committee	PAC	Public Affairs Centre
CAH	Community Action for Health	PDS	Public Distribution System
CBPM	Community Based Planning and Monitoring	PFI	Population Foundation of India
CLICS	Community-Led Initiatives for Child Survival	PHC	Primary Health Centre
DPMC	District Planning and Monitoring Committee	PHMIS	Peoples Health Management Information System
FRHS	Foundation for Research in Health Systems	PIP	Program Implementation Plan
GOI	Government of India	PRI	Panchayati Raj Institution
HLEG	High Level Expert Group	RKS	Rogi Kalyan Samiti
ICDS	Integrated Child Development Services	SAHAJ	Society for Health Alternatives
JAA	Jan Aarogya Andolan	SC	Scheduled Caste
MDG	Millennium Development Goals	SHC	Sub-Health Centre
MGIMS	Mahatma Gandhi Institute of Medical Sciences	SHRC	State Health Resource Centre
MHMC	Maternity Home Monitoring Committee	SOCHARA	Society for Community Health Awareness, Research and Action
MLA	Member of Legislative Assembly	SPAD	Society for People's Action for Development
MMR	Maternal Mortality Ratio	ST	Scheduled Tribe
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act	VCC	Village Coordination Committee
MOIC	Medical Officer InCharge	VHN	Village Health Nurse
MSAM	Mahila Swasthya Adhikar Manch	VHSNC	Village Health, Sanitation and Nutrition Committee
		VHSND	Village Health, Sanitation and Nutrition Day
		VPMC	Village Planning and Monitoring Committee

EXECUTIVE SUMMARY

Communitization of the health system has been defined as one of the five pillars of the National Rural Health Mission (NRHM). The two key instruments for communitization under the NRHM are the ASHA programme and the Village Health, Sanitation and Nutrition Committees (VHSNCs). After a pilot programme to strengthen the village committees and facilitating community action, the communitization process has been institutionalized in several states now promoting community participation and action as part of their Annual State Program Implementation Plans (PIPs).

This review of various experiences of community action for health in India and globally has been undertaken so as to use the learnings and challenges to inform future policy and programmes. The review draws from field visits to five different projects implementing community action programmes/projects in health across the country. In addition, a literature review was done on community participation in health experiences in India and globally.

In the review, a description of the various aspects of a community participation programme are presented along with a brief analysis of what seems to work and why, under the following headings:

1. Structures for community participation
2. Processes for community participation
3. Role of the context in community participation
4. Outcomes of community participation

Finally, a section on learnings and challenges drawn from these experiences, and a possible way forward to up-scale community participation and action efforts is included.

Some of the key recommendations from this review for policy and programme are:

Policy-level recommendations

- Community participation cannot be effective if restricted to the health sector alone. It needs to be broadened to other social sector issues like education, Right to Food, etc.
- Long-term commitment and investment in the processes of community participation is necessary for it to truly result in outcomes.
- The committees for community participation should be formally recognized through a law or through an executive order in order to give them legitimacy.
- The design of the planning process at the district level must be adapted to provide adequate space for village and block level plans to be incorporated so as to ensure bottom up planning.
- Finances must be devolved to the Gram Panchayat level to truly foster community participation and bottom up planning.
- Concomitant investments in health systems strengthening need to be made alongside investments in community participation.

Programme recommendations

- The VHSNC's role needs to be broadened to include other inter-sectoral issues related to health. In urban areas, civic entitlements and social determinants of health like sanitation and water must be included in community participation efforts. Operational mechanisms need to be set up to put this in practice.
- In order to achieve maximum inclusiveness and representativeness, VHSNC members must be democratically elected. In addition, places must be reserved for members of marginalized communities on these committees. Adequate support must be provided to marginalized communities to overcome difficulties in participating effectively, including travel and efforts to build their capacities.
- In urban areas, establishment of basti-level committees which then find representation in ward -level committees will help encourage participation of people living in slums.
- In order to promote community participation beyond the village level, committees need to be created/strengthened at block and district levels. Clear linkages between these and the village-level committees and other institutions at the block and district level like the Rogi Kalyan Samiti and Panchayati Raj institutions need to be established. Block and district level committees need to be cross sectoral and must be under the leadership of an administrative authority at this level who can promote convergence across sectors.
- Capacity building of committee members is critical. This must be needs based and must include knowledge and perspective components. This must also include skills for use of tools for information collection, planning and action. Such capacity building efforts need to be provided on an ongoing basis.
- A clear and capable support structure that is independent of the formal health system should be established to provide facilitatory support to community participation programmes. In urban areas, an Urban Health Resource Centre with the support of civil society organizations may be established to provide such support.
- Mechanisms need to be put in place to collate information coming in from monitoring efforts by the community at the village / Panchayat level so that local action can be planned and implemented. In addition to this, clear mechanisms need to be put in place to collate this information at the block, district and state level and identify health system gaps causing the issues identified. The health system must be committed to act on these gaps. Grievance redressal mechanisms need to be instituted so as to make health systems responsive to the community's needs.
- Special efforts need to be made to engage with health providers to sensitize them to community participation.
- In order to widen the scope of community participation, planning at all levels of the health system including facility level planning must include community representatives.
- Suitable flexibility must be allowed in community participation programmes to allow for the effect of health system, socio cultural and political situation contexts on community participation.

CHAPTER 1

BACKGROUND AND INTRODUCTION

1.1. Background

The National Rural Health Mission (NRHM) was launched in 2005 as the flagship programme of the Government of India (GoI) to provide effective healthcare to the rural population of the country, undertaking architectural corrections of the health system, and improving access to equitable, affordable, accountable and effective primary health care. The Framework of Implementation detailing the vision, mission and strategies of the programme defined communitization of the health system as one of the five pillars of NRHM.(1)

Nearly three-fourth of the population of the country live in villages. This rural population is spread over more than 10 lakh habitations of which 60% have a population of less than 1000. If the Mission of Health for All is to succeed, the reform process would have to touch every village and every health facility. Clearly it would be possible only when the community is sufficiently empowered to take leadership in health matters. The Panchayati Raj institutions, right from the village to district level, would have to be given ownership of the public health delivery system in their respective jurisdiction.

The two key instruments towards communitization under the NRHM were –

- a) the implementation of a Community Health Worker (ASHA) programme, and
- b) the institutionalization of community action through the formation of Village Health, Sanitation and Nutrition Committees (VHSNC).

In addition, specific amounts of funds were provided as untied funds to the VHSNCs in order to promote some extent of financial devolution.(1)

In order to spearhead community action initiatives under the NRHM at the national level, the Ministry of Health and Family Welfare (MoHFW) of the Government of India constituted an Advisory Group on Community Action (AGCA) in 2005.(2) The AGCA comprises eminent public health professionals associated with major NGOs. The Population Foundation of India (PFI) hosts the Secretariat for the AGCA.

The AGCA initially suggested a phased learning process in each state to ensure state specific learning and ownership of the community action process. A pilot programme to introduce the process of Village Committee strengthening and action was launched in nine states across the country - Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu. In

each state, three blocks each in three to five districts were selected for this and the programme was implemented in five villages each of three Primary Health Centres (PHC) in each of these blocks.(3) The overall goal of these processes was to establish the feasibility of involving village level committees in health system strengthening efforts and through this, increasing the community ownership on the health system as well as the accountability of the system to the people. It was felt that such processes and involvement of the people will lead to the ultimate goal of Health for All.(1) An evaluation of the pilot phase suggested that while the processes showed a lot of potential, there was a need for long-term systemic support to take the processes forward.(4)

After this pilot phase, three states – Tamil Nadu, Maharashtra and Jharkhand – continued the process by including it in their state Program Implementation Plans (PIPs), each evolving their own state specific models over the years. Karnataka continued the process differently by focusing on capacity building of training VHSNCs across all districts of the state.

Since 2011, the process has been institutionalized in several states now promoting community participation and action as part of their PIPs. In the Financial Year 2013-14, 22 States/ Union Territories have included the community action for health component in their Annual State National Health Mission (NHM) PIPs.(5)

In addition, several other important policy documents have subsequently placed community participation as an important process that needs to be institutionalized. The High Level Expert Group constituted by the Planning Commission on Universal Health Coverage recommends “strengthening institutional mechanisms for community participation in health governance and oversight at multiple levels (rural and urban)”.(6) The 12th Five Year Plan Document also details the role of communities and Panchayati Raj Institutions in health, and plans for greater efforts at community involvement in planning, delivery, monitoring and evaluation of health services.(7)

It is at this crucial juncture when the 12th Five Year Plan is being rolled out and a discourse on Universal Access to Health is gaining momentum in the country, that this review of various experiences of community action for health in India and globally has been undertaken. The learnings and challenges from these experiences could inform future policy and programmes.

1.2. Objectives of the review

This review was undertaken to answer the following questions:

1. What are the different models of community participation in health in terms of
 - a) Structures of the model
 - b) Processes undertaken
 - c) Context in which community participation has been attempted
2. What are the outcomes of community participation as documented from these models and their evaluations?
3. What are the learnings and challenges from the models that will inform future implementation / expansion of such community action programmes for health?

1.3. Methodology and limitations

This review draws from field visits to five different projects implementing community action programmes/projects in health across the country. These include

1. Community Action for Health project, Tamil Nadu
2. Swasth Panchayat Yojana, Chhattisgarh
3. Community Based Planning and Monitoring project, Bihar
4. Community Development Committees in urban slums, Vadodara, Gujarat
5. Monitoring of Maternity homes, Bengaluru, Karnataka

These five projects were chosen for the different models they represent of promoting community participation in health and also to present a good mix of community participation in rural and urban settings. In each of these projects, key stakeholders of the community participation programme/project were met with. These included implementers of the programme, members of different levels of community participation committees, community representatives, health department officials, health care providers and Panchayati Raj representatives. Interviews with these stakeholders were guided by the objectives of the review and evolved organically based on the nature of the programme/project.

In addition to drawing on experiences of these projects for the review, detailed case studies of each of these has also been presented. Some models like that of community monitoring in Maharashtra, as it was well documented, were studied from the literature available.

In addition, a literature review was done of community participation in health experiences in India and globally. This drew largely on published reviews and significant publications of various experiences of community participation, and relevant grey literature from 2000 onwards. A list of the various experiences in community participation in health, which were reviewed, is provided in Annexure 2. This body of literature has been used to describe the wide variety of structures, processes and outcomes of community participation in health and draw out learnings and challenges.

Limitations

This review is not a systematic review, but rather draws from relevant literature to answer key questions for policy and programmes towards up-scaling community participation. In this sense, it could be termed a scoping review. The review has focused on the use of committees both at community and facility level towards community participation and action as this was seen as the main requirement to plan further policy and programme in the country. While it is recognized that community participation can take multiple other forms as citizens' charters, report cards etc., these have not been included in the review. Similarly, the other large component of community participation includes community health workers which is also beyond the scope of this review. Also, this review is restricted to participation and action in the health sector, though some lessons from other sectors presented in the literature have been included.

1.4. Introduction

Globally, the Alma Ata Declaration of 1978 identified Primary Health Care as the core strategy to achieve Health for All and placed community participation as an important component of Primary Health Care.(8)

*The people have a **right and duty to participate** individually and collectively in the planning and implementation of their health care.*

*Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their **full participation** and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of **self-reliance and self-determination**.*

The Alma Ata declaration reflects the values of **social justice**, where every person has the right to make choices regarding their lives, and **participation**, where every individual has voice to make such choices. The underlying vision of the declaration was that good health could not be achieved without values related to democracy like empowerment, health promotion and collective action.(9) It was expected that such empowerment where people take charge of their own lives and act to change their own life situations would result in improved health.(10)

Since the Alma Ata declaration, there have been several efforts at promoting community participation. In a context of weakened health systems and resource limitations, community participation has over the years been increasingly seen as a way forward in order to achieve Health for All. The Right to Health movement has also called attention to the need to involve people in decisions regarding their own health and to ensure the participation of marginalized communities in such decision making.

Community participation has been conceptualized at the global and academic level with large institutions like the World Health Organization playing a significant role - However, over the years, it has also been seen that the actual experiences and challenges of community participation are at the ground level. Thus both a conceptual level understanding of what community participation is or is not, and an analysis of actual experiences are critical to understand its impact on health.(9) This review will, therefore, attempt to bring in both these perspectives – conceptual level understanding and actual experiences – to draw lessons.

Definition

Since the Alma Ata declaration, community participation, involvement or mobilization has been variously defined and understood.

1. It is commonly understood as “collective involvement of local people in assessing their needs and organizing strategies to meet those needs.” (11)
2. Zakus and Lysack define community participation or involvement as “the process by which members of a community, either individually or collectively and with varying levels of commitment, develop the capability to assume greater responsibility for assessing their health needs and problems; plan and then act to implement their solutions; create and maintain organizations in support of these efforts; and evaluate the effects and bring about necessary adjustments in goals and programmes on an ongoing basis.” (9)
3. It has also been defined as “a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others”.(12)

In the NRHM Framework for Implementation, it is clearly articulated that communities must be “empowered to take leadership in health matters” in order for the programme to reach every village.(1) The Village Health Sanitation and Nutrition Committees (VHSNC) set up under the NRHM are “envisaged as being central to ‘local level community action’ under NRHM, which would gradually develop to support the process of Decentralized Health Planning. Thus VHSNCs are expected to act as leadership platforms for improving awareness and access of community for health services, support the ASHA, develop village health plans, specific to the local needs, and serve as a mechanism to promote community action for health, particularly for social determinants of health.” (13)

The High Level Expert Group of the Planning Commission on Universal Health Coverage specifically recommends strengthening institutional mechanisms for community participation in health governance and oversight at multiple levels.(6) Similarly, the 12th Plan document also has a specific section on community participation that recommends “government health facilities at the level of blocks and below can become more responsive to population needs if funds are devolved to the Panchayati Raj Institutions (Village Council or its equivalent in the Scheduled Areas), and these institutions made responsible for improving public health outcomes in their area.” (7)

The purpose of community participation

In the literature, community participation has been cited to have several benefits including in better dissemination of health knowledge, better organization of services according to community’s needs, more acceptable and relevant services, increased community satisfaction, more rational use of resources, and increased community responsibility for their own health. (9, 11) Rifkin lists the following as the reasons for involving communities, as argued by WHO.(14)

1. “People are more likely to use and respond positively to health services if they have been involved in decisions about how these services are delivered, thus helping to make the services sustainable”
2. “People have individual and collective resources (time, money, materials and energy) to contribute to activities for health improvements in the community”
3. “People are more likely to change risky health behaviours when they have been involved in deciding how that change might take place” “People gain information, skills and experience in community involvement that helps them take control over their own lives and challenge social systems that have sustained their deprivation.”

Thus, the need for community participation has been conceptualized in different ways – as a strategy to improve health outcomes, to use resources from the community for better health outcomes, as a right to participate, as a way of sharing power and control.

These conceptualizations reveal differing perspectives on the purpose of community participation – it could varyingly be seen as **a means** to better health outcomes, or alternatively as **an end in itself**.(15) In the first scenario, community participation is seen as a means to achieve the health outcome goals of various programmes – here the programmes are planned and goals set by policy and programme makers and community participation is enlisted towards achieving these goals. Many national-level programmes across the world have looked at community participation from this perspective. Here, participation is one of the many interventions within a programme. On a similar frame, market-led models of health proposed by international financial institutions have seen community participation as a way of utilizing resources that communities bring in. This is seen as increasing the **efficiency** of health systems.

However, in the second scenario when community participation is seen as **an end** in itself, the **empowerment** and ownership provided by it are seen as important outcomes in themselves.(15) Zakus and Lysack say the most important benefit of community participation is “the heightened sense of responsibility and conscientiousness regarding health and the concomitant gain in power achieved through the acquisition of new skills and control over resources.”(9) In this perspective, because it is seen as people’s power and control, community participation is viewed as an integral part of the Right to Health by various activists and health movements.

Taylor categorizes these different perspectives as four different conceptual approaches to community participation as given in Table 1.(16) Here, the contributions and the instrumental approaches belong to the first scenario of community participation as a means, while the community empowerment and developmental approaches belong to the second scenario of community participation as an end in itself.

Table 1 – Four conceptual approaches to community participation

Approach	Description
Contributions	The contributions approach considers participation primarily as voluntary contributions to a project, such as time, resources, or community-based knowledge. Professional developers, usually external to the community, lead participation and make the decisions about how the contributions will be used.
Instrumental Approach	The instrumental approach defines health and wellbeing as an end result, rather than as a process with community participation as an intervention supporting other public health or primary health care interventions, health planning, or service development. Participation is usually led by professionals and the important components of the interventions or programmes are predetermined according to local and national priorities.
Community empowerment	The community empowerment approach seeks to empower and support communities, individuals, and groups to take greater control over issues that affect their health and well being. It includes the notion of personal development, consciousness raising and social action.
Developmental Approach	The developmental approach conceptualizes health and social care development as an interactive, evolutionary process, embedded in a community or place of interest. Local people, in partnership with professionals, have a role in decision making and in achieving the outcomes they consider as important. The developmental approach is underpinned by principles of social justice.

According to the Framework for Implementation,(1) the National Rural Health Mission sees the communitization process as a mix of both, a means towards achieving health outcomes of the Mission, and also as an empowering tool in itself. The various processes undertaken in different states reflect these differing perspectives as seen in the sections below.

Levels of participation

Given the different perspectives and reasons for community participation, the levels of participation can vary across different programmes depending on how participation is conceptualized. This has been widely described by various authors in literature. Arnstein defines the “ladder of participation” where she describes eight levels of participation – moving from the lowest levels of manipulation, to the mid levels of tokenistic participation in the form of consultation and information, to the highest levels which pave the way for citizen power and control.(17)

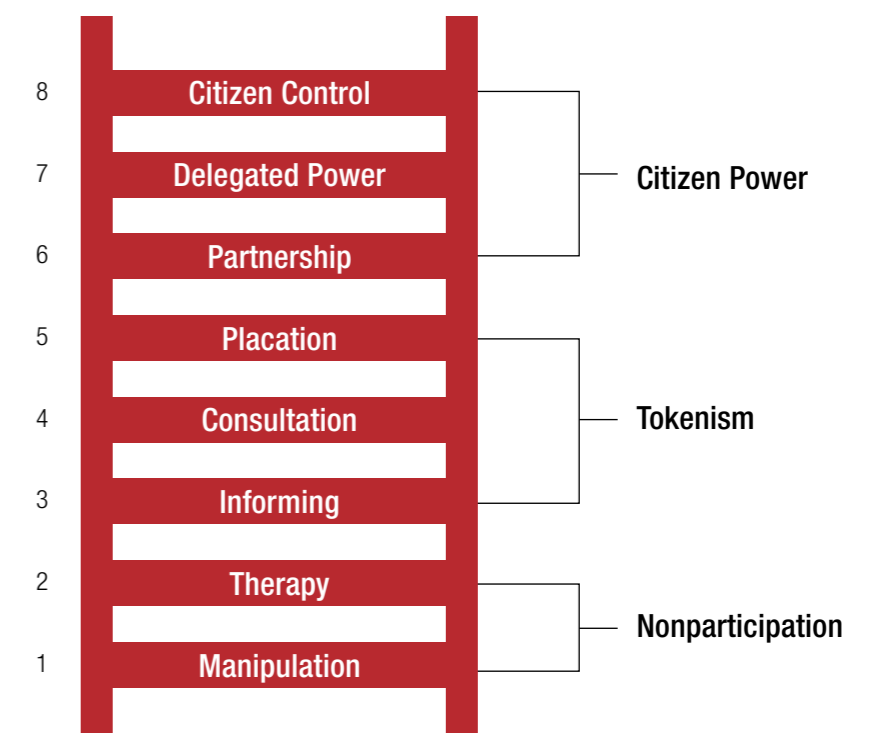


Figure 1 – Arnstein's ladder of participation

Murthy and Klugman use different domains of participation such as definition of the community, who represents the community, rationale for community participation, depth, scope and mode of community participation to grade levels of participation as in the table below.(18) Participation is seen to be at the highest level when marginalized groups participate, when participation is seen as a right in itself, and when it involves all levels of the health system including policy making.

Table 2 – Levels of community participation (Murthy and Klugman)

	Lower degree of CP	Middle degree of CP	Higher degree of CP
Definition of community	Clients or users	Relatively easy to reach people living in an area	Marginalized groups of the population
Who represents the community	Powerful clients	Powerful groups in population; NGO who represent the community	Marginalized groups in the population; NGOs who represent their interests
Rationale for CP in health	CP as a means to <ul style="list-style-type: none"> • expand outreach • raise resources • support infrastructure 	CP as a means to <ul style="list-style-type: none"> • improve management of local health services (efficiency) 	CP as a means to <ul style="list-style-type: none"> • increase effectiveness • increase accountability
Depth of CP	Manipulation Informing	Advice / consultation	Collective or community decision-making
Scope of CP	Service delivery	Service delivery and management at periphery	Health policy, health management and service delivery at all levels
Mode of CP	As individuals	As members of small collectives	As members of mass based organizations and small collectives
	Through invitation by government	Often through invitation by government	Both through invitation and demands from below

The National Rural Health Mission proposes several different mechanisms to involve communities in health. These include both community and facility-based committees, involvement of communities in deciding local priorities and planning for local health needs at various levels up to district level planning, and provision of untied funds to promote community-led action for health. While it does not provide any scope for communities to participate specifically in decisions regarding policy, the participatory planning process up to the district level is conceptualized to give communities a voice in programme planning. Thus, the Framework for Implementation document of NRHM proposes a high level of community participation as defined by the frameworks in literature described above.(1) Whether this translates into reality at the ground level is discussed in subsequent sections.

Community participation and accountability

A close link has been made out in the literature and in various programmes between the concepts of community participation and accountability. The NRHM has seen community participation as one of the means to ensure **accountability** of the health system to the people – community monitoring has been seen as one of a three-pronged process to promote accountability (the other two being external surveys and internal monitoring). However, the relationship between participation and accountability has been shown in literature not to be a given, but something that depends on the type and level of participation.

Accountability has been seen as an important component of achieving the Right to Health.(19) Accountability has been defined by the World Bank as “the degree to which governments have to explain or justify what they have done or failed to do”.(18) It has also been seen as “as a moderator or referee of the dynamics in two-way relationships, e.g. between service providers and patients, different levels of health care service delivery, health and finance ministries, donors and funding recipients, elected representatives and health officials, and elected representatives and voters.” (20) What it essentially means is the degree to which answerability exists between specific stakeholders regarding a certain set of entitlements or interventions.

The two key criteria of accountability are seen as **answerability** – the ability to hold a specific actor responsible to provide answers regarding doing or failure to doing a specific action, and **enforceability** – the ability to penalize for non performance.

Accountability has also been seen to take a variety of forms – financial accountability, administrative accountability, performance accountability, etc. It has also been classified as managerial or political. **Managerial accountability** refers to accountability to perform certain pre set tasks according to pre set criteria. **Political accountability** refers to accountability related to decision making.

Murthy and Klugman classify accountability into three levels based on criteria of who is accountable, to whom, regarding what, when, why and how this is operationalized.(18) Higher degrees of accountability are achieved when all levels of health personnel, including policymakers, are accountable to communities and elected representatives in all matters including those related to health policy, both before and after programme implementation, with mechanisms put in place to enforce such accountability.

Table 3 – Levels of accountability (Murthy and Klugman)

	Lower degree of AC	Middle degree of AC	Higher degree of AC
Accountability of whom	Health workers	Health workers, doctors, trainers, and middle level managers	Health personnel at all levels, including policy makers
Accountability to whom	Higher up	Higher up and colleagues	Community members (including marginalized) and elected representatives.
Accountability with respect to what	Input Management	Input, finance and output	All variables, in particular impact and social relevance Political dimensions
When accountable	Ex-post (post-implementation)	Ex-post	Ex-ante(policy formulation and design stage) and ex-post
Purpose of accountability	To detect any error	To detect any error	To prevent error, as well as detect
How accountability is operationalized	Bureaucratic rules and procedures	Professional self-regulation	Legal mechanisms and pressures from below

Improving accountability is seen as a key strategy to improve health systems. One of the mechanisms to increase accountability has been to increase **“voice”**. Community participation initiatives, by increasing citizens’ voice and providing a space for such voice have been seen as improving accountability. However, as seen in the sections that follow, experience shows that merely promoting participation does not automatically result in accountability, and specific measures have to be put in place if this is to be achieved.

The different frameworks used in literature to classify levels of participation and accountability that have been described in this introductory section have been used to analyse the various programmes on community participation in subsequent sections.

CHAPTER 2

BRIEF DESCRIPTION OF THE COMMUNITY PARTICIPATION PROJECTS VISITED

This chapter provides a brief description of the five projects that were visited as part of this review. A more detailed description of each of these projects is presented in Annexure 1.

Of the five projects visited, three – in Tamil Nadu, Chhattisgarh and Bihar – were programmes supported by the state governments under NRHM. Of these, the Tamil Nadu and Bihar programmes follow the AGCA pilot model of NGO-supported implementation, Tamil Nadu since the pilot phase of the communitization programme in 2007-08, and Bihar, more recently since 2011. The Chhattisgarh programme pre-dates the programme under NRHM. Each of these three programmes has several components that are similar while others differ considerably.

The other two programmes – those of SAHAJ in Vadodara and Public Affairs Centre in Bengaluru – are initiatives that have explored different strategies towards community participation in urban slums. The SAHAJ project explores formation of community based committees in urban slums, while the Bengaluru initiative explores the use of Citizens' Report Cards and Community Score Cards to monitor health facilities.

1. The Community Action for Health project, Tamil Nadu

As part of the communitization process recommended under the National Rural Health Mission, Tamil Nadu has been implementing the Community Action for Health (CAH) programme since 2007. The pilot phase was implemented in 2007 – 08 in six districts. Following an external evaluation of this phase, the programme is now being implemented in 446 panchayats of 14 blocks.¹

The Community Action for Health (CAH) programme in Tamil Nadu is implemented as a government - civil society partnership initiative with designated nodal NGOs at the state, district and block levels. At the beginning of the project, already existing VHSNCs with a predominance of service providers were expanded to provide broader representation to community members, especially those from marginalized groups. Following capacity building of these VHSNC members, three rounds of monitoring of public health services based on entitlements promised under NRHM have been completed – a simplified tool that colour codes the grading of services has been used for this. The information collected through the monitoring process is collated into a panchayat-level report card and presented to the Gram

¹ The programme is not being implemented since July 2012 as funds have not been released towards this by the state health department.

Panchayat.² In addition to the village level monitoring, VHSNC members monitor facilities available at Health Sub Centres and Primary Health Centres.

One of the significant features of the Tamil Nadu CAH programme is the planning component. A Village Health Planning Day is observed once every six months and is attended by the Panchayat President, Panchayat ward members, other community members and health care providers including the Village Health Nurse and the medical officer of the Primary Health Centre. A discussion is held based on the coloured grades awarded to various services in the Panchayat level report card. – The objective of the planning exercise is “to change Red to Green, in six months, together”. Out of the list of areas identified as needing improvement, two or three are chosen by consultation with everyone present. Plans are then made to find solutions for these issues. These are followed up at regular VHSNC meetings held every month.

In addition, the information generated at village level is also collated and analysed at the state level, and has been used by the state and district level NGOs to advocate with health authorities.

2. Swasth Panchayat Yojana, Chhattisgarh

The Swasth Panchayat Yojana is being implemented since 2005-06 in Chhattisgarh as part of the effort towards communitization of health systems, and covers the entire state. Initially, the programme focussed on conducting Swasth Panchayat surveys and identifying panchayats eligible for an award based on their performance on health indicators (see below for details). The component of VHSNC strengthening and community action was included post the implementation of the AGCA pilot in 2009. The programme aims to place health on the agenda of panchayats and increase their participation and capacity to act on health issues. The programme uses Mitans (Community Health Worker/ ASHA) and VHSNCs as the main fora for implementation. The programme is run by the state Department of Health and Family Welfare with assistance from the State Health Resource Centre (SHRC), an independent public sector institution.

VHSNCs have been constituted at the village level by a democratic process through the Gram Sabha. Each VHSNC meets on a fixed day every month to monitor the health situation in its village and also plans action on any gaps identified. The village health status is monitored along with a pre determined set of 29 questions, and a birth and death register is maintained. Based on this monitoring, two to three issues are identified for action every month. Their causes are analysed and possible solutions planned along with clear delineation of responsibilities and time frame.

In addition, approximately 12-16 VHSNCs are brought together under one cluster and meet once every month. This space is used to identify problems that are common to several villages that may require coordinated action, and problems that may require higher officials in various departments to be approached.

In order to take the processes at the village and cluster level to the block, public dialogues or Swasth Panchayat Sammelans are held annually at the block level. At these sammelans, issues that need the attention of block level officials of the various departments concerned with health and development are taken up.

SHRC also conducts annual surveys (Swasth Panchayat surveys) that assess the health situation of each village and Panchayat. This

² For more details on the colour coded grading and Panchayat report cards, please refer to the case study on the CAH project of Tamil Nadu in Annexure 1.

information is filled into a panchayat-level score card that is presented to the Sarpanch of the panchayat. In addition, the hamlet-level data is centrally analysed to arrive at consolidated panchayat-level indicators and a composite panchayat-level Health and Human Development Index, based on which well performing panchayats are rewarded.

3. Community Based Planning and Monitoring Programme, Bihar

The Community Based Planning and Monitoring Programme (CBPM) is being implemented with support from the State Health Society, Bihar under the National Rural Health Mission since May 2011 in partnership with civil society organizations. It covers 300 villages across five districts. The programme is based on the strategies and processes developed and tested during the pilot phase of the Community Monitoring Programme implemented in nine states across the country in 2007-09 under the Advisory Group on Community Action (AGCA). The bedrock of the programme is strengthening of the VHSNC to monitor and support improvement of services provided under NRHM. While the VHSNC has been constituted at the Gram Panchayat level in Bihar, at the village level, Village Planning and Monitoring Committees (VPMC) have been constituted under the CBPM programme. In addition to these village and Panchayat level committees, committees have been formed at the block and district level – the Block Planning and Monitoring Committee (BPMC) and the District Planning and Monitoring Committee (DPMC) to foster community action and ensure that issues emerging from the CBPM process are appropriately addressed at these levels.

VPMC members monitor services provided on the Village Health Sanitation and Nutrition Day. In addition, a pre-designed tool has been used by the VPMC members to monitor health services in the specific pre determined domains. This is collated into a report card at the village and Panchayat level to arrive at a colour code that grades services as good (green), average (yellow) or poor (red). These report cards are then presented both at a village level meeting and at the Panchayat level and discussed with the community for suggestions on possible improvements. These community level enquiries have been supplemented by facility surveys that have assessed the availability and quality of services at Sub-Health Centre (SHC) and Primary Health Centre (PHC). In addition, as part of increasing engagement between communities and the public health system, Jan Samwads – facilitated public dialogues between people, local governments and health care providers – are held as part of the CBPM programme. Efforts are being made to develop village level health action plans to facilitate bottom up planning.

4. Community Development Committees in urban slums, Vadodara, Gujarat

Society for Health Alternatives (SAHAJ) has been working in urban slums in Vadodara since the early 2000s and has promoted community participation towards health. One of the strategies adopted has been to develop and strengthen Community Development Committees who can undertake community based advocacy for their health and civic entitlements. These committees, now active in 17 slums, have been formed after a series of community meetings where developmental issues faced by the community are discussed and volunteers selected from the community as members of these committees. The membership to the committee remains open and flexible as the work is voluntary.

Following formation of these committees, several sessions are held with committee members to build their capacity for community action – the areas for capacity building are decided in consultation with the community based on the needs of the issue at hand. The committees meet every month to discuss issues that are present in their *bastis* and plan solutions for various issues. Issues are prioritized based on consultations among community members – these are usually wide ranging and include civic entitlements like the Public

Distribution System, education, water supply and sanitation. SAHAJ and the community members see these issues as intimately related to health, that need to be addressed to meet the immediate requirements of the community. Once the issues are identified, plans to solve these are made with assignation of responsibility. Such plans could involve meeting the concerned authorities and giving an application, organizing demonstrations, filing Right to Information applications to get more details regarding entitlements. The actions are followed up in subsequent meetings and further plans made based on earlier results.

SAHAJ's programme does not have a readymade tool that is used by the community to monitor services on a regular basis – rather, any monitoring is taken up by the community's decision as and when need arises.

SAHAJ has also formed a federation of these committees – the *Samanvay* (Coordination) *Samiti* – in order to have a forum that will encourage cross learning and also take up issues that are common to several *bastis* across the city at a larger level.

5. Monitoring of Maternity homes, Bengaluru, Karnataka

Public Affairs Centre (PAC), Bengaluru has used innovative methods to monitor the quality of maternity services in Bengaluru's municipality-run health centres. In the year 2000, PAC undertook a Citizen Report Card survey of these maternity homes. This survey showed poor quality of services in these homes and a high degree of corruption. As a follow up to this initial survey, in the year 2009, PAC took up a repeat monitoring of these facilities along with its partner NGOs to understand the current status of services provided in them.

The first round of Citizen Report Cards in 2010 covered 12 maternity homes in Bengaluru municipality area and included interviews with health care providers, users and Board of Visitors (forum of users). Data from the above interactions was centrally entered and analysed at PAC and collated to form the Citizen Report Card. The findings of these were then shared with the Bengaluru municipality authorities to advocate for change.

Following this, indicators for a Community Score Card were developed which were based on interactions with users of these facilities. These Community Score Cards were filled in three maternity homes, as a group exercise with users and also with health care staff. The findings of the Community Score Cards were then discussed at an interface meeting that brought together staff of the maternity homes, higher authorities from Bengaluru Municipality and users of the facility. This resulted in a discussion along with planning for action to improve the services related to each indicator on the score card.

As the interface meetings received a lot of positive feedback from users, staff and Bengaluru municipality officials, it was decided that a users' group be formed to carry out monitoring of the facilities and engage with the staff on an ongoing basis. Thus, Maternity Home Monitoring Committees (MHMCs) have been formed in these maternity homes. MHMC members take turns to visit the maternity home and monitor services provided based on a check list that has been given to them by PAC and meet once every 15 days to discuss issues. Interface meetings with committee members, staff of the facilities and Bengaluru municipality staff are held once every three months where actions are planned to improve the gaps identified by the monitoring exercise.

Community participation experiences reviewed

In addition to the five projects described above, this review is based on the following community participation experiences that were reviewed from available literature.

Experiences from India

1. Community Based Monitoring and Planning Programme, Maharashtra(21,22)
2. Communitization of Public Services, Nagaland(23,24)
3. Foundation for Research in Health Systems Project, Karnataka(25)
4. Community Led Initiatives for Child Survival (CLICS), Wardha(26,27)
5. Mahila Swasthya Adhikar Manch, Uttar Pradesh(28)
6. People's Health Management Information System (PHMIS), Rayagada, Odisha(29)
7. Swasth Plus project, Karnataka(29)
8. Integrated Planning Project, Lalitpur, Uttar Pradesh(30)
9. Rogi Kalyan Samitis in various states(31,32)

Global experiences

1. Participatory Health Councils, Brazil(33–39)
2. WARMI project, Bolivia(40)
3. Models based on WARMI project – Makwanpur study,(41) Ekjut study,(42) Bangladesh study,(43) Mumbai study(44)
4. Community Based Monitoring, Uganda(45,46)
5. Local Committees for Health Administration (CLAS), Peru(46,47)
6. Health Centre Committees, Zimbabwe(46,48)
7. Health Centre Co management Committees, Cambodia(49,50)

A short description of some of these projects referred to in this review is given in Annexure 2.

Review findings

In the following sections, a description of the various aspects of a community participation programme are presented along with a brief analysis of what seems to work and why. These sections are organized as follows:

5. Structures for community participation
6. Processes for community participation
7. The role of the context in community participation
8. Outcomes of community participation

Each section also highlights case studies from the field visits to describe and reiterate the points made in the review. Finally, a section on learnings and challenges drawn from these experiences and a possible way forward to up-scale community participation efforts is included.

CHAPTER 3

STRUCTURES FOR COMMUNITY PARTICIPATION

One of the prerequisites for community participation is a mechanism to institutionalize participation. Murthy and Klugman point out that institutionalized structures need to be established to promote community participation.(18) Zakus and Lysack also point out that a suitable formal organization needs to be established and sustained for community participation.(9)

In order to promote community participation, different programmes/ models have used different mechanisms.

- One of the most widely used mechanisms is the selection and training of a volunteer from the community – **the community health worker**. Under the NRHM, the ASHA worker is appointed at hamlet level to fulfil this role.
- The other commonly used mechanisms are **committees – both community based and health facility based**. The community based Village Health, Sanitation and Nutrition Committee at village level and the Rogi Kalyan Samitis (Patient Welfare Committees) at various levels of facilities are committees constituted under the NRHM for this.
- The other mechanisms that have been tried globally are **citizen charters** and **report cards**.

This review, as stated earlier, looks specifically at committees for community participation. This section presents a review of the structures of these committees and is organized under these headings:

- the types of space committees provide for participation
- the support structures to these committees
- financial support to the committees
- their interface with the health system.

3.1 Spaces for community participation

Institutionalized structures provide a space for communities to participate and several different spaces have been used in various experiences of community participation. These various spaces for community participation have been classified as formal and autonomous.

Formal spaces, otherwise known as **invited spaces**, are

- a) Those that are institutionalized by the government or the health system for example, the Village Health, Sanitation and Nutrition Committees under the NRHM. Other examples include the participatory health councils set up under the constitution in Brazil(34) and

Health Watch Committees under the health sector reforms programme in Bangladesh.(51) Or

- b) Those instituted by NGOs and are accepted and/or funded by the government, for example in the Foundation for Research in Health Systems (FRHS) project in Karnataka that formed village health committees as part of an operations research project to promote community involvement in reproductive and child health.(25)

As opposed to the formal or invited spaces, **autonomous or claimed spaces** are those that evolve from the community, based on a common interest or goal. The Community Development Committees in urban slums of Vadodara formed with the support of SAHAJ, an NGO or the Mahila Swasthya Adhikaar Manch in Uttar Pradesh(28) are examples of this.

How does a community participation space being formal or autonomous affect the programme? While a formal space implies state support for the community participation effort, such support may be more difficult to get when the space is purely autonomous or claimed. In fact, in several projects that have used autonomous spaces, a long struggle has been needed to get those in power to even acknowledge the community's right to participate – this is illustrated in some of the case studies from SAHAJ presented subsequently. On the other hand, when the space is formal, there is very little scope for the community to decide on what the scope of participation should be and towards what outcome; autonomous spaces are more open for the community to decide the design and scope of participation.

Legitimacy of the space

One of the important aspects of the space used for community participation is the level of **legitimacy** it has and where it gains it from. The higher the legitimacy of the space, the better the chances of community participation succeeding. Legitimacy can be seen from two perspectives:

- a) legitimacy in the eyes of the system and
- b) legitimacy in the eyes of the community.

Legitimacy in the eyes of the system can be achieved either formally or informally. Formal means include the enactment of laws like in Nagaland – the Nagaland Communitization Act of 2002(23) – and the Brazilian constitution(34) or the Law of Popular Participation in Bolivia(39), all of which create legal spaces for community participation. Formal legitimacy can also be achieved by specific programmes that create institutions and spaces for community participation – these include the VHSNCs under NRHM. Some programmes also use other mechanisms to achieve legitimacy, for example, the Community-Led Initiatives for Child Survival (CLICS) programme of Wardha uses a formal Memorandum of Understanding to legitimize the space – this is signed between the implementing organization Mahatma Gandhi Institute of Medical Sciences and the Village Coordination Committees set up at the village level.(27)

Legitimacy in the eyes of the system can also be achieved through informal means – support from a higher authority, presence of a supportive official significantly high up in the health system are examples of these. Senior NGO representatives or officials involved in the Tamil Nadu, Bihar and Chhattisgarh communitization programme acknowledge the significance of higher officials who have played such a supportive role to take the programme forward.

Sustained civil society - health system engagement in Tamil Nadu

One of the key features of the Tamil Nadu programme, according to members of the state nodal NGO, has been the sustained engagement between civil society and health authorities. While the state NGO has been committed to such engagement, senior bureaucrats and health officials in the health system have been seen as change agents who have remained engaged with, and committed to, the community based process. Regular personal face-to face communication of the implementing NGO with both senior level officials and those at the mid level, heading government sections has helped foster this process and build trust. Both the state NGO and senior government authorities have taken specific care to proceed with the process in a non-confrontational and non-sensationalizing manner.

This engagement has helped address issues constructively and strategize towards best ways to engage health authorities and providers in the process. It has also helped determine best ways to up -scale the process within the state.

The programme has also engaged with district and block authorities beyond the health department – for example, Block Development Officer, District Collector – by inviting them to trainings and meetings and regularly sharing reports with them. This has helped widen the ambit of the programme beyond the health department and forge inter-sectoral convergence at block and district levels.

While legislation or programme orders can achieve legitimacy in the eyes of the formal system, it is also important that community participation efforts achieve legitimacy in the eyes of health care providers, both front line providers and those in health facilities. Some efforts at sensitizing providers to the need for participation and establishing legitimacy for community participation in their eyes are discussed in subsequent sections.

Legitimacy in the eyes of the community is more nebulous – most projects engage with elected and traditional community leaders to enlist their support, thus gaining some measure of legitimacy. This is seen in the Bihar, Tamil Nadu, Chhattisgarh and Vadodara programmes. However, this process also needs to ensure that interests of marginalized groups are safeguarded while engaging with community leaders who may belong to dominant groups and are usually men – this aspect is detailed subsequently.

The process of selection of members to represent the community – how democratic this process is perceived to be, and how inclusive and representative the space is – is another factor that influences legitimacy. When participation is seen to represent issues of the community, has mechanisms by which interests of marginalized sections are voiced within the space, and finally the results that participation brings in, all of these enlist some measure of legitimacy in the eyes of the community. For example, one of the internal reports of the Community Action for Health project in Tamil Nadu documents the sharing by a Panchayat President of how the changes brought in after the project have led people to support the process more. Similarly, in Vadodara, successful action by committee members against corruption in the Public Distribution System in one of the *bastis* helped garner more support from the community and get more people to become members of the committee.

Establishing such legitimacy in the eyes of the community becomes even more important when the space for participation is a formal or invited space. For example, an invited space such as the VHSNC or the Rogi Kalyan Samiti needs time to be accepted by the community as a space where genuine participation is possible. In order to foster this legitimacy, the health system needs to demonstrate its commitment to “listening to people’s voice” as well as invest in improvements in public health services. This also means a long-term investment in the process rather than expecting gains within a project period of a year or two.

Inclusion and representativeness of the space

Given that community participation is based on a value of social justice and equity one of the key concerns regarding communities participating in spaces created for such participation is the level to which marginalized groups in the community are able to participate.

Several mechanisms have been tried to ensure participation and inclusion of all groups in the community. It is important to have an in depth understanding the community – its structure, groups within it, its needs and resources – to form a space that is inclusive and representative of the community.(9) Selection processes that are democratic and reservation of membership for certain groups in specific committees are some of these mechanisms. For example, in Chhattisgarh, the VHSNCs were constituted democratically using the forum of the Gram Sabha. The Community Based Planning and Monitoring Programme in Bihar has a seat reserved for *dalits* and religious minority groups in the Village Planning and Monitoring Committees.

Including the excluded in Bihar

The Community Based Planning and Monitoring (CBPM) programme in Bihar has made specific efforts to include marginalized communities in the process.

Each Village Planning and Monitoring Committee (VPMC) has a rule representative from the Scheduled Caste (SC)/Scheduled Tribe (ST) community or from a religious minority. These members raise issues specific to the marginalized communities and also engage with them to raise their awareness regarding health and health care entitlements. These efforts have seen an improvement in the health-care seeking behaviour of the marginalized communities.

Manju Devi is a ward member from the Musahar and Muslim tola of Roopin village in Morhe Panchayat, Fatehpur block, Gaya district. Manju also represents her community in the VPMC. According to her, while the ANM used to visit the tola even earlier for immunization, women would not take their babies to her for immunization as they feared it would make their babies get fever. However, after the implementation of CBPM programme, awareness has increased in the community as a result of the VPMC meetings and the staging of *nukkad natak* (street plays). Now, the number of babies getting immunization has increased. Similarly, more women now seek antenatal care services unlike a few years earlier. She also feels the quality of care they receive in the Primary Health Centre has improved. However, Manju feels many of their needs are still not being met. Several women have white discharge per vaginum and menstrual problems. There are no services for this at the PHC though some medicines are given for white discharge, and neither is there a woman doctor. Women have to travel up to the district headquarters to access any services for these complaints. She feels these services need to be introduced at the PHC itself.

The CBPM programme also ensures that the needs of the marginalized communities are represented in the village enquiry process. Special meetings are ensured in the hamlets in which these communities live to capture specific issues related to them in the enquiry process. Similarly, the sharing of the report card is also done specially in these hamlets.

In an interesting experiment in Karnataka, the FRHS project explored four different ways of forming health committees in sub-centres.(25)

1. Through nomination and selection in the Gram Sabha, a democratic body consisting of all citizens of the village
2. Through nomination by Panchayat leaders
3. Through nomination by health workers
4. A combination of all of these.

Interestingly, they found that the committees formed through involvement of the Gram Sabha performed the best (conducting health-related programmes, establishing good relations with the health staff) and also were most inclusive in giving representation to various groups, including women. However, this method was also the most time consuming and required a lot of effort by external community

facilitators. **This experiment highlights the importance of a democratic process in the formation of the committee and selection of members, though the process itself may require a lot of investment.** Such selection through a democratic process involving Gram Sabhas has also possibly contributed to the long sustained community processes through the VHSNCs in the Chhattisgarh Swasth Panchayat Yojana.

However, the process of forming the committee is not the only step that influences its representativeness. When committees are seen as spaces interacting with the formal system, and therefore, as spaces of gaining power, there is a danger of **elite capture** of these committees. This has been documented in various studies – Loewenson documents how in an experience of forming health centre committees in Zimbabwe, members were chosen based on their status in the community even though a process of democratic selection was in place.(46,48) Similarly, experiences from various states in India of selection of ASHAs and VHSNC members show that persons close to the Sarpanch or prominent in the community were chosen.(52) Also, just by choosing persons with some kind of knowledge on health and also willing and able to contribute time, projects may end up having only elite members of the community in the space.

Even if the process of selection succeeds in forming a committee that is inclusive and has representation from various marginalized committees, poor and marginalized groups face other limitations in actually participating effectively in these committees. Membership in these committees is often honorary and requires members to give considerable time without remuneration. The poor subsisting on daily wages may not be able to afford the time and resources required for this. Also, results from such participation are often not tangible and are rather symbolic than bringing in returns in economical terms. As a Village Planning and Monitoring Committee member in Bihar noted:

“We have to give up our work and give time for this, that is difficult. However, I suppose if one has to gain something, one has to lose something...”

In addition, in a forum that has mixed representation, persons from poor and marginalized groups very often find they do not have voice to represent their issues. Women very often may not be able to speak up against men in a patriarchal setting even though they may be designated equal members in the committee. Poor and marginalized persons also often lack the knowledge, education and negotiating skills required to actively voice their opinions in these forums.

Experiences with Rogi Kalyan Samitis in Bihar show that these committees remain spaces where a lot of struggle for power takes place. In some instances, this results in the medical officers of the concerned facilities ensuring that this power is retained with them by appointing members of their choice who remain passive in the decision making process. In other instances, this power play results in vested interests making an effort to occupy this space. An interesting case study from Bihar documents the different ways in which this power play occurs. In this particular case study, the existent power struggles within the committee and the efforts to capture this space were countered by committed elected representatives.

Power struggles in Rogi Kalyan Samitis in Bihar

Shivnandan Singh is a member of the Zilla Parishad of Gaya district and has earlier been the head or Mukhiya of his Panchayat. He is a member of the Rogi Kalyan Samiti (RKS) of Fatehpur Primary Health Centre. As a member of the RKS, Shivnandan Singh has been actively involved in making efforts to improve the facility. He knows that the building is in a poor condition, the staff quarters are run down, and there are far fewer beds than required. He also knows that there are vested interests in the town that pressurize staff to prescribe medicines from private medical shops run by “*dabanggs*” (powerful groups/ individuals).

In spite of all of the above limitations, Shivnandan Singh feels as an elected representative he has a significant role to play in improving the health situation in his district. In the *Jan Samwad* (Public Dialogue) that was held as part of the Community Based Planning and Monitoring Programme, the role of the RKS was discussed and it was decided that the RKS needed to be strengthened. This was in response to the issues raised of vested commercial interests affecting the functioning of the PHC. In the RKS meetings which he attends regularly, several important decisions have been taken to ensure appropriate use of the RKS funds. One of the most important ways in which the RKS has helped break the hold of private pharmaceutical shops is to buy emergency drugs for the PHC from RKS funds, thus ensuring patients are not forced to run to these shops when they need drugs. In addition, Shivnandan Singh has been strategically using his political power as an elected representative to support the PHC staff to carry out their duties when the “*dabangg log*” pressurise them. In one RKS meeting, when one of the members who was a supporter of the vested interests threatened the Medical Officer In Charge (MOIC), Shivnandan Singh stood up for the MOIC and made sure the meeting ran smoothly and constructive decisions were taken.

Another elected representative who has been playing a similar active role in Rajauli block of Nawada district is Vinay Kumar Singh, Mukhiya of Rajauli West Panchayat. He has ensured that the untied funds are used appropriately in all the villages of his panchayat. Vinay Kumar is also a member of the RKS of the Rajauli Sub District Hospital. He has been attending the meetings regularly and making efforts to improve the facility. Through the staff of the block NGO of the Community Based Planning and Monitoring Programme, Vinay Kumar got to know that the RKS had powers to ensure financial accountability for the use of RKS funds. Armed with a copy of the RKS guidelines from the State Health Society given to him by the block NGO, he demanded to be shown the accounts at an RKS meeting. Since then, the MOIC dissolved and reconstituted the RKS. Singh and several others in the block feel this was not done democratically, and hence have written to the Panchayat Samiti (block level Panchayati Raj Institution) and other authorities questioning the action of the MOIC and are now awaiting further action from these authorities.

Very often, people from poor and marginalized groups, due to long years of feeling excluded and disempowered, do not feel the need to participate as they see no benefit accruing from it. In Brazil, the discourse on democracy and rights has been seen as discordant with the daily realities of people – the constitution mandates participation and devolution of power while people struggle with experiences of daily living in conditions of poverty. (39,53)

Zakus and Lysack add to this saying that often members of minority groups may be suspicious of community participation efforts seeing it as a poor substitute for the professional help they see themselves as being denied. They give examples from disability groups towards this. (9)

Key points in this section

- Spaces for community participation can be classified as formal or autonomous. While a formal or invited space implies state support for the community participation effort, such support may be more difficult to get if the space is purely autonomous or claimed. On the other hand, autonomous spaces are more amenable for the community to decide the design and scope of participation.
- The higher the legitimacy of the space, the better the chances of community participation succeeding in achieving its goals. Legitimacy in the eyes of the system can be achieved either formally through legislation or through specific programmes, or informally through support from individuals in senior official positions.
- Sensitization sessions with individual health care providers are also necessary for the programme to achieve legitimacy in their eyes.
- Some measure to enlist legitimacy in the eyes of the community are to ensure that participation represents issues of the community, has mechanisms by which interests of marginalized sections are voiced, and brings in positive results.
- One of the key concerns regarding community participation is the level to which marginalized groups in the community are able to participate. Selection processes that are democratic, and reservation of membership for marginalized groups in specific committees, are some mechanisms that have been tried to ensure inclusion and representativeness of committees.
- Since committees are seen as spaces interacting with the formal system, and therefore as spaces of gaining power, there is a danger of elite capture of these committees. This needs to be safeguarded against.
- Poor and marginalized groups face other limitations in actually participating effectively in these committees – these include inability to take time off from wage work, lack of education and negotiating skills, absence of visible outcomes from participation and inability to voice their concerns in the presence of members from dominant groups.

3.2 Support structures

Institutionalized spaces for community participation are critical. However, to be effective, these spaces also require support on an ongoing basis. One of the common features of most community participation experiences is the presence of a structure that provides support and facilitates participation.

In order to support community members occupying community participation spaces, a tier of community level facilitators supported by a structure for supportive supervision is usually established. A diagrammatic representation of the structures in the state government supported communitization processes in Bihar, Chhattisgarh and Tamil Nadu is depicted below. In Bihar, VHSNCs are supported by community level facilitators who in turn are supported by coordinators at block and district level and NGO appointed staff at the state level. A similar structure is seen in the Tamil Nadu CAH project too. In Chhattisgarh, Mitatin trainers provide the facilitatory support at the community level and block and district level coordinators support the programme. At the state level, the public sector established autonomous agency State Health Resource Centre supports the programme.



Figure 2 Bihar - Support structure of CBPM programme

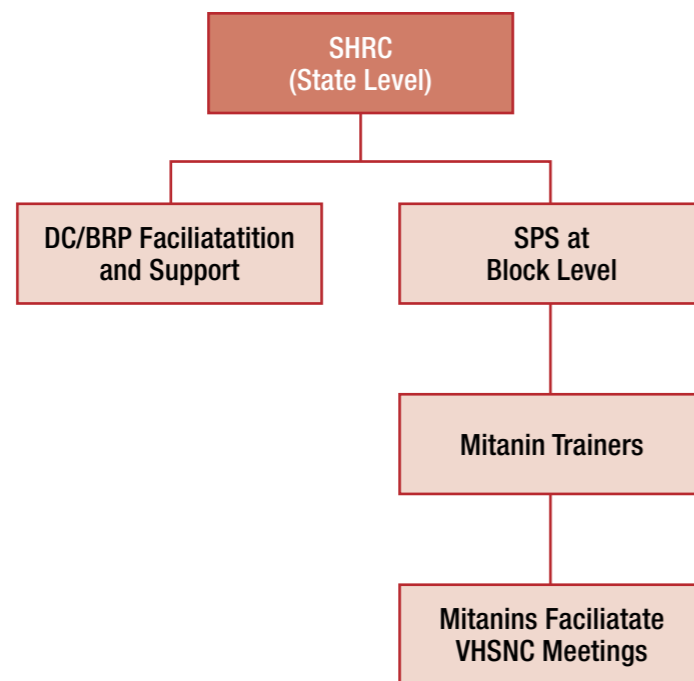


Figure 3 Chhattisgarh – Support structure of Swasth Panchayat Yojana

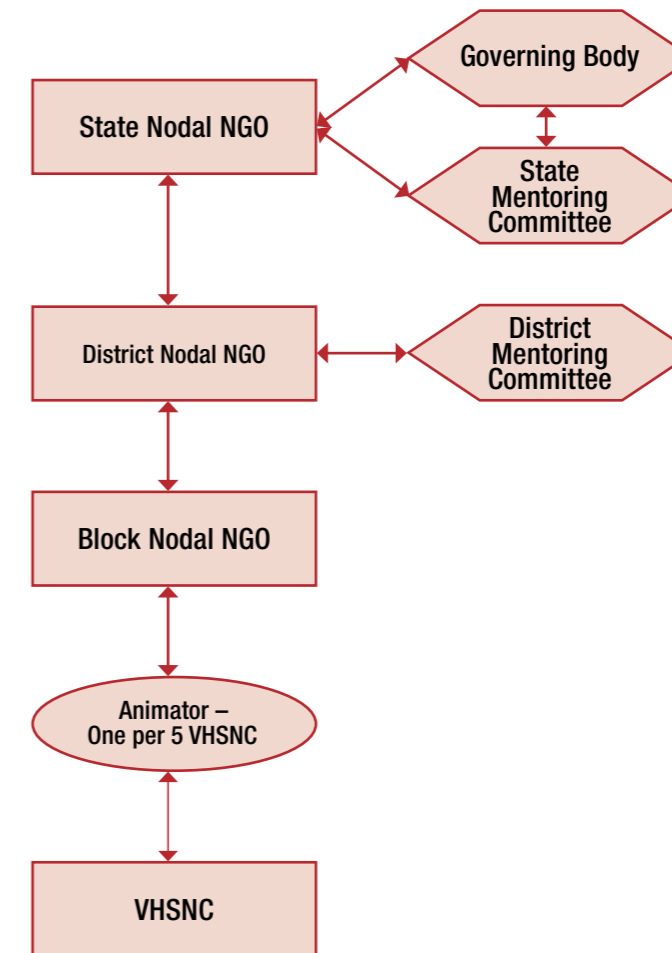


Figure 4 Tamil Nadu CAH project support structure

While NGO implemented projects like those of SAHAJ and PAC Bengaluru do not have such a clear structure, the role of community level facilitators is crucial in these projects too. These facilitators are in turn supported by the NGO through training and supportive supervision.

Community level facilitators are generally drawn from the local community and facilitate regular meetings of committees including capacity building of committee members, facilitating local monitoring and action. The number of committees a facilitator is responsible for varies from project to project. In Chhattisgarh, a Mitanin trainer who facilitates the process of panchayat involvement in health through Mitanins and VHSNCs, supports five to six VHSNCs on an average; in Bihar, a community facilitator supports 15 VHSNCs; in the MIRA trial in Nepal, which looked at supporting women's groups through an action learning cycle in maternal and newborn health, there was one facilitator for every intervention cluster conducting nine women's group meetings every month.(41)

The role of the facilitator seems crucial in keeping together the committee, making sure members attend the meeting, providing knowledge inputs, helping to monitor services and strategizing for action. Thus, the facilitator plays a pivotal role in supporting community participation and action. A key intervention that needs considerable investment, is building the capacity of these facilitators. This is discussed subsequently.

As regards the tiered support structures, different states have tried out different models. Tamil Nadu, Maharashtra and Bihar have NGOs providing support to community based committees – the state nodal NGO is usually a rights based NGO working on health rights, and is in turn supported by nodal NGOs at district and block levels. These NGOs, by bringing in the rights perspective, have been able to move the agenda of communitization forward in these states. They have several innovations to their credit and at times have pushed boundaries with the state health department to make participation more meaningful by bringing in accountability. They have in some cases also formed specific structures at block and district level to support the programme in an institutionalized manner. For example, the state nodal NGO staff in Tamil Nadu recall the support provided by the District Mentoring Committee to the programme especially in the initial stages.

In Chhattisgarh, on the other hand, the support structure is provided by the State Health Resource Centre, a public sector autonomous body that has been able to maintain its independence while continuing to work closely with the state health department. The SHRC's prior experience with providing support to the Mitadin programme, strong leadership with a rights perspective, a unique civil society engagement in its functioning, and the presence of a strong support structure developed for the Mitadin programme have all contributed to the sustained supportive supervision that has been provided to the communitization programme in this state.

What do these experiences mean therefore for up-scaling? All successful experiences of community participation point to the presence of a clear and a capable support structure that facilitates the process – that this has to be independent of the health system, whether civil society based or in the form of an autonomous institution, is critical. Only then can it engage both with communities and with the health system in a manner that negotiates spaces between the two. Thus, it is not just enough to constitute and form committees for participation, but it is also important to invest resources in establishing and sustaining such a support structure.

Key points in this section

- To be effective, community participation spaces require support on an ongoing basis. Towards this, a tier of community level facilitators supported by a clear and capable structure for supportive supervision has been established in various experiences.
- Community level facilitators are generally drawn from the local community and support between 5-15 committees each in different experiences. They play a crucial role in facilitating regular meetings of committees, including the capacity building of the members, local monitoring and action.
- The support structure, whether civil society based or in the form of an autonomous institution, has to be independent of the health system. It is important to invest resources in establishing and sustaining such a support structure.

3.3 Financial mechanisms

Funding for community participation programmes

Community participation experiences require finances to support the various processes described in subsequent sections that are necessary to promote participation. Small models and research projects with community participation have been financed by various agencies and sometimes even from contributions from communities. From the point of view of up-scaling, it is necessary to understand the funding of various large experiences of community participation at national or sub national level. At this level, most projects have been financed by governments, as in the communitization projects under NRHM. However, the difference lies in whether this funding has been project based for individual projects or has been institutionalized within the health system as a routine activity.

Decentralization of finances

One of the basic objectives of community participation is decentralization. True decentralization is seen as putting power in people's hands and promoting accountability. However, many projects, while claiming to promote decentralization, in reality do not do so. Murthy and Klugman describe two experiences – that of the World Bank Andhra Pradesh First Referral Health System Project which experimented with “de-concentration” of the health administration from the state to district and hospital levels, and the World Bank supported reforms in the Philippines that sought to strengthen the process of devolution. In both cases, by actually keeping crucial components including financing and fund transfers centralized, the projects did not actually achieve complete decentralization.(18)

On the other hand, there are a few examples where complete financial devolution has taken place and community participation has been achieved even in the budgetary arena. The participatory health councils of Brazil where participatory budgeting takes place are seen globally as a pioneering example of financial devolution.(35) One significant example is from India - the Nagaland Communitization Act, which has succeeded in devolving finances to a large extent. Powers and assets and their management have been transferred to village committees to the extent that salaries are paid to front-line health staff by these committees.(23) The Kerala experience of devolving financial powers to panchayats has also been well documented.(54) Chhattisgarh has recently explored with some success the possibility of involving panchayats in paying incentives to the Mitadins, the community health workers, thus increasing the community's ownership and control of the Community Health Worker.

Payment of incentives to Mitanins through the Gram Panchayat

The Mitanin or the community health worker programme was launched in Chhattisgarh in 2002. Mitanins form one of the crucial components of many of the state's health programmes. Since the advent of the National Rural Health Mission, Mitanins are paid incentives for several health related tasks that they perform at the community level. In the past, these incentives were paid through the health system. But since September 2012, the state has started paying these incentives through the Gram Panchayats in order to increase the community's ownership over the Mitanin and to make her accountable to the community that she belongs to and serves.

The payments through the Gram Panchayats were started on a pilot basis in Tokapal block of Bastar district in September 2012. This block was chosen because the then District Collector of Bastar was supportive of the idea. The actual process was preceded by a series of meetings with Gram Panchayat representatives, health authorities, health providers, Mitanin trainers and Mitanins. After an implementation phase of four months, the pilot was deemed successful and was gradually up-scaled to cover the entire state from July 2013.

The Process: Based on the tasks done by them every month, Mitanins fill in a claims form in a pre determined format – this details the number of tasks done by them and is validated by the concerned beneficiary from the community who signs on the form to show her agreement with the concerned claim. The form is then cross verified and validated by one of the Panchayat Ward Panchs. This form is then verified by the Mitanin trainer and submitted to the Gram Panchayat office. The disbursements are then made on a pre fixed day by the Sarpanch and the secretary of the Gram Panchayat. Random checks are also made on these forms by Block and District Coordinators to ensure the validity of these claims.

The funds are transferred from the District Health Society's budget head for Mitanin incentives to the Gram Panchayats through the Block Panchayat office. Each panchayat is given an advance of Rs 15000 which is used for disbursements and refilled based on a utilization certificate submitted by the panchayat.

Outcomes: This author interacted with Mitanins, Sarpanch, and secretaries of Gram Panchayat and programme staff of the Mitanin programme to understand their perspectives on this process and its outcomes. All the Mitanins expressed satisfaction with the process. Earlier they had to make several trips to the block Community Health Centre (CHC) to receive the cheque and then to the bank to deposit it even though the amount they received might be very meagre. Also, they earlier received incentives only for accompanying women for delivery and for complete immunization. Other incentives, like those for preparing a malaria slide, were not given to them. Now, they felt the system of receiving incentives from the panchayat itself saved them the bother of making those multiple trips to the CHC and the banks. It also made people in the community more aware of what they did, and the honorarium they received for it.

Both the Sarpanch and the secretaries felt that the system offered them an opportunity to engage with the Mitanins' work. The fixed day payment schedule also gave them a space to interact with all Mitanins of the village to learn from them on new schemes and to pass on any information that they wanted to. The District Coordinator informed that while with the earlier system, much of the amount earmarked for Mitanin incentives remained unspent, now the disbursements had actually increased as they were being paid all the incentives they were eligible for, thus making the system more efficient.

Financial control

In other experiences of community participation under the NRHM in various states in India, while the processes are funded by the government, either through their own departments or through NGOs, depending on state specific contexts, complete financial control by communities has not been achieved. This was also seen to be true in the projects visited in Tamil Nadu and Bihar. This level of centralized financial control has sometimes proven counter productive with state and district level administrations using this control to establish power, and direct the community participation process against the spirit of the process. For example in Tamil Nadu, the release of funds for the continuation/expansion phase of the CAH project has not been approved by state health authorities for almost one and a half years

at the time of this review. This has affected adversely the morale of NGOs implementing the project and has also resulted in a large gap in capacity building and facilitation of VHSNCs. As discussed earlier, such breaks in continuity affect the legitimacy of the programme in the eyes of the community and raise questions about the health system's commitment to the participation process.

This level of centralized financial control also raises questions regarding enforcing accountability. If state level officials control the funds for community level action, how is it to be expected that communities will be able to hold them accountable when there is always a fear of backlash and delay in or stoppage of release of funds? In such a scenario, both participation and accountability remain restricted, if at all, to the grassroots level and to front line providers. This precludes achieving any level of political accountability even at higher levels.

Untied funds

Some progress towards financial control by communities, however, may be seen as having been made under NRHM in providing untied funds, unlike earlier where all funds were earmarked for particular activities. Indeed, this fund has been used remarkably well for local action on health in the projects visited. Even here, there have been problems with line departments dictating how the funds are to be used and vested interests within communities making decisions regarding its use. While untied funds for community's use as per its needs are welcome, this small concession towards financial control could from another perspective be seen as tokenistic and taking away from complete decentralization.

Use of untied fund in Bihar

One of the key features of awareness of health entitlements through the Community Based Planning and Monitoring (CBPM) programme has been awareness on the untied fund. As the VHSNC in the state is constituted at the panchayat level, an amount of Rs 10,000 per revenue village is usually transferred to an account at the panchayat level. Generally, awareness regarding this fund and how it can be used has been very low.

Sachendra Paswan is the Mukhiya of Bahadurpur Panchayat in Rajauli block of Nawada district. He has been elected from a constituency reserved for the scheduled caste community and this is his second term as mukhiya. Paswan came to learn of the untied fund after the CBPM programme was implemented in his panchayat. He says even though he was the mukhiya earlier, he did not know anything about this fund and that it could be utilized for local priorities. This year, he has ensured complete expenditure of the money with the help of the Village Planning and Monitoring Committee (VPMC) members in various villages in his panchayat. The money has been spent on installing taps, repairing hand pumps, and constructing soak pits. Plans have also been made to use some of the fund for helping needy patients access health care next year.

In Bahadurpur village in the same panchayat, we met VPMC members - Sitaram Prasad, Kapil Dev Prasad, Brinda Devi and several community members. They told us about an additional Primary Health Centre that is functioning in their village in the premises of the Panchayat Bhavan. Only one ANM comes there on some days of the week and provides services. The VPMC members along with the community are for the last year making representations to higher authorities to get the facility fully functional. In the meanwhile, the VPMC decided that they would use the untied fund for buying essential equipment and furniture for the additional PHC. This has helped the ANM provide better services and improve the quality of antenatal care. Some community members raised questions about the money being used for this rather than for installing taps and repairing hand pumps in the village, but the VPMC members were able to explain to them that equipping the additional PHC was priority.

In Gaya district, the untied fund had been used in many villages to buy a fogging machine by pooling the money at the panchayat level apparently on instructions from district authorities. In Mananbhiga village of Kunjeshwar Panchayat, VPMC members were unhappy with this. They felt the purpose of the untied fund was for it to be used for local priorities. Instructions on how to use the fund from higher authorities they felt was against the principles of communitization and local democracy.

Key points in this section

- One of the basic objectives of community participation is decentralization. There are a few successful examples of financial devolution leading to true decentralization and community control.
- On the other hand, centralized financial control has sometimes proven counter productive with state and district level administrations using this control to establish power, and direct the community participation against the spirit of the process. This also precludes communities enforcing accountability from higher authorities.

3.4 Interface with the health system

One of the key features of the structure of community participation is the mechanisms that have been built in for them to interface with the health system. Committees for community participation could be at two different levels – community based committees and health facility committees. Each of these interacts with the health system at different levels.

Community based committees

Community based committees usually interact only with front line health providers – this could be during committee meetings in which health care workers participate, or through non formal interactions with these providers when they were met during the provision of services. Community based committees do not in general get to meet providers/officials at higher levels unless specific spaces are created for these. Creation of such spaces widens the influence of community participation committees beyond just village level and opens up spaces for wider action. For example, in the Community Score Card initiative by PAC in Bengaluru, periodic interface meetings are held with committee members and health staff and higher authorities of the municipal corporation, thus feeding in the community perspectives into provision of services in the facilities. Similarly, in the FRHS project in Karnataka, a meeting of presidents of the various committees was organized periodically to which higher authorities were invited, thus creating a platform for interaction between the committee and higher officials.(25) In some projects, committees have been federated and these federated committees get to interact with higher level providers and staff across departments – the federation in Thirumanur block in Tamil Nadu is an example.

In the absence of such spaces, community based committees interact primarily with frontline health providers only as in the case of VHSNCs in Chhattisgarh. While very active in promoting local community actions for health, their interaction with the health system is largely limited to that with front line providers. This limits the extent of influence that VHSNCs can have on provision of health care services. In order to complement the community action efforts at local levels, the Swasth Panchyat Yojana has instituted periodic surveys that feed information to the higher levels and block level *sammelans* that help community representatives feed in their concerns to block/district level authorities.

Federating VHSNCs at the block level – the Thirumanur experience from Tamil Nadu

While VHSNCs plan community level solutions at the panchayat level, the experience in Tamil Nadu shows that very often issues that are common to several panchayats or require solutions at the block and district levels.

In order to expand the planning exercise to a higher level, the block and district nodal NGOs in Thirumanur block used their experience of federating women's self help groups to create a block level federation of VHSNCs. Two active members from each VHSNC were selected as members of this federation. In addition, Gram Panchayat Presidents of these villages, Block Medical Officer, Community Health Nurse, Child Development Project Officer from Department of Women and Child Development, Assistant Educational Officer from the Education Department, Project Officer from Rural Development Department were invited to be members of this body. Some representatives from local NGOs were also invited. Initially there were some problems in getting the members, especially from the various departments, as well as the Panchayat Presidents, to attend the meetings of this block federation. Subsequently this space has been used to discuss several issues and also find local solutions. For example, issues of some Village Health Nurses (VHN) not going to *dalit* hamlets to give immunization was brought up in this space and was immediately sorted out with the Block Medical Officer taking the concerned VHNs to task and ensuring that the problem was sorted out. The block NGO staff also believe that this space has given them an opportunity to raise issues like staff vacancies and create pressure on the department to fill these.

NGO staff in the programme feel that such federation of VHSNCs is a step forward and needs to be up-scaled to other districts. There have however been some challenges too. Integrating this block level structure with the existing Rogi Kalyan Samiti has not been possible so far. Also, taking this process beyond the block level has also been a problem as the programme as of now does not cover the entire district. Up-scaling the CAH programme to the entire district, and similar federated structures formed at the district level with the involvement of the district collector will help in ensuring community participation and inter-sectoral convergence at the district level, they feel.

Some projects have used other modalities for facilitating community interaction with higher officials. Public hearings is one such strategy that has been tried out across projects in several states in India.(21,22) These serve as a forum where community members are able to present their views and grievances related to the performance of the health system to higher officials in a space that is facilitated by a third party. A detailed case study of such public dialogues is presented in a subsequent section.

Health facility based committees

Health facility based committees serve as a forum where community members can interact with providers in that particular facility. Several experiences from such committees have been reported in literature from Africa(45,46,48) and from Peru in Latin America.(46,47)

Several limitations have however been reported in the functioning of these committees. A key constraint has been the committee members' lack of clarity on their own role and lack of authority over personnel and finances. A traditionally hierarchical relationship between professionals and 'lay' community people also results in an imbalance of power between these two groups in these committees. Professionals often see community members as lacking the technical knowledge and skills necessary to participate effectively in these committees.(46,50) The experiences of Rogi Kalyan Samitis under NRHM from several states also point to the fact that this space is often controlled by the Medical Officer who has been provided convening powers over the committee, with community members often not being aware that they are even members, let alone participate. There are however exceptions – the experience from one PHC in Bihar shows the potential for the use of this space both to ensure financial accountability and to provide grievance redressal.

Activation of Rogi Kalyan Samiti in Bihar

Rogi Kalyan Samitis (RKS) have been formed at various levels of health facilities under the NRHM to ensure the local community's participation in the management of these facilities. An untied fund is also provided annually to these samitis to be used for improvement of these facilities.

In Bihar, while these samitis have been formed in facilities, they did not meet regularly earlier, and very often the local community was not aware of how the funds allotted were being spent. Under the Community Based Planning and Monitoring programme, district and block level NGOs have made special efforts to activate these samitis.

Block Pramukh Fasih Ahmed Khan is a member of the RKS of Imamganj PHC in Gaya district. According to him, RKS meetings were held very irregularly earlier. Things changed when during the Jan Samwad, the role of the RKS was discussed and several suggestions were made for solving issues through the RKS. Since then, the RKS has been meeting every month and deciding on issues related to the management of the PHC. The meetings have also been used to scrutinize the accounts of the RKS. A decision has been taken to use the RKS as a forum for grievance redressal. Plans have been made to install a complaint box in the PHC that will be opened on a regular basis by an RKS member and appropriate action taken.

The Medical Officer In Charge of Imamganj PHC, Dr Ramamoorthy Singh, was also happy with the way the RKS was contributing to the improvement of the services in the PHC. Essential medicines, including emergency drugs like oxytocin and anti-rabies vaccine were in short supply at the PHC. Activation of the RKS had led to some of these medicines being purchased from the RKS funds. This meant patients did not have to go running to medical shops during emergency for essential medicines. In addition, RKS funds had been used for buying tables and chairs, getting a platform built around a tree for patients and relatives to sit on, and getting the approach road to the labour room that was potholed filled up. The doctor now ensures that RKS meetings are held regularly. In his capacity as the RKS chairperson, he sends out written invitation letters every month for the meetings so all members receive timely communication regarding it.

Thus appropriate use of the RKS, the space for communitization in facilities, has resulted in remarkable improvements in patients' comfort levels and an improvement in the quality of services.

One big limitation with how community participation experiences interface with the health system is that in almost all experiences studied, the interaction for participation stops at either frontline staff or providers in lower level facilities. There seem to be very few where community members have participated in higher level facilities or in policy making bodies. Murthy and Klugman describe three experiences in which community based organizations were part of fora that were planning health reforms, either in design or in determining programme priorities. However, mere presence in these spaces did not give them voice and they were merely consulted without being able to take part in actual decision making. (18)

Key points in this section

- Community based committees usually interact only with front line health providers. Specific spaces need to be created for community based committees to interact with higher level providers. There seem to be very few experiences where community members have participated in policy making bodies.
- In health facility based committees, several factors affect the functioning of the committee - members' lack of clarity on their own role, lack of authority over personnel and finances, a traditionally hierarchical relationship between professionals and the 'lay' community – all of these result in an imbalance of power in these committees.

CHAPTER 4

PROCESSES FOR COMMUNITY PARTICIPATION

Community participation experiences from India and around the world are rich in processes. The literature underlies the importance of these processes in achieving genuine participation. This section describes the various processes that have been undertaken in different projects and experiences towards community participation. These are listed under the following heads:

1. Community mobilization and formation of committees
2. Capacity building
3. Community action – Information collection, monitoring, planning, action and follow up

4.1 Community mobilization and formation of committees

The first and probably the most challenging step towards community participation in most experiences is the formation of the committees of community participation. This usually takes several steps.

Engaging with the community

As a first step in most projects, efforts are made to engage with the community through its leaders and other members to help them understand the need for community participation. In projects where community participation is sought towards implementing a specific health intervention, the step involves explaining to the community the nature of the project and expected outcomes before enlisting its support and participation.

In order to ensure that participation is representative and inclusive of the community, it is necessary to understand the different groups within the community, and the hierarchies and power relations within them. This step of engaging with community leaders and the different groups has to consciously address these hierarchies and include different groups, especially the marginalized ones. The communitization process in different states under NRHM has seen such engagement. Several projects have used different methods towards this – for example, the Community Based Planning and Monitoring project in Bihar has used the local theatre form of *kalajathas* to engage with and mobilize communities and explain the details of NRHM and provisions for community participation under it. Significantly, in order to avoid elite capture of these committees and to ensure the inclusion of marginalized communities, in addition to meetings with village

leaders who are mostly male from dominant groups, meetings were held specifically in hamlets of marginalized communities and with women to engage them in the process. Similarly, in Tamil Nadu, as district and block nodal NGOs were already working in the project area on different issues prior to the communitization process of NRHM, they used the knowledge they had of the social hierarchies within the community to form a more representative VHSNCs as seen in the section below.

Where formal or autonomous spaces for community participation are being formed, the expected benefits of participation and expectations from the community are shared. In Gujarat, SAHAJ, which was trying to set up an autonomous space, used mass meetings in urban slums to establish communication with the community and to help them understand why participation was important.

Deciding design and composition of committee

The initial steps in forming and populating the committee, the space for community participation, also includes the **design of the committee**. Where the spaces are 'invited', that is, the programme is designed and implemented by the government, this design has already been done at the conceptual level by programme makers at the higher level. However, sometimes local modifications to this design are done to accommodate concerns of the community and to make the committee more representative. For example, in Tamil Nadu, existing VHSNCs were expanded at the beginning of the CAH project to make the membership inclusive of various marginalized groups. The VHSNCs constituted earlier had primarily front line health care providers as members with very little community representation. After repeated negotiations with public health department officials by the rights based NGOs implementing the project, it was agreed that the NGOs would expand the committee in the project villages with wider community representation from each hamlet of the panchayat, thus ensuring both geographical and caste-based representation. An expanded committee with wider community representation was thus constituted. The NGOs then advocated with the state government to get this recognized as the official VHSNC. Similarly, in Bihar, while the VHSNCs had been constituted at the panchayat level, the communitization process constituted a village level Village Planning and Monitoring Committee to make participation more decentralized and meaningful.

As opposed to the formal spaces described above, where autonomous spaces are concerned, a lot of scope exists for the community to decide what the space would be, who would be its members, what would be its role etc. For example, mass meetings held by SAHAJ helped communities have a say in the role of the committee and its membership, although SAHAJ placed before them a list of non negotiable conditionalities in order to ensure inclusiveness and representation. Similarly, before beginning its intervention, the FRHS project in Karnataka convened a meeting of various key stakeholders including health staff, active women panchayat leaders, local NGOs and representatives of youth groups and mothers' health groups(25). This served as an opportunity to understand concerns from various groups and to incorporate their suggestions in the design of the space. For example, it was suggested at this meeting that committee members should be selected by the community and not government staff, that there must be adequate representation of women and different castes, that committees must be given some seed money to start work and should participate in deciding what needs to be done. All of these helped decide the composition and functions of the committee.

Thus, it is seen from the various experiences that where possible, efforts need to be made to involve the community in deciding the composition and mechanisms of formation of the committees. This ensures that the community's local knowledge is made use of to make the committees more specific to the local context, increases ownership and makes the committee more inclusive and representative of the community.

Selection of committee members

Once the community has been mobilized and the composition of the committee planned, the next step in the process has been to **select committee members**. Different means have been used for this – most commonly, election through a democratic space like the Gram Sabha. This method was used in Chhattisgarh to form the VHSNCs. As already pointed out, this is the means possibly to ensure the greatest inclusiveness and representation of the committee. Other methods include those where active members of the community are suggested by either health workers or facilitators of the project who are then ratified through democratic means – this method was followed largely in forming Village Planning and Monitoring Committees in Bihar. In projects where the intervention is for specific interest groups, members from these groups are chosen, for example, the selection of women and adolescents in the Community-led Initiatives for Child Survival (CLICS) project in Wardha, to ensure their perspectives were represented to address Reproductive and Child Health issues.(27) Sometimes, already existent community groups are strengthened to facilitate participation, as in the Warmi project of Bolivia and the subsequent MIRA trial in Nepal where existent women's groups were the space for participation.(40,41)

The life of the committee, that is the tenure of membership, varies from project to project. Under the NRHM, it has been suggested that the VHSNC would be active for the same duration as the Panchayat, i.e. five years, and would be reconstituted after a subsequent election. (13) For example, in the Tamil Nadu CAH project, the VHSNC was reconstituted after panchayat elections were held. In more autonomous spaces, the tenure is more flexible. In the Vadodara experience of SAHAJ, committee members remain active as long as they wish to or their life circumstances allow them to and more members are taken in as and when they show interest or older members drop out. This helps retain a large pool of interested persons in the community as even members who drop out remain aware and participate in activities as and when the need arises.

It has very often been seen that this process of forming the committees could be derailed by people perceived as elite who nominate their own friends or family to these groups to keep their power. This has been a phenomenon that most projects have been aware of and made efforts to avoid with varied degrees of success. One of the ways this has been done is to engage with the whole community in transparent public meetings and evolve criteria as to who can be members of the committee and who cannot. Such a method was used in the SAHAJ project to form the Community Development Committees. Experiences from the Community-led Initiatives for Child Survival (CLICS) project in Wardha(26) and the FRHS project in Karnataka(25) that used such a community consultation show that this can to some effect mitigate the influence of elite members in the community.

Thus it is seen that formation of community participation committees is a critical step that involves intensive processes. It has often been seen that VHSNCs and Rogi Kalyan Samitis are constituted in several states through nomination of members who are considered close to the powers that be. If genuine participation has to be ensured, then investment of time and resources needs to be made in the process of forming committees and selecting its members.

Key points in this section

- Community participation programmes are process intensive and investing in these processes is important to achieve genuine participation.
- As a first step, community leaders and other members of the community need to be engaged with to help them understand the need for community participation. During this, the programme has to consciously address hierarchies within the community and include different groups, especially the marginalized.
- Efforts need to be made to involve the community in deciding the composition and mechanisms of formation of the committee to ensure it is specific to local context, ownership of the committees is present, and the committee is inclusive and representative of the community.
- Selection of committee members through election by a democratic space like the Gram Sabha ensures the greatest inclusiveness and representation of the committee.
- The process of forming the committees could be derailed by the elite who nominate their own friends or family to these groups to keep their power. Efforts must be made to avoid this. Public consultations held widely in the community to evolve criteria for selection of members is one strategy that has been tried with some success.

4.2 Capacity building

Capacity building of committee members

Once the committee has been formed and members selected to it, the next step is to build the capacity of its members to understand the issues at hand and act on them. According to Zakus and Lysack, this capacity building is around five domains: community organizing, problem solving and priority setting, health information collection and analysis, health intervention planning and delivery, and programme evaluation.⁽⁹⁾

However, in addition to the above, most NGO-led projects have had a core component of attitude building that included sessions on **human rights and health entitlements**. These are seen by these NGOs as a critical component of the capacity building for community representatives to understand the rights framework and apply it in their subsequent functioning.

Various groups have done the capacity building differently. Most projects have pre designed modules that cover various topics in the capacity building. Additional topics are then added on based on the needs of the project and demands from the community. For example in the Tamil Nadu CAH project, a lot of focus has been given to the logic of the health system, the reasons why services are structured in a particular way, so that communities can interface with the health system with such an understanding. In others like the SAHAJ project, the capacity building is completely need based and dependent on demands for inputs arising from the community.

While capacity building is a crucial step, preparatory steps including the presence of dedicated state and district level teams of trainers, development of curriculum and training methods that are peer reviewed and field tested, quality control of cascade structure of training are important issues that programmes need to plan and invest in. As many committee members belong to poor and marginalized groups and may not have high levels of formal education, the methodologies for capacity building in several projects are informal and include use of songs and theatre, and audio visual material.

One important component of capacity building is through **ongoing training at periodic meetings** of the committees and problem solving with the help of community facilitators. For example, in Chhattisgarh, the Mitadin trainer attends every VHSNC meeting and uses this opportunity to give knowledge inputs and also facilitate an action plan. She also helps follow up on actions planned at previous meetings. Similarly, in Tamil Nadu, field animators on the project attend most VHSNC meetings to provide supportive supervision. In Vadodara, SAHAJ staff attend meetings of the Community Development Committees in the early months of their formation in order to facilitate their functioning. While after the initial few months they stop attending every meeting in order to foster independent functioning of the committees, they remain available if the committee needs help and support at any time. Programmes need to factor this component of ongoing capacity building while planning community participation programmes. Thus, support needs to be provided to community facilitators to sustain this component beyond the period of committee formation and initial capacity building.

Capacity building of support staff

In addition to capacity building of committee members, most large projects include cascade training where training is given to support staff who in turn train staff down the line and community facilitators. While pedagogical issues related to these trainings are beyond the scope of this review, one key challenge faced in these trainings has been to ensure that staff in the support structure play a facilitatory role and foster participation, rather than cross the thin line to become instructors who direct the community on what “should” be done.

Many projects have made use of staff who are already trained and experienced in community processes through other programmes. In Chhattisgarh, the role of the community facilitator is played by the Mitadin trainer who has already undergone several rounds of training under the Mitadin programme. This enhances her ability to provide ongoing supportive supervision to the VHSNCs. Similarly, in Tamil Nadu, the facilitators are field animators who have already worked under the community based literacy programme, Arivoli Iyakkam, or in the earlier Border District programme. In both these examples, the communitization programmes’ sustainability stems from the use of these available resources.

Sensitization of health system staff

While most community participation experiences have focussed on training community members belonging to the various committees and members of the support structure including facilitators, various studies have also shown that a big failing in many projects has been the inability of health care providers and health system staff to understand the value and purpose of community participation. As McCoy states in his paper, “Community participation in health programmes ask as much of health professionals as they do of citizens, by requiring them to learn new skills (such as adult learning approaches, conflict resolution, facilitation and participatory research) and to view health in a more holistic way, not solely from a disease-oriented perspective.”⁽⁴⁶⁾ While this is a tall order for health professionals who have spent their lives in traditional hierarchical health systems, very little effort seems to have been made to actively engage with this group and build their attitudes and capacities towards this. Several studies have pointed out that negative attitudes of providers and their lack of skills to negotiate with community members leads to adverse outcomes in community participation experiences. One positive example is the effort made within the Tamil Nadu CAH project to engage with health providers and sensitize them to the values of participation and accountability.

Sensitizing health care providers and panchayat representatives to community participation

In the pilot phase of the CAH programme in Tamil Nadu, it was seen that health care providers at the level of the village and primary health centres had several misconceptions about the programme. They felt it was an NGO- run programme, was questioning their competence and authority, and turned people against them. Since their traditional lines of accountability ran up the system, they did not understand the need to be answerable to the community. Similarly, Panchayat Raj representatives also did not seem to understand the aim of the programme – they felt they had no right to question the health department. Panchayat representatives also felt they came under the Department of Rural Development and would only implement any activity if the department gave them instructions to do so. Also, as in Tamil Nadu, there is a strong presence of political parties at even the Gram Panchayat level, questioning the department was seen as questioning the ruling establishment and party.

These reactions of health care providers and panchayat representatives brought home strongly the need for engaging with them in the initial phases of the programme and sensitizing them to the need for community participation. The state and district nodal NGOs, thus decided to hold sensitization sessions with these two groups. The sessions were held differently in different districts. Where support from district health authorities was available, this was held under the aegis of the health department. Where district level panchayat members gave support to the programme, they took on the onus of organizing such events. Half to one day sessions were held with health care providers and Panchayati Raj representatives.

Following these sessions, the state and district NGOs report a change in attitude of both health care providers and Panchayati Raj representatives. Providers now see this as part of NRHM, and thus demonstrate increased ownership and response to the programme, participating more readily in meetings and responding to VHSNC members. Panchayat Presidents feel this has increased the level of awareness on health entitlements in their villages. They themselves are able to use the results of the monitoring to hold front line staff accountable.

Key points in this section

- An understanding of human rights and health entitlements is a critical component of capacity building for community representatives in addition to knowledge and skill inputs.
- Preparatory steps towards capacity building including the presence of dedicated state and district level teams of trainers, development of curriculum and training methods, quality control of cascade structure of training are important issues that programmes need to plan and invest in.
- Training at periodic meetings of the committees and problem solving with the help of community facilitators is an important component of ongoing capacity building. Support needs to be provided to community facilitators to sustain this component beyond the period of committee formation and initial capacity building.
- Cascade training for support staff and community facilitators needs to ensure that the staff in the support structure play a facilitatory role and foster participation.
- An important failing in many projects has been the inability of health care providers and health system staff to understand the value and purpose of community participation. Efforts need to be made to engage with health providers and sensitize them to the values of participation and accountability.

4.3 Community action

Once the committees are formed and their members have been trained, the actual process of communities participating in health systems actually begins. Community participation can take many forms and is expected to result in community action for health. This section describes the various types of actions performed by committees towards participation, monitoring, and action. It is organized under the following headings:

- Collection of information and monitoring
- Planning, action and follow up

While these steps are cyclical and linked with each other, for reasons of convenience and understanding, they are arranged and described individually.

Collection of information and monitoring

Committee members need to understand the health status of their community before undertaking action to improve it. Thus, the first step in community participation described in most projects in the literature is the collection of information – about existing health status, about gaps, about factors affecting health - that can then guide further planning and action. Different projects on community participation collect different types of information based on what their guiding principles and objectives are, and have different ways through which such information is collected.

Many projects have **pre-designed tools** for collection of information by community participation committees. The Tamil Nadu CAH project has used such a tool for collection of **information regarding fulfilling of entitlements**. However after the first round of information collection, the tool was simplified after feedback and inputs from community members. Similarly, the Community Based Planning and Monitoring projects in Bihar and in Maharashtra have also used such a pre-designed tool. Some of these tools are used at the health facility too, both in Maharashtra and Tamil Nadu. The tools also involve monitoring availability and quality of services by committee members at their local health facilities. One significant feature of all these tools has been the efforts made to simplify them and make them understandable for even a non literate audience. In the Tamil Nadu and Bihar projects for example, services are graded on a colour coding system based on a traffic light logic – green for good, yellow for average and red for poor. In Maharashtra, pictorial tools with the use of a specific number of *bhakis* (local bread) to determine levels of satisfaction have been used to make the tool friendly to the local context.(21,22)

The above mentioned projects, as many others, have collected information on access to entitled services and benefits as they are guided by holding the government accountable to its promises. Some others have collected **information on health outcomes** with a view to using this information for local action. In the Swasth Panchayat Yojana of Chhattisgarh, VHSNC members collect information on births and deaths in the community, in addition to information on 29 indicators related to health. These again inform planning and also help to identify maternal deaths or infant/child deaths. Similarly, health outcomes were monitored in some earlier projects that pre dated NRHM. In the Peoples Health Management Information System (PHMIS) project in Rayagada district of Odisha, community monitors maintained a Swasthya Patta register detailing births and deaths, which was then used to discuss causes of deaths and possible action to address these (29). In the Swasth Plus project in Karnataka, community based Neighbourhood Leaders collected information on “individual red alerts”, risk factors for reproductive and child health problems, to identify at risk women and children. The information was then shared with concerned line departments.(29)

Some projects have not used a formal tool, but committee members use the community participation space to discuss lived experiences of their daily lives and identify gaps and points of action through this. The Community Development Committees in Vadodara are examples of this. Here, specific issues identified by the community during these discussions have subsequently at times been supplemented with information collected through specifically designed surveys around these issues. Similar methods have been used in the Warmi project and its offshoots in Nepal, Jharkhand and Bangladesh where women's groups were facilitated by volunteers to analyse their lived experiences to carry out a process of auto diagnosis and action – learning cycles.(40–43) Similarly, the Mahila Swasthya Adhikar Manch, a community based initiative for maternal health rights in Uttar Pradesh, supplements information from women's lived experiences with periodic surveys on specific entitlements to inform action.(28)

Monitoring the Anganwadi

In addition to forming Community Development Committees, SAHAJ has also helped form specific user groups in some *bastis*. Matru mandals or mothers' groups of pregnant and lactating women, and mothers of young children are one such group of users of services from the Integrated Child Development Services (ICDS) programme.³

In Gayatri pura, a *basti* in Vadodara, women of the Matru Mandal have been engaging with the anganwadi for over a year now. Earlier, the anganwadi lacked a helper. Thus, against the 30-35 children in the *basti* who should be going to the anganwadi, only 10-12 children would do so as their mothers who went out early morning as domestic helps could not drop them off at the scheduled time. The lack of a helper also affected the quality of food served to the children.

When the members of the Matru Mandal spoke to the Anganwadi worker about these issues, they got to understand that the lack of the helper was the root cause. They then sent out applications to the ICDS Department and got the post of helper filled. Since then, more children have been attending the anganwadi everyday.

The Matru Mandal members also decided that they had to ensure the quality of the food served to their children. Therefore, they devised a system by which one of them in turn goes to the anganwadi everyday before the food is served to the children, tastes and checks its quality.

Apart from the community's own efforts at collecting information, projects have supplemented the collection of information through **surveys done by implementing NGOs** or support structures of the project. The results are then fed back to the community to facilitate action. For example in Chhattisgarh, the SHRC facilitates the Swasth Panchayat survey in addition to the regular monitoring by the VHSNCs to identify performance levels of various panchayats. Similarly, in the Public Affairs Centre (PAC) project in Bengaluru, PAC and its partner NGOs conducted a Citizen's Report Card exercise that was then used to facilitate action at the local level. Similar exercises have been carried out in Uganda.(45)

One interesting feature in the PAC experience in Bengaluru is that the tool used for the Community Score Card Exercise was filled both by the community and health facility staff independently. This was then compared and contrasted, and reasons for any differences in scoring on specific indicators were discussed at the interface meeting. This helped health care providers to put across their perspectives and challenges regarding service provision.

In addition to the periodic collection of information as detailed above, some projects also have **events like the Public Hearing or Public Dialogue** for which specific information on certain subjects like denial of care is collected and shared. In Bihar, where a round of Public Dialogues have been conducted in the various districts where the Community Based Planning and Monitoring project is being implemented for the past year, Village Planning and Monitoring Committee members and NGO staff identified cases of denial of care from

the community and obtained written testimonies validated by elected representatives to present at the Public Dialogue. This is described in more detail as a case study subsequently. Similar Public Dialogues at various levels including block, district and state levels, have been conducted regularly in Chhattisgarh and Maharashtra.(21,22)

The primary goal of all these various methods of collecting information is to guide community action. Once the information is collected, most community participation experiences use the information for local action by the community. In Chhattisgarh, the information collected is used by the VHSNC to identify gaps and plan local action. Similar is the case in other projects in Bihar, Maharashtra or Tamil Nadu. Even when no formal tool is used to collect information, sharing of experiences in the committee facilitates use of this information for local action.

In some projects, the information, in addition to being used locally, is also fed in to the project support structures to facilitate advocacy at different levels, like the state or district. In such cases, compilation of such information coming from different geographic areas is done by the support structure of the project. This is seen in the Swasth Panchayat Yojana in Chhattisgarh and in the Tamil Nadu CAH project. Thus, even though the community may not have a space to voice its views with higher levels of the health system, information collected by it informs programmes in some form at least. Rarely, in some projects like the Swasth Plus project in Karnataka, the information, in this case on Red Alerts, is fed in to the project and subsequently to various line departments to help service provision, and is not used by the local community itself.(29)

The type of information collected varies according to the objectives of the project. In projects that promote local action for local problems, the information collected is usually related to health status and gaps. However, in projects that look at community participation to increase accountability of the health system, the information collected is related to entitlements promised by the state and access to them. The information is thus used as a way of monitoring by communities and holding the state accountable. However, as mentioned earlier, not all projects collect information with the purpose of monitoring. While some projects promote local participation, Others demand accountability by engaging with entitlements that are due to the community.

However, it must be mentioned that information collected even for monitoring pertains only to health services that are promised to the community. There do not seem to be spaces in any of the projects reviewed to monitor policy making. Thus information collection is also not geared towards this.

Planning and action

The next step after collection of information is planning and action. Most community participation experiences have some form of local planning and action towards change or towards project objectives, that completes the cycle of monitoring and action.

In most community participation experiences in the literature reviewed, planning and action are predominantly at the local level. Committee members plan and implement action that they themselves can carry out with help from Community Health Workers or community members. For example, in Chhattisgarh, monitoring around 29 indicators leads to local action plans like pouring kerosene in ditches with water to prevent mosquito breeding, repairing hand pumps, getting the drinking water tank cleaned etc. Similar is the experience of planning from the Tamil Nadu CAH project. In the MIRA trial in Nepal, women's groups strategized around maternal and newborn issues and some examples of local solutions were local generation of funds for care, provision of clean delivery kits, preparation of audio visual material for awareness building.(41)

Sometimes, the plan is for action by front line health providers with whom community members have established contact on a regular

³ ICDS programme of the Government of India aims to improve the nutritional and health status of children in the age-group 0-6 years.

basis. Presence of health workers in committee meetings aids this further by helping them understand each others' perspectives and limitations and making plans to overcome such issues. Such actions could include requesting/demanding that the ANM visit regularly, or that the Anganwadi worker serve more wholesome food in the Integrated Child Development Scheme (ICDS) centre. Sometimes, interface between the community and front line health providers also leads to community action to help support these providers – for example, arranging for a cot to facilitate abdominal examination during antenatal care or buying a blood pressure apparatus.

Strengthening of Village Health, Sanitation and Nutrition Day

The Village Health, Sanitation and Nutrition Day (VHSND)⁴ has been envisaged as an opportunity for convergence at the ground level of activities of the Integrated Child Development Services (ICDS) programme and the health department's outreach programme. However, according to reports from community members in the Community Based Planning and Monitoring programme in Bihar, this translated very often only to distribution of Take Home Rations and routine immunization.

This was the situation in Nawadih village of the panchayat of the same name in Kawakol block of Nawada district too, before the implementation of the CBPM programme. The Village Planning and Monitoring Committee (VPMC) members of the village Sangeeta Devi, Kanchan Kumari (ASHA), Usha Devi (Anganwadi worker), Ramavtar and Ranjit Kumar, understood the importance of the VHSND and the services that they were entitled to as part of the trainings they were provided under the CBPM programme. They realized that the ANM had some limitations in providing the full component of antenatal care services in the Anganwadi centre in their village, the venue of the VHSND. The ANM did not have a blood pressure (BP) apparatus and there was no privacy to perform abdominal examinations on pregnant women. They discussed it at their VPMC meetings and subsequently with their block and district level NGOs too to explore solutions for the problem.

Subsequently, they discussed the issue with community members in their village and explored local solutions – a community member now donates a cot on the day of the VHSND that is placed in a small room attached to the ICDS centre to facilitate abdominal examination. Since the community had made a contribution from its side, the district NGO, Grameen Nirman Mandal, decided to give the ANM a BP apparatus that it had to ensure BP check-ups for pregnant women. Now the full component of antenatal care services is being provided on the VHSND along with routine immunization.

In Rajauli block of Nawada district too, there were several misconceptions among people about immunization. Parents did not want their children immunized. *"Ham iske bare mein baat karte the, to hamein dande lekar bhagaate the"* ("we were chased away with sticks if we talked about it") says Maya Devi, cluster coordinator of the block NGO under the CBPM programme. However, the awareness created through the CBPM programme has changed this. In Gariba village of Bahadurpur panchayat in the same block, VPMC members now take an active interest in the VHSND taking place in their village. Earlier, according to Lalan Yadav, VPMC member, they did not even know if the ANM visited their village.

"Hamein ANM, ASHA, anganwadi se koi matlab nahin tha!," he says,

But they now realize the importance of the services that should be provided to them. At the monthly VPMC meetings, each VPMC member brings up issues of people from the *mohalla* he or she lives in. In addition, they also motivate them for immunization. They have also ensured that BP examination is done for pregnant women at the VHSND. After each VHSND, they meet the ANM and ask her what services she had provided on that day and how many children were immunized.

In an interesting case study from Tamil Nadu, village level committee members have found space to participate in planning meetings at the local Primary Health Centre. This has been done at the initiative of a supportive PHC medical officer and shows how individuals within the system who are supportive of the programme can open up further spaces for community participation.

⁴ Village Health, Sanitation and Nutrition Day (VHSND) is envisaged as a medium to take primary health care delivery to every doorstep, under the NRHM. It provides a platform for communities to easily avail of all the provisions of preventive and promotive health care services under one roof and in their own village.

Community participation in PHC planning

One of the innovations that has emerged out of the Tamil Nadu CAH programme is to involve community members in regular planning meetings at the PHC. This was initially attempted in Thirumanur block of Ariyalur district.

The medical officer belonging to one of the PHCs in the block of the project area is very supportive of the CAH programme. He believes that by bringing health providers in direct contact with community representatives, the process helps detect any problems in the initial stages and find solutions before the issues become too big to solve. In order to increase such interaction between community members and health providers, he invites members of VHSNCs and representatives from Gram Panchayats that his PHC covers to the monthly planning meeting held at the PHC. This provides an opportunity for community members to present any issues they may have in their villages, or in the facility. It also helps them understand the workings of the PHC, any issues they may be facing and participate in the planning of activities at the PHC. The state nodal NGO is now making efforts to up-scale this process to the entire programme across the state.

The response of all medical officers has however not been so welcoming. Another PHC medical officer this author interviewed felt the process was leading to a lot of confrontation between communities and health care providers. He also questioned the validity of the monitoring process and felt exit polls bring in negative feedback that demoralizes health staff.

Sometimes when local action does not achieve desired results, community members have scaled up the level of action to include protests, and meeting with higher officials. In the SAHAJ project, when community members failed in their initial action to improve services at the Public Distribution System (PDS) outlet, they gradually escalated levels of action to include protests and submission of memoranda to higher officials.

Addressing corruption in the Public Distribution System

One of the first issues taken up by the Community Development Committee of Mujmahuda *basti* was that of corruption in the Public Distribution System (PDS) shop. This issue was brought up repeatedly during committee meetings. In order to understand the issue in further detail, committee members, with the support of SAHAJ staff, undertook a small survey in the *basti* that revealed several shortcomings – the shop was opened for fewer hours than recommended, adequate quantities of grains as per entitlements were not being distributed, the price charged was much higher price than the stipulated rate and the shopkeeper was probably siphoning off goods to his private shop. In addition to the survey, committee members were supported by SAHAJ which held training sessions for them on PDS entitlements and also printed material on this.

Equipped with knowledge regarding their entitlements and information on the existing situation in their *basti*, committee members decided to take action. Attempts to dialogue and reason with the shopkeeper proved futile. Committee members then photocopied ration cards of households that documented the irregularities and submitted them to the PDS department and also petitioned the Deputy Collector. However, since no follow up action resulted, the committee organized a protest rally to the shop.

On the day of the rally, as the issue resulted in widespread resonance in the community, several hundreds of people joined in and marched to the PDS shop to protest against the irregularities. SAHAJ staff helped with focusing media coverage on the event. The rally and the associated media coverage gained the attention of concerned authorities who suspended the license of the shopkeeper for a couple of months.

Following this, a committee member was chosen by the community to temporarily receive, store and distribute stocks with the help of the PDS department till the issue could be sorted out. Committee members also faced threats from the shopkeeper, but remained unfazed and in fact lodged formal complaints against him for the threats.

Subsequently, the same shopkeeper was re-awarded the license due to his political connections. However, people now receive their entitlements as they are able to question him and monitor what they receive.

According to committee members, this successful action against corruption greatly energized the committee members. It also raised their standing and support in the community with more members opting to join the committee after this campaign.

When the committees are at the health facility level, plans and actions revolve around services provided at these facilities. This could include use of local funds for better drug availability, ensuring better staff behaviour etc. Again, the coming together of community members and health providers in these committees facilitates their understanding of each others' problems and limitations.

Maternity Home Monitoring Committee at GG Halli maternity home in Bengaluru

The Maternity Home Monitoring Committee (MHMC) members of GG Halli maternity home all live in slums around the home. The members say a lot of changes have taken place in the last two years that the committee has been functioning. Earlier, they would hardly ever go to the facility fearing caste and language-based discrimination. Even though they lived in the city and near the centre, many deliveries took place at home. But since the formation of the committee and the raised awareness about their entitlements, they have begun spreading this awareness among their community members and this has resulted in several changes.

The women use their informal everyday interactions with others in the community to talk about the things they learn during the committee meetings. This has resulted in many more women now accessing services from the facility. The ID cards they have been given as committee members have also added to their acceptance, both in the community and in the facility. Earlier, they used to be afraid to talk even to the guard at the centre, but are now treated with respect, even by the doctors. Another area that they have seen remarkable improvement in is in the decrease in corruption levels at the centre. The interface meetings give them an opportunity to present their issues before providers and also helps them understand their problems. For example, they now understand that many of the services promised to them are not being provided because there is a shortage of doctors in the centre. They have now submitted a letter to higher authorities requesting additional doctors for the facility.

In literature, the role of health facility committees has been described as spanning the following domains: governance, co-management of the facility, resource generation, community outreach, advocacy on behalf of the community, providing intelligence on community needs and as a social leveller helping marginalized communities access care. Thus, some actions are seen to be "inward looking" towards the health facility and some "outward looking" towards the community.(46)

Sometimes the planning and action is mediated by a third party facilitator. During public dialogues in India, such third party facilitators are part of the design and help achieve negotiated plans and solutions to issues raised. Experiences from Maharashtra and Bihar show how issues like drug availability at facilities have been resolved through discussions during public dialogues.

While the above experiences are all of action by communities locally to improve their health, thus in a way operationalizing Peoples' Health in Peoples' Hands, in very few cases this local planning or action fed to higher levels of the health system. In some cases like in Tamil Nadu, the facilitators and support structures supplemented local action by raising some of the issues coming up across various geographical areas at the state level. However, this was not done by communities directly as space for such engagement was absent. Similarly, in a state like Chhattisgarh, where regular local planning is being done by VHSNCs, this has not fed into block or district level planning – the reason again being the absence of space for the local process to feed into higher levels of planning at the block, district or state level. Also, district plans are made on a set prescribed format that leaves very little scope for any flexibility for the community's perspective to be built in. The short time frames that are part of these planning processes also leave very little room for intensive processes that are needed for decentralized health planning to be meaningful.

In addition to lack of space to take the planning and action up to higher levels, the actions emerging out of community participation initiatives have remained limited to local level and not those concerning policy or programme design. For example, poor drug availability in facilities has been solved to some extent through local purchase with local funds, without actually changing drug procurement and distribution policies that have actually led to the unavailability in the first place. Similarly, issues like human resource availability have also

been solved through ad hoc solutions rather than resulting in systemic change. This is because the space for community participation has been limited to the local level and even where some space has been created at the district or state level, this has very little voice in policy or programme making.

Jan Samwad – the experience in Bihar

As part of increasing engagement between communities and the public health system under the Community Based Planning and Monitoring (CBPM) programme, Jan Samwads facilitated public dialogues between people, local governments and health care providers - are held in Bihar.

The process of holding a Jan Samwad is intense. Block and district level NGOs have to put in a lot of effort to prepare for it. According to Ashok Kumar, block coordinator of the CBPM programme in Rajauli block of Nawada district, the project staff were initially given training on how to hold a Jan Samwad and also provided a check-list by the state nodal NGO for the same. Following this, they identified instances of denial of health care and issues emerging from these. With the support of Village Planning and Monitoring Committee (VPMC) members, NGO staff got written testimonies from persons who had faced such denial. These testimonies were also signed and stamped by the concerned Panchayat Ward members so as to validate them. As an additional step of validation, these testimonies were submitted to the respective Mukhiyas of each of these Panchayats who then independently verified that such denial had indeed taken place and then countersigned the testimonies. After this, with the support of the Mukhiyas of these panchayats, some of these testimonies were selected for presenting at the Jan Samwad – this was done so as to cover a range of issues emerging from the testimonies.

A public venue was selected at the block headquarters for holding the Jan Samwad. In different blocks, the invitation for the Jan Samwad was extended by different persons belonging to the health system. In some, this was done by the Medical Officer In Charge and in some, by the Block Planning and Monitoring Committee (BPMC). This increased ownership of the process by the system. A group of eminent panellists was also invited to facilitate the Jan Samwad. These included elected representatives from the district and block level, district health officials, block authorities and in some cases, rights activists and media representatives.

On the day of the Jan Samwad, in addition to presentation of the testimonies, generic issues like drug availability and informal payments that came up repeatedly in the testimonies were collated and presented by the different Mukhiyas who had taken responsibility and prepared ahead for this. The issues raised were discussed by the panellists and solutions were based on these discussions. Follow up action was then taken up accordingly.

The Jan Samwad was seen as a watershed event in all the blocks and districts of the project. Several issues came up from the testimonies presented at the Jan Samwad. These included issues of drug availability in the health care facilities, rude behaviour of staff towards patients, charging of informal payments, need for grievance redressal mechanisms. Many practical solutions also came out of the Jan Samwad. Panellists recommended in various blocks strengthening of Rogi Kalyan Samitis (RKS), use of RKS funds for purchasing locally emergency drugs, setting up of complaint boxes in the facilities. Medical Officers In Charge apologized for rude behaviour of their staff and the informal payments and promised to make amendments so these instances did not recur. Follow up action has resulted in several changes – strengthening of the RKS in Imamganj and Fatehpur, plans to set up a complaint box in Imamganj PHC, purchase of emergency drugs in Fatehpur and Imamganj PHCs.

The Jan Samwad has resulted in communities realizing that they can demand accountability from health care providers. With motivation from project staff and VPMC members, people reported speaking up about issues that had been troubling them for a long time. While earlier they would feel scared to even talk in front of the doctor and other officials, the CBPM programme had taught them that health was their *adhikaar*(right). The presence of independent panellists and the strength provided by numbers helped them overcome their fears to speak up about these issues. Most VPMC members and Panchayati Raj representatives felt that these Jan Samwads need to be held regularly. Many reported that there seemed to be change in the attitudes of health care providers towards patients and that informal payments had stopped at least temporarily in many facilities. Some community members however seemed to misconstrue this process. Several used language that blamed the health care providers and portrayed the process as a trial - "*Doctor ko sar jhukana pada*", "*Judgement bhi diya gaya*".

An interesting experience from Maharashtra provides further insights into this. SATHI, the state nodal NGO of the Maharashtra Community Based Monitoring and Planning programme, also tried to promote decentralized health planning through a complementary project. Workshops were held with health providers and panchayat representatives to discuss issues emerging from the community monitoring and planning process and to explore how these could be incorporated into the Project Implementation Plan (PIP) development process at district level. Capacity building was also provided for civil society organizations involved in the community monitoring programme to understand the process of PIP development. A subsequent study of Rogi Kalyan Samitis showed that expenditure of funds on issues raised by the community monitoring process was greater in the year of the intervention than in previous years.(22) This shows that the incorporation of community's inputs into decentralized health planning will not take place automatically. Appropriate capacity building for community participation for needs to be provided so that action plans from the communitization processes can be incorporated into decentralized health planning process.

One of the serious limitations with respect to such bottom up planning is the absence of financial mechanisms that support such processes. Experiences from Brazil and Kerala show that true participation from below is possible only when communities are also provided with matching financial powers.(35,54) As one senior administrator interviewed as part of this study said , “ The design of the district planning process as it is presently does not allow bottom up planning by its lack of financial devolution”.

Key points in this section

- Community participation can take many forms and can include collection of information, monitoring, planning, and action for health.
- The type of information collected varies according to the objectives of the project.This can include information on health status of the community, health entitlements and health outcomes.
- Information could be collected through various means – pre designed tools, discussion of daily lived experiences, surveys through supporting organizations, and through public dialogues like the Jan Samwad.
- Whatever the means used, it is important to make the process user friendly for persons with low education levels, simple and to include marginalized communities.
- Communities, when adequately supported, use the information collected to plan action. Presence of health workers in committee meetings aids actions to improve community based health services by helping them understand each others' perspectives and limitations and making plans to overcome such issues.
- While there are several examples of local community action for health, in very few cases this local planning or action went up the ladder to higher levels of the health system as space for such engagement was absent.
- In order to incorporate community's inputs into decentralized health planning, appropriate capacity building in spaces for community participation needs to be provided.
- Similarly, actions emerging out of community participation initiatives have remained limited to the local level and do not concern policy or programme design, because the space for community participation has been limited to the local level and has little voice in policy or programme making.
- One of the serious limitations with such bottom up planning is the absence of financial mechanisms that support such processes of decentralization. Communities being provided with matching financial powers are one of the mechanisms that has been tried with some success.

CHAPTER 5

THE ROLE OF THE CONTEXT IN COMMUNITY PARTICIPATION

As community participation is dependent largely on processes rather than being an intervention in itself, it plays out differently in different contexts. Various community participation experiences show that the context in which community participation is implemented plays an important role in how it develops and the impact it has. Here, the context is discussed around three areas.

- Context of the health system
- Socio cultural context
- Political context

5.1 Context of the health system

First, while community participation has been seen by institutions like the World Bank as increasing efficiency and bringing in extra resources, community participation experiences show that it can work only in the context of a functioning primary health system, or at least where commitment is present to make it functional. Only in such a situation can health systems respond to expectations and demands that arise out of communities' monitoring efforts or analysis of information to plan action. In situations where the health system is neither functional nor is there commitment to do so, efforts of the community are usually limited in the best case to changes they can make themselves, and in the worst, to cynicism that precludes further participation.

One example that reiterates this is the contrast between community involvement in the Border District Programme in Tamil Nadu in the 90s and the CAH programme in the same state under NRHM. In the former, while investments were made to foster community involvement, this was not accompanied by concomitant investments in the health system. However, the community involvement under NRHM has happened in a context where substantial inputs are being given to the health system and the state is recognized as a role model of primary health care. According to a senior district coordinator of the programme who has been involved with both programmes, the latter situation with a functioning public health system has seen community participation being much more effective and meaningful for all involved.

In the case study below, in a context where the health system has traditionally been very weak and vested interests have a stranglehold in some areas, the use of the Public Dialogue, a space for community participation, by an ASHA to bring up issues of drug availability only resulted in her being threatened with no real solutions in sight. Similarly, there is a danger of spaces like the Rogi Kalyan Samitis also being taken over by such vested interests.

An ASHA stands up against corruption

One of the important outcomes of the increased awareness arising out of the communitization programme of NRHM has been that people are questioning corruption and informal payments within the public health system. This is one such instance. The names and other identifying features of the persons concerned are not being kept revealed at the ASHA's request.

An ASHA learnt through the communitization programme trainings that services in public health facilities were supposed to be free of charge. She had known this even earlier through the ASHA training, but the communitization programme reiterated this and also provided support in the form of other committee members in her village. In spite of this, two women she accompanied for delivery to the PHC were asked to pay for services and also asked to buy drugs from outside.

The ASHA raised this issue by presenting her experience in the Public Dialogue held in the block. While the issue was discussed and decisions made to buy emergency drugs from the RKS funds, she was subsequently targeted by politically powerful individuals affected by this. She also faced threats to her life. When she complained to the block authorities against this, she was asked to give a written complaint which she did. However, no action has yet been taken on this.

The ASHA shared with us that she was not worried about being targeted; she knew she had done the right thing and would therefore continue to do what she believed in. What she was upset about was the fact that when she faced threats to her life, none of her colleagues or the staff at the PHC came to her support. The only quarters she received support from were the staff of the communitization programme and her own family members.

This instance brings to the fore the risks that individuals at the grassroots face when they attempt to realize their rights and play the role of change-makers. The programme needs to build in systems to support such individuals and respond in a timely fashion to such instances. To expect individuals to stand up on their own in the face of powerful opposition and grave danger to themselves without such systemic support would be unrealistic and probably unethical too.

Also, the role of a functioning health system is vital when it comes to scaling up innovations/ pilot models of community participation. The time and resources that need to be invested in intensive processes that are a feature of these small models can only be provided if the health system is adequately staffed, well functioning and genuinely committed to promoting participation.

Thus, the next issue about health systems and how they influence community participation is how committed the system is to community participation and how responsive it is. Different experiences have shown that while community participation may be built into projects as a component, it may not be fully accepted by staff from within the health system thus failing to support it or in some cases even actively opposing it. For example, in Tamil Nadu, while the CAH programme is part of NRHM and is funded by the government, ownership for it has been mixed – high in some areas, but very low among some primary level health providers, thus making them not very responsive to demands generated by the community participation process. In Bihar, while the health authorities attended the Public Dialogues organized as part of the Community Based Planning and Monitoring Programme, when faced with questions from the community regarding their performance, they both passively subverted and actively refused to support the process any further. Similar experiences are seen in health facility committees like the Rogi Kalyan Samiti where community members are not seen as equal partners by health professionals though the spaces occupied are equal.

Health providers' response to community accountability mechanisms

While Jan Samwads have been largely welcomed by the community in Bihar, health care providers were not all appreciative of the process. Dr Ramamoorthy Singh, Medical Officer In Charge (MOIC) of Imamganj PHC, felt the process had been one sided and had not considered the constraints under which providers in the public health system were functioning. Dr Shivkumar Singh, MOIC Fatehpur, while acknowledging that the Jan Samwad had resulted in some constructive action, was not happy that health care providers were pulled up in the process. Dr Ramamoorthy felt issues brought up at the Jan Samwad could be discussed in the Block Planning and Monitoring Committee (BPMC) before being brought up in a public forum.

NGO staff also reported that the Jan Samwad had resulted in a lot of interest in the project from the community. But it had also resulted in lack of cooperation from block and district level officials for a few months after the Jan Samwad. In one block, the MOIC had refused to meet project staff or hold any meetings of the BPMC after the experience of the Jan Samwad. However, persistent efforts by the NGOs have helped establish smooth relations again.

The third important component of the health system is the presence of a change agent – an individual sufficiently high up in authority who understands and supports the community participation process. It has been seen that the presence of one such supporter adds to the success of the project. For example in Tamil Nadu, state nodal NGO staff acknowledge the support received from senior bureaucrats in key positions who supported and pushed through the programme at key junctures. Similarly, SHRC in Chhattisgarh has tapped on the support of key persons in senior positions to carve a niche space where it is able to negotiate for greater community engagement. Maharashtra also documents such support from senior health officials as crucial to the success of the programme.(21)

Key points in this section

- A functioning primary health system, or at least commitment to make it functional, is an essential pre requisite for community participation to achieve results. In the absence of this, participation is limited only to local action by the community and cynicism at the lack of results can preclude future participation.
- The role of a functioning health system is also vital when it comes to up-scaling small models of community participation.
- Although community participation may be built into projects as a component, it may not be fully accepted by staff from within the health system. They thus fail to support it, or in some cases, even actively oppose. Active efforts need to be made to engage with the health staff to sensitize them to the need for participation.
- The presence of an individual change agent within the health system who is supportive of community participation, helps greatly in the process.

5.2 Socio cultural context

Community participation experiences cannot be seen devoid of the context in which they function in, and the socio cultural context plays a major role in determining how these experiences shape up. As the inherent value of community participation is to engage communities as active partners, and inclusiveness and representativeness are key determinants, societies which are inherently more equitable would be more conducive for community participation. Where this is not true, efforts need to be made pro actively within the community participation programme and outside of it towards overcoming social hierarchies and achieving equity and justice.

How do determinants like caste and gender influence community participation? Community participation initiatives have been implemented under NRHM in states as diverse as Maharashtra, Tamil Nadu, Chhattisgarh and Bihar. While Maharashtra and Tamil Nadu have a long history of social movements against caste and gender based discrimination, this may not be true of the other states. Does this influence community participation?

Tamil Nadu with its history of the Periyar and the *dalit* movements has a strong background of caste assertion. Also, a traditionally more equitable gender attitude has been reinforced by the self help movement that has encouraged more women's participation in the public domain. This, the staff of the state nodal NGO feel, has resulted in more meaningful participation. While the community remains heterogeneous with inherent hierarchies and tensions, the sense of entitlement provided by the social milieu has resulted in a culture of assertion that leads to marginalized groups wanting to voice their issues within community spaces they occupy. For example, in a village where the Panchayat President belonging to the dominant caste refused to go to the *dalit* hamlet, committee members in a show of assertiveness chose to go ahead and conduct the meeting without him.

Where gender based inequity is rampant, a history of exposure specifically to gender-related issues also enables members to articulate these issues. Murthy, in her study of accountability to sexual and reproductive health through Rogi Kalyan Samitis in Tamil Nadu, documents the case of a self help group member, who after training on gender issues by a feminist organization, was able to articulate that the committee's role included making sure services for gender-based violence were available within the primary health system. (55) In an interesting case study from Chhattisgarh, Nandi documents how Mitans took up the issue of gender-based violence in one district. She cites the training of Mitans that emphasized social determinants and gender, and a support structure that facilitated their action, as some of the important reasons for the Mitans to be able to address an issue as entrenched as gender-based violence. (56) It is noteworthy here that the prevalence of domestic violence is one of the 29 indicators monitored by the VHSNCs in Chhattisgarh, reaffirming the programme's commitment to raising awareness and facilitating action on this issue.

While the prevailing socio cultural milieu has a significant role to play in determining the shape of community participation, the role of the facilitating organizations/structures to negotiate with these socio cultural factors to promote equity and social justice through community participation needs to be emphasized. Community participation efforts can, and should, address issues of equity and justice. At each step of the process of implementation, supporting organizations can play a role in ensuring this. Various experiences from different states where community participation has been implemented under NRHM, show rights based NGOs indeed making such efforts. It needs to be stated here that this may however not be true of all NGOs.

The other factor thus is the presence of NGOs that have a history of rights-based action. In Maharashtra, where NGOs implementing the Community Based Monitoring project in different districts are a mix of rights based people's organizations and service related NGOs, the programme has brought 'rights to health organizations' and health to 'rights organizations'. (21) Where there is a culture of collective action as with social movements, communities are able to participate more meaningfully. In Tamil Nadu, the CAH programme chose to engage with volunteers from previous programmes who had such experience with rights and community action. Community facilitators were drawn from the pioneering literacy programme Arivoli lyakkam. In Chhattisgarh too, the Swasth Panchayat Yojana chose to use the already existing Mitanin programme to build its communitization initiative. Thus, the considerable inputs on rights and health that the Mitans had been given and their rootedness in the community were used to foster community action through the VHSNCs. This also helped the programme use the vast support structure of the Mitanin programme to constructively support the VHSNCs. The examples from the Pagoda committees in Cambodia and the women's groups in Peru signify the importance of a pre existing community network in building participation in health. In both these cases, a pre existing milieu that promoted collective action, either around a Buddhist community feeling, or in women's groups, made participation projects easier to implement. (47,49,50)

Key points in this section

- The socio cultural context of a community plays a major role in determining how community participation experiences work in it.
- Community participation efforts can and should address issues of equity and justice and at each step of the the process of implementation, supporting organizations can play a role in ensuring this.
- Where there are already rights based NGOs and a culture of collective action as with social movements, communities are able to participate more meaningfully.
- Community participation efforts can use pre existing community networks like self help groups and prior community based programmes to build a more rooted and sustainable programme.

5.3 Political context

Community participation is a deeply political issue that challenges existing power hierarchies and thus cannot be seen outside its political context. (10,14) Participation is supposed to enable communities to regain power and control over circumstances of their own lives. If gaining power is seen as the primary outcome of community participation, such a process would not be possible to be implemented in a larger context without a vibrant democratic system.

Experiences from Brazil demonstrate how the presence of a progressive democratic system that was committed to genuine devolution of governance and power to the grassroots helped establish community participation in various spheres including health. (33) According to John Gaventa, "where combined with processes of empowerment and inclusion in the social as well as the political spheres, greater participation in decentralized governance processes can be achieved and in turn can contribute to social justice goals". (57) In India, in Nagaland, political will has seen financial devolution up to the community level thus promoting complete decentralization. (24)

On the other hand, Murthy and Klugman, drawing from a review of World Bank supported reforms projects in Asia, point out how community participation is also a key component of the contemporary neo-liberal discourse on development, promoting a market- led model where participation is seen as bringing in more resources. (18) They caution that community participation is not a strategy to help the state roll back on its responsibilities, but rather, what is necessary is strengthening democracy and fostering a culture of rights.

The different experiences of communitization under NRHM have all been implemented under varying political contexts and research is needed to examine how this has affected participation. For example Tamil Nadu has a well functioning primary health system. The state government, irrespective of which political party heads it, has historically been committed to providing primary health care services even in rural areas. A committed and efficient bureaucracy and professional public health managers have contributed to Tamil Nadu's success in emerging as a pioneer in its public health interventions. (60) The political climate in Tamil Nadu is however marked by a politics of populism – where the political establishment sees voters as passive recipients of free services and dole outs, rather than as active participants. In such a climate, how does a programme that uses the framework of rights, entitlements and accountability convince the community to the need for community participation? Also, political parties have made inroads into the village level so much that even Panchayat elections are fought on party lines. Caste based political formations are growing significantly and divide the electorate on caste lines. In such a situation, how can communities be mobilized to work together as a united group, while at the same time addressing issues of inequity within themselves?

Literature also shows that community participation will not work if restricted to the health sector alone.(14) SAHAJ's experience in Vadodara shows that people's priorities are more immediate issues of daily living all of which are intimately linked to health. Thus, unless participation is broad based across different sectors, it would only serve specific programme objectives and not really empower in the true sense. Also, for a true sense of citizenship, communities need to have control over all spheres of their lives and thus participation needs to be seen being implemented across sectors.

Key points in this section

- Community participation is a deeply political issue that challenges existing power hierarchies and thus cannot be seen outside its political context.
- The presence of a progressive democratic system that is committed to genuine devolution of governance and power to the grassroots helps establish community participation.
- Community participation is not a strategy to help the state roll back on its responsibilities but rather what is necessary is strengthening democracy and fostering a culture of rights.
- Community participation will not work if restricted to the health sector alone and needs to be broadened to include other social sectors.

CHAPTER 6

**OUTCOMES OF
COMMUNITY
PARTICIPATION**

What interests a policy or programme maker in a programme is its outcome. How does the programme affect health and health indicators. However, one of the key challenges of community participation has been to attribute outcomes to it. As seen in the sections below, because of its inherently complex nature and the great dependence on processes and the context in which it plays out, reported outcomes of community participation have been varied and even extreme in different projects.

As pointed out in the introductory section, community participation programmes can be seen either as a means to achieve specific project objectives, or as participation as an end in itself. Based on what perspective a programme is implemented from, the type of outcomes expected will also vary. As Gaventa asks:(57)

What is the theory of change and how does that affect the outcomes one is searching for? What are appropriate indicators, how can we gain attribution, and how can we measure success across contexts? And, consistent with the persistent question of assessing impact in the evaluation field: whose reality counts in deciding which changes are most meaningful?

The inherent logic behind community participation is that it increases people's voice and accountability. Through this, it is expected to contribute to

- a) Changes in **developmental outcomes** including broader development goals like the Millennium Development Goals
- b) Changes at an intermediate level including in policies, behaviours and power and control – these could otherwise be called **democracy related outcomes** and would be more political in nature than the set of outcomes in point (a).(57)

In this section, the outcomes of various experiences of community participation have been collated under the following heads:

1. Developmental outcomes
 - a) Health outcomes
 - b) Health system outcomes
2. Democracy related outcomes
 - a) Equity, justice and participation related outcomes

6.1 Developmental outcomes

a) Health outcomes

Community participation has often been seen as a means through which by giving more information to people, making them more involved in health services and by making health services more relevant to the community's needs, positive health outcomes will occur. Very often, as Rifkin points out, community participation has been seen as an intervention that would lead to project or programme objectives, rather than as a process with its inherent and unique dynamics.(10) Zakus and Lysack point out that it is however very hard to make such causative conclusions between community participation and health outcomes. They point out that since community participation is so dependent on the context in which it is implemented, it is very difficult to compare between different community participation experiences to measure outcomes. In addition, it is very difficult to single out the unique contribution of community participation among several interventions to a particular health outcome.(9) Given all of the above, there have been very few experiences that have documented objective effects on health outcome through community participation initiatives and some of these are detailed in this section.

In a model that is very different from that implemented under NRHM, the Warmi project in Bolivia between 1990 and 1993 organized women's groups to identify local problems through a method of auto diagnosis and then plan and implement an action plan to solve them. The study showed that over the project period perinatal mortality decreased by 65%.(40) Following this landmark study, several other groups have tried to replicate the success of this model. The MIRA trial in Makwanpur district of Nepal was designed as a cluster randomized controlled trial that studied the effect of action learning cycles through women's groups on health outcomes – the study showed a 30% lower neonatal mortality rate and 80% lower maternal mortality ratio (MMR) in intervention areas as compared to control areas. The study also showed healthier behaviours and better health care seeking in intervention areas.(41) The Ekjut trial, a large trial involving more than 2,28,000 women in Jharkhand, India, also used a similar methodology to show a 32% lower NMR in intervention clusters.(42)

However, when the same methodology was tried in a scaled up manner in a study in Bangladesh, it failed to show any difference in NMR between intervention and control clusters.(43) Similarly, a recently concluded study in Mumbai with a similar intervention also showed no difference in neonatal and perinatal mortality rates between intervention and control arms. It has been concluded that there may be a critical limit of coverage and facilitation required for such interventions to be effective.(44)

Some small scale projects in India that are closer as models to the VHSNC than the Warmi models have also documented improvements in health outcomes. One of these is the FRHS project in Karnataka. In this experience, the involvement of village level health committees saw improvement in institutional deliveries, treatment seeking for RTI/STI and weighing of babies at birth.(25) Another project that showed impressive health outcomes is the Community-led Initiatives for Child Survival (CLICS) project from Wardha – here Village Coordination Committees worked on improving household behaviour of child care practices and improving access to child care services. At the end of a 4-year period, use of ORS in childhood diarrhoea increased from 6.8% to 68.9%, early initiation of breastfeeding went up from 0.6% to 68.7%, recognition of neonatal danger signs improved from 11.3% to 99.7%, and infant mortality rate decreased from 49.2 to 29.5 per 1000 live births.(26)

Thus, while very few experiences actually document health outcomes because of the methodological issues involved, evidence seems to point that community participation and action does result in improvement in actual health outcomes.

b) Health system outcomes

One of the main outcomes of community participation is expected to be on health systems. It is felt that when communities participate in health, the resources of the health system are distributed more equitably and according to people's demands and needs. Several experiences with community participation do document positive changes as regards the way communities perceive and act on their own health, the health system performs and the way communities and health systems interact with each other.

At the community level, community participation experiences have shown to increase community's knowledge and awareness regarding health. This has been shown to result in improved health behaviours and improvement in seeking of health care. In Bihar, the Community Based Planning and Monitoring programme experience has increased attendance of outpatient services in Primary Health Centers where the project is being implemented. It has also led to an increase in community members seeking services like immunization and antenatal care. In many projects, this increase in health seeking has also resulted in communities seeking better quality of care. This is an important outcome in various community participation projects across different states under NRHM. (21)

Demanding quality of care

A realization of their health care entitlements under the Community Based Planning and Monitoring (CBPM) programme has led to people demanding better quality of care from health care facilities in Bihar.

Munwa Devi is a member of the Village Planning and Monitoring Committee (VPMC) in Pakadih village of Pakadih Guriya panchayat in Imamganj block of Gaya district. She says the training she got under the CBPM programme and the *nukkad nataks* staged as part of the programme in her village have helped her realize her rights related to health. She recounts an instance where she recently accompanied a woman from her village to Imamganj PHC for delivery. The woman was in great pain but when Munwa Devi went to get the nurse to come and see her, the nurse refused saying she was not due for delivery till 9 pm. Earlier, Munwa would have been too scared to even talk to the nurse. But the "*jaankari*" and awareness she got from the training has emboldened her. She introduced herself as a member of the VPMC, chided the nurse for predicting the time of delivery without even seeing the patient and demanded that she see the woman immediately. The nurse was taken aback and came to see the woman immediately and took good care of her till she delivered. This incident has motivated Munwa further to use the skills she has gained from the programme for the betterment of the people in her community. She attends the VPMC meetings regularly and actively takes part in decision making. She says her family members are very supportive of the role she is playing now in the community.

Naresh Paswan of Bagahi village in Kunjeshwar Panchayat in the same block is a VPMC member who shares a similar experience. He had gone with a woman from his village to Imamganj PHC for delivery. The doctor there referred her further to a different facility. Since the doctor had not explained adequately the reasons for the referral, Naresh Paswan asked several questions of him demanding to know why the woman could not be delivered in the PHC itself. The doctor then decided not to refer her and the woman delivered normally at the PHC itself, saving the woman and her family a lot of trouble and expenditure. Naresh Paswan also made sure the family did not have to pay any informal charges at the time of discharge from the facility.

Community participation experiences also result in communities promoting local action towards better health behaviour. Examples of this: the adoption of better home care practices during pregnancy and delivery, as shown in the Warmi project and the MIRA trial,(40,41); improving health environment by taking action towards safe drinking water, mosquito control measures and support to front line providers to provide better services. In Tamil Nadu, VHSNC members have been alert to outbreaks like diarrhoea, take action and also report it to the health system.

Community participation experiences in India have also demonstrated improvements from the side of the health system. The Tamil Nadu CAH project has shown an improvement in the quality of care provided by front line providers, and specifically, an improvement in the

educational component of their service provision. The graphs below show some of these improvements in specific areas like postnatal care and immunization. For example, Figure 5 shows that the quality of postnatal home visits has improved over the three rounds of monitoring in the state with more women being counselled about contraception and nutrition, receiving iron folic acid tablets and more babies being examined during these visits. Figure 6 shows that indicators for availability, quality and the educational components of immunization services improved between the first and second round of monitoring.

Graphs from the CAH programme in Tamil Nadu

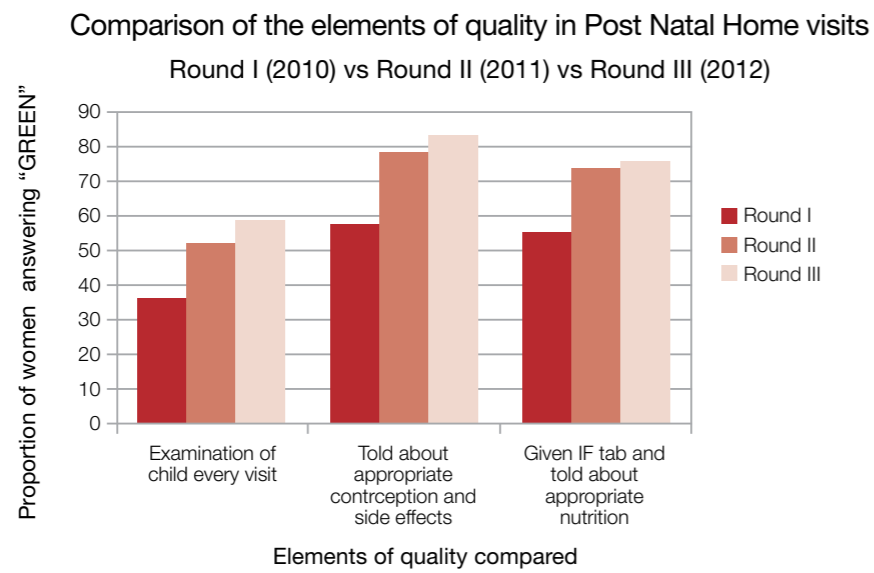


Figure 5

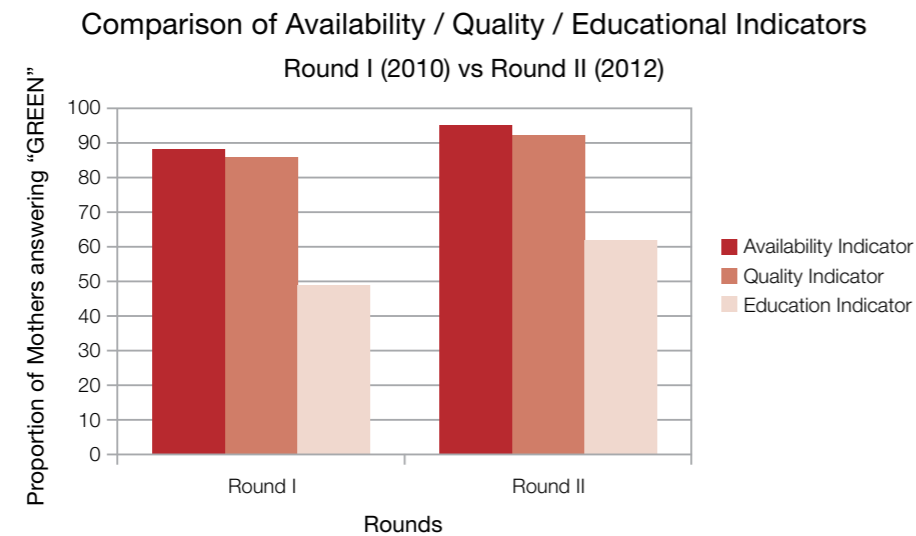


Figure 6

Similar results are available from Maharashtra – Figure 7 shows sustained improvement in several components of health services including curative services, use of untied funds and disease surveillance.(21)

Graph from the Maharashtra Community Based Monitoring and Planning Programme

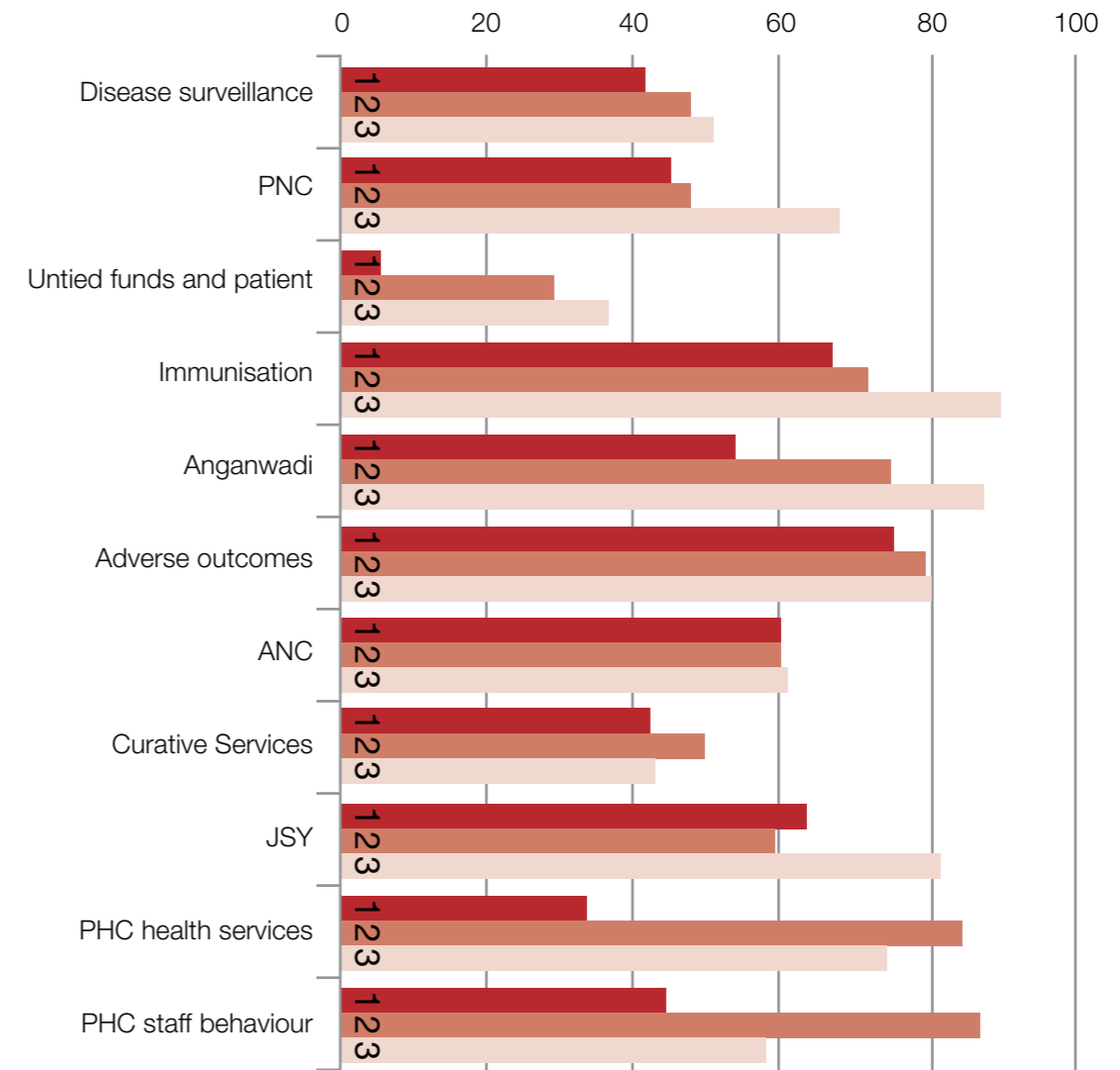


Figure 7

Graph 2: Per cent of villages that rated indicators 'Good' during First, Second and Third Rounds CBM in 225 Pilot Villages in Maharashtra

Similarly, in Nagaland, communitization of health systems has led to better attendance by health staff, improved attitudes towards patients.(23) The CLICS experience in Wardha had health staff showing increased motivation and receiving need-based training inputs. (27) In addition, several experiences have also shown improvements in measurable outcomes like drug availability, better utilization of locally available funds.(21,23)

At another level, community participation promotes better coordination between communities and health systems. In the Tamil Nadu CAH project, the staff report better understanding by communities. For example, they now accept the fact that a trained nurse is adequately

skilled to conduct a normal delivery instead of the earlier perception that a doctor/gynaecologist was necessary. This led to communities agreeing to go to nurse staffed PHCs for delivery rather than private clinics. In Bihar, understanding the need to have a minimum number of babies for immunization before a BCG vial could be opened so as to prevent wastage led communities to travel the extra few miles for a village cluster-level immunization rather than blame the health system for not doing it in their village. Similarly, the FRHS project showed that regular engagement between community members and front line providers helped develop cordial relations between them.(25)

One key feature of the effect of community participation is that actions and subsequently outcomes tend to be inter-sectoral in nature. This is because communities traditionally perceive health in a holistic manner and do not limit actions to artificial boundaries created by line departments. The Community Development Committees in Vadodara are an example. The outcomes of their actions span a broad range of sectors including food and nutrition, sanitation and health. Similarly, in Bihar in one village, efforts were made to integrate at the ground level the immunization service provided by the health department and the Take Home Rations provided by the Department of Women and Child Development. Similar experiences have been reported from Maharashtra and Tamil Nadu too.

Several projects have shown that communities, when they understand health and plan action towards it, define health broadly and act on determinants of health. In the SAHAJ project, for example, communities prioritized their immediate civic needs – sanitation, drainage, shelter, food – as the first steps towards health, thus improving health determinants. In Chhattisgarh too, VHSNC members monitored as part of their regular monitoring efforts social determinants including domestic violence. Thus, these initiatives have been able to address the **social determinants of health**.

Negotiating solutions with the health system

The Community Based Planning and Monitoring (CBPM) Programme in Bihar has not only resulted in increased community awareness, but NGOs implementing the programme have also made efforts to understand the constraints of the system and explore solutions for these with the help of the community.

Samagra Seva Kendra is the block NGO implementing the CBPM programme in Imamganj block of Gaya district. During the various village level meetings they held to understand issues related to health in the project villages, they found that many children were not getting timely BCG vaccination. When they discussed the issue with different ANMs, they realized that the BCG vaccine was in short supply and ANMs would not open a vial unless they had at least five children for the vaccine. Parents were therefore asked to bring their children to the PHC for vaccination which, because of the distance and expenses involved, the parents were not doing.

Samagra Seva Kendra discussed the issue with Village Planning and Monitoring Committee (VPMC) members in different villages and came up with a solution that would address both the community's problem and the health system's limitation. They negotiated for BCG immunization to be provided at two additional PHCs that were closer to the villages than the PHC. They also enlisted the support of VPMC members to convince parents to take their children to these PHCs. This has resulted in improvements anecdotally in the levels of BCG immunization.

Samagra Seva Kendra has also raised the issue of the short supply of BCG vaccine at the district level with support of the district NGO. They hope the supply will improve soon.

While the descriptions above are from community based committees, studies in literature of health facility committees have also shown the impact of these on health systems. The use of health facility based committees, CLAS in Peru, showed that facilities with committees reported better access for the poorest and better user satisfaction.(46,47) In rural Zimbabwe, facilities with Health Centre Committees reported better use of the facilities, better staffing patterns, better funding as they were able to draw in more resources, and better relations between the community and the staff.(46,48) Experiences from Kenya and Uganda also support similar findings.(46)

In India, Rogi Kalyan Samitis have been institutionalized at block and district-level facilities. Experiences from different states seem to indicate that unless specific investments are made in processes that sustain a good working arrangement between staff and the community, these facility level committees may not be successful in promoting genuine participation. The experience of the Maternity Home Monitoring Committees in Bengaluru also underlines the role of external facilitators in strengthening and supporting such processes. This case study also portrays the importance of community participation being part of a larger Right to Health movement in order to make it more sustainable.

Action for school building

The Kavi Dayaram school in Mujmahuda basti in Vadodara is more than 40-years old. The school functions from a single room in which four teachers handle classes from the first to the seventh standards. The school building is in a poor condition with no functioning toilet for the students.

The Committee members in Mujmahuda have been demanding a new school building for the past few years. They say they cannot afford to send their children to private schools. The lack of facilities also leads to the quality of education being very poor – a small survey they undertook with the help of SAHAJ showed them that children lack even basic literacy skills. They are concerned that this will lead their children to become *looters* and “thieves.”

The committee members initially sent several applications to concerned authorities in the education department and also to their elected representatives. They even met the Education Minister. However, despite repeated assurances, nothing was done towards a new school building. Frustrated, in early 2010, committee members decided that they had to take some drastic action.

In January 2010, committee members organized other members from the community and marched to the school and locked the building saying they would not allow the school to function in such a dilapidated building. This resulted in a posse of police and the media arriving there. Even when faced with threats of lathi charge by the police, the committee members stuck to their demand. This led to the authorities promising to sanction a new building.

However, as nothing happened for over a year after that, committee members again went on a hunger strike to highlight their demand. After four days of the strike which was covered by the media, a new building was sanctioned and budget allocated. Committee members then organized a drawing competition for children to help them express what they wanted in a school. The construction of the new school building has finally begun!

The Maternity Home Monitoring Committees in Bengaluru

The Society for People's Action for Development (SPAD) is a partner NGO that has been working with the Maternity Home Monitoring Committees (MHMC) set up by the Public Affairs Centre in Bengaluru. SPAD has made several conscious efforts to strengthen these committees and ensure their sustainability beyond the project period. One such initiative is the formation of solidarity groups consisting of marginalized caste and religious groups in these communities that act as a support structure for MHMC members. They also welcome community members who are active and take up social causes to join the MHMC.

In addition, SPAD, an active member of the Jan Aarogya Andolana (People's Health Movement) in Bengaluru and Karnataka, involves MHMC members in activities of the larger movement. MHMC members recently participated in JAA's campaigns against privatization and for free drugs in the public sector. This has helped them understand the larger issues around health policy and make better demands from the health system.

SPAD also encourages leaders from these communities to make an annual community level action plan. Community leaders are brought together once a year and trained in assessing community needs. They go back to the community, carry out a needs assessment and come back together to discuss an action plan which is then implemented with SPAD providing necessary support.

6.2 Democracy related outcomes

a) equity, justice, participation related outcomes

Another significant outcome of community participation is related to democracy and voice. The level of change achieved in this area has varied between different projects and based is on the outlook with which it was implemented – more when community participation has been seen as a right, rather than when seen as a means to increasing efficiency of the system.

An important outcome of community participation is the attempt to achieve **equity**. Several projects have attempted this in the process of community participation itself by making efforts at being inclusive and representative. In addition, many community participation efforts have achieved some level of equity in access to health and health care services. In Bihar, the programme has made specific efforts to involve members from marginalized communities as its members. These members have made specific efforts to improve awareness in their communities and that health care services are available and accessible. Evidence from health facility level committees in Africa also show that they increase access for members of poor and marginalized communities.(46,48)

In addition to the above, the most important outcomes expected of community participation are in the democracy related arena. Many projects have indeed shown that such outcomes do result from community participation. But many challenges have also been documented.

Experiences of community action projects under the NRHM in Maharashtra and Tamil Nadu show how **accountability** can be improved through community participation and monitoring of health services. The Public Dialogues have provided a moderated space for communities to hold providers accountable and demand changes. All this has definitely increased people's **voice** and sense of citizenship. The experience of community members getting involved in PHC level planning is an example. Similarly, Maharashtra reports that "people have a growing sense that their opinions about the public health department are being taken into consideration. And now that they have some say in the planning and functioning of the outreach and PHC services".(21,22) However, while these projects may have been successful in enforcing accountability from the managerial perspective from lower level health staff, how successful they have been in achieving political accountability, that is, accountability in policy making, is questionable.

All this points to ways community participation can help in actually **deepening democracy**. However, several challenges have also been reported. One of the key challenges is to overcome existing power hierarchies – within communities, between committee members, between providers and the community. The Nagaland experience with communitization shows how decentralization, including devolution of financial powers, can put power and control in people's hands.(23,24) However, further studies are necessary to conclude whether such transfer of power actually takes place. The experience with Rogi Kalyan Samitis and the FRHS experience show that there is a difference between the professional voice and the community voice, even within equal spaces.(25) Such challenging of existing power hierarchies then brings in the risk of threat, either overtly or covertly, from power structures, both within the community and the health system, as seen in the case study of the ASHA earlier. To quote Zakus and Lysack then, "Does local action itself lead to greater power and control? Does it sufficiently challenge power structures?"(9) These are questions that need to be answered in each project within its own context.

CHAPTER 7

LEARNINGS, CHALLENGES AND THE WAY FORWARD

The preceding sections have shared details of several experiences of community participation from around the country and the world. What do these experiences mean in terms of up scaling such programmes? What lessons do they hold for future policies and programmes in this area? This section tries to capture some of these learnings and challenges in conceptualizing and implementing community participation programmes. As this document is meant to be of relevance to policy and programme makers in India, the discussions are specific to the programme scenario in the country. However, the principles behind these are generic and can be broadened to other settings.

Inclusion and representativeness

1. *Inclusiveness and representativeness of the committee is a crucial requirement for it to promote participation effectively. In order to achieve maximum inclusiveness and representativeness, VHSNC members must be democratically elected. In addition, places must be reserved for members of marginalized communities on these committees. It is important to invest in the processes of facilitation required towards this.*

Several experiences from around the country and the globe show the importance of the committee for community participation being inclusive of various marginalized groups in the community and being representative of these groups. In India under the NRHM, this committee is the VHSNC at the village level. The most effective way to achieve such inclusiveness and representativeness is by democratic election in the Gram Sabha, as shown by experiences of the VHSNCs in Chhattisgarh and the FRHS project in Karnataka.(25) In addition, reservation of places for women, scheduled castes and tribes, and religious minorities in the VHSNC has also been shown to ensure inclusiveness.

This however has many challenges. Experience has shown that if such an election is undertaken without adequate preparatory processes (including an in depth understanding of the various groups within each community, and adequate facilitation to elect the most active and interested members from the various marginalized groups) The process can be undermined and would end up with only the elite in the community being part of the VHSNC. Thus, it is important to invest in the processes of facilitation required towards this. This also becomes very important considering that the committee gains legitimacy in the eyes of the community only when it is seen as representing the voices of the marginalized groups and thus, investing in this process will contribute to the long-term impact of the process.

2. *Persons from marginalized communities have difficulties in participating effectively even if elected as members of committees. They must be adequately supported towards this.*

It is well known that persons from marginalized communities, even if elected to committees, have several difficulties in participating effectively in them. These include lack of resources like time and loss of wages to participate in meetings, inability to voice their opinion in the presence of other dominant members in the committee, and lack of knowledge and education.

Adequate support must be provided to marginalized communities to overcome these. Support for time and travel may be built into programmes. Efforts to build their capacities, both in terms of knowledge and also negotiating skills, need to be undertaken.

3. *In urban areas, ward-level committees represent a heterogeneous group of slum dwellers and middle and upper class populations. Establishment of basti level committees will help encourage participation of people living in slums.*

Urban areas contain a heterogeneous mix of populations. With increasing urbanization, large proportions of urban populations live in slums. Ward-level committees do not adequately give representation to these slum dwellers who are not able to adequately find a voice in a space that has mixed representation from various classes.

In order to ensure that people living in slums are able to participate in these committees effectively, it is necessary to establish *basti* (slum)-level committees which then find representation in ward-level committees. This will ensure that the voice and concerns of people in slums are adequately represented.

Recognition

4. *The committee for community participation should be formally recognized through a law or through an executive order to give it legitimacy.*

Various experiences have highlighted that it is important for committees to be given official legitimacy so that providers and authorities within the health system accept them. This legitimacy needs to be formalized in the form of either a law, as in Nagaland,^(23,24) or through an executive order that clearly states the constitution, roles and responsibilities of the committee, such as VHSNCs.

Promoting inter-sectoral convergence

5. *Promoting inter-sectoral convergence is a crucial aspect of community participation. Community participation cannot be effective if restricted to the health sector alone. It needs to be broadened to other social sector issues like education, Right to Food, etc.*

The VHSNC's role needs to be broadened to include other inter-sectoral issues related to health like water, sanitation, nutrition, MNREGA (Mahatma Gandhi National Rural Employment Guarantee Act)⁵, pensions. In urban areas, civic entitlements and social

determinants of health like sanitation and water are key priorities of people. Community participation efforts must be broadened to include these. Operational mechanisms also need to be set up to put this in practice.

It is very clear from various experiences from around the world that community participation cannot happen around health alone. If it is seen as a means of providing voice to people and fostering social justice, it has to include all social sectors.

It is, therefore, important to broaden efforts at fostering community participation across all social sectors. The setting up of an independent social audit cell that would foster this across sectors would be useful.

Health is much broader than health care alone. One of the positive features of several community participation experiences has been that communities define health broadly and act on several determinants of health. It has also been seen that health cannot be achieved without acting on social determinants. It is thus important to broaden the role of the VHSNC to other inter-sectoral areas related to health.

In order to operationalize this practically, it would be important to recognize the VHSNC as the site of convergence of community participation of different line departments so that the VHSNC can plan local action around all of these and also interact with the respective line department officials, wherever necessary.

Experiences also show that civic entitlements like ration cards, voter cards, recognition of living areas like slums and social determinants like water, drainage, sanitation, shelter are important issues in urban areas. Community participation efforts need to be broadened to include these so people's priorities are addressed before they can participate effectively on issues of health and health care.

Moving beyond the village level for bottom up planning

6. *Specific efforts need to be made to promote community participation beyond the village level. Committees need to be created/strengthened at block and district level to facilitate participation at these levels. Clear linkages between these and the village-level committees need to be established. Linkages also need to be established between these committees and other institutions at the block and district levels like the Rogi Kalyan Samiti and Panchayati Raj institutions.*

One of the weaknesses of many community participation efforts has been that they are limited to the local level. Lack of a formal committees/ spaces at higher levels constrains participation and action to the village level or utmost to the level of the Gram Panchayat. This also precludes communities from participating in decisions regarding planning programmes and policies that are taken at district and state levels.

If genuine participation has to occur, it is important to create spaces for such participation at block and district levels. Clear linkages of committees at these level to the village level committees have to be established. One possible way could be to federate village-level committees at the block and then at the district level.

Clear linkages also need to be established between these committees and already existent committees at these levels like the Rogi Kalyan Samiti. While the RKS is a health facility level committee, these federated committees would look more holistically at public health at the block and district level.

⁵ The Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA) is an Indian law that aims to guarantee the right to work and ensure livelihood security in rural areas by providing at least 100 days of guaranteed wage employment in a financial year to every household whose adult members volunteer to do unskilled manual work.

Also, linkages need to be established between these committees and the block and district level Panchayati Raj Institutions (PRI). Given that these committees are a way of promoting participation and accountability, they could be designated as committees of these PRIs.

7. Block and district-level committees need to be cross sectoral and must be under the leadership of an administrative authority at this level who can promote convergence across sectors.

In order to promote convergence, the block and district-level committees could be designated to act across social sectors. To facilitate this further, these committees could be brought under the leadership of an appropriate administrative authority, for example, the District Collector/ Magistrate, who can facilitate such convergence across line departments.

8. The design of the planning process at the district level must be adapted to provide adequate space for village and block-level plans to be incorporated so as to ensure bottom up planning.

In order to promote true community ownership, efforts must be made to involve communities in the planning process. While policies recommend bottom up planning, the actual situation does not lend itself conducive to this.

In order to truly promote participatory planning from the grassroots, it is necessary to change the design of the planning process as it is presently. The present process, while treating the village as a unit of planning, actually focuses at the district where plans are drafted. While village level planning should be promoted to focus on local issues, capacity must be built at the block level to collate village-level plans to identify common issues emerging and plan for the block accordingly. These block level plans can then be compiled at the district level. This responsibility could be tasked to the District Community Mobilizers (DCM) and Block Community Mobilizers (BCM) under the NHM programme.

9. Genuine community participation cannot occur effectively without devolution of financial powers. Finances must be devolved to the Gram Panchayat level to truly foster community participation and bottom up planning.

Experiences from around the country and the globe show that community participation remains tokenistic till true devolution of power and control occur – towards this, devolution of financial powers is critical. Models like those of Nagaland and Kerala in India, and Brazil are examples of such devolution that need to be further studied and implemented according to the different contexts.(23,35,54)

Support required

10. Community participation programmes require a clear and capable support structure that is independent of the formal health system.

Community participation committees need ongoing support in the form of mentoring, supportive supervision and ongoing capacity building. It is necessary that clear support structures are established for this.

Various experiences also show that this support structure has to be independent of the formal health system. This is critical as the support structures have to play an independent facilitatory role in helping communities and health systems negotiate the interface between each other.

Different models, including involvement of rights-based NGOs and the use of autonomous public sector institutions like the SHRC in Chhattisgarh, have been tried towards this. These need to be adapted according to context. In urban areas, an Urban Health Resource Centre with the support of civil society organizations may be established to provide such support.

These supporting institutions need to have adequate capacity to facilitate the community participation processes. Investments need to be made in capacity building. In addition, adequate care must be taken that these supporting institutions facilitate the participation of the community rather than taking over and directing action themselves.

11. Capacity building of committee members is critical. This must be needs based and must include knowledge and perspective components. This must also include skills for use of tools for information collection, planning and action.

Members of the community in the committee need inputs to build their capacities to monitor health systems, plan and act on the information. These capacity building inputs need to be both knowledge and perspective building that include the values of participation, social justice, accountability and rights.

Capacity building must also include skills to use tools to collect information regarding the health system, local health status and determinants of health. User friendly tools that are simple yet provide adequate information need to be developed by supporting organizations.

Such capacity building efforts cannot be seen as a one-time effort only, and need to be provided on an ongoing basis depending on the needs of the community. Supporting organizations must provide ongoing support and must be provided adequate resources for this.

Health system responsiveness

12. Community participation can be effective only in the context of a functioning primary health system or commitment to make it functional, so that the health system is responsive to demands from the community. Concomitant investments in health systems strengthening need to be made alongside investments in community participation. Grievance redressal mechanisms need to be instituted so as to make health systems responsive to the community's needs.

Community participation cannot be a substitute for a state provisioned health system. On the contrary, for community participation to be effective, a functioning primary health system, or a commitment to make it functional, is essential.

Investments must be made to strengthen health systems concomitantly with investments in community participation. Adequate resources must be provided for health systems to be responsive to plans and actions emerging out of community participation.

13. Information collected by communities during their monitoring efforts needs to be collated at village / panchayat level for local action. In addition, it needs to be collated at block, district and state levels to identify systemic issues contributing to health system gaps. Health system must be committed to addressing these gaps and must take necessary systemic action towards this.

It is often seen that community monitoring experiences often result in local action without addressing systemic issues that may be the root of the problem. Purchasing drugs locally to tide over unavailability without addressing drug procurement and distribution policies, is an example of this.

Mechanisms need to be put in place to collate information coming in from monitoring efforts by the community at the village / panchayat level so that local action can be planned and implemented. However, in addition to this, clear mechanisms need to be put in place to collate this information at the block, district and state levels and identify health system gaps causing the issues identified. The health system must be committed to act on these gaps. Else, community participation will only result in small local efforts without addressing the root of the issue systemically, leading in the long term to frustration among both communities and health personnel.

14. Health providers and health authorities in hierarchical health systems are often not responsive to community participation. Special efforts need to be made to engage with health providers to sensitize them to community participation.

While most community participation programmes invest in capacity building of committee members, these programmes also require health providers and authorities to develop new skills including valuing participation and responding to communities as equal partners. Without these skills, several community participation programmes find that participation is undermined and hostile relationships develop between communities and health staff.

It is, therefore, necessary to engage with health staff and sensitize them about the value of participation and the need for accountability to the community. Some efforts towards this have been made in specific projects around the country and need to be adapted according to context.

15. When communities interact with health providers and health authorities for example in Rogi Kalyan Samitis, there is an inherent hierarchy of power in the interaction. Special efforts need to be made to balance this power imbalance – communities must be equipped with necessary technical skills to participate in these forums. Health providers need to be sensitized to the value of the perspectives that community members bring in. Planning along with the community must be made an integral part of all planning even in health facilities.

Community members are not treated as equal partners when interacting with health providers and authorities, especially in health facility level committees like the Rogi Kalyan Samitis. Special efforts need to be made so that committee members belonging to the community are equipped with the specific technical skills necessary to participate in these committees. This must be part of their capacity building.

Health care providers need to be sensitized to understand the value of participation that such committees provide and to value the different perspectives that community members bring in to these forums.

In order to widen the scope of community participation, planning at all levels of the health system, including facility level planning, must include community representatives. Models from various projects in the country cited earlier can be adapted towards this.

Long-term investment in processes

16. Community participation cannot be seen as an intervention, but rather as a right. It needs to be seen as a long-term process that builds ownership and voice of the people and promotes accountability of the health system. Long-term commitment and investment in processes of community participation is necessary for it to truly result in outcomes.

Community participation cannot be seen one of the many interventions in a programme towards a specific objective. It has to be seen as a right rather than as a means to improve efficiency. Community participation is a process that when effective, increases people's voice, their sense of citizenship, their ownership of the health system and the health system's accountability to them.

To foster such genuine community participation requires investment in long-term processes. The health system must be committed to such long-term investment in communities rather than just focus on short-term gains in terms of objectives. Adequate resources must also be provided for this.

17. Community participation is context specific. Suitable flexibility must be allowed in community participation programmes to allow for the effect of health system, socio cultural and political situation contexts on community participation.

Community participation programmes evolve depending on the local health system, socio cultural and political context. Thus a one-size-fits-all model of community participation is not possible. Adequate flexibility must be allowed at even block and district level for community participation programmes to develop according to the local context. Supporting organizations must be provided adequate capacity and resources to support such flexibility and local modifications.

18. Community participation committees need to be integrated with larger rights based social movements to ensure sustainability.

Community participation is based on the values of rights and social justice. Committee members will develop a larger perspective and will be able to participate in and support health systems better if they are exposed to and part of larger social movements, like the People's Health Movement, the Right to Food movement etc. Such inter linkages will also help make these initiatives sustainable by providing motivation to these community members.

Key recommendations for policy and programme

Policy-level recommendations

1. Community participation cannot be effective if restricted to the health sector alone. It needs to be broadened to other social sector issues like education, Right to Food, etc.
2. Long-term commitment and investment in processes of community participation is necessary for it to truly result in outcomes.
3. The committees for community participation should be formally recognized through a law, or through an executive order, in order to give them legitimacy.
4. The design of the planning process at the district level must be adapted to provide adequate space for village and block level plans to be incorporated so as to ensure bottom up planning.
5. Finances must be devolved to the Gram Panchayat level to truly foster community participation and bottom up planning.
6. Concomitant investments in health systems strengthening need to be made alongside investments in community participation.

Programme recommendations

1. The VHSNC's role needs to be broadened to include other inter-sectoral issues related to health. In urban areas, civic entitlements and social determinants of health like sanitation and water must be included in community participation efforts. Operational mechanisms need to be set up to put this in practice.
2. In order to achieve maximum inclusiveness and representativeness, VHSNC members must be democratically elected. In addition, places must be reserved for members of marginalized communities on these committees. Adequate support must be provided to marginalized communities to overcome difficulties in participating effectively. This includes support for time and travel and efforts to build their capacities.
3. In urban areas, establishment of *basti*-level committees which then find representation in ward-level committees will help encourage participation of people living in slums.
4. In order to promote community participation beyond the village level, committees need to be created/strengthened at block and district levels. Clear linkages between these and the village-level committees and other institutions at the block and district levels like the Roji Kalyan Samiti and Panchayati Raj institutions need to be established. Block and district-level committees need to be cross-sectoral and must be under the leadership of an administrative authority at this level who can promote convergence across sectors.
5. Capacity building of committee members is critical. This must be needs based and must include knowledge and perspective components. This must also include skills for use of tools for information collection, planning and action. Such capacity building efforts need to be provided on an ongoing basis.
6. A clear and capable support structure that is independent of the formal health system should be established to provide facilitatory support to community participation programmes. Different models, including involvement of rights-based NGOs and the use of autonomous public sector institutions like the SHRC in Chhattisgarh, need to be adapted according to context. In urban areas, an Urban Health Resource Centre with the support of civil society organizations may be established to provide such support.
7. Mechanisms need to be put in place to collate information coming in from monitoring efforts by the community at the village / panchayat level so that local action can be planned and implemented. In addition to this, clear mechanisms need to be put in place to collate this information at the block, district and state levels and identify health system gaps. The health system must be committed to act on these gaps. Grievance redressal mechanisms need to be instituted so as to make health systems responsive to the community's needs.
8. Special efforts need to be made to engage with health providers to sensitize them to community participation.
9. In order to widen the scope of community participation, planning at all levels of the health system, including facility-level planning, must include community representatives.
10. Suitable flexibility must be allowed in community participation programmes to allow for the effect of health system, socio cultural and political situation contexts on community participation.

The way forward

The preceding section describes the various lessons that can be learnt from experiences of community participation in India and around the world. The National Rural Health Mission has institutionalized community participation by providing space through VHSNCs for communities to play an active role in monitoring health systems and planning local action. This experience has been met with mixed levels of success in varying states. What then is the way forward?

It can be concluded unequivocally from the preceding sections that community participation has to be a necessary component in achieving Universal Access to Health, both from a rights based perspective and an efficiency perspective. When one looks at scaling up community participation programmes, it would be difficult however to say a particular model works best, or even to pick up components of models to put together. This is because community participation is inherently complex and needs to be viewed as a process rather as an intervention. A few generic principles could be stated that need to be followed when instituting community participation programmes.

- Community participation programmes are process intensive and come to fruition only in the long term. Policy makers must be aware of this and must be prepared for the long haul and provide sustained support if participation is to be facilitated.
- Institutionalized structures need to be set up to support the communitization process. Independently functioning Health Resource Centres at the state level, and also Urban Health Resource Centres, would be a way to operationalize this.
- Community participation needs to be seen as a process that pans across social sectors and must not be restricted to the health sector alone.
- For communities to be able to participate effectively, participation needs to be institutionalized beyond the village level – this would mean devolution of financial powers and institutionalizing spaces for participation in district level planning and in policy making.

This review shows that when community participation is genuinely fostered, it can serve to achieve health outcomes while at the same time addressing issues that have remained challenges for the health system such as social determinants, equity and justice. It is hoped that this review will help policy makers and programme planners in taking forward NRHM's agenda of community participation more effectively.

ANNEXURE 1

CASE STUDIES OF PROGRAMMES THAT WERE VISITED

THE TAMIL NADU COMMUNITY ACTION FOR HEALTH PROJECT

Background

Tamil Nadu in southern India is a state well known nationally and globally for its performances in the social sectors and human development. Tamil Nadu has a well functioning public health system that has been recognized for its innovations. As part of the communitization process recommended under the National Rural Health Mission, Tamil Nadu has been implementing the Community Action for Health (CAH) programme since 2007.

The context

Tamil Nadu in southern India is recognized as one of the better developed states in the country. The state has better health and human development indicators than many other states of the country. In the last decade, Tamil Nadu has been seen as a pioneer in its investments and commitment to develop its public health system. The state presently has a well functioning primary health system with several innovations to its credit. A long-term policy of recruiting and supporting village level nurses and a network of primary health centres has resulted in availability of primary health care in rural areas. The state also has pioneered a drug procurement and distribution system that is seen as a model for other states in the country.(58-60)

Tamil Nadu also has a rich history of social movements. The Periyar led Dravidian movement and the more recent dalit movement have resulted in a strong political sense and a demand for equality and rights in public consciousness.(60) Tamil Nadu is seen as being much more gender equitable than states in northern parts of the country.(58)

More recently, over the last three decades, Tamil Nadu has been seen as having a strong and stable bureaucracy that has been instrumental in bringing in several changes in the social sector including health. The state is also unique in having a cadre of specialized public health managers at the district level.(58)

Objectives

The communitization effort of NRHM aims to place the community at the centre of health interventions. Towards this, the Advisory Group for Community Action (AGCA) proposed a pilot of a community monitoring of health system initiative in 2007. Tamil Nadu was one of the nine states in which the programme was piloted. The stated objectives of this pilot programme were:

1. To set up a common mechanism for implementing the process of community monitoring on a large scale and through building relationships between civil society, citizens and government.
2. To develop a comprehensive tool kit for implementing community monitoring that can be implemented with local adaptation across different socio-cultural contexts (states).
3. To demonstrate the feasibility of community monitoring conducted using the commonly developed mechanisms and tools as a method for generating community based and community owned feedback that can be used both for initiating local corrective action and for triangulation purposes along with other forms of data.

By involving communities in monitoring and planning for health, the CAH programme aims to increase the ownership of the health system by the communities. It is envisaged that such increased ownership will lead to increased utilization of the public health system, and also increase its accountability to communities.

Structure

The pilot phase was implemented between 2007 – 09 in six districts of Tamil Nadu covering 14 blocks and 210 panchayats. Following the pilot phase, an external evaluation recommended continuation of the programme with extension of geographical coverage to entire blocks.(4) Thus, the programme is now implemented in 446 panchayats of these 14 blocks across six districts.

The CAH programme in Tamil Nadu is implemented as a government civil society partnership initiative with designated nodal NGOs at the state, district and block levels. The state nodal NGO is SOCHARA – Society for Community Health Awareness, Research and Action (Tamil Nadu Science Forum was the nodal NGO in the pilot phase). The state government has ratified the programme by issuing a Government Order allowing the state nodal NGO to take charge of the implementation of the project. The government provides financial support to the programme with the funds routed through the state nodal NGO to district and block level NGOs for implementation.

The Village Health, Sanitation and Nutrition Committees (VHSNC) formed under the NRHM are the bedrock of the programme. In Tamil Nadu, VHSNCs have been formed at the Gram Panchayat level, and not at revenue village level, as recommended by national guidelines. An untied fund of Rs 10,000 is given to the VHSNC at the Gram Panchayat level.

When the pilot phase of the CAH began (then called the Community Monitoring and Planning Programme), VHSNCs had already been formed with five members each – the Panchayat President, the Village Health Nurse, the Health Inspector, the Anganwadi Worker and member of one women's self help group. As this committee has a large number of service providers, the CAH project subsequently expanded it to include a larger cross section from the community. The process is described later in the section. Thus the programme uses a formal space recognized by the public health system as its main arena of community action.

In addition, in a few districts, an attempt at federating the VHSNCs at block level has been made – this process is described subsequently too. This effort, wherever successful, represents an attempt to broaden the sanctioned formal space.

While the programme is implemented by designated nodal NGOs at the state, district and block levels, support structures to the programme have been set up in the form of state and district level mentoring committees that have representation from both civil society and technical experts. For oversight of the project, a governing body has been formed at the state level after the pilot phase.

Process

In order to implement the Community Action for Health programme, several processes have been put in place. These are described in sequence in this section.

1. Expansion of the VHSNC

As a first step, the already existing VHSNCs with a predominance of service providers were expanded. For this, two to three community meetings were held in each of the panchayats covered by the programme. The membership of the committee was extended to include at least two persons from each hamlet in the Gram Panchayat area. In addition, care was taken to ensure adequate representation of different caste groups, especially *dalits*, women and religious minorities. The VHSNCs thus constituted have 10 – 15 members each. The state government issued a Government Order (GO) that this expanded committee would be the official VHSNC in the areas in which the programme was implemented.

2. Orientation and training of VHSNC members

Following the expansion of the VHSNC, orientation sessions were held for all members on the CAH programme, its objectives, NRHM and the community's entitlements under NRHM. Two persons from each VHSNC were trained intensively on carrying out monitoring of the health system. Subsequently in the second year, four more persons from each VHSNC received training.

3. Monitoring of the health system

a) Panchayat-level monitoring of health

Following the training, VHSNC members were supported to monitor the public health system. In the pilot phase, a common tool used across the nine states was adapted and translated into the local language, Tamil. However, the evaluation of this showed that the tool was felt to be too lengthy and needed to be simplified.

The state nodal NGO, in partnership with district and block NGOs, the health department and some community members simplified the tool. The present tool is considered to be shorter and simpler, more user friendly and uses a lot of visual representation for information collected. Colour codes of green, yellow and red are used to grade services as good, average and poor respectively. In addition, questions in the tool have been made clearer and more objective with less ambiguity in order to facilitate ease of filling as well as validity. Entitlements

promised by the NRHM have been used as the basis for the tool. The tool provides alongside questions the details of the entitlement, thus facilitating awareness building even during the process of monitoring. The present tool monitors eight aspects of health – maternal health services including antenatal, intra natal and postnatal care; immunization; village level health services; services of the ICDS; the school health programme; adolescent services; tuberculosis programme and health infrastructure. Iterations to the tool have also been made based on feedback from the community and NGOs and based on evolving government programmes over the three rounds of monitoring.

So far, three rounds of monitoring have been completed. While the initial round of monitoring was completely led by NGO staff, subsequent rounds have seen the VHSNC members leading the monitoring process increasingly, with hand holding by NGO staff.

According to members of the state nodal NGO, one of the major gains of the monitoring process was the awareness it generated in the community on entitlements. Thus, even though the initial round of monitoring was more NGO staff led, this awareness generation, they felt, would lead to people using the health system more and also demanding accountability. The monitoring process also made communities more aware of the health situation in their own villages, thus facilitating the next step of planning and action.

The information collected through the monitoring process is then collated into a panchayat level report card and presented to the Gram Panchayat.

One cycle of monitoring is done every six months. So far, three rounds have been completed.

b) Facility-level monitoring

In addition to the village-level monitoring, VHSNC members monitor facilities available at Health Sub Centres (part of the village-level monitoring) and the Primary Health Centre. This is done once in six months. Where a PHC covers more than one Gram Panchayat, representatives from VHSNCs of all of these Gram Panchayats participate in this monitoring exercise.

In addition, once in six months, an exit interview is held at the Primary Health Centre. Patients coming to the facility that day are asked to put in a coloured token based on their level of satisfaction with the services – a green coloured token for satisfactory services and a red coloured one for unsatisfactory services. These are then collated in the presence of elected representatives and block/district level health officials and the report presented to the medical officer in charge of the facility. Patients are also asked to write their feedback on pieces of paper – this is then used as a basis for planning any improvements in the facility. Some of the issues that have come up during this exercise include lack of privacy, rude behaviour of staff and corruption. In some districts, this exercise has been extended to cover taluk-level and district hospitals too.

4. Planning

One of the key features of the Tamil Nadu CAH programme has been to encourage community action on health through planning exercises. A designated Panchayat Health Planning Day is observed once every six months. On this day, the Panchayat Report Card is presented to the President, Panchayat Ward members and other community members. Health care providers including the Village Health Nurse and PHC medical officer are invited to this meeting. A discussion based on the coloured grades awarded to various services is held. The objective of the planning exercise is “to change Red to Green, in six months, together”. Out of the list of areas identified as needing improvement, two or three are chosen by consultation with everyone present and plans are made to find solutions for these issues. These plans are filled on to a pre filled format that spells out the plan with assigning of responsibilities and time frame.

The VHSNC meets every month to reassess the progress on these plans and to make course corrections if any. In addition, any new issues are brought up at these meetings.

According to staff of the state nodal NGO, care has been taken to ensure that the planning exercise focuses on systemic solutions rather than put blame on individuals. This is reiterated during training and orientation sessions for VHSNC members. Also, efforts are made to ensure that the planning exercise comes up with solutions that can be achieved at the community's level. This prevents frustration setting in because of unrealistic expectations. The experience so far has been that communities push to achieve solutions rather than engage in blame games. Contrary to initial scepticism from authorities in the health department that the planning exercise will lead to each panchayat asking for a full fledged hospital in their village in a highly medicalized state like Tamil Nadu, not one of the panchayat-level plans so far has indeed asked for a hospital.

Interestingly, unlike in other states where the AGCA model included the component of Jan Sunwais, Tamil Nadu does not have periodic Jan Sunwais or Public Dialogues to present cases of denial of health care. This is because after the pilot phase in which Jan Sunwais were held, there was feedback from health providers and health authorities that they were uncomfortable with the process. One, they felt they did not have prior information on the issues that were being raised in the Jan Sunwais; second, many of the issues that were being raised needed policy level changes which the health providers or authorities at district or block level did not have any power to change. Thus, a decision was reached that community participation and planning would be institutionalized systemically at panchayat and facility levels and not just periodically through Jan Sunwais.

5. Use of information generated for state-level advocacy

The Tamil Nadu CAH programme has set up a system by which VHSNC members transmit through mobile based SMS the results of the panchayat based village health monitoring and facility survey. This is done through a simple user-friendly code based system developed specially for this and in which at least one volunteer from each VHSNC has been trained. The results are received by a centralized server that is presently maintained by the state nodal NGO. Results received from each of the 446 panchayats under the programme are downloaded and analysed centrally. Presently, the analysis is done manually, but efforts are being made to set up an automated process by which panchayat-level analysis of the data can be done and fed back to the panchayat, block and district levels.

The information generated and analysed has been used by the state and district-level NGOs to advocate with health authorities. The data has been used to show trends in health care services and caste based disaggregation of health indicators. The state NGO has used this data to analyse health services in the domains of access, quality and educational component. This analysis has been used to bring attention to gaps, and efforts have been made to resolve them by the state level authorities. Some graphs from this analysis are presented here for indicative purposes. Figure 8 compares the availability of emergency services at the PHC level between the first and third rounds of monitoring and shows an improvement in the availability of services for dog bite and stings and utilization of these services. Figure 9 shows improvement over the rounds of monitoring in postnatal care services at the hospital. Figure 10 shows data for various elements of the ICDS programme monitored during the second round including whether the centre was open on scheduled days and time, and whether an Anganwadi worker was posted. Figure 11 compares the availability, quality and educational components of antenatal care over the three rounds of monitoring – while the availability and quality components were high even in the first round and have shown some improvements in the subsequent rounds, the educational component can be seen to have significantly improved over the three rounds.

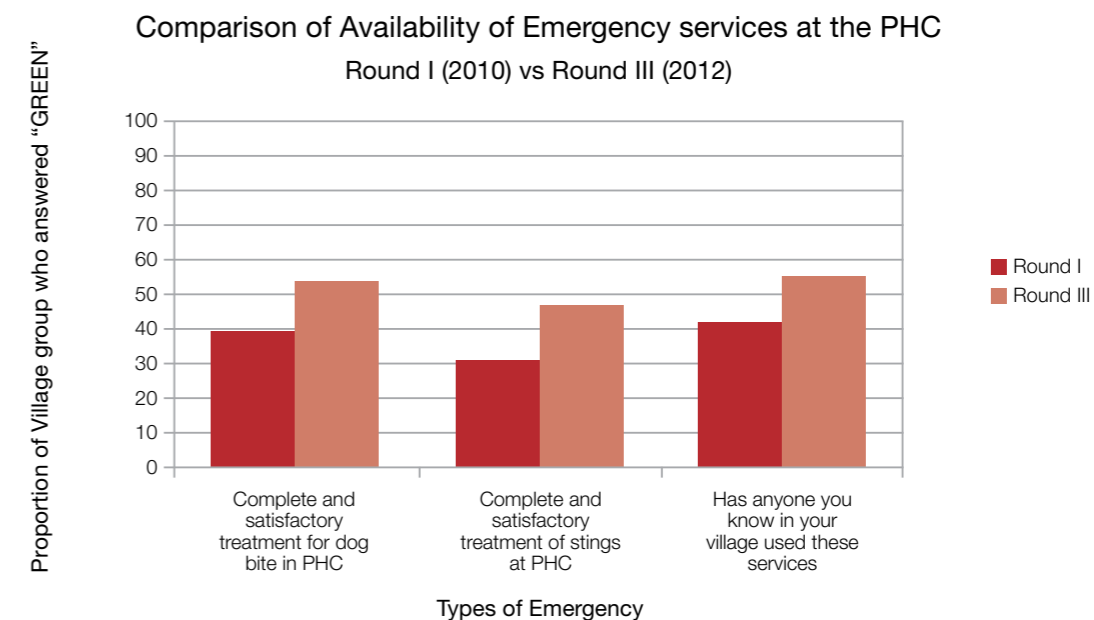


Figure 8

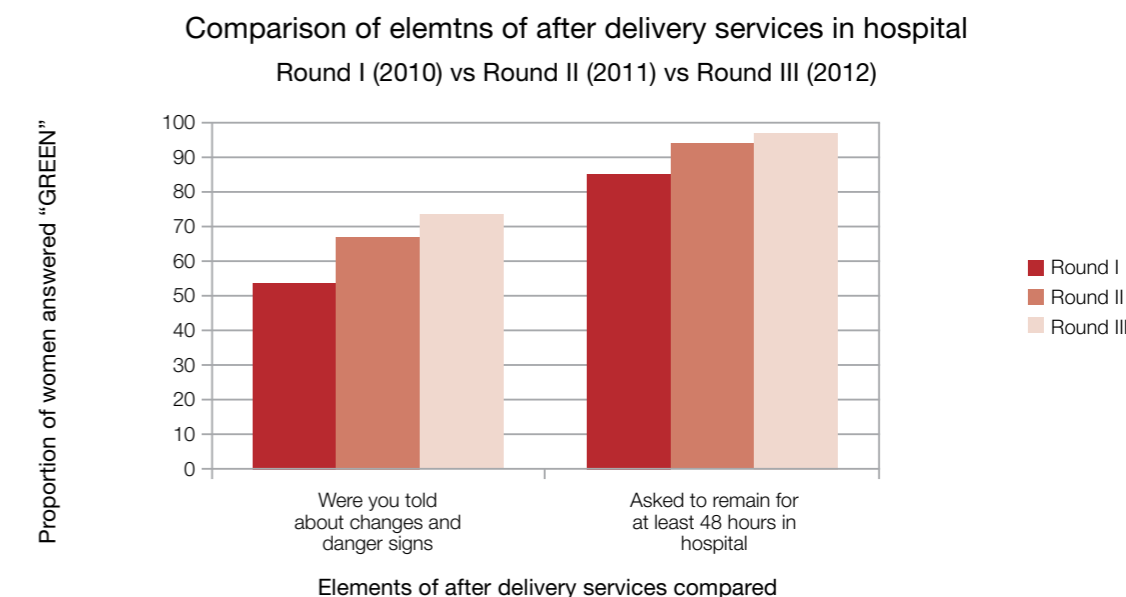


Figure 9

Comparison of various elements of ICDS within Round II
Round II (2011)

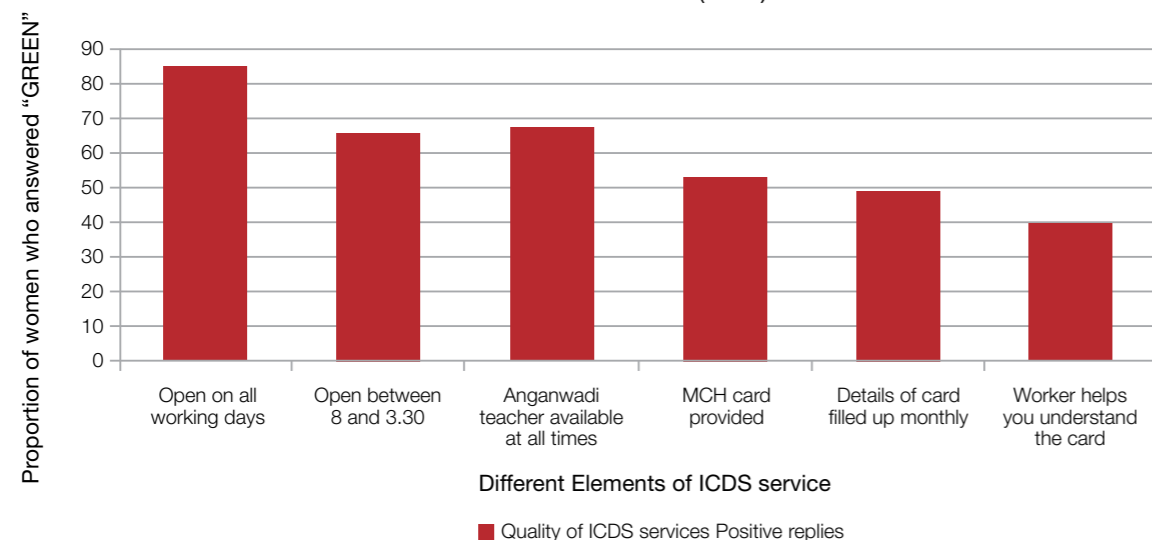


Figure 10

Comparison of Availability / Quality / Educational Indicators - ANC
Round I (2010) vs Round II (2011) vs Round III (2012)

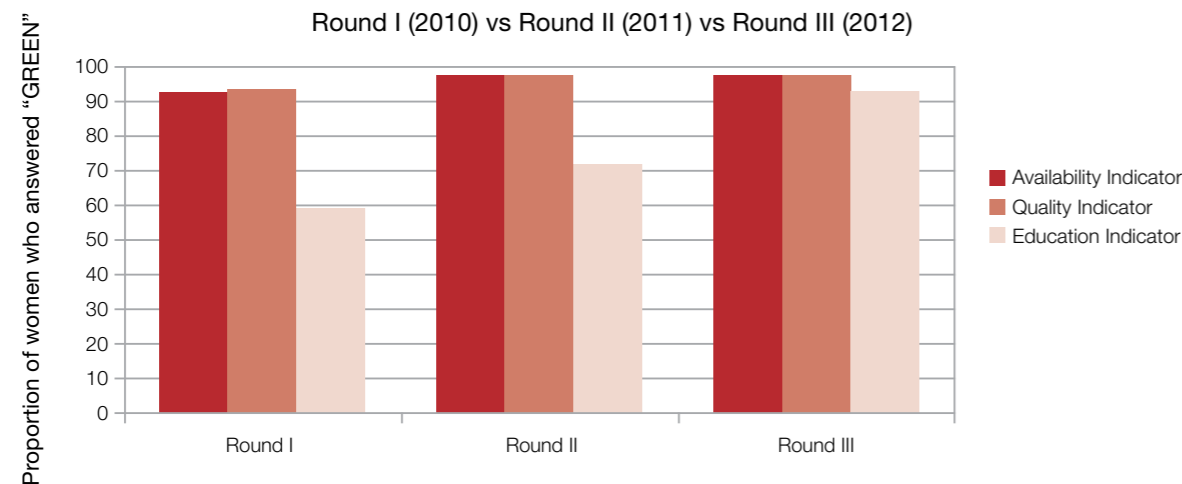


Figure 11

Outcomes

1. Use of a formal space to promote community's awareness and participation in health.
2. Increase in accountability of frontline service providers to the community.
3. Local action for health in order to promote local solutions with periodic monitoring and follow up of such action.
4. Inter-sectoral convergence at the local level due to integrated monitoring and planning of all services related to health.
5. Increase in engagement of health providers with community representatives.

6. Increase in interest in Panchayati Raj Institutions and representatives in issues related to community's health.
7. Generation of local data on health for local use.
8. Setting up of systems and use of locally generated data for district and state-level advocacy.
9. Increase in interest in health system and communitization of health services.

Learnings

1. With appropriate inputs, formal spaces in the community like the VHSNC and Panchayati Raj membership can be used to promote accountability in health.
2. Communities can, with some technical support, generate information on their health status locally, and use this to plan action for change.
3. Such local planning promotes convergence as communities go beyond line departments in their action process.
4. Community participation can improve the relevance and appropriateness of planning even in health facilities.
5. Specific efforts need to be made to engage with health care providers to increase their understanding, ownership and engagement with any community participation efforts.
6. Need for a committed engagement of civil society with health authorities to facilitate community based processes.
7. Importance of role of external facilitators and change agents within the system in promoting community based accountability mechanisms and fostering a culture of accountability in the system.

Challenges

1. Getting support from health system to community participation – moving this from beyond an NGO project to a systemic initiative that encompasses the rights framework.
2. Understanding by health system authorities that this is process intensive rather than implementing in project mode and thus need for sustained, long-term commitment to the process, including allocation of adequate human and financial resources.
3. Getting people within formal systems to understand the need for accountability to the community in addition to horizontal accountability within the system.
4. Taking the process beyond the Gram Panchayat level to block and district levels.
5. Integrating any block-level community process with the existent facility based Rogi Kalyan Samitis.
6. Scaling up from the NGO project to cover the entire health system – Some plans have been made in the state towards this:
 - Making the programme part of an institutionalized structure through more involvement of government health staff in training and implementation.
 - Whole administrative blocks to be covered by the programme to increase its significance.
 - In order to reduce dependence on NGOs and to make this an institutionalized programme of the government, the role of civil society would be more and more in technical capacity building, facilitation and oversight.

SWASTH PANCHAYAT YOJANA, CHHATTISGARH

Background

Chhattisgarh state in central India has been making significant efforts towards communitization of its health programme since the launch of the Mitadin programme in 2002. The state has initiated several efforts towards this, one of the most important being the Swasth Panchayat Yojana. Beginning in 2005-06 in a few blocks, the programme now covers the entire state.

The context

Chhattisgarh state in central India was carved out of Madhya Pradesh in the year 2000. The state has a predominantly tribal population living in geographically remote and scattered locations. The state also has low literacy levels and one of the lowest Human Development Indices in the country. Chhattisgarh is well known for its mineral resources. It has also been faced with left wing extremism in several of its districts in the recent years. This, coupled with the state's response to it, has resulted in a conflict situation in several districts of the state.(61–63)

Health indicators in Chhattisgarh have been traditionally poor. The public health system in the state faces several challenges in the areas of infrastructure and human resource.(63) In spite of this, Chhattisgarh has also been characterized by several innovations and efforts at health systems strengthening – its Mitadin programme has been one of the models for the nation wide ASHA programme and the State Health Resource Centre has been well recognized for its role in supporting the public health system.(56,63)

Objectives

The Swasth Panchayat Yojana aims to put People's Health in People's Hands by making health an integral part of the Gram Panchayat. In tune with the spirit of the 73rd and 74th amendments bringing in Panchayati Raj, the programme aims to place health on the agenda of panchayats and increase their participation and capacity to act on health issues.

The stated objectives of the programme are:

1. To involve communities, including panchayat members and Village Health, Sanitation and Nutrition Committees (VHSNC) in assessing the status of health in their village/panchayat.
2. To award top ranking panchayats based on a composite performance index to encourage to engage in health issues.
3. To mobilize communities and to facilitate stakeholder dialogue at panchayat and VHSNC levels for preparing and executing participatory village health plans on health and underlying issues.
4. To build capacity of VHSNCs (including their PRI members) to undertake village health planning and execution through collective action.
5. To mobilize communities (as represented by VHSNCs) and organize them to take up community advocacy.

Structure

The Swasth Panchayat Yojana programme uses the community health worker programme (the Mitadin programme) as its bedrock. In addition, the Village Health, Sanitation and Nutrition Committees (VHSNC), a sub-committee of the panchayat mandated and formed under the National Rural Health Mission (NRHM), is the main forum through which the programme is implemented. Thus, the programme uses an already existing formal space at the village level as its main space for community action.

As support structures to this space, the Swasth Panchayat Yojana again uses human resource which is part of the Mitadin programme – Mitadins, Mitadin trainers, Block Coordinators and District Coordinators. In addition to this, the programme also has **one additional staff at block level called the Swasth Panchayat Samanwayak (SPS)** who also supports and coordinates the programme at block level.

The programme is run by the State Department of Health and Family Welfare with assistance from the State Health Resource Centre. Thus, the programme again uses staff from within the public health system, but separate and autonomous from actual service providers, to implement the programme.

The VHSNCs in Chhattisgarh are constituted according to national guidelines. The members have been chosen through a democratic process at the Gram Sabha meetings. They usually include PRI members, self help group women and other residents of the village. The VHSNC is headed by one of the women PRI members of the village and convened by one of the Mitadins of the village. A recent study of a sample of 320 VHSNCs across eight districts of the state has shown that a large proportion of VHSNCs have women as more than half their members and that about two-thirds of the VHSNC members belong to the scheduled castes or tribes.(64) Thus, there seems to be adequate representation of marginalized communities in this space.

Process

In order that panchayats engage with health as a key issue, capacity building sessions have been held for VHSNC members. The Seventh and Eleventh round of Mitadin trainings have been specifically on this issue and have also involved PRI members.

In order to engage panchayats on the issue of health and initiate community action, several key processes have been put in place and institutionalized. Guidelines for each of these have also been made by SHRC. The following are these processes.

1. Monthly VHSNC monitoring and planning session

Each VHSNC meets on a fixed day every month to monitor the health situation in its village and also plan action on any gaps identified. These meetings are convened by one of the Mitadins of that village and attended by all other Mitadins, VHSNC members including Panchayat members and other interested persons from the village. The meeting is facilitated by a Mitadin trainer. The meetings are also expected to be attended by ICDS staff and the ANM – while the attendance of ICDS staff seems to be quite high according to the VHSNC survey, the attendance of the ANM at these meetings is quite low. Strategically, in many villages, these meetings are held on the day of the Village Health, and Nutrition Day (VHND) to facilitate attendance by the ANM. Each of these meetings has a pre-set format and undertakes the following processes.

- a) **Singing an inspirational song and sharing their own success stories** – These are meant to keep the level of motivation high in the VHSNC and build hope for positive action.
- b) **Maintaining birth and death registers** – Births in the last month are recorded including a discussion on whether the birth was institutional, the mode of delivery, the birth weight and details of the post natal check ups undertaken by the Mitanin. Details of deaths are discussed and the perceived cause of death recorded. Where this is either a maternal or child death or death due to a major communicable disease is analysed further and becomes part of any action plan to prevent such deaths in the future.
- c) **Monitoring of village health status along a pre determined set of 29 questions** – These questions relate to access to health care services, nutrition programmes, education, sanitation, public distribution system, pension schemes and domestic violence. Each of these questions is answered after consultation among all persons present at the meeting. This monitoring is recorded in a register with month wise columns that helps identify any improvements achieved against each indicator.
- d) **Village health planning** – This is done based on gaps identified through the monitoring exercise. Two to three issues are identified for action every month, their causes analysed, possible solutions planned along with clear delineation of responsibilities and time frame. These are then reviewed at the next meeting and any follow up plan made accordingly.

2. Cluster-level VHSNC meetings

In addition to the space at the village level, VHSNCs that come under the area of two Mitanin trainers (approximately 12-16 VHSNCs) are brought together under one cluster. VHSNCs under one cluster meet once every month. As these meetings are voluntarily attended with no financial support for travel, some members from each VHSNC attend in rotation every month. The stated objectives of this space are to –

1. Build a larger community organization of VHSNCs
2. Create solidarity among rural communities
3. Share their learning
4. Devise solutions for common problems

This space is used to identify problems that are common to several villages and may either require coordinated action or higher officials in various departments to be approached.

3. Swasth Panchayat Sammelans

In order to take the processes at the village and cluster level to the block, public dialogues (Jan Samwads) or Swasth Panchayat Sammelans have been held in 2012-13 (after an initial round in 2006) at the block level. At these sammelans, issues that need the attention of block level officials of the various departments concerned with health and development are taken up. Over 50 of these block-level sammelans have been held so far.

The stated objectives of these sammelans are to –

1. Provide an opportunity to communities to place their issues before block-level authorities.
2. Make block-level authorities aware of problems in the communities they serve
3. Increase the participation of PRI representatives in issues of health
4. Empower VHSNCs

The process:

Preparations are made before the sammelan by District and block coordinators and mitanin trainers in discussion with VHSNCs identify the main issues that need to be brought up at the sammelan. On the day of the sammelan, block-level authorities from Health, Women and Child Development and other related departments, and elected representatives, including block and district-level PRIs and MLAs, are invited as guests. The community is represented by Mitanins, VHSNC members, Gram Panchayat elected representatives and active persons from the community. The identified issues are then presented before the invited guests by community representatives. These are also then submitted as written requests/applications to the concerned officials. Follow up on the status of these applications is made by the district and block-level staff of the programme.

Outcomes:

Interactions with the staff of the Mitanin programme revealed that many of the issues brought up at these sammelans have been resolved subsequently. These include problems like the prescribed menu not being followed in the Mid Day meal programme, Ready to Eat food not being distributed in anganwadis, pensions not being given to eligible persons, etc.

4. Swasth Panchayat survey

Apart from the community-level processes described above, the SHRC also conducts annual surveys that assess the health situation of each village and panchayat. Four such surveys have been conducted from 2006 onwards and the fifth is ongoing in 2013.

- a) **Objectives:** To assess the status of health services at the panchayat and hamlet levels, and to rank panchayats in order of their composite performance and identify specific weak areas in terms of defined indicators.
- b) **Indicators:** A set of indicators that reflect aspects of health status of the panchayat, access to health care services, health-related community behaviour, nutrition, education, water and sanitation, and gender, have been developed for the purpose of this survey. For the first two rounds, a set of 26 and 32 indicators were used respectively, but subsequently, they have been brought down to a set of ten indicators. According to SHRC, these indicators include aspects which are critical as per the Millennium Development Goals (MDG) and thus allow monitoring of MDG goals for each panchayat in the state.
- c) **The process:** The data is collected by Mitanin trainers. The information is based on the 10 indicators collected house-to-house at hamlet level and also through hamlet-level meetings. In order to reduce bias, the Mitanin trainers do not carry out the survey in their own district but in a different district. This information is filled into a panchayat-level score card that is then presented to the Sarpanch of the panchayat. This enables the Sarpanch to identify specific aspects that need to be improved in his/her panchayat. In addition, the hamlet-level data is centrally analysed to arrive at the consolidated panchayat-level indicators and composite panchayat-level Health and Human Development Index. Panchayats are then ranked block wise based on these indices and the top ranking panchayats are given cash awards to encourage them for their good performance.

Outcomes

1. Active involvement of community representatives and PRI members through VHSNCs in monitoring of a wide range of health, health care, nutrition and related issues at village level on a regular monthly basis.
2. Development of village-level action plans to resolve issues identified through monitoring and based on a process of local prioritization.
3. Local community members taking on responsibilities to solve issues based on above plans.
4. Shared learning among a cluster of villages through cluster-level meetings.
5. Shared problem solving through cluster-level meetings of common problems.

Learnings

- a) The use of formal democratic spaces provided for under Panchayati Raj can promote local planning and action for health in its broad sense.
- b) The role of Mitani as a catalyst in sustaining this community action.
- c) The important role of the sustained facilitation and support provided by the Mitani support team for this process.
- d) The need to focus on processes.
- e) Communities through formal institutions like VHSNC and PRIs can even take on responsibilities for financial disbursements.

Challenges

1. Taking this process beyond the community level to block and district level – SHRC itself supports this process through Swasth Panchayat surveys and state-level Community Based Monitoring reports. However, there is no formal space beyond the cluster level for VHSNCs to participate. Block-level sammelans have been seen as one such space to interact with block-level officials.
2. Involving block and district panchayats in these community action processes.
3. Making available more spaces for interaction with the health system at block and district level.
4. Empowering communities to monitor availability and quality of healthcare services at facilities beyond the community level – PHCs, CHCs, district hospitals.
5. This increases democratic action, local participation. Does it increase accountability?

Monitoring indicator checklist used by VHSNC

Sl. No	Indicator	Comments
Nutrition Services through the ICDS Program		
1	Do the Anganwadi Centres (AWC) regularly open	Yes/No
2	How many children are enrolled in the age group of 3-6 years (out of the total of children in the age group)	Numbers
3	How many children (3-6 years) are regularly coming to receive services at AWC	Numbers
4	Was growth monitoring of all children enrolled in the AWC done in the last month	Yes/No
5	Were all children enrolled for pre-school education provided supplementary nutrition (rice, dal & Vegetables) in the last week	Yes/No
6	Were weekly Take Home Rations regularly distributed in the AWC (in the last month)	Yes/No/ No of weeks
7	How many children of age group of 6 -9 months have not yet initiated complimentary feeding	Number
Health Services		
8	Did the ANM provide immunization for children in the last month	Yes/No
9	How many children were not immunized in the last month, (mention hamlet/ family)	Number
10	Did the ANM check the blood-pressure of pregnant women in the last Nutrition and Health / Immunization Day	Yes/No
11	Does the ANM regularly provide free medicines for common illness	Yes/No
12	Do all Mitanins have adequate stock of Chloroquine tablets (more than 10 doses)	Yes/No
13	Did all Mitanins have Cotrim available in the last month (more than 10 doses)	Yes / No
14	Was free transportation facility available for serious patients, pregnant women, referral of malnourished children	Yes/No
15	How many families are regularly not using the mosquito bednets	Number
16	How many deliveries have occurred at home (last one month)	Number
17	Does the Sub Health Centre open regularly (last one month)	Yes/No
18	How many people have suffered from diarrhea	Number
19	How many persons suffered from fever last month	Number
Public Distribution		
20	Did people receive regular ration from the ration shop (Rice, Wheat)	Yes / No
Old Age Pensions		
21	Did all old age persons in the village receive their pension in the last month. Mention the number of pending cases	Yes/No/ Number
Education		
22	How many girls in the age group of 6-16 years have not been attending to school in the last last month	Number
23	Did all the teachers / head masters regularly attend school in the last month	Yes/No
Mid Day Meals		
24	How many days were children provided rice, with dal and vegetables, mention details of each class in the school	Number
Hand Pumps		
25	How many hand-pumps are non-functional or needs to be repair	Number
26	In how many hand-pumps , there is collection of waste water	Number
Others		
27	In the last month how many cases of domestic violence (women) were noticed / observed	Number
28	Are payment of wages under MNREGA being made as per the designated minimum wages and in a timely manner	Yes/No
<i>Other indictors can be added by the VHSNC based on local issues / priorities</i>		

Swasth Panchayat survey indicators

SI No	Aspects of data collection	Denominator	Numerator
1	Institutional delivery	Total no. of delivery during last year	Total no. of women who had institutional delivery
2	Complementary food to children of 6-12 months	No. of children of age 6-12 months in the hamlet	No. of children in this age group who were getting regular complementary feeding
3	Use of mosquito net by pregnant women	Total no. of pregnant women in the hamlet	No. of pregnant women using mosquito nets
4	Cleanliness around handpump	No. of hand pumps in the hamlet	No. of hand pumps without stagnant water around them
5	Use of Safe Drinking Water	Total no. of families in the hamlet	No. of families using safe drinking water
6	Use of Toilet	Total no. of families in the hamlet	No. of families which are using domestic/ community toilet
7	School education attainment of girls	Total no. of girls in 14-18 age group in the hamlet	No. of girls in this age group who have passed 8th standard
8	Access to Rozgar Guarantee Yojana (MRNREGA)	No. of families in the hamlet	No. of families who got more than 20 days of work during last one year under Rozgar Guarantee
9	Malnutrition	Total no. of children weighed in age 0-3 years	No. of these children in any grade of malnutrition
10	Infant death	No. of deliveries in the last year	No. of deaths of any child below one year

COMMUNITY BASED PLANNING AND MONITORING PROGRAMME (CBPM) IN BIHAR

Background

The Community Based Planning and Monitoring Programme (CBPM) is being implemented in Bihar with support from the State Health Society of Bihar and in partnership with civil society organizations under the National Rural Health Mission (NRHM) since May 2011.

The context

Bihar is a state in the eastern part of India which in ancient times was a centre of culture and education as part of different empires. It has the third largest population in the country. It is also one of the high focus Empowered Action Group states under the NRHM. Over the last few years, Bihar has been noted for its good governance and rapid economic development.

In the health sector, Bihar faces large gaps in health infrastructure and human resource. As per SRS, 2013, the IMR is 48, against the national figure of 42. But many indicators like the Under 5 Mortality Rate (U5MR) is at 70 against the national figure of 52 and Maternal Mortality Ratio (MMR) still remain high at 274 compared to the national average of 178 as per AHS 2012-13. The number of institutional deliveries has shown a consistent decline from 85.4 % in 2009-10 to 76.0 % in 2012-13. (<https://nrhm-mis.nic.in/SitePages/Pub-FW-Statistics2013.aspx> accessed on June 12, 2014)

Community monitoring and planning is an important component for achieving quality health outcomes with accountable health services which are responsive, promote community ownership and participation and take care of the needs of the poor and vulnerable sections of the society. The community based planning and monitoring process involves a three way partnership between health care providers and managers (health system); the community, community based organizations and CSOs and the Panchayati Raj Institutions. Keeping this in view, the Bihar State Government initiated the process of community based planning and monitoring (CBPM) in selected districts of the state.

Goal & Objectives

The stated goals and objectives of the programme are as follows:

Goal

To develop and strengthen community involvement in accountability, planning and action mechanisms and processes to improve access and utilization of health services under NRHM

Objectives

1. Provide regular and systematic information about community needs
2. Provide feedback according to locally developed parameters
3. Provide feedback on status of entitlements and functioning of various levels of the public health system, identify gaps/ deficiencies in the services and levels of community satisfaction
4. Increase responsiveness of the public health system

Structure

The CBPM programme is being implemented by the State Health Society of Bihar under the NRHM with support of civil society organizations. The first phase of the programme is being implemented in five districts (Bhagalpur, Nawada, Gaya, Darbhanga and Jehanabad) with five panchayats in two blocks of each of these districts covered under the programme.

Population Foundation of India (PFI) is the State Nodal cum Technical NGO for implementing the programme. PFI is supported by district and block level NGOs for implementing the programme at these levels.

The programme is based on the strategies and processes developed and tested during the pilot phase of the Community Monitoring Programme implemented in nine states across the country in 2007-09. The bedrock of the programme is the VHSNC. However, as the VHSNC in Bihar has been constituted at the Gram Panchayat level, the CBPM programme has formed Village - level Planning and Monitoring Committees (VPMC) to take the programme down to the grassroots.

In addition, committees have been formed at the block and district levels – the Block Planning and Monitoring Committee (BPMC) and the District Planning and Monitoring Committee (DPMC) - to foster community action.

The programme is supported by a community facilitator / cluster coordinator for every 15 villages and coordinators at the block and district level. In addition, there is a Training Officer at the district level to support and guide the capacity building processes,

A State Advisory Group on Community Action and a State Technical Advisory Group mentor and provide oversight for the programme.

Process

1. Community mobilization

The first step of the community level processes in the programme was to mobilize the community and generate awareness regarding NRHM and their entitlements. This was done through a series of measures.

Community facilitators met with panchayat and village leaders, the ANM, the Anganwadi Worker and community members and held

community meetings in different hamlets to engage with the community on these issues. Participatory Rural Appraisal techniques were also used at these sessions to understand village-level issues. In addition, a larger village-level meeting was held to bring everyone together on the issue.

The above steps were supported by the use of the local theatre form the *kalajatha*. They performed street plays (*nukkad natak*) at several places in each village so as to generate awareness on health entitlements under NRHM and discussion on the issues. These seem to have been appreciated greatly in the community and were remembered and talked about even a year later. In addition, wall paintings and posters reinforced these messages.

Subsequently, meetings were also held with other groups like SHG women, adolescent girls and religious leaders to get their support for the programme.

2. Formation of VPMC

In Bihar, the NRHM mandated VHSNCs have been formed at the Gram Panchayat level. As it was felt that there needed to be a committee at the village level to take the process upto the grassroots, a Village Planning and Monitoring Committee (VPMC) was formed.

The members of the VPMC were chosen by villagers at the larger village level meeting. Names of active members of the community were proposed chosen after achieving a consensus from everyone present. Places were reserved for members of the scheduled castes and minority communities on these committees in order to ensure inclusion and representativeness.

Subsequent to the formation of the VPMC at village level, VHSNC meetings were held where VPMC members were introduced to the VHSNC members. In some places, efforts were also made to expand the VHSNC to include some of the VPMC members. These meetings also served as a form of ratification of the VPMC by the panchayat. In many villages, the process was later endorsed in a larger Gram Sabha meeting.

3. Training of VPMC members

Following the formation of the VPMCs, capacity building sessions for the members were held at the panchayat level. Five to six members of each VPMC received two rounds of training of two days each. A training module was prepared for the same by the state nodal NGO and the district and block level NGO staff were trained on this.

The sessions for VPMC members covered the following topics:

- Determinants of health
- The Health system in India / various level services availability
- NRHM and service guarantees at various levels
- Health rights
- Community monitoring tools, collation and sharing formats

- The Role of the VPMC
- Jan Samwad
- Health /village planning process
- Utilization of untied funds at various levels
- VHSND and the VPMC's role in functioning of same

A manual on community monitoring that detailed the process and monitoring the Jan Samwad and also contained the tools, and a booklet on the community's health entitlements were given to the participants.

4. Monitoring

Subsequent to this, VPMC members meet regularly every month. These meetings are facilitated by the community facilitators (cluster coordinators) and are used to monitor health services and also for planning further action. The monitoring activities can be categorized as follows:

1. Monitoring Village Health Nutrition and Sanitation Days (VHSND) services

Community level services are held under the NRHM on a fixed day called the VHSND. One of the critical activities of the VPMCs has been to monitor and support these VHSNDs.

VPMC members have been trained in understanding the activities of the VHSND and provided with a format to assess the services provided there. These formats have been used by the VPMC to understand any gaps in the VHSND services. Meetings are then held with the VPMC members and community members and the ANM and Anganwadi worker to understand the reasons for these gaps and arrive at possible solutions. Such solutions have included VPMC members motivating community members to access services at the VHSND and also providing equipment like cots and blood pressure apparatus to ensure that a full range of services is available at the VHSND. In some facilities, community members have also made efforts to make facilities that were not functional active by using the untied fund to buy equipment, carry out maintenance and repairs of buildings.

2. Community level enquiry and health facility surveys

A pre designed tool has been used by the VPMC members to monitor health services in the following domains - disease surveillance, curative services, untied fund, quality care, roles and responsibility of ASHA, women's perception on ASHA, maternal health, child health, Janani Evam Bal Suraksha Yojana, adverse outcome, and the equity index.

Separate meetings are held with different groups of people including women and mothers of young children and in different hamlets including in dalit hamlets to understand different groups' perspectives on these. The scores given by different groups are then collated into a report card at village and panchayat level to arrive at a colour code that grades services as good (green), average (yellow) or poor (red). These report cards are then presented both at a village level meeting and at the panchayat level and discussed with the community for possible improvements.

These community level enquiries have been supplemented by facility surveys that assess the availability and quality of services at facilities.

Both of these processes in the initial phases have required a lot of support and hand-holding by the block level NGO. These sessions have also served as knowledge building sessions initially because communities were largely unaware of their entitlements.

3. Jan Samwad

The third mechanism of monitoring has been the use of facilitated public dialogues or Jan Samwads between communities and health providers.

5. Planning

Efforts have been made to develop village level health action plans to facilitate bottom up planning. A workshop for decentralized planning has been held with block-level stakeholders and efforts.

6. Block and district level processes

In addition to the community level processes mentioned above, block and district planning and mentoring committees have also been formed comprising a mix of community members, block and district level health and development authorities, PRI members and civil society staff. The role of these committees is to facilitate community action at these levels on issues arising from various village and panchayat level enquiry processes. Efforts are being made to ensure active participation of PRI members in these committees and ensure that the issues emerging from the facility surveys are being resolved in a timely manner. In addition to these, block and district level NGOs have also made efforts to activate the health facility committees, Rogi Kalyan Samitis, formed under NRHM. Efforts are being made to ensure active participation of PRI members in these committees and ensure that the issues emerging from the facility surveys are being resolved in a timely manner.

Outcomes

1. Establishment of a formal space to facilitate community participation in health
2. Monitoring and support of health systems by communities
3. Increased accountability of front line health providers.
4. Increased access of health care services especially for marginalized communities
5. Increased demand for better quality of care
6. Local action for better health care services
7. Increased engagement of PRIs with health issues.

Learnings

- a) A formal space like the VPMC and VHSNC can be used to promote community accountability in health.
- b) Communities, when empowered with knowledge and awareness, will be able to monitor health systems and also initiate local action to support health care providers and services.
- c) Specific efforts need to be made to involve marginalized communities in such community action in order to increase their access to public services.
- d) Elected representatives can play an important role in supporting community participation and in balancing power hierarchies between communities and health providers.

Challenges

- a) Getting health providers in traditional hierarchical systems to internalize accountability to the community and be responsive to demands for these.
- b) In a socio political context that is marked by inequities, power hierarchies and vested interests, to foster genuine community participation as a means of vesting power and control in communities is a challenge.

COMMUNITY DEVELOPMENT COMMITTEES IN URBAN SLUMS

SAHAJ's initiative in Vadodara, Gujarat

Background

Data from the recent census (2011) shows that about one-third of India's population lives in urban areas and about one-third of this is estimated to live in urban slums.(67) While a lot of attention has been focussed on rural health, especially post the National Rural Health Mission, urban areas have not received as much attention.

Society for Health Alternatives (SAHAJ) has been working in Vadodara, Gujarat's third largest city, since 1994. Since the early 2000s, SAHAJ has been working in several slums across the city to promote women's and girls' health. Their work has involved mobilizing the community around issues of health and offers some important lessons on achieving community participation in health in urban areas.

The context

Vadodara is the third largest city of Gujarat, a state in western India. Economic development of Gujarat has been seen as successful, however, the state lags behind some of the more developed states like Kerala and Tamil Nadu in its social development status.

In Vadodara, 20% of the population lives in more than 300 slums across the city. These slums are situated largely around the peripheries of the city and lack access to transport and other public facilities. Many of these slums are not legally recognized and the people living there face the constant threat of eviction. In addition, because they are unrecognized, they also lack several civic amenities like water supply and sanitation.

The communities living in these slums are migrants from other parts of Gujarat and also several other states. The men work as daily labourers or for wage work in the industries in the city, while the women largely work as domestic help. Many of these migrants have been living together for almost a generation, and therefore, have a sense of community belonging within the slum.(68)

Objectives

The aims and objectives of this initiative that has been implemented over the last few years as part of several projects have been

To bring about sustainable social change in the marginalized communities living in bastis in Vadodara

- by creating awareness among the community members on their health as well as civil rights
- by enhancing their capacities to interact with the local administration and fight for their rights to decent living through peaceful means to the extent possible.

One of the strategies towards achieving this objective has been to develop and strengthen Community Development Committees which can undertake community based advocacy for their health and civic entitlements. In addition, SAHAJ also does intensive work with adolescents and women in these communities. Some of this part of SAHAJ's work is mentioned here in relation to the work with Community Development Committees.

Structure

SAHAJ's work with Community Development Committees extends to 17 slums/*bastis* across Vadodara. The work in some of these *bastis* is an organic evolution of previous years' work in them where SAHAJ has worked with adolescents and on maternal health. In addition, Community Development Committees have also been formed in some *bastis* where SAHAJ felt there was a need for these based on the population living there - presence of scheduled castes/religious minorities.

In each of these *bastis*, the SAHAJ team first interacts with community members explaining their work and objectives to community leaders and other members. Following this, a mass meeting is organized where again the objectives of SAHAJ's work with the community are shared. At this point, if the community members evince interest in participating in the process, SAHAJ takes the work forward.

At the mass meeting, community members are encouraged to bring up issues that they may be facing. After this, the possibility of forming a committee of interested persons from the community that could work towards solving these issues is raised. Certain ground rules about the committee are also discussed – every committee should have at least half its members as women and should be representative of the population of the *basti*. In addition, potential committee members are expected to work voluntarily for the benefit of the community, attend meetings regularly, have good communication skills and maintain peace and harmony in the community. Educational qualifications are not a criteria for membership. The role of the committee would be to represent people's issues at various levels, be aware of different issues of the *basti* and find solutions for the same through regular meetings, disseminate information to the community, liaise between government officials and the people from the *bastis*, monitor various government schemes and services available in the *basti* and mobilize the community for various events.

Following this discussion, community members present at the meeting elect/nominate members from the community to the committee. The membership to the committee remains open and flexible as the work expected is voluntary. As and when any person drops out or is unable to find time to give to the committee, new persons are elected to replace them.

Subsequently, SAHAJ has formed three sub committees out of each of these committees – one each on health, education and community development. This helps reduce the burden on the committee of working on several priority issues at the same time. It also helps widen the net of active members in the committee and helps them develop specialized skills for working in a particular focus area.

Thus, SAHAJ's work uses an autonomous space formed specifically for the purpose of community action. This space is representative of the community and is granted legitimacy by the community. However, it does not have any official sanction.

In addition, SAHAJ has formed a federation of these committees – the Samanvay Samiti – in order to have a forum that will encourage cross learning and also take up issues that are common to several *bastis* across the city at a larger level.

Process

Subsequent to the formation of the committees, the following processes are implemented:

1. Capacity building of committee members

Several sessions are held with committee members to build their capacity for community action. SAHAJ does not follow a systematic curriculum for this – the areas for capacity building are decided in consultation with the community based on the needs of the issue at hand. For example, when a committee wanted to take up the issue of corruption in the Public Distribution System (PDS) shop, sessions and materials on entitlements under PDS and Right to Food were prepared for use by the community. In addition, certain areas which are of use generally in advocacy and demand for entitlements, eg. Right to Information Act, are part of the capacity building sessions. These sessions are held periodically based on need. In addition, selected committee members are also taken on exposure visits to witness work done by other groups so they can be inspired and learn from it.

2. Monthly meetings

The committees meet every month to discuss issues that are present. Initially, these meetings are attended by staff of SAHAJ, but over a period of several months, SAHAJ moves to attending these meetings only when specific help and support is sought from the organization in issues that are beyond what the community can act on – for eg. to meet a senior bureaucrat / politician, contact the media etc. Thus, over a period of time, this process becomes owned by the local community making it sustainable.

3. Action plan and implementation

The space of the monthly meeting is used to discuss and plan solutions for various issues. Issues are prioritized based on consultations among community members – very often civic entitlements like ration cards, roads, drainage take precedence over issues directly related to health or health care. Some of these *bastis* also face constant danger of eviction and demolition. However, as these are the community's immediate survival needs, SAHAJ believes that they must be addressed and acted on before any meaningful discussion on health can take place.

Once the issues are identified, plans to solve these are made by the committee members with assignment of responsibility. Such plans could involve meeting the concerned authorities and giving an application, organizing demonstrations, filing Right to Information applications to get more details regarding entitlements. The actions are followed up in subsequent meetings and further plans made based on earlier results.

In many cases, because of the nature of the issues taken up, action needs to be long drawn out. Many committees have engaged with specific issues over two to three years highlighting the strength and sustainability of the process. In some instances, committee members have also planned data collection and regular activities like monitoring, as detailed in the case studies below.

SAHAJ's programme does not have a ready made tool that is used by the community to monitor services on a regular basis. Rather, any monitoring is taken up by the community's decision as and when need arises.

SAHAJ also believes that its role in any action planned is only facilitatory – even where higher authorities have to be met to resolve a particular issue, SAHAJ puts the community in contact with them to directly interact. Limiting their role to facilitating, SAHAJ believes, empowers the community and makes the process sustainable for the community to take forward even without SAHAJ's support in the future. Also, since the community is involved directly in any action, they have realistic expectations from any actions planned and do not end up being frustrated with long drawn out struggles.

Outcomes

1. Local communities coming together for local community action for local issues in urban area.
2. Priority setting by communities resulting in a wide range of issues being taken up resulting in a very wide definition of health, thus work on broader determinants of health.

Learnings

1. Urban communities have unique and specific challenges – civic amenities and determinants of health assume a crucial role in achieving health for all.
2. Contrary to generally held views about urban areas, it is possible to organize urban communities around specific issues that affect all of them.
3. It is important to address community's immediate priorities like shelter and sanitation before any work on issues like education and health can begin. In urban areas, health care is not so much an issue as determinants of health are.
4. Issues addressed have to go across and beyond the health sector and not just health care.
5. Knowledge and awareness regarding entitlements can be a major trigger for change.
6. Flexibility in the membership of committees leads to the development of a larger pool of leadership resource as people who have dropped out of committees also continue to play a leadership role in the community whenever the need arises.
7. Effective and strategic engagement with the media can help support people's action.

Challenges

In this case, the NGO has played a facilitatory role by organizing the community, training its members, providing support and facilitating direct contact with authorities. In the event of up scaling this to entire urban communities, SAHAJ team had a few suggestions.

1. Present ward committees do not reach upto the grassroots and have a heterogeneous representation of both slums and middle and upper class residents. It would be good to have *basti*-level committees federated into core committees which then are represented on ward committees, so unique issues of such *bastis* have space to be raised.
2. The role played by the NGO here can be replicated by forming an Urban Health Resource Centre – with civil society representation or support from civil society, this could play a facilitatory role of supporting and building the capacities of *basti*-level committees.

MONITORING OF MATERNITY HOMES IN BENGALURU

Background

The Public Affairs Centre (PAC) is a not for profit organization based in Bengaluru in the southern Indian state of Karnataka. Established in 1994, PAC works to improve the quality of governance in India. Towards this, PAC undertakes research and facilitates collective citizen action. PAC is well known globally for its pioneering Citizen Report Cards that facilitate citizen action to improve governance in various development sectors. PAC has used such report cards to monitor the quality of maternity services in Bengaluru's municipality run health centres.

The context

Bengaluru or Bangalore is the capital of the southern state of Karnataka. It is one of the major metropolitan cities of India and is well known for its information technology industry. The city is governed by the Bruhat Bengaluru Mahanagara Palike (BBMP) or the Greater Bangalore Municipal Corporation.

Official figures show that Bengaluru has close to 500 slums. Most people living in these slums are migrants from other parts of the state and from neighbouring states. They work in the construction industry or in various service industries, mostly in the unorganized sector.(69)

Objectives

Bruhat Bengaluru Mahanagara Palike (BBMP) or Greater Bangalore Municipal Corporation runs 24 maternity homes in the city of Bengaluru that provide antenatal care, delivery services, post natal care, family planning and immunization services. In the year 2000, PAC undertook a Citizen Report Card survey of these maternity homes and interviewed 500 users and 77 staff members of these facilities. This survey showed poor quality of services in these homes and high degree of corruption.(70)

As a follow up to this initial survey, in the year 2009, PAC took up a repeat monitoring of these facilities along with a budget analysis to understand the current status of services provided in them. The outcomes expected to be achieved by this were stated as follows:

1. Enhanced capacity of community groups working on health related issues to engage with local government finances and public service issues.
2. Informed, motivated and mobilized communities, holding government to account for state finance and public services.
3. Co-operative partnerships between civil society organizations and government agencies to improve the allocation, spending and auditing of municipal finances to benefit citizens.
4. Measurable improvements in public service delivery.

Structure

The present study was carried out by the Participatory Governance Research Group of PAC along with partner NGOs - Centre for Advocacy and Research (CFAR), Society for People's Action for Development (SPAD) and Association for Promoting Social Action (APSA). PAC conceptualized and took responsibility for anchoring the project and the budget analysis while the partner NGOs supported field activities.

Process

The following processes contributed to the monitoring of maternity homes.

1. Citizen Report Cards

The first round of Citizen Report Cards was carried out in the first quarter of 2010. Fifty per cent of the maternity homes were covered i.e. 12. This entailed the following components carried out by a Bengaluru - based agency that was experienced with such surveys and was trained by PAC.

- a) *Interviews with users of these facilities* – 10 users per facility were selected from the community around the facility for this.
- b) *Interviews with staff of these facilities* – At each facility, the Assistant Surgeon in Charge, another doctor, and an ANM were interviewed.
- c) *Interviews with Board of Visitors of these facilities* – The Board of Visitors comprising of local leaders, NGO representatives had been constituted at each facility after the 2000 study to monitor and advise BBMP staff on services. Feedback was also collected from a few of the members of this Board.
- d) *Observations of these facilities* – A physical observation of these facilities was also done by the survey team to understand the facilities available and the services provided.

Each of these interviews covered the following domains of the services provided at these facilities.

1. Availability
2. Access and usage
3. Service quality and reliability
4. Problem incidence, responsiveness and problem resolution.
5. Costs, including corruption
6. Satisfaction and suggestions for improvement

Data from the above interactions was centrally entered and analysed at PAC and collated to form the Citizen Report Card. The findings of these were then shared with BBMP authorities to advocate for change.

2. Budget analysis

In addition to the above, a secondary analysis of budget and expenditure related documents at three of the maternity homes were also done. This showed that record keeping was poor, guidelines regarding user fees were not systematically followed and procurement of drugs using user fee collections was not as per guidelines. The results of this were also shared with BBMP officials.

3. Development of indicators for Community Score Cards

Following the above exercises, a Community Score Card initiative was planned. These Score Cards developed by the World Bank and used in Africa are useful to monitor local, micro-level issues where immediate local action can be instituted. This is as opposed to the Citizen Report Card that looks at more macro-level issues. The Community Score Cards were expected to provide –

1. A forum for direct and constructive engagement between the service user and the service provider
2. An opportunity for joint decision making
3. Immediate feedback to the provider on areas for improvement
4. Quality, efficient and effective service delivery.
5. platform to promote good governance (accountability, transparency, participation) in the process of public service delivery.

Towards this, three 'input tracking exercises' were held in three maternity homes (Cox Town, GG Halli, Nandini Layout), one each in each of the three health zones of the BBMP. These were meetings held with users of these maternity homes. Discussions with them were on their entitlements and the actual services being provided.

Based on the above input tracking exercises, the Citizen Report Card and the budget analysis results, a set of indicators was developed for the Community Score Cards. This were done by PAC and comprise the following:

1. Availability of Medical Facilities
 - a) Scanning
 - b) Lab
 - c) OT/operations
 - d) Medicines for Maternal health
 - e) Medicines for minor ailments
 - f) Injections for ANC
 - g) Child immunisation
 - h) Stock of syringes
2. Availability of General Infrastructure
 - a) Toilets and water in toilets
 - b) Drinking water
 - c) Hot water
 - d) Linen
 - e) Bed

3. Display of information
 - a) Awareness
 - b) Grievance Redress
 - c) Availability of Services
4. Cleanliness of the premises
 - a) Toilets and water in toilets
 - b) Other areas
5. Staff Availability
 - a) During Working hours
 - b) After working hours
6. Behaviour of staff
 - a) Internally
 - b) Users
7. Extending benefits from Schemes
 - a) Madilu scheme (Scheme providing a kit containing 19 items to women who have recently delivered)
 - b) Janani Suraksha Yojana
8. Counselling and Advice
 - a) ANC
 - b) PNC
 - c) Delivery
 - d) Child care
 - e) Family Planning
9. User Fee
 - a) Receipt
 - b) Issue of receipt
 - c) Maintenance of records
 - d) Utilization
10. Food for Inpatients
 - a) Milk
 - b) Other food items
11. Efficiency in budget preparation
12. Efficiency in record keeping

4. Filling of Community Score Cards

The Community Score Card exercise was carried out in the three maternity homes selected, one each in each of the three health zones. Two different sets of filling of the score cards were done – one by users and others by staff of these facilities.

1. By Users

This was done as a group exercise, one in each of the three maternity homes, with women users of these maternity homes who had actually used the services in these homes over the last two years. They were selected by the partner NGOs from the catchment area of the centres and brought together in a public place in the area.

The session was facilitated by staff from PAC and the partner NGO. The users were given information about their entitlements to services in these homes. Posters were also used to facilitate this. Standard norms and government orders regarding various schemes and programmes were used as the basis for this.

Following the information sharing, the users were asked to grade the services for each of these indicators on a score of 1-5, '1' being the least score and '5' the highest. This was done through a process of consensus building among the users and required facilitation from the project staff. Reasons for giving a particular score for an indicator were also recorded alongside.

As there was fear of retaliation by health staff when giving negative scores, no individual names were identified during the exercise. Also, no financial incentives were paid to the participants.

2. By providers

The same set of indicators was then scored by the staff of these three maternity homes. Staff across hierarchies participated. As lower grade staff may not be open about their feedback in front of their superiors, these were given to all staff as individual questionnaires and they were asked to fill with reason. The respondents were kept anonymous and their cadre was also not mentioned. This was in a sense a self evaluation by staff of their services.

5. Interface meetings

The findings of the Community Score Cards were then discussed at an interface meeting. These meetings brought together staff of the maternity homes, higher authorities from BBMP, users of a facility and were facilitated by PAC and the NGO partner. One meeting was held at each of the three maternity homes where the score card exercise was completed. These meetings were held at the maternity home at a time convenient to all participants.

PAC and the partner NGOs had shared the processes completed at each stage so far with providers of the maternity homes and BBMP staff. This helped them understand that the process was meant to be constructive rather than as a confrontational process, and therefore enlist their support during the interface meetings.

At the interface meeting, each indicator was presented with the scores given for it by the users and the staff along with the reasons for

such scoring. This was followed by a discussion along with planning for action to improve services related to that indicator.

For example, for the indicator 'availability of toilet', the users had given a score of '3' while staff had given a score of 5. This was because according to the users, water was not available in the toilet. A decision was taken to dig a borewell to ensure water supply to the toilet.

In addition to the designated 12 indicators, space was also provided in the format for the interface meeting to bring up other issues if necessary.

6. Maternity Home Monitoring Committees

As the interface meetings received a lot of positive feedback from users, staff and BBMP officials, it was decided at these meetings to form a users' group that would carry out monitoring of the facilities and engage with the staff of these facilities on an ongoing basis. Thus, Maternity Home Monitoring Committees (MHMCs) were formed at each of these three maternity homes.

In order to form these committees, a meeting was held with users from the communities that all of these three maternity homes served. The meetings were used to brainstorm on possible indicators that could be monitored by the committee. Community members were asked to volunteer to be part of this committee. A committee of 8-10 members each was formed for each of the three maternity homes. In the second phase of the project ending January 2013, the MHMCs have been expanded to include a total of five maternity homes and three referral hospitals of the BBMP.

MHMC members take turns to visit the maternity home and monitor services provided based on a check list that has been given to them by PAC. They also make detailed notes with regard to dates, names of concerned patients and providers so as to be able to validate their reports at the interface meeting. They meet once every 15 days to discuss issues – these meetings are facilitated by the partner NGO and serve as opportunities for inputs on entitlements by the NGO staff. Interface meetings with committee members, staff of the facilities and BBMP staff are held once every three months and are facilitated by PAC and NGO staff. The meetings are used to plan actions to improve gaps identified by the monitoring exercise.

MHMC members also contact other government departments/ authorities when necessary to take forward some of their demands. For eg., no delivery services were being offered in one of the maternity homes as the building was in poor condition with water seepage. MHMC members submitted a memorandum after meeting officials of both Health and Public Health Engineering departments. A new building has now been sanctioned and construction has begun.

PAC and the local NGO support the MHMCs by facilitating their meetings, giving them periodic knowledge inputs on their entitlements.

Outcomes

1. Users of health facilities monitor the availability and quality of services at these facilities.
2. Creation of a space for regular interaction between service users and health providers
3. Increase in accountability of front line service providers to the community.
4. Increase in engagement of health providers with community representatives.
5. Capacity building of MHMC members to understand and engage with broader health system issues.

Learnings

- a) Community members, with appropriate capacity building and support, are able to monitor health facilities even at the referral level.
- b) Creation of spaces that encourage regular interaction between facility users and service providers can promote understanding of issues and problem solving.
- c) Such spaces require external facilitation and support to function constructively.
- d) Engagement of community members with larger social movements widens their perspectives, helps them understand larger health system issues and also build in sustainability to the programme.

Challenges

- a) Since it is process intensive, upscaling of such an initiative is a challenge. Making this a systemic initiative with external facilitation by an Urban Health Resource Centre supported by civil society could be a way forward.
- b) While this project has shown that communities can monitor services upto the referral level, taking this to tertiary facilities, given the amount of technicalities involved in medical care at this level, is a challenge.

ANNEXURE 2

SOME COMMUNITY PARTICIPATION EXPERIENCES

Community Based Monitoring and Planning Programme, Maharashtra

The Community Based Monitoring and Planning Programme is being implemented in Maharashtra since 2007 under the National Rural Health Mission. As of April 2013, it covers 615 villages in 116 PHCs of 35 blocks in 13 districts. In the project villages, VHSNCs are trained and facilitated to monitor specific components of health and health services at the village level. In addition, VHSNCs also monitor PHCs and Rural Hospitals. Jan Sunwais serve as a forum for public hearing on poor quality of services and denial of services. Four rounds of monitoring have so far been conducted. The programme has documented improvements in “good” ratings of services in successive rounds of monitoring. In addition, the programme reports increased attendance of patients in public health facilities, improved attitude and behaviour of health care providers towards patients and reduction in illegal practices like informal payments.(21,22)

Foundation for Research in Health Systems (FRHS) project, Karnataka

The Foundation for Research in Health Systems conducted in 2000 an 18-month pilot project in one block of Mysore district. The project explored forming village-level health committees in coordination with the health department. A total of 64 committees were formed. Committee members were chosen by the community and adequate representation was ensured for women and marginalized groups. Community facilitators supported selection of members and also their functioning. Each committee was given a one time grant of Rs 2,000 to facilitate activities. Committee members carried out events to promote awareness of health services, planned community needs assessment, carried out village level health activities and fostered trust between the community and the health services. At the end of the project period, improvements were documented in health outcomes including institutional deliveries, treatment seeking for reproductive tract infections and weighing of babies at birth. Improvements were also noted in process indicators like increased awareness, local networking by committees, mobilizing of resources and in cordial relations between community and health staff. Credibility of the committee in the eyes of the community and a coordinating role with the health system, rather than a confrontational role, were some factors attributed for the success of the committees.(25)

Community Led Initiatives for Child Survival (CLICS), Wardha

The Community Led Initiatives for Child Survival (CLICS) programme covered 67 villages of Wardha district in Maharashtra and was implemented by the Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sewagram, between 2004 and 2008. The project involved mobilizing communities through formation of women’s self help groups, adolescent groups and farmers’ groups and forming Village Coordination Committees (VCC) with representatives from these groups. The VCC was legitimized through a panchayat resolution. VCC members carried out a needs assessment of child care issues and made action plans. A Memorandum of Understanding was signed with MGIMS with these action plans as “social products”. MGIMS supported the committees in their actions through community organizers who facilitated implementation of these action plans. End line survey showed remarkable improvements in health outcomes indicators like use of ORS, initiation of breastfeeding and infant mortality rate.(26,27)

People’s Health Management Information System (PHMIS), Rayagada, Odisha

The People’s Health Management Information System (PHMIS) was set up in seven Gram Panchayats of Rayagada, Odisha for one year in 2005-06 and was jointly implemented by the district administration, UNICEF and MITRA, the community health wing of Christian Hospital, Bismacuttack. The objective was to set up a health information system that would be maintained by the local community which would use the information generated for local action. A Swasthya Patta register was maintained at the village level by a self help group member or panchayat member with help from a volunteer on the project – the information maintained was on births and deaths in the community with a cause of death mentioned. A Gram Panchayat level meeting was held every month to discuss the information generated and analyse the cause of death. The meeting was also attended by front line health providers and local action was based on it.(29)

Swasth Plus project, Karnataka

The Swasth Plus project is a community monitoring project implemented since 2002 in four blocks of two districts of Karnataka. The project is supported by UNICEF and Government of Karnataka and is implemented by SAMUHA, a development NGO. The community is divided into Neighbourhood Groups of 20 households each for which a Neighbourhood Leader (NHL) and an Assistant Leader are selected by the community. These NHLs collect monthly information on “Individual Red Alerts” – a risk factor identification mechanism for reproductive and child health issues. This is facilitated by a Gram Panchayat Organizer from SAMUHA who collates these reports and submits them to the concerned line departments for action.(29)

Mahila Swasthya Adhikar Manch (MSAM), Uttar Pradesh

Mahila Swasthya Adhikar Manch is a membership based grassroots organization of rural women covering nine districts of Uttar Pradesh. As of March 2013, MSAM has over 12,000 members organized into about 170 groups. The organization is facilitated by SAHAYOG, a rights-based NGO which is in turn supported by community based organizations in each of these districts. Each group of MSAM has five elected leaders working on the five themes of health services, livelihood security, food security and nutrition, social

security and violence against women. These leaders are trained in their entitlements in their respective themes and work with the community to claim these entitlements. In addition, every year, SAHAYOG facilitates monitoring around a particular theme, eg use of untied fund and Janani Shishu Suraksha Karyakram. The information is used to promote local action as well as for district and state level advocacy.(28)

Communitization in Nagaland

Nagaland passed the Nagaland Communitization of Public Services and Institutions Act in 2002 to improve public delivery systems by transferring ownership to the hands of the community. Under the Act, boards of user communities were set up and the government's powers and management functions were transferred to these boards – this included disbursement of salaries and power to withhold pay for no work. Assets of the government were also transferred to these boards through an MoU. The government's role is one of assistance, monitoring and regulation. The sectors of education, health and power and public health engineering were communitized. Capacity building was done for both board members and staff within the system. Village Health Committees were set up for the health sector. In addition, Health Centre Management Committees were set up for PHCs and CHCs. As of January 2009, all of 21 CHCs, 63 of 89 PHCs and all of 397 sub-centres had been communitized. An evaluation of the process in 2009 showed that attendance of health staff had improved, their behaviour with patients was better, attendance of patients in public health facilities, especially that of women and children had improved, and drug availability was better.(23,24)

Participatory Health Councils, Brazil

Brazil promoted participatory governance as an important component of its new constitution since 1988 and institutionalized mechanisms towards this at each tier of government. Participatory Health Councils are one such mechanism. These have 50% representation of user groups with the 50% represented by health workers and government representatives. Their mandate includes auditing health plans, budgets and expenditure. The councils meet once every month to discuss priority setting and planning for these.(34)

Warmi project, Bolivia

The Warmi project was conducted between 1990 and 1993 in 50 communities of one province in Bolivia to involve communities in improving maternal and child health. Study teams met once a month with already existent women's organizations in these communities and engaged in a process of "auto-diagnosis". This consisted of four steps cyclically - (i) identification and prioritization of problems (ii) group development of a formal action plan (iii) implementation of the plan and (iv) evaluation. At the end of the project, an impressive decrease in peri-natal mortality from 117 to 43.8 per 1,000 births was reported.(40)

Models based on Warmi project

Based on the impressive results of the Warmi project, a series of studies were conducted in a cluster randomized controlled trial design to replicate the results.

In Makwanpur district of Nepal, a study looking at 12 pairs of clusters (28,931 women) reported a 30% lower neonatal mortality rate after three years in intervention clusters as compared to control clusters by using the Warmi methodology. Maternal mortality ratio was 80% lower in the intervention clusters.(41)

A subsequent study in Jharkhand India by Ekjut with 36 clusters and 2,28,186 women showed a 32% lower neonatal mortality rate in intervention clusters after three years of intervention.(42)

Subsequent studies in Bangladesh and Mumbai using a similar methodology did not show any significant difference in neonatal mortality rates in the two arms.(43,44)

Health Watch Committees, Bangladesh

Health Watch Committees were set up in Bangladesh in 1998 as part of health sector reform. These were at Upazila (sub-division) and Union (lower than sub-division) level. The committees were set up with the support of rights-based NGOs. Representation for women and marginalized sections was ensured. The committees met once every month to discuss issues and plan actions. It was seen that these committees increased awareness in the community about health services, attendance in health facilities increased and attendance of health providers also increased.(51)

Community Monitoring, Uganda

This was carried out in Uganda covering 55,000 households. A report card survey was carried out with community members and also with health facility staff followed by an interface meeting and development for action plans for gaps identified. Health Unit Management Committees were also set up. At the end of six months of intervention, increased attendance at facilities, increase in immunization and Vitamin A supplementation coverage were reported. Staff absenteeism was less and facilities were reported to be cleaner.(45)

Health Centre Committees, Zimbabwe

A case control study comparing facilities with Health Centre Committees (HCC) with those without in Zimbabwe reported that those with HCCs had higher attendance, higher use of antenatal care, less diarrhoea, higher use of ORS and better relationships between communities and the health staff.(48)

Local Committees for Health Administration (CLAS), Peru

CLAS committees were set up in Peru in 1993 and covered about 25% of all facilities and had 33% representation of elected members from the community. They had a formal three-year contract and received funding from the Ministry of Health. Their mandate included health needs assessment, appointment of personnel, and decisions regarding user fees. A study of CLAS showed that facilities with these committees reported better user satisfaction and provided better access to the poor.(47)

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