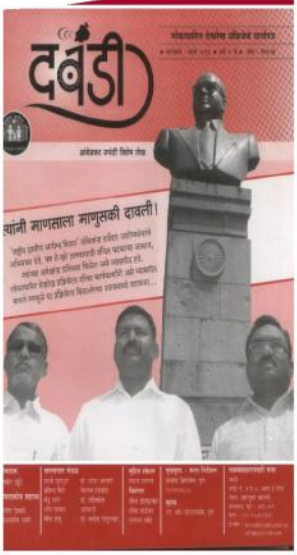
Evaluation of Community Based Monitoring and Planning of health care services under National Rural Health Mission (NRHM) [Pilot phase] in Maharashtra





NATIONAL RURAL HEALTH MISSION
NRHM
राष्ट्रीय ग्रामीण आरोग्य अभियान
महाराष्ट्र

Project report

"Evaluation of Community Based Monitoring and Planning of health care services under National Rural Health Mission (NRHM) [Pilot phase] in Maharashtra"

By

State Health Systems Resource Centre, (SHSRC), Pune

Through Consultant organisations:

Pravara Institute of Medical Sciences (PIMS) (DU), Loni

and

Gramin Samasya Mukti Trust (GSMT), Yavatmal

Report Synthesis

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PREFACE

Community Based Monitoring and Planning (CBMP) process provides systematic feedback to health functionaries on actual functioning of health services at gross root level. It is kind of social audit of Public Health Services, to facilitate active participation of people and also generates momentum for improvement in Public Health Services at local level. It is an innovative accountability process which ensures the improvements in public services. In 2007 CBMP was launched on a pilot basis in nine states of India and Maharashtra state was one of them.

In order to understand the actual process, its outcome and difficulties while implementation of this complex social process, a study "Evaluation of community based Monitoring and Planning of health care services under National Rural Health Mission (NRHM) in Five pilot phase districts of Maharashtra" had been undertaken by SHSRC, Pune through Pravara Institute of Medical Sciences (PIMS), Loni and Gramin Samasyamukti Trust (GSMT), Yawatmal. I would like to thank SHSRC, Pune and NRHM, Maharashtra for giving us this opportunity to undertake this esteemed study.

It gives me immense pleasure to say that this study has been successfully conducted by dedicated team of our institute lead by Dr. (Mrs.) P.A. Chandekar as a principal investigator along with two senior researchers Dr.Rahul Bais (GSMT) and Mr.T. Sivabalan (PIMS) and all other team members. I congratulate Dr.Mrs P.A. Chandekar and team for their persistent and dedicated efforts in accomplishing this study.

I hope the findings and recommendations of study will help in improving the health services for community.

Dr. S.D. Dalvi
Vice Chancellor
Pravara Institute of Medical Sciences, Loni

ACKNOWLEDGEMENT

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Dr. Satish Pawar (Jt Director (T), NRHM), for entrusting this activity to SHSRC, Pune. We would also like to thank Dr.U.H. Gawande, Executive Director, SHSRC for the guidance and support in completing the study. We would also like to thank Mr. Girish Bhalerao, Joint Director (Non-Technical), NRHM. We also express our gratitude to Dr. Motiram Kamble, Sr. Consultant, SHSRC, Dr. L.S. Sale, Dy Executive Director, SHSRC and Dr.Deepak Paropkari, Assistant Director (T), NRHM for their important suggestions and comments during the project.

We also express our gratitude to Hon.Mr.Rajendra Vikhepatil, CEO, Trustee and Secretary and Dr. S.D. Dalvi, Vice Chancellor, PIMS, (DU), Loni for providing constant support and guidance in conducting the study. We express our sincere thanks to Prof. K.V. Somasundaram, Director, CSM, PIMS (DU) for his guidance and timely advice.

Our heartfelt appreciation to all state, district and Taluka level govt officials as well as health care providers and committee members at the different level for extending full cooperation and support during the data collection activity. We also express profound thanks to Dr. Abhay Shukla and Dr. Nitin Jadhav from SATHI (State Nodal Agency) for their support, critical comments and suggestions which helped in sharpening the focus of the study. We thank all Civil Society Organization partners in the five study districts for their cooperation and support.

We thank our collaborator in the study Mr.Kishor Moghe, Director, GSMT, Yawatmal and his team for their efforts and support while conducting the study. We would also like to thank all the team members specially Mr. T. Shivabalan for his constant and untiring efforts in accomplishing this study. Our warm gratitude to Dr. Netrali Dalvi, Sr.Consultant, SHSRC for her inputs.

We will be failing in our duty, if we do not recall and express our heartfelt gratitude to the study participants (various committee members, ASHAs, ANMs, PRI members, community), without their cooperation, participation and involvement study would have not been possible. We express warm appreciation to all those who have helped directly and indirectly to make this study possible.

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List of Abbreviations

SN	Abbreviations	Expansion
1	NRHM	National Rural Health Mission
2	NHRC	National Human Rights Commission
3	AGCA	Advisory Group for Community Action
4	VHNSC	Village Health Nutrition and Sanitation Committee
5	RKS	Rogi Kalyan Samiti
6	PIP	Programme Implementation Plan
7	NGO	Non Governmental Organisation
8	SSI	Semi structured interview
9	IDI	In-depth interview
10	FGD	Focus Group Discussion
11	ANM	Auxiliary Nurse Midwives
12	MPW	Multi Purpose Health Workers
13	ASHA	Accredited Social Health Activist
14	PHCMPC	Primary Health Centre Monitoring and Planning Committee
15	BHMPC	Block Health Monitoring and Planning Committee
16	DHMPC	District Health Monitoring and Planning Committee
17	JSY	Janani Suraksha Yojna

Chapter1 - Executive Summary

Introduction:

Community Based Monitoring and Planning (CBMP) of health services was initiated in 2007 on pilot basis, in 9 states of India, and Maharashtra state was one of them. Total 35 districts from 9 states (Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu) were identified for the pilot phase. Maharashtra state was the first in the country Dto include CBMP component of NRHM in the State Programme Implementation Plan (PIP). The CBMP process in Maharashtra was initiated in 5 districts (Amravati, Nandurbar, Pune Thane, and Osmanabad) in June 2007. Later in 2010 it was expanded to 8 more districts and at present the Community based Monitoring and planning process is being implemented in 13 districts, 35 blocks and 116 PHCs covering 615 villages of Maharashtra. Over 25 civil society organizations (CSOs) are involved collaboratively in facilitating CBMP in these 13 districts.

In order to understand the actual process of CBMP, its outcome and thereby barriers in implementation of this whole complex process, the State Health Systems Resource Centre (SHSRC), Pune has undertaken the evaluation of CBMP process implemented under NRHM in Maharashtra. The evaluation study has been conducted by consultant organisations empanelled by SHSRC, Pune namely Gramin Samasya Mukti Trust (GSMT), Yavatmal in collaboration with Pravara Institute of Medical Sciences (PIMS), Loni (Bk), Ahmednagar.

Title of the project

Evaluation of Community Based Monitoring and Planning of health care services under National Rural Health Mission (NRHM) [Pilot phase] in Maharashtra

Objectives

1. To examine the execution of the objectives of 'Community Based Monitoring and Planning' of health services under NRHM.
2. To assess the effectiveness of the decided process of implementation of 'Community Based Monitoring and Planning' of health services under NRHM.
3. To assess the impact of 'Community Based Monitoring and Planning' of health services under NRHM.
4. To assess the sustainability of 'Community Based Monitoring and Planning' of health services under NRHM.

Findings:

CBMP is a method, which is used to get beneficiary feedback about a particular service; it's a kind of social audit of public health services which serves to facilitate active participation of people. Evaluation study findings revealed that the process of CBMP in Maharashtra is well established and showing positive results at various levels (village, PHC, block, districts). in all 5 pilot phase districts where the CBMP was implemented The interviews and FGDs with various stakeholders comprising government officials of various levels, civil society organisation representatives and community have emphasised that the CBMP is beneficial and effective process.

1) Execution of CBMP objectives:

A) Needs assessment:

- Regular needs assessment is done and systems are established for the regular and systematic data collection for the community needs. Committees at each level are regularly assessing the community needs. Innovative strategies are also being used for needs assessment.
- There is variation in frequency of data collection across blocks and districts. In order to have more structured systems, bare minimum uniformity in data collection across districts is essential and therefore based on the experience; NGOs can suggest modifications in data collection formats/ methodology.

B) Feedback according to locally developed yardsticks:

- National Level tools were used as template and NGOs have modified these according to local needs and relevance. Various tools were developed during the process.
- Health report cards are being routinely filled up. During initial period of CBMP implementation these were regularly displayed at the health centre or village for community review. However later it was observed that those indicators which were repeatedly poor with no or minimal improvement in spite of giving regular feedback, created sense of dejection and hopelessness among the community. This resulted in lowering the significance or complete neglect of such activities.

C) Feedback on functioning of various levels of health systems and services:

- Range of issues is being reported about the functioning of health services by the committee members at all levels.
- Regular visits of committee members to the health facility has ensured optimum level of services and also created the positive pressure on the HCPs. During such visits issues of HCPs are also getting reported and further getting discussed and resolved during committee meetings.
- Issues of entitlements such as JSY benefits etc. are getting effectively resolved at the committee levels.

D) To enable community and CBOs to become equal partners in the planning process:

- NGOs role in the CBMP process is to create awareness, capacity building, local advocates and data collection and analysis. Various efforts and innovative strategies have been implemented to sensitise the community about the process and health rights. At the initial period media also gave wide coverage to the CBMP process. But sometimes it was felt that media has sensationalised the news and as a result it became too negative which at times became detrimental for the synergistic process of CBMP.
- Overall awareness about the process among PRI members as well as in community is increasing resulting in positive involvement in the CBMP process. Active involvement of community and NGOs is increasing resulting in heightened awareness and sense of ownership among community about the public health system. This has helped in inculcating the feeling of equal partnership among community. Gov. Officials also perceive that there is equal partnership among

gov. and community in CBMP process. However NGOs do not strongly feel that yet there is equal partnership in the process.

- Government officials felt that NGOs /community should provide alternative or suggestions for better planning and NGOs says that they do give suggestions but these are often ignored or not taken seriously. There is still some amount of disagreement which is hampering the equal partnership process.
- Though in overall process there is increasing trend of equal partnership, however planning process part is still weak. In existing planning process there is no space for community representation. State officials should ensure appropriate platforms for involving community in planning process.
- Attitudinal change is necessary among all stakeholders in order to have more synergistic process.

2) Effectiveness of decided processes:

- Various committees at each level are formulated and working fairly well. However considering VHNSC as the first level of interaction with community, there is need for capacity building and strengthening for its efficient functioning.
- Range of issues are getting reported and resolved at each level. However Some issues need policy level interventions. When such issues are not properly addressed it de-motivates the community and negatively affects the process. Repeated negligence may prove detrimental for the process. Appropriate state level structural redressal should be devised and some feedback should be mandated in a time-bound manner.
- Many policy level issues such as deployment of HR, Medicines etc. gets inculcated and resolved at the state monitoring committee level. There has been substantial delay in formation of this committee. State level review of the committee is also lacking and therefore processes at state level need strengthening.
- Jansunwai has provided very effective platform for putting up people's issues related to health system in front of government authorities. Many issues get resolved immediately, thus improving the overall accountability of the health care system. It also helps in reducing political influences in decision-making and personal favouritism and thus makes health delivery systems more transparent.
- As a result, involvement of people in their own health systems is increasing which translates in to good awareness about their health rights. It has also resulted in increasing the sense of accountability among HCPs.

3) Impact of CBMP:

- This study can conclusively state that CBMP has resulted in various changes in health care services such as infrastructure, availability of HR, attitudinal changes in HCPs, reduction in malpractices etc. and has improved the range of services being provided.
- Although these changes varied from place to place, the processes involved in CBMP implementation were complex and required local tailoring. At each place interactions between committee members and health functionaries, attitude of

stakeholders, influences by the other PRI etc. were found to be very crucial in identifying the outcome of the decided processes.

- However it is important to note that despite all the complexities related to power dynamics during stakeholder interaction, CBMP has been successful in giving a platform and creating a structure where such interactions were possible.

4) Sustainability:

- Although it is imperative that the Role of NGOS should eventually be minimised and they should be involved peripherally, all stakeholders in this study agree unanimously that if NGOs pull out now, then CBMP may not proceed effectively. NGOs still play a crucial role in sustainability, awareness generation, capacity building, and act as catalyst and it may take time for community to actively take over from them. Active involvement of PRIs would be crucial.
- In this study, government officials have stressed the need of exit policy for NGOs. However there has been no discussion about alternative systems within the government to facilitate the process as the NGOs currently do.
- NGOs in the study have stated that their roles can be modified and gradually moved to passive roles as long as integrated systems are developed within the government to ensure proper monitoring of the CBMP process.

Challenges:

1) There are issues in record maintenance and finances from both government and NGO side. In order to resolve this issue, reporting formats should be simple enough and there has to be clear guidelines given to the NGOs about submitting the required documents and expenditure reports. NGOs should also abide to the guidelines and time line given by the state officials.
2) Training and capacity building of service providers as well as the committee members is the area which needs to get strengthened. There is a need for joint sensitization training workshop for NGOs and health service providers. It is felt by Gov. Officials that during the revision of the monitoring tools Gov. Officials should also get involved and their training is also essential.
3) Attitudinal and communication related issues are put up by both government officials as well as from NGOs. It was felt by Gov. Officials that during Jansunvai or any other meetings community/committee member's/NGOs attitude is too aggressive which at time become offensive for the Gov. Officials to cope with it. Way of presentation of the issues and discussion should be assertive but not aggressive and rigid.
4) However NGOs are having another viewpoint that no adequate/needed response is being provided by the service providers. The people have not developed the concept of ownership; people feel that if we raise issue we may not get adequate/needed treatment from service providers. Also many times the govt officials were not present for the meetings.
5) Therefore NGOs should work on the issue of communication during the meetings and Jansunvai. And Gov. should also sensitize the officials at the different level who would be involved in the CBMP process. This would lead to more productive process by giving appropriate importance to the process.

6) Planning component in the CBMP needs to be strengthened. Though currently there are few efforts which have been taken in this regard, in order to have need-based planning and ultimately reflecting it in PIP, comprehensive systemic arrangements are essential.

Recommendations:

1. Structured tools to ensure uniformity across blocks and districts should be developed and data should be systematically collected and reported.
2. Communication among community/NGOs and government officials should be improved.
3. Attitudinal changes among all stakeholders are essential in order to have more synergistic process. Recurrent orientation trainings at all level can be useful for this.
4. IEC/Reading/Training material for government officials is also essential in order to have reorientation to them regarding CBMP process
5. State level process should be strengthened. Frequent reviews at state level are essential in order to maintain the pace and effectivity of this process.
6. Planning process should be given serious thought in next phase. NGOS should give appropriate framework and Government should also provide proper platforms where CBMP/community can be represented in planning process.
7. Proper inbuilt mechanisms for CBMP should be developed by the government so that role of NGOs can be minimized and seamless transition can be possible.

Chapter2 - Introduction

The Government of India has launched the National Rural Health Mission (NRHM) on 12th of April 2005 with the objective to carry out "necessary architectural correction in the basic health care delivery system to improve the availability and access to quality health care by people, especially for those residing in the rural areas, the poor, women and children". It emphasizes on improvement in the health status of the rural community, mainly by strengthening the public health system focusing on Primary Health Care. The accountability framework proposed in the NRHM is a three pronged process that includes internal monitoring, periodic surveys and studies and Community Based Monitoring (CBM).

Community Based Monitoring and Planning (CBMP) of health services was initiated in 2007 on pilot basis, in 9 states of India, Maharashtra state was one of them. Total 35 districts from 9 states (Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu) were identified for the pilot phase. The CBMP process in Maharashtra was initiated in 5 districts (Amravati, Nandurbar, Pune Thane, and Osmanabad) in June 2007.

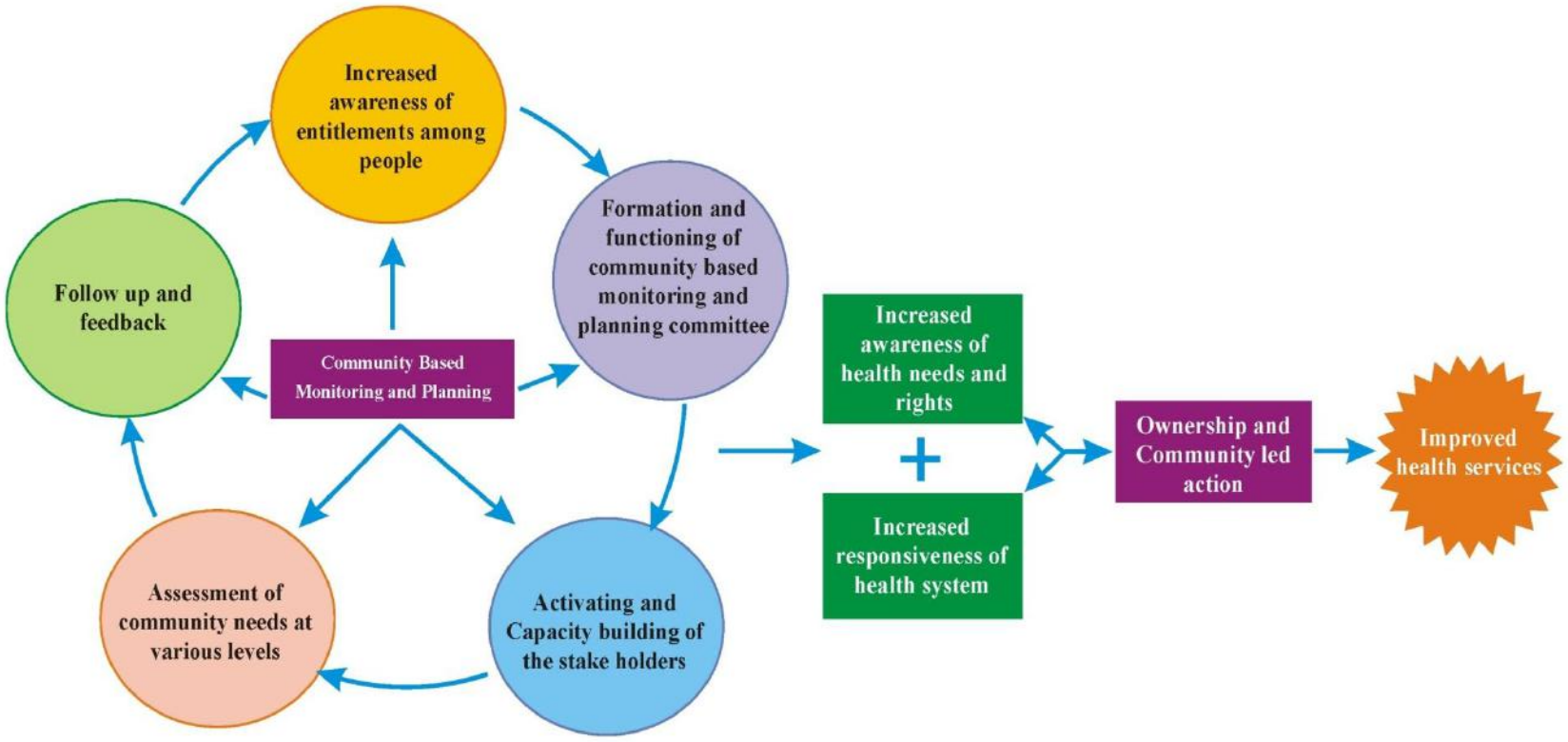
The evolution of CBMP process

People's Health rights are the focal point of Community Based Monitoring concept. The role of Jan Swasthya Abhiyan (JSA) was crucial in raising the issue of right to health care at state and national level and thus advocating for improvement and strengthening of public health system[1]. In 2004 JSA and National Human Rights Commission (NHRC) organized public hearing (Janasunvai) with an aim to establish the right to health care. The NHRC endorsed the concept of Community Based Monitoring as a methodology to ensure social accountability of health services as well a measure to ensure people's right to health care and the NHRC also forwarded its recommendations to the health ministry.

The National Advisory Group for Community Action (AGCA) was formed as part of NRHM and it explored ways to ensure community participation. The AGCA formulated the CBMP framework with approval from NRHM and also prepared the CBMP implementers manual[2].

Objectives of Community Based Monitoring and Planning process are,

- To provide regular and systematic information about community needs, which will be used to guide the planning process appropriately.
- To provide feedback according to the locally developed yardsticks, as well as on some key indicators.
- To provide feedback on the status of fulfilment of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.
- To enable the community and community-based organizations to become equal partners in the health planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system.



Conceptual Framework : Out come of the Process of CBMP

Development of CBMP in Maharashtra

Maharashtra state was the first in the country to include CBM component of NRHM in the State Programme Implementation Plan (PIP). The provision for Monitoring and Planning Committees has been made at Villages, PHC, Block, District and State level. The comprehensive frame work of CBMP places the people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.

As mentioned earlier as well, the CBMP process in Maharashtra was initiated in 5 districts (Amravati, Nandurbar, Pune Thane, and Osmanabad) in June 2007 and in 2009 – 10 the expansion of CBM into new 8 districts was done (Aurangabad, Solapur, Kolhapur, Raigad, Nashik, Beed, Chandrapur and Gadchiroli) (ref: CBMP, G.R. NRH 1007/letter no. 172/health 7 A dated 15th September 2008). At present the Community based Monitoring and planning process is being implemented in 13 districts, 35 blocks and 116 PHCs covering 615 villages of Maharashtra. Over 25 civil society organizations (CSOs) are involved collaboratively in facilitating CBMP in these 13 districts.

In Maharashtra the CBMP has made progressive growth and development. In June to August 2007 CBMP commenced with a state workshop with participation of stakeholders.

Following table shows the year wise expansion of CBMP in Maharashtra

Table 1: Year wise expansion and major activities during the period of CBMP in Maharashtra

SN	Period	Major activities
1	August 2007 to June 2008	290 CBMP committees formed with training in 225 villages, which are covered by 45 PHC in 15 blocks from 5 districts
2	July 2007 to September 2008	Compilation of Phase I report cards were carried out in 220 villages, 40 PHC's and 12 RH
3	July 2007 to October 2008	50 public hearings of phase I from 45 PHC's were carried out
4	November 2008	State culmination workshop for review of Phase I of CBMP
5	March to April 2009	272 report cards were filled up by village and block level committee in phase II
6	April to May 2009	extension of CBMP process to 500 villages under 78 PHC's in 23 Blocks from 5 districts
7	June to September 2009	Process of CBMP implementation from village to block level in extended area.
8	October to December 2009	275 report cards of health services were filled up by village and block level committee
9	January to March 2010	50 public hearings were organized in 5 district of CBMP
10	April 2010	Second state level culmination workshop arranged for review of Phase II in CBMP and extended CBMP for 8 new districts
11	May 2010	Organized state level workshop to commence planning

		process together with monitoring
12	May to October 2010	visit were carried out by committee members in 500 villages, PHC's and RH
13	November to December 2010	Report cards were filled up in Phase 4 for 500 villages, 500 Anganwadi, 217 Sub centres, 78 PHC's and 23 RH by CBMP committee.
14	January to March 2011	45 public hearings were organized at PHC and block level
15	April 2011	CBMP process extended to 680 villages which are covered by 139 PHC's in 37 blocks from 13 districts

CBMP of health services was aimed to promote decentralized inputs for better planning of health activities, based on the locally relevant priorities and issues identified by various community representatives.

In order to understand the actual process of CBMP, its outcome and thereby barriers while implementation of this whole complex process, the State Health Systems Resource Centre (SHSRC), Pune had undertaken the evaluation of CBMP process implemented under NRHM in Maharashtra. The evaluation study was conducted by consultant organisations empanelled on SHSRC, Pune namely Pravara Institute of Medical Sciences (PIMS), Loni (Bk), Ahmednagar in collaboration with Gramin Samasya Mukti Trust (GSMT), Yavatmal.

Chapter 3 - Title and Objectives

Title of the project

Evaluation of Community Based Monitoring and Planning of health care services under National Rural Health Mission (NRHM) [Pilot phase] in Maharashtra

Objectives

1. To examine the execution of the objectives of 'Community Based Monitoring and Planning' of health services under NRHM.
2. To assess the effectiveness of the decided processes of implementation of 'Community Based Monitoring and Planning' of health services under NRHM.
3. To assess the impact of 'Community Based Monitoring and Planning' of health services under NRHM.
4. To assess the sustainability of 'Community Based Monitoring and Planning' of health services under NRHM.

Considering the above said objectives a detailed study framework was developed where objective specific evaluation component, proposed evaluation indicators, means of verification and tools/methodology used for the same were decided. *(Annexure I)*

Chapter 4 - Methodology

Study method

A mixed method approach was used to evaluate the CBMP in five districts (of pilot Phase) of Maharashtra.

Study setting

The project was carried out in CBMP implemented five pilot districts in Maharashtra, i.e., Amaravati, Nandurbar, Osmanabad, Pune and Thane. In these districts CBMP process was initiated from 2007-08 and till 2012 the processes under CBMP were assumed to be more well established than the districts in which the CBMP was recently implemented.

A non CBMP district for comparison was not considered a feasible option for the study because of the complexity of the CBMP implementation where number of social, cultural, geographical and ideological factors play role. Therefore for this evaluation only districts in pilot phase were considered.

Even among the five pilot phase districts there is a lot of variation with respect to socio-economic as well as background characteristics. Some districts are predominantly tribal, some are rural, some have predominant issue of periodical outmigration and remote locations etc. The implementing nodal agencies (NGOs) also had different ideological origin and therefore different working pattern. But all had background of working with issues related to human rights, health rights and health related issues. The List of NGO's involved in the CBMP project are given in Table 2.

Table 2: List of State, District and Block level nodal agencies implementing CBMP in five pilot districts of Maharashtra

SN	Level	Name of the place	Name of the Nodal agency
1	State	Maharashtra	SATHI, Pune
2	Districts	Amaravati	KHOJ Melghat
		Osmanabad	Lokpratishthan*
		Nandurbar	Janarth Adivasi Vikas Sanstha
		Thane	Vanniketan
		Pune	MASUM
3	Blocks	Dharni	Apeksha Homio Society
		Chikhaldara	KHOJ
		Akkalkuwa	Loksangharsh Morcha
		Shahada	Janartha Adivasi Vikas Sanstha
		Osmanabad	Lokpratishthan
		Tuljapur	Halo Medical Foundation
		Purandar	MASUM
		Velhe**	Rachana
		Dahanu	Kashtkari Sanghatana
		Murbad	Van Niketan

* Note: The state nodal agency (SATHI) found that the work of Lokpratishthan was not satisfactory, and due to the financial (fund management) problem and administrative difficulties the NGO was withdrew from the system, and not functional for more than a year. In the initial phase, TISS has taken up the responsibility as district coordinator, but later they were unable to take the responsibility as block nodal agency. After one year due to the lack of feasibility, the TISS withdrew from CBM as they did not have field work experience.

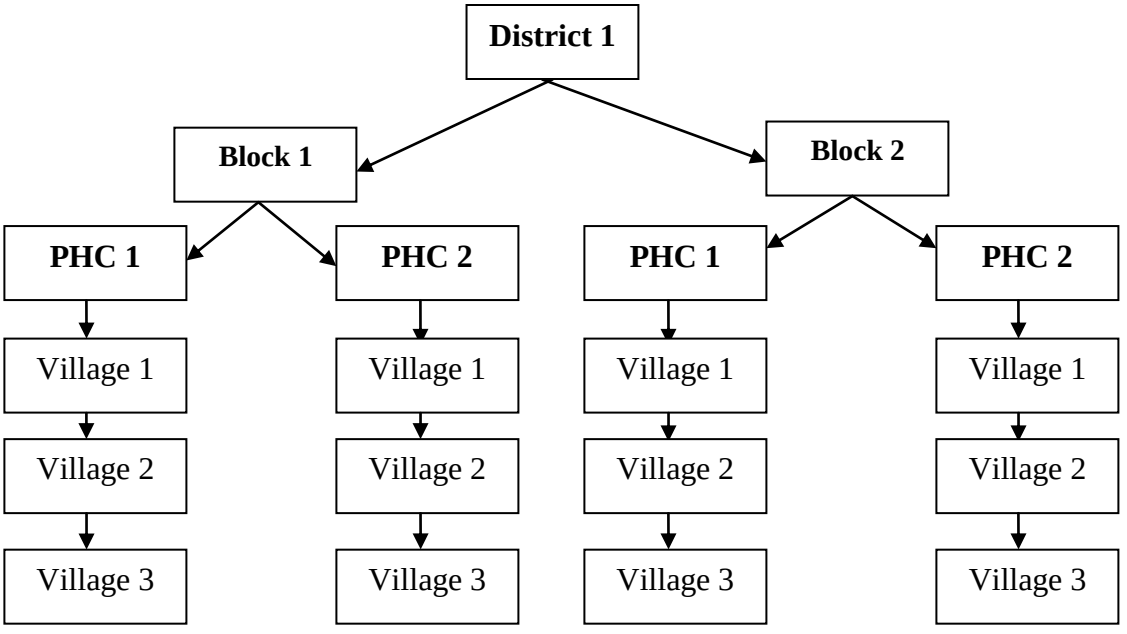
** Note: According to SATHI, during the data collection period it was noticed that, as the Khed block was an industrial area with good road connectivity, the people preferred to use the private health sector than public health system, and felt the selection was not correct. Thus Khed block was dropped out. Hence in the present study instead of Khed block Velhe Block was included.

Population and Sample

As mentioned above, the evaluation activity was carried out in five pilot phase districts which are Pune, Thane, Nandurbar, Osmanabad and Amravati. In each district CBMP is being implemented in 3 blocks and in each block 3 PHCs and in each PHC 5 villages were covered for CBM implementation. Therefore the population of the study consist of 5 pilot phase districts, 15 blocks, 45 PHCs and 227 villages which were covered under CBMP.

Therefore from this sampling frame, for the present evaluation study from each district 2 blocks, from each block 2 PHCs and from each PHC 3 villages were selected *(Annexure II)*. This pattern of selection was adopted across all districts (Figure 1), thus in 5 districts – total 10 blocks, 20 PHCs and 60 villages were chosen for the study by adopting simple random sampling technique.

Figure 1: Schematic representation of selection of samples



Method of data collection

Mixed methods approach (both qualitative and quantitative) was used for data collection to get the comprehensive information from all data sources. Various data collection tools/techniques were used and they are as follows;

1. Semi structured interview (SSI)
2. In-depth interview (IDI)
3. Focus Group Discussion (FGD)
4. Observation and record verification

The study tools were prepared in English and then translated in to Marathi by language expert. As the study was at gross root level, the language of data collection was mostly Marathi except at few places such as some villages of Amaravati and Nandurbar district (where Hindi or local language was used with the help of local translator).

Training of data collectors/field investigators

The key aspect of this project was the training for the field supervisors for supervisory function and investigators for data collection. The training session was carried out on 14 th and 15 th December 2012 by the lead trainers for two days with the objectives to orient them on CBMP and capacity building for interview and focus group discussion at Pravara Institute of Medical Sciences, College of Nursing. First session of the training involved detailed orientation to field investigators on CBMP followed by session on qualitative data collection techniques by senior researcher from KEM Hospital Research Centre, Pune. During the training the project coordinator from SHSRC, Pune was also present. The study tool was discussed in detail. CBMP programme coordinator from NRHM, Mumbai also interacted with the team on some of the field issues while implementing the CBMP. At the end of training the project team members discussed the tentative plan of action for data collection.

Evaluation team

Before commencement of the project the project team was constituted and each individual was assigned a job to execute *(Annexure III*)

Pilot testing

The pilot study was carried out to determine the technical flaws and the practical difficulties of proposed project study design as well as in data collection tools and then to take appropriate corrective measures. The Amravati district was chosen randomly as pilot study area. From the chosen district - Achalpur block was selected, from the block Yesurna and Dhaman PHCs were selected, and Yesurna – Yevtha, Rasegaon and Yesurga; Dhaman – Kalvit, Kumbi and Dhamangaon villages were included in the study. Thus in 1 district – 1 block, 2 PHCs and 6 villages were covered for the pilot phase and the duration was one week.

Legal/ethical considerations

The institutional ethics committee approval was sought from the Institutional ethics committee of PIMS (DU). Vverbal informed consent was taken from officials/beneficiaries/ participants before inclusion in the study. Prior to commencement of project the written communication through SHSRC, Pune has been done to inform the respective institutions from Districts, Blocks, PHC's, Villages, Nodal and implementing NGOs about the study.

Period and Duration of the project

The GSMT, Yavatmal and PIMS (DU), Loni has carried out the evaluation study. The duration of the study was 15 weeks (from 12.12.2012 to 31.03.2013), which includes the part of

preparatory phase, pilot study, data collection, analysis and submission of the first draft of the report.

Data collection

The data collection was carried out by project team and the field investigators as per the planned schedule. As mentioned in the sampling section total 10 blocks, 20 PHCs and 60 villages were covered across 5 districts during data collection. The pilot study areas were not included in the main study.

During the data collection in depth interviews, focus group discussions and semi structured interviews were conducted with various stakeholders. The detail list of stakeholders with method used and sample covered is given in Table 3. Field observations as well as secondary data from records available at the centres were also collected. The data collected were both qualitative and quantitative in nature. The data collection process was executed by the project team as per plan of action and was supervised by the field supervisors.

Data analysis

The quantitative data was entered in to excel and exported in SPSS software. Descriptive statistical analysis was performed on the quantitative data. Tape records of in-depth interviews and focus group discussion were transcribed in to English and compiled with the actual field notes. These transcripts were coded and were analysed thematically. The detailed findings of the project were presented in the forth coming sections.

Table 3: List of interviews conducted for the project

SN	List of Interviewee	Tools used	Number
1	State Level Government Officials and Office Bearers	IDI	02
2	State Level Nodal Agency for CBM	IDI	02
3	District Level Government Officials and Office Bearers	IDI	16
4	District Level Nodal NGO for CBM	IDI	05
5	Taluka level Government Officials and Office Bearers	SSI	20
6	Block Level implementing NGO for CBM	SSI	10
7	PHC Level Health Service Providers and Office Bearers	SSI	55
8	Village Level Health Service Providers, Office Bearers	SSI	354
9	Beneficiaries of Village	SSI	120
10	Beneficiaries, VHSC and Gram Sabha Members	FGD	10
11	Beneficiaries of Primary Health Centre	SSI	80
12	Beneficiaries of Rural/Sub-District Hospital	SSI	40

Chapter 5 - Study Findings

The study results are organised and presented in line with study objectives. In order to execute the study objectives, various components of the CBMP were identified and then in line with those components, indicators for evaluation were identified.

1) Execution of the objectives of CBMP

a) To provide regular and systematic information about community needs:

Regular and systematic data collection of community needs is imperative and important step in the CBM process, as based on this information further planning can be done and demands can be generated. Various systems have been established to ensure the regular and systematic information collection on the community needs. Village health and Sanitation Committee (VHSC) is the village level committee which is expected to do need assessment at village level. At the initial period quarterly data collection would be done and village report card would be prepared. This was important and systematic way for village level community needs assessment. The report cards along with issues observed in the report card are communicated to the higher monitoring committees such as PHCMPC/BMPC. At PHC, RH and District level further committees such as PHCMPC, BMPC, DMPC and SMPC have been established. Issues unresolved at the each level are further reported to the higher level committee.Additionally needs assessment was also done at PHC, Block and District level Monitoring and Planning Committee level. In all the five study districts the committees at each above mentioned level are formulated and functioning.

Apart from this systematic and regular reporting, different approaches and innovative strategies have been used in different blocks for community needs assessment. At some places through village meet, discussion and informal interviews with villagers by the VHNSC member's community needs assessment was done. Other activities such as observation of health day, organisation of relevant exhibitions, talks, movie-shows etc. are also performed. Since community members are present for such events in large numbers this opportunity is sought to collect the data for needs assessment. One of the NGO representatives also mentioned that such activities generate lot of positive discussion among the community members and thus becomes much more productive rather than just collecting data on community needs. At some places suggestion/complaint boxes are also placed at the health facility.

Detailed report card with information regarding vital indicators, health care services provided and viewpoints of beneficiaries on quality of health care delivery, is being filled up. Additionally specific information is also being collected on particular indicators from time to time such as data collection on availability of specific drug stock through SMS.

As mentioned above during the initial period data collection and filling up the monitoring tools was regular activity. However after having few rounds of data collection, it was realized that the similar data is being getting generated and not adding any new information to the previous findings. Also the underlying objective of these monitoring tools was very well understood by the committee members and thus issues that need to get monitored through these tools are automatically getting assessed during their routine activities. Thus NGOs have

deliberately decided to reduce the frequency of filling up the monitoring tools at least for the older pilot districts.

However in order to maintain the uniformity in the data collection and thus in reporting, there has to be bare minimum data collection systems and structures/framework provided for the committees.

b) Provided feedback according to locally developed yardsticks:

All the monitoring tools were adapted from National level tools. During initial phase, the basic structure of tools were discussed and finalized at national level in 2007. In Maharashtra, formats which were finalized at national level were adapted and further modified. During these workshops, representatives from all the concerned organisations participated and this enabled them to have their viewpoints and inputs on the tools. Accordingly tools were modified so as to make them appropriate for the field situations. Based on local needs, and importance of key issues, tools were revised in consultation with all implementing organizations in successive years. Tools were both qualitative and quantitative in nature. Different types of tools were developed which were based on level at which Health services are being provided such as village, Anganwadi, Sub-centre, Primary Health Centre, Rural Hospital and Sub-district/district Hospital.

The list of tools prepared under CBMP:

a. Questionnaire at various levels: village, PHC, RH, Anganwadi (booklet)

b. Village health calendar

c. Village and PHC level report card

The village health calendars were filled only in some of the selected blocks as it was an optional activity. As mentioned earlier during initial years till 2010, monitoring tools were regularly filled in and communicated to respective NGOs. Apart from managerial issues, committee members also reported concerns regarding issues not getting solved in spite of reporting it repetitively. Even reporting of some issues to higher committee doesn't result in to resolving the issue at that level. So it was frustrating to see same issues coming again and again without having any resolution.

Block coordinator of Murbad mentioned that, in report cards red colour indicated poor health outcomes. As in some cases for some indicators, in spite of reporting such poor health indicators for consecutive years there was no corrective action and hence no improvement in these indicators. Therefore it was frustrating to see such report cards and they have gradually stopped preparing the report cards and displaying it. Even the villagers who were said to be part in the monitoring process didn’t remember or said that it was hard to remember the monitoring tools.

Charter of citizen’s health rights was displayed prominently in all the public health facility. But we hardly noticed the PHC level and Block level health plan; though it is mentioned in the CBM implementer’s manual to have such plan. The State nodal NGO reported that development of such separate plans was not taken up in Maharashtra, due to the existing limited scope for civil society inputs in the existing PIP development process. However specific suggestions related to local planning have been provided through the CBMP process, particularly for RKS and block level PIPs in several blocks.

c) Provided feedback on functioning of various levels of public health system and service provided, fulfillment of entitlements and availability of essential drugs, equipment and infrastructure:

Based on the report card, interviews with beneficiaries, exit interviews and observations at the health centre, committee members at each level of health facility identify the issues regarding the functioning of health system. These identified issues further get discussed with the head of institution of public health system with expectation to have corrective steps on the concerned issue. Additionally there is regular interaction of the committee members with the service providers at all health systems levels. Annual/Six monthly organisation of Jansunvai also ensures that the issues get reported publically and get discussed in larger platform where all the possible stakeholders would be present. Unresolved issues at each level would further get reported to the higher level monitoring committee.

Usually the committee members have a quarterly visit at the respective health centers to verify the medicines stock as per the register records, whether the stock of essential drugs have been displayed on board or notand also availability of other assured services. Additionally during this visit they also informally talk with the beneficiary about the services they received and their satisfaction. FGDs with the beneficiary and community members revealed that due to regular visit of committee members, positive changes have occurred in the services at health facility such as availability and attitudinal changes in HR, availability of medicines, improvement in infrastructure etc. The Jan Sunvai has a greater role in bringing these issues in front of the community and is thus responsible for these changes. In Jansunvai the concerns and issues of local people get heard and are taken in to consideration.

Block co-coordinator from Shahada has cited one example,

"A mother reported to one of the CBMP committee members that the ANM is asking bribe to give the JSY benefits. After verifying facts of this situation, the issue was raised in the Jansunwai. Medical Officer very promptly took action and assured to clear all issues related to JSY. Because of this even in non CBM PHCs and villages this matter was solved."

Similarly exit interviews and informal discussion with beneficiaries are also carried out during these visits to get their feedback about the attitude of the health care providers and experience of any malpractice. Committee members mentioned that they ask patients admitted in the health care facility about the food quality, whether any medicines have been prescribed to them or HCPs asked for bribe etc. This creates the effective positive pressure over the HCPs.

Such type of monitoring identifies various issues which further get reported if not resolved at that level. Following are few examples:

"Population under this PHC has increased so high that it has become population of two PHCs. Even for service providers it becomes difficult to cater such high population. Thus we have reported and raised this issue in Jansunvai, also reported at district level." (Block Co-coordinator, Nandurbar)

"In Murbad Rural Hospital the Medical Superintendent is not there since past ten years. This issue was discussed at block level, district level but nothing has happened. Somebody is sent to take care but that is not enough, sometimes there is nobody to sign the pay sheet. If there is no leader or a driver how the vehicle will run efficiently? (Jar leader/chalakach nasel tar gadi suralit pane kashi chalnar?") (Block Coordinator, Murbad)

d) Enabled the community and CBOs to become equal partners in the planning process

The role of NGOs conceived in the original NRHM document was of Capacity building, local advocacy and collection and analysis of information. Since beginning, participation and involvement of NGOs in the whole process was high, however eventually the involvement of community members in the process has increased. For capacity building and awareness generation, various initiatives have been undertaken by NGOs. At various levels the training of committee members was provided to increase the awareness among community. After the formation of committee, the second major step of state nodal agency and the implementing agencies was to conduct the capacity building. The training was carried out in relation to CBMP committees at various levels, roles and responsibilities of the committees, fund utilization and report writing etc. However there was a poor response from the committee members of VHNSC for the training and that was a major concern reported by the NGOs. While conducting these trainings innovative training strategies were used to make it more interesting and easily comprehendible.

The State nodal agency (SATHI) prepares and disseminates information through 'Dawandi' for awareness generation. Dawandi which means public announcement, is a state level newsletter for community based monitoring, published by State Nodal Agency. This is widely circulated at the time of Jan Sunwai, and across Maharashtra from village health committee to state health officials. Various issues and problems related to health system, positive efforts by health functionaries and any innovations etc. are being published in Dawandi. Popularity of this newsletter has increased so high that there is demand for this newsletter even from the districts which are not under CBMP. Apart from this, SATHI has developed lot of other material such as posters, booklets and audio visual aids as an IEC material for building understanding and preparedness of community for CBM process.

From village to state level the media gave good coverage to CBMP which has created awareness amongst all stakeholders in relation to NRHM and CBMP process. The media helped in creating awareness, raised issues and created impact not only at grass root level but also at state level. The wide spread media coverage helped by giving wide visibility to the issues and thus in having immediate corrective measures. However at certain times media coverage became detrimental for the process as it just hyped the negative issues raised in the Jansunvai which negatively affected the synergistic process of CBMP.

PRI members' involvement is also increasing over a period. Some of the PRI members reported that they are now become more aware about the health rights with the help of NGOs. They also agreed that the CBMP is good and worthy; it shall be there in every block of the districts. But they also mentioned that though they are involved and monitoring the functions of health services, involvement of NGOs in the process is vital as they are aware about the health issues and does better follow-up.

Majority govt officials and the office bearers expressed that there was an equal partnership exists in CBMP. They also feel that NGOs and community representatives should be little gentle while presenting the issue because officials at times feel offended by their harsh attitude. The govt official from district level said that the NGOs approach and communication was not at par, they should focus more on awareness generation among people about the process rather than concentrating more on public hearing. Almost all Medical Superintendent of RH and CS were unhappy regarding communication and approach of the NGO co-ordinator and/or other CBM Committee members during the

Jansunvai. They felt that there is need for proper training on communication with Govt. officials to the committee members. One of the gov. officer quoted this situation as, "People with bare feet, with no proper words in their mouth, stands and ask question in front of hundred people to the class I officers (Payat Chappal Nahi, Tondat shabd nahi anni he Lok Class-I Officer la Sambhar Lokanmadhe prashna Vichartat)"

This was offending for the government officials, however on the other hand the above quote is also emphasising on the increasing participation of the community in Jansunvai and also a sign of empowerment of community.

Thus it was noted by almost all the government officials that the NGOs and the community members were interested only in negative-monitoring and never provided alternatives or options or suggestions for better planning. However NGO representatives claimed that they give suggestions for improvement when possible, though these suggestions are often not taken seriously. NGOs also felt that they were equal partners in CBMP and actively participate in the activities related to CBMP.

Though in overall process there is increasing trend of equal partnership, however planning process part is still weak. The State nodal agency reported that development of separate plans based on the needs assessment was not taken up in Maharashtra, due to the existing limited scope for civil society inputs in the existing PIP development process. However specific suggestions related to local planning have been provided through the CBMP process, particularly for RKS and block level PIPs in several blocks. Considering the current PIP preparation process, there is little scope to incorporate the needs/suggestions from the community. Adequate spaces for participation in processes like RKS meetings and PIP preparation, along with capacity building are required for community representatives to get involved in Planning.

Though the PIP – Programme implementation plan, State action plan and State mission guidelines have mentioned the CBMP implementers manual, it was not adopted in Maharashtra state, but the NGO's and the Health officials mentioned that the issues raised through monitoring and public hearing are considered for PIP at district level.

2) Effectiveness of the decided process of implementation of CBMP

I. Village Health Nutrition and Sanitation Committee

In all the study villages VHNSCs have been formulated. Human resource composition in a committee was as per the guidelines for the VHNSC formation. Meetings of VHNSC have been conducted once in a month in all the study villages. All the committees have also received untied funds for its functioning. The women representatives and PRI members were also present in the committees.

However there were little awareness among members regarding roles and responsibilities of the committee. Also very few members have attended the training and can recapitulate issues discussed in the training. (Annexure IV)

Training of these VHNSC is conducted by Block level NGOs and representative from State nodal agency. As mentioned earlier also the response of VHNSC members to these trainings is low as there are several reasons reported by VHNSC members/NGOs such as involvement in other committees, other priorities etc. As there is lot of attrition rate among the committee

members some of the PRI members mentioned that the trainings should be more frequent and its component has to be more structured and should get strengthened so that monitoring of the health services can be carried out more effectively. The frequency of training varies at each district (once in three months/once in six months). During these trainings issues such as committee's functions, public health care services, utilisation of RKS and UT and various reporting formats etc. are covered.

Various issues such as denial of health services, entitlements, drugs etc. are getting discussed during the meetings. Additionally discussion on reporting formats and funds utilization etc also takes place during such meetings. Based on the discussion in the meeting further actions are taken up. Following is the example of Manipur village where intervention of the VHNSC committee brought a desired effect.

"Last year during monsoon, patients were not treated properly in the PHC. They were not given medications. Even the attitude of staff and communication with patients was not proper. With help of KASTAKARI SANGHATANA we took MORCHA on PHC after that situation was improved" (Member, Manipur village committee)

However as VHNSC is the first port for needs assessment and contact to reach out the community this needs strengthening. There are recurrent changes in the members and it was observed that all the committee members were at equal plane with respect to roles and responsibilities of this committee.

II. Primary Health Centre Monitoring and Planning Committee

The PHCMPCs were constituted as per the guidelines and functioning well. The frequency of meetings is usually once in month but it varies based on needs and the availability of members. Committee members visit the health facilities quarterly and review the situation such as drug stock, other records, fund utilisation and over all attitudes of the HCPS. However constitution, functioning and other details about the committee across districts was varied. *(Annexure V)*

Training of PHCMPC was conducted by Block level NGOs and representatives from State nodal agency. The trainings were conducted at the initial period only, for the new committee members the trainings were conducted by old members who attended the training from NGOs. The focus of these trainings was on committee's functions, utilisation of funds, referrals, records keeping etc.

In Dhasai PHC, due to the active involvement of PHCMPC the sub-standard materials used for the construction of PHC building was stopped and made provision to change materials and used quality products for the construction of PHC. There was no denial of health service reported in the PHCs of CBMP districts.

Block level coordinator from Murbad has reported that before implementation of CBMP PHCs used to charge Rs.20/- for injections but now due to PHCMPC intervention all this medication is free of cost. Now people have started utilizing PHC services. Earlier there were mostly referrals from the PHC but now services are being provided in PHCs.

III. Block Health Monitoring and Planning Committee

Study results revealed that the BHMPC was constituted based on the guidelines of CBM and the frequency of committee meeting varies based on needs and the availability of members,

while at few places it was not conducted regularly. Overall the meetings were conducted regularly and frequency of these meetings was monthly. The member's participation in the meet was less. The training provided to the members was related to roles and responsibilities and functioning of the committee. The block level Jan Sunwai is conducted and attended by block and district level govt officers and initiates corrective actions for the issues raised. The BHMPC receives the report from the PHCMPC.

Many committee members and NGO representatives mentioned that block level issues are more of the policy level which cannot get resolved at the local level. So we put forth these issues during Jansunvai and also report to District Monitoring committee. But In spite of pursuing the issues for long time, it doesn't get resolved then it becomes frustrating.

Block co-ordinator Shahada reported that in Nandurbar Civil Hospital as well as in RH Akkalkuwa there is no Blood storage/blood bank facility available, therefore no surgical procedure (LSCS) would be performed and patients were referred outside. These issues were reported during the block level committee meeting and further follow up has been taken by the committee members. However as these are policy level issues yet no change has been observed.

"In our tribal area one PHC is shifted to Tokawade. In panchayat samiti decision was taken to have separate PHC for tribal area ahead of Tokawade.. DPC took decision to make PHC. But when the state government declared the list of PHC in that our name was not there then frustration comes. In CBM process we put forth the needs of the community and issues for improvement but if they doesn't get solved and also without any proper clarification then our interest goes down." (Member, BHMPC, Murbad)

Such experiences can be demotivating for the committee members and thus could be detrimental for the CBMP process. Structural arrangements in the system/process need to be made to address such unresolved issues.

IV. District Health Monitoring and Planning Committee

The District Health Monitoring and Planning Committee were constituted based on norms and functioning in all districts. The members of the committee had training on CBMP, while the mobilisation of govt officers and newly elected members did not underwent training. The committee meetings were conducted regularly while the frequency of meeting varies. The implementing NGO coordinator maintains the record of minutes of meetings and peruses the feedback (action taken) of issues discussed in the meetings.

The district level Jan Sunwai is conducted and attended by district level govt officers and initiates corrective actions for the issues raised. The DHMPC receives the report from the BHMPC. In Nandurbar district the PRI members active involvement at block level was lacking whereas at district level the PRI members expressed his concern and said the CBMP process is good and they attend meeting and actively involved in CBMP. Overall at district level it was found that there are partnership issues between government officials and NGOs/committee members. Government officials felt that there has to be some manual or training booklet for them as there is recurrent postings are happening and then new comer doesn't have any understanding about this whole process.

V. State level bodies and major events

Three major structure and processes are established at the state level with respect to CBMP process i.e. State Monitoring and Planning Committee, State Mentoring Committee, and State Culmination workshops.

The State Monitoring and Planning Committee:

The State Monitoring and Planning Committee was formed on 21st August 2012. All other committees such as VHNSC, PHCHMPC, BHMPC and DHMPC were formulated in all pilot districts soon after initiation of the CBMP in Maharashtra. However after recurrent follow up on the issue in AGCA reviews, on 3rd August 2011, in review meeting at Arogya Bhawan, Mumbai, and issue was discussed regarding formation of state monitoring and planning committee.

As per the NRHM CBMP framework member secretary/convenor of the SMPC should be NGO representative however there was difference of opinion from Government officials and therefore formation of state level committee got delayed. However now convenor and member secretary is MD, NRHM and it was decided that meetings will be decided in consultation with state nodal NGO. After the formation of the committee till date one SMPC meeting has been conducted.

State Mentoring Committee:

State mentoring committee meeting was held in 13th March 2009, 20th January 2010, and 14th September 2010, followed by several review meetings and the last SMC meeting was conducted on 16th August 2012. Role of SMC is to guide the CBMP process and take decisions related to the project as and when required.

As per the State nodal Organisation, in the first 2 years the SMC and State level quarterly reviews were quiet regular and was functioning well. However after that frequency and regularity of the meetings was decreased.

State culmination workshop:

First State Culmination and review workshop was organised in November 2008, followed by the second such workshop which was held on 28th April 2010 at Mumbai. The workshops were attended by various govt higher health officials, PHC medical officers, TMOs, DHOs, and civil surgeons and all block and district nodal agency representatives. Civil society activists and PRI members presented key issues which have remained unsolved despite being raised through the CBM process. Issues raised were shortage of medicine supply; vacant post of staff, poor quality of construction of health facility etc were discussed.

The issues like non availability of medicines, recruitment of doctors and specialists, recruitment of ANM, MPW, ASHA, regular reimbursement to SHG and corruption issues etc were addressed in State level Jan sunwai which was conducted on 3rd July 2012 at Arogya Bhawan, Mumbai. 160 participants participated in the meeting. Participants were PRI, Public health officials from state, district and block, MO from PHC's, Public health experts from state mentoring committee, representatives of facilitating NGO were present. Aim of this Jan sunwai was to discuss and resolve the health services related issues in CBM pilot districts at Amravati, Thane, Pune, Osmanabad and Nandurbar.

In nutshell, the systems regarding CBMP till district level are well established however at state level considering the huge scope of the state level committees and issue of availability of the state level officials, more feasible systems and processes needs to be established.

Janasunvai:

Janasunvai- Public Hearing is the important component of community based monitoring process. It provides platform for community and all the different stakeholders to publically present the issues related to health care system. As most of the concerned authorities and stakeholders are present at the time of Jansunvai probability of issue getting resolved immediately increases. At the initial period this was the time when lot of clashes between health care providers, managers and other government authorities and community, NGOs were used to happen. However over periods of time the communication among them has become healthier, positive and developed synergistic relationship.

The JanSunvai dates are usually decided well in advance, so that enough time is available to collect necessary evidence and testimonies. The event is usually held in the campus or vicinity of public health facility itself, or at the common place easily accessed by people. For the actual process, preparations required are,

a. Mobilization of people from local communities to attend Jan Sunwai

b. Involving and inviting Panchayat representatives

c. Inviting legislator

d. Inviting governmental health officials

e. Constituting panel of judges

f. Seeking media attention for the event

g. Follow up

After the JanSunwai, a follow up meeting of monitoring and planning committees at the relevant level is usually planned to discuss and resolve the issues. The NGO discusses with service providers the detailed plan of action to improve the health services based on the recommendations, and raise the need for action on key decision during the follow up meetings. If needed regular meetings are held to ensure the proper implementation of the Jan Sunwai recommendations.

Table 4: List of Jan Sunwai conducted at various levels

Jan sunwai	2008-2009	2009-2010	2010-2011	2011-12	Total
PHC Level	42	45	70	56	**213**
Block Level	*	*	16	12	**28**
District Level	5	5	4	2	**16**
State level	1	-	1	1	**3**

* Jan Sunvai at block level was not part of plan during pilot phase (2008 – 2010)

VI. Viewpoints of government officials and office bearers about effectiveness of CBMP

To understand the various dimensions of the overall effectiveness of CBMP and the processes involved in it, in-depth interviews of the government officials as well as representatives of Civil Society organisations were conducted.

Most of the government officials perceived CBMP as an effective process to improve quality of health services. It helps in making quick decisions which directly helps in improving quality of health services.

"The CBM is a good system based on community focused approach and has helped in improving the various health indicators. Here the local people are like watchdogs and CBM implemented health faculties (Doctors and Paramedical's) know that there is someone to ask/question." ***(State Gov. Official, NRHM)***

It provides platform at each level to present issues/problems in health care delivery system and thus possibility of resolving the issue immediately has increased a lot.

*"The CBM have brought out the unresolved problems at state level like human resources (vacancy) and facilities at health centres. The Govt is making maximum efforts to resolve the issues and to ensure that the better services would reach the needy and poor" (****State govt official, NRHM)***

Over a period of time awareness among community about their health rights is increasing and thus it creates pressure on health system as well to provide quality and assured health services. As result accountability among health care providers has increased and even their issues are getting resolved through this process. Utilisation of services has increased and now people started preferring public health services. It also provides platform/opportunity for innovations and creativity.

Following are the verbatim from some of the government officials which focuses on the effectiveness of the CBMP

*"In CBM the exit interview concept was innovative and purposeful which helps in making quick decision and improving the quality of service" (**District govt official, Pune)***

*"The CBM concept was good for the health services at different levels. It ensures that the difficulties/issues of people would get resolved at each level and NGOs brings out the valuable points which could bring positive changes in the system" (**District govt official, Osmanabad)***

*"Outcome at the CBM implemented PHCs is good, as the monitoring is there and demand is getting generated" (**District govt official, Thane)***

*"The accountability has risen among service providers and Jan Sunwai made a path to understand the problems of common man. The CBM made the people more aware about their health rights" (**District govt official, Nandurbar)***

*"The CBM have made changes in the communication and approach of the health service providers, while the human resources were increased at various levels. The people's issues were solved promptly with help of available funds" (**District govt official, Nandurbar)***

"*The CBM made very significant changes in health indicators and functioning of health officials, where the immunization clinic have been conducted regularly, conscious efforts made to celebrate the health days, most importantly the institutional delivery has increased significantly, the better referral services have been enacted and the public issues were raised and corrective actions were taken"(**Block govt official, Nandurbar)***

*"Currently the health services are better and noticed improvement in IPD and OPD patient's attendance" (**Block govt official, Akkalkuwa)***

*"The significant aspect of CBM was the public hearing and public dialogue which serves as base for resolving the public issues, CBM process made availability of physical infrastructure (Belsar PHC) and manpower to render a quality health services. There was a change in trend (increase) of OPD patients visit and institutional deliveries" (**Block govt official, Pune)***

Similar to health official's viewpoint civil society organisations also perceive CBMP as an effective process however their perception about effectiveness is more from a rights perspective. Many of the CSO representatives mentioned that people/community have now become more aware about their health rights.

*"The CBM made people aware about their health rights, functioning of health care system and demands quality service. The people's contribution and participation in health care system have improved. The greater accountability was inculcated along with the reduction of malpractice" (**State nodal agency official)***

"After the CBM process the public has developed trust worthiness for public health system, they are become more aware about their rights and thus demand better services. The CBM

brought the following changes in the community like, new PHC was established in Belsar, number of patients increased in OPD, PNC mother gets benefit of JSY on time, no prescription was given to patient to buy medicine from private dispensaries, sonography started in RH, number of institutionalized deliveries have raised, referrals have improved and developed more accountability among service providers"(***Block nodal agency, Pune)***

They have become more strong and responsible for their own health. Thus this automatically creates pressure and demand for quality health care services. Positive attitudinal change in HCPs and thus healthy communication between patient and health care providers was also reported by the NGOs. Systems such as formation of different committees at each level has helped in reducing malpractices and thus enabled proper utilisation of funds such as RKS, UT, AMG etc.

"The CBM have made change of behaviour among the service providers. Previously many were unaware about untied fund, only ANM and Sarpanch shared (50%) the money; currently many were aware and it was used effectively for health related activities. With best of my knowledge the increase of OPD attendance and availability of medications were the significant achievement of CBM. It has resolved variety of issues e.g. the reuse of disposable syringes in patient care. The public hearings made the service providers to be accountable and initiated them to make efforts to bring the red colour code to green colour in report card" (***District nodal agency, Nandurbar)***

Jansunwai has provided very effective platform for putting up the peoples issues/problems related to health system in front of government authorities and many issues get resolved immediately, thus improving the overall accountability of the health care system. It also helped in reducing the political influences in decision-making and personal favouritism or biases and making processes more transparent.

*"Through Jan Sunwai the people's problems were raised and with help of committee members the problems were resolved. The people started receiving the JSY benefits. The service providers must have caring and positive attitude towards patients and the CBM have made improvement in the approach and way of communication among health care providers" (****District nodal agency, Thane)***

During the process attitude/approach of health care providers, especially working at the grassroots, towards their work has changed notably.

Following are the verbatim of some of the NGOs representatives

"The CBMP is good for public system, it's a generalized principle. CBM ensures the guaranteed health services to the people and the issues/grievance was resolved" ***(State Nodal Agency official)***

"The CBM developed the change of behaviour and communication among the service providers, while it has increased OPD attendance" ***(District Nodal agency, Pune)***

"The CBM made significant improvement at all level, and the public health system has changed. The Jan Sunwai was the platform for people to raise the issues/difficulties, which enabled them to receive the best possible services from health service providers" ***(Block nodal agency, Dahanu)***

*The CBM has provided platform (Jan Sunwai) for discussing and resolving the health related issues of people. The CBM brought many changes like, asking money for the health services was stopped, availability of medicines was substantially improved and there was an increased referral services. The two CBM implemented PHCs have been upgraded to RH level. However CBM created more awareness among people on their health rights and demand for better health services. The denial of health care was reduced drastically. CBM made significant impact on change in the behaviour of the service providers and reduced the political and personal influence" (****Block nodal agency, Thane)***

*"The CBM is a work through people's assembly. Through CBM people become strong and responsible for their own health. After the public hearings, the service providers reached to unreached people and started speaking. Though there was resistance in initial stage, followed by mutual participation was increased gradually. The CBM helps to resolve the issues related to infrastructure, human resources etc" (****Block nodal agency, Osmanabad)***

*"Initially the awareness of Jan Sunwai and the participation in the meet was minimal, after the involvement of DHO, the govt officials and others all was present for subsequent Jan Sunwai's. The people's issues and problems were raised like shortage of HR, lack of medicines etc. The Tuljapur PHC building was not ready for long time, the issue was discussed with higher officials and they took decisions, now the work is carried out smoothly. CBM made popularity of toll free number 102 among people for accident/emergencies and Ante natal care etc. Currently people are very much aware about the health system and its functioning, here the issues were raised followed by the services/solutions were offered" (****Block nodal agency, Osmanabad)***

*"CBM has provided opportunity for innovativeness and made the public more knowledgeable. Further it created sensitization and made the people and service provider's involvement in health system. The change of approach was evident as the ANM; MPWs were willingly working in tribal and hilly areas. While the high work in CBM was not neglected, it is acknowledged and appreciated e.g. the service providers (THO: 02) was felicitated at state level for their good work in CBM"(****Block nodal agency, Pune)***

3) Impact of CBMP

a) Changes in conditions of health care services: (Infrastructure/ IPHS standard/Attitude/Range of services)

Range of health services related issues such as development in infrastructure; different services, schemes, medicine availability, attitudinal issues of staff etc. were identified at each level committee and addressed accordingly. Mentioned by committee members and CSOs representatives due to CBM many such changes have occurred. Following are some of the examples:

1. In Osmanabad, Tuljapur PHC building was not ready for long time (4 – 5 years), the issue was discussed by PHCHMPC members with higher officials such as DPM, DHO and they took decisions, now the work is carried out smoothly.
2. In Pune, because of CBMP push the new PHC was established in Belsar.
3. In Pune, Panshet unit has got new building.
4. In Dhasai, due to the active involvement of PHCMPC members the sub-standard materials used for the construction of building was stopped and made change in use of quality products for construction of PHC.
5. The psychiatric patients were referred to specialty hospital, because of unavailability of psychiatric specialist. With repeated request by the NGOs and committee members, a fixed day psychiatric OPD has started in the Civil Hospital, Nandurbar.
6. In Nandurbar district, the Nandurbar Doctors association (Magmo) who boycotted the Jan Sunwai, after the clear understanding and debriefing of functioning of CBMP at Arogya Bhavan, they acknowledged, accepted the significance and participated in CBMP.
7. In Thane district, the Jamsar village the sub centre was sanctioned but the contractor had delayed the construction. The VHNSC members raised the issue at block level monitoring committee meetings thus the construction of building was completed and currently it is functioning.
8. In Ganjad PHC, the IPD patients were facing difficulty in getting assistance whenever required by HCPs, as nurses and attendants could not be always in the IPD ward due to paucity of staff in the PHC. The issue was raised and discussed at Jan Sunwai, and came out with solution of instalment of simple call bell at head end side of bed. Now the call bells are installed and patients receiving help promptly.
9. The VHNSC creates awareness on health by celebrating the village awareness day, where people start doing collective voluntary work (shramdan) on cleaning of public places and drains etc. This bridges the gap between the service providers and people.
10. The block nodal agency reported that there is change of approach in service providers as the ANM and MPWs were willingly working in tribal and hilly areas.
11. It was noticed that all the PHCs and RHs have displayed the Charter of citizen's health rights.
12. It was observed that there was an improved availability of medicines in the centres and referrals services.
13. Through Jan Sunwai the issues of not getting the JSY fund was raised, and currently the beneficiaries have started receiving the fund.

Above examples are self explanatory and focuses on the impact of CBM process. However processes involved in it were quite complex. At each place interactions between committee members and health functionaries, attitude of the all stakeholders, influences by the other PRI etc. are very crucial in identifying the outcome of the decided processes. However the whole CBM process has facilitated and given platform and created structure where all these interaction and dynamics among different stakeholders were possible.

At village, PHC and RH level beneficiaries were interviewed to understand what the different services they get are and whether they are satisfied about those services. This was considered to be an indirect indicator of the impact of CBM.

At village level, beneficiaries interviews revealed that majority of the eligible beneficiaries got the JSY benefits however almost around 20% did not know about scheme. Though JSY entitlement is not 100% in CBM areas it is considerably higher from the overall state specific uptake of JSY (52%).Beneficiaries were satisfied about the food provided during ANC camps at Anganwadi and visits of ANM, MPW in the villages are also satisfactory. Most of the beneficiary also reported the availability of referral transport. These results are similar across all study districts, with slight variation in some of the variables. (Annexure VI)

All PHC beneficiary respondents mentioned that all the required staff is available for PHC. Most of the beneficiaries reported availability of medicines, laboratory services, referral vehicle, adequate water supply, with slight variation across districts. All the beneficiaries expressed that the behaviour of the service providers was good and they have never being asked by HCPs for any illegal charges for health care services.

Beneficiary from Dhasai PHC stated that the behaviour of the staff and the treatment provided was good; therefore he came here to get treatment. “Upchar changla aahe mhanun me ethe aalo” (Annexure VII)

All respondents from RH have reported that the doctors and other paramedical staff is available at the facility, they did not asked to purchase the medication from outside, got the referral service with free of cost and there was an adequate water facility in the toilets. However with more or less variation, across all districts toilet cleanliness was not satisfactory. (Annexure VIII)

The public hearings made the service providers more accountable. The increase of OPD attendance and availability of medications were the significant achievement of CBM. It has resolved variety of issues e.g. prohibition of the reuse of disposable syringes in patient care.

PNC mother gets benefit of JSY on time, no prescription was given to patient to buy medicine from private dispensaries, sonography started in RH, number of institutionalized deliveries has risen, and referrals have improved and developed more accountability among service providers.

The FGDs were conducted in 10 villages of study areas, where the committee members, beneficiaries, villagers and PRI members were present during the discussion. These FGDS also revealed that due to such kind of monitoring process public health system has improved. Now they receive the optimal level of services. There was an increase in visits of service providers like ANM, MPW to the village which enabled better referral services mainly for MCH care. This indicated that CBM process aimed primarily at mandated services to public. Secondly they have also mentioned that the CBM brought changes in the availability of HR, medicines, better infrastructure etc. The Jan Sunwai has greater role in

bringing these changes, where our concerns and issues were listened and taken for considerations. Thirdly they have specifically observed the positive attitudinal change of the health care providers which helped in changing community perception about the public health services and regaining the confidence over it. Most members satisfied with the services of sub centre and primary health centre. These findings suggest that the health service providers have more accountability and villagers clearly prefer public health service than private care

b) Changes in rights consciousness regarding Citizen's charter of health rights and concrete service guarantees

The PRI members have become more aware on entitlement of health rights with help of NGOs. The respondents agreed that the CBM process is good and worthy; it shall be there in every block of the districts. Though we does monitoring of functions and health services, while the NGOs involvement is vital as they are aware about health issues and does better follow up.

PRIs contributed significantly towards changes of health services in rural hospitals (via Jan Sunvai) along with NGOs. The significant changes were infrastructural change, availability of human resource, reduced absenteeism in duty of service providers and better cleanliness and sanitation. They felt satisfied because their efforts have been successful reaching to the unreached and providing health services to neglected.

PRIs stated that because of CBM process, the service providers have more accountability as someone is there to watch and endorse them. The much needed awareness on health services have created among public. Now a day's people have started verbalizing there problems/issues. The monitoring committee members are local therefore ownership and concern feeling has been established.

Medicine stocks were displayed on board, Citizen Charter, grievance redressed numbers, and committee contact details etc. displayed on most of the health centres is the importantoutcome.

Involvement of PRI members is also increasing in the process. They have mentioned that they have become more aware on entitlement of health rights with help of NGOs and also reported the role of NGOs in this process is vital.

Overall the PRI members have felt it is essential to undergo training so that monitoring of health services could be carried out effectively. The PRIs were well acquainted with health issues of the area; attends and actively participates in the committee meet, and possess knowledge on utilizations of RKS funds.

PRIs contributed significantly towards on changes of health services in rural hospitals (via Jan Sunvai) along with NGOs. The significant changes were infrastructural change, availability of human resource, reduced absenteeism in duty of service providers and better cleanliness and sanitation. They felt satisfied because of their efforts have been successful by reaching to the unreached and providing health services to neglected.

Further, it was noticed, that initially the CBM committee members and health service providers had strand relationship whereas currently the behaviour have changed at all levels of employees and initiated better cooperativeness.

PRIs stated that because of CBM process, the service providers have become more accountable as there is someone to watch and endorse them. The much needed awareness on health services have created among public. Now a day's people have started verbalizing there problems/issues. The monitoring committee members are local therefore ownership and concern feeling has been established.

A success story of impact of CBMP

Active involvement of PHCMPC at DHASAI

The active member of PHCMPC enumerated the impact of CBM by narrating the story which has taken place in his premise.

The Dhasai PHC was under construction, we thought that it is going to be good but when we have visited the site as member of PHCMPC, it was observed the materials used for construction was old materials with poor quality.

We have collected samples of substandard material and informed to C.O. and B.D.O via telephone and written communication, while nothing has changed, and situation remained as it is. Followed by we have collected sample materials from the site and went to public hearing at state level in 'Arogya Bhawan'. There we have raised this issue before health Director; by director's order the material was sent for testing and found to be substandard. Then the district officials came to visit construction site. Concerned engineer came and inspected the material and she said it is substandard. She asked the PHC doctor by saying how can outside people came and collected material from site, but doctor replied that they are PHCMPC members so we can't say no to them.

After that also they did not change faulty sand and continued construction with substandard material only. Then we had insight that even some of the govt officials were also involved in this matter along with contractor, as substandard sand use was continued to build PHC building.

Then we went to people and explained them about quality of material used to build PHC, thereby the public realized the problem. We (PHCMPC, NGO, and public) have decided to protest against this offence. We had planned one day protest on 22 August 2012, while it went for two days and we collectively made them to stop the constructions. Followed by the BDO and engineer had given us in writing that they will change substandard sand. Then sand was changed and good quality material was bought and PHC constructed.

Further PHCMPC members had constant check on the materials used. Our Endeavour was very well supported by NGO. Currently people were very much satisfied with PHC construction but only thing is that before we could take action contractor had constructed 3 – 4 feet with substandard material.

4) Sustainability of CBMP

Even mentioned earlier, that the role of NGOS in the whole CBM process is as a capacity building, facilitator, local advocates and help in data collection and analyzing the data. As the first pilot phase of CBM has ended with positive results and the process has been expanded to further 8 districts, sustainability of the CBMP process has become a crucial issue. From government officials side the issue of exit policy for NGOs has been recurrently verbalized however at the same time it is also getting reported unanimously that in current CBMP process role of NGOS is very crucial. Majority of officials and office bearers verbalized that the involvement of Non Governmental Organizations is vital for the sustainability of CBMP in the Maharashtra state. Many Gov. Officials also mentioned that NGOs should concentrate more on awareness generation among community for sustainability of the process. People should more actively get involved in to the process. While some of the officials had opinion that to strengthen this process and to make it sustainable still few more years are required.

Following are some verbatim of Gov. Officials on sustainability

*"For sustainability, the NGOs have to act as catalyst, and function as mediator between civil society and the health services. NGOs must identify the shortfalls of health care institutions and make contribution to improve it. The NGOs must be retained and they should act as facilitators" (**District govt official, Pune)***

*"The people shall be prepared to speak and ask for their rights, here only NGOs speaks. If NGOs are removed then CBM will not sustain. The active involvement of PRI members was very essential for the sustainability" (**District govt official, Thane)***

*"The NGOs contribution in CBMP is vital, if NGOs are removed the sustainability may be difficult because the desired response was not attained and the public awareness was less" **(Block govt official, Pune)***

*"For sustainability of CBM, proper care to be taken while selection of NGOs and there should be proper exit policy and handing over to general active people. Confidence in service provider and in community should be developed. People should also understand the difficulties within the system, there should not be any suspiciousness about the system. Even service providers have to face various problems and issues while performing their work. The people should be involved at maximum in CBMP and have to be on continuous process. The present system emphasizes a curative aspect but it should be more on preventive aspects. Regular health visits will be important which will ensure the sustainability of the process" (**State govt official, NRHM)***

It is very clear from the Gov. Officials interviews that they emphasis on the need for community involvement and reducing/change in the role of NGOs from active to passive or at background for sustainability of CBMP process. However none of them have mentioned any solutions about the need for the inbuilt system or mechanisms from the government side in order to have smooth functioning of the process and thus for its sustainability.

As like Gov. Officials, NGOs also affirmed that the role of NGOs is vital in facilitating the process. It needs attitudinal changes at larger level among community and also among service providers. As it is very complex dynamic social process involving various stakeholders mere awareness generation among community is not enough. Constant capacity building, motivation and monitoring is essential. Representative from State Nodal agency mentioned that minimum skeletal framework is essential to run the process.

"There is need to create a system for accountability. For any process to work support system is very crucial. At least a minimum skeletal structure is essential to run this process. Gov. should think about establishing such systems in order to ensure the sustainability of CBM. Then in that case role of NGOs can be at the drop back and thus we can then think of handing over policy rather than exit policy. Without having such systems, reducing the role of NGOS would be hampering the process of CBM)" (State Nodal Agency)

Additionally NGOs also mentioned that they have suggested certain points to Gov. those can be starting point for the sustainability of the CBM. These are

1) Ensure universal publicity of entitlements of health services
2) Establishment of Grievance redressal cell at block level comprising of PRI member, health officials and NGO representatives
3) Organization of open forum like Jan samvad every six monthly to address the health related issues of the people with the presence of govt officials
4) Toll free help line for patients and health service users to ensure easy access of health services and grievances

Following are some verbatim of NGO representative's interview:

*"The sustainability of CBM will depend on functioning of the committees and the change in attitude of people and service providers. CBM should not be looked as programme but must be considered as a principle. As health is secondary issue for people, there is a need for change of policy at every level. If NGOs are not there, the work will not take place and future networking will be difficult" (**State nodal agency official)***

*"The role and involvement of NGO is important for the survival of CBM" (**District nodal agency, Nandurbar)***

*"The sustainability of CBM without NGOs will be difficult. The CBM can't be strengthened with 2 – 3 years, it needs time and patience. The innovations and involvement of various aspects is needed for future survival, otherwise it will become targeted CBM" (**District nodal agency, Thane)***

*"To have better impact and results of CBMP needs 10 – 15 years; and if NGOs does not function properly the sustainability of CBM will be in query. The role of RKS members, the awareness of service providers and the public are essential" (**Block nodal agency, Pune)***

*"The sustainability of CBM without NGO will be hard, if NGOs are retained then only the CBM will sustain" (**Block nodal agency, Thane)***

*"Currently the response rate from the people was less, and to sustain there is need for innovative approach in the CBM process and requires more time." (**Block nodal agency, Thane)***

*"There must be good communication between the two parties thereby the difficulties can put forward to the authorities and amicable solutions can be drawn, ultimately the people get benefited. To achieve the maximum benefit it needs lot more years and the NGOs force the people to speak and if the NGOs are excluded, the system may become lethargic and less vibrant" (**Block nodal agency, Pune)***

*"For better functioning and sustainability of CBM, adequate manpower, proper training and, periodical reviews are required, while the NGO plays significant role in sustainability of CBM" (**Block nodal agency, Osmanabad)***

Challenges faced by Gov. Officials and NGOs:

1) Administrative issues:

- Government officials reported that NGOs should timely submit the reports, bills and other documents required by the system in order to have proper fund flow.
- However NGOs are also facing the same issue. The CBM was full time work, and facilitators are limited. All the activities of CBMP are fund based, but fund comes very late and fund utilization is also very tricky (many queries are raised in auditing).
- The state nodal agency also stated that they face difficulty in receiving the funds in time from the government which severely affects implementation of all activities.
- It was observed that the health service providers and NGOs have to keep and maintain numerous records and registers including the utilization of fund. While the record keeping consumes lot time and human energy when there is paucity of required manpower.

  There are issues in record maintenance and finances from both government and NGO side. In order to resolve this issue reporting formats should be simple enough and there has to be clear guidelines given to the NGOs about submitting the required documents and expenditure reports. NGOs should also abide to the guidelines and time line given by the state officials.

  NGOs are also facing issue in formation of VHNSCs as number of service providers was already under various committees as members, where selection and recruiting them in to one committee was difficult task of NGOs. As in many places a single dedicated ANM/MPW not available and they have to provide service for more than one villages, therefore getting ANM/MPWs on committee is also sometimes difficult. Similarly NGOs are also facing difficulty in selecting the PRI members for the committee, because of periodic elections and replacement of PRI members. The availability and acceptance of member also have significant contribution in selection of PRI members.

2) Trainings and capacity building:

- It was reported by both Gov. Officials as well as NGOs that Training and capacity building of service providers and the committee members/community is the area which needs to get strengthened. There is a need for joint sensitization training workshop for NGOs and health service providers. It is also felt that during the revising the monitoring tools and its training gov. officials should be involved.
- The training on CBMP was provided by NGOs, the common areas of training were CBMP, roles and responsibility of the committees, utilization of fund and filling the report card etc. While many of the committee members don't attend the trainings conducted by NGOs, this attendance has to improve. The training of new members is the important issue in training process of CBMP.
- It was observed that in public health system, the frequent mobilisation of health service providers was common. In some villages (Khalad) the Sarpanch changes every year, so yearly the chairmen also changes for the committee. The NGOs find difficult for training new members, and acquaint them with the system (CBMP) takes lot time.
- Gov. Officials also had an opinion that in the monitoring committees there must be the gov. official with sound technical skills so the different perspectives will count and effective monitoring is ensured. Government officials felt that, awareness should be created among community about current scenario of health system among the public. The

NGOs must have background knowledge on health and health programmes for smooth functioning of CBMP (*To avoid unrealistic demand by the committee members).* The people have less awareness on health and health care system, while in public hearing only 3 – 4 members speak and other community members don't have any voice.

- There is a need for the govt officials to take part in CBMP, it's a govt process under NRHM, and thereby the issues in health system can be overcome.

3) Attitudinal and communication issues:

- Attitudinal and communication related issues were put up by both government officials as well as from NGOs. Government officials were of the opinion that during Janasunvai or even during other meetings way of talking of NGOs/community members with government officials is bit harsh. It feels offended and then they become more repulsive rather than to have more productive process.
- They also felt that The public hearing is a good platform for resolving many issues, however before the Jan Sunwai the NGOs would meet and discuss with MO, instead of raising issues before public, putting the officer in 'criminal cage'. The CBM has inculcated criticism than ownership; the NGOs nature was fault finding therefore could not enjoy the process outcome. The NGOs targets the service providers and did not look or provide alternatives/solutions.There is a need for more community participation during Jan Sunwai, and the NGOs should create awareness among people.
- However NGOs were having another viewpoint that no adequate/needed response is being provided by the service providers. The people have not developed the concept of ownership; if we raise issue we may not get adequate/needed treatment from service providers. Many times the govt officials were not present for the meet and regular change of officials (mobilization) made the job more difficult and complex.

4) Planning and Policy level issues:

- Planning component in the CBMP needs to get strengthened. Though currently there are few efforts which has been taken in this regard, in order to have need based planning and ultimately reflecting it in PIP systemic arrangements are essential.
- NGOs representatives have mentioned that appropriate planning has to be done before undertaking any activity/decision. For example In Thane and Nandurbar district, during the up gradation of PHCs in to RH, the sub centres were joined with existing PHCs. These sub-centres were geographically far located and thus even inconvenient for people to have access to those PHCs if required. So these practical feasibilities and filed situations must be considered while planning.
- The CBMP has been reasonably effective at local, PHC and block levels but the required health policy and structural decisions have not been taken at state level – this is a significant gap that needs to be addressed. There is a need for the strong political will for sustaining of CBMP.
- The smooth functioning of public health system depends on adequate human resource and other facilities, whereas there is a need for adequate health professionals and medications.
- The unresolved issues at district level (like vacant post, proper geographical allocation of villages to PHCs) sent to state level needs to be addressed for smooth functioning of health system.

Chapter 6 - Conclusion

CBMP is a method, which is used to get beneficiary feedback about a particular service; it's a kind of social audit of public health services which serves to facilitate active participation of people. Evaluation study findings revealed that the process of CBMP in Maharashtra is well established and showing positive results at various levels. In all 5 pilot phase districts the CBMP was implemented well at different levels (village, PHC, block, districts). The interviews and FGDs with various stakeholders comprising government officials of various levels, civil society organisation representatives and community have focused that the CBMP is beneficial and effective process.

1) Execution of CBMP objectives:

A) Needs assessment:

- Regular needs assessment is done and systems are established for the regular and systematic data collection for the community needs. Committees at each level are regularly assessing the community needs. Innovative strategies are also being used for needs assessment
- There is variation in frequency of data collection across blocks and districts. In order to have more structured systems, bare minimum uniformity in data collection across districts is essential and therefore based on the experience; NGOs can suggest modifications in data collection formats/ methodology.

B) Feedback according to locally developed yardsticks:

- National Level tools were used as template and NGOs have modified according to local needs and relevance. Various tools were developed during the process.
- Health report cards are being routinely filled up. During initial period of CBMP implementation these were regularly displayed at the health centre or village for community review. However later it was observed that those indicators which were repeatedly poor with no or minimal improvement in spite of giving regular feedback, created sense of dejection and hopelessness among the community. This resulted in to lowering the significance or complete neglect of such activities.

C) Feedback on functioning of various levels of health systems and services:

- Range of issues is being reported about the functioning of health services by the committee members at all levels.
- Regular visits of committee members to the health facility ensured optimum level of services and also created the positive pressure on the HCPs. During such visits issues of HCPs are also getting reported and further getting discussed and resolved during committee meetings.
- Issues of entitlements such as JSY benefits etc. are getting effectively resolved at the committee levels.

D) To enable community and CBOs to become equal partners in the planning process:

- Role of NGOs in the CBMP process is to create awareness, capacity building, local advocacy, data collection and analysis. Various efforts and innovative strategies have

been implemented to sensitise the community about the process and health rights. At the initial period media also gave wide coverage to the CBMP process. But sometimes it was felt that media has sensationalised the news and as a result it became too negative which at times became detrimental for the synergistic process of CBMP.

- Overall awareness about the process among PRI members as well as in community is increasing resulting in to positive involvement in the CBMP process. Active involvement of community and NGOs is increasing resulting in heightened awareness and sense of ownership among community about the public health system. This has helped in inculcating the feeling of equal partnership among community. Gov. Officials also perceive that there is equal partnership among gov. and community in CBMP process. However NGOs do not strongly feel that yet there is equal partnership in the process.
- Government officials felt that NGOs /community should provide alternative or suggestions for better planning and NGOs said that they do give suggestions but they are often ignored or not taken seriously. There is still some amount of disagreement which is hampering the equal partnership process.
- -Though in overall process there is increasing trend of equal partnership, however planning process part is still weak. In existing planning process there is no space for community representation. State officials should ensure appropriate platforms for involving community in planning process.
- Attitudinal change is necessary among all stakeholders in order to have more synergistic process.

2) Effectiveness of decided processes

- Various committees at each level are formulated and working fairly well. However considering VHNSC as the first level of interaction with community, it needs capacity building and strengthening for its efficient functioning.
- Range of issues are getting reported and resolved at each level. Some issues need policy level interventions. When such issues are not properly addressed it demotivates the community and negatively affects the process. Repeated negligence may prove detrimental for the process. Appropriate state level structural redressal should be devised and some feedback should be mandated in a time-bound manner.
- Many policy level issues such as deployment of HR, Medicines etc. gets inculcated and resolved at the state monitoring committee level. There has been substantial delay in formation of this committee. State level review of the committee is also lacking and therefore processes at state level need strengthening.
- Jansunwai has provided very effective platform for putting up the people's issues related to health system in front of government authorities. Many issues get resolved immediately, thus improving the overall accountability of the health care system. It also helps in reducing political influences in decision-making and personal favourisim and makes the health care delivery systems more transparent.
- As a result, involvement of people in their own health systems is increasing which translates in to good awareness about their health rights. It has also resulted in increasing sense of accountability among HCPs.

3) Impact of CBMP:

- This study can conclusively state that CBMP has resulted in various changes in health care services such as infrastructure, availability of HR, attitudinal changes in HCPs, reduction in malpractices etc. and improved range of services being provided.
- Although these changes varied from place to place, the processes involved in CBMP implementation were complex and required local tailoring. At each place interactions between committee members and health functionaries, attitude of the all stakeholders, influences by the other PRI etc. were found to be very crucial in identifying the outcome of the decided processes.
- However it is important to note that despite all the hurdles and complexities related to power dynamics during stakeholder interaction, CBMP has been successful in giving a platform and creating a structure where such interactions were possible.

4) Sustainability:

- Although it is imperative that the Role of NGOS should eventually be minimised and they should be involved peripherally, all stakeholders in this study agree unanimously that if NGOs pull out now, then CBMP may not proceed effectively. NGOs still play a crucial role in sustainability, awareness generation, capacity building, and act as catalyst and it may take time for community to actively take over from them. Active involvement of PRIs would be crucial.
- In this study, government officials have stressed the need for exit policy for NGOs. However there has been no discussion about alternative systems within the government to facilitate the process as the NGOs currently do.
- NGOs in the study have stated that their roles can be modified and gradually moved to passive roles as long as integrated systems are developed within the government to ensure proper monitoring of the CBMP process.

Challenges:

1. There are issues in record maintenance and finances from both government and NGO side. In order to resolve this issue reporting formats should be simple enough and there has to be clear guidelines given to the NGOs about submitting the required documents and expenditure reports. NGOs should also abide to the guidelines and time line given by the state officials.
2. Training and capacity building of service providers as well as the committee members is the area which needs to get strengthened. There is a need for joint sensitization training workshop for NGOs and health service providers. It is also felt that during the revision of the monitoring tools gov. Officials should also get involved and their training is also essential.
3. Attitudinal and communication related issues are put up by both government officials as well as from NGOs. It was felt by Gov. Officials during Jansunvai or any other meetings community/committee/NGOs attitude is too aggressive which at time become offensive for the Gov. Officials to cope with it. Way of presentation of the issues and discussion should be assertive but not aggressive and rigid.
4. However NGOs are having another viewpoint that no adequate/needed response is being provided by the service providers. The people have not developed the concept of

ownership; if we raise issue we may not get adequate/needed treatment from service providers. Many times the govt officials were not present for the meetings.

5. Therefore NGOs should work on the issue of communication during the meetings and Jansunvai. And Gov. should also sensitize the officials at the different level who would be involved in the CBMP process. This would lead to more productive process by giving appropriate importance to the process.
6. Planning component in the CBMP needs to be strengthened. Though currently there are few efforts which have been taken in this regard, in order to have need-based planning and ultimately reflecting it in PIP, comprehensive systemic arrangements are essential.

Chapter 7 - Recommendations

1. Structured tools to ensure uniformity across blocks and districts should be developed and data should be systematically collected and reported.
2. Communication among community/NGOs and government officials should be improved.
3. Attitudinal changes among all stakeholders are essential in order to have more synergistic process. Recurrent orientation trainings at all level can be useful for this.
4. IEC/Reading/Training material for government officials is also essential in order to have reorientation to them regarding CBMP process
5. State level process should be strengthened. Frequent reviews at state level are essential in order to maintain the pace and effectivity of this process.
6. Planning process should be given serious thought in next phase. NGOS should give appropriate framework and Government also should provide proper platforms where CBMP/community can be represented in planning process.
7. Proper inbuilt mechanisms for CBMP should be developed by the government so that role of NGOs can be minimized and seamless transition can be possible.

Chapter 8 - References

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Chapter 9 - Annexure

Annexure I: CBMP Evaluation Framework

Objective of the Evaluation Study	Components of CBM to be evaluated	Proposed Evaluation Indicators for the Components	Means of Verification	Tools/Methods used
To examine execution of the objectives of the Community Based Monitoring of health services	Provided regular and systematic information about community needs	Systems established for needs assessment (BHNSC, PHCMPC, BMPC,SMPC) Reporting	Reports on community needs by VHSC	Examination of the VHSC reports; Interview and Focused Group Discussions with the VHSC members, beneficiaries, and the officials
	Provided feedback according to locally developed yardsticks	Prepared Locally developed yardsticks (process of developing) Its usage and effectiveness	Planning documents at PHC, Block and District level	Examination of the planning documents at PHC, Block and District level; Interview and Focused Group Discussions with the members of monitoring and planning committee at PHC, Block and District level, and the officials
	Provided feedback functioning of various levels of public health system and service, status of entitlements, and identified gaps and deficiencies of health services	Feedback on availability essential drugs, and availability of essential equipments, infrastructure and facilities Feedback on doctors and other staff, attitude of the HCPs Feedback on JSY entitlements Feedback on other assured service delivery/entitlements (medicines, referral etc.) Feedback on identified gaps and deficiencies ins services and level of community satisfaction	Monitoring tools practiced at village, PHSC, PHC, and RH level	Examination of monitoring reports at village, PHSC, PHC, and RH level; Interview and Focused Group Discussions with the members of monitoring committees, and the officials

	Enabled the community and CBOs to become equal partners in the planning process	Participation of Community and CBOs in overall CBM process and in the planning process	Planning meeting minutes, Planning documents at PHC, Block and District level	Examination of the Planning meeting minutes, and planning documents at PHC, Block and District level; Interview and Focused Group Discussions with the members of the community and the community-based-organizations, and the officials
To assess the effectiveness of the decided process of implementation of CBM	Periodicity and working of VHSC	Village report card Periodicity of meeting Issues discussed and overall working Hurdles/barriers/issues faced	Village Report Card by VHSC, Minutes of the meetings and reports	Examination of the reports; minutes, Interviews and FGDS with VHNSC members and beneficiaries.
	Periodicity and working of PHCMPC	Periodicity of meeting Issues discussed and overall working Hurdles/barriers/issues faced Organization of Public hearing (Jansanvad)	Report cards, minutes of the meetings	Examination of report cards, Semi structured and IDIs with committee members, Beneficiary interviews.
	Periodicity and working BMPC	Periodicity of meeting Issues discussed and overall working Hurdles/barriers/issues facedOrganization of Public hearing (Jansanvad)	Report cards, minutes of the meetings	Examination of report cards, Semi structured and IDIs with committee members, Beneficiary interviews
	Periodicity and working of DMPC	Periodicity of meeting Issues discussed and overall working Hurdles/barriers/issues facedOrganization of Public hearing (Jansanvad)	Report cards, minutes of the meetings	Examination of report cards, Semi structured and IDIs with committee members, Beneficiary interviews
	Periodicity and working of SMPC	Periodicity of meeting Issues discussed and overall working Hurdles/barriers/issues	Report cards, minutes of the meetings	Examination of report cards, Semi structured and IDIs with committee members

		faced Organization of Public hearing (Jansanvad)		
To assess the impact of CBMP impact of	Changes in health care service conditions (infrastructure/ IPHS standard/Attitude/Range of services etc.)	Quantitative and qualitative data regarding conditions of health facilities Improvements over past few years OPD/IPD/No. of deliveries data	Baseline documents and progress reports submitted by nodal and implementing NGOs	Examination of the reports; interview and focused group discussions with the beneficiaries, and the officials
	Changes in rights consciousness regarding Citizen's charter of health rights and concrete service guarantees	Qualitative data regarding perceptions about changes in rights consciousness of community	Baseline documents and progress reports submitted by nodal and implementing NGOs	Examination of the reports; interview and focused group discussions with the beneficiaries, and the officials
To assess the sustainability of CBMP	Role of NGOs	Qualitative data from different stakeholders regarding perceived role of NGOS	Baseline documents and progress reports submitted by nodal and implementing NGOs; meeting minutes and reports of the community-based-organizations	Examination of the meeting minutes and reports; interview and focused group discussions with the community members
	Exit policy	Qualitative data from different stakeholders regarding exit policy	Baseline documents and progress reports submitted by nodal and implementing NGOs; meeting minutes and reports of the community-based-organizations	Examination of the meeting minutes and reports; interview and focused group discussions with the community members

Annexure II
Sampling Unit for study

District	Block	PHC	Villages
Amrawati		Harisal	Chopan, Malur, Chaurkund
		Sadrabadi	Dadra, Hirabambai, Rehtya
	Chikhaldara	Salona	Kohana, Bandri,Jaithadehi
		Semadoh	Raipur, Bhavai, Makhala
	Achalpur (For Pilot study)	Pathrot	Payvihir, Upathkheda, Jambla, Shindi, Kakda
		Yesurna	Savali (bu), Yevtha, Isegaon, Rasegaon, Yesurga
		Dhaman	Malhara, Gondvihir, Kalvit, Gaurkheda, Kumbi, Dhamangaon
Nandurbar	Akkalkuwa	Moramba	Ambabari,Moramba, Rampur
		Khapar	Guli Umar, Mandara,Tavli
	Shahada	Kusumwada	Kusumwada, Fattepur, Kansai
		Shahana	Vadagaon, Shahana, Malgaon
		Yedshi	Kumalvadi, Jahaghirdarwadi, Shingali
		Pohner	Kekthavadi, Gaonsudh, Radhuchivadi
Osmanabad	Tuljapur	Naldurg	Ajmodi, Murta, Dahitana,
		Thee.Salgarai	Javalaga (Mesai), Hangarna, Borandivadi
	Kalam	Moha	Shingoli, Kamasvadi, Nagjarwadi, Borda, Dhanora Shelka
		Shirdhon	Hasegaon, Nipani, Nagulgaon, Vadvada, Vadgaon
		Etkur	Kotalvadi, Satra, Havargaon, Pathardi, Athardi
Pune	Velhe	Velhe	Sakhar, Margsani, Dhanep, Gunjvane, Lavhi Bu.
		Panshet	Kurna Khu., Rule, Kurna Bu., Kondave, Varasgaon
		Pasali	Kelad, Bhatti, Vihir, Nivi, Anthrolli
	Purandar	Belsar	Khalad, Shivri,Valuj
		Parinche	Vir, Pangare, Mandar
	Khed	Vada	Aakar Wadi, Kaman, Bohkal
		Khed	Shiroli, Padali, Chandpur
Thane	Dahanu	Dhundalvadi	Halad pada, sisane, Karanjveera
		Ganjad	Chandvad,Ganjad, Manipur
	Murbad	Dhasai	Dahigaon, Akaldar, Madh, Kalbhan, Koloshi
		Tokavade	Kudshed,Vaishakhare, Pangul gavhan
		Shiroshi	Phangloshi, Merdi, Vahilvare

Red : Pilot study areas

Annexure III

List of professionals of project team

SN	Name	Category	Number
1	Dr. (Mrs). P.A. Chandekar	Principal investigator	01
2	Dr. Rahul Bais and Mr. T. Sivabalan	Senior researchers	02
3	Mr. Pankaj Kale and Dr. Pallavi Lele	Lead trainers	02
4	Mr. Pankaj Kale and Mr. Prafull Ukey	Field supervisors	02
5	Mr. Sachin, Mr. Bhutkar, Mrs. Kalpana Kale, Mr. Sandeep Mhaske, Mr Dilip Kadu, Ms. Heera Jayasheela and Mr. Kishore Chaudhari, Mr. Mahesh Dhawale, Mr. Sumedhi Bharsankar, Ms.Tima Devi Raut, Ms. Sonal Gawade, Ms. Sapana Bawaner.	Field investigators	12
6	Mr. Londhe Dinkar	Data entry operator	01
7	Mr. Hemanth Pawar	Statistician	01
8	Mr. Bhalerao B. B.	Language expert	01

Annexure IV

I. Village Health Nutrition and Sanitation Committees across all five districts (n =60)

SN	Components	Pune (%)	Thane (%)	Osmanabad (%)	Amaravati (%)	Nandurbar (%)
1	Human resources	100	100	100	100	100
2	Formation of the committee	100	100	100	100	100
3	Functioning of the committee	100	100	100	100	100
4	Untied fund received	100	100	100	100	100
5	Training conducted	100	100	100	100	100
6	Did not had training	31	44	48	54	48
7	Public hearing conducted	100	100	100	100	100
8	VHNSC Meeting conducted	100	100	100	100	100
9	Did not attended the meeting	34	44	37	36	34
10	Regularity (monthly)	100	100	100	100	100
11	Prepared village health plan	-	-	-	-	-
12	Prepared village health record	-	-	-	-	-
13	Prepared village health calendar	-	-	-	-	-

Annexure V

II. Primary Health Centre Monitoring and Planning Committee (n=20)

Components	Pune (%)		Thane (%)		Osmanabad (%)		Amaravati (%)		Nandurbar (%)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Formation of the committee	50	50	100	-	25	75	-	100	50	50
Functioning of the committee	50	50	100	-	100	-	75	25	100	-
Fund received	25	75	75	25	100	-	-	100	25	75
Public hearing conducted	50	50	75	25	100	-	75	25	100	-
PHC monitoring										
Meeting conducted	25	75	50	50	-	100	-	100	100	-
Regularity (monthly)	25	75	-	100	-	100	-	100	25	75
Village report card prepared	-	100	-	100	-	100	-	100	-	100
Exit interview conducted	75	25	100	-	100	-	50	50	75	25

Annexure VI

Beneficiaries feedback on village health services (n= 24)

Components	Pune (%)			Thane (%)			Osmanabad (%)			Amaravati (%)			Nandurbar (%)		
	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't kown
JSY scheme benefit	79	-	21	79	8	13	29	50	21	96	-	4	62	17	21
Anganwadi nutrition	96	-	4	100	-	-	100	-	-	96	-	4	96	4	-
Visit of ANM	96	-	4	92	8	-	83	17	-	100	-	-	75	21	4
Visit of ASHA	75	17	8	83	13	4	74	13	13	88	4	8	66	17	17
Vehicle for referral	88	4	8	83	17	-	71	21	8	100	-	-	79	13	8
Visit of MPW	75	17	8	75	21	4	62	21	17	-	83	17	67	8	25
Water purification															
Gram Panchayat	71	-	4	75	21	4	62	-	-	88	8	4	63	-	-
Water testing	25	-	-	92	8	-	25	-	-	88	8	4	8	-	-
Malaria prevention															
Spray	13	-	-	87	13	-	-	-	-	-	-	-	33	-	-
Blood sample taken	25	-	-	87	13	-	21	-	-	-	-	-	21	-	-
Medicines	38	-	-	87	13	-	21	-	-	-	-	-	46	-	-

Annexure VII

Feedback on functioning of Primary Health Centre (n=16)

Components	Pune (%)		Thane (%)		Osmanabad (%)		Amaravati (%)		Nandurbar (%)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Availability of staffs	100	-	100	-	100	-	100	-	100	-
Availability of medicine	100	-	100	-	100	-	100	-	100	-
Laboratory facility	100	-	100	-	75	25	100	-	100	-
Collection of illegal charges	-	100	-	100	-	100	-	100	-	100
Availability of vehicle	100	-	100	-	100	-	100	-	100	-
Hot water facility for indoor patients	75	25	50	50	75	25	100	-	100	-
Adequate water supply in toilets	100	-	100	-	100	-	100	-	100	-
Cleanliness of toilet	75	25	63	37	81	19	81	19	69	31
Availability of bed sheet on mattress	100	-	100	-	94	6	100	-	100*	-
Behaviour of the service provider was good	100	-	100	-	100	-	100	-	100	-

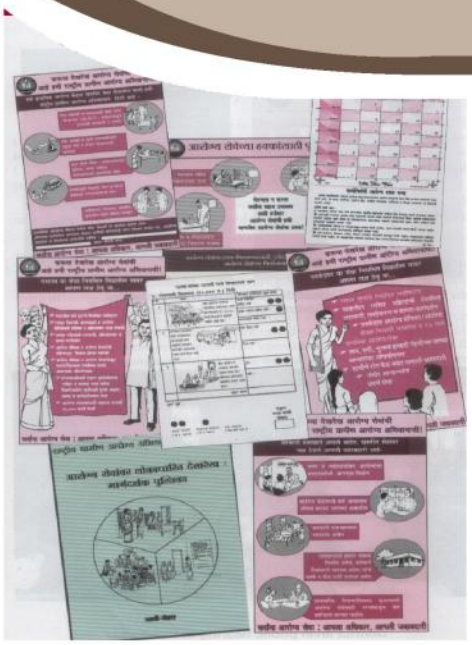
Annexure VIII

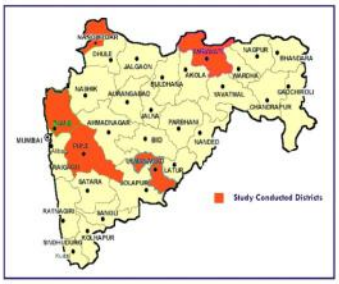
Feedback on functioning of Rural Hospitals (n=8)

Components	Pune (%)			Thane (%)			Osmanabad (%)			Amaravati (%)			Nandurbar (%)		
	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know
Availability of Doctor and paramedical's on duty	100	-	-	100	-	-	100	-	-	100	-	-	100	-	-
Medicine purchased from outside	-	100	-	-	100	-	-	100	-	-	100	-	-	100	-
Laboratory facility with free of cost	87	-	13	87	-	13	100	-	-	87	-	13	100	-	-
Got receipt for paid money	87	13		87	13		100	-	-	75	25	-	100	-	-
Referral service with free of cost	100	-	-	100	-	-	100	-	-	100	-	-	100	-	-
Facility of LSCS	37	13	50	37	13	50	100	-	-	50	50	-	50	50	-
Facility of Hot water in bathroom	50	50	-	50	50	-	100	-	-	87	13	-	50	50	-
Cleanliness of toilet	37	63	-	37	63	-	50	50	-	50	50	-	37	63	-
Facility of water in toilets	100	-	-	100	-	-	100	-	-	100	-	-	100	-	-
Availability of bed sheet	87	13	-	87	13	-	100		-	75	13	12	75	25	-
Cleanliness of bed sheet	50	50	-	50	50	-	50	50	-				50	50	-

SHSRC

Maharashtra





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