



Community Based Planning and Monitoring

In Bihar

Community Based Planning and Monitoring Programme (CBPM) - Bihar

Community Based Monitoring of health services is a key strategy of National Rural Health Mission (NRHM) which places people at the centre of the process for ensuring that the health needs and rights of the community are being fulfilled. It allows them to actively and regularly monitor the progress of the NRHM interventions in their areas.

Community Based Monitoring process involves; formation and strengthening of Village Health, Nutrition and Sanitation Committees (VHSNCs) at the village level, and Planning and Monitoring Committees at the Primary Health Centres (PHC), block, district and state levels, creating community awareness on NRHM entitlements, roles and responsibilities of the service providers, training of VHSNC members to collect data and monitor health services, and use of social audits for advocacy with key stakeholders to highlight gaps and find solutions.

The first phase of community based monitoring program was implemented in 1,620 villages across 36 districts in nine states - Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu from March 2007 to July 2009. Thereafter, the program has been scaled up in the states of Tamil Nadu, Jharkhand, Maharashtra, Karnataka.

Community Based Monitoring, in the first phase of NRHM has proved to be a key mechanism for ensuring accountability of the health system to the community. Carrying this forward, the Community Based Planning and Monitoring Programme (CBPM) was conceptualized and is being implemented in the state of Bihar since May 2011 by the State Health Society. The programme was included in the state Programme Implementation Plan under the National Rural Health Mission (NRHM).

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.

The CBPM programme is being implemented in the state since May 2011. The 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

- Provide regular and systematic information about community needs
- Provide feedback according to locally developed parameters
- 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
- Increase responsiveness of the public health system.

Structure

Population Foundation of India is the state nodal NGO and technical agency implementing the CBPM program. PFI is supported by district and block level NGOs implementing the programme. The first phase of the programme is being implemented in five districts. Five panchayats in two blocks each of these districts are covered under the programme.

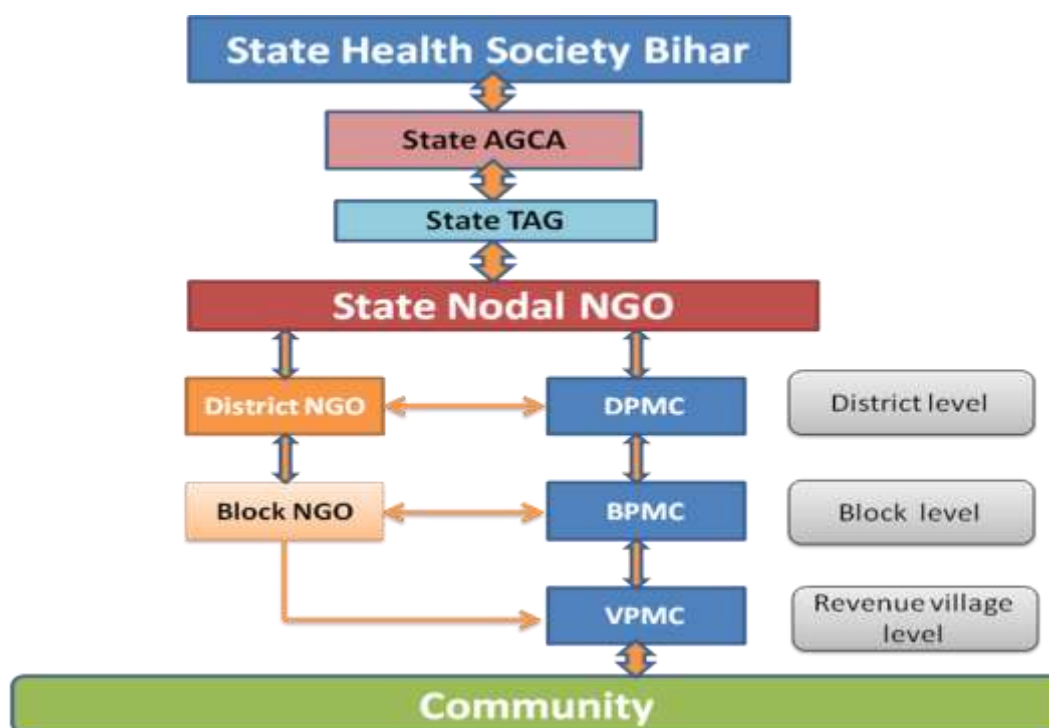
The programme is based on the strategies and processes developed and tested during the pilot phase of the Community Monitoring Programme implemented in nine states across the country in 2007-09. The bedrock of the programme is the Village Health Sanitation and Nutrition Committee (VHNSC). However, as in Bihar, the VHSNC is 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 at these levels.

The programme is supported by a community facilitator / cluster coordinator for every 15 villages and coordinators at the block and district levels. 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 (S-AGCA) and a State Technical Advisory Group (S-TAG) play a supportive role in mentoring the programme.

Implementation structure of the CBPM program



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 Workers (AWWs), and community members.

- They held community meetings in different hamlets to engage with the people on these issues.
- Participatory Rural Appraisal techniques were used at these sessions to understand village level issues.
- A village mapping exercises (Know your village) were undertaken to identify local issues, gaps and priorities.
- A larger village level meeting was also held to bring everyone together on the issue.



Picture 1 Know your village exercise through village map



Picture 2 Awareness generation through Kalajatha

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

In Bihar, the NRHM mandated that the VHSNC be 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 and chosen after achieving a consensus from everyone present. Memberships 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 the village level, VHSNC meetings were held in which the VPMC members were introduced. 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.

3. Training of VPMC members

Following the formation of the VPMCs, capacity building sessions were organised for the members at the panchayat level. Five to six members of each VPMC participated in the two sessions of two days each. A training module had been prepared by the state nodal NGO, the Population Foundation of India, and district and block level NGO staff had been trained on this.

The sessions for VPMC members covered the following topics:

- Determinants of health
- The health system in India / provision of services at various levels.
- Objectives of NRHM and service guarantees at various levels like SHC & PHC
- Health rights
- The role of the ASHA and AWW
- Objective of CBPM, its importance and institutional arrangement and processes
- Role of VPMC and its members
- The Village Health Sanitation and Nutrition Day (VHSND) and the VPMC's role in improving its services.
- Tools and formats for Community monitoring
- Village health planning process

These sessions were supplemented by a manual on community monitoring that included a discussion on the process of monitoring and the Jan Samwad in detail. The manual also contained the tools. In addition, a booklet on the community's entitlements vis a vis the health system was also shared.

4. Monitoring

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

a) Monitoring Village Health Sanitation and Nutrition Days (VHSND) services

Community level services are held under the NRHM on a fixed day called the VHSND. One of the crucial activities of the VPMC 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 which has been used to assess the services and identify the gaps in the VHSND services. Meetings are then held with the VPMC members and community members and the ANM and AWW to understand the reasons for these gaps and arrive at possible solutions. The solutions included VPMC members motivating community members to access services at the VHSND and also providing equipments like BP apparatus and a cot to examine ANC clients, hence 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.



Picture 3 ASHA mobilizing the community for VHSND



Picture 4 ANM examining the client and filling up the MCP card

Strengthening of Village Health, Sanitation and Nutrition Day

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

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

Subsequently, they discussed the issue with community members in their village. A community member now lends a cot for 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, Gram Nirman Mandal, decided to give the ANM a Blood Pressure (BP) apparatus to ensure that BP check-ups take place for pregnant women. Now the full component of antenatal care services is being provided along with routine immunization on the day.

In Rajauli block of Nawada district too, there were several misconceptions among people about immunizations. Parents did not want their children immunized. *“Hum 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 quite a bit. 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, a member of the VPMC in this village, they did not even know if the ANM visited their village.

“Hamein ANM, ASHA, anganwadi se koi matlab nahin tha,” he said.

But they now realize the importance of the services that should be provided to them. At the monthly VPMC meetings, each member brings up issues of people from the *Mohalla* (Hamlet) he or she lives in. In addition, they also motivate them to get the children and pregnant women immunized. They have also ensured that BP examination is done for pregnant women at the VHSND. After each VHSND, an evening meeting is held with ANM, ASHAs and AWWs to review the services imparted in the VHSND.

As part of the CBPM programme, Village Planning and Monitoring Committees (VPMC) have been formed at the level of revenue village. The members of these committees have undergone training on looking at health as a basic human right and on health entitlements. This has, in some villages, resulted in these members making active efforts to make their Health Sub Centres (HSC) functional.

Mananbhiga village is a part of the Kunjeshwar panchayat in Imamganj block of Gaya district. The VPMC here was formed in 2011. The VPMC members have over the last few months, succeeded in making their Sub Centre functional. The HSC of this village is about 1.5 km away in the next village Nagwa, part of a different panchayat. The HSC building was being used by the villagers there to tie their cattle and store cattle feed. As a result, the ANM had no place from where she could render her services.

According to Sanjay Prasad, an active VPMC member, the training they received as part of the project included details on the role of the ANM and her functions. When the VPMC members became aware of this, they discussed the status of their HSC in the training with the NGO facilitators and also subsequently in their VPMC meetings. They decided that the centre had to be made functional. Towards this, they first met the ASHA of the next village and discussed the issue. Then all the VPMC members, Sanjay, Sunita Kumari (ASHA), Kanti Devi and Manju Devi (SHG members) along with Arun Kumar, an active community member, visited Nagwa village and discussed the issue with the community there. Since most of the villagers there were friends and relatives, they did not face much problem in communicating with them. Once the community members in Nagwa realized that the functioning of HSC would benefit them too, they convinced the persons who were using the HSC for personal use to vacate the space. The VPMC members then used the maintenance funds of the HSC to paint and repair the building. The building had been painted with a new sign board.

The VPMC members are now trying to convince the ANM to stay in the HSC instead of at her present residence in the block headquarters in Imamganj. According to them, while the ANM is herself willing to do so, she is often deputed to other areas of the block due to shortage of ANMs and hence is worried about being able to travel from this remote village. Thus, while they felt good about their achievement, they were also upset that they had not yet reaped the benefit of their actions.

The VPMC members also reported that the community in Nagwa was surprised at their level of knowledge and motivation. They had repeatedly asked them how they were so motivated “kaise pririt hue?” When they got to know of the CBPM programme, they wanted it started in their village too!

Similar efforts have also been made in Malhari village of the same block. Here, the Sub-centre had its own building, but since it was in a rundown condition, the ANM had to provide her services from the verandah of the centre, which was difficult during the rains and winter. When the VPMC members got to know of the importance of the ANM's functions and the HSC, through the training, they decided to renovate the centre. They went to the block headquarters at Imamganj and met the Medical Officer In Charge (MOIC) with a request. As the funds available from the HSC maintenance and untied funds were sufficient only for material costs of the renovation, the

community decided to provide free labour through shramdan. The building was renovated and is being used. The VPMC has used the untied fund to buy essential equipment for the HSC like BP apparatus, thermometer, measuring tape, examination table and furniture. The ANM, Mandvi Kumari, was very appreciative of the VPMC's efforts and said she could now expand her services to provide all necessary components of antenatal care, including BP check and abdominal examination. She was also hopeful of starting delivery services there soon.



Picture 5 The Sub-Centre in Malhari village (Before)



Picture 6 The Sub-Centre in Malhari village (After the VPMC intervention)

The experiences at Mananbhiga and Malhari show that community members when provided with knowledge and awareness can make great efforts to improve the health care available to them and the CBPM must continue to provide this critical component of awareness. They also contribute time and energy to this. Systemic constraints, like the lack of human resource, however limit the extent to which their efforts can provide results. Thus changes in policy need to be advocated for, that can explore solutions for these systemic issues.

b) Community level enquiry and health facility surveys

A pre-designed tool have 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 dalit hamlets, to understand different groups' perspectives on these domains. 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.

The community level enquiries have been supplemented by facility surveys that assessed the availability and quality of services at the Health Sub centre (HSC) and Primary Health Centre (PHC). The facility survey also included interviews with Medical Officer (MO) regarding the functioning of Rogi Kalyan Samiti (RKS).

In the initial phases, both of these processes required a lot of support and handholding by the block level NGO. These sessions have also served as knowledge building sessions for the communities.

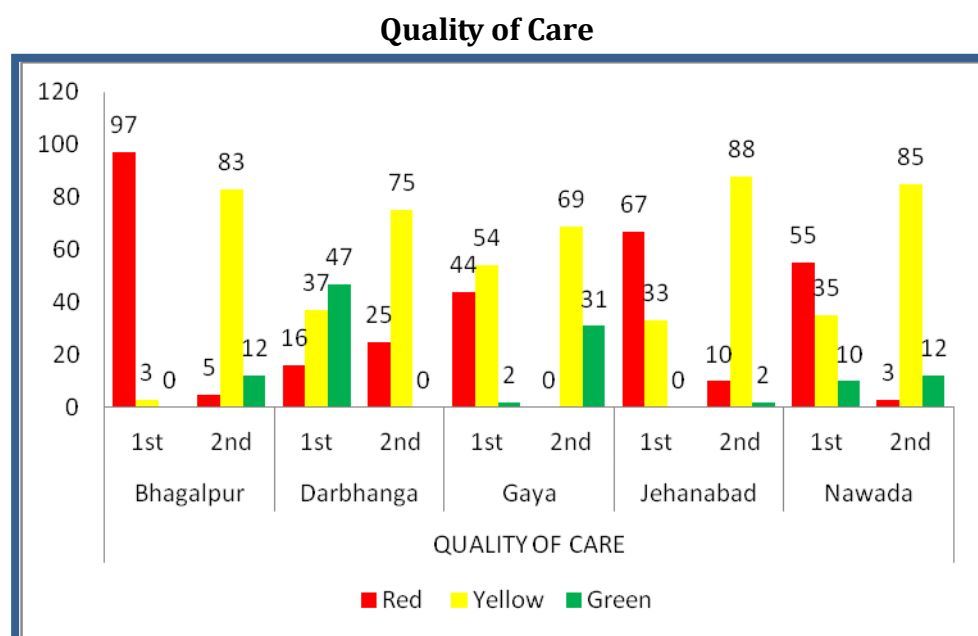


Figure 1 shows the change in quality of care in 2 rounds of Community enquiry

The change in quality of care was measure through data collected through group discussion with the community, especially with pregnant women who availed institutional delivery services. The issues discussed were to understand:

- behavior of ANMs, nurses and doctors at SHC, PHC and CHC
- client satisfaction on services
- emergency care and treatment services

- d) instances of denial of services and
- e) demand for informal payments.

The data from the first and second round on community enquiry showed that the behaviors of ANMs at SHC and nurse/ doctors at the PHC and CHC have improved as a result of the active monitoring of health services by the RKS. Regular RKS meetings are also being organized, wherein feedback is provided to the staff on the services provided. Some the positive changes also include medicines are being provided for TB, diarrhoea, cough and cold in PHC Rajauli in Nawada district, etc., significant increase in the outpatient services. The institutional delivery has increased nearly to double, compare to first round community enquiry in PHC Imamganj in Gaya district.

The OPD timings, alongwith the duty roster of doctors and nurses are displayed in the PHC and CHC In Bhagalpur district, referral services to PHC and CHC has increased from 28% to 51% over the two rounds of community enquiry. In addition, diagnosis sheets are being appropriately filled and ambulance services are being provided with proper paper work including ambulance services, except marginalized communities at Rajauli (Nawada), Fatehpur (Gaya), Bihpur (Bhagalpur) blocks, ambulance services (i.e. 102) have become very active at other places. In addition, demand for informal payments for providing services at PHC and CHC have significantly reduced. In Bhagalpur district, demands for informal payments have reduced from 73 % to 10 % over the two round of community enquiry.

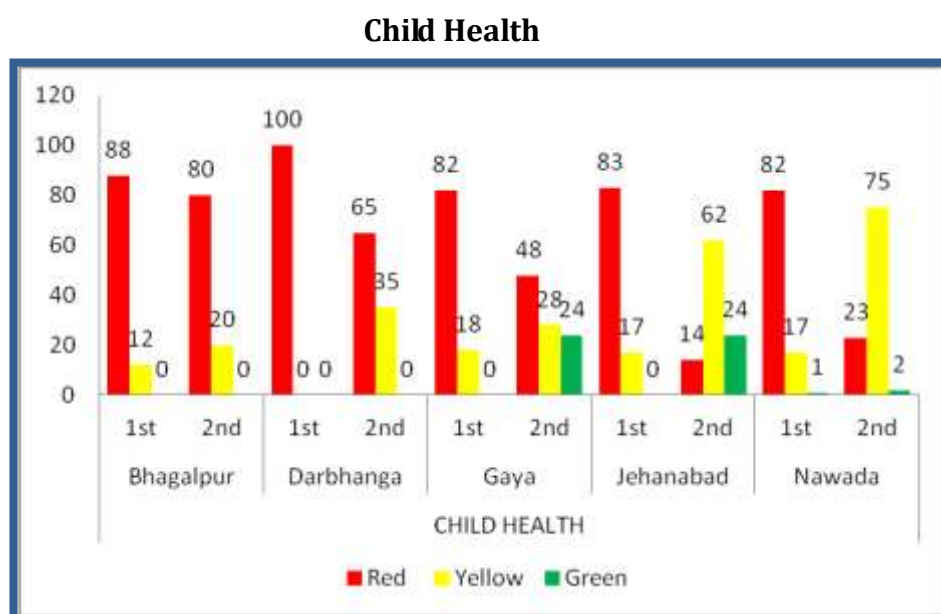


Figure 2 shows change in provision of child health services in 2 rounds of Community enquiry

Child health services provided by the ANM, ASHA and AWW included issues such as :

- a) provision of immunization services during VHSND;
- b) Growth monitoring;
- c) nutrition counseling and referrals to PHC/ FRU;
- d) curative services for children upto five years and
- e) postnatal home visits.

The data was collected through group discussion with women in general and marginalized community at each intervention village. The data from the first and second round on community enquiry shows that in most villages, ANMs are visiting immunization sites/ AWC on a monthly basis during the VHSND. This includes provision of immunization, ANC services and THR. VPMC/ VHSNC members are creating awareness about the importance of specially immunization, through group meeting and home visits among marginalized communities. They also provide support the front line health workers in organizing VHSND and reaching the left out community. The VPMC members are insisting that all children are weighed by the AWW on the designated VHSND. However, in many villages, such as at Sadar block of Jehanabad district growth monitoring of the children are not being systematically done due to non-availability of weighing machine at AWC hence the AWWs are unable to record and track growth faltering. The AWW and ANM lack skills to screen, provide appropriate nutritional counseling and facilitate timely referral of malnourished children to Nutritional Rehabilitation Centers (NRC). The availability of curative services and provision of medicines for children across all the sub-centres is weak. Post natal home visits are rarely being done by ANM.

Similar encouraging results have been reported in increased efficiency of ASHAs, increase in institutional delivery through Janani Evam Bal Suraksha Yojana (JBSY) with over 90% deliveries assisted by ASHAs, awareness of untied fund and some increase in its usage.

In addition, individual interviews were conducted to record any adverse outcomes. Individual interviews with 5 women in each intervention village were held with an aim to understand about any adverse experiences such as: a) neonatal mortality b) infant mortality c) still birth.

The data from the first and second round on community enquiry shows that due to improved participation from VPMC member on generating awareness on do's and don'ts during and after pregnancy in the implementation villages have shown results that infant/ neonatal morbidity and mortality has decreased in the field. For example; Singhwada block at Darbhanga district has shown decline in neonatal mortality from 14 to 3. In the same district infant mortality and still birth also decreased from 21 to 4 and 18 to 3 respectively. The situation has also improved at other places as well.

क्र.सं.	विवरण	2017-18	2018-19	2019-20
1	कुल छात्र संख्या	0	0	30
2	कुल छात्र संख्या (अ+ब+क)	0	17	13
3	कुल छात्र संख्या	20	1	9
4	कुल छात्र संख्या	16	14	0
5	कुल छात्र संख्या	2	28	0
6	कुल छात्र संख्या	20	9	1
7	कुल छात्र संख्या	15	13	2
8	कुल छात्र संख्या	0	19	11
9	कुल छात्र संख्या	1	13	16
10	कुल छात्र संख्या	0	0	30
11	कुल छात्र संख्या	26	5	1
12	कुल छात्र संख्या	20	10	9
13	कुल छात्र संख्या	11	16	2
14	कुल छात्र संख्या	20	8	2

Picture 7 Community enquiry report card

Demanding quality of care

A realization of their health care entitlements under the CBPM programme has resulted in people demanding better quality of care from health care facilities.

Munwa Devi is a member of the 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. Munwa says earlier she 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 sees 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 to further use the skills she has gained from the programme for the betterment of the people in her community. She attends the VPMC meetings regularly, taking an active part in decision making. She says her family members are very supportive of the role she is playing in the community.

Picture 8 Awareness through wall paintings



Naresh Paswan of Bagahi village in Kunjeshwar panchayat in the same block is a VPMC member who shares a similar experience. He had accompanied a woman from his village to the Imamganj Primary Health Centre for delivery. The doctor there referred her further to another facility. As 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 deliver in that PHC itself.

The doctor then decided not to refer her and the woman delivered normally at the PHC, 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.

Negotiating solutions with the health system

The CBPM programme 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 organized to understand issues related to health in the project villages, they found that many children in these villages were not getting timely BCG vaccination. When they discussed the issue with different ANMs, they realized that BCG vaccine was in short supply and ANMs would not open a vial of BCG unless they had at least five children needing the vaccine for the fear of wasting it. Parents were therefore asked to bring their children to the PHC for vaccination which, because of the distance and expenses involved, they were not doing.

Samagra Seva Kendra discussed the issue with 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 anecdotal improvements in the levels of BCG immunization.

Samagra Seva Kendra have continued with their efforts. They have taken the support of the district NGO Agrami India in raising the issue of the short supply of BCG vaccine at the district level. They hope the supply will improve soon.

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

Jan Samwad

As part of increasing the engagement between communities and the public health system, Jan Samwads - facilitated public dialogues between people, local governments and health care providers are held under the CBPM programme.

The process of holding a Jan Samwad is intense, and block and district level NGOs have put in a lot of effort in preparing 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 were provided with a checklist by the state nodal NGO. Following this, they identified instances of denial of health care and issues emerging from these. With the support of 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 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. An effort was made to cover a range of issues emerging from the testimonies.

A public venue was selected at the block headquarters for holding the Jan Samwad. The invitation for the Jan Samwad was extended by different persons belonging to the health system. In some blocks, this was done by the MOIC and in others by the BPMC. This increased the ownership of the process by the system. A group of eminent panellists was also invited to facilitate the dialogue. These included elected block and district level representatives, district health officials, block authorities, and in some cases, media representatives. VPMC members were given responsibility for bringing the persons with the testimonies and community members for the Jan Samwad.

At the Jan Samwad, in addition to presentation of the testimonies, generic issues like drug availability and informal payments that had come up repeatedly in the testimonies, were also presented. Different Mukhiyas had taken the responsibility and prepared ahead for this. The issues raised were discussed by the panellists and solutions emerged 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 that had come up in the testimonies were 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, and the need for grievance redressal mechanisms. Many practical solutions also came out. The panellists in various blocks recommended the strengthening of the Rogi Kalyan Samiti (RKS), use of RKS funds for locally purchasing emergency drugs, and the setting up of complaint boxes at the facilities. The Medical Officers In Charge apologized for the rude behaviour of their staff and the informal payments, and promised to make amends so that these instances did not recur. Follow up action has resulted in several changes – the RKS has been strengthened in Imamganj and Fatehpur, emergency drugs purchased in Fatehpur and Imamganj PHCs, and plans are afoot for the setting up of a complaint box in Imamganj PHC.

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 spoke 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 or entitlement). The presence of independent panellists, and the strength provided by numbers, helped them to overcome their fears to speak up about these issues. Most VPMC and PRI members felt that the 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 jhukna pada”, “Judgement bhi diya gaya”(A judgement was passed and the doctor had to agree to it)



Picture 9 Woman sharing her concerns in Jan-samwad



Picture 10 The panellist answering the questions in Jan Samwad

Everything was not rosy after the Jan Samwad either. Not all health care providers were appreciative of the process. Dr Ramamoorthy Singh, 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 function. Dr Shivkumar Singh, MOIC Fatehpur, while acknowledging that the Jan Samwad had resulted in some constructive action, was not happy that the 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 before being brought up in a public forum.

PRI representatives, in general, seemed very happy with the process. According to Fasih Ahmed Khan, Pramukh of Imamganj block, the Jan Samwad had provided an opportunity for open face-to-face communication between people and health care providers. Ravindra Kumar Singh, another PRI representative in Imamganj block, said the Jan Samwad has given the health care providers a sense of “being watched” and this has led to improvement.

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. In one block, the MOIC had refused to meet project staff or hold any meetings of the BPMC after a Jan Samwad. However, persistent efforts by the NGOs have helped establish smooth relations again.

The experience with this one round of Jan Samwads shows that the process can be a powerful tool for change, especially where several systemic issues lead to frequent denial of health care services. However, it is necessary for both the community and the NGOs facilitating the process to have realistic expectations from the Jan Samwad and see it as a constructive dialogue rather than as an exercise of apportioning blame and punishment. It may also be good practice to share with health care providers issues and testimonies that are being brought up at the Jan Samwad so that they feel better prepared for answering questions and not threatened by the process.

5. Planning

Efforts have been made to develop village-level health action plans (VHAP) to facilitate bottom up planning. A workshop for decentralized planning has been held with block-level stakeholders and efforts are being made towards these. In many districts, issues emerging from the VHAP have been used as inputs for developing the Block and district PIPs.

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 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. In addition to these, block and district level NGOs have also made efforts to activate



Picture 11 Orientation of officials

the health facility committees, the 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.

Activation of the Rogi Kalyan Samiti (RKS)

Rogi Kalyan Samitis have been formed at various levels for health facilities under the NRHM to ensure the local community's participation in their management. An untied fund is provided to these samitis on an annual basis to be used for the improvement of these facilities.

In Bihar, while these samitis existed before the launch of the CBPM programme, they were not meeting regularly and very often, the local community was also not aware of how the funds allocated were being spent. Under the CBPM 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 irregular earlier. Things changed when during the Jan Samwad, the role of the RKS was discussed and several suggestions were made for solving the issues through these samitis. 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. Decision has also been made 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. After the RKS was activated, some of these medicines were purchased from the RKS funds. This meant patients did not have to run to medical shops in times of 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 potholed road to the labour room filled up.

Dr Ramamoorthy Singh now ensures that RKS meetings are held regularly, In his capacity as RKS chairperson, he sends out written invitation letters every month for the meetings so that all members receive timely communication regarding it.

Appropriate use of the RKS is contributing to an improvement in the quality of service and also provides a forum for grievance redressal.

The CBPM programme has led to the following outcomes

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

The learnings

- A formal space like the VPMC and VHSNC can be used to promote community accountability in health.
- 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.
- Specific efforts need to be made to involve marginalized communities in such community action in order to increase their access to public services.
- Elected representatives can play an important role in supporting community participation and in balancing power hierarchies between communities and health providers.

Challenges

- Getting health providers in traditional hierarchical systems to internalize accountability to the community and be responsive to demands for these.
- 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.