

**Review of the
Community Monitoring Activities
at Chirang District of Assam**

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a. Executive Summary:

Assam was also chosen among nine states for piloting of community monitoring activities. To do the appraisal of Community monitoring in Assam, Chirang district was chosen and in Chirang, one block was to be chosen. Under Chirang, two development blocks namely, **(i) SIDLI, (ii) BAROBAZAR** was taken. Under each development block, **one PHC each namely (i) SIDLI and (ii) BALLAMGURI** was taken for study; Under each block PHC, **one SC village namely “NIZLAGURI” and “THANGABARI”** was chosen for study. The qualitative and quantitative research methods and field level analysis were followed for the review of community monitoring at Chirang Dist by a team of experts which includes Consultant Community Mobilization, RRC-NE. The State NGO Coordinator, NRHM, Assam and member of VHAA, the State Nodal NGO also accompanied the team of RRC-NE. The study revealed the following findings.

1. Community monitoring processes have started empowering people;
2. The District Nodal Agency took up series of steps for effective functioning of the community monitoring initiatives but in absence of the expected support of the service providers, it failed to deliver the expected result of the community monitoring;
3. It seems that for the district and block health authorities, community monitoring was seen as the job of the District Nodal Agency & Block Nodal Agency, where the district / block health authority has little to do. This thinking needs to be changed;
4. Paucity of time was also another factor, which has affected the overall performances;
5. The District Nodal Agency has to develop appropriate need based quality training module in consultation with the State Nodal Agency and a copy of the same has to be kept;
6. Funding pattern to the District Nodal Agency demands streamlining. The booking of different activities under different heads and the money allocated in the respective head has to be more rationale so that booking of activity can be done without much hassle.
7. The District Nodal Agency started activities much before receiving the formal approval from State Nodal Agency. So, at the initial phase the support from SNA was missing;
8. More close support by the SNA could have improved the quality of the program;
9. Record keeping of the different activities of the District Nodal Agency needs improvement;
10. The District Nodal Agency may see community monitoring as a balanced mixture of the rights based activity as well as making community more responsive towards extending their best support to the service providers so that the gap between the parties is bridged;
11. The authority of the District Health Services has to own the program and to take more active steps. Leaving the implementation to District Nodal Agency will not be of any help;
12. Regular holding of meeting of the different committees has to be ensured for better result;

Recommendations for scaling up (Chirang experience):

- The community monitoring has ensured a new beginning as far as generating awareness among masses regarding the health rights, what to do in case the health rights are violated etc;
- More time has to be given, minimum 12 months for a particular phase;
- Funding pattern needs streamlining;
- The Quality of training needs improvement in terms of more post training follow up support for the trained persons;
- The State Nodal Agency has to work more in close coordination with the District / Block Nodal organizations;
- The frequency of holding the regular meeting of all committees has to be ensured. The agenda of such meeting has to be responsiveness to the practical need of that time;
- Few well spell out indicators need to be set at all levels of committees so as to see the impact of the intervention in owning the program and also in reducing the gap between service provider as well as service seekers;
- Exposure visit for the state level / district level mentors may be organized so that they can learn and have see chances of replication of such good practices;

Review of the Community Monitoring activities of Chirang district, Assam,

b. Background:

As it is well established fact that effective community participation is key to success to any developmental intervention and of late to ensure effective program implementation, it has been envisaged to do community monitoring, which is *critically dependent on active intervention by, and capacity building of a whole set of actors outside the Health department*. Unlike most other NRHM activities that would be implemented directly by the Health department, by definition Community Monitoring cannot be 'implemented' by Health department officials alone. Rather this involves drawing in, activating, motivating and capacity building of a wide range of beneficiary representatives, community based organizations, people's movements, voluntary organizations and Panchayat representatives and placing these actors, who form over two-thirds of the membership of all monitoring committees, at the centre of the monitoring process.

NRHM looks that the health system to be efficient, transparent and accountable in delivering affordable & quality services. To ensure that the NRHM is accountable and is successfully delivering quality health services, community monitoring is considered as an important component. Monitoring is an ongoing process and continuous management function, which gives feedback. It tracks the actual performances against what was planned / expected. Community monitoring data forms a component of monitoring data which is more reflective of the user's perspective. The Community Monitoring involves a 3 way partnership between health system, the community and the Community Based Organizations (**CBOs**) / Panchayati Raj institutions (**PRIs**). The success of Community Monitoring depends upon the ownership and a developmental spirit of fact finding and learning lesson for improvement rather than fault finding.

Assam was also chosen among nine states for piloting of community monitoring activities. In Assam, 3 pilot districts were chosen and in each district 3 blocks and in each block three Primary Health Centres (PHCs) and in each PHC, 5 revenue villages were to be chosen as per the national framework. Under Chirang, one block was to be chosen. In Assam context, the definition of the development block does not go in conformity with the definition of health block. Moreover, Chirang being a newly created district does not have many PHCs in one development block. So, two development blocks namely, (i) SIDLI, (ii) BAROBAZAR was taken. Under each development block, one PHC each namely (i) SIDLI and (ii) BALLAMGURI was taken for study; Under each block PHC, one SC village namely "NIZLAGURI" and "THANGABARI" was chosen for study.

c. Methodology for Review of Community Monitoring at Chirang:

The qualitative and quantitative research methods, report analysis and field level analysis were followed for the review of community monitoring at Chirang Dist by a team of experts which includes Consultant Community Mobilization, RRC-NE, State NGO Coordinator, NRHM, Assam and member of VHAA, the State Nodal NGO. To understand the process of community monitoring, a detail discussion was carried out with the state officials. Then, discussion was carried out with Dist Nodal NGO, the ANT, the District Monitoring team members and Joint Director of the Health Services, Chirang. The detail of the methodology for community monitoring review used is discussed as under:

- I. To understand the initiatives, which have been taken by the state, **discussion in detail was done with State NGO Coordinator**, who is notified as State Nodal Officer of the community monitoring initiatives of the state.
- II. Discussion with the officials of the State Nodal Agency namely “ Voluntary Health Association of Assam (**VHAA**)” was also done to understand the role being played by the organization for community monitoring activities;
- III. Interaction with the Joint Director of Health Services, Chirang, District Programme Manager, NRHM, Chirang, District Media Expert, NRHM, Chirang, Block Programme Manger of SIDLI PHC, Block Accountant of Ballamguri PHC was also done to understand the community monitoring processes;
- IV. Member of the District Mentoring Team was also consulted to understand the processes;
- V. Members of the Village Health & Sanitation Committee (**VH & SC**) were also consulted to understand their perspective on community monitoring;
- VI. Community members were also consulted to understand their awareness and degree of involvement in rolling out the community monitoring processes;
- VII. Service providers, like ANMs, pharmacist were also consulted;
- VIII. ASHAs, who have been working very closely with NRHM were also consulted to understand their involvement in community monitoring processes;
- IX. Discussion with the member of the District Mentoring Team was also done;
- X. The documents, which were collected from State, State / District / Block Nodal Agency, were referred. The national framework of community monitoring was also referred.
- XI. The entire exercise was done during 15th Dec'08 – 20th Dec'08. The field visits were carried out during 16th & 17th Dec'08. During field visit, the State NGO Coordinator, NRHM, Assam, Ms. Jyotika Baruah from VHAA also accompanied during the field visit.

d. **Institutional Mechanisms:**

• **Assam's initiatives since beginning**

1. A letter was addressed to Secretary Health & Family Welfare (**H & FW**), Government of Assam (**GoA**) by **A. R. Nanda** of Population Foundation of India (**PFI**) dated 29th March'07 that
 - AGCA members namely **Dr. Vijay Aruladal & Dr. Narendra Gupta (co-opted member of AGCA)** would visit Assam;
 - State to designate one "**State Nodal Officer**" who would coordinate with AGCA member & also would oversee the Community Monitoring activities in Assam.
2. **In June'07**, state workshop was to be held and the same was to be attended by **Dr. Narendra Gupta**, AGCA member;
3. **On 5/6/07, Secretary, H & FW, GoA wrote to MD, NRHM Assam regarding**
 - Appointment of State Nodal Officer;
 - Constitution of State Mentoring Group with State NRHM Officer and representatives from civil society;
 - To hold a two days workshop, where participants would be key officers of state, districts and CBOs working in health in state and in identified districts;
4. **On 16th June'07, Mr. Z. A. Mazumder** was named as "**State Nodal Officer**", who would coordinate with AGCA member & also would see the activities of Community Monitoring.
5. **On 16th June'07**, it was decided that Voluntary Health Association of Assam (**VHAA**) would be the "**State Nodal NGO**" and the organization namely "**The ANT**" would provide **technical support** to the State Nodal Organization. The selection of State Nodal Organization was done on consensus; no formal application was sought from the civil society organizations seeking their willingness to work as State Nodal Organization.
6. It was also resolved that **Chirang, Dhemaji and Kamrup (Rural)** will be the districts to take up the activities of Community Monitoring. The name of Cachar district was thought of but considering the fund position, it was not considered.
7. **On 16th June'07**, the names of the State Mentoring Group members and the names of the District Nodal Organization and the Blocks under the respective district were chosen.
8. **On 6th Aug'07, State Mentoring Group, District Nodal Organization and the selected blocks** were notified. The lists of all these are annexed as **annexure – I**.
9. **On 13th Aug'07**, PFI wrote a letter to MD, NRHM, Assam asking to inform the following
 - State Nodal NGO selected
 - Members of the monitoring group;

- Name of the pilot districts;
10. **On 14/7/07, VHAA** wrote to MD, NRHM requesting him to inform PFI that VHAA is identified as State Nodal Organization under community monitoring;
 11. On **20th Aug'08**, MD, NRHM wrote to PFI that **VHAA** is selected as State Nodal Organization and "**The ANT**" will give technical support to the State Nodal Organization. The pilot districts as Chirang, Kamrup (R) and Dhemaji.
 12. On 9th Sept'08, VHAA informed MD that on 27th Sept'07, during post lunch session, the meeting of the State mentoring Group would be held and on 28th & 29th Sept'07, workshop of the state / district mentoring group members would be held. The MD, NRHM, Assam was requested to ask the following participants to attend the program.
 - CM & HOs of the Dhemaji, Kamrup (R) and Chirang;
 - DPMs of the Dhemaji, Kamrup (R) and Chirang;
 - District Nodal NGOs of Dhemaji, Kamrup (R) and Chirang;
 - District Facilitators of Dhemaji, Kamrup (R) and Chirang;
 - 1 Block Facilitator from 9 blocks in 3 districts Dhemaji, Kamrup (R) and Chirang;
 - All mentoring group members: 16
 13. **The MD, NRHM, Assam wrote letter to all participants on 29th Sept'07** to attend the state workshop on community monitoring would be held **on 10th & 11th Oct'07 at IIBM.**
- **Major State level and State Nodal Agency's initiatives:**
 1. Civil Society / Government Officials had a meeting at Khadi Guest House, Kharboli, Guwahati on 20th April'07 regarding operationalisation of community monitoring of health services under NRHM. This 1st meeting was also attended by Dr. Narendra Gupta from AGCA, Ms. Sudipta Mukhopadhyay from PFI and Ms. Ruth Vivek from Centre for Health & Social Justice, New Delhi. The agenda of the meeting was:
 - Introduce the concept of community monitoring of health services under NRHM as per approved proposal of MoHFW, Gol;
 - Finalize the districts, where the process could be piloted;
 - Identification of civil society members for the State Mentoring Group;
 2. On 9th Oct'07, the 1st State Mentoring Group meeting was held at the office of the VHAA.
 3. On 19th Dec'07, the State Mentoring Group meeting was held at the office of the VHAA. The list of the members, who attended the meeting as annexed as **annexure – II.**

4. On 29th Jan'08, the State Mentoring Group meeting was held at the office of the VHAA. The list of the members, who attended the meeting as annexed as **annexure – III**. In the meeting, the roles and responsibilities of the State Mentoring Group circulated among members. Ms. Jyotika Baruah from State Nodal Agency also shared inputs in the meeting.
5. On 8th May'08, at state level meeting of the state mentoring group on community monitoring was held at 11 a.m. in the conference hall of MD, NRHM. The list of the members, who attended the meeting as annexed as **annexure – IV**.
6. On 10th & 11th Oct'07, state level workshop on community monitoring of health services held at IIBM, Guwahati. In the meeting the tentative timeline for various state, district and block and village level activities to be taken up were decided.
7. On 18th & 19th Feb'08, a workshop was held for the state managers / district managers to brief them about the different community monitoring aspects and how community monitoring can play a pivotal role in streamlining the entire NRHM intervention. The workshop attended by, all three Joint Directors of Health Services, District Program Managers of the identified districts, State level members of the Mentoring Group, members from AGCA, who took sessions on community monitoring.

e. Process:

Details of selection Criteria:

In the meeting, which held on 20th April'07 in presence of Dr Narendra Gupta, AGCA member, it was decided the “**the ant**” would work as District Nodal Agency for Chirang district. In the mean time, the head of the “**the ant**” attended national workshop, where Dr. Narendra Gupta from AGCA suggested to start up the activities of community monitoring on the basis of the draft guideline of community monitoring, as shared by Dr. Sunil Kaul. So, instead of waiting for the final guideline of community monitoring, **the ant** decided to start up the activities on the basis of the draft guideline in two different development blocks of Chirang. In Borobazar block, **the ant** itself took up the job of Block Nodal Agency and for Sidli block, **the ant**, which is the District Nodal Agency, decided to take **BLES - Bodoland Life Establishment Society** (as the organization has been working on Rights since long) for Sidli Block as Block Nodal Agency. All these were started by the organization, without going in to any sorts of formal agreement with the State Nodal Agency “**VHAA**”. **15 villages** each from the two identified blocks were taken,

where the community monitoring activities would be implemented. Since, ~~the ant~~ did not receive any formal approval and budgetary limit from VHAA, so, **only one District Coordinator and two Block Coordinators** were selected.

Formation of VHSC:

To begin the real field level activities, it was decided that the volunteers of the two organizations **would go and stay in the identified villages** and would hold “**Chinaki Meetings** (introducing meeting) with the villagers so as to develop rapport. During their stay at village, they could learn that out of the 30 villages, many of the villages have their VHSC and for very few (only 8 in Sidli block) VH & SCs were formed by the identified Block Nodal agency. After the village level introductory meeting, the Village Health Services Profile, Health Facility level (SC, SD, MPHC, PHC) Score Card was also prepared through village meeting, interaction with the health service providers etc. Even before receiving the formal approval, ~~the ant~~ started field level activities but only in Jan’08, the organization could officially get information from VHAA that the project is on and expenditure of the activities done after that can only be booked.

Committee Formation:

Thereafter, the organization conducted “**District Workshop**” at the conference hall of the Deputy Commissioner, Chirang on 10th March’08. After the preparatory meeting, the District had no any meeting and the **District Planning and community Monitoring Committee** also could not be formed. The absence of the district level committee had brought adverse impact on the entire performances of the community monitoring. The **Block Facilitators** of the two blocks were trained during **11th – 12th March’08 and 7th – 10th April’08** at Udangshri Dera, Rowmari. The State Dispensary level Planning & Community Monitoring Committees are also formed and were given orientation for two days during June – July’08 in different venues. **The PHC level Planning & Community Monitoring Committees are also formed for both the PHCs** but only the members of the Ballamguri PHC Planning & Community Monitoring Committee are trained in June – July’08 and for Sidli PHC, it is yet to be conducted. **The members of the VH & SC (which is village level community monitoring committee) were given orientation** by the block facilitators in phases for three days during May – June’08. All these committees were formed as per the national guideline. **The organization did not wait for the guideline to be issued by the state. Since, the national training module was not available with the organization, so the organization could not use the national module. Need based training module was used for training all the cadres of different committees. The training modules as prepared by the District Nodal NGO could not be seen as copies were not provided to us during our visit to the organization. It**

was revealed during discussion that the main thrust was on generating awareness among participants regarding their health entitlements, what to do in case of denial of health services, monitoring the functioning of the health services, supporting field level health staffs etc. The dates of the training imparted to different committees are annexed as **annexure – V**.

Report Card Preparation:

Report Card was prepared after the formation and reformation of VHSC and in VHSC meetings. Then the orientation of VHSC members were organized on the issues of community monitoring by the ANT. The district, the block level NGO workers and the field workers from various villages organized VHSC meetings where the village report cards were filled up. The ANT and the block facilitators also visited the related PHCs for the proposed facility survey activities. The block facilitators and the VHSC members were trained about the Report Card preparation process. So, they could not find difficulties in preparing the report cards. The sample of report cards preparation by the district Nodal NGOs is annexed as annexure for further details.

Media workshop:

On 17th July08, a **district media workshop was organized at Kanisko Hotel**, Bongaigaon for the media personnel. All total, representatives from 21 media house attended the workshop. The workshop dealt in detail about the roles, which could be played to generate awareness among masses regarding health rights, action to be taken in case denial of health rights, responsibilities of the community members in supporting health service providers in ensuring quality health care and most importantly reporting health service related news with responsibility.

Jan Sam wad (public dialogue):

Since, as per the terms of reference (**ToR**) the pilot phase was up to only 31st Aug'08, so the organization decided to have at least **one public dialogue (Jan Sambad)** in each of the six dispensaries (PHC in national terms) and **two public dialogue** in two Block PHC area by 31st August'08. Accordingly, the organization had **8** (eight) public dialogue.

The dates of the **Jan Sambad** and venue are mentioned below.

Block	Venue	Date	Participants
Borobazar	Amteka Community Hall	25 th Aug'08	Male: 120, Female: 130
	Subhajibhar playground	28 th Aug'08	Male: 80, Female: 210
	Makra Patkiguri	21 st Aug'08	Male: 120, Female: 140
	Ballamguri Market	11 th Sept'08	Male: 170, Female: 200

Sidli	Shantipur open field	22 nd Aug'08	Male: 110, Female: 145
	Ranchidham ME School	02 nd Sept'08	Male: 57 Female: 196
	Bengtol State Dispensary	10 th Sept'08	Male: 45, Female: 100
	Sidli Community Hall	12 th Sept'08	Male: 55, Female: 65

Community Monitoring at Chirang Dist: Field Research methodology & findings:

Nizlaguri Sub Centre at Nizlaguri village under Sidli Block PHC:

During field visit to this sub centre and following the interaction with the villagers, it was revealed that the members of the VH & SC are trained on community monitoring for 3 days and the sub centre has opened bank account at State Bank of India. The VH & SC has 12 members (4 female + 8 male). The members of the Block Nodal Agency gave the orientation. The ANM & ASHA has also attended the training but ANM attended only for 1 day. During the training, no hard copy reading materials were supplied. Regarding the contents of the orientation, few of the trained persons told that the orientation was more on generating discussions regarding health rights, monitoring of the health facilities, what to do in case of denial of health rights etc. How best the community can play an active role in mitigating the gap between the health service providers and service seekers was found missing. The ANM / ASHA could hardly recall the contents of the orientation. The orientation also did not specify the measurable indicators so as to understand that the impact of the community monitoring initiatives by both the service providers as well as service seekers. The VH & SC president told that although the SC has been functioning in a rented house but the ANM was doing delivery at this SC but under NRHM, she is asked not to do delivery at the present SC and thus the villagers have started preferring home delivery as the functioning health facility, which has got community's faith is located at far. The VH & SC also did not receive fund till date but the President of the VH & SC knows that the VH & SC has got entitlement of Rs. 10,000/-. The SC has received untied fund and many need based items have been procured with this fund. The Block Programme Manager (**BPM**) bought all the items as the amount was deposited in a bank, which was jointly operated by BPM and ANM. ASHA has got training for 23 days and she has escorted 138 deliveries since Aug'06 to till date, as reported. Out of total deliveries, 4 children died within 45 days of birth and in the VH & SC meeting, it was never discussed so as to find out the root cause of the death.

The meeting of the VH & SC is also not very regular but villagers said that ASHA is active as she is seen visiting households every now and then. The register of ASHA shows that on 26/4/07, 23/12/07, 12/6/08, 11/8/08, the VH & SC had meeting to discuss regarding ASHA

selection, discussion on community monitoring, filling up of village health report card and orientation of VH & SC members respectively. The villagers also attended the recent “**Jan Samvad**” organized by the District Nodal Agency. The SC immunization day is Wednesday and on that day the VH & ND takes place, as reported. The documentation of activities done needs improvement. ASHA informed that since Aug’08, mothers, who delivered at hospital, are yet to get fund and the ASHA incentive is stopped since April’08. The population, projected in the village health service profile, is found wrong as the villagers said that the village has 300+ households but in the report only 165 households were shown. Filling up of the village health service profile should have been made more participatory to get more accurate data of village.

Issues found during the field visit at the SC village:

- VH & SC fund not released; Mothers and ASHAs are not enjoying JSY fund for long;
- Villagers need more clarity regarding purpose, concept and aim of community monitoring;
- More regular holding of VH & SC meeting and village of issues of concerns are to be discussed;
- District / block health service providers support to address the burning issues is not encouraging;
- ANM to work in close tandem with ASHA so as to further enhance the institutional delivery;
- Record keeping of the ANM as well as ASHA needs much improvement to reflect their activities;
- Renovation of SC has to be taken up on priority;

Thangabari Sub Centre at Thangabari village under Ballamguri PHC under Borobazar block:

While visiting the SC, it was seen that ASHA, ANM all were waiting to start the immunization and few of the beneficiaries also came. The community organizers engaged by the unit were also present at the venue. The SC has got 2 ANMs, one was on leave. The SC has opened bank account for the Thangabari village has VH & SC. To open the bank account, ASHA paid Rs. 500/- from her own pocket but she is yet to get her money as the VH & SC is yet to get the VH & SC fund. All the members of the VH & SC are trained on community monitoring processes. While sharing about the inputs given during the training, few of the members, who attended training, told that the most of the inputs were given regarding *health rights, supervision and monitoring of the health facilities, actions to be taken in case of denial of health rights, what community could do to ensure that such health rights are not violated etc.* It seems that the orientation was given more focusing the rights of the citizens and monitoring the actions of the health service providers. Even though, the ANM and ASHA attended the orientation, as told by them but they could hardly recall about the contents of the workshop. The orientation also did

not specify the measurable indicators to understand the impact of the community monitoring initiatives by both the service providers as well as service seekers. While looking at the ASHA register, it was seen that the ASHA has been conducting monthly meeting but all these meeting were conducted on health day. Since, 21/6/07, the VH & SC has 15 meetings and the last meeting was on 19/11/08. The regular holding of the VH & SC meeting of the village needs appreciation, only more support needs to be given so that the discussion of the VH & SC becomes more fruitful. Since, April'08, ASHA did not receive any incentive and 2 mothers also yet to receive fund even though they had institutional delivery. Out of the deliveries, which were escorted by the ASHA, 2 infants were died. The reasons of death are not known to ASHA. The Thangabari SC comes under Subhajibhar SD. While sharing with the villagers regarding the service aspect of the ANM of the SC, SD, ASHA, they were of the view that ASHA has been performing to the entire satisfaction of the villagers, ANM also supports her but the villagers had serious allegations against the doctor, who is posted at Subhajibhar SD. While citing an example of denial of health rights, one villager told that on 17/12/08, at 3 a.m., one mother was escorted by ASHA with severe labour pain and the doctor of the Subhajibhar SD did not even bother to have a look at her and the case was referred at the Ballamguri PHC. The villager said with this worst degree of denial of health rights, what best out put can be expected out of the entire community monitoring processes. So, he urged that once such worst form of denial of health rights are reported to the higher authority then immediate action should be taken so as to stop further occurrence of such event, otherwise people will loose confidence of the system and situation will become further worse, which may even cause social instability. The villagers also attended the recent "Jan Samvad" organized by the District Nodal Agency. "In the "Jan Samvad", lots of hope regarding the guaranteed health services were given but when the case of worst form of denial of health rights is seen (as it happened in case of a mother, who was with labour pain but was not seen) then all hopes go in vain and we get highly de-motivated", as said by the President of the VH & SC. Such concern needs to be addressed on priority.

Issues found during the field visit at the SC village:

- VH & SC fund not released; Mothers and ASHAs are not enjoying JSY fund for long;
- Villagers need clarity regarding purpose, concept and aim of community monitoring;
- The strength of holding of VH & SC meeting has to be derived out through extending support by the support organization. Setting up of few indicators to assess the

effectiveness of VH & SC may be found of immense help. In the VH & SC meeting, major issues of concern & the means of overcoming those concerns can be discussed;

- District / block health service providers support to address the burning issues is not encouraging;
- ANM to work in close tandem with ASHA to further enhance the institutional delivery;
- Record keeping of the ANM needs much improvement to reflect her activities;
- The doctor of the Subhajibhar SD has to give a patient hearing of the villagers problem and if he has got serious problem, the same can be shared with the villagers so that villagers can create pressure on authority to address his problem. This initiative would bring respect for each other.

Ballamguri PHC under Borobazar block:

During visit to the PHC, the Medical Officer could not be met, as he was at District HQ attending workshop on District Health Action Plan (**DHAP**). The Block Programme Manager (**BPM**) has resigned and the Block Accounts Manager (**BAM**) has been looking after the activities of the Block Programme Manager, but unfortunately, the BAM has been found blank, who does not know much about other activities except his accounts job. While discussing with many staffs, it was revealed that the PHC planning and community monitoring committee is constituted on 8th Aug'08. The meeting of the constitution of the committee held at Bijni Town Hall. It was also known that the members are trained but none of the staffs could recall the contents of the training. Even, the BAM informed that he attended the training of service provider for one hour as he was busy with other assignments. Many ASHAs were met at the PHC and while sharing with them, it was known that ASHAS did not get JSY incentive since April'08 and the mothers, who are delivering at the facility, are also not getting the incentive since Oct'08. All the ASHAs have opened their bank account but none of them have received the VH & SC grant. The hospital has hospital management society (**HMS**), which had only three meetings on 6th July'06, 15th July'07 and 5th April'08. So, the frequency of the HMS meeting is too less and to make the hospital functioning, holding of regular HMS meeting has to be ensured at a fixed interval.

Issues found during the field visit at Ballamguri PHC under Borobazar block:

- The committee members of the PHC planning and community monitoring committee need more clarity regarding purpose, concept and aim of community monitoring;
- Mothers and ASHAs are not enjoying JSY fund for long;

- The meeting of the HMS has to be more frequent in a fixed interval of time gap. Actions on the resolutions of the meeting has to be taken to make the PHC more responsive;
- The PHC planning and community monitoring committee meeting has to analyze the report of the village health profile, facility score card and actions are to be taken;
- The Block Nodal Agency has to ensure that each of the activity planned for the PHC goes well and the activities performed and the result of each activity has to be recorded properly so that more corrective steps can be taken for improvement;
- The District Nodal Agency also needs to record the events of the PHC regarding the community processes and the same to be shared with the district so as to required support for improvement;

Sidli PHC under Sidli block:

During visit to the PHC, the Medical Officer on duty could not be met, as he left office half an hour of his scheduled departure. No Medical Officer was seen at the PHC, only pharmacist was seen. Since absence of the Medical Officer, no concrete information could be revealed regarding the community monitoring initiatives taken at the PHC. The discussion with the health staffs, who were found over there, could reveal that the staffs of the Block Nodal Agency are seen at the PHC but why do they make visit at the facility is not known to them. The report of the District Nodal Agency says that the PHC Planning and community monitoring committee is formed but no orientation could be given so far to the members.

Issues found during the field visit at Sidli PHC under Sidli block:

- The PHC planning and community monitoring committee members are to be trained soon on purpose, concept and aim of community monitoring;
- Mothers and ASHAs are not enjoying JSY fund for long;
- The BPM has to take more proactive role in addressing all these problems regarding effective functioning of the community monitoring initiatives;
- The Block Nodal Agency has to ensure that each of the activity planned for the PHC goes well and the activities performed and the result of each activity has to be recorded properly so that more corrective steps can be taken for improvement;
- The District Nodal Agency needs to record the events of the PHC regarding the community processes and the same to be shared with the district so as to required support for improvement;
- If any PHC specific problem is found, which is creating problem for carrying out community monitoring initiatives then it is to be brought at district level for immediate reprisal;

Discussion with the Joint Director of Health Services, Chirang

The discussion with the Joint Director of Health Services, Chirang reveals that the Joint Director of Health Services could not understand the purpose, concept and aim of community monitoring, even though he was trained at the state level by the State Nodal Agency. He thought that the implementing the activity is the job of the District Nodal Agency and he has very little role to play. The good part about him was that he attended few “**jan sambad**”, held at different places. He told that he needs to look after many activities in the district on day to day basis, which are of prime importance, so he does not get much time to look after the community monitoring initiatives. He asked the District Programme Manager and the District Media Expert to take the job of the community monitoring more seriously so that in days to come, the performances can further be improved. He was found happy regarding the initiatives of the District Nodal Agency as well as the initiatives of the Block Nodal Agency. The District planning and community monitoring committee, which could not be formed is another major cause of not being able to implement the community monitoring initiatives in the identified areas, he observed.

Discussion with the Dr. Pradeep Narzary, member of the District Mentoring Team:

Dr. Pradeep Narzary (*a dedicated only doctor working at Crafts Memorial Hospital*), who is a member of the district mentoring team said that only once, all the members met at the conference hall of the deputy commissioner, Chirang and thereafter no meeting held regarding community monitoring. He said that he is ready to effectively contribute to make the community monitoring initiatives a reality, but for that he needs orientation so that he understands the purpose, concept and aim of community monitoring. The way, he has been single handedly managing the show of the Crafts Memorial Hospital needs to be appreciated.

f. Programme Management:

- **Capacity Building:**

The organization conducted “**District Workshop**” at the conference hall of the Deputy Commissioner, Chirang on 10th March’08. **Block Facilitators** of the two blocks were trained during **11th – 12th March’08 and 7th – 10th April’08** at Udangshri Dera, Rowmari. The State Dispensary level Planning & Community Monitoring Committees are also formed and were given orientation for two days during June – July’08 in different venues. The PHC level Planning & Community Monitoring Committees are also formed for both the PHCs but only the members of the Ballamguri PHC Planning & Community Monitoring Committee are trained in June –

July'08 and for Sidli PHC, it is yet to be conducted. The members of the VH & SC (which is village level community monitoring committee) were given orientation by the block facilitators in phases for three days during May – June'08. All these committees were formed as per the national guideline. The details of the formation and orientation of the committees are as follows:

Formation of District Mentoring Team for Community Monitoring:

The district of Chirang has constituted district mentoring team for community monitoring with the following members. The team had only meeting once on 10th March'08 at the conference hall of Deputy Commissioner, Chirang. The members of the committee are annexed as **annexure – VI**.

Formation of the District Planning & Community Monitoring Committee:

This committee is yet to be constituted in the district.

Formation of the PHC Planning & Community Monitoring Committee:

The PHC planning & community monitoring committee has been formed in both the PHCs (Sidli & Ballamguri) under Chirang district.

Orientation of the PHC Planning & Community Monitoring Committee:

Out of the two PHCs (Sidli & Ballamguri), in Ballamguri PHC, the members are oriented but the members of the Sidli PHC are yet to be oriented.

Formation of State Dispensary / Mini PHC level planning & community monitoring Committee:

In all the identified SDs / MPHCs, under both the PHCs, the planning and community monitoring committee have been formed.

Orientation of State Dispensary / Mini PHC level planning & community monitoring Committee members:

In all the identified SDs / MPHCs, under both the PHCs, the members of the planning and community monitoring committee have been oriented on community monitoring aspects.

Formation of village planning and community monitoring committee (VH & SC):

In all the 30 villages, this committee is in existence. The Block Nodal Agency had to form only 8 committees under Sidli PHC and rest VH & SCs were constituted before initiation of community monitoring activities in the district.

Orientation of village planning and community monitoring committee (VH & SC):

In the 30 villages, the members of this committee are trained on community monitoring aspects.

- **HR/Staffing Issues:**

No issues came up about HR in the review process as the NGO has its overall presence in the whole district with public support. The documentation is found as a gray area, where the organization needs to improve.

- **Monitoring of the Programme:**

The monitoring support from the state as well as from the state Nodal NGO was less. The officials of the District Health Services also hardly monitor the performances of the District Nodal NGO. While discussion it was revealed that guidelines or the TOR for the community monitoring process was changed several times, which created confusion during implementation. Moreover, the time was quite short for the implementation of the programme and during the peak hours (in the month of June – July) of the program implementation, most of the areas under community monitoring were inaccessible because of flood.

- **Budget & Finances:**

The budgets of the finances were an issue as the ANT did receive funds after January 2008, where as the organization started work in early Nov'07. The organization did not wait for the fund to come and then to start the work. Even, the organization could not book the expenditure of the activities, which they did before Jan'08, as told by VHAA to the NGO.

g. Relation to other communitization process:

h. Potential Outcomes of Community Monitoring at Chirang:

1. Community monitoring processes have started empowering people, which is revealed during the field visit. People have started speaking out what they are liking and what not;
2. The District Nodal Agency took up series of steps for effective functioning of the community monitoring initiatives but in absence of the expected support of the service providers, it failed to deliver the expected result of the community monitoring;
3. Because of the initiatives taken up by the District as well as Block Nodal Agency, the people have been made aware about their health rights, what to do in case of denial of health rights, but if community is also equally made aware about how best they could cooperate with the health service providers then the impact of the community monitoring initiatives would be more. This will also result mutual trust for each other;
4. It seems that for the district and block health authorities, community monitoring was seen as the job of the District Nodal Agency & Block Nodal Agency, where the district / block health authority has little to do. This thinking needs to be changed;
5. Paucity of time was also another factor, which has affected the overall performances;
6. The District Nodal Agency has to develop appropriate need based quality training module in consultation with the State Nodal Agency and a copy of the same has to be kept;
7. Funding pattern to the District Nodal Agency demands streamlining. The booking of different activities under different heads and the money allocated in the respective head has to be more rationale so that booking of activity can be done without much hassle.
8. The District Nodal Agency started on community monitoring even much before the formal approval letter is given by the State Nodal Agency. So, at the initial phase of the program initiation by the District Nodal Agency, the support from State Nodal Agency was missing;
9. More close support by the State Nodal Agency could have improved the quality of the community monitoring initiatives in the district;
10. Record keeping of the different activities of the District Nodal Agency needs improvement;
11. The District Nodal Agency needs to train the functionaries of the Block Nodal Agencies regarding proper documentation of the activities;
12. The District Nodal Agency may see community monitoring as a balanced mixture of the rights based activity as well as making community more responsive towards extending their best support to the service providers so that the gap between the parties is bridged;
13. The authority of the District Health Services has to own the program and to take more active steps. Leaving the implementation to District Nodal Agency will not be of any help;
14. Regular holding of meeting of the different committees has to be ensured for better result;

j. Recommendations for scaling up (Chirang experience):

- The community monitoring has ensured a new beginning as far as generating awareness among masses regarding the health rights, what to do in case the health rights are violated etc;
- More time has to be given, minimum 12 months for a particular phase;
- Funding pattern needs streamlining;
- The Quality of training needs improvement in terms of more post training follow up support for the trained persons;
- The State Nodal Agency has to work more in close coordination with the District / Block Nodal organizations;
- The frequency of holding the regular meeting of all committees has to be ensured. The agenda of such meeting has to be responsiveness to the practical need of that time;
- Few well spell out indicators need to be set at all levels of committees so as to see the impact of the intervention in owning the program and also in reducing the gap between service provider as well as service seekers;
- Exposure visit for the state level / district level mentors may be organized so that they can learn and have see chances of replication of such good practices;

Annexure - I

Government Representation:

- | | |
|--|----------|
| 1. Mission Director, NRHM, GoA | Chairman |
| 2. NGO Co-ordinator, NRHM, GoA | Convenor |
| 3. Regional Director, MoHFW, Gol, | Member |
| 4. Director, RRC-NE | Member |
| 5. Director of Health Services, GoA | Member |
| 6. Director of Family Welfare, GoA | Member |
| 7. Director of Panchayati Raj Rural Development, GoA | Member |
| 8. Director of Social welfare, GoA | Member |

Civil Society Organization Representation:

- | | |
|------------------------------------|------------------|
| 1. Ms. Ruchira Neog, Co-Convenor | Project Director |
| 2. Dr. Narendra Gupta, AGCA member | Member |
| 3. Dr. C. Kakoty, NESPYM | Member |
| 4. Dr. D Borkokoty, SRC | Member |
| 5. Dr. Sunil Kaul, The ANT | Member |
| 6. Fr. George Parakkal, NECHA | Member |
| 7. Mr. Ravindranath, RVC | Member |
| 8. Mr. Tapan Sarma, GVS | Member |
| 9. Ms. Ananya Goswami, CRS | Member |
| 10. Ms. Arunita Pathak, NEN | Member |

State, District & Block Nodal NGOs:

Name of the SNO	Address	Contact person
Voluntary Health Association of Assam (VHAA)	East Jyoti Nagar, Guwahati College Road P.O. Bamuni Maidan, Guwahati-21, Assam Phone: 0361-2656785 Email: neog.ruchira@gmail.com , jbarua@gmail.com Website: www.vhaofassam.org	Ms. Ruchira Neog

Name of the DNO	Address	Contact person
Chirang	The Action Northeast Trust (The ANT) Udangshri Dera, Village Rowmari P.O.Khagrabari, Distt Chirang via Bongaigaon BTAD, Assam-783380 Phone: 03664 - 294212/294043 Email: antnortheast@gmail.com	Dr. Sunil Kaul
Dhemaji	Rural Volunteers Services (RVC) Village & P.O.Akajan Via Silapathar, District Dhemaji-787059 Phone: 9435089275/9954957342 Email: ruralvolunteerscentre@yahoo.co.in , ruralvolunteerscentre@gmail.com	Mr. Ravindranath
Kamrup Rural	Guwahati Gana Sewa Society (GGSS) Peace Centre, GNB Road Ambari, Guwahati-781001 Phone: 9435146903 , 0361-2600908, 2630161 Email: abhggss@yahoo.com , baraprakash@rediffmail.com	Mr. Prakash Bara

District	Block	Block Nodal NGO	Contact person
Chirang	Sidli	Bodoland Life establishment Club c/o The BLES Secretary H.O.+ P.O. Basugaon, P/S Basugaon Distt Chirang, BTAD Assam Phone: 9864817541 (Rwmwi)	Rwmwi Rwmwi Basumatary
	Borobazar	The Action Northeast Trust (The ANT) Udangshri Dera, Village Rowmari P.O.Khagrabari, Distt Chirang via Bongaigaon, BTAD Assam-783380, Phone: 03664- 294212/294043 Email: antnortheast@gmail.com	Dr. Sunil Kaul

Dhemaji	Jonai	North Star Club Village M, P.O. Jonai, Dhemaji- 787060, Phone: 9864996484 Email: krishnachetry@rediffmail.com	Mr. Krishna Chetry Mr. Rajib Pegu (Chief Functionary)
	Sissiborgaon	The ACT Village Jyoti nagar, Near Silapathar Commerce college P.O. Silapathar, District Dhemaji, Assam. Phone: 9954636718	Mr. Bidiya Chetia, Ms. Swarnalata Sangmai
	Bordoloni	Socio Economic Development Organisation (SEDO) Village Kuwaphala, P.O. Dhemaji, Dhemaji, Assam, Phone: 9954832170 Email: sedodhemaji@rediffmail.com	Mr. Nava Dutta
	Dhemaji	Amateur Village Kulamua, P.O. Silapathar Dhemaji, Assam Email: dhanbahadursonar@rediffmail.com	Mr. Dhan Bahadur Sonar
Kamrup Rural	Rangia	Fatima Development Centre Kroot Niwas, P.B. No.2 Rangia Cantonment, Kamrup, Assam- 781354, Phone: 03621-242376 Email: krootniwas@sify.com	Sr. Jancy K. D.
	Kamalpur	Rural Women's Development Society (RWDS), Borka, P.O. Pub-Borka, Kamrup, Assam-781127	Ms. Bonolata Baishya
	Boko	Prayas Nagarbera, District Kamrup Assam- 781127, Phone: 9854591277	Mr. Anwar Hussain

Annexure – II

Sl. No.	Member	Designation	Representative (Govt. / CSO)
1.	Ms Keya Bordoloi		NEN, Guwahati
2.	Dr. Sunil Kaul		The ANT, Chirang
3.	Mr. Prakash Bara		GGSS
4.	Mr. Zahir Abbas	State NGO Coordinator	Govt.
5.	Ms. Jyotika Baruah	Training Coordinator	VHAA
6.	Ms. Ruchira Neog	Executive Secretary	VHAA

Annexure – III

Sl. No.	Member	Designation	Representative (Govt. / CSO)
1.	Mr. Ravindranath		RVC, Dhemaji
2.	Dr. Sunil Kaul		The ANT, Chirang
3.	Dr. Chiranjeev Kakoty		NESP YM
4.	Mr. Zahir Abbas	State NGO Coordinator	Govt.
5.	Ms. Jyotika Baruah	Training Coordinator	VHAA
6.	Ms. Ruchira Neog	Executive Secretary	VHAA

Annexure – IV

Sl. No.	Member	Designation
1.	Dr. P. J. Gogoi	RD, MoHFW, Gol
2.	Dr. Motilal Nunisa	Director, FW, GoA
3.	Dr. Narendra Gupta	AGCA member
4.	Ms. Ruth Vivek	AGCA member
5.	Ms. Sudipata Mukhopadhaya	AGCA member
6.	Dr. Joydeep Das	SF, Assam
7.	Mr. Zahir Abbas Mazumder	State NGO Coordinator
8.	Ms. Ruchira Neog	Executive Secretary, VHAA
9.	Ms. Sikha Borthakur	BCC Expert, NRHM, Assam
10.	Ms. Jyotika Baruah	VHAA representative
11.	Mr. Ravindranath	Director, RVC, Dhemaji
12.	Mr. Prakash Bara	Coordinator, GGSS
13.	Mrs. Alka Bhattacharjee	NESPYM
14.	Ms. Anurita P. Hazarika	Northeast Network
15.	Mr. Tapan Kr. Sharma	GVS, Assam

Annexure --- V

Under Borobazar Block		
VH & SC training under Amteka SD		
Date	Venue	Total members
23 rd – 24 th May'08	Amteka Community Hall	Male: 20, Female: 20
VH & SC training under Subhaijhar SD		
Date	Venue	Total members
9 th – 10 th May'08	Subhaijhar Community Hall	Male: 15, Female: 20
VH & SC training under Makra Patkiguri MPHC		
Date	Venue	Total members
7 th – 9 th June'08	Boro Laogao Community Hall	Male: 15, Female: 30
Under Sidli Block		
VH & SC training under Shantipur SD		
Date	Venue	Total members
14 th – 16 th May'08	Shantipur L. P. School	Male: 25, Female: 30
VH & SC training under Bengtol SD		
Date	Venue	Total members
3 rd – 5 th June'08	Bengtol CHC meeting hall	Male: 15, Female: 30
VH & SC training under Ranchaidham SD		
Date	Venue	Total members
27 th – 28 th April'08	Ranchaidham ABSU meeting hall	Male: 15, Female: 25
Formation of SD / MPHC level planning and community monitoring committee under Borobazar Block		
Amteka SD		
Date	Venue	Total members
10 th July'08	Amteka Community Hall	19 (PRI – 7, MO / ANM – 1)
Subhaijhar SD		
Date	Venue	Total members
22 nd June'08	Subhaijhar ABSU unit office	16 (PRI – 7, MO / ANM – 2, VH & SC – 5, CSO - 2)
Makra Patkiguri MPHC		
Date	Venue	Total members
23 rd July'08	Makra Patkiguri Community Hall	20 (PRI – 7, MO / ANM – 3 VH & SC – 5, CSO – 5)

Formation of SD / MPHC level planning and community monitoring committee under Sidli Block		
Shantipur SD		
Date	Venue	Total members
18 th June'08	Shantipur L.P. School	21 (PRI – 5, MO / ANM – 6 VH & SC – 5, CSO – 6)
Bengtol SD		
Date	Venue	Total members
16 th July'08	Bengtol Community Hall	18 (PRI – 6, MO / ANM – 4 VH & SC – 5, CSO – 3)
Ranchaidam SD		
Date	Venue	Total members
17 th June'08	Ranchaidam SD	16 (PRI – 7, MO / ANM – 2 VH & SC – 5, CSO – 2)
Orientation of SD / MPHC level planning and community monitoring committee members under Borobazar Block		
Amteka SD		
Date	Venue	Total members
10 th – 11 th July'08	Amteka Community Hall	Male: 10, Female: 20
Subhaijhar SD		
Date	Venue	Total members
22 nd – 23 rd June'08	Subhaijhar community hall	Male: 10, Female: 15
Makra Patkiguri MPHC		
Date	Venue	Total members
23 rd – 24 th July'08	Makra Patkiguri community hall	Male: 15, Female: 15
Orientation of SD / MPHC level planning and community monitoring committee members under Borobazar Block		
Shantipur SD		
Date	Venue	Total members
5 th – 6 th July'08	Shantipur L.P. School	Male: 10, Female: 15
Bengtol SD		
Date	Venue	Total members
29 th – 30 th July'08	Bengtol Community Hall	Male: 16, Female: 10
Ranchaidam SD		
Date	Venue	Total members
28 th – 29 th June'08	Basugaon Town meeting Hall	Male: 15, Female: 10

Formation of Block Planning & Community monitoring committee under Borobazar Block		
Ballamguri PHC		
Date	Venue	Total members
8 th Aug'08	Bijni Town Hall	21
Formation of Block Planning & Community monitoring committee under Sidli Block		
Sidli PHC		
Date	Venue	Total members
8 th Aug'08	Sidli Block PHC	23
Orientation of Block Planning & Community monitoring committee under Borobazar Block		
Ballamguri PHC		
Date	Venue	Total members
8 th Aug'08	Bijni Town Hall	21
Orientation of Block Planning & Community monitoring committee under Sidli Block		
Sidli PHC: orientation not done.		

Annexure – VI

Sl. No.	Member	Designation	Representative (Govt. / CSO)
1.	Deputy Commissioner	Chairman	Govt.
2.	Joint Director of Health Services, Chirang	Convenor	Govt.
3.	Chief Executive Officer, Zila Parishad	Member	Govt.
4.	District Programme Manager, NRHM	Member	Govt.
5.	Project Director, DRDA	Member	Govt.
6.	District Elementary Education Officer	Member	Govt.
7.	Superintendent (Food & Civil Supplies)	Member	Govt.
8.	Executive Engineer, PHE	Member	Govt.
9.	District Social Welfare Officer	Member	Govt.
10.	Dr. Sunil Kaul, Director, The ANT	Member	Civil Society Orgn.
11.	Dr. Pradeep Narzary, Crafts Memorial Hospital	Member	Civil Society Orgn.
12.	Fr. Selvaraj Ignatus, Director, BGSS	Member	Civil Society Orgn.
13.	Mrs. Bharati Barman, Secy, ASHA Association	Member	Civil Society Orgn.

Report of Review of Community Monitoring Pilot Chattisgarh

Community based monitoring was initiated in Chattisgarh state with the beginning of Mitani programme by 'Adiwasi Adhikar Samiti' under the guidance of Dr. T. Sundararaman, Executive Director, NHSRC. The local Community based organisations, Self Help Group (SHG) and NGOs felt the need of a proper monitoring of a welfare services provided to the people. National Rural Health Mission has provided an opportunity and mandate to the state to start community based monitoring for strengthening the community process in Health services under National Rural Health Mission.

As per guidelines of National Rural Health Mission(NRHM) Community Monitoring Pilot has been initiated in 9 states of the country for which Population Foundation of India took the lead and 'Advisory Group for Community Action' (AGCA) has been formed in each state. In Chattisgarh, the 'Community Based Monitoring' (CBM) process has started little later as they have received fund in Mid 2008. In this context a meeting of Civil Society organisations was held on 6th July, 2007 in which the nodal person from 'Population Foundation of India' briefed the NGOs representative, state health personnel about the CBM process and purpose of pilot project. This was followed by organising state level orientation workshop on 16-17th August 2007 in which 40 representative participated from different civil society organizations, state health officials including District programme manager, Chief Medical and Health Officer (CMHO) etc. With the outcome of state level orientation workshop Department of Health and Family Welfare, Government of Chhattisgarh constituted State level CBM Mentoring Group on 20th August, 2007 vide letter No 10106.

Methodology of Review:

Review of CBM was an attempt to strengthening the health services of the country under NRHM. Three district i.e. Kawardha(Kabeerdham), Bastar and Koriya were selected for pilot of CBM as per guidelines provided under NRHM. Similarly as per guidelines for review team for CBM Pilot, Koriya is middle performing district in Chhattisgarh out of these three districts of state. Similarly, methodology was followed in selection of block and PHCs and sub-centre village of each PHCs. For the purpose Manendragarh block was selected in Koriya district and Kelhari PHCs of this block was selected as good in performance and Biharpur PHC was selected as poor in performance of the district. The health personnel was not available in sub centre therefore Bara Bahera village under Biharpur PHC was selected for knowing the community and

Mitanin Perception and their role on CBM. Similarly under Kelhari PHC, Dihuli sub center was chosen for the purpose.

The Convener of Mentoring group was approached and the visit to the state for review of the CBM was finalized. The meeting and interview was finalized with state officials, NGO representatives, Service provider and Community. Interview, Focus group discussion and visit to concerned Department, PHCs, Sub Health Centre and village were followed for the review.

Institutional Mechanism

Under the National Rural Health Mission, the department of Health and Family Welfare formed the state level body for facilitating community level monitoring according to guidelines issued by AGCA, NRHM, Government of India through the office order No.1106 dated 20th August 2007. This order also empower the collector to finalize the district, Blocks-PHCs level monitoring committee in consultation with the Chief Medical and Health officer, concerned department and NGO mentoring group as per guidelines. The structure of state body consisted of 21 members in which 10 representing from state officials, 9 members including convener of Civil Society Organisations and two members from Population Foundation of India represented as the permanent invitees of AGCA. A consortium of NGOs has been formed to perform as the State Nodal NGO, so as to facilitate wider participation in Pilot process of Community Monitoring at state level. This consortium comprised of 'Chhattisgarh Voluntary Health Association', 'Population Foundation of India- Regional Resource Center' and 'Sandhan Sansthan'. The Secretary of 'Sansadhan Sansthan' Shri D.N.Sharma was designated as convener.

The following organizations represent the Civil Society in this Group :

- State Health Resource Centre, Raipur
- Jan Swasthya Abhiyan, CG, Koriya
- Sankalp Sanskritik Samiti, Raipur
- Help-NGO, Raipur
- Sahayata, Raipur
- Chattisgarh (CG) Voluntary Health Association, Raipur

- Sandhan Sansthan, Durg
- Jan Swasthya Sahyog, Bilaspur
- Ramkrishna Mission, Narayanpur

District level Support Team

As per decision taken during the state level meeting of District Programme Manager, all collector were requested to form 15 members committee with the consent of 'Chief Medical and Health officer' and nodal NGOs for Community monitoring that comprises of Chairman of Health sub-committee of District Board as a Chairman, 'Chief Medical Officer' as working chairman, 4 members of District Board as a member, 3 members from Block NGOs or organization working for health rights, 2 Non-Governmental members from Block Monitoring Committee and 1 member from 'Rogi Kalyan Samiti' of District Hospital.

Block level support team

The member of 'Block Monitoring Committee' comprises of Chairman of Janpad Panchayat as Chairman of CBM, Sector Medical officer as Working chairman, 4 members from Janpad Panchayat –one women member (if possible), 3 – 4 members from Government officials (Chief Executive officer from Block, Medical officer from selected PHCs, Project officer –ICDS), 3 members from Block NGOs or organizations working for health rights, 2 Non-governmental members from PHC level Monitoring committee and representative from 'Rogi Kalyan Samiti' from Community Health Center.

PHC Level Support Team

The members of PHCs level committee comprises of Member of Block Panchayat as a Chairman, Sector Medical officer as working chairman, 5 members from Janpad Panchayat in which out of five three are Sarpanch and two members from Panchayat (One must be women),

3-4 members from Governmental sector (Specially Medical officer, sector supervisor-ICDS), 3 members from Block NGOs and organizations working on Health Rights and 3 non-governmental members from Village Health and Sanitation Committee.

Village Health and Sanitation Committee

This committee comprises of 15 members. The member of health sub-committee of Panchayat is chairman of the committee. Selection has been made as per guidelines provided in NRHM. The Secretary of Panchayat is the secretary of this committee. The selected Mitanin of village is convener and member are from Self Help Groups, Women’s Health Committee, Youth Committee, chairman of civil society of village, panchayat members of all ward of village, ANM, Co-ordinator of Rashaan shop(if it is their) or members from Self Help Group, recognized MBBS or BMS Doctors and Mitanin Master Trainer.

Process : Selection of Project Area

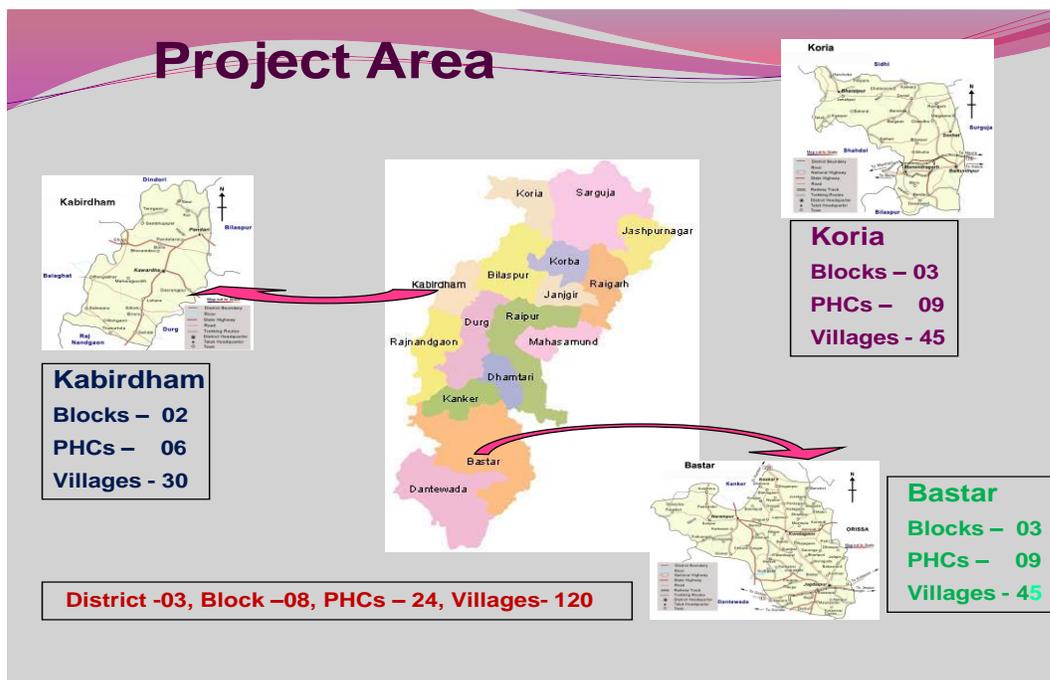
- Districts were selected by State Health Department in consultation with civil society representatives.
- Blocks were selected by District Health Officers and District Administration in consultation with nodal persons.
- PHCs and SHCs and Villages were selected by District Health Officials in consultation with BMOs and Nodal persons.

The project area is as follows:

District	Block	PHC	Village
Kawardha (Kabeerdham)	Lohara	Rampur	Dani Ghatoli, Mohbhatta, Singhori, Karhikuan, Khairjhiti,
		Odiya	Kauhari, Baroda, Gangpur, Irimkasa, Daihandihi
		Bhimori	Bicharpur, Narothe, Basin-Jhhoki, Kholva, Katori
	Bodla	Rengarkharkala	Chhitpurikala, Boda, Souru, Kuman, Baarendiwani
		Taregaon	Liladadar, Jamvani, Ghabhoda, Chhapartola, Ghumashapar

		Daldali	Andharikachhar, Kurmi, Mundadadar, Koilari, Chendradadar,
	Kawardha	Bamhni	Kuteli, Badhutola, Jhhalka, Dhuvadeeh, Chuchrungpur
		Indori	Litipur, Badhamuda, Baiji, Tamaruva, Navagaon
		Marka	Khairwar, Navagaon(Koliha), Ghorewara, Koilari, Kritbandha
Bastar (Jagdalpur)	Tokapal	Singhhanpur	Singhhanpur, Markapal, Potanar, Ghat- Dhanora, Kodanoor
		Tahkapal	Deurgaon, Karanji, Kurenga, Ran- Sargipal, Tekameta
		Chhapar- Bhanpuri	Chhapar- Bhanpuri, Sakargaon, Sirisguda, Gumiapal, Burjee
	Badekilepal	Kaakloor	Bade Bodenar, Kumar -Sadra, Sadra- Bodenar, Palanar, Aadval
		Mutanpal	Mutanpal, Jamagaon, Baastanar, Borja, Birgali,
		Kapanar	Kapanar, Toyenar, Routpara, Gajopara, Pitarpara
	Darbha	Pakhnar	Pakhnar, Beespur, Kelaur, Paadavarli, Chandragiri
		Koleng	Koleng, Tahkawada, Dharbha, Chhindgud, Bhandrimahu
		Southnar	Kokawada, Sautnar, Edjepal, Jangarval, Naamapara
Koriya	Khadgawan	Salka	Phunka, Amadand, Katkona, Jarondha, Manghora,
		Bacharapodi	Bade Kalua, Baima, Ratanpur, Gainji, Taamdand
		Chirmi	Sous, Saanval, Indrapur, Padma, Chhotesalhi
	Manendragarh	Kelhari	Dodki, Dihuli, Dugla, Rojghi, Trilokhan
		Nagpur	Barbaspur, Morga, Ujjiyarpur, Semra, Lohari
		Biharpur	Ghutra, Pendri, Kachhoud, Garuddol, Badkaabakra
	Jankpur	Kotadol	Kawarji, Muluknar, Katwar, Jyuli, Khamrod,
		Madisarai	Badvahi, Deogarh, Domra, Nodia, Markhoi

		Kunwarpur	Phuljhar, Toji, Kanjia, Tilouli, Aara
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Community Processes:

Community Processes at District level NGOs

In order to facilitate the activities in each district, District Nodal NGOs were selected by the State CBM Mentoring Group in its meeting Dated 15-16 August 2008. Following are the District Nodal NGOs

District	District Nodal NGO
Bastar	VANYA- Voluntary Association for Nature & Vocal Awareness, Dantewada
Koriya	Chaupal Gramin Vikas Prashikshan evem Shooudh Sansthan, Ambikapur
Kabirdham	Sankalp Sanskritik Samiti, Raipur

As decided in State level Orientation Workshop (August 16-17, 2008), State CBM Group directly support the CBM process in selected districts instead of District Nodal NGOs. Members of the Group/Resource Person were nominated in the District Level Support

Teams for providing support to the district officials and Block NGOs as per description given below:

District	Name	Role
Kawardha	1.Mrs Manisha Sharma, Member (State CBM Group)	Nodal Person
	2.Mrs Vijay Laxmi, Member (State CBM Group)	Support
Bastar	1.Mr Jay Narayan Singh, Resource Person	Nodal Person
	2.Mr Somesh Pratap Singh, Member (State CBM Group)	Support
Koriya	1.Mrs Sulakshana Nandi, Member (State CBM Group)	Nodal Person
	2.Mr Shailesh Shrivatava, Member (State CBM Group)	Support

Community process at Block level

Block level NGOs were selected by CMHO and Collector in consultation with the nodal and support members of State Mentoring Group. The applications of willing NGOs were scrutinized and a matrix was prepared. On the basis of this matrix a panel of the names of NGOs was suggested to CMHO for selection. The selected Block NGOs are as follows:

District	Block	NGO
Kawardha	Sahaspur Lohara	Community Advancement and Rural Development Society (CARDS)
	Bodla	Zila Sakshatra Samiti, Kawardha
	Kawardha	Bharat Mata Seva Samiti
Bastar	Tokapal	Emmanuel Hospital Association
	Badekilepal	PAHAL Samajsevi Sanstha
	Darbha	Bastar Samajik Jan Vikas Sanstha
Koriya	Khadgwan	Sarai (Social Action Research and Advocacy Institute)
	Manendragarh	Adivasi Adhikar Samitee
	Janakpur	Chaupal Grameen Vikas Prasikchan avam Shodh Sansthan

State level Training of Trainers (TOT)

A state level Training of Trainers was organized at Regional Leprosy Training and Research Institute, Raipur from 16th to 20th December 2007. A total of 59 participants including 39 block level trainers from 9 Block of 3 Districts.

Orientation workshop on “Community Based Monitoring (CBM)”

District Managers’ Orientation Workshop at state level

A workshop for District Managers was organized on 20-21 January, 2008. A total of 32 participants including civic society members of State CBM Mentoring Group participated in the workshop. On the first day, chief executives of 8 block NGOs participated. On the first day of the workshop, District Managers were oriented about NRHM, CBM and their roles in pilot project. On second day, District Health Officials (CMO, DIO, DPM etc) join the workshop, and detailed discussion was held in regards to the composition and roles of various committees, tools to be used in CBM, Roles of different stakeholders etc.

District level Orientation Workshops

Kawardha (Kabeerdham) District-

District level orientation workshop was organized in Kawardha on 27th January, 2008. A total of 45 participants attended the workshop. The participants included CMHO, DIO, CS, Chief Executives of Block NGOs, BMOs and Sector Medical Officers of the project area and other district officials.

Koriya District-

District level orientation workshop was organized in Vaikunthpur (Koriya) on 12 March, 2008. A total of 31 participants attended the workshop. The District Magistrate inaugurated the workshop. The participants included CMHO, DIO, CS, DPM, Chief Executives of Block NGOs, BMOs and Sector Medical Officers of the project area and other district officials.

Bastar (Jagdalpur) District-

On 17th March, 2008 District level orientation workshop was organized in Jagdalpur. A total of 53 participants attended the workshop. The participants included CMHO, DIO, CS, DPM, Chief

Executives of Block NGOs, BMOs and Sector Medical Officers of the project area and other district officials.

Status of Activities as per MOU

Completion Status of Activities as per MOU		
Activity in MOU	Number	Status
Publication of Guidelines	01	<ul style="list-style-type: none"> •Published a set of Two Guidelines •Published a set of three Folders • Published a set of two Posters
State Level Workshop (2 Days)	01	Organised on 16-17 August, 2007
State TOT Workshop (5 Days)	01	Organised on 16-20 December,2007
District Workshops (1 Day) One in each district	03	Organised all 03 Workshops District Kawardha: 27 January, 2008 District Koriya: 12 March, 2008 District Bastar: 17 March, 2008
-	-	State level District Manager' Workshop was organised on 20-21 January, 2008
-	-	State level Consultation for Planning Activities of Second Phase,11&12May 08

Process

A consultation for planning the activities in pilot period was organized on 11 & 12 May, 2008 in State Health Training Centre, Raipur. The National Secretariat of this pilot project indeed initiated this meeting and provided required support. Members of the Advisory Group for

Community Action of NRHM Dr Indu Capoor and Dr Almas Ali, Member of the Technical Advisory Group Dr Rakhal Gaitonde and Representative of National Secretariat Ms Sunita Singh, Dr K R Anthony Director, State Health Resource Centre, Dr Kamlesh Jain, State Programme Manager(RCH) & State Programme Coordinator (NRHM), Members and representatives from Civil Society Organisations of State CBM Mentoring Group and Office Bearers of District and Block Nodal NGOs participated in this two days meeting. Tentative District Plans were worked out. During this workshop, following Consortium Members were nominated as In-charges of the districts on the suggestion of AGCA members:

District	Consortium Member	
Bastar	Mr Somesh Pratap Singh-CG VHA	
Koriya	Mr D N Sharma-Sandhan Sansthan	
Kabirdham	Mr Jagannath	kompella-RRC-PFI

Status of Activities (June-November 2008)

Activity	Target / Output	Bastar	Koriya	Kabirdham	Total
Training of Trainers	Planned	01	01	01	03
	Output	01	01	01	03
VHSCs Formed	Planned	45	45	30	120
	Output	45	45	30	120
VHSCs Oriented	Planned	45	45	30	120
	Output	45	45	30	120
Village Health Profiles collected	Planned	45	45	30	120
	Output	45	45	30	120
PHC Monitoring & Planning Committees Formed	Planned	09	09	08	24
	Output	09	09	08	24
PHC Monitoring & Planning Committees Oriented	Planned	09	09	08	24
	Output	09	09	06	24
Block Monitoring & Planning Committees Formed	Planned	03	03	02	08
	Output	03	03	02	08
Block Monitoring & Planning Committees Oriented	Planned	03	03	02	08
	Output	03	03	02	08
generated	Output	45	45	30	120
Number of PHC level Report Cards generated	Planned	09	09	09	24
	Output	09	00	00	24
Number of PHC Facility Cards generated	Planned	09	09	08	24
	Output	09	09	08	24
Number of Block level Report Cards generated	Planned	03	03	02	08
	Output	03	03	02	08
Number of CHC Facility Cards generated	Planned	03	03	02	08
	Output	03	03	02	08
Number of PHC level Jan-Sunavais/Jan-Sambads undertaken	Planned	09	09	06	24
	Output	09	09	06	24
Number of Block level Jan-Sunavais/Jan-Sambads undertaken	Planned	03	03	02	08
	Output	03	03	02	08

S No	Issue	Color Code	Bastar (31)	Koriya (29)	Kabirdham (17)	Total (77)	%
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Outcome of Community Monitoring

Following reports are generated after consolidation of Report Card of Villages/Sub health Centres/PHCs and CHCs prepared by the Community structures formed for the purpose.

Status of SHCs on the basis of Facilities & Services being provided

Chhattisgarh State level Consolidation of SHCs' Report Cards

Total Number of SHCs under Project -77

1	Structure & Man Power	Green	08	06	01	15	19.4
		Yellow	12	06	08	26	33.8
		Red	11	17	08	36	46.8
2	Equipments & Supplies	Green	13	06	15	34	44.1
		Yellow	14	07	02	23	29.9
S No	Issue	Color Code	Bastar (09)	Koriya (09)	Kabirdham (06)	Total (24)	%
1	Structure &	Green	01	00	00	01	04.1
3	Availability of Services	Green	11	07	06	24	31.1
		Yellow	14	13	07	34	44.2
		Red	06	09	04	19	24.7
4	Performance of ANM	Green	24	08	13	45	58.5
		Yellow	05	12	04	21	27.3
		Red	02	09	00	11	14.2

Colour Code -

Green	Good	Yellow	State of Concern	Red	Poor/ State of Serious Concern
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Status of PHCs on the basis of Facilities and Services being provided

Chhattisgarh State level Consolidation of PHCs' Report Cards
Total Number of PHCs under Project-24

	Man Power	Yellow	03	05	00	08	33.3
		Red	05	04	06	15	62.6
2	Equipments & Supplies	Green	03	05	01	09	37.5
		Yellow	06	02	04	12	50.0
S No	Issue	Color Code	Bastar (03)	Koriya (03)	Kabirdham (02)	Total (08)	%
3	Av of						
1	Structur	Green	03	01	01	05	62.5
4	Inf						
	Expenses	Yellow	03	05	00	08	33.3
		Red	03	04	03	10	41.7
5	Quality of Care Services	Green	02	05	03	10	41.6
		Yellow	06	01	02	09	37.5
		Red	01	03	01	05	20.9
6	Functioning of Rogi Kalyan Samities	Green	05	05	00	10	41.7
		Yellow	03	02	03	08	33.3
		Red	01	02	03	06	25.0

Colour Code –

Green	Good	Yellow	State of Concern	Red	Poor/ State of Serious Concern
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Status of CHCs on the basis of Facilities & Services being provided
Chhattisgarh State level Consolidation of CHC's Report Cards
Total Number of CHCs under Project -08

	e & Man Power	Yellow	00	01	00	01	12.5
		Red	00	01	01	02	25.0
2	Equipments & Supplies	Green	03	01	01	05	62.5
		Yellow	00	02	00	02	25.0
		Red	00	00	01	01	12.5
3	Availability of Services	Green	03	01	00	04	50.0
		Yellow	00	02	01	03	37.5
		Red	00	00	01	01	12.5
4	Informal Expenses	Green	01	01	01	03	37.5
		Yellow	01	00	00	01	12.5
		Red	01	02	01	04	50.0
5	Quality of Care Services	Green	01	01	01	03	37.5
		Yellow	02	01	00	03	37.5
		Red	00	01	01	02	25.0
6	Functioning of Rogi Kalyan Samities	Green	02	02	01	05	62.5
		Yellow	01	01	00	02	25.0
		Red	00	00	01	01	12.5

Colour Code -

Green	Good	Yellow	State of Concern	Red	Poor/ State of Serious Concern
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Following Table shows the status of Villages on the basis of Health Services being provided
(Chhattisgarh state level Consolidation of Village Health Service Report Cards)

Total No of village under project – 120

Colour Code-

Green		Good		Yellow		State of Concern		Red		Poor/ State of Serious Concern	
S No	Issue	Color Code	Bastar (45)	Koriya (45)	Kabirdham (30)	Total (120)	%				
1	Maternal Health	Green	18	07	07	32	26.7				
		Yellow	11	34	21	66	55.0				
		Red	16	04	02	22	18.3				
2	Janani Suraksha Yojna	Green	14	13	01	28	23.3				
		Yellow	08	16	07	31	25.8				
		Red	23	16	22	61	50.9				
3	Child Health (General Women)	Green	19	24	13	56	46.6				
		Yellow	15	19	17	51	42.5				
		Red	11	02	00	13	10.9				
4	Child Health (Deprived Women)	Green	16	07	11	34	28.3				
		Yellow	18	23	19	60	50.0				
		Red	11	05	00	26	21.7				
5	Quality of Care Service (Gen. Women)	Green	18	19	13	50	41.7				
		Yellow	07	19	16	42	35.0				
		Red	20	07	01	28	23.3				
6	Quality of Care Services (Deprived Women)	Green	17	12	08	37	30.8				
		Yellow	06	13	21	40	33.3				
		Red	22	20	01	43	35.9				
7	Prevention & Cure	Green	27	24	16	67	55.8				
		Yellow	18	15	13	46	38.3				
		Red	00	06	01	07	05.9				
8	Services of ANM, MPW & Mitanins	Green	28	30	16	74	61.6				
		Yellow	13	11	11	35	29.2				
		Red	04	04	03	11	09.2				
9	Untied Fund	Green	00	15	01	16	13.3				
		Yellow	00	18	02	20	16.7				
		Red	45	12	27	84	70.0				
10	Services of Mitanins (Gen Women)	Green	32	37	26	95	79.1				
		Yellow	13	08	04	25	20.9				
		Red	00	00	00	00	00.0				
11	Services of Mitanins (Deprived Women)	Green	27	23	22	72	60.0				
		Yellow	15	08	08	31	25.9				
		Red	03	14	00	17	14.1				
12	Discrimination of services	Green	18	24	02	44	36.7				
		Yellow	08	03	19	30	25.0				
		Red	19	18	09	46	38.3				

Observation at Koriya District

It was told that due to Christmas and holidays no members from the District committee except Ms Sulakshana Nandi, Member state CBM group and convenor of Jan Swasthya Abhiyan was available for interview and Focus Group discussion. She has reported that in the beginning of the project there was lack of resources and health personnel involvement. As per her, the work got delayed due to delay in fund release. Now the work would gear up as project is going to end.

The main function of Community Based Monitoring has already been started by Mitandin and the recent formal structure is developed now only. 'Jan Swasthya Abhiyan' and 'Adiwasi Adhikar Samiti' is monitoring the health services from the beginning of Mitandin programme.

The present form of CBM is working actively in Block and PHCs level but it could not become more active at district level because of frequent transfer of collector. When the CBM process started, the contemporary collector took interest in the process and formation of committee, empowering the community to initiate the process and involve in its ownership. He has involved 'Zila Saksharata Samiti' in 'District Monitoring Committee' to strengthen the process and making it more participatory and in bringing community involvement through inter-sectoral co-ordination. His predecessor withdraws the 'Zila Saksharata Samiti' from the committee on his own ground as he was not finding any relationship between 'Zila Saksharata Samiti' and health service providers and community. District Collector has changed 3-4 times, and those who have joined later are not understanding about CBM process and its use of providing health services to community. Nodal NGOs tried to brief but it was not effective. This District collector never found any rationality to support or promote monitoring by the community. It is necessary to mention here that District Collector was approached during review, but he was not available.

Mitandin is the main source of information regarding the availability of health services, functions of Village Health and Sanitation committee, ANM performance and problems in delivery of Health services.

District unit in CBM process is weak in Koriya district as its improper functioning is highlighted by Ms. Sulochana associated with state CBM mentoring group and belong to Jan Swasthya Abhiyan(State Nodal NGO) and 'Adiwasi Adhikar Samiti' and 'Chaupal'. They need some kind of patronage to get outcome of the CBM process. It may be in form of state support.

Manendragarh Block

Community Health Centre was situated in Manendragarh. This is centre where people came for institutional delivery. Mitandin bring pregnant women from remote places to Community Health Centre for delivery. Since there are no delivery facilities available in most of the Private Health Centre and Sub-Centre. Adiwasi Adhikar Samiti was known in the block as right based approach and through Adiwasi Adhikar Samiti and Jan Swasthya Abhiyan monitoring of health services was done since a long time. For them Mitandin was the source of information regarding health service delivery to the people. The nodal NGOs maintain the record of proceedings and outcome of CBM processes. The 'Chaupal Gramin Vikas and Sahyog Sansthan' and 'Adiwasi Adhikar Samiti' conducts regular meeting and Jan Sunwai at Block, PHCs and village level as per mentioned in their register. They have also developed a quarterly chart to express the

shortcomings at Block and District level. This assessment report has been presented to In-charge of concerned Primary Health Centre and Community Health Centre. The Village Health and Sanitation committee has been formed in all the pilot villages, and joint Account in the name of Secretary and Mitanin convener and Sarpanch and ANM for untied fund has now begun to operate. Untied fund has already been released by state Government and has reached to concerned account except in Bastar district.

Kelhari Primary Health Center

Kelhari Primary Health Center was regarded as well performed PHCs of district under CBM Pilot. Two Medical officers has posted at Kelhari Primary Health Centre with one compounder, one dresser and one ward boy .Lab facilities for blood, urine, malaria test is available. But there are no facilities for institutional delivery. For safe and institutional delivery people has to run till Community Health Center at Manendragarh. Medical officer reported that transportation support has been provided to referral centre as per availability of fund. It was observed that the medical officer was involved in PHC monitoring committee but he was not much motivation for it. Although he highlighted a point in support of community member that there was some negligence cases of immunization by ANM came to his knowledge in Jan Sunwai. He made his interference and therefore, ANM has improved in her services. With continuously reporting such cases in Jan Sunwai, weekly visit of ANM in villages has increased. As per vigilance of the people some of the life saving drugs, antibiotic are available in Primary Health Centre for last few months. Medical officer reported that Monitoring committee should also highlight the issues of non-availability of quarter facilities and educational facilities, lack of equipment, ambulance etc at PHC level. There are no facilities of providing 24X7 hrs health services to community.

It was also observed that AYUSH clinic with PHC has started functioning and concerned physician visit twice in a week to clinic.

But no ANM or any facilities was available at Dihuli sub centre. The sub centre was running on rent and ANM was only visiting during immunization.

Perception of Mitanin

Mitanin are equivalent to ASHA under NRHM in terms of providing health services at village level. Her role in community is to motivate people for institutional delivery, providing first aid to the people and creating health awareness among community. During review of pilot of Community Monitoring, meeting of Mitanin was organised at Dihuli village under Kelhari PHC of Manendragarh Bullock. Mitanin has been involved in Village Health and Sanitation Committee and also in CBM process at Primary Health Centre level. They reported that sometimes they didn't receive motivational money while promoting institutional delivery. As a result of 'Jan suwai' under CBM process, situation has improved but not at satisfactory level. Sometimes they have been told about motivational support that they will receive only after receiving the fund from Government.

It was reported that as being part of Village Health and Sanitation committee one mitanin was able to provide nominal support of Rs 500 for a poor patient who was suffering from paralysis and other who was suffering from pain in chest from untied fund. Mitanin has reported about

negligence of service facilities, equipment, medicine, vehicle at Kelhari PHCs which created hardship for them to take pregnant mother for delivery at CHC Manendragarh. Sometimes they don't have money or vehicle for promoting institutional and safe delivery.

Community Perception

During Review of Community Monitoring Pilot, visit was made to Dihuli village where a meeting of community and Mitadin was organised under the initiative of 'State Health Resource Centre' and 'Adiwasi Adhikar Samiti'. Community reported about the scarcity of facilities at Sub-Center and Primary Health Centre level particularly at the time of delivery and occurrence of malaria cases or any epidemic. Although they have received medicine for malaria, diarrhoea and other diseases from Mitadin, Mitadin did blood test to find out whether patient is suffering from Malaria or not. ANM was not making regular visit to community even for delivery.

Biharpur Primary Health Centre

Biharpur Primary Health Centre is regarded as weak performing centre under pilot of CBM. There are only one Medical officer (BMS) with a ward boy. There is no facilities of lab, ambulance, compounder and dresser etc. Only normal Blood test has been done at PHC level, only slide for Malaria test is available that is further send to Manendragarh for final test. Medicine to some extent is available at PHC. Delivery can be done at PHC but no facilities even the incentive money for it is available. Medical officer is staying 24 hrs in Primary Health Centre and he has reported that one day he received very complicated case of delivery. Child has turned in wrong side in exist of uterus and mother was crying fast. As per lack of vehicle and other equipment he was unable to refer such serious case to CHC which was far away from such remote area. Even in night the poor community can not hire a vehicle for the purpose. He decided to handle the case and manage to successful delivery in his own. So, the single Medical officer handle all complicated delivery cases sometimes with the help of Mitadin. Although people prefer to go Manendragarh CHC for the purpose. The Medical officer of the PHC was involved in CBM process. He reported the positive outcome of CBM, as in some cases of ANM negligence of their duty has been sorted out. He reported about the lack of mechanism to **maintain the transparency even in CBM process.** (WHAT DOES THIS MEAN?) He also highlighted the need of development of mechanism to provide a mandate to Monitoring committee to improve the situation. Though he was aware of the availability of untied fund but secretary of 'Panchayat Samiti' was not keen to open the Account. It was only possible when this attitude came to bring in knowledge of CO then only process was materialised.

Although, still confusion is prevailing about the proper use of untied fund, he has also highlighted the problem of co-ordination among the member of committee and lack of people's active participation in monitoring process.

Perception of Mitadin

As per information of Medical officer about the non-availability of ANM at sub centre during review of pilot visit was made Barka Bahara village under Biharpur PHC. A meeting of Mitadin was organised as per initiative of State Health Resource Centre, Chattisgarh.

As reported earlier that Mitadin was involved in Village Health and Sanitation Committee as convener as well as member, they also active in the process of CBM. It was reported that

Mitanin was working as service provider without any incentive provided to them. Earlier they were getting Rs 50 for immunization now that amount has been taken by ANM now. Although she is neither staying in village nor sub centre or visiting village regularly. Mitanin has been facing problems due to unavailability of vehicle in bringing the pregnant women for delivery . They have reported that if money is not available in Janani Suraksha Scheme then they received meagre amount and later money was mismanaged by concerned authority. Due to Monitoring Committee some of the work and scheme become known to people and health awareness work of Mitanin was getting recognise as feeling expressed in the meeting.

Perception of Community

Community of Barka Bakara village highlighted about the lack of availability of health services for them. It was reported that no facilities and personnel are available at Sub centre and Primary Health Centre. Medicine for smaller health problem made available to them by Mitanin. But health facilities made available to them nearby. As per their perception ANM has visited their village often. Since village are situated in remote area and she has to cover 4-5 villages at long distance. It seems that they were not much aware about CBM process and but they were aware about Jan Sunwai organised by Adiwasi Adhikar Samiti. They interested to participate in it. It was also observed that community has little aware about village Health and Sanitation committee and untied fund and those who are aware reported that at the time of its need or emergency secretary was not available to withdraw the money. However, through Jansunwai community become aware about the availability of different scheme like Janani Suraksha Yojna, ICDS programme, Mid Day Meal scheme etc.

Outcome of Community Monitoring Pilot

- It was observed at state level that institutional mechanism has been developed as a result of subsequent office order from Mission Director to District Collector and CMHO. Therefore Committee has been formed from Primary Health Centre level to state level in all three districts chosen for Pilot.
- Under the regular 'jan sunwai' and meeting of Monitoring committee , Village Health and Sanitation Committee has been formed in all villages of Koriya and Kawardha district. Fund has been released and bank account is in operation. Untied fund has not reached to Bastar district as informed in NGOs meeting during review.
- People are made aware about the benefit of institutional delivery, benefit provided through different schemes like Janani Suraksha Yojana, preventive measures from communicable diseases, availability of untied fund with Panchayat.
- The work of Mitanin and other service provider getting recognition and their role and capacity has been valued by health personnel.
- The cases like non-availability of ANM in centre, non-availability of medicine, information about JSY, Nutritional days and health behaviour of people are getting noticed by the community as well as health personnel that can be transformed in reality.

- The role of NGOs is useful as reported in monitoring and raising the right based approach, Adiwasi Adhikar Samiti, Jan Swasthya Abhiyan, Bastar Jan Samajik Vikas Sansthan and Chupal was good while Sanklap and Sandhan was found very sound in documentation of the process, case and learnings. (Annexure II) Although Social Action Research and Advocacy , Khadgawan found less motivated and not very tune for the process.
- Effective functioning of VHSCs is observed in comparison to Non-CBM District with special reference to use of untied fund and record keeping for that
- CBM as a process strengthening of Community as well as health delivery systems
- Health services becoming gradually community centered
- Building Relationship (Synergy,co-ordination and integration)
- Right based approach for Entitlement
- Equity being addressed
- Betterment of Accountability
- Services(Accessibility, Access and quality)
- Community in focus activity by the community for the community

Gap in implementing of CBM process

- It was observed that all members of PHC monitoring committee were not much aware of the work of CBM. They are gradually involving in it. Even the Medical officer of Kelhari PHC has taken time to recall the CBM committee
- It was also observed during NGOs presentation that word 'Jan Sunwai' cannot be appropriate to use in context of CBM process. In reporting from Bastar district it was told that people get confused if they organise Jan sunwai on behalf of Monitoring committee as this word has been used by naxal groups in Bastar. 'Jan Samwad' has been proposed to use or practice instead of Jna Sunwai.
- Although committee has been formed as per order by subsequent authority but there is lack in community ownership at district and state level. Community ownership has promoted to some extent in block and village level.
- It was also observed that there is lack of orientation among administrative officials about the CBM. Similarly there are lack of guidance for proper utilization of untied fund of VHSC.
- At Primary Health Centre, Biharpur or even in Kelhari, it was found that there is lack of equipment, man-power and service facilities, but in one of the report prepared by NGOs at Manendragrah, there is mentioning about the improvement of satisfactory level in terms of equipment and facilities at Primary Health Centre.
- Lack of sensitization among Community about CBM and right based approach.
- Lack of proper mechanism to utilize the VHSC untied fund

- Lack of inter-sectoral coordination
- Lack of exchange of experiences or learning among CBM group
- Lack of mechanism of capacity building, co-ordination and keeping accountability in CBM process.
- Media sensitization was nil all over the pilot process. There is only one member from Dainik Jagran in Block Level Monitoring Committee at Manendragarh who was not available.
- There was lack of incentives for Mitran services in comparison to ANM and ASHA. Mitran seems to start losing their motivation due to lack of proper incentives.
- Budget was sufficient for CBM process from village level to state level. The problems arise only when it is delayed that affects the work and provide short span of time for its utilization.

Review Recommendations

- Stakeholders consultation for prioritizing remedial actions on CBM outcomes
- Active involvement and Formation of essential strategies such as state level Monitoring and Planning Committee, District as well as Block level committee
- Expansion of CBM process in all district in phase manner-3 District are already proposed in state PIP (08-09)
- Cost effective sustainable strategy and Action Plan for CBM in all villages of the district is to be worked out in consultation with multiple stakeholders
- Need of proper orientation of state officials, members of monitoring committee about the scope of CBM processes including expected role of concerned officials. Simultaneously a proper training has to be organised for VHSC members, contributions of Mitran for proper utilization of untied fund.
- Community sensitization on aims, objectives and benefits of CBM processes
- Grass roots Level community mobilization , involving Self Help Groups, right based group and NGOs participation should be encouraged to ensure its replicability within state and outside the state.
- Media should be sensitized to identify the roles and responsiveness for effective media involvement in CBM processes
- Transparency should be maintained in developing criteria's and involvement of NGOs with specifically designed TOR for the state, district, block and PHC level of support
- Sharing of district specific experiences and concerns for timely incorporation of corrective measures on a regular basis
- Undertake Capacity building related measures to initiate mechanism for inter-sectoral coordination among various functional committees under CBM

			8.00 pm	Departure for Koriya District
5	26.12.2008	4	4.45 am	Reached District H.Q Baikunthpur
				Approach to District Committee & Collector Nobody was available
6			11.00 am	Reached Manendrgarh Block approach Block Committee. Meeting with members and district co-ordinator of SHRC

S.No.	Date	Day	Time	Description of work
			11.30	Departure for Biharpur PHC Meeting with Medical officer and Member of PHC Monitoring Committee at Biharpur
7			4.00 pm	Meeting with Panchayat member, Community leader and Mitanin at Bag Bahara village
			7.00 pm	Reached Manendragrah and Meeting with Block level NGOs Participants: Chaupal Gramin Vikas and Sahyog Sansthan Adiwasi Adhikar Samiti Social Action Research and Advocacy Institute
8				Halt at Manendragarh
9	27.12.2008	5	8.00 am	Departure for Kelhari PHC
			10.00 AM	Meeting at Kelhari PHC with Medical officer, staff of PHC, ANM and Members of PHC Community Monitoring group
			1.00 pm	Meeting with Community/Mitanin/Members of Panchayat at Dihuli
10			4 .30 pm	Approach to collector, Koriya at Baikunthpur

			6.30 pm	Meeting with Community at Kharganwa
11			9.30 pm	Departure for Raipur
12	28.12.2008	6	8.00 am	Reached Raipur
			11.00 am	Meeting with PFI-RRC (Nodal National NGO) Review Meeting with State NGO convenor Meeting with key officials of SHRC
			3.45 pm	Departure for Delhi by Chhattisgarh Exp
13	29.12.2008			----
14	30.12.2008		12.00 Night	Reached Delhi

Annexure-II

खण्ड . स जिला तथा अधिनस्थ स्तर पर संचालित गतिविधियों का प्रतिवेदन

1. जिला निगरानी व नियोजन समिति :

सदस्यों की कुल संख्या : 16 जिला पंचायत सदस्यों की संख्या : 05

विकास खण्ड के गैर शासकीय प्रतिनिधि : 05

गठन तिथि : 04.10.08

नागरिक संस्था संगठन :01

क्र.	प्रसंग ;)चमबजद्ध	अभ्युक्तियां / विवरण
1.	गठन की प्रक्रिया	<p>समुदाय आधारित निगरानी कार्यक्रम के अर्न्तगत जिला स्तर पर जिला निगरानी व नियोजन समिति का गठन किया जाना था। सर्वप्रथम मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी से भेंट कर कार्यक्रम में होने वाली गतिविधियों की पूरी जानकारी दी गई। यह निर्णय लिया गया कि पहले ग्राम स्तर की समिति ,पी.एच.सी. स्तर की समिति तथा विकास खण्ड स्तर की समितियां तो गठित हो चुकी है लेकिन मितिंग कर इन समितियों को थोड़ा एक्टिव करने के पश्चात् यहां से कुछ सदस्यों को लेकर जिला स्तर की कमिटी गठित करेंगे। प्रक्रिया पुरी होने पर सी.एच.एम.ओ.ने मि. साहू को निर्देशित किया की जिला स्तर की समिति का नियमानुसार गठन कर अनुमोदन हेतु भिजवा दें ! सदस्यों का चयन करने के पश्चात् कुछ ही दिनों में मि. नोन्हारे का तबादला हो गया तथा साहु जी का भी तबादला हो गया !</p> <p>जिला निगरानी समिति के बारे में नये सी. एच. एम. ओ. को जानकारी दी गई उन्होने मि. चौधरी जो कि स्वास्थ्य विभाग में एकाउन्टेण्ट है के उपर डाल दिया। उन्होने कुछ दिन तक कहा कि समिति की सुची उनके पास है जिसे अनुमोदन हेतु भेजा गया है। उसके पश्चात् पुनः सरकारी आदेशानुसार समिति का गठन किया गया।</p>
2.	कौन सी समस्याएं आई	<ol style="list-style-type: none"> 1. शासकीय अधिकारियों का तबादला। 2. शासकीय अधिकारियों के पास कार्य की अधिकता होने की वजह से इस परियोजना पर ध्यान न देना। 3. शासकीय अमले को लग रहा था कि शासन द्वारा उनके कार्यों का मुल्यांकन करवाया जा रहा। 4. स्वास्थ्य विभाग के पास गठन हेतु शासकीय पत्र न होना। 5. संचार सुविधा का अभाव।
3.	समस्याओं को सुलझाना	<ol style="list-style-type: none"> 1. शासकीय अधिकारियों को परियोजना की पुर्ण जानकारी देना। 2. लगातार सम्पर्क में रहना।
4.	कोई सहजकारी कारक	मुख्य स्वास्थ्य एवं चिकित्सा अधिकारी।
5.	जिला पंचायत की भूमिका	1. सकारात्मक रही।
6.	जिला अधिकारियों की भूमिका	सहयोगात्मक।
7.	जिला नोडल एन. जी.ओ.की भूमिका	<ol style="list-style-type: none"> 1. शासकीय अधिकारियों को परियोजना की पुर्ण जानकारी देना। 2. लगातार सम्पर्क में रहना। 3. शासकीय विभाग ; समुदाय ; थछळ्ळ ; एवं राज्य के बीच बेहतर तालमेल। 4. थछळ्ळ का सतत् मार्गदर्शन एवं सहयोग।
8.	जिला सलाहकार समूह की भूमिका	<ol style="list-style-type: none"> 1. प्राथमिक स्वास्थ्य केन्द्र स्वास्थ्य समितियों की रिपोर्ट पर विचार विमर्ष। 2. वित्तीय रिपोर्टिंग और संसाधनों के प्रवाह में यदि कोई बाधा हो तो दुर करना। 3. आधारित संरचना , औषधि और स्वास्थ्य कर्मियों से संबधित सुचना और विसंगतियों को दुर करना। 4. सेवाओं के परामर्षी उपयोग , देखभाल की गुणत्ता आदि की सुचना पर बल देते हुए प्राथमिक स्वास्थ्य केन्द्र की प्रगति रिपोर्ट बनाना। 5. जिले की स्थिति और प्राथमिकताओं के मुल्यांकन पर आधारित जिला स्वास्थ्य योजना के विकास में योगदान।

		6. यह सुनिश्चित करना कि रोगी कल्याण समिति/अस्पताल प्रबंधक समितियां ठीक से कार्य कर रही हैं । 7. परिपत्रों राज्य स्तर पर किये गये निर्णयों या नितिगत परिवर्तनों पर विचार विमर्ष जिला स्थिति के लिये उनकी संगतता के बारे में निर्णय । 8. रिपोर्ट किये गये ऐसे मामलों पर ध्यान देना जिसमें स्वास्थ्य अधिकारियों को दिये जाने से इन्कार किया गया हों और उचित निवारण सुनिश्चित करना ।
9.	सदस्यों की रूचि /सहभागिता कैसी ?	सकारात्मक थी ।
10.	कोई अन्य टिप्पणी	समुदाय आधारित निगरानी कार्यक्रम को सभी जिलों में क्रियावित करना चाहिए ।

5. जिला सलाहकार एवं नियोजन समिति का अभिमुखिकरण

तिथि : 15.10.08

स्थान : भारत माता कार्यालय कबीरधा

क्र.	प्रसंग ; चमबजद्ध	अभ्युक्तियां/विवरण
1.	प्रतिभागियों की संख्या	09
2.	प्रतिभागि समूह के लिये रूपरेखा की उपयुक्तता	संलग्न ।
3.	सामने आई समस्याएं	1. षासकीय अमले की कमी । 2. षासकीय भवनों कमी । 3. सक्रिय सहभागिता की कमी ।
4.	समस्याओं का समाधान	1. मांग । 2. सहभागिता को सक्रिय करना ।
5.	कोई सहजकारी कारक	1. प्रषिक्षण का तरिका ।
6.	राज्य स. आ. नि. सलाहकार समुह /राज्य स्रोत दल की भूमिका	.
7.	राष्ट्रीय सचिवालय की भूमिका	.
8.	षासन – राज्य मिषन ; मुख्य चिकित्सा अधिकारी की भूमिका	1. प्राथमिक स्वास्थ्य केन्द्र स्वास्थ्य समितियों की रिपोर्ट पर विचार विमर्ष । 2. वित्तीय रिपोर्टिंग और संसाधनों के प्रवाह में यदि कोई बाधा हो तो दुर करना । 3. आधारित संरचना , औषधि और स्वास्थ्य कर्मियों से संबधित सुचना और विसंगतियों को दुर करना । 4. सेवाओं के परामर्षी उपयोग , देखभाल की गुणत्ता आदि की सुचना पर बल देते हुए प्राथमिक स्वास्थ्य केन्द्र की प्रगति रिपोर्ट बनाना । 5. जिले की स्थिति और प्राथमिकताओं के मुल्यांकन पर आधारित जिला स्वास्थ्य योजना के विकास में योगदान । 6. यह सुनिश्चित करना कि रोगी कल्याण समिति/अस्पताल प्रबंधक समितियां ठीक से कार्य कर रही हैं । 7. परिपत्रों राज्य स्तर पर किये गये निर्णयों या नितिगत परिवर्तनों पर विचार विमर्ष जिला स्थिति के लिये उनकी संगतता के बारे में निर्णय । 8. रिपोर्ट किये गये ऐसे मामलों पर ध्यान देना जिसमें स्वास्थ्य अधिकारियों को दिये जाने से इन्कार किया गया हों और उचित निवारण सुनिश्चित करना ।
9.	बजट आवष्यकताएं	हों ।
10.	कोई अन्य टिप्पणी	समुदाय आधारित निगरानी कार्यक्रम को सभी जिलों में क्रियावित करना चाहिए एवं समय समय पर प्रषिक्षण भी होना चाहिए ।

Review of Community based Monitoring Process in Jharkhand

Objectives of the Review:

1. To review whether the objectives of the community monitoring process were fulfilled in the state.
2. To identify the key learning and challenges for each state
3. To highlight successful innovations that were tried out in the state

The review process-

The review process was important to study the impact of this pilot initiative in Jharkhand to understand the intensity of the framework designed for initiating the process for ensuring community participation and accountability at all level. Initiating the process needed a system which can materialize the strategy to reach the purpose of CBM and in Jharkhand, the initiative was facilitated by Child In need Institute (CINI), State Nodal NGO, District Nodal NGOs to facilitate at the District level and Block Nodal NGOs for front line process. This system has to be studied to comprehend its functioning and affectivity followed by the process of monitoring the quality of health services through community participation.

Evaluation Schedule

Date	Site	Activities proposed	Persons to meet
6.12.08	Ranchi	FGD with the State Nodal NGO team	<ul style="list-style-type: none"> • Members of state mentoring group • State Nodal NGO Team members • Head of district nodal NGOs • Health Secretary/ Mission Director • State Nodal Officer
	Ranchi	Half day meeting with all the Program In-charge of District Nodal NGO under CBM	<ul style="list-style-type: none"> • The District Nodal NGO Program In-charge of all the three districts
8.12.08	Chakradharpur, Dist- W. Singbhum	<ol style="list-style-type: none"> 1. Meeting with District Nodal NGO (Ekjut) 2. Meeting with heads of 3 Block NGOs of the district 3. Meeting with the DMG members 4. Individual meetings with CS (if available) 5. Interview with Media Fellow 	<ul style="list-style-type: none"> • District Nodal NGO Program In-charge • Member of District Mentoring Team • Heads of 3 Block NGOs • CS, WS • Media Fellows
9.12.08	Chakradharpur Block	<ol style="list-style-type: none"> 1. Interview with the MOIC, PHC 2. Meeting with other MOs in PHC 3. Interview with the CDPO 4. Meeting with the Block Planning and Monitoring Team 5. Meeting with Block facilitation 	<ul style="list-style-type: none"> • MOIC • MOs • CDPO • BPMC members • Block facilitation team

		team (NGO)	
10.12.08	Sub-centre	<ul style="list-style-type: none"> • Meeting with VHC Cluster members (2 from each village under the Sub-centre including the Sahiyya) • Meeting with the ANMs • Meeting with the CBM team members 	<ul style="list-style-type: none"> • VHC Cluster members with Sahiyya • ANMs • CBM team members
	Village	<ul style="list-style-type: none"> • Meeting with the VHC members along with the ANM and AWW • Interview with the Sahiyya • Meeting with the Community people • Interview with the AWW 	<ul style="list-style-type: none"> • VHC members • Sahiyya • AWW • Community people

The review was done, based on the schedule stated above and we came up with the following understanding;

The context-

The process of Community Monitoring started with a joint meeting with Civil Society Organizations and Govt. health and administration functionaries followed by a State level workshop with the participation of State and District level CSO representatives, District health functionaries etc. for introducing community participation mechanism to ensure accountability and quality at all level.

The CBM Process in the State

In Jharkhand, it started with a State level workshop of CBOs, which was convened in Ranchi and attended by the CSOs, Health Department Officials, Development Partners and the National Secretariat (PFI and CHSJ) representatives. The objectives of NRHM and CBM were shared with the participants along with the **Road Map** for the process and the **selection of Three Districts** was done. It was done in transparent and inclusive manner in both, State and District level.

State Mentoring Group

Constitution of State Mentoring Group and its notification delayed the process in a huge way and it took more than six months to get sanctioned.

Transfer of authorities was one of the reasons. This delay slowed the process initially, though it was picked up later.

Involvement of all the State Mentoring Group members could not be ensured (though its meetings were held), other than in meetings. So, the inputs from them couldn't be taken which would have given a mileage to the process.

Committees

All the committees have been constituted in a transparent and democratic method. The Sub-centre Planning and Monitoring Committee could function properly but the Block Planning and Monitoring Committee could not function as derived.

State Advisory Committee

Child In Need Institute (the State Nodal Agency) has constituted a State Advisory Committee comprising of resourceful people from related field, so as to get technical inputs for the initiative.

These advisors helped the process with a great deal and gave resourceful inputs and support.

Government health and administrative Officials

Though the orientation on Community Based Monitoring of Health services was done, but the administration took a lot of time to understand that this process will only help them and is not at all a fault finding exercise, though the early support and cooperation was least encouraging, it picked up afterwards.

Capacity building

The trainings were properly done, the materials and pamphlets were adequate and the tools were adopted according to the field conditions. Though, a printed material (a facilitation guideline) could have been provided to the facilitators.

Materials

The state nodal agency has developed 4 posters, 1 handbill and has facilitated to develop 1 pamphlet at District level, which is having relevant and locally understandable contents.

An innovative Village Health Register has been developed for recording the village profile its health status, current issues can be recorded and a Village Health Plan can be prepared for the community to follow. It is indeed an important tool for sustainability of Community Participation and can be replicated in the whole State.

The community monitoring process

The process of introducing Community based Monitoring through **Gram Swasthya Samwad** was a good move followed by the *Kala-jattha* initiative in the pilot villages has given positive results and it has actually helped in developing understanding in the community and informed people, as a result in many villages, VHCs have been reconstituted and sensitized the VHC members about their role and responsibility.

The *kala-jattha* performance should have been done in all the villages and not only in the clusters as done.

Selection of CBM team through a Gram Samwad during the Gram Swasthya Samwad was a process which actually ensures people's participation. Involving 50% women in the process was kept in mind in the 6 member CBM team in each of the villages.

The State Nodal NGO

The State Nodal NGO cell was always leading from the front and has given ample time and staff for the process and to reach the target. The staff's approach is very proactive.

District NGOs

The District NGOs (though not all) could match up to the speed of the process. All the Block NGOs in their capacity did a commendable job, though the delay in the process has dampened the spirit of the workers.

Jan Samwad (Public hearing)

In one of the District, the District administration was hesitant to allow this process, as they felt that it could lead to people's anger, but in other places, it has provided a platform for sharing and putting up their grievances. It was rather a face-to-face dialog between the community people and the Govt. health functionaries.

Documentation: Process documentation was done and the inputs of the NGO were noteworthy.

Media fellows:

The coordination between the NGOs and media fellows was not satisfactory. As media has a big role to address the issues related to public health, there is a need to strengthen the coordination and understanding.

Case studies

The Sub-centre started opening Regularly

Sub-centre – Koiripatra

PHC/Block – Lesliganj

District - Palamau

I. Distance – 23 k.m. from Daltongunj

Koiripatra is a health Subcentre under Lesliganj PHC covering 5 villages approx 5685 population. As per the observation of Local people the Subcentre was did not open and the ANM Indrawati Devi deputed for that Subcentre rarely visited the village. The community members were ignorant about the services that were to be delivered from these Subcentre. Although VHC were formed and Sahias were selected but neither of them bothered about functioning of Subcentre. In May 2008 the Pilot project – Community Based Monitoring Process under NRHM were introduced in that area. At the very out set the VHC were mobilized, reorganized and their meetings were regularized under the programme. In the course of meeting the villagers became aware about the service guarantee that NRHM promises to the rural community.under the CBM programme CBM team were formed in each village and trained in Monitoring process

of healthcare services and available infrastructure in the light of NRHM and IPHS guidelines. When the Gram Paricharch started on 30 August 2008 these issues were raised vehemently by the villagers a result now (from 1st of Sept 2008) the centre opens regularly and on time. When the Lok samvad were organised on 11sept2008 these irregularities were again raised at Subcentre level were the Dr. BD Paswan MOIC and Dr.Sunil Baraik, MO assured the villagers and instructed the ANM infront of the villagers since then the villagers are satisfied with the healthcare services

Gram Paricharcha



Lok Samwad



Lok samwad at Subcentre Koiripatra

Anita Poipai of Sirkapi Village in Chakradharpur Block

Anita is being treated in MGM Hospital, Jamshedpur, she will be released in few more days.

Anita says, “Yahan tak ana sambhaw nahi ho pata agar Gaon wale samiti ke log sahayata nahi karte, hamare pas itna paisa nahi hai”.

This was not the scene, when she was pregnant, 1 ½ years ago.

Anita’s family is very poor and they earn their livelihood through tending of cattle. She delivered a baby (male) with a very low weight. She even did not get any PNC and as a result, her health deteriorated.

Matha Poipai, the lady’s husband said that, “the community here, didn’t know about all this services, this was only happened after people came to our village and gave us the information through a *natak (Kala Jattha)*”.

People came to know about how a VHC should be formed, what a VHC will do, about VHC untied fund and what are the role of Service Providers. As a result, people conducted a meeting on the spot and formed the VHC.

In Anita Poipai's case, the people of the community took initiative and collected Rs.4000/- (approx.) for the lady's treatment. They took the lady to Chakradharpur PHC. When she was referred the Sadar Hospital in Chaibasa (West Singbhum), they didn't get the Ambulance, as the MOIC was on leave and he only was the in-charge of Ambulance.

After consulting the Doctor in Sadar Hospital, the lady was advised to go to MGM Hospital to get better treatment. The Ambulance driver was asking for Rs. 500/- for the service, but when the community people came forward and refused to give any money, he came down to do his assigned work.

In MGM Hospital also, the family was asked to spend money time to time for buying syringe, medicines etc. but they were told not to spend any money for the treatment.

Koiripatra- a Health Sub-centre in Palamau

Koiripatra is a health Subcentre under Lesliganj PHC covering 5 villages with 5685 population (approx). As per the community people, the Sub-centre hardly opened and the ANM deputed for that Sub-centre rarely visited the villages.

The community was ignorant about the services that was suppose to be delivered from the Sub-centre. Although VHC were formed and Sahiyas were selected but neither of them bothered to take initiative for making it functional. In May '08 the Community Based Monitoring Process under NRHM was introduced to the community. At the very out set, the VHCs were mobilized, reorganized and meetings were regularized. In the course of meetings the villagers became aware about the service guarantee that NRHM promises to the rural community. Under the CBM programe, CBM team were formed in every village and trained in Monitoring process of healthcare services and infrastructure in the light of NRHM and IPHS guidelines.

When the Gram Paricharcha started on 30th August 2008, these issues were raised vehemently by the villagers, as a result, now (from 1st of Sept 2008) the centre opens regularly and on time. When the *Lok Samvad* was organized on 11th Sept, 2008, these irregularities were again raised at Sub-centre level were Dr. B. D. Paswan (MOIC) and Dr. Sunil Baraik (MO) assured the villagers and instructed the ANM in-front of the villagers. Since then, the villagers are satisfied with the healthcare services in the village level.

Outputs

- The VHCs have been empowered
- It has triggered the process of account opening by the VHCs
- ANM visits more frequently
- Massive awareness
- Community and health functionaries are coming together

- Capacity building of NGOs on NRHM and community health

Lacunae

1. Lack of convergence between ICDS and Health, poor participation in the process by the AWWs, CDPOs and the DPOs
2. No participation of State level Officials in the community process, though their support and participation in trainings and other events was satisfactory
3. District and State level Mentoring Groups need to be more active in such processes

Learning

1. The state has now capacitated for scaling-up the CBM process
2. A working relationship between community based groups, Govt. health functionaries and the civil society bodies have been developed, which was the basic concept of CBM
3. Micro plan at the village level has to be developed at the community level with the participation of front line workers in the health department and the VHCs has to be capacitated for the same

Recommendation

The process was well thought and orientation on Community Based Monitoring and its need at all level. The community is well versed about the concept and it can actually take it forward through a community lead process. The program can be scaled-up in the State, but scaling it up in the whole State can be a bit difficult as managing the CSOs and the community based groups can be a difficult task, but in the next financial year, it can be executed in 10 districts, including the pilot districts.

Assessment of Community Monitoring in Karnataka
Final Draft Report, January 5, 2009

Summary of key findings

- Karnataka state was a relatively late entrant to the process of Community Monitoring (CM). Although planning began in July 2007, actual activities were initiated in April 2008 in contrast to the eight other states where the process was launched early 2007. Despite this the roll out has been rapid, and 567 Village Health and Sanitation Committees (VHSC) have been formed in four districts covering four Primary Health Centers (PHCs) per Taluka, against the original target of 180 villages in three PHCs per Taluka.
- Karnataka chose to make two significant deviations from the national design. One was to expand the process to “planning and monitoring” instead of just “monitoring”. Thus the initiative in Karnataka is referred to as Community Planning and Monitoring Health Systems (CPHMS). The second was in terms of geographic coverage. The departure from national guidelines of covering five villages in each PHC area to attempt universal coverage of all villages in the PHC area has resulted in 80% to 100% coverage of villages under each PHC.
- Key outputs in all PHC areas include: formation of VHSC, developing village action plans, filling up of score cards and facility cards, and organizing Jan Samavad in 36 of the total of 48 PHCs. Taluka and District Samavads are yet to be organized.
- The state government has strong ownership of the programme and has worked in close partnership with civil society.
- State mentoring and monitoring group comprises of non governmental organizations that share a common vision and commitment. They have worked successfully in the past on common platforms, and the shared commitment to the process has facilitated coordination at state and district levels and significantly influenced outcomes.
- The availability of committed district and nodal Taluka NGOs to actually implement the programme has strengthened the quality of community processes and the pace of scaling up.
- The State has already provided resources of Rs. 3, 20,000 and has made commitments of Rs. 250,000,000, to the process, beginning April 2009 for the process to be scaled up in the entire state over the next three to five years.
- State level ownership is yet to be fully translated at district, Taluka levels, and PHC levels, both in the PRI and in the public health system.

- The review of the intervention was premature. Taluka and District committees have not been formed and Taluka and District Jan Samavad have not yet been held.
- Kalajatha as a prelude/precursor to VHSC formation served not only to mobilize communities, but as a facilitating factor in general community acceptance of marginalized groups. Another initiative that resulted in high community acceptance of the process was a series of meetings held with different caste groups prior to the VHSC training.
- Appointing ten community resource persons (CRP) at Taluka level to create VHSC, was a critical measure in achieving scale with quality. The CRP invested substantial time in working with all sections of the community in these areas where casteism is high to ensure appropriate representation on VHSC. Several of these individuals could, serve as Taluka coordinators or resource persons in other Talukas and districts when the programme is scaled up.
- A common focus across districts was the high level of investment in village processes including- three member CRP team to (i) mobilize community, (ii) form VHSC, (iii) train VHSC members and (iv) facilitate score card filling. Has resulted in strong VHSC.
- Several variations from guidelines in capacity building processes, strengthened the process-
 - district level TOT for nodal NGO rather than one common state level TOT,
 - high level of the on the job mentoring and support by district NGOs to Taluka NGOs,
 - Use of PRA as the method of choice for VHSC formation and developing village action plans
 - VHSC manual provided to every member of VHSC.
- Jan Samvads have resulted in action being taken in some areas- such as use of untied funds at PHC and SC level for repairs and equipment. Posting of personnel was effected in some cases.
- In order to build ownership of the community monitoring process among health providers, implementing NGOs had to strike a delicate (and often fragile) balance between engaging in “too much activism, too early”.
- VHSC formation and training, requires intensive supervision by Taluka and district coordination. The other functions of documentation, review of village action plans, and ensuring VHSC score card quality, needed better supervision, but time and human resources posed a key constraint.

- Support and supervision of the village processes, networking and liaison with the public health system could have been strengthened with additional human resources at Taluka, district and state levels.
- The present pace and depth of coverage is unsustainable unless adequate human resources and commensurate financial support are provided for.
- The convergence between health and ICDS was strengthened at the village level, because of the Anganwadi Worker (AWW) taking on a leadership role as a co-convener, and in many instances serving as the de facto convener. ASHA's involvement in the VHSC will need to be skillfully managed when she comes on board. Convergence with Panchayat still needs strengthening because PRI members are not yet fully engaged with the process, despite Gram Panchayat leadership/members being conveners of the VHSC.
- The score card was found complex to fill and utility was not clear to a significant proportion of VHSC members. The formats and the score card need to be simplified to enable better understanding and use.
- VHSC funds either unused or being used on items where PHC or panchayat already has funding.

I. Background

Karnataka ranks among the better performing states of the country. However the state includes four of the 100 most backward districts in the country¹.

Although the process of Community Monitoring was launched in eight states in 2006, Karnataka was included later as the ninth state. Two of the National level AGCA members were from Karnataka and felt that the timing and circumstances (strong civil society and high political commitment) were opportune to launch Community Monitoring (CM) in the state, despite the fact that is not a National Rural Health Mission (NRHM) focus state. The ASHA programme has been launched recently in the state. ASHA training is presently underway.

Karnataka has been the focus of several innovations related to “communitization”, in public health and other social sectors. Key among these are the Jana Aarogya Andolana Karnataka (JAAK: the state level equivalent of the Jana Swasthya Abhiyaan or the National People’s Health Movement), past initiatives supported by the government and UNICEF for community monitoring, as part of the Border District Cluster Fund, and on the whole, a positive environment for civil society activism. Karnataka also has a history of partnerships with the NGO sector in managing public health facilities. NGOs managing these centers have, in turn instituted processes to improve governance and accountability.

To date however, none have been as systematically designed as the Community Monitoring process, nor has there been such significant government support and commitment to past initiatives.

II. Methodology and Team Composition

The review of the Community Monitoring (CM) in Karnataka was part of a country wide review of the process in nine states. The Terms of Reference (TOR) and the methodology were common for all nine states. The review team Members for Karnataka included: Ms. Sudipta Mukhopadhyay, (PFI- Secretariat- Advisory Group on Community Action-AGCA), Ms. Sunita Singh, (Center for Health and Social Justice-AGCA secretariat, providing technical assistance for Community Monitoring), and Dr. Rajani Ved (External Consultant). At the state level, the team met with the State Mission Director, representatives of the State Mentoring and Monitoring Group, AGCA representatives, and all four district nodal NGOs.

To review the CM processes, the team visited Raichur district, selected in consultation with the state nodal NGO. The team visited all three Talukas of Raichur district, two PHCs, two Sub centers and three VHSC. Details of persons met and places visited are at Annexe 1. The team also conducted a desk review of key

¹ Planning Commission’s list of 100 backward districts for RSVY programme available on <http://www.empowerpoor.com/backgrounder.asp?report=20> accessed on 1st Jan’09)

documents provide by the Secretariat and the state and district nodal NGOs. The list of documents reviewed is in Annexe 2. A limitation of the desk review was that several documents such as the training material, and particularly meetings of minutes at District and Taluka levels, were in Kannada, a language which none of the team members could read. However key documents were translated (verbatim and verbally) for the team.

III. Institutional Arrangements

(i) State Mentoring and Monitoring Group: The institutional mechanism designed at the national level was followed in Karnataka as well. In February 2008, a state mentoring and monitoring group (SMMG) was formally constituted by the state government. The SMMG, chaired by the Mission Director, was composed of three representatives from the health department (Director Family Welfare, Director State Institute of Health and Family Welfare, and Project Director Reproductive and Child Health), the Director, Panchayati Raj and eight representatives from civil society organizations² including two AGCA members. The selection of organizations to be represented on the SMMG was made by the state government in consultation with the representatives of Karuna Trust and Community Health Cell who are also members of the AGCA at the national level. State representation on the SMMG was limited to the Health and PRI department. *The Department of Women and Child Development (DWCD) should be represented on the SMMG, given that the Anganwadi worker is the co-convener in the Village Health and Sanitation Committee. (VHSC).*

The SMMG appears to be an active body and met about three times over the process of implementation with participation from state government. Key decisions pertaining to project implementation were discussed extensively in the SMMG and were based on consensus. In some instances, for instance on the expansion of the CM to all villages in the PHC area, opinion was divided on the pace of the programme but majority vote prevailed. The leadership of the state nodal NGO and the high credibility of the other partnering NGOs make the SMMG in Karnataka an effective body.

Members of the SMMG also provided support for activities at the district and taluka levels, a significant contribution especially given the pace of the intervention. SMMG members participated in the District and Taluka sensitization workshops as well as in the Training of Trainers at district levels. In addition some SMMG members also took part as resource persons in the VHSC trainings. *The hands on experience of SMMG members in implementing the CM in the pilot phase, is an important contribution and must be used effectively to operationalize scaling up of the CM to other areas.*

The team met with most of the civil society representatives and the Mission Director. Given the paucity of time the team could not meet other SMMG members such as technical staff of the health department and staff of other line departments such as PRI and WCD to assess their appreciation, interest and understanding of the process. *Ensuring ownership and buy in*

² Karuna Trust, Community Health Cell, AID India, Thamate, Institute of Public Health, Bharat Gyan Vigyan Samiti,

of mid level bureaucracy in the public health system is as critical as commitment from senior officers, for sustainability of the process. .

(ii) *State Nodal NGO*: The state nodal agency selected by common consensus was Karuna Trust. Based on its outstanding work over the last few decades the state nodal NGO, Karuna Trust has high credibility with the state government and other civil society organizations. Two state nodal coordinators were appointed by the state nodal NGO over the life of the project, but there was significant overlap between the two so that there were no lacuna and project activities continued unhindered.

The job responsibilities of the state nodal NGO coordinator were diverse and numerous. They included *inter alia*, convening meetings, liaising with the national secretariat, members of the SMMG, support to the district coordinators in implementation, oversight to the translation of the CM material from English into Kannada, review of reports from districts, and documentation. She acknowledged the substantial support received from the state nodal NGOs and members of the SMMG in all her tasks. Support to the CM for financial management and administration was provided by the state nodal NGO on a part time basis.

(iii). *District Nodal NGOs*: Four NGOs represented on the SMMG, (Community Health Cell (CHC), Bharat Gyan Vigyan Samiti (BGVS), Action for Development (AID), India, and Karuna Trust were selected to be the district nodal NGOs. Three of the organizations already had a district presence and representatives of the fourth have long standing connections with the district.

District nodal coordinators were appointed by the district nodal NGO. Responsibilities of the district NGO coordinator included: liaison and networking with PRI, Health and allied departments, support and supervision of block nodal NGOs, oversight and management of the implementation process of community monitoring, including trouble shooting and conflict resolution (given the nature of the process, and the social structure of the districts), documentation and reporting.

(iv) *Taluka (Block) Nodal NGOs* : Three talukas per district were selected for implementation of the programme. Although three Taluka level NGOs were selected in each district, informal support was provided by several other organizations in the Taluka that were committed to the process. As such the pilot initiative in the state has created consciousness and provided hands on implementation experience to several NGOs beyond the 12 Taluka NGOs.

Block Coordinators were responsible for the community monitoring process at the block level and for ensuring the quality of the process. Their task required a high level of understanding of community and of the public health system at block levels and below. In addition they were expected to network, and build relationships with the grass roots staff of the Health, ICDS and PRI departments. The block coordinators also had to supervise the team of ten Community Resource Persons (CRP).

Table 1: Details of coverage and nodal NGOs at district and Taluka level.

Name of pilot district	Name of District Nodal NGO	Name of Talukas in district	Name of Taluka nodal NGO
Tumkur	AID India	1. Pavagada 2. Madhugiri 3. Gubbi	1. Thamate-AID India 2. Jeevika 3. BGVS
Gadag	Bharatiya Gyan Vigyan Samiti (BGVS)	1. Rona 2. Gadag 3. Mundaragi	1. Samatha 2. KVK 3. BGVS
Chamarajnaragar	Karuna Trust	1. Yelandur 2. Chamarajnaragar 3. Kollegal	1. Karuna Trust 2. VGKK 3. Sisters of the Holy cross
Raichur	Community Health Cell (CHC) with Roovari	1. Raichur 2. Manvi 3. Devadurga	1. Roovari 2. JMS 3. Samuha

(v) Relationship with the National Secretariat: The state nodal NGO was responsible for dealing with the secretariat at Population Foundation of India, in Delhi. While they expressed overall satisfaction over the relationship there a gap in communication regarding the actual quantum of funds to be released, created implementation hurdles in the process and actually changed the nationally mandated design. This issue has been more fully discussed in Section V.d. While the village level processes were accomplished in the Phase II villages, several other consequences resulted. The programme was severely underfunded, and staff was paid poorly. The level of effort of the district NGOs was not compensated for adequately. Some Community Resource Persons of Phase I (where only five villages per PHC and three PHCs in each Taluka were selected) dropped out. Despite all this, the district and Taluka level NGOs worked exceedingly hard to ensure project outcomes in Phases I and II. *However the rapid pace of roll out, effort is neither sustainable nor productive and detracted from functions of monitoring, supervision and reviews of processes such as the VHSC formation and functioning, follow up of village action plans; Jana Samvad and score cards at village and facility levels.*

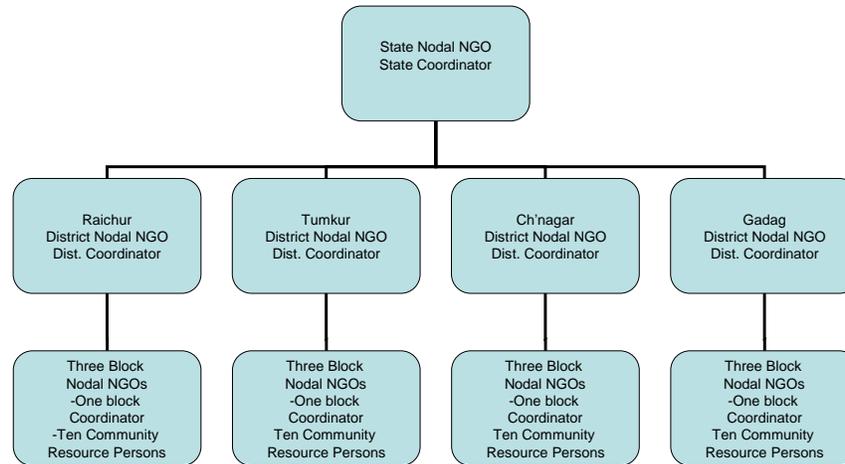
Ownership at the state level is high but this has not uniformly translated to the district, Taluka and facility levels. Only a few Medical officers actually attended the VHSC training. In some cases the Medical Officers that the team met had to be reminded of the process. They were not familiar with the facility score card. However the Jana Samavada was the event which they were clearly able to recall, somewhat unenthusiastically. *Since the entire process is geared to enforce accountability from the health providers, in a system long oblivious to community needs, more effort will need to be invested in building ownership and perspective at this level of health system providers.*

The SMMG members by virtue of being district and block nodal NGOs (Table 1) were able to obtain first hand expertise of the community monitoring process, enabled early identification of threats and weaknesses, and provided early alerts to possible problems. The participation also enabled adherence to the national guidelines, protocols, and manuals. Their membership in the SMMG also facilitated state level actions, such as early release of Government Orders; bring the attention of problems at taluka and district level to the notice of the state, and providing regular feedback on the process to the Secretary HFW and The Mission Director. *Civil society organizations involved in the SMMG need to have state level presence, a strong and continuing record of action at the grass roots, and the ability of constructive engagement with the public health system to ensure credibility, coverage and quality of the process*

Convergence: Since Taluka and district level committees are yet to be set up, the team was unable to assess the convergence angle of the process. At the village level, however, clearly the AWW is very much part of the process. She is the co-convenor of the VHSC and in all the VHSC the team visited she was very active. There are reported cases of AWW requesting that they be divested of this function since this increased their workload. One possibility is that the ASHA take on the mantle of co-convenor of the VHSC. However as of now the convergence with the ICDS system seems very much in place, with nutrition occupying an important part of the planning and monitoring process.

The role of the PRI members is one of concern. In the team's discussions in Raichur and with other Taluka coordinators, the interest of the elected representatives in the process seems low. In one of the VHSC the evaluation team visited, the VHSC convener was a PRI Adhyaksha who resides in another district and is not available to sign cheques or participate in important decisions. *The interest of PRI needs to be stimulated and sustained through separate meetings in coordination with the parent department, , particularly since there is some overlap of functions and consequent fund use (or misuse) between the PRI and the VHSC, such as village sanitation, anti malarial source reduction measures, and construction of Household latrines.*

Institutional Structure



Organogram and staff adequacy: The CM process in Karnataka had one state coordinator, one coordinator per district and one coordinator per Taluka. At the block level, each coordinator was responsible for ten CRP. The coordinators need to play the multiple roles of Programme Manager, Accounts Manager, MIS and reporting manager, network, liaison and advocacy officer. Much of the time of district and block nodal coordinators was spent in the village processes, Jana Samawad and liaison at PHC, Taluka and district levels with a consequent compromise in the other functions. *The staffing was inadequate to meet the demands of the programmes and unless addressed quickly, both follow up and important learning from the programme is likely to be lost.*

In Raichur and Tumkur, the district NGO coordinator required much more inputs, from the already overworked state coordinator, and this is reflected in the quality and pace of coverage in comparison to Chamrajnagar and Gadag.

The state mentoring group has been very active in overall guidance and support to the process, However the activity in this phase need more full time committed staff to manage the functions of : district support and coordination, monitoring, IEC and documentation development (translations and adaptation), MIS, and accounts, they were all virtually managed by one or two individuals. *The state nodal NGO needs at least three full time staff with a mix of skills to meet these various requirements. The functions at the district and block levels also need two full time staff to be carried out effectively.*

Commitment of senior government officers, particularly the current Principal Secretary Health and the current Mission Director to the process has thus been a facilitating factor to the rapid and successful roll out of CM in the four districts. This is linked partly to the personal traits of the individuals in question both of whom have strong belief in the ethos of community participation. What is not clear however is the commitment of other staff in the directorate and supporting

organizations such as the SIHFW to the process, although the first state level workshop was organized by the SIHFW. Given the short time that the CM has been underway and the plethora of activities during this initial phase, the next phase needs to focus on building commitment among individuals at this level. The state does not have a point person to provide oversight to the CM process. On the whole direct access of SMMG to the senior leadership in the department has worked well in this initial phase. *However when the project is rolled out at scale, a state level secretariat to perform the functions of the state nodal NGO will be critical.*

IV Process of Community Monitoring

So far, 567 VHSC have been trained in CM and score cards for all developed. In addition 36 PHC Jan Samvada in all four districts have been conducted. Jan Samavadas in the remaining nine PHCs, Taluka and District level Jan Samavadas are expected to be completed by December 31. Facility score cards for 45 PHCs and 45 PHC committees have been set up, PHC, Taluka and District level committees have yet to be set up.

a. Selection of NGOs, pilot districts and PHCs: The state nodal NGO in consultation with members of the SMG developed a matrix for selection of district and Taluka level NGOs. While all four NGOs met the criteria laid down in the matrix, the selection of organizations with a history of activism and spearheading movements was an underlying common thread. These qualities permeate all organizations- in SMMG, district and block nodal NGOs. While this trait was of paramount importance, all implementing agencies also needed a sound understanding of public health systems, particularly related to service delivery. This varied among the implementing NGOs, particularly at the block levels. While district and block coordinators, were largely aware of most issues related to service delivery, they were somewhat lacking in depth and details. There is substantial confusion on the JSY and Madilu entitlements among the NGOs. Random and adhoc posting by district authorities of staff in knee jerk responses to the Jana Samavad were accepted as filling the need for a “doctor” without considering if the “doctor”, could really meet community needs. *Perspective building of staff of community based organizations of public health systems in conjunction with sensitization of health providers is critical to ensure that all participants have a common framework of understanding.*

Four districts – Tumkur, Raichur, Gadag, and Chamrajnagar were selected. The following criteria were used:

- The district should have a strong presence of at least on civil society organization (CSO) working on the health sector which can work as the lead NGO in that district.
- The districts chosen should be representative of social, economic, developmental, and cultural diversity of the state.
- The lead NGO should have strong linkages with the government and other CSOs working in health and development sector in that district.

While all of the selected districts ranked poorly in socio-demographic indicators the final decision hinged upon the presence of committed NGOs working in the area. Selection of PHCs was also based on the presence of active NGOs in the vicinity and also consideration of whether these were border PHCs as past experience in the state demonstrates that these tend to be underperforming PHCs. However all processes were transparent and made in consultation with the state leadership and district health authorities. The SMMG had considerable autonomy of selection and three of the four districts were selected by the SMMG, with Tumkur replacing Kolar as the government’s choice. While this was appropriate for the pilot phase, it is unlikely that the availability of committed and competent NGOs will be high in other parts of the state. *One way of addressing this issue will be to develop common systems and procedures and identify*

key nodal organizations for capacity building so that the key components of the model are adhered to while scaling up.

Formation of Committees at various levels: Committees at several levels were anticipated in the national design. They include the Village health and Sanitation Committee, the PHC Planning and Monitoring Committee, the Block Monitoring and Planning Committee, the District Monitoring and Planning Committee, and the State Community Monitoring and planning Committee. Given the late start in Karnataka, only the VHSC have been formed and/or strengthened as yet. However it is expected that the rest will be in place by March 31, 2009.

Community participation /mobilization: Given the nature of NGOs involved in the programme there were no compromises in the process of community mobilization. Taluk coordinators, and CRPs, assisted by the district coordinators conducted several meetings in the villages before the process of VHSC training. This ensured representation of marginalized communities in the VHSC as well as their participation in the training. The *Kala Jathas* organized in every single village also appears to have stimulated community mobilization and engagement with the process appears to have contributed to the process. In each district a team of 10-12 artists was selected and trained in the issues related to community monitoring at a state level workshop. Five teams were formed to conduct KalaJathas in the villages in each district. VHSC members were enthusiastic about the process and attributed increasing levels of community awareness of the process to the Kal Jatha. The Karnataka experience demonstrates that there are no short cuts to the process of communitization and investment of time and effort in the process yields high dividends.

Table 2: Status of VHSC formation in pilot phase

Name of pilot district	Name of Taluka nodal NGO	Number of PHC (four per block)	Total number of VHSC
Tumkur	1. Tamata 2. Jeevika 3. BGVS	12	Phase 1: 45, Phase 2:119
Gadag	1. Samatha 2. KVK 3. BGVS	12	Phase 1: 44, Phase 2: 64
Chamarajnar	1. Karuna Trust 2. VGKK 3. Sisters of the Holy cross	12	Phase 1: 45, Phase 2: 93
Raichur	1. Roovari 2. JMS 3. Samuha	12	Phase 1:45, Phase 2: 105

b. Village Health and Sanitation Committees: A large number of VHSCs had been formed by a GO issued after the launch of the NRHM in the state. However taluka coordinators and the block CRP in all districts spent significant time to revitalize, reconstitute and strengthen the VHSC in order to ensure that the composition of the committees included marginalized populations, minorities and women in proportion to the demographic composition in the village. Block CRPs shared that they had to conduct several meetings with separate caste groups to

ensure buy in before the Gram Sabha was held to finally nominate/re-nominate members to the VHSC. While the AWW workers, co conveners of the VHSC were enthusiastic, knowledgeable and articulate, in contrast the participation of PRI, the conveners, in the VHSC is low or marginal. Although not mandatory, in the VHSC training phase, the participation of staff of the public health system, including ANMs, ranged from 40% to 70% across the districts.

The VHSC untied funds have been released in a substantial proportion of cases. In Raichur district, untied funds were not being used in most places. This was partly due to the lack of clarity on the part of the VHSC and the NGO on the actual use of the funds. In one instance a Taluka officer affirmed that he had” instructed all VHSC in my area to use the VHSC funds only for Emergency Transport.”. VHSCs are not too interested in the use of VHSC funds. In some places there are reported tussles with PRI members (co-signatories with the AWW) over the use of funds. As a result even in areas where funds have been received they have not been spent.

A team of three CRP, supported by the Taluka facilitator conducted the VHSC training in each village, with the duration of training lasting for three days. Only few VHSC had 100% participation on all three days. AWW who were non resident did not come about 30% to 50% of the time for all three days. In areas where there was a GO from Taluka Executive Officer and ICDS, there was better attendance of AWW and PRI. Public sector health functionaries that we met were aware of the Jan Samvada but were somewhat vague about the VHSC process- in some areas they participated in the training process in others they were indifferent.

Phase I VHSC had met more than once in the past few months. The team met members of two VHSC. (in the third village, no member, other than the AWW was available because of the harvesting season). The composition as mandated by the guidelines has been adhered to faithfully. However it appears that women members dominate men in numbers. The translation of knowledge and understanding is mixed, but it appears less than half the members understood the nature of the presence and its significance. Currently AWW has taken a key role in doing this- however in some areas AWWs have expressed reluctance in doing so- given their existing workload- since ASHA is expected to be rolled out, the challenge would now be to ensure how to enable ASHA to fill the role of co-convenor in the state. The role of the ANM in the VHSC is unclear. She is often called upon to clarify an issue or answer questions related to service delivery. She does not appear to be integrated in the VHSC or the community monitoring process. The minute books were well kept, primarily because it is the AWW who is responsible, given her experience with maintenance of AWW registers. The representation of minorities and of scheduled caste met stipulated guidelines because of the presence of the block NGO. It will be a challenge to ensure this in the absence of NGO facilitation.

From the Karnataka experience it is clear that having NGOs facilitate the process is critical. There is no single institution that can undertake the various complex functions related to community monitoring. Where no NGOs are available, large NGOs can be supported to field teams of resource persons and work in collaboration with community based groups or others that enjoy community rapport which forms the basis for the mobilization.

The process has resulted in more accurate reporting of deaths. For instance in the last six months, in one Taluka alone, the VHSC process has identified six infant deaths and one maternal

death which were not picked up by the system. The potential for data triangulation and validation exists, (a key rationale for institutionalizing the CM) but only when there is equal participation and buy in to the data gathered at village level by the public health system.

c. *Report Cards:* Report cards of all VHSCs were completed during the VHSC training itself, in many cases by the CRP themselves. In the Phase I villages however, a second round of preparation of village score cards have been filled by VHSC members facilitated by the CRP. The score card format is complex and the filling of the score card has entailed much time and agony. The Row for equity score remains unfilled in a large majority of the cards. Even district and block coordinators were confused about how to complete the equity indicator. The facility score cards for the PHC have also been completed. Thus far, however, the activity remains restricted to interested VHSC members, CRP and Taluka coordinators, with the public health system yet to take an active interest.

d. *Jana Samawad:* The second important outcome was the PHC Jana Samwad. The process of preparation appears to be elaborate with the team conducting village meetings with the VHSC to identify case studies/testimonials to be brought before the public hearing. Issues raised by the Jan Samwad include: Corruption, non receipt of funds under JSY, non receipt of Madilu kit, malnutrition at village level, non use of untied funds because of lack of proper guidelines, referral to district hospital without proper reference documents, poor infrastructure in sub center, denial of delivery services, corruption in Bhagyalakshmi, lack of respect for flag hoisting, (MO deputing male MPW), staff vacancy at all levels, where good staff are available, they are stretched too thin, (great MO but being sent off every where as a resource persons), apathy of health system, poor infrastructure at PHC, Lack of facilities: water, electricity, doctors not residential because of poor living quarters, no anti snake venom, TB medicine.

Interestingly the presentation summary (in Raichur) is made by the block coordinator, rather than VHSC member. The emphasis appears more to highlight the shortcomings of the system, including corruption. The process needs to now transition to the VHSC members making the presentation to shift the focus away from the block and district level NGO to the community.

e. *Media:* In all intervention districts the district coordinator has networked with local media to enable periodic articles in the vernacular press about the process and ensuring coverage to the Jana Samwada. However this was not a priority intervention. Also since the philosophy underlying community monitoring in the state was “that too much activism” was detrimental to the programme, the media component was restricted to articles in the newspapers. In Gadag district, one media professional was engaged by the district nodal agency to ensure that several articles were published through using his contacts. Since there was no such initiative in Raichur district, the team was unable to interview any media personnel.

Table: (to be filled by Karuna Trust/Partners)

District	Community Composition	VHSC with funds	VHSC without funds
C'rajnagar	General : 631,727	72	66

	SC: 237,624 ST:106,111		
Gadag	General : 7,08,011 SC: 1,37,414 ST: 54,410	108	0
Tumkur	General : SC: ST:	139	25
Raichur	General: 16,69,762 SC: 3,17,270 ST: 3,30,042	131	19

VI. Programme Management

a. *Capacity Building:* A range of sensitization and training workshops were undertaken as part of the CM process. State level planning workshops were held for participating NGOs and for the SMMG members. In each district TOTs were held for the key staff of the district nodal NGOs and block nodal NGOs. District and Taluka level sensitization workshops were held for functionaries of the public health system to enable understanding of the process and ensure buy in and ownership. Although no training reports are available, the profile of participants and numbers indicate that almost all key stakeholders were represented in these meetings.

The CRP underwent training for five days in Phase I. After some dropped out, a second three day phase of training was undertaken, which was described as being insufficient. The CRP in Raichur said that they felt that another round of training would help them become more efficient in their functions, especially in filling the format and the score card. In addition to the formal training process, CRP and Taluka Coordinators were provided with substantial field based on the job mentoring not only by district and state coordinator but by the representatives of the respective organizations. This has been of great benefit to the programme, not budgeted for and not discussed often but highly significant nonetheless.

The Taluka NGOs while familiar with community monitoring needed training in the specifics of the health system, financial systems and perspective building on the community monitoring process. The CRP played a crucial role in the training of the VHSC, especially in ensuring participation of the marginalized. About 30% to 50% of these young men and women belonged to the SC community and experienced fewer difficulties in mobilizing those castes. However casteism remains a significant issue and was often cited as a barrier in getting the gram sabha or VHSC together. While the modules covered all aspects of the training, the focus was primarily on MCH and Nutrition. The process of mobilization and formation of VHSC has succeeded in raising community awareness of VHSC, entitlements for Mothers and newborns and malnutrition issues. There was no documentation of training or pre and post evaluation of training programmes. Resource persons have been used from Taluka and district levels, but primary resources persons appear to have been those affiliated to the organizations or the SMMG members. Other members of the SMMG were involved in the phases of manual development, providing support as resource persons for district and taluka training and participation in review

meetings. For instance, IPH is not one of the implementing agencies was an active participant in training of CRP and VHSC.

b. Monitoring and reporting: One of the key innovations in the Karnataka CM was the linking of monitoring to planning. In all VHSC, Village Action plans were developed. Predesigned formats were provided by the SMMG. However the follow up of the village action plans is the next important step and requires more persistence and support from the Taluka team. This remains to be planned. At the state level, Quarterly reports are provided to the National Secretariat. No periodic reports are provided from the districts to the state. The state nodal NGO coordinator makes regular visits to the districts and Talukas and this report serves as monitoring report. While there is frequent telephonic discussion and overall a sound knowledge of happenings, no systematic system process documentation and written reporting has been instituted at taluka and district levels. VHSC meeting and training minutes have been kept by the CRP and Taluka Coordinator but they have not been studied to understand overall trends, or identify common problems. One of the reasons for this has been the pressure of scaling up the initiative in this phase itself.

At the SMMG and state nodal NGO documentation followed the national guidelines. Meetings were well documented and findings analyzed to a fair degree. This is indeed commendable, given the lean staffing pattern at all levels. Given the pace of implementation, the district and Taluka coordinator found little time for reflection and analysis. Had there been additional staff at district and state level, the quality of these functions could have been improved. This was done by the State nodal NGO and members of the SMG. District level meetings with the Taluka coordinators were held but those that were have been honestly documented. However there was no time allocated for reflection on the findings. They are valuable documents and provide very clear insights on the implementation issues which need to be reviewed before embarking on a state wide programme.

All material provided by the national secretariat was translated into Kannada and adaptations made for local context.

f. Financial Management: Given the paucity of time, the team was unable to review the financial management systems in detail. However it is clear that at the state level, budget discussions were transparent between SMMG, district and block NGOs. Adherence to financial systems at all levels was closely monitored.

Fund flow has tended to depend on the release of funds from the National Secretariat which in turn was depended on the Central Government. One event in particular was cited by the state nodal NGO as having been both a blessing and an impediment. A total of Rs. 76, 65, 280 was committed to Karnataka, to be sent in two tranches. The first was for an amount of Rs. 23, 44, 160 and the second for Rs. 53, 21, 120. However the SMMG and Karuna Trust were under the impression that the overall amount was limited to the first installment. Thus they were conservative in their spending, given the relatively low amount available. In September 2008, when the second tranche was released, the SMMG felt that since they had already achieved several of the outcomes envisaged for the entire pilot, they could afford to expand to other

villages in the existing PHCs and include one additional PHC. Thus the programme in the state was rolled out in two phases:

Phase 1: covering the original five villages per PHC in three PHCs

Phase 2: expected to cover all villages in the PHC area in four PHCs

The implementing agencies felt that the second tranche had enabled the expansion, but had forced them to engage fewer staff and pay less than market rates resulting in high turnover.

Budget Break up: (Provided by Karuna Trust to Evaluation Team)

SL.NO.	PARTICULAR	AMOUNT	PERCENTAGE (%)
1.	STATE LEVEL	875,000	11.42
2.	DISTRICT LEVEL	572,000	7.46
3	TALUKA LEVEL	2,790,000	36.40
4	PHC'S LEVEL	1,062,000	13.85
5	VILLAGE LEVEL	1,545,000	20.16
6.	OFFICE ADMINISTRATION	821,280	10.71
	TOTAL BUDGET	7,665,280	100.00

VI. Relation to other communitisation processes: Since Karnataka is not an NRHM focus state, the decision to engage ASHA was made only recently. Thus the ASHA in some districts have only recently undergone training and have not been part of the VHSC or Jan Samvada process. It is therefore too early to comment on this aspect.

VII. Assessment of potential outcome of CM: The process of VHSC formation and Jan Samavada has resulted in high levels of community awareness regarding Maternal and Child Health (MCH) and Nutrition (N) package, entitlements and service guarantees. Positive outcomes include of the Jan Samavadas include reduction of time in releasing JSY funds to beneficiaries, reduction of corruption, refurbishing of PHC and sub center using untied funds for each facility,

However the increased demand is not commensurate with the present supply, driving the community to the private sector. There is also lack of uniform understanding on details of entitlements. Also in spite of guidelines, individual officers issue instructions based on their understanding and whims. For instance the guidelines for JSY are different in three blocks of Raichur district:

- In Deva durga Taluka has been distributed to all deliveries taking place in private sector, but revoked as of December 2008
- In Manvi Taluka, no JSY to any woman delivering in a private sector nursing home
- In Raichur Taluka, all private sector deliveries to be treated as home deliveries, for purposes of entitlements but reported as institutional deliveries.

Accountability of the system appears to have improved ostensibly, but it is not clear how far reaching or sustainable these changes are. For instance, in one PHC Jan Samavad, a clerk who was identified by name as one who had been charging Rs. 150 for every JSY cheque of Rs. 500 has now gone on leave and the MO refuses to clear any payments as he wants to steer clear of controversy. Thus women are not receiving JSY funds. Another MO who was also identified as taking bribes for JSY payment releases now keeps his fingers out of the JSY till but continues to charge patients for services.

Other service guarantee issues such as fully staffed PHCs and sub centers remain out of reach of the community given the overall shortage in the system. Post Jan Samvads reshuffling takes place and Ayush and non MBBS doctors are posted, but after a period of a few months, they are transferred. It appears that everybody has given up on the issue of making staff be resident in the headquarters.

Following is the status of MOs who actually stay at the HQ:

Chamrajnagar: 8/12 PHCs

Tumkur: 0/12: PHCs

Gadag:6/12 PHCs

Raichur 6/12 PHCs

Source: Discussion with District Coordinators, December 8, 2008

Given the shortage of ANMs in the system, the government has now engaged GNMs and posted them in sub centers. The GNM have no understanding of public health issues and there is no programme of orientation.

However it is too early to assess outcomes, given the relatively short duration of time. What the process has demonstrated so far has been that given certain pre conditions, it is possible to strengthen communitization processes. It also highlights the fact that long term capacity building of community and public sector providers, careful management of the process, including monitoring and reporting, and the presence of committed NGOs on the ground, is necessary in order to ensure that community planning and monitoring actually translates into improved health outcomes. It also demonstrates that while NGO facilitation is critical, more community ownership is necessary for institutionalization.

Section V: Lessons for Scaling up

The rapid roll out of the programme in the state demonstrates that the model can be rolled out provided certain preconditions are in place. These include: strong community based groups, well developed capacity building programmes, substantial field level mentoring, high level political commitment, and a well organized management structure.

At the state level, the interest, commitment, and support to the Community Monitoring process is high. The state has already committed Rs. 25 cores from the World Bank supported Karnataka Health Systems Reform and Development Project (KHSDRP) to the process after the national funding ceases in March 2009. The state is also exploring the inclusion of funds from the Karnataka Health Promotion Trust, (supported by the AVAHAN-AIDS initiative of the Gates

Foundation). The latter is seen as an additionally to enable the state to promote the use of research and technological innovations in monitoring and strengthening the community monitoring process, such as the use of optical readers to ensure that the village score cards are interpreted in timely fashion and periodic feedback provided to the Talukas and districts rapidly and also serve as a monitoring tool for the state.

The next phase of the programme needs intensive field follow up and support to the VHSC so that the community does not get disillusioned. For this reason it is critical that the SMMG and the current crop of NGOs stay engaged with the process and ensure that the scaling up follows the same quality standards laid down in the pilot phase.

The programme needs a much stronger management structure than the present. Remuneration of staff should also be increased in accordance with other programs as there is a likelihood of rapid and high turnover.

The monitoring and reporting system at all levels needs to be more systematic so that feedback is provided at the appropriate time to the implementing agencies

Simplification and appropriate follow up of score cards is necessary to enable better understanding, use and consequent ownership by the community.

Assessment of Community Monitoring in Madhya Pradesh

Summary of Key Findings

The Community Monitoring pilot programme in Madhya Pradesh has shown promising results. The VHSCs have been formed and oriented to the task of Community Action in 225 villages. Awareness of health entitlements and rights is beginning to increase amongst the VHSC members. They are beginning to show potential for motivating the health system to become responsive. The Jan Samvads have resulted in increasing dialogue between communities and health care providers. There is evidence of increase in accountability of the health care system because of the Report Cards and the Jan Samvads.

However, the current assessment indicates that the review is too early. The process requires nurturing – it has not yet taken root. Much work needs to be done to further build capacities of the VHSCs, and the PHC, Block and District level Committees. At least three years of dedicated investment – both in terms of skilled human resources and as well as finances will be required to make this system of Community Action (including Community Monitoring) work.

A summary of the detailed findings are given below.

- a) Ownership by the State Health Department has been insufficient. The State Nodal Officer has not shown any interest, neither has the State Mentoring Group. Greater advocacy is required to build state level ownership. The meaning of Communitisation and Community Action within NRHM has to be discussed repeatedly at the state level so as to create an enabling environment for Community Monitoring.
- b) Although the national level resource material provided valuable guidelines, technical assistance and ongoing support through field visits by AGCA or TAG members needs to be institutionalized and budgeted for.
- c) Similarly for the state level support team. One State NGO Coordinator is not enough- a team of around 3 persons would have provided adequate support to the districts.
- d) The State Resource Group functioned inadequately because many members were not from organizations involved in the Community Monitoring. The Resource Group consisted of members from different organizations, dedicated human resource is required for supporting community monitoring.
- e) Block level facilitation is extremely critical. It needs to be recognized that the Block Organizations were not all health organisations. It is very critical to have a plan of

ongoing capacity building of the Block Facilitation Teams both in health issues and in community action issues.

- f) There appears to be a question about the duplication of Committees at the PHC and CHC levels – the Rogi Kalyan Samiti (RKS) of the health care facility and the PHC Planning and Monitoring Committee and the Block Planning and Monitoring Committee. One line of thinking suggests that the Planning and Monitoring Committees should be the umbrella committee with the RKS as a subcommittee of the facility. However the RKS is chaired by the bureaucrat/technocrat and the Planning and the Monitoring Committee by the elected representatives. It is unlikely that the technocrat (doctor) will accept to be reporting to the elected representative. This issue may need to be flagged and addressed.
- g) The tool was found to be too complex to be used by the VHSC members. It needs simplification and to be designed so that progressively sophisticated monitoring can take place as capacity is built in the VHSC or as the health system moves to higher level of responsiveness.
- h) The tool has a tremendous value of educating people about their health entitlements and rights – the act of getting responses from people increased their awareness of their rights.
- i) PHC and Block level Planning and Monitoring Committees are not yet functioning – the members need greater clarity of their roles, kinds of issues that they need to take up, how to enforce accountability and what redressal mechanism are required.
- j) Resource material needs to include more participatory tools and exercises for training VHSCs. A workshop to share material across districts would be useful to create this toolkit.
- k) Jan Samvads have been appreciated by diverse Stakeholders to improve dialogues between users, health system and PRI members. This can be a critical activity of the Community Monitoring exercise.
- l) It is important to work with the health system at each level to increase their responsiveness to the demands created by community monitoring - capacity building of the health system in how to respond to community monitoring should not be overlooked.
- m) The programme can be expanded to all the villages in the existing districts plus an additional 5 districts with modifications in the institutional mechanisms and the monitoring tool.

I Background and Context

Socio-economic, geographical context.

Madhya Pradesh is an extremely sprawling state with wide distances and a less than adequate road infrastructure. Transport and communication is not very easy. Tribal population in the state is 23% and the community monitoring pilot is going on in 7 tribal blocks. In two blocks of Sidhi and one block in Chhindwara STs are in large numbers while two blocks of Bhind district are Scheduled Caste dominated.

History of rights based health work

The background of the programme in the state and the selection and involvement of the state nodal NGO is rooted in the rights based work in the state on Right to Food and Health for all campaigns. JSA and its member organizations played a key role in being involved and implementing the programme in the state. The Joint State Nodal NGOs, MPVS and SATHI CEHAT have a history of rights based health work in the state. Over the past eight years MPVS had been involved in various state and district level processes towards bringing out people's perspective on health and other social development issues and the status of entitlements³.

In the 2004, NHRC-JSA Jan Samvad, the cases from MP received no relief from the public health system. On the contrary, families of those whose cases were presented were victimized by the local health system. Health and other organizations who had mobilized the people actually felt ashamed to go back to these villages – they felt that they had let the people down.

In the late 80s a MP Mahila Manch came together. It was quite dynamic for a few years and was an example for other states, like Gujarat. In the Community Monitoring pilot, MP Mahila Manch did not get involved as an organization, individuals from the Mahila Manch have been contributing.

Health System in Madhya Pradesh.

In the late 90s when Digvijay Singh was the Chief Minister in the Congress Govt. the Health department in MP was activated by bureaucrats like Gopal Krishnan and Harsh Mander.

³ These included 12 district study report on Alma Ata, participation in people's health assemble in Bangladesh, involvement in the Right to Food campaign and the 220 village report on the status of BPL entitlements, Midday Meal, anganwadi and the PDS system in MP, 2003 report on the Swasthya Jeevan Seva Guarantee Yojana in MP, the MP silicosis study, 2004 Western Region NHRC-JSA Public Hearing on denial of Health Care, organizing second National Health Assembly in Bhopal which included community monitoring session etc.

Five years ago under Digvijay Singh's Congress government 7 committees were formed at the Gram Sabha and 3 at Panchayat level as part of decentralized planning. These were on education, health and other social issues. The effort was supported by EU, UNICEF, DANIDA. As part of the programme GP level training programmes were held for the committees. The new government discontinued the programme and recognized only the Gram Sabha and some committees at Panchayat level.

In 2001, the government of MP started the Swasthya Jeevan Seva Guarantee Yojna which has as its components the Iodine Mission, Water Mission for potable drinking water, Total Sanitation Campaign and so on under the Rajeev Gandhi Mission. MP also had the Jan Swasthya Rakshak with 6 months training.

The Health Department has seen considerable turmoil in the last one year. The Director of Health (also the State Nodal Officer for Community Monitoring) was suspended on charges of large scale corruption. Some other officials of health department are also facing corruption charges. Officers appear to be wary of community monitoring.

Initially when the Community Monitoring pilot started, the then Principal Secretary of Health was very supportive and the other officers had to fall in line. At this point in time, it appears as though the officers at the state level do not fully understand the concept of community monitoring and community action, or appreciate its potential. At the district level, there appears to be much greater support.

II Methodology

The assessment of MP took place between Nov. 30 and Dec. 3 2008. External team members were Renu Khanna and Sudipta Mukhopadhyay (National Secretariat – PFI). From within MP, Dr. Ajay Khare (State Nodal NGO Coordinator), Dr. Pragya Dube (MPVHA), Dr. Savita Jain (State Representative NHSRC), Biraj Swain (MP TAST) were part of the review team. It was not possible to have a meeting of the State Mentoring Group during the assessment. The assessment consisted of discussions with the State Coordinator, field visit to Guna, discussions with Block Facilitators in Guna, a day long meeting with District Coordinators and members of the State Resource Group. The State Nodal Officer was not available for discussions.

According to the Managers' Manual, the review was to have been based on the Process Documentation generated by the State Mentoring Group (Managers' Manual). Since the State Mentoring Group has not functioned, this documentation was not available. An end- of- the- review meeting at the state level was not held because of impending elections. The findings of the review could not be shared or validated with a larger group especially from within the State Health Department.

Annexure 1 and 2 contain a list of persons met and the documents read.

III Institutional Mechanisms

Preparatory phase work

The preparatory phase work in the MP programme consisted of the following:

1. Finalising selection of state nodal NGO through government order.
2. Finalisation of pilot districts, selection of district nodal NGOs, selection and notification of state mentoring group through government orders.
3. Finalisation, translation and publication of state level brochures, pamphlets, posters and adaptation of community monitoring manuals.
4. Undertaking the state orientation workshop and state training of trainer's workshop.
5. Selection of Media fellow and support to districts

State level

Selection of state nodal NGO

The selection of MPVS and SATHI-CEHAT as state nodal NGO was based on its strong field presence in the state particularly in couple of districts, strong rights based work on health and other issues and its linkages with the government. It appears that ultimately MPVS performed the co ordination role; SATHI CEHAT has been more active as the Barwani District Nodal Agency along with Asha Gram Trust. SATHI CEHAT's senior staff members tried to play an active role liaising with the State Health Department.

The community monitoring programme provided an opportunity to systematize the rights based work. Two AGCA members and a National Secretariat member were part of the selection process meetings. **Till date no government order has been issued.** ON WHICH ASPECT...EARLIER THERE IS A MENTION THAT THE GOVERNMENT ORDER ISSUED FOR FINANLISING SELECTION OF STATE NODAL NGO & FINALISATION OF PILOT DISTRICTS ETC (FIRST & SECOND LINE IN THIS PAGE)

The State Coordinator is a government doctor (an ophthalmologist) seconded to MPVS by the State Health Department. He is positioned very interestingly as an 'insider outsider' - he is well known amongst the doctor throughout the State. As a member of the MPVS, he brings in the rights perspective.

State Mentoring Group

The State Mentoring Group was also constituted in the same meeting with the health department. The mentoring group members are individuals involved in JSA and rights

based work. In addition there were representatives from the state department. Total number of members was 10 with 6 as civil society members.

The State Mentoring Group is chaired by the P S Health and Family Welfare Dept., the Director NRHM is the State Nodal Officer. Two members of the AGCA, Director Panchayat and Social Welfare, and members of networks like MPVHA and MPBGVS in addition to other NGOs are members of the State Mentoring Group.

The meeting with the state health department for selection of NGOs and pilot districts helped in discussing the programme objectives with the state department officials, bringing transparency in the selection process as per the national criteria and providing the impetus for rolling out the implementation in the districts. Subsequent to the meeting, the government order was issued notifying the names of the pilot districts selected for the programme. This helped in gaining a buy in from the district government, both health and district panchayat department.

The State Mentoring Group has met once during the period of the pilot programme. There has been no follow up of the minutes of this meeting. Members are not able to give time for meetings. A couple of members are active and communicate with the State Nodal NGO regularly. Most communication with the state government is being done by the State Nodal NGO. State government is not interested in participating in the state mentoring meetings. Recent reshuffle in the Health Department has led to changes in the Director, Jt. Director, and support staff. There is also an opinion expressed that the role of the State Mentoring Group was not clearly spelt out even at the inception of the pilot programme and there was no official mandate for this committee to function appropriately.

During the field visit there was no meeting of the State Mentoring Group.

A State level resource group of 14 members was also formed.

State level resource group has not been effective. Only 4 persons have provided training in other places. One of the reasons is that they work with NGOs who are not part of the programme.

District Level

(a) Selection of districts and district nodal NGO

This was initiated by the state nodal NGO through a process of discussion with the state health department and principal secretary. The health department conducted a meeting with AGCA members, NGOs in the state with strong district presence, experience on

working on health and strong rights based work. The Commissioner Health and the Principal Secretary Health were present in the meeting along with the Director.

The criteria for selection of districts were

- Performance in NRHM and key RCH indicators particularly poor performing districts
- Regional representation.
- Strong civil society presence particularly in health and rights based work.

Based on the above criteria 5 districts were selected which were Siddhi, Chhindwara, Barwani, Bhind and Chhattarpur. However the state Health Department felt that a better performing district should also be included – the Principal Secretary suggested Guna. Therefore instead of Chhattarpur, Guna was selected as the fifth district. Guna has been a district into which much input has gone because of administrative and political reasons. A number of sops were given to this district’. UNICEF has invested a lot in Guna too. Guna appears to be a ‘prized’ district.

The government also accepted the district nodal NGOs selected for the five districts. Till date no government order has been issued for district nodal NGOs. Only the districts have been officially approved.

(b) District and Block NGOs

<i>District</i>	<i>Organisation</i>	<i>Block</i>	<i>Organization</i>
Guna	MPVHA	Guna	Moti Shiksha Samiti
		Raghogarh	Sushil Shiksha Samiti
Sidhi	Gram Sudhar Samiti	Bamori	Hareeth
		Sidhi	Gurukul Shiksha Samiti
		Majhauri	Gurukul Shiksha Samiti
Chhindwara	MPVS	Kusmi	Gram Sudhar Samiti
		Tamia	MPVS
		Parasiya	MPVS
Barwani	Asha Gram Trust	Junnardeo	MPBGVS
		Barwani	Asha Gram Trust
Bhind	SATHI CEHAT	Pati	SATHI CEHAT
		Paansemal	SATHI CEHAT
		Bhind	MPBGVS
	MPBGVS	Gohd	MPBGVS
		Mehgao	MPBGVS

District mentoring group was formed in all the five districts. However the group has met only once. A major problem is members' inability to give time.

The programme framework did not provide clarity on roles and responsibilities and accountability of the district mentoring team. Many members have asked about the role and powers of such a team and the future nature of such a team within the district health department.

Following are suggestions for future role of district mentoring group.

- Provide guidelines for role of the mentoring group in future when the programme goes to scale. Mentoring group should operate as an advisory body to the district government and not operate as a body constituted by the District Nodal NGO as is the case now.
- Role of the District mentoring team could also be to ensure quality of interventions by the District and Block Nodal NGOs.
- Mentoring team should also review various reports that are produced by the District Nodal NGO.
- One or two mentoring team members could also be involved in important decision making processes of the District Nodal NGOs.
- May be merge the District Monitoring and Planning Committee with the mentoring group. (There were two opinions on this. It was felt that theoretically these committees are suppose to support, do trouble shooting for the District Nodal NGOs, and also facilitate liasoning with District health officials etc. Whereas by very constitution the monitoring committees are broad based with monitoring as the specific function.)
- Reconstitute District Mentoring Group.

(d) The District Nodal Organization of Guna is MPVHA. MPVHA is part of JSA. It has large number of NGO members in state It has not done the Community Monitoring exercise in any of the three blocks. Members of MPVHA were involved in implementation of Community Monitoring in Guna. During the pilot period two of its staff who were overseeing the community monitoring have left the organization. At the time of the of the field visit, the third person who is currently in charge, was away on another commitment. A recent recruit into MPVHA who is responsible for the Targeted Interventions Project, was with us during the field visit.

(e) In Barwani District, Asha Gram Trust and SATHI- CEHAT have been listed as Joint District Nodal NGOs. SATHI - CEHAT did the Community Monitoring in two blocks and Asha Gram Trust in one block. There appears to be ambivalence on the part of SATHI - CEHAT to own this position of the Jt. Dist Nodal Organization. SATHI - CEHAT states that they have been providing the technical input into the CM pilot at the District level while Asha Gram has been doing the coordination and programme management.

Asha Gram Trust is a mental health and disability related organization and does not claim to be a flag bearer of the rights based perspective, although some of their actions - eg mobilization of 100 differently-abled persons demanding CBR during the Disability Commissioner's visit – indicates that their interventions are based on a rights based perspective.

SATHI CEHAT is working through mass based people's organization in the two blocks.

(f) MPBGVS is working in Bhind from quite a long time. It started its work with the literacy campaign in Bhind and is now working on strengthening panchayats, women's empowerment, health etc. It has a presence in all the blocks. It is also part of JSA and is involved in rights based work.

(g) Gram Sudhar Samiti is active in social issues and worked with JSA in Peoples' Rural Health Watch. It has a good presence in Sidhi district.

(h) MPVS is implementing community monitoring in Chhindwara district. It is involved in many other activities for income generation of tribals in Patalkot region and other parts of Tamia block since a decade.

Relationships

(a). National to State

- Visible support by AGCA members and national secretariat to the State CM team, more in the initial stages.

AGCA members were involved in varying degrees in the MP Community Monitoring pilot. One AGCA member and his organization SATHI CEHAT have been working for at least five years in Barwani District in supporting local people's organisations to integrate health rights agenda. Another AGCA member and her organization, CHETNA have also worked in MP. Another AGCA member organisation CHC had a long history in helping the MP Government in various areas - compiling the HDR, evaluating the Mitani Program, preparing to initiate a Community Health fellows programme, preparing to augment the Public Health technical resources in the State, and so on. Two AGCA members made the first visit to the State to discuss the idea of Community Monitoring with the Principal Secretary Health and facilitate the formation of the State Mentoring Group, selection of the Districts and the District Nodal Agencies. Another AGCA member was present for the State TOT.

- Some interventions were made by the MD NRHM to State Health Officers, although there is a hesitation to overstep boundaries because Health is a state subject. In fact there appears to be a perception that the CM agenda is an imposition on the states by the National level.

(b). State

- Principal Secretary (Health) showed readiness and support.
- There were changes in the MD NRHM during the pilot phase period. There appears to be resistance to idea of Community Monitoring because of fear that irregularities will be revealed.
- Principal Secretary WCD is reported to be supportive to the State Coordinator.
- State Mentoring Group is practically non functional, State Resource Group is partially active.

Representation from the ICDS Department has been missing at the State Level. The State has seen several transfers during the pilot phase - three Principal Secretaries (Health), three Commissioners of Health, as well two Directors of NRHM changed. Two cases of major corruptions were exposed resulting in one Director NRHM being suspended.

(c). State to District

- District Coordinators' meetings were held.
- The State Coordinator and Resource Group members visited districts and were involved in training etc, but it looks like more handholding was required - eg mistakes in Guna's report card (Sagar) were not identified till our field visit, from the District Coordinators' feedback it appears that an exchange of teaching methods could have been facilitated.
- There also appears to be a constraint of competent human resources at the state level.

(d) District Level

- Relationship with the CMO and BMOs appears to be good in Guna, Chhindwara, Bhind and Sidhi. In Sidhi, the CMO had not attended any program but the BMOs were responsive. In Chhindwara and Bhind, all PHC and CHC Jan Samvads were attended by PHC in charge or BMO. In Barwani CMO was not pleased with the media reports and this may affect the formation of the District Monitoring and Planning Committee. Although it is reported that in the District Workshop, the CMO assured full cooperation and facilitation through necessary orders. In Pansemal Block the BMO was uncooperative.
- Many orders were issued by the CMOs and BMOs to support the process and ensure participation. Some BMOs also gave appreciation letters for the Community Monitoring process

(e) District to Block

– In Guna, the District Nodal Agency was persuaded to take on the responsibility even though the organization does not have direct field presence in the district. The result is that monitoring and supervision and support have been less than adequate. Also as mentioned elsewhere, there has been a turnover of the staff responsible for the CM process in the District Nodal Agency.

(f) Participation of Panchayat Members

– At the level of the VHSC, involvement and participation of the **VHSCs PRIs?** appears to be better than at the higher levels. The representation of the Zilla Parishad Health Sub Committee members has not been satisfactory. In some blocks, eg Sidhi, the Chairperson of the Health Sub Committee demanded to be reimbursed jeep expenses for attending meetings.

- Jan Samvads were attended by PRI members and they appreciated the Community Monitoring. In future they may be more interested considering how the process resulted in visibilising the issues.

- Gram Sabhas are thinly attended; participation of women in Gram Sabhas is reported to be weak.

- According to the District Health Officers of Guna, regarding PRI support they mentioned that at village level it was possible to garner their support but not at the block and district level.

- There is an opinion that the PRI representatives at the village and block levels would need training.

(g) NGOs

– A number of persons interviewed have the opinion that health related capacity of NGOs in the state needs to be increased. Many are active in the right to food campaign, the panchayat strengthening programmes and other rights based programmes – enhancing their health competencies will increase their effectiveness.

- In the entire state, the combination of the NGOs participating in CM, is very good. The diversity adds strength. Many are also contributing in the ASHA Mentoring Group and capacity building of VHSCs.

- The negotiating capacity of the NGOs needs to be increased.

- There was lack of collective thinking by all the NGOs involved in the pilot programme from the 5 districts. This did not lead to any cross learning of innovative approaches and adaptations.

- The District Coordinators felt that there was need for greater structured facilitation and institutional monitoring of the programme. The entire process should include decentralized planning in the framework, adequate capacity building at all levels particularly for NGOs.

It seems that there are three types of NGOs involved in the process of community monitoring in MP:

- NGOs which have a well defined rights based perspective which is reflected in their community level interventions. These NGOs have a somewhat difficult relationship with the state.
- NGOs who have a core identity as a developmental organisation. However, these organisations may have an activity based association with rights based coalitions or networks. Barring a few exceptions, NGOs in this category are state supported and their vulnerability to the reaction of state is well known.
- Organisations who do not have a well articulated position or a perspective and who exist on a project to project basis with an agenda that is determined by the availability of funds.

Interesting details from the State TOT process....

A professor from the PSM Dept, Bhopal mentioned that VHSC had been formed earlier and that Community Monitoring is not a new concept.

Speakers also emphasized the role of the PRI representatives and the RTI Act for Health Rights. It was also emphasized that though community based monitoring has a potential to seriously challenge existing power equation between the provider (health functionary) and recipient (community member), it is extremely difficult to sustain such a process without official mandate

The CHC doctor's inputs were valuable - he identified the record in each facility that the CM teams should scrutinize.

Experiences of Rajasthan and Maharashtra were also shared by the AGCA members present.

Emerging Issues related to the Institutional Mechanisms

(a) Ownership by the State Health Department has been insufficient. The State Nodal Officer has not shown any interest. Greater advocacy is required to build state level ownership. The meaning of Communitisation and Community Action within NRHM has to be discussed repeatedly so as to create an enabling environment for Community Monitoring.

(b) Although the national level resource material provided valuable guidelines, technical assistance and ongoing support through field visits by AGCA or TAG members needs to be institutionalized and budgeted for.

(c) Similarly for the state level support team. One Nodal Person is not enough- a team of around 3 persons would have provided adequate support to the district.

(d) The State Resource Group functioned inadequately because many members were not from organizations involved in the Community Monitoring .The Resource Group

consisted of members from different organizations, dedicated human resource is required for supporting community monitoring.

(e) In terms of duration of appointment, amongst the range of appointees for facilitation of CBM, shortest appointment was of the Block Facilitator. Block level facilitation is extremely critical. It needs to be recognized that the Block Organizations were not all health organisations. It is very critical to have a plan of ongoing capacity building of the Block Facilitation Teams both in health issues and in community action issues.

(f) There appears to be a question about the duplication of Committees at the PHC and CHC levels – the RKS of the health care facility and the PHC Planning and Monitoring Committee. And the Block Planning and Monitoring Committee. One line of thinking suggests that the Planning and Monitoring Committees should be the umbrella committee with the RKS as a subcommittee of the facility. However the RKS is chaired by the bureaucrat/technocrat and the Planning and the Monitoring Committee by the elected representatives. It is unlikely that the technocrat (doctor) will accept to be reporting to the elected representative.

This issue may need to be flagged and addressed.

IV PROCESS OF COMMUNITY MONITORING

Activities conducted at the district and block level as part of this programme are as follows:

1. Formation of District Mentoring Groups
2. Formation and orientation of VHSCs on process of community monitoring
3. Formation and orientation of PHC, Block and District Monitoring and Planning Committees
4. Undertaking community enquiry with VHSC members and developing village level report card
5. Organisation of health providers' orientation workshops
6. Undertaking facility survey and conducting facility level interviews and meetings to develop facility level report card.
7. Conducting district media workshop and media reports.
8. Conducting PHC, block level Jan Samvad

The section below summarises the activities

VHSC formed and oriented	225
PHC, PMC formed and oriented	41
Block PMC formed and oriented	14
District PMC formed	04
District PMC Oriented	03
Village health profiles	225
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Jan Samvad at block	07

a. Selection criteria – geographical and partner

As mentioned at the beginning of the report, the criteria for selection for the NGOs was strength of work on health at the block and village level, rights based approach. Several persons interviewed have also stated that there is a paucity of health organizations in

the state and this affected the selection process. In the district visited during the review, it appears that the NGOs exist on project to project basis.

The selection of villages was undertaken in consultation with the CMOH based on accessibility, motorable road, remoteness from health facilities, and representation from tribal blocks. In many cases CMOH suggested better off villages, NGOs tended to select those villages where they had strong presence. The villages were selected in the state TOT. The final selection was done in the Districts in consultation with the CMHO.

b. Village Health and Sanitation Committee

At the beginning of the programme, it was found that selected villages had government constituted VHSCs which were on paper only, ie they were not active. Most of the villagers were not aware of the existence of the committee other than the village panch, ASHA, ANM and Anganwadi worker. As part of this programme the block NGOs had to form and in most cases reconstitute the VHSC as a 10 member committee. The 45 VHSCs formed in this district were ratified by a special Gram Sabha. Otherwise in MP most Gram Sabhas are usually held four times in a year i.e. on national days 26 Jan, 2 Oct, and 15 August. Many times Gram Sabhas are held without informing anyone and decisions are taken by dominant caste groups or interested party. Initially villagers were skeptical of setting up another committee but block NGOs provided orientation to villagers on the need for VHSC to demand for quality health services.

Reports of NGOs indicate that formation of Committees was a long\drawn out process, and took upto five visits for preparation before the Committees could be formed. In many blocks, NGOs reported, that committees already existed. In Guna for instance the Sanitation Committees had been set up in the early 2000s as a part of the CM's efforts to activate communities. These Sanitation Committees had to be reoriented towards becoming Health and Sanitation Committees. The NGOs had to reform the committees according to the NRHM guidelines and then get approval from the Gram Sabhas. People in the villages did not understand why new committees had to be formed. The Block facilitations reported that where there were old Sanitation Committees existing with the powerful luminaries of the village, they used the strategy of elevating the more powerful into a group that would monitor the more representative new Health and Sanitation Committee that they were making. NOT CLEAR. ALSO THE TWO PARAS SEEM TO BE SLIGHTLY REPETITIVE...

Block Facilitators mentioned that a lot of the programme time went in forming and activating the VHSC. Guna being a high profile district, there was a lot of political pressure and pressure from the sarpanch during reconstitution of the VHSCs.

In the Pati block of Barwani district, VHSCs were already formed. However upon enquiry it was found that none of these committees were formed in the Gram Sabhas and the constituent members of these committees were only ASHA, AW worker, ANM and Sarpanch. When the Nodal NGO representative objected to this procedure, the

BMO suggested that Gramsabhas be organised to constitute the VHSCs as stipulated in the official framework. The present VHSCs in the pilot villages of Pati and Pansemal were constituted through a genuinely participatory approach

During the field visits in Raghogarh Block, we found that all the VHSCs comprise of women only, in a few villages an MPW is the only male member. The reason for women only committees in this Block was not clear. In other Districts, the VHSCs have male and female members. Most VHSCs have ASHA and she is the Secretary of the VHSC.

In a few VHSC (Sabatkheri for example) the membership appears to be from one community only - Kushwas. When asked, the Block facilitator replied, 'We've only kept the women who don't do parda -there are women from one Samaaj only.' Ooniganjpora has 10 Bheel members and 1 Ahirwar, Dirauli VHSC has 9 Meena members, 1 Sehariya, 1 Harijan and 1 Gadri.

Scrutiny of the VHSC members' lists' indicates that in most others there is representation from all social groups in a village.

Majority of the VHSCs in Raghogarh Block Community Monitoring pilot village have not received the Rs. 10,000 untied fund. Many other non CM Villages have received the fund (eg. Peepalkheri whose AWW and Sahayika we met). In Sagar, the first village that we visited, the committee members were unclear whether the fund had come in. The women Sarpanch's son (who is incidentally referred to as the 'Sarpanch') reported that the money had come into the bank account. The members of this VHSC had no idea what the Untied Fund was meant for.

By the Ex CMHO of Guna District, we were told that the Untied Fund has been released to only those VHSC which are working. 'By mistake' only Rs 2000 was deposited in the bank accounts. In one block Rs. 10,000 was given. The money has been used for painting the AW Centers, cleaning the village, treatment of BPL families, buying weighing machines etc. He felt that part of the untied fund could also be used to facilitate the ASHA's working, she works out of her home, may be some space can be organized for her.

Representatives of others VHSCs (Gocha Amaliya, Sabatkheri, Jetpur) stated that their Committee had not done anything because they had no money. When asked 'What will you do when do get the money'? The standard reply was "Saaf safai"? In most of our meetings in Raghogarh Block with VHSC members, we found that there was a major preoccupation with lack of payment to attend VHSC meetings or discharge the VHSC responsibilities. Clarity on the roles and responsibilities of the VHSC, of themselves as members, of the Jan Samvaad was not very high among the VHSC members. While minute books showed regular meetings, there was no note of what was discussed or decisions taken. In the Avan PHC meeting where representatives from Sabathkeri and Jetpur were present, there appeared to be a confusion about whether they belonged to the VHSC or to a 'SamooH" VHSC members were not aware of their health entitlements.

In the Avan PHC, we saw the Sagar Village Report Card Stuck on the wall. Instead of only the first column being filled up for Quarter I, all four columns were filled up for Jan, Feb, March and April. The constitution of the PHC Monitoring and Planning Committee was also pasted on the wall of the PHC. It showed the name of the PHC doctor and stated his position as the 'gramwaasi'. These are indicative of poor monitoring by the Block NGO supervisors and the District Nodal NGO.

Most of the VHSC members appeared to be demotivated since they felt that with no funds they could not do any development work. Post VHSC training no handholding or supportive supervision appears to have been provided to VHSCs to strengthen their functioning or activate their role in communitisation.

Discussions with the representatives of VHSCs of Gocha Amaliya, Sabatkheri, Ooniganjpura, Dharunia indicated that the women are powerful and these VHSCs have a tremendous potential, if members are properly trained over a period of time. Some women have opened the bank accounts with their personal money.

c. Formation of Planning and Monitoring Committees

PHC level Planning and Monitoring Committees

Although we visited two PHCs, Avan and Jamner and had good meetings with the VHSC members, it looks like the PHC level Committees are not yet functioning adequately. At Jamner we were told that the VHSCs' members have not brought up any issues to the PHC level Committee meetings so there has not yet been any agenda for these meetings. Yet in our presence, the VHSC members articulated that not receiving the untied fund was a big hindrance for their functioning. It was pointed out that this could have been an agenda for the PHC Committee meeting! At least in the Raghoghar Block, it looks like the PHC Committees have not received sufficient orientation to their role and responsibilities.

According to the Block Facilitators, although all VHSCs raised the issue of JSY corruption, accounts not being opened and lack of untied funds, the facilitators were not aware that this was an issue to be raised at the PHC/CHC committee meetings.

The redressal system is not yet in place. Accountability in the PHC or at the Block level is not fixed so the VHSCs cannot expect any relief from the next level yet.

From some other Districts, we received reports that the BMO was asking for a share of the VHSC fund before he gave orders for its release.

The Block Planning and Monitoring Committees have been formed but are not really functioning yet.

The Raghogarh Block Planning and Monitoring Committee members were not aware of the roles and responsibilities of the members and the committee. They demonstrated no clarity in understanding of community monitoring. Members showed reluctance in involving Panchayat members at any level. They felt that panchayat members were cooperative only at the village level. They suggested that community monitoring reporting should be part of health system's regular reporting procedures and frameworks and that the committee should have powers to review the performance of VHSCs through field visits

During our visit a tubectomy camp was being conducted at the Raghogarh CHC. A large number of women were waiting till 5 PM for their operation. The BMO was not particularly interested in meeting us. He could be persuaded to meet us briefly.

The District Committee has 30 members of which 3 are the elected members from the District Health Subcommittee of the Zilla Parishad, 4 are RKS members, 1 officer from DWCD, 1 DEO and 1 CMHO.

The planning and monitoring committees were set up towards the end of the programme. Since then due to the elections there has not been continued engagement with the committees to decide on their roles, powers and accountability in monitoring.

d. Report card

The process of Community Enquiry consisted of filling the facility checklists, doing facility level interviews and making the village profile.

Feedback from all quarters is that the Report Cards were difficult to fill. The Block NGO head in Guna District also admitted that she found it difficult to help her Block Facilitators in doing the calculations of percentages. Extraction of information from the cards became too difficult.

The community enquiry and preparing report cards has been done mainly by the Block Facilitators, not by the VHSC members. VHSC members do not recall being part of the community enquiry process or developing a report card. In Gocha Amaliya, only the anganwadi worker remembered being part of the community enquiry process. Other members were not aware of the monitoring process or the role of the VHSC in monitoring health services.

The Block Facilitators said that it took between 5-6 days to complete the village profile. The District Coordinators said that the community enquiry tool was ambitious – it became a scoring system and data gathering process and did not reflect community perception nor does it have the space. Scoring and percentage process was difficult.

The Equity Index was uniformly left blank in all blocks.

In Raghogarh Block we saw only one report card (Sagar) filled out and as mentioned earlier, not correctly. We did not see any facility level report cards.

The general feedback was that the Community Enquiry tool needs simplification. Since it cannot be completed in one go, community enquiry should be done in a phased manner linked to progressive indicators.

Another issue raised by different groups was that since everyone in the VHSC except the service providers are illiterate, it is the service providers who fill the form. Or the service providers are present with the Block Facilitators when questions are being asked and the forms filled. How then can questions related to the service providers be asked and honest answers obtained? There is discomfort on the part of the village folk to point out in the presence of ANM, that she is irregular in visiting the village. The Block Facilitators stated, 'However, they would tell us frankly in private.'

The Block Facilitators reported that despite all the problems with the checklists and forms, they were a great instrument for increasing the awareness amongst community members. The very act of answering the questions, made women aware of their entitlements. Block Facilitators felt that families in remote villages were very interested in knowing about the information in the form though they had least access to health services. Also the ANMs and MPWs have become more conscious of their services after they see orange and green on the report cards. ASHA's work in the village has also improved after the report card exercise.

The problems cited by them were as follows: non acceptance by health system staff that positions were vacant or staff were absent; pressure to change the orange to green by the BMO; pressure on VHSC members to bring women for immunization when this showed up as red or orange in the report card.

Some ways of simplifying the questions suggested by the Block Facilitators were as follows:

- does the ANM come to the village on the appointed day?
- does she tell people about the side effects of the immunization?
- does the MPW give chlorine or not?
- does the ASHA visit all pregnant women?
- do all women have ANC cards?
- are new needles used for every injection?
- How many medicines does a patient need to buy from outside?

According to the District Coordinators, the report cards were used as follows:

1. Presented to CMO who showed it to other service providers in their meetings.
2. Presented CHC card in block providers training after which action was taken on HR issues.
3. Used in Jan Samvad.
4. Used in media workshops and articles.
5. Presented card to Lok Manch before elections.

6. Cards presented in Gram Sabhas. Sabha members felt it was an important tool and a vital link between VHSC and service providers and beneficiaries.
7. Report card seen as an output by service providers.

Future planning should include strategies for community action to improve services. The report cards need to go back to the village which has not been the case in the current programme. In some districts report cards are used to prepare a plan to improve the score card

PHC report card is filled by PHC committee members in consultation with Block Facilitators. Process of sharing the cards has started. All the PHC Committee members are not participating in these activities but some members are Supporting it.

e. Jan Samvad

From all account Jan Samvads have been the most significant activity of the community monitoring. NGO heads, District Officers, Block Facilitators, all are unanimous in their appreciation for the Jan Samvads.

In the Raghoghar CHC meeting, members present shared their experience of participation in the Jan Samvad. They felt that the Jan Samvad provided first opportunity to directly interact with government officials on the same platform but most of the Jan Samvad was not undertaken with adequate preparation. There was a mix of issues raised in these meetings including general complaints. No grievance redressal mechanism was discussed by the NGOs in consultation with the block/district health department for post Jan Samvad follow-up. Overall the people were excited about Jan Samvad. In one such meeting announcement was made of appointment of additional doctor in newly upgraded CHC. The CHC already had high case load. Government asked Jan Samvad to be announced which led to large number of people congregating. Non payment of JSY reimbursement was major issue along with lack of availability of medicines in sub centres and with depot holders. Jan Samvad was also seen as confrontational. At times the police had to control the crowd.

Due to lack of preparation, local pressure and fear of backlash, some beneficiaries tend to change their statements in the Jan Samvad.

Impact of Jan Samvad

Following are the issues related to Jan Samvad as highlighted by Block Facilitators

- 1 Most health departments are apprehensive of Jan Samvad. They feel that it is confrontational. They are reluctant to have NGOs monitoring the health department. On the other hand, some are very positive and participate actively. Many Jan Samvads were attended by the PHC in charge or the BMOs
- 2 Villagers see it as a formal platform for grievance redressal.

- 3 For the first time there is awareness amongst some villagers of the range of facilities that should be available at PHC/CHC
- 4 Some immediate relief is also provided – for example, increasing stocks of medicine, instructions to field staff, etc.

The DPC (ICDS) Guna, felt that the community monitoring programme has helped create good VHSCs. He has also participated in the district workshop and two of the Jan Samvads. He felt following was the impact of the Jan Samvad.

1. It is a big platform for villagers.
2. The larger participation of women is a good opportunity.
3. The process of the Community Enquiry and the Jan Samvad is a learning opportunity for health department.

Usefulness of Jan Samvad: Process, Impact and Suggestions

Process

1. Information of Jan Samvad given at VHSC level.
2. Discussion held with BMOs to brief on the process and also decide on dates. This also helps in allaying fears of health department who view this as a confrontational process especially those officials who have attended other Jan Samvads on food and water.
3. Jan Samvad can become health service provision opportunity e.g. in Sidhhi where it became a camp for providing medicines on seasonal diseases.
4. Separate invitation letters sent to PRI members.
5. Jan Samvad date and venue were announced through loud speakers and jeeps.
6. Haat day (market day) chosen for Jan Samvad for maximum participation.
7. Preparatory meetings held to decide on type of panel for Jan Samvad.
8. Arrangements made for transportation for people wanting to attend the Jan Samvad.
9. Community action and monitoring part as part of preparatory work of Jan Samvad e.g. in Pati block of Barwani district.

Issues raised in Jan Samvad

1. Charges in hospital.
2. Range of problems highlighted e.g. Deen Dayal cards not available.
3. Highlighted many corruption cases.

4. Problems of closed PHCs.
5. Information provided on new schemes, Janani Express.
6. Accounts not opened for VHSCs.
7. Untied funds not released by health department. Of the 225 VHSCs formed under this programme, only 50% have received untied funds. Many among them have not received the entire amount.
8. ANM, AWW doing good work facilitated as a motivational gesture.

Impact of Jan Samvad

1. Compounder asked to open PHC regularly and medicine sent. Government asked community to support PHC.
2. Doctor started visiting the PHC.
3. Reduced private referrals.
4. Information provided on Janani Express services.
5. Interest expressed to monitor district hospital.
6. Reduced private practice of PHC doctor e.g. in Tami block in Chhindwara.
7. Signed charter of the PHC mentioning time of doctor availability and that they will not undertake private practice.
8. Doctors acknowledged in public that red in the report cards should change to yellow.
9. Doctors have reduced writing prescriptions for buying medicine from outside.
10. Unintended outcome – request of Jan Samvads to be held in non pilot villages. Jan Samvad seen as confrontational. Doctors referring patients to other blocks. In some places - eg. Pati Block of Barwani - doctors refusing posting due to fear of Jan Samvad in those blocks.

There is need for government orders in Jan Samvads.

The overall impact of Jan Samvad is very visible and very high. But it needs preparation both in logistics, engagement with health department, preparation with beneficiaries and follow-up actions. Jan Samvads should also be used to appreciate good work done by health workers and officials.

Post Jan Samvad

1. Need to make the process continuous and not stop at one Jan Samvad.

2. Minutes of decision taken in Jan Samvad should be signed by officials.
3. Date of next Jan Samvad should be announced in the current Jan Samvad.
4. Deadlines and responsibilities should be decided.
5. Adequate preparation on what 'health issues' can be raised.
6. Follow-up of cases.

f. Media Involvement

In Madhya Pradesh decision was taken to have a single state level media fellow instead of at district level. The reason was to avoid conflicts at the district level between various papers.

The state media workshop resulted in scripts for 15 plays and 12 songs. District media workshops have been held in 4 of the 5 districts (except in Guna). There appears to have been a wide coverage in the print media in the districts. Elections in the state are reported to have been the reason for a stop in the media activity.

The media involvement began largely with Jan Samvads. Journalists enquired why they were in so late into the process and were told that something had to happen before they could be informed – the Jan Samvads would in fact highlight the issues that the media could pick up.

A manual or orientation material was required for the media.

Overall the media reported community monitoring as an event (e.g. Jan Samvad) rather than highlighting it as a process. The NGOs involved had no control over the final printed version. Many had very catchy headlines to attract reader's attention. There needs to be greater discussion on how to engage media in such a process – what could be the role for the media, what should be the boundaries for the media?

Emerging Issues

- (a) The tool was found to be too complex to be used by the VHSC members. It needs simplification and to be designed so that progressively sophisticated monitoring can take place as capacity is built in the VHSC. The Report Card was filled by Block Facilitators.
- (b) The tool has a tremendous value of educating people about their health entitlements and rights – first the act of getting responses from people increased their awareness.

V Programme Management

a. Capacity Building

Workshops

State workshop

The state workshop conducted by the state nodal NGO for 2 days provided the platform for orientation of the state health department, the WCD and PRI department, the district nodal NGOs and other civil society groups in the state on the objectives of the programme and in building a perspective on community monitoring.

It was attended by 51 participants from different districts of MP, including CMOs of Bhind, Badwani (two of the pilot districts), Khandwa, DPMs and Chairpersons of the Health Committees of the Zilla Parishad of Guna and Sidhi (two other pilot districts). During the workshop, the blocks, PHCs and villages were finalized, as well as the schedule of activities at the state and district level was decided. 16 persons present were from MPVS/BGVS

The report on the State Meeting indicates that the main problems foreseen for the CM especially in Bhind were political interference and caste problems. The participants also felt that the existing VHSCs would have to be modified and approved by the Gram Sabha

State Training of Trainers Workshop

The state nodal NGO conducted the state ToT. The objective was to train a group of resource persons who would in turn undertake the capacity building at the district and block level on the process and tools of community monitoring. All district nodal NGO representatives particularly trainers and state level trainers were trained in this workshop.

State TOT was conducted from Aug 16-20 / 2007. It was attended by 47 participants including Director, NRHM, two members AGCA, two Doctors from medical colleges, two IEC Consultants from CMO's offices in Chhindwara and Bhind, a DPM from Bhopal, a CHC doctor from Barwani. District wise representation appears to have been as follows: Sidhi 5, Chhindwara 4, Bhind 3, Guna 2, Barwani 4. Organization wise representation is as follows: BGVS 9, MPVS 8, Gurukul Shiksha Samiti 2, Gram Sudhar Samiti 2, MPVHA 3, Asha Gram Trust 1, Moti Sikha Samiti 1, Hareeth 1. Other NGOs not involved in Community Monitoring project have also attended ie Samavesh, Manthan, Shilpi Kendra, Anupama Education society, Divya Jyoti Social Development Centre, Deen Bandhu Samajik Sanstha. In state ToT tools received from National Secretariat were adapted and visit to sub centre, PHC, CHC done along with interview of PHC, CHC in charges and ASHA, Anganwadi worker and ANM.

The district nodal NGOs and their coordinators responded that the capacity building framework needed revision in the programme. The current programme only provided a one time capacity building opportunity from state downwards in a cascading manner which led to no time for follow-up or refresher training. A lot was lost at various levels with finally the Block Facilitators not having an opportunity to understand the exact purpose and objective of community monitoring or the clarity of its various processes. The District Coordinators mentioned that the State TOT was not sufficient. They needed much more guidance in the initial phase and the manual and training materials came in much later.

As mentioned earlier the Block Facilitators require much more capacity building. They need information on health rights and entitlements, how they can help VHSC if the Committees run into problems like not receiving the Untied Funds.

The District Coordinators mentioned that to prevent dilution, the Block Facilitators should be trained at the state level and the duration of trainings for different level should be inverted.

The Block Facilitators of Guna mentioned that in addition to the 5 days' first training (3 days of classrooms and 2 days of field visits) they required a refresher especially after the form was changed and before they went into the villages. They felt that the forms were filled wrong in all areas because they were not oriented to the changed forms. They suggested that they required 3 to 4 training workshops; they require further training on the community monitoring process particularly on data gathering and analysis

Capacity building of Block Facilitators is required in technical aspects of Health in addition to over issues listed above.

Facilitators felt that VHSCs needed 15 days of simple phased training (with practical exercises) to understand the purpose and process of community monitoring.

VHSCs also require more training and in ways that can understand. Methodology of training has to be more participatory based on pictorial training material as in Barwani. None of the VHSC members whom we met in the Avan PHC carried or were aware of any poster or brochure developed under the community monitoring programme. Women remembered attending the VHSC training programme although they could not recall what was discussed.

Capacity building of all levels of the health care system is also very important so that the providers' responsiveness increases. Special training of health functionaries to orient them about the processes of community monitoring would be required. And responsiveness to Community Monitoring has to happen from within the system – example, the CMHO has to be mandated from his higher ups to attend the Jan Samvads, it should not be the districts Nodal Agency's responsibility to persuade the CMHO to be present.

We heard several report of how satellite training of ASHAs was full of pitfalls. This route may be avoided for VHSC training

Adaptation and Publication of Material

MPVS adapted the material produced at the national level. Formats were developed in state TOT. They were pretested in Guna and then a workshop was organised in Bhopal in which the tools were finalised.

The feedback from the District Coordinators meeting was

- (i) The material reached late.
- (ii) Manual:
 - language needs to be simpler, there should be pictures,
 - VHSCs' role and responsibilities should be more elaborately described,
 - a content page is required,
 - the manual is not really a training manual,
 - there should be a module for the media workshop,
 - there should a FAQ section – What can we do if the BMO does not respond? What is the process for grievance redressal?
 - The report card should be short, simple, pictorial,
 - the indicators should de designed for different stages – stage 1 does the ANM visit the village or not? Stage 2 what does the ANM do during her visit?
 - There should be more activities and exercises, tools, role plays.
- (iii) Brochure: bullets are required for simpler reading.
- (iv) Poster: more illustrations are required, bigger fonts, key messages only.

One resource person from MPBGVS produced a book which received much praise from the District Coordinators.

Most surprising was the fact that during our field visit to Raghogarh block, we saw no evidence that the Block Facilitators or the VHSCs had received or used any material.

b. Staffing

The programme was grossly understaffed. At the state level a team of at least three persons is required as well as an administrative/secretarial staff. At the district level two full time persons are required as well as a provision is required for a pool of resource persons and trainers The block is the most critical level in this entire effort. A team of three to four persons is needed at this level.

c. Monitoring and Reporting

Monitoring of the programme in the Districts and Blocks appears to be variable. Monitoring of the outputs was done by the National Secretariat according to the weekly format provided. Monitoring the quality of the implementation appears to have been lacking at all levels. The National Secretariat team made two visits to the state to oversee the implementation although monitoring was not strictly in the purview of their responsibilities. The feedback that we received was that the focus was on achieving the deadlines for the activities to be done, there was no time to reflect on the quality of the programme. The Process Documentation formats were by and large not filled satisfactorily. The AGCA members could have been formally asked to help in the monitoring of the pilot programme.

The problem also is the institutional arrangements. Some organisations have multiple responsibilities – SATHI CEHAT is the Joint State Nodal Organisation, as well as an implementing organisation at the block level. Who will monitor SATHI CEHAT's implementation? Similarly, MPVHA is the District Nodal Organisation in Guna without any implementation experience in any of the blocks. Also it does not have any field presence in the district. Some of these institutional issues need to be streamlined with clear role and responsibilities for monitoring and reporting.

d. Finances

According to the State Coordinator the release of funds was perceived as a major problem. The cumbersome process of the MOU and many suggestions and changes in the MOU delayed the release. The perception is that the delays happened at the GOI level. The budget for human resources at all levels (especially state and district level) was main difficulty. Coordination and travel were also under budgeted.

Orientation and trainings had sufficient funds. Some times when number of participants increased in trainings specially VHSC then it was just sufficient. District orientation was reduced to one day so there was less expenditure. Printing and innovation should have more funds. In present project there was no fund for innovation

Our opinion is that the programme was under staffed. Capacity building is a major requirement and supervision, monitoring and support also require intensive human inputs as well as travel support.

e. Relation to other communitisation processes.

There do not appear to be any formal arrangements for coordination between the community monitoring and other communitisation processes. In a few VHSCs active ASHA is the secretary. Lately however the NHSRC representative in MP in charge of communitisation has been a supportive force understanding of how to situate community monitoring within the larger communalization effort. Similarly a

representative of the TAST-DIFD, is trying to provide synergy for accountability measures, one of which is community monitoring.

There are plans to establish an ASHA Resource Centre and facilitator at the Block level. It may be worthwhile to expand this to become a Communitisation/Community Action Resource Centre and facilitator and accommodate ASHA, VHSC, and Community Monitoring Community Planning as components of this. The current involvement of ASHA was a good opportunity and much needed. The proposed ASHA Dal Samanvayak (community mobiliser at block level part of the ASHA Resource Centre) will be a welcome addition for proper supervision and mentoring of ASHAs.

One issue came up in several discussions was the emerging conflict between the ANM, AWW and the ASHA, related to the JSY incentive. Block Facilitators, District Coordinators all agreed that the interest of the ASHA has to be safeguarded and that the VHSC can play a role for this.

Emerging issues related to programme management issues

1. Phased capacity building of the Block Facilitators and VHSC is required over a period of time. This needs to be budgeted for.
2. PHC and Block level Planning and Monitoring Committees are not yet functioning up to the desired level - need greater clarity of their roles, kinds of issues that they need to take up, how to enforce accountability and what **redressal** mechanism are required.
3. Resource material needs to include more participatory tools and exercises for training VHSCs. A workshop to share material across districts would be useful to create this toolkit.
4. Jan Samvads have been appreciated by diverse Stakeholders to improve dialogues between users, health system and PRI members. This can be a critical minimum activity of the Community Monitoring exercise.
5. It is important to work with the health system at each level to increase their responsiveness to the demands created by community monitoring- capacity building of the health system in how to respond to community monitoring should not be overlooked.
6. State Nodal Officer of a higher grade is important. Timely orders, CMHO follow up and convergence with other departments will happen only after the state government takes the initiative

VI POTENTIAL OUTCOME

Building relationships

- There is some evidence of partnerships being built between the health system and community groups. The Block Facilitators of Guna District state that the Report Cards have resulted in ANMs and MPWs greater presence in the villages to prevent the reds.
- At the District level too there is some building of relationships between the District Health Officers and the civil society. The PRIs at the District level however have been difficult to mobilize.
- The biggest problem has been the support at the state level. Coordination between civil society and the state health officers has been an issue. In fact the biggest lesson learnt according to the State Coordinator has been to not let communication break down. The TAST DFID representative has helped by facilitating dialogue.
- Power issues between bureaucrats/ technocrats and communities need to be addressed. 'How can village people monitor health care providers?' A related challenge is how can we prevent the community monitoring effort from being reduced to fulfill the state's agenda of fulfilling the need for statistical indicators? As a strategy, do we embed a few service delivery indicators to win over the state? Can the criteria for community monitoring include along with certain accountability criteria some service delivery indicators? The criteria can be prioritised by the community.
- Many instances have been reported of the responsiveness of the BMOs as a result of the Jan Samvads.
- Within civil society, an issue has been the project nature of this community monitoring exercise. It is difficult to attract people's movements to activities which appear projectivised and not issue based. The pace of activity determines who will get involved and who will not get involved.
- Intersectoral convergence appears to be beginning between Health and ICDS structures. IMNCI has also been incorporated into the Village Health and Nutrition days, at least in Guna District. At the state level there is commitment to bring in Anaganwadi activities into the purview of the community monitoring exercise. There is commitment from the Principal Secretary, Women and Child Development Department for this.

- Institutional mechanisms are required for regular interaction at the state level. Initial advocacy is very important, ministerial level meetings might help. Conceptual clarity on communitisation is required.
- Strategy for a broad based coalition to build partnerships with the state health department may be required?

Entitlements

- The community monitoring tool itself has served as a tool for increasing awareness of entitlements. Block Facilitators mentioned that in remote areas, for the first time people became aware of what each level of health care delivery system was supposed to deliver. There are a few reports of people beginning to get their entitlements – the health care providers are more present in the villages and the health care facilities. Corruption in the health system appears to be the most difficult thing to root out. At the lower levels, Community Monitoring helped communities to raise the issue of corruption.
- Evidence of increased coverage appears to be (i) due to remote villages and areas being taken for community monitoring pilot programme, (ii) jan samvad being used as an occasion for providing services through a health camp in an under served area.

Equity

- The lists of VHSC members indicates that dalits and tribals are being included in the VHSC. It is difficult to comment on the extent and quality of their participation. A Process Documentation report mentions 'For the first time VHSC has provided space for tribals, dalit women to speak out about health issues in their villages and also about their own health problems.'
- Redressal of grievances appears to have been an issue. No one – VHSC members, Block facilitators, NGO Coordinators – appear to have any clue of what to do if a grievance is not addressed.

Accountability

- This appears to be improving. There are reports from Barwani that MOs have written out what services are available at the health care facility and have put this up on the walls. Doctors have made public statements at the Jan Samvads saying that the reds and oranges must change to green on the Report Cards. Accountability can improve further if integrated/ interlocking committee system can be made to function.
- Information dissemination - In Sidhi district, Banjara PHC displayed list of medicines available, JSY beneficiaries and the number of staff posted. In Delakhari

PHC, district Chhindwara displayed the JSY beneficiaries' list, kept the register of referred patients etc.

VII Recommendations for Scaling up

On Nov. 24 2008 a state level meeting on Community Monitoring was organized and facilitated by the Technical Assistance Support Team (TAST) representative and the State nodal NGO under the chairmanship of the Health Commissioner. The minutes of the meeting are awaited. However, some of the decisions taken for the 'Way Forward' are as follows:

1. Department of Public Health & Family Welfare to recommend to AGCA and Gol NRHM, to include in the reporting framework of Community Monitoring positive deviance in service delivery and health indicator targets (ANC, PNC, Immunisation etc.), and staff absenteeism.
2. State NRHM, State CM team and TAST to explore ways of integrating the Monitoring Committees into statutory bodies like RKS, Janpad, Zilla Parishad etc.
3. Mission Director NRHM and JD NRHM to treat CHC Monitoring Committee's findings as legitimate issues for grievance redressal and set up formal grievance redressal bodies at the Block level. Mandate CMHO and DPO to be present at the Block level Jan Samvads.
4. The department to institutionalize mechanisms to ensure that the findings of the Community Monitoring flow into the health planning exercise at all levels especially the District Health Action Plans.
5. State Mission to ensure scale up to all villages in the existing districts as well as take on five more districts in the next phase.
6. Build capacity of VHSCs to use untied fund judiciously.
7. State mission to provide interim support (Jan09 to June 09) to the initiative till the operationalisation of the next PIP.
8. The Mission Director, CM Team, and TAST to organize a larger state level meeting with other allied departments like WCD, PRI and education.

(Source: Note by Biraj Swain, TAST)

The abovementioned decisions are heartening. Our recommendations to build upon the recent developments are as follows:

a. Institutional mechanism

The most important issue at this time is to consolidate and create a buy in for the Community Monitoring idea amongst the State Health Department. Strategic advocacy is required by a broad based alliance to create an understanding of communitisation and the place of community monitoring within this. AGCA members also need to become part of this alliance. Involvement of NHSRC state representative and the MP TAST team member is a strength and needs to be promoted.

An analysis is required of why the State Mentoring Group failed and what alternatives can be designed for this.

Community monitoring needs to be positioned within communitisation and made a part of the proposed Block level ASHA facilitation task, which should be expanded to become Block Communitisation Support function. Other recommendations given earlier for expanding the state, district and block level teams for Community Monitoring need to be examined in this context.

Roles and responsibilities need to be clarified for provision of greater monitoring and support at the district and block levels. Facilitating collective learning and production of material also needs to be factored in.

A related concern is who will undertake the challenging task of capacity building for community action in Madhya Pradesh. The demands are enormous and quality training and resource material has to be produced. Can SIHFW, SHSRC or a consortium of organizations be entrusted with this task?

b. Community Process

The expansion and up scaling of community monitoring should be done in the existing blocks and districts with the modified institutional mechanisms. All the villages under the PHCs can be taken in the next phase of upscaling. The Block and District planning and Monitoring Committees can then begin to work optimally in the existing districts. As mentioned above five new districts can also be included in the next phase.

The Community Monitoring tool and Report Card needs to be modified so that it allows for progressive levels of monitoring, from the very simple formats to be used where the VHSCs are just being formed and the health system is unresponsive to increasing levels of complexity to suit maturing VHSCs and health care delivery system. The frequency of the Report Cards can be reduced from once a quarter to once in four or even six months.

The methodology can be adapted to become more of an Appreciative Enquiry than a fault finding exercise.

The Jan Samvads have been appreciated as a tool for increasing dialogue between multiple stakeholders and increasing accountability. The process – preparation, facilitation and follow up of the Jan Samvads can be improved. The frequency should be reduced to once in six months.

Annexure I: Schedule of Visit

Nov. 30 - Dec. 4, 2008

Nov 30	10 am to 3 pm	Discussion with Ajay Khare, Savita Jain (NHSRC), Pragya Dube (MPVHA), Biraj Swain (MP-TAST)
	3 to 8 pm	Travel to Guna
Dec 1	8 am – 10.00	Discussion with O.M. Goswain (Susheel Shiksha Samiti)
	10.00 – 11.30	Mamta Singh (Moti Shiksha Samiti)
	11.30 pm – 12.30 pm	Travel to Sagar
	12.30 – 1.30 pm	Meeting with VHSC, Sagar ANN, Sarpanch. Discussion with Community Members and users.
	1.30 – 3.00 pm	Travel to Avan PHC
	3.30 – 5 pm	Meeting with representatives of VHSCs of Jetpur+Sabatkheri Facility visit, interview with MO.
	8 – 10 pm	Meeting with Block Community at Raghosarh CHC Meeting with BMO
	8 – 10 pm	Meeting with CMO, Dist Nodal Offr. Leprosy, DPO IMNCI
Dec 2	8.30 – 10.30 am	Meeting with Block Community at Raghosarh CHC Meeting with BMO
	10.30 – 12.00 noon	Meeting with CMO, Dist Nodal Offr. Leprosy, DPO IMNCI
	12.30 – 3 pm	Meeting with VHSC. Meeting with Adhyalsha and 2 tribal members of the VHSC (Sahariya) Meeting with recently delivered mother
	12.30 – 3 pm	Visit to Jamner PHC Meeting with reps of VHSCs, and PHC Committee Members. Meeting with a woman in delivery room.

	4.30 pm	Interview with non pilot village AWW + Sevika of Peepalkheri
	8 – 10 pm	Debriefing meeting - review team
Dec 3	8.30 – 10.30 am	Meeting with Block facilitators and District NGOs
	11.30 – 12.30	Meeting with DPO ICDS
	12.30 – 1.30 pm	Visit to Helpline Visit to Call Center Visit to SNCU, Dist Hosp.
	1.30 – 2.30	Interview with Sarpanch, Miyana
Dec 4	9.30 am to 5.30 pm	Meeting with Dist. Coords. and Block Coords.
Dec 8	11.30 am to 1.30 pm	Meeting with Dr. Thelma Narayan (AGCA Member) Bangalore

Annexure II: DOCUMENTS READ

1. Community Monitoring of Health Services, MP: Report from April 07 to July 08.
2. Community Monitoring of Health Services: District Guna Activities.
3. Report of State level workshop on Community based Monitoring of Health Services in MP, May 29-30, 2007
4. Process Documentation: Madhya Pradesh (no other details available – date? Source?)
5. Minutes of Meetings :
 - a) Resource Group Meeting, Jan 18, 2008
 - b) District Coordinators Meeting Oct 15 and Oct 17, 2008.
 - c) State Mentoring Group Meeting, Jan.17, 2008
6. Reports of District Workshops :
 - Sidhi 27.10.07 – 28.10.07
 - Guna 23.9.07
 - Chhindwara 30.10.07-31.10.07
 - Bhind 23-24.11.07
 - Badwani 18.10.07
7. Reports of Guna District
 - a) Community Monitoring based Health Services (Printouts from OM Goswami)
 - b) Compilation of notification of VHSC member to the Block Health Office
 - c) Various reports of activities under Community Monitoring in Guna District (a bound volume sent by Ajay Khare)
 - d) Lists of Committee members Names
 - e) Problems in Jan Samvaads and their Solutions compiled report of Sidhi District – Gram Sudhar Samiti, Sidhi

National Rural Health Mission

Community Monitoring Review in Maharashtra

A. Dyalchand & P. Shirsat

a. Background

National Rural Health Mission: The National Rural Health Mission (NRHM) strives to provide effective healthcare to the rural population throughout the country, with a special focus on the states that have poor health indicators and/or a weak health infrastructure. NRHM undertakes a structural correction of the health system and effective integration of health services through decentralized management at various levels, in order to improve access to health care for rural people. It seeks to provide universal access to equitable, affordable and quality health care, responsive to the needs of the people.

NRHM proposes an intensive accountability framework through a three pronged process of community based monitoring, external surveys, and stringent internal monitoring. As envisaged in the Right to Information Act, NRHM has made it mandatory for health institutions to prominently display information regarding grants received, medicines and vaccines in stock, services provided to the patients, and user charges if any.

People's Movement Regarding Health as a Right: Following the international People's Health Assembly in the year 2000, a large number of Indian delegates to this Assembly, initiated the People's Health Movement in India, which strives to intervene at the policy-making level. This Movement has started advocating for community involvement in the planning and implementation of health care. According to the Alma Ata declaration "*The people have the right and duty to participate individually and collectively in the planning and implementation of their health care*". NGOs in Maharashtra have been in the forefront to advocate the health right's of people in the State.

Objectives of Community Based Monitoring⁴

- Conducting community needs assessment
- Generating information about health services
- Providing feedback of generated information to health care institutions
- Providing feedback on the status of the fulfillment of entitlements, functioning of the public health system, and identifying gaps in demand and supply
- Enabling the community to become equal partners in the health planning process
- Improving responsive functioning of the health system

Community Monitoring Initiatives in Maharashtra: In 2000, the European Union, through EPOS, supported the establishment of District Health Societies. The District health societies were part of the Sector Investment Programme, and endeavour at Sector Reforms. The

⁴ Das A et, all - A promise to better health care services for the poor/ community entitlement book – national secretariat on community action NRHM

investment was in improving management and governance of the health sector through a process of decentralization, delegation of responsibilities and participation of civil society. The initiative included the formation and strengthening of Rogi Kalyan Samitis. Pilot interventions were undertaken in Satara district in the rural context and Aurangabad district in the urban context.

The other important initiative was the WHO supported initiative in 1999, known as “Empowerment of the rural poor for better health care. Under this programme, village health committees were established and tools were developed for monitoring of health providers and Primary health centres by Kashtakari Sangathan in Thane district and by Institute of Health Management, Pachod in Aurangabad district. Several of the mechanisms and tools designed in 1999, under this project have been modified for use in the present CBM initiative.

In 2004, the NGO sector lobbied for the establishment of Village health committees through the Jan Swasthya Abhiyan. The Government of Maharashtra, passed a government resolution at that time and village health committees were established in all the village of the State.

b. Executive Summary

Community based monitoring of health services is an important strategy for achieving the goals of the National Rural Health Mission. Several qualitative rapid assessment methods were used for reviewing the Community Monitoring component of NRHM in the State of Maharashtra.

Through the involvement of NGOs at the State, District and block levels, Village Health and Sanitation Committees have been established in 225 villages, 5 villages from each of 45 PHCs. Due to delays in administrative approvals, committees at the PHC, block and district levels are either not established as yet or have not held any meetings.

One AGCA member, heading Sathi Cehat, was selected to operationalize the community monitoring process in the State. Fifteen organizations were identified by Sathi Cehat for implementing CBM in the State, on the basis of their rights based ideology, and experience in community monitoring. The names of five NGOs were proposed to undertake the responsibility of District Nodal Agency. The names of these NGOs were sent to the state mentoring committee for final approval.

The organizations involved in CBM were active in Jan Swasthya Abhiyan. Membership in a pre-existing network, and a shared ideology, provided an enabling environment for effective coordination among the NGOs at various levels. The relationship between the NGO network and the Government has been successful at the administrative level but not at the policy level.

The community mobilization process was undertaken over a period of three days through small group meetings. In several villages convening a Gram Sabha was not possible and list of VHSC members ended up being prepared by the Sarpanch and the Gramsevak in several villages, and the process of forming VHSC ended up being a mere formality.

Their skills of VHSC members in community monitoring are very limited and the CBM process is still heavily dependant on NGOs. The focus of CBM is on attendance of providers and maternal health services at the village level. The data mostly highlighted grievances and denials,

shifting the focus more towards curative health needs. No attempt was made at triangulation of data.

Data collected were used to prepare a report card for the village. The main use of the report cards was for the Jansunwai / Jansamwad that followed the data collection. Report cards were prepared only with the aim of emphasizing gaps in service delivery, deficiencies in performance of workers and denial of rights and entitlements. Media tried to sensationalize the information that they received during Jansunwai. The manner in which Jansunwais were conducted was described as 'Kangaroo Courts' and has not been appreciated by Government workers or officials.

Community involvement in health care services is one of the prominent features of the NRHM and the process of community based monitoring is the best avenue for achieving rapid and large health benefits. An 'Action Taken Report' to be submitted by health providers must be instituted if the CBM process is to be sustained. Equity needs to be a priority objective for CBM in future.

On the contrary, it should be made mandatory for health providers to present a report of their performance to the VHSC. Data being collected through CBM are subjective, based on people's perception. Primacy is being given to denial of services and rights. The process so far has resulted in providing a forum for grievance redressal. CBM data should be used for planning, provision of services, monitoring, and grievance redressal, to bring about a systemic change in the health delivery system. Media need to be involved through a sustained campaign to improve the health delivery system. Grievance redressal through the media should be restricted to cases of very serious denials.

To promote sustainability, GOI and the state government must ensure continuity of support. The engagement between NGOs VHSCs and health providers needs to continue. CBM should be scaled up to cover entire PHCs rather than 15 villages per PHC and bring about a change in the health system because of which denial of rights occurs. Only then will a sustainable and replicable model emerge from this initiative.

The present CBM strategy is not replicable, it needs to be redesigned. The CBM should function in a collaborative mode with health providers to improve the health delivery system and if that does not work Jansunwai and media be used to advocate change.

c. Methodology

Several qualitative rapid assessment methods were used for reviewing the Community Monitoring component of NRHM.

One district (Pune) out of the five districts where CbM was implemented was visited by the reviewers. However, information on all relevant issues was collected from representatives of all the 15 districts.

Information collected by one set of stakeholders was shared with other stakeholders that were involved in the CBM process in the State. The conclusions of the reviewers were based on a process of triangulation of information collected from various individuals that participated in the review process.

The key methods used for the assessment were:

- a. In-depth interviews of key actors
- b. Focus group discussions with VHSC members, AWWs, PHC staff, NGO staff
- c. PRA tools such as listing and ranking
- d. SWOT analysis was conducted using the PARC method developed by IHMP, Pachod
- e. Triangulation of data collected from various sources.

Refer Annexe 1 for details of persons interviewed, meetings conducted and schedule

d. Institutional Mechanisms

Village Health and Sanitation Committees: A village health and sanitation committee (VHSC) has been established in each revenue village. The committee is made up of Gram Panchayat members, ASHA, ANM, anganwadi sevikas, self help group members, or a representative of any community based organization. The VHSC is responsible for creating awareness regarding entitlements and health programmes. It is expected to assess the health needs of the community and develop health plans according to village priorities. VHSCs are supposed to monitor the work of the ANMs, MPWs, and anganwadi worker, and produce a bimonthly report. Under NRHM, every village with a population of 1500 is entitled to receive Rs. 10,000 as an untied fund, and VHSCs are expected to ensure the judicious use of these funds.

Health Monitoring and Planning Committees at the PHC Level: The PHC committee is expected to monitor the performance of sub-centers and primary health centers. It is responsible for consolidating village health plans and developing the PHC plan. This committee is also expected to initiate action in cases where services are denied. In PHCs that were visited during this review, it was found that the committees had been established, but a meeting to review data collected through CBM had not been convened, nor had the PHC prepared any action plan. It needs, however, to be kept in mind that the actual CBM process is only three to four months old.

Health Monitoring and Planning Committee at the Block Level: The block level committee is expected to monitor all primary health and community health centres in the block. It is expected to consolidate PHC level plans and prepare an action plan for the block. This committee is supposed to review and monitor human and material resources. It is expected to prepare a report every two months and make recommendations to the district committee. The committee is also supposed to review cases of denial of health services and initiate appropriate action. In Maharashtra, block level committees had not been established till the time the CBM assessment was carried out.

Health Monitoring and Planning Committee at District Level: The district level committee is expected to be composed of Zilla Parishad representatives, district health officials, CBO and NGO representatives, district hospital management committee members, and representatives from the block monitoring committees. The district level committee is supposed to monitor the financial, physical and human resources in the entire district and provide inputs in developing the district health plan according to the priorities drawn from PHC and block plans. The district committee is also expected to ensure proper functioning of the hospital management committee. It is expected to take cognizance of cases of denial of services and ensure appropriate action.

District level committees had not been established till the time the CBM assessment was carried out.

Health Monitoring and Planning Committees at the State Level: The State monitoring committee is expected to have members from the legislative assembly, conveners of district committees (on a rotation basis), NGO representatives, officials and administrators from the State Health Department, Women and Child Development and Water and Sanitation departments. The committee is expected to give suggestions on programmatic and policy issues related to health services, and review the implementation of NRHM and the State health plan. It is expected to take appropriate actions to correct administrative lapses in making health care accessible. The State monitoring committee has not yet been established in Maharashtra.

State Nodal NGO: The State Nodal NGO is expected to provide support for the process of community monitoring at the district and block levels. Such support includes human resources, logistics and administrative set-up for the community monitoring program.

Selection of State Nodal Organization: The responsibility of facilitating the process of community monitoring in Maharashtra was given to two members of the AGCA. To initiate the process in Maharashtra, there was regular communication between the Department of Health and AGCA members. One AGCA member was requested by the Department of Health to undertake the responsibility of operationalizing the community monitoring process in the State. SATHI CEHAT has played a major role in Jan Swasthya Abhiyan and has had experience in community monitoring. The selection of SATHI CEHAT as State Nodal NGO was approved by the state mentoring committee. The individuals involved in the selection of the state nodal NGO were:

- Principal Secretary Health
- Director of Health Services
- Director, NRHM
- Secretary and Commissioner Health and Family Welfare
- Deputy Director, NRHM
- Deputy Director, RCH

Formation of the State Mentoring Committee: A key initial meeting was held between an AGCA member and the Principal Secretary, Health, NRHM Mission Director and Director of Health Services, on 4 May 07, where names of districts and State Mentoring Committee members were finalized. Six meetings of the State mentoring committee have been organised, in which senior state level health officials, including the Mission Director participated actively.

Selection of Districts: Norms for the selection of districts were formulated at the national level, and in the first phase of Community Monitoring, 30 districts were sanctioned in the 8 selected states. The key criteria were regional diversity and the presence of credible district level NGOs which could implement CBM. In accordance with these norms, 4 districts were sanctioned for the implementation of the pilot phase in the State of Maharashtra. However, the Department of Health in Maharashtra insisted on the sanction of one district each from five regions.

Table 1: Districts for community monitoring

Sr. No.	Region	District	Nodal NGO
1	Vidarbha	Amravati	KHOJ
2	Marathwada	Osmanabad	TISS
3	Khandesh	Nandurbar	Janarth Adivasi Vikas
4	Paschim Maharashtra	Pune	MASUM
5	Konkan	Thane	Van Niketan

Selection of District Nodal NGOs: In each of the selected districts, non government organizations working in the area of health were enlisted. Fifteen organizations were identified on the basis of their rights based ideology, and experience in community monitoring. The identified organizations from each selected district were invited to the state level workshop. Necessary information regarding community monitoring was given to the organizations in the state level workshop. NGOs from each district were formed into small groups. The groups were asked to select the nodal NGO from each district. One organization from each group was proposed and the names of these NGOs were sent to the state mentoring committee for final approval. The proposed organizations were approved by the state mentoring committee as district nodal organizations.

Selection of Block Nodal Agencies: In the selected districts, the secretariat set up by the state nodal agency identified blocks in which organizations were involved in the Jan Swasthya Abhiyan. Three NGOs from each of the five districts, a total of 15 organizations, were invited to the state orientation workshop. The organizations that attended the workshop were involved with work on issues of tribal and forest law, education, health and women's empowerment. Most of these organizations were known to have a rights based ideology. Organizations present at the state level workshop were selected for the block level implementation. No screening was done to select the block level implementing agencies because of paucity of time. The basic criteria for the selection of the organizations were experience of working in the field of health, involvement in Jan Swasthya Abhiyan, and presence at the grassroots. The decision regarding the selection of the block implementing agencies was communicated to the district health officers of the concerned districts. This selection was later approved by the state level mentoring group in its meeting.

Table 2: Selected blocks and NGOs for the implementation of the first phase of community monitoring

District	Block	Organization
Amravati	Dharni	Apeksha Homeo Society
	Chikhaldara	KHOJ
	Achalpur	Mamta Bahuuddeshiya Sanstha
Osmanabad	Osmanabad	Lokprathisthan
	Tuljapur	Halo Medical Foundation
	Kalamb	Lokprathishthan
Thane	Jawahar	BAIF

	Dahanu	Kashta kari sanghatna
	Murbad	Van Niketan
Pune	Purandar	MASUM and FRCH
	Khed	Chaitanya Samajik Sanstha
	Velha	Rachna Trust
Nandurbar	Akkalkua	Loksangharsh Morcha
	Dhadgaon	Narmada Bachao Andolan
	Shahada	Janartha Adivasi vikas sanstha

The villages were selected by the block level implementing organizations. Villages where these NGOs had a long standing presence were selected for community monitoring.

Establishment of Mentoring Committees at the District Level: District monitoring committees were in existence in the districts where monitoring through Jan Arogya Abhiyan had been established. In these existing committees, there was no participation of government officials. To establish the mentoring committees, orders were issued from the mission director NRHM to the district level authorities. According to NRHM guidelines, the mentoring committee at the district level was to be reestablished by the district nodal NGO with the help of the district health officer. Selection of members of the mentoring committee was done according to the guidelines provided by the state nodal agency. This committee included government officials and the representative of the district level nodal NGO. The guidelines to conduct meetings were provided by the state nodal agency. The district nodal agency representative was asked to convene the meetings.

Table 3: Meetings of district mentoring committees

District	No. of meetings*
Amravati	3
Nandurbar	7 to 8
Osmanabad	4 to 5
Pune	2
Thane	5 to 6

*some of the respondent could not tell the exact number of meetings held.

The following issues were discussed in the district mentoring committee meetings:

- Establishing village level committees
- Reorganizing existing VHSCs
- Discussing ways to deal with the non-cooperation of ICDS workers and gramsevaks, and of ways to involve them in the process
- Reviewing the work done and planning for the future
- Identifying and solving problems faced at various levels - block, PHC, village
- Discussing the processes of community monitoring

Under the community monitoring process guidelines, the Chief Executive Officer of the Zilla Parishad is a member of the district mentoring committee. His presence created the necessary pressure on the district level health officials, especially on the District Health Officer, to participate.

Relationships and Linkages

NGO Network: Fifteen non government organizations formed a network, in a strategic partnership with the government, to implement the community based monitoring programme in Maharashtra. The main criterion for the selection of these organizations was their rights based ideological perspective. These organizations were active in Jan Swasthya Abhiyan and were already monitoring health services in their operational areas. Membership in a pre-existing network, experience, and a shared ideology, provided an enabling environment for effective coordination among the NGOs at various levels. Decisions taken through a participatory approach enabled the network to function as a collective. This network of NGOs is now an established platform for sharing experiences, collective decision making, and collective ownership of the programme. The network has helped organizations to liaise with government officials from the village to the state level.

Despite the shared ideology of a rights based approach, the NGOs are very different in the kind of work that they are involved in, and the kind of strategies they adopt. There is considerable variation in their capacity and expertise, which has created diversity in the understanding of the process of community monitoring, and substantial variation in the way community monitoring has been implemented in the five districts.

NGO Relationship with the Government: At an administrative level, the relationship between the NGO network and the Government has been successful. The same cannot be said about coordination at the policy level. On occasions it has not been possible to organise meetings as a result there was significant delay in issuing the order for establishing PHC, Block, and District level committees. One reason for the resistance toward CBM was due to the perception that the earlier initiative to establish village health committees has not produced any outcome and even if they are effective this time, there is little scope for taking disciplinary action against erring medical officers and health workers.

NGO Relationship with Health Providers: The relationship between NGOs and health providers, which included ANMs, MPWs, medical officers, and block and district officials, was found to be cordial. The Jansunwai at the village and PHC levels created opposition among some of the government field workers and similar resistance at the block and district levels. Occasionally, NGOs had to depend on administrative orders from higher authorities to enforce attendance at these meetings.

NGO Relationship with VHSCs: Village Health and Sanitation Committees were established by block level NGOs. CBM is, therefore, perceived by the community as an NGO project. People were apathetic because of previous experiences with similar village committees. However, since NGOs had a pre-existing rapport and a relationship with their communities

because of their longstanding social welfare work in these selected villages, they were able to establish committees in the stipulated period of time.

Relationship between VHSCs and PRIs: Participation of PRI members was an exception rather than a rule. By and large they were indifferent to this process. Several NGOs did not make a serious effort to enlist the participation of PRI. Except for stray incidents, there were no serious conflicts between the PRIs and VHSCs.

e. Processes and their Implementation

Community Mobilization: The primary objective of community mobilization was to create awareness in the community and establish VHSC's. To mobilize the community, the block facilitator organized three meetings in each village out of which one was conducted for marginalized households (dalit vasti). These meetings were conducted with small groups. Gatekeepers in the community, especially PRI members, were sensitized through separate meetings.

Strategy Adopted for Community Mobilization

- A memorandum was circulated
- Separate meetings were held with the Sarpanch and local leaders
- Small group meetings were held with community groups
- Four posters advertising the meetings were placed at the PHC and Sub-centers

In these meetings (Gram-sabha), community members were persuaded to become part of the VHSC. Gram-sabhas were organized to create awareness about health issues and the importance of the monitoring process. Issues discussed during the Gram-sabha were:

- Establishment of the VHSC
- Invitation to community members to become committee members
- Information of VHSC roles and responsibilities
- Untied fund

It was expected that individuals nominated by the community would be selected through a community meeting (Gramsabha). This did not occur because of constraints such as lack of quorums and local power dynamics.

The time allotted for community mobilization was limited. The focus was on establishment of VHSCs in the available time period. Another reason for poor community mobilization was the apathetic attitude of PRI members towards the process.

Gramsevak, who needed to play an important role in convening Gramsabhas and forming village committees, remained uninformed about the process and their lack of interest and motivation was apparent.

The list of VHSC members ended up being prepared by the Sarpanch and the Gramsevak in several villages, and the process of forming Village Health and Sanitation Committees ended up being a mere formality in those villages.

Establishment of VHSC: Initially, an attempt was made to establish VHSCs through the Government of Maharashtra. Orders were issued for conducting Gram-sabhas in each village through the Gram Panchayat. The BDO and block level NGO instructed the Gramsevak to conduct the Gram-sabha. However, Gram-sabhas could not be conducted in several villages. Subsequently, in several villages, small group meetings were conducted and people came together to identify potential members for the VHSC. The names of potential VHSC members were nominated by community members who participated in these meetings. The AGCA norms were adopted as the basic criteria for the selection of VHSC members. In some villages, the gramsevaks prepared the list of VHSC members and gave them to the block level NGOs. In a few villages a Gram Panchayat resolution regarding the selection of the VHSC committee was passed and circulated by the sarpanch and the Gramsevak. According to NRHM officials, it is not the mandate of NGOs to select and establish VHSCs but only to make them operational.

Training of VHSC Members: The training of VHSC members was conducted by the block level NGO. Taking resource and time constraints into consideration, three members from each VHSC were trained in community based monitoring. These members were trained for three days. The training was conducted in five sessions; two sessions each on day 1 and day 2, and one session for practical skills on day three.

On the first two days of training, the focus was on developing cognitive skills. On day one participants were instructed on the basics of a right's based approach to health, the guarantee of services under NRHM, and the need for community monitoring. In the first session on the second day of training, the focus was on services provided by the ANM, MPW and AWW at the village level. At the same time, members were informed about various government schemes under NRHM and about untied funds to be distributed by the Government to VHSCs. During the second session on day two of the training, VHSC members were given orientation on the indicators for community based monitoring and the tools for data collection. Members were trained in collecting data and preparing village health cards. On day three field visits was conducted. For these field visits, three members from each VHSC were selected to form four teams. These teams were asked to conduct group discussions with villagers, individuals from the marginalized sections of society and women. The topics of discussion were: communicable diseases, surveillance, curative services provided by PHCs and CHCs, and untied funds meant for VHSCs. Discussions also included denial of services or any unpleasant experiences that villagers might have had with service providers. The teams were taken to the PHC and CHC to practice using the tools for PHC and CHC evaluations, and for conducting personal interviews with medical officers and other service providers.

Objectives of the Training

- To create awareness about NRHM and community monitoring.
- To sensitize VHSC members regarding their role and responsibilities related to the process of community monitoring.
- To develop a perspective towards a right's based approach and equity in health care.
- To develop an understanding about the services provided in the village.
- To develop an understanding about the functioning of ANM, MPW and AWW.
- To impart practical skills for using the tools for community based monitoring.
- To impart skills for data collection through discussions and personal interviews.

- To enable VHSCs to prepare village health cards

In some districts, training was imparted to only three members of each VHSC with the assumption that trained individuals would share the cognitive and practical skills that they had acquired with the other members of their VHSC. This resulted in a large variation in knowledge about community monitoring within each committee. Despite the fact that the major focus of the training was to enable VHSC members to use effective tools for data collection, block level NGOs were not confident in their capacity to perform this task adequately. As a result, data collection and the preparation of village health cards were done by the block NGO facilitator. None of the VHSC members that were interviewed had the skills for collecting data and preparing report cards independently.

Data collection by the VHSC: Data collection was carried out by the block NGO facilitator along with VHSC members. Data were collected by conducting beneficiary, provider and exit interviews; focus group discussions and observations. Beneficiaries of various groups were interviewed (different sections of the community, dalits, women and minorities). Discussions were held between VHSC members and the villagers. On the monthly Health Day, 'Arogya Divas,' at the village level, monitoring data were collected through group discussions and by interviewing pregnant women who had come for antenatal care. Data were based on the perceptions of the respondents and VHSC members. No effort was made at triangulation of the data. At the end of the first round of data collection, a report card and a cumulative report card were generated at each level. Most of the data were anecdotal and based on the perception of individuals that participated in the assessment process.

Monitoring Indicators

- Attendance of providers
- Services provided by MPW, ANM
- Maternal death and neonatal death
- Maternal health
 - ANC services
 - PNC services
- Child health
 - Immunization
 - Services provided at anganwadi
- Janani Suraksha Yojna
- Experiences with Primary health center
 - Services provided at PHC
- Behavior of health providers

According to most of the VHSC members, the key objective was to monitor the attendance of providers and maternal health services at the village level. Committee members participated in data collection and preparation of the village health cards and were able to understand the colour code given to the village and facility. The data mostly highlighted grievances and denials, shifting the focus more towards curative health needs.

The indicators that received the greatest attention during CBM were attendance of service providers. Apart from regular attendance, maternal health services were prioritized, particularly institutional delivery. Receipt of benefits of the Janani Suraksha Yojana and Matrutwa Suraksha Anudan by eligible women received a lot of attention. The CBM also took cognizance of the availability of curative services.

No attempt was made at triangulation of data, firstly because data collected through CBM do not lend themselves to triangulation, and secondly because of lack of a mechanism through which these data could be compared to information collected by health providers.

The information generated through CBM was disseminated to the concerned health institutions and workers by the block nodal NGO. At the village level, this information was disseminated through posters, and discussions were held to create awareness in the community about the CBM findings.

Summary of the Community Monitoring Process

- More time is required for community mobilization and formation of the committees
- Participatory rapid assessment was done by the NGO facilitators with the participation of VHSC members
- The village health cards were prepared by the NGO facilitators
- No attempt was made to involve VHSCs in preparing village health plans as it was not an objective in the first phase of CBM.
- VHSC's are unable to maintain village registers and report cards independently
- VHSC's need further capacity building
- One training session for the VHSC was not enough to build the capacity of the committee members, enabling them to understand the process
- Continuous efforts are required from the NGO's in ensuring the participation of VHSC members
- VHSC's are not capable of sustaining the process without support from NGO's

Preparation of Report Card: Data collected were used to prepare a report card for the village. Information generated from the process was consolidated on this report card in the presence of village level providers. These report cards were prepared by the NGO facilitator with the participation of VHSC members. Report cards, in the form of posters, were displayed at various places in the village. The report cards were used for:

- ❖ Discussions conducted in the village
- ❖ Sharing with government officials
- ❖ Use during Jansunwai
- ❖ Dissemination to media

During the review and assessment process, the evaluators found that only a few VHSC members understood the report card. In a few places the report cards were not filled properly and evaluators were told that this was because of a paucity of printed score cards and posters. The report cards were not used for planning health services in any of the villages or PHCs that were visited during the assessment as this was not included as an objective for the first phase of

community based monitoring. The main use of the report cards was for the Jansunwai / Jansamwad that followed the data collection. **(Refer Annexe 2 for filled report card)**

Jansunwai at the Village Level: Jansunwai (or Jansamvad) is the organisation of periodic public hearings at the village, PHC, block and district levels. Jansunwai was conducted after data collection, with the aim of creating awareness in the community regarding the status of health services in their village and PHC. In only one of the 15 blocks, i.e. Purandar block, there was an alternative process of 'Jahir Arogya Sabha' (Public health meeting) organised at village level with participation of the PHC medical officer, panchayat representatives and community members. This innovative strategy appears to have a potential in future. Issues regarding health status and health care were raised in the Jansunwai in the presence of the ANM and AWW. This process has created a space for dialogue between the community and health providers. In the course of piloting community monitoring in Maharashtra, Jansunwai was organized in five districts covering the health issues of 225 villages. Most of the VHSC members were enthusiastic about issues raised in jansunwai. In a few villages the main issue discussed during Jansunwai was the availability of potable water in the village, and a decision was taken to appoint a person for the chlorination of water. It was decided to pay the appointed person a remuneration of Rs. 100 per month. The chlorination of the water supply was monitored by the VHSC.

Jansunwai at the District Level: Jansunwai was conducted in all the five districts where community monitoring had been piloted. The community was mobilized for the jansunwai through pamphlets and VHSC meetings. Information was provided to health care providers at the village level, PHC level and district level by the block level NGO. Jansunwai was conducted in the presence of community members, VHSC members, CBO representatives, health care providers and media representatives.

Participants in Jansunwai

- DHO
- Dy. CEO (ICDS)
- THO
- VHSC
- NGOs
- Denial cases
- Community members
- Media

Major Issues Raised During Jansunwai at District Level

- Cases of denial of services.
- Untied fund
- Complaints about providers not having enough information on regulations and services available through the health care institutions.
- Regularization of services provided by the sub-centre and primary health centre.
- Money demanded by health providers for providing services
- Unavailability of service providers, guaranteed services and medicine at the primary health centre and sub-centre.

- Denial of benefits of Janani Suraksha Yojna
- Behavior of the service provider
- Private practice of the government health care providers.
- Absenteeism of health care providers

Outcome of Jansunwai and Media Dissemination: The process of Jansunwai was found to be time intensive as it took substantial effort to mobilize the community as well as providers. VHSC members were critical of the fact that even though decisions were taken during the Jansunwai, concomitant action was often not taken by concerned health providers. This led to conflict situations in some places and may finally result in skepticism among VHSC members if they find that CBM does not result in a measurable change in health delivery and quality of care.

Most health providers were critical of the way Jansunwai was conducted. Their perception was that the report cards did not highlight the efforts put in by the workers and were prepared only with the aim of emphasizing gaps in service delivery, deficiencies in performance of workers and denial of rights and entitlements. However, several district and block level NGOs and VHSC members agreed that the report cards had been successful in improving the attendance of health workers.

Media Involvement: Jansunwais attracted the attention of the media and was extensively covered by local news papers as the media participated in the process in large numbers, thus creating awareness in the community regarding gaps in the public health care system. All the stakeholders that were interviewed during the review, including the district and block level NGOs, agreed that the media tried to sensationalize the information that they received during Jansunwai. But, they also agreed that the media was useful in creating pressure on health care personnel.

The way Jansunwais were conducted and the manner in which the media reacted has not been appreciated by health providers, officials and administrators at any level. Some officials described the process as conduction of ‘Kangaroo Courts’ and were unsure whether it can be sustained.

Key innovations in implementing the CBM process in Maharashtra:

- Specially designed pictorial VHSC tools used in Thane, Nandurbar and Amravati districts keeping in mind tribal population and lower literacy levels
- Village and PHC report cards published in poster format and publicly displayed for greater accountability
- Design and use of Village health services calendar in some districts
- ‘Arogya Jagruti Divas’ organised in villages of Thane district, with mass participation and community mobilization followed by data collection and report card preparation,
- Block level conventions with mass participation organised with multi-stakeholder dialogue, at an early stage of the process in blocks in Thane district
- ‘Jahir arogya sabhas’ organised at village level in Purandar block with participation of the PHC medical officer, panchayat representatives and community members

- State level convention organised in March 08 with participation of all concerned PHC medical officers, Taluka Medical officers, DHOs or representatives, all Block and District nodal NGOs and State nodal NGO representatives, Secretary- Family Welfare, NRHM Mission director, officials from Directorate of Health Services for comprehensive mid-term review and planning of CbM at state level
- Appointment of State Media consultant and block level media fellowships to ensure adequate media coverage at various levels
- Two “Peoples Organisations” were block nodal agencies in Thane and two “Peoples Organisations” were block nodal organisations in Nandurbar district. A number of innovations and initiatives for rights based community mobilization were made by these organizations.
- Government of Maharashtra has published a manual with detailed guidelines to facilitate decision making at all levels. The manual will be disseminated to medical officers and block health officers.

f. Programme Management

Orientation Workshop at the District Level: In accordance with the decision taken in the state mentoring committee meeting to sensitize the providers at block level, and the PHC level officials, an orientation workshop was organized at each district. This workshop was organized by the district nodal organization. Concerned PHC medical officers and THO from the blocks, and representatives of the State nodal NGO attended the workshop. The main issues discussed during the workshop were:

- Objectives of NRHM
- Introduction to community monitoring
- Role of stakeholders in community monitoring – THO, MO, district nodal agency
- Roles and responsibilities of the different stakeholders in community monitoring
- The composition of the committees at the block and village levels
- Process of the community monitoring system
- Establishment of committees at the village level (VHSC’s)
- Process of collecting information at the village and PHC levels
- Tools to be used for collecting information in the process of community monitoring
- Preparation of village health cards and jansunwai
- Training of trainers

Training of Trainers: All district coordinators were identified as trainers. Five days of training were organized for the trainers, which included three days of in-house training and two days of field work. The training methodology included classroom teaching, group work, discussions and games. The objective of the training was to develop an understanding of NRHM and the process of community monitoring. The trainees were trained on tools of community monitoring and formation, and the roles and responsibility of the VHSC. Major emphasis was given to community mobilization. According to the respondents in the training they were able to learn:

- The process of community monitoring
- How to control a mob situation
- How to understand and solve people’s questions and problems

- How to facilitate discussions
- How to conduct participatory training

District Level Workshop: In some places, the training of trainers and the orientation workshops were conducted at the same time. In others places, the orientation workshop was followed by the training of trainers. The objective of the orientation workshop was to sensitize government officials. The participants in the workshop were – DHO, MO, CDPO, AWW, ANM, PRI members, DPM and Mukhya Sevika ICDS. This workshop had to be conducted three times since participation by government workers was poor.

Objectives of the Workshop

- Introduction to community monitoring
- Introduction of NGO and NGO personnel to government officials
- Formation of committees
- Introduction to the tools of community monitoring

The main purpose of the workshop was to communicate decisions and to explain the role of the various stakeholders to government officials.

Manual providing Guidelines for Decentralization under NRHM

One of the key gaps in the implementation of NRHM, was the lack of guidelines for utilization of untied funds and exercise of powers delegated to various levels under NRHM. The Government of Maharashtra has published a manual with detailed guidelines and it is expected that decision making will be streamlined after it is disseminated to medical officers and block health officers.

Another innovation in the management of NRHM is that the ANM has been given powers, as a sole signatory, to issue cheques for JSY payment.

g. Relation to Other Processes of Communitization

The existing network of the peoples rural health watch had already established a rapport with the community. These connections were helpful to the NGO's in mobilizing the community. Linkages between self-help groups and the NGO's facilitated the process of community mobilization. The process of community mobilization and formation of VHSC's was carried out with the help of self-help groups. Membership in a self-help group was one of the criteria used for selecting VHSC members. There was active participation of SHG's in data collection and the Jansunwai. There was no separate strategy adopted to sensitize PRI institutions. As a result, they remained ignorant about the process. Few PRI members, only those who were members of monitoring committees, took interest in the process. Their overall participation was not satisfactory.

h. Potential Outputs and Outcomes

It is too early to assess the outputs and outcomes of community based monitoring, but certain trends and potential results are obvious even at this stage. There is consensus that the attendance of health workers has improved, thereby improving the availability of primary level health services. There are several instances where Jansunwai and media involvement have been successful in redressal of grievances. However, several factors are impeding the implementation of CBM. There is a paucity of human resource (vacant posts), which are not being filled despite demands by the community. Similarly, there are glaring deficiencies of equipment, drugs and supplies. In the light of such scarcity, health care institutions are not able to cater to the demands generated by the CBM process.

i. Conclusions and Recommendations

CBM is a highly commendable initiative taken by the Government under NRHM. It has the potential of yielding results that can lead to rapid and large health benefits. The Government needs to be commended for creating a space for the participation of civil society to ensure that the basic health rights of the community are addressed efficiently. Maharashtra was the first state to include CBM in the State Programme Implementation Plan (PIP) for 2008 – 2009, which reflects its commitment to the process.

A positive start that has been made in CbM, in 225 villages and hamlets across the state, despite obstacles at various levels and in various forms. It is strongly recommended that this initiative be continued and the innovations and lessons learnt from the first phase of Community monitoring are included in the replication of the process in the State.

Community participation: The participatory nature of the CBM process is its biggest strength. Inclusion of community mobilization in this process provides an opportunity to sensitize the community about its rights as well as its responsibilities. It is a unique initiative in that space has been created for dialogue between the community and health providers. CBM has the potential to create awareness about health services and generate demand. Community involvement in health care services is one of the prominent features of the National Rural Health Mission and the process of community based monitoring is the best avenue for achieving this.

The process involved, and the time allocated for community mobilization will most certainly not be sufficient if NGOs are asked to replicate this process in villages where they have no previous contact. It is recommended that more time and resources be allotted for this important process.

Establishment of VHSCs: AHSAs or AWWs should be instructed to ask every 20 to 40 households to nominate their VHSC representative. The State Government must ensure the cooperation of the Gramsevaks in organizing Gramsabhas where the nominated individuals are formally selected. There has been marginal involvement of PRI members. Further efforts will be required to involve PRIs and develop mechanisms for developing an interface between the VHSCS and PRIs.

Prime Responsibility for Ensuring Effective CBM: The structure of the committees at every level needs to be examined carefully to balance power relations within the committees. Block NGO facilitators performed most of the roles expected from VHSC members, thereby

compromising the sustainability of the process. There is no evidence that the VHSC can function independently, which needs to be rectified in future.

Linkages between the Government and the NGO Sector: Some NGOs have adopted a confrontationist approach, advocating immediate change in a system that has functioned lackadaisically for decades. A more gradual and systematic approach needs to be adopted that will bring about sustainable change. The State Nodal Agency should moderate the functioning of such NGOs.

Maharashtra has included community monitoring in the State PIP. The State must ensure the establishment of committees at various levels and the participation of Government staff in the context of CBM. The State must also ensure that there is a measurable response by health providers to the demands made and gaps identified by CBM. In conjunction with the CBM report card a concomitant 'Action Taken Report' (ATR) by health providers must be instituted if the motivation of VHSC members in the CBM process is to be sustained. A Nodal officer needs to be appointed to monitor the implementation of CBM and ensure that follow up action is taken and ATRs are prepared in every district.

Relationships and Linkages: Even with a limited number of NGOs there have been ideological differences, variations in strategies, and in the capacity to undertake this initiative. When the CBM initiative is scaled up, the challenge will be to find more NGOs who have the required combination of shared values and expertise. Finally, CBM needs to be implemented in 45,000 villages and 1816 PHCs. Considering the limited reach of the NGO sector their future role needs to be reviewed. Instead of being implementers they should undertake the responsibility of introducing the best practices identified at the pilot level, in the scaling up initiative being undertaken by the State.

Presently, the demand for change is coming from NGOs who are acting as spokespersons for the community. VHSCs are not empowered enough to act independently. However, if the participation of civil society is institutionalized and sustained, it will ultimately lead to VHSCs taking the responsibility of ensuring the health rights of the community.

Constitution of VHSCs: The key responsibility of village health and sanitation committees is to ensure accountability of health care providers in the delivery of health services. Therefore, health providers themselves should not be members of the committee. On the contrary, it should be made mandatory for health providers (ANM, MPW and AWW) to attend the monthly VHSC meeting and present a report of their performance to the VHSC.

Monitoring Process: Primacy is being given to denial of services and rights. The quality of data needs to be reviewed so that it can be used for health micro-planning. There is a potential for the CBM data being used for preparing village, sub-centre and PHC plans.

Monitoring Indicators: Several NGOs agreed that data being collected are subjective, based on people's perception. The monitoring indicators for CBM need to be objective and verifiable. The CBM data should permit triangulation.

Since data are subjective, there is resistance and non-acceptance of the findings by health providers, especially at the level of Primary and Community Health Centers. This also indicates a communication gap between the NGO facilitators and health service providers. This needs to be rectified and opportunities should be sought to make the process more inclusive and collaborative.

Tools and Report Cards: The tools for collecting monitoring data need to be revised urgently. Using simple quantitative data, such as beneficiaries covered versus beneficiaries not covered, can be incorporated to make it more objective.

Jansunwai: Data collected through the CBM were used during Jansunwai, and focused mostly on denial of services and entitlements. The process so far has resulted in providing a forum for grievance redressal for individual cases of denial of service, rather than any attempt to address systemic problems. The denial of Janani Suraksha Yojana (JSY) money to eligible pregnant women is a case in point why a change in strategy is required in order to make CBM outcomes systemic. JSY payment was a repeated issue that was raised in Jansunwais conducted at the village level. The CBM succeeded in getting some of the women reimbursed; however, the operational system for JSY payment, with all its glaring gaps, remains unchanged. The evaluators concluded that, while CBM has succeeded in rectifying denials and in grievance redressal at an individual / local level, there is little evidence of introducing mechanisms that may change the health systems because of which these denials result.

Grievance Redressal Mechanism: Establishing a separate and enduring grievance redressal mechanism, where denial of rights and entitlements can be recorded and addressed, should be made mandatory for all PHCs and sub-centres. Then, it will not be necessary to use Jansunwai as the forum for grievance redressal, and it can be used for introducing sustainable systemic change in the health system. This can happen only if CBM is implemented through a health systems approach.

Involvement of the Media: The way the media have been involved at present is causing apprehension among health providers and administrators; hence the role of media needs to be reconsidered. Media need to be involved through a sustained campaign to improve the health delivery system. Grievance redressal through the media should be restricted to cases of very serious denials that defy rectification through other means.

Outcome of the Monitoring Process: It is recommended that CBM information be first used for planning of services at the village, sub-centre and PHC levels. Following this, the information should be used for monitoring the provision of services in collaboration with health providers. Following these collaborative actions, if service provision is lacking, the issues can be taken to the level of Jansunwai and media intervention.

Community Health Needs: There is meagre evidence that the CBM system is assessing the health needs of the community. It is recommended that this should be undertaken.

Triangulation – Data Validity: There is no evidence of triangulation of data. The reason why triangulation is not possible is because of the nature of data being collected under CBM. It is recommended that more objective information be collected which lends itself to triangulation.

Coverage and Equity: At present, CBM does not have the capacity to address issues related to coverage and equity. Data collected under CBM should be redesigned to ensure better coverage, including coverage of marginalised households/ individuals in society.

Entitlements: There is evidence that VHSCs have some knowledge of entitlements, but this does not exist as yet at the community level and hence requires greater importance.

Accountability: There is evidence that this process will bring about accountability of the service providers. The CBM needs to be redesigned so that this outcome is strengthened.

Service Guarantee: As mentioned earlier, CBM is at present giving primacy to grievance redressal and individual denial of rights. To some extent CBM is also addressing availability of services. However, CBM needs to be strengthened so that it can address issues related to accessibility and quality of services.

Sustainability: The fund allocation and approval of time schedules for community based monitoring have been somewhat erratic. None of the NGOs were sure whether the CBM will be continued once the first phase is over. The result is that several facilitators employed by the District and Block level NGOs have resigned and moved on to take up other jobs and assignments. Some of the NGOs will have to appoint fresh staff and orient them again if they wish to continue to participate in the next phase of CBM. Long term planning is required at the central level to make CBM a more sustainable process.

The engagement between NGOs and VHSCs on the one hand, and health providers on the other, needs to continue. This engagement is threatened because health providers are feeling intimidated. Health providers perceive NGOs and VHSCs as adversaries. This can be reversed if health providers are encouraged to use CBM data for demand generation, micro planning, implementation, concurrent monitoring, and supervision. If health providers find that the data are of use to them in improving their performance, the threat element will be removed.

In order to sustain the process, it is highly recommended that CBM be scaled up to cover entire PHCs rather than 15 villages per PHC. Only then will a sustainable and replicable model emerge from this initiative.

Replicability: At every level, which includes NGOs, district and state level health administrators, the perception was that the present CBM strategy is not replicable suggesting that the CBM strategy needs to be redesigned. A possible alternative strategy is that ASHA becomes the ears and eyes of the VHSC. She should assess the health needs of her community on a monthly basis (200 houses @ 10 houses a day) and give her assessment to the ANM. The ANM must provide primary level services on the basis of the needs assessment done by ASHA. On a monthly basis, AHSA must report to the VHSC if the health needs assessed by her were addressed by the ANM, and the PHC, including institutional deliveries and referrals. This way

the CBM will be used for health planning and implementation. This will also ensure triangulation of data. If after this collaborative effort, there are still gaps in service provision and denial of services, these can be taken up in a Jansunwai. It is believed that the change in strategy recommended above will create a more replicable model of CBM, and will be much more acceptable to health providers, administrators and policy makers.

VHSC members did not have the necessary cognitive or practical skills to undertake community monitoring independently. When implemented at a State level, the present strategy of capacity building does not appear replicable. It may not be possible to orient all VHSC members from over 45,000 villages in the State. It is recommended that CBM be included in the curriculum for the induction training of ASHA. In addition to ASHA, only one person from each VHSC, preferably the chairperson or secretary should be invited for training in CBM.

At the time of scaling up community mobilization and formation of VHSCs may not be accomplished in a matter of three days. The present strategy employed in 225 villages, is not replicable in 45,000 villages in the State. It is recommended that every 20 to 40 households must be asked to nominate and select a representative for their VHSCs so that there is effective representation of each sub-group in the community.

Review of Community Monitoring in Orissa: A Report

Executive Summary

There have been significant gains from the community monitoring implemented in Orissa. The pilot phase has been effectively implemented for about 18 months. During this duration the gains realised from the process include: the translation of materials for orientation and training, forming committees at different levels, undertaking capacity building through training and orientation, mobilising the community, preparing report cards, organising Jan Samwads, engaging the media, organising advocacy with key stakeholders in the government, and preparing for the scaling up.

The gains have been impressive, given the time and the intensive effort required for these tasks. The spirit of volunteerism, commitment and passion that has gone into the process is also commendable. Community monitoring has set in motion the efforts to bring the community centre-stage in health delivery. VHSCs have given voice and visibility to the community. Communities have a better sense of their entitlements and hence their expectation from the public health system has increased. They have also begun to understand the constraints of the department, especially the front line workers. It has enabled a better connect between the community and the health department. It has also enabled a better accountability of the department- in engaging and in responding to the community.

The Review recommends the continuation and scaling up of community monitoring in the entire state.

However, it is recommended that the scaling up be done in an incremental manner to build capacity of the community and acceptance by the department. It recommends that planning and monitoring go together. While scaling up, the Review recommends a substantial simplification of the tool and the processes. It is recommended that community monitoring be anchored in an existing arrangement in the health department to ensure buy-in by the health department. The oversight responsibility however, should be separate and this could include representatives from the government and civil society. To ensure success, the process should go through a minimum of three cycles, before a decision on restructuring and revamping is taken. The State Mentoring Team, Resource Team and the various arrangements at the district level, ought to be the resource pool to facilitate scaling up.

Background

Orissa in the eastern coast of India is divided into 30 districts and has 51,124 villages. Orissa has two distinct physiographic regions, the coastal plains in the east and the hilly tracts called the Eastern Ghats to the west and south. The bulk of the 22 percent of the tribal population lives in the mountainous Eastern Ghats and forests, where physical access remains a considerable problem⁵. Orissa is predominantly an agricultural state. Poverty and unemployment continue to plague the state, despite various interventions of the Government.

Orissa lives in its villages. About 87 percent of the population lives in the rural areas. The average village population in the state is the fourth lowest among the major states of India. Further, 61 percent of the villages in Orissa have population less than 500 persons. Except Himachal Pradesh, no other state has such a large proportion of relatively small villages. This has an impact on health service provision.

Despite gradual improvement in health status over many years, preventable mortality and morbidity in Orissa are high. There are number of reasons for this. Poverty, low levels of literacy, poor public health system, barriers to accessing health, and poor demand for health care are some of the causes. In Orissa, dependence on public health system is very high. Since mid 1990s, the health department in Orissa has embarked on number of reform initiatives, to improve the delivery of services. There are also many development partners, who are involved in the state. Orissa is a part of the EAG states under NRHM Programme.

The Community Monitoring was piloted in Orissa. It was one of the nine states, in which the piloting was done. The pilot phase of community monitoring was implemented in four districts in Orissa.

⁵ Nearly 2 persons out of every five in the state belong to the disadvantaged community of SCs and STs.

I. Review Methodology

The review was part of a countrywide review of the process in nine states. The Terms of Reference (TOR) and the methodology were common for all nine states. The review team included Ms. Sunita Singh, (Center for Health and Social Justice-AGCA secretariat, providing technical assistance for Community Monitoring), Dr Manmath Mohanty from the SAGCA, Orissa and S Ramanathan (External Consultant).

The Review was spread over six days. The first day was spent in meeting the SAGCA members. The second day was spent in meeting other officials- the State NGO Coordinator, State Programme Officer, NRHM. The field visit was undertaken in Bolangir district, selected in consultation with SAGCA. The field visit for three days, included visits to villages, SCs, PHCs and meeting with district health officials and Zilla Parishad Chairperson. On the last day, the initial results of the review were presented to the SAGCA and select representatives from the development partners. A brief meeting with Mission Director, NRHM was also held on the last day of the visit.

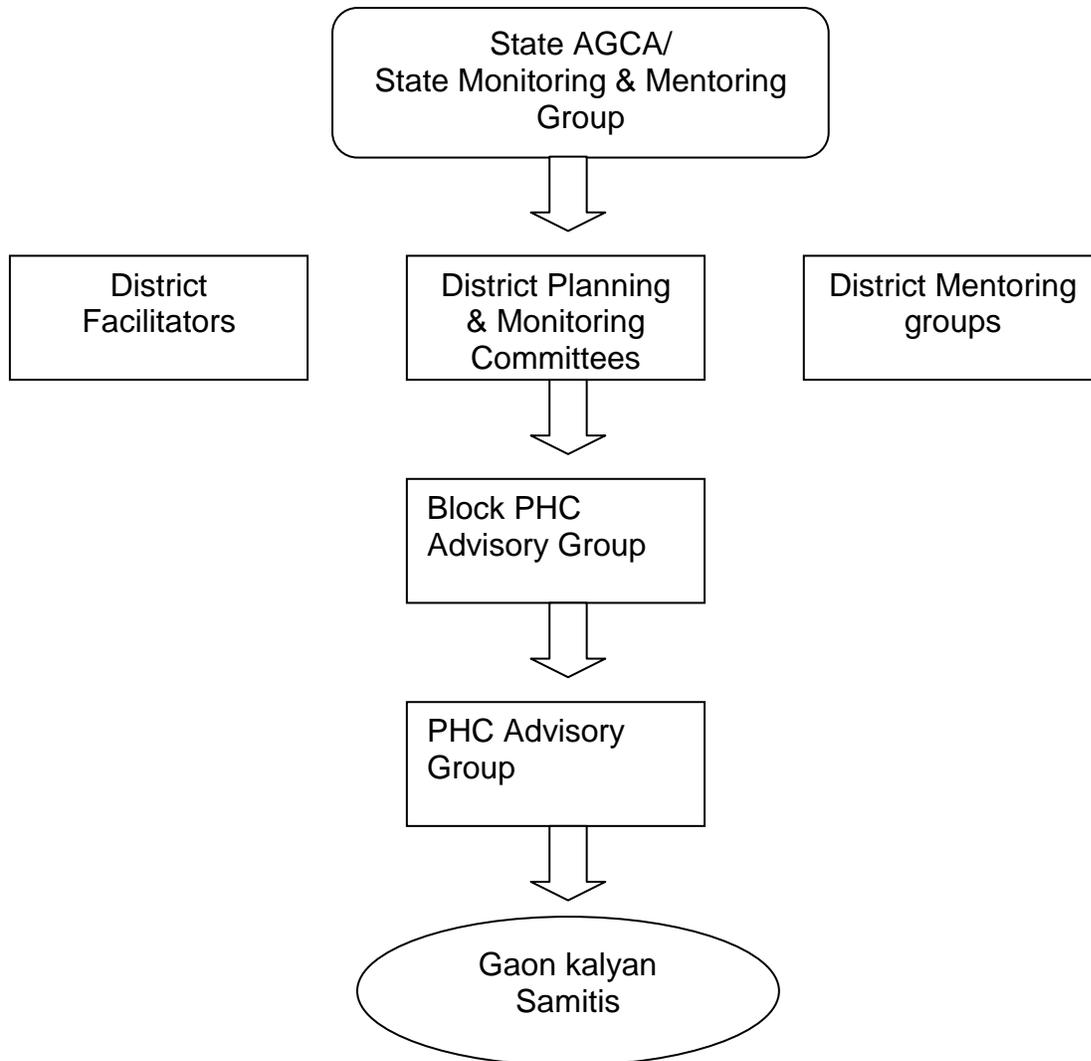
A re-visit was made to Orissa on December 17, 2008 to participate in the State sharing workshop, which provided an opportunity to meet the representatives from the four districts and to validate many of the findings.

Details of persons met and places visited are at Annexe 2. The team also conducted a desk review of key documents provide by the Secretariat and the state and district nodal NGOs. The list of documents reviewed is in Annexe 3.

III. Institutional Mechanisms:

III.a. State level Institutional Arrangement

The institutional structure in Orissa for Community Monitoring is depicted below



The process for the establishment of the institutional arrangements for community monitoring began in April 11, 2007. A meeting convened on this date with a representative from National AGCA and about 30-35 representatives from NGOs, proposed the formation of the State Community Monitoring and Mentoring Group (CMMG). Following this meeting, a select group of persons met the Secretary, Health and Mission Director, NRHM on April 12, 2007. A notification informing the constitution of the CMMG was issued by the Director, NRHM on May 24, 2007. In the first meeting of this group, held on June 4, 2007, it was decided to rename this group as Advisory Group on Community Monitoring (AGCM). In September 2007, on the suggestion of the State Health Secretary, it was decided to refer to this process as community action rather than community monitoring, hence, the group was named as State Advisory

Group on Community Action (SAGCA). Henceforth, the acronym SAGCA will be used throughout the report and this refers to the state monitoring and mentoring group.

The notification of the Mission Director, NRHM on May 24, 2007 listed the members of the SAGCA. It included 16 members- 9 from the civil society and 7 from the Government. The Mission Director, NRHM is the chairperson of the group⁶. The NGO representatives included senior NGO representatives from the state as well as representative from National AGCA.

There are two perspectives within SAGCA on how the selection of members from the civil society was done. Some maintain that the selection was institution based and some hold the view that it was individual based. The different views also emerge from the two different management systems adopted across the four districts. In Kendrapara district, OMRAH and in Mayurbanj district SODA provide support as institutions and the funds are routed through them to the block NGOs. In Nabarangpur district, the support is individual based and in Bolangir district two individuals, who are also affiliated with JSM and BGVS provide support. In Nabarangpur and Bolangir, the funds are transferred directly to the block NGOs from the state⁷.

There are different perspectives on which is a better arrangement. There is a view, that if the process of community monitoring were to be scaled-up, then a district NGO as a nodal agency would be helpful.

Until December 2008, 16 meetings of SAGCA have been held. The details of the meetings held are given in the Annex 1.

When the process began, it was proposed that the NGOs selected for implementing the process in each block would form a consortium and manage the process at the district. However, in a decision taken on June 22, 2007, it was decided to identify four district facilitators from among the SAGCA members. The district facilitators were responsible for facilitating the process in each district.

A letter from the Health Secretary on October 12, 2007 to the District Collectors of the four districts, informed the need to form the District Advisory groups⁸. Following this, district level workshops were organised in November-December 2007 to initiate the

⁶ The other government representatives included the Director of DWCD, Director, Special Projects, Panchayati Raj Department, Director of Health, Deputy Director, Demographic Cell, Health and Family Welfare Department, State NGO Coordinator, State Programme Manager NRHM.

⁷ This issue was discussed in the 10th internal meeting of AGCA on December 26, 2007. The meeting decided that the representation of the members will be on individual basis along with the organisation represented by the individual. In case a person has no organisational affiliation then the representation is on individual basis. It was also decided that those who are represented with an organisational affiliation cannot change the member or substitute any member to the meeting. It appears that the reason for this acquiring importance is due to the fact that many of the members of the AGCA had changed their organisational affiliation during the implementation of pilot phase of CM. Hence, the varying perspectives and issues with respect to organisational arrangements.

⁸ In his letter he suggested that the district body could include the Collector, the CDMO, NGOs, public representatives, PRIs and officials from the other line departments.

process for the formation of the district Planning and Monitoring Committees. Besides this, a District Mentoring Group was also formed in each district. The district mentoring group is meant to be a technical support agency to facilitate the implementation.

Institutional arrangements such as the block level groups and PHC level committees were also formed and were followed by the formation of the VHSCs in the villages. The table below provides the details of the institutions formed.

Table: Institutions formed in Orissa

State	VHSCs	PHC committee	Block Committee	District Committees
Orissa	180	36	12	4

III.b Relationships and Convergence

Relation with the health department: The process of interaction with the Health Department began with a meeting with the Health Secretary and the Director, NRHM on April 12, 2007 with a small team of members identified for the State Mentoring Group. As mentioned above, this followed the meeting of the NGOs on April 11, 2007. There were some interactions prior to this with the Government but the formal process of engagement with the Health Department began after this.

The Mission Director, NRHM is the point of contact between the state group and the health department. Following meetings, a decision was taken on the representation of the Government representatives in the SAGCA. As mentioned above, a letter issued by the Mission Director on May 24, 2007 listed the members of the SAGCA. The Mission Director is its head.

During the State Level TOT on September 13, 2007, the Health Secretary suggested that term monitoring might lead to poor support from lower level functionaries. Besides, he felt that the community ought to be first involved in improving the health system before they begin to monitor it. He felt that the community involvement is necessary to ensure that the funds available at the local level are utilised by them. Based on this view, it was suggested to rename the process to Community Action rather than Community Monitoring. It is held by the state nodal NGO that this paved the way for a better rapport with the health department. In October 12, 2007 the Health Secretary also sent a letter to the District Collectors of the four districts where the community monitoring is implemented, requesting their support⁹.

⁹ The copies of the letters were also marked to the Chief District Medical Officers (CDMOs) of the four districts. In this letter he said "...community monitoring is complex and sensitive in nature....your active cooperation is absolutely needed to make the effort successful. There is a fear of normal health delivery system to see this as fault finding of an audit of their activity (sic). Therefore there may be some kind of initial suspicion from the lower level functionaries in sharing the information. In this context, it requires your personal involvement to make the programme successful in the district. I will request you to extend necessary support and assistance to them".

An important factor that affects the interaction with the health department is the frequent change in key officials. In almost all the districts, there is frequent turnover of the CDMOs. This is true of Directors at the state level. Consequently, the mid level and the higher level officials of the health department- the CDMOs and the Directors- are not particularly aware of the process. In fact, the Director, Health is hardly aware that community monitoring is implemented in the state. In the state sharing meeting held on December 17, 2008 only the Mission Director came for the inaugural session. No other official from the health department, either from the state or districts, was present in the meeting at any point during the day. The State NGO Coordinator, although a member of the SAGCA, is not involved and rarely attended the meetings.

The response from the health department at the lower level varied. There are instances of many Medical Officers, who did not want to support it in any way without a directive from the district officials. However, there are instances of MOs who are supportive of the process. The MO (i/c) of one of the block PHC in Bolangir district was supportive of the process when he was interviewed for the review. The MO said that monitoring would help to assess the services and it could encourage competition between ANMs to provide better services. However, following the Jan Samwad, held subsequently, where some instances of denial of services and non-provision of JSY were highlighted, it is learnt that the same MO has become critical and non-supportive of the process.

Relation with DWCD: Although, there is a representative of the DWCD in the SAGCA, there is no significant coordination occurring with the DWCD. This should be addressed when the process is scaled up. There is convergence between DWCA and community monitoring at the village level, as Anganwadi worker is represented at the VHSCs. The Anganwadi worker, being a senior compared to ASHA, often, takes on more responsibility in the VHSCs.

Relation with PRIs: The officials of the health department do not appear keen to involve the Panchayats in community monitoring. In their view, the Panchayat do not have the capacity to undertake this. Interestingly, the Panchayats appear more involved in the process and it appears that the NGOs facilitating the process of community monitoring have been able to strike a better rapport with the Panchayats than with the health department. In the State dissemination workshop at Bhubaneswar on December 17, 2008, there were many Panchayat representatives. However, there are also many instances of PRI representatives, not attending the Gaon Kalyan Samiti (GKS) meetings. The PRI representatives, head the GKS. At the state level, there has been no significant partnership with the Panchayati Raj Department.

Relation between NGOs: In Bolangir district, two representatives from JSA/BGVS facilitate the process. The block NGOs in the district appear to have a good rapport with them. These two persons, as district facilitators are proactive in providing support and appear to have a much better sense of mobilisation process. However, the relation between the NGOs working in the districts does not appear very structured and no attempt is made to facilitate cross learning between them. One of the NGO in the district

had made some interesting posters to depict entitlements and service provision. These were neither used by the other NGOs in the district nor by the state nodal team. The process of cross learning between NGOs does not appear to have been attempted at any level.

The different perspectives within the civil society representatives in the SAGCA appears to be having an impact on the way the process is undertaken in many districts.

Key Issues

- All the institutional arrangements, as proposed are in place.
- However, the arrangements at the PHC, block and district levels do not appear vibrant and no significant details of their work emerged during the review.
- In the SAGCA, the civil society representatives, have differing perspectives. This could affect the implementation, in the expansion phase of community monitoring.
- The District Nodal NGOs/ individuals provide support at the district level and they hold the process together.
- There is an acceptance of the process at the level of Mission Director, NRHM but there is no acceptance of the process by the Directors and other officials at the state level and no significant acceptance of the process with the officials lower down in the district and blocks.
- The DWCD is represented in AGCA and Anganwadi worker is a member of the VHSC. Besides this, no significant details of convergence with DWCD emerged.
- There is a varying level of acceptance of the process by the PRI representatives. In Bolangir district, the Zilla Parishad Chairperson is involved in the process. Many block representatives are also keen on the process. However, at the village level, many PRI representatives, did not participate in the meetings.

IV. Process

IV.a Selection process: geographical and institutional

In the meeting held on April 11, 2007 the Kalinga Centre for Social Development (KCSD) was identified as the State Nodal NGO for the purpose of CM. In this meeting, it was also decided to select districts across the four regions. Accordingly, Nabarangpur, Kendrapara, Mayurbanj and Jharsuguda were chosen. A letter to this effect was issued by the Mission Director on May 22, 2007 to the CDMOs informing of the decision. However, in June 4, 2007, in the first SAGCA meeting, it was decided to have Bolangir district in lieu of Jharsuguda district¹⁰.

The initial meeting on April 11, 2007 had made a tentative selection of five blocks in each district. However, in the first meeting of the SAGCA on June 4, 2007, broad criteria¹¹ for the selection of the blocks was framed and it decided to constitute two sub-committees of SAGCA members to discuss with the district officials and finalise the blocks and the NGOs¹². One sub-committee¹³ visited Bolangir and Nabarangpur and the other¹⁴ visited Mayurbanj and Kendrapara districts, in June 2007, to finalise the selection of blocks and NGOs. They met district officials and held consultations with NGOs. They also visited a few NGOs to assess their capacity. This process of engaging the district officials is seen as strategic, as it enabled their involvement in the process.

In the meeting of the SAGCA on June 4, 2007, it was decided that the three NGOs from each block, would form a consortium and facilitate the district level activities. Subsequently, this idea was modified and the district level facilitators were identified for managing the district level processes. This meeting had also decided that the NGOs already working in health and NRHM activities in specified block will be excluded from undertaking the community monitoring in that block. The argument for exclusion was that the NGOs who are implementing the health projects would be biased. However, the process of community monitoring is to be facilitated by the NGOs and to be done by the communities¹⁵. Hence, the reasoning behind this argument does not appear very clear. It appears that consequent to this exclusion, the State NGO coordinator, who has been

¹⁰ The decision apparently was based on the fact that Jharsuguda is a small district and isn't representative of the western region of the state. Jharsuguda was proposed by the SAGCA, initially due to the presence of BGVS in the district.

¹¹ The broad criteria outlined for the choice of the blocks were

- Presence of individual NGOs/CBOs in the area.
- Geographical accessibility of the blocks.
- Need of the community (served and underserved area)

¹² In Bolangir district, the SAGCA had proposed Luisinga, Khatrapal, and Sointhala blocks. The district changed it to Patnagarh & Muribahal as they anticipated some political problems in few blocks and also MOs were not available in these blocks.

¹³ Consisting of the representatives from following NGOs Jan Swasthya Abhiyan, Bharat Gyan Vigyan Samiti, National Alliance of Women's Organisation, Orissa Voluntary Health Association & Kalinga Centre for Social Development.

¹⁴ Consisting of representatives from OMRAH, NIAHRD, SODA & KCSD

¹⁵ This was apparently a guideline from the national AGCA.

coordinating the involvement of the NGOs with the health department, did not play any major role in the selection of NGOs.

The sub-committees during their visits circulated a format for NGOs to submit their organisational profile along with an EOI. The initial response was very poor and the AGCA members were tasked with the responsibility to ensure more applications from NGOs. The process of receiving applications concluded on June 27, 2007.

A six-member sub-committee of AGCA members scrutinised and ranked the applications by assessing the NGOs experience in implementing projects on health, right based work and their presence in the blocks. Subsequent to the short listing, a rapid assessment of their capacity was done, often, by crosschecking with district administration. Three NGOs were chosen for each district and they in turn finalised the PHCs and villages, often, in consultation with the health department.

State Nodal NGO: KCSD- KIIT			
District	District Nodal NGO	Block	Block Nodal NGO
Mayurbhanj	SODA	Rairangapur	Voluntary Action for Rural Reconstruction and Social Action (VARRASA)
		Bangirposi	Orissa Liberal Association for Movement of People (OLAMP)
		Rasgobindpur	UNNAYAN
Kendrapada	OMRAH (Orissa Medical Research and Health Services),	Derabisi	Joy Bharati Sathi Samaja (JBSS)
		Rajnagar	BAT NET
		Patamundai	Chale Chalo
Nawangpur	KCSD-KIIT	Rajghar	Society for Agriculture, Health & Education, Animal Husbandry & Rural Development Action (SAHARA)
		Tentulikhunti	Association for Voluntary Action (AVA)
		Nawangapur	Democratic Action
Bolangir	Jan Swasthya Abhiyan (JSA)	Muribahal	Social Empowerment for Welfare and Action (SEWA)
		Loisingha	Palli Niketan
		Patnagarh	The Humanity

In Bolangir, in one block, it is observed that the villages chosen for implementing community monitoring are very scattered. This appears to have an impact on training and providing support. Villages could not be clustered together for training purposes as they are far off and people are unwilling to travel long distances to attend training.

IV. b Community Mobilisation

The preparation of the village health profile paved way for rapport building. The profiles are prepared by block NGO. Except Kendrapara district, where the preparation of the village profiles preceded the formation of the VHSC, in other districts, preparation was done after the VHSCs were constituted. The profile is intended to be a baseline to determine progress. However, in many instances, it is observed that the details mentioned in the profile are nearly the same across all the villages, only the name of the village and distance and population vary. These appear more to be a cut and paste job, defeating the very intent behind the preparation of the profile.

Process of Community Mobilisation in Kendrapara included¹⁶

- Meetings with key persons from the villages
- Discussion with PRI members
- Small group meetings with in different hamlets and with women SHGs and youth club members
- Distribution of leaflets on NRHM
- Village level meetings on NRHM and proposed community action programme
- Informal meetings with AWW, ASHA, ANM, MOs, teachers and representatives of SC/ST communities

Not all districts probably followed the processes as Kendrapara. Most NGOs had many informal consultations with various stakeholders in each village, leading to the formation of the VHSCs. Many NGOs undertook formal meetings too. The box below indicates the details of meetings organised by an NGO in a village in Bolangir district. It organised a meeting every month on various issues. This is an example of the process followed to mobilise the community. In most villages, people were sceptical of the process and were not very enthusiastic. This is evident from the number of participants in the village meetings in the box given below. For many NGOs, the process of convincing the community to be a part of monitoring took considerable time. The response from the health department at the lower level too is not very encouraging¹⁷. Many Medical Officers in the PHC said that they have not received any guideline from the district

¹⁶ Source: Community Action under NRHM in Kendrapara district: a process documentation report, OMRAH

¹⁷ The ANMs in some of the villages were of the view that mobilising the community is an uphill task. In a meeting, one of the ANM gave vent to her frustration of working with the community. She told the group that had gathered that the community had never bothered to understand her difficulties- she has to cover a population of 8500 as against the norm of 3000. Yet, every one wants that ANM be available all the time. Despite informing the community time and again about the preventive action that the community could do to prevent outbreaks- for instance in the context of diarrhoea and malaria- the community continues to follow the same practices.

officials on this. Most are unwilling to act based merely on directions from the state administration. Many PRI members too are not very keen.

This combined with the fact that mobilisation occurred during an intense heat wave condition in the state also reduced the enthusiasm of the community for the process.

However, from the discussion with the NGO representatives and village visits it appears that the poor are keen on the process as they probably rely on the public health system the most. The mobilisation depends on the credentials of the NGOs too. For many NGOs, the villages chosen are new and they had to build a rapport with the community first, before embarking on the process of engaging them on Community monitoring. For almost all the NGOs, the process of community monitoring itself is very new and they are trying to find their feet as well.

The involvement of PRIs in the process appears to be more than that of the health department. There are instances of very active involvement by the PRIs. The Chairperson of the Zilla Parishad in Bolangir appears very keen on the process. Her keenness is also evident from the fact that she was present the entire day in the final state sharing workshop on community monitoring. On the contrary, there are also instances of PRIs shirking their responsibility and refusing to chair the meetings. Their involvement therefore is mixed.

The process of forming VHSCs appears rushed through to ensure their formation, especially in Bolangir. The entire process of informing the community, mobilising them, electing the office bearers for the VHSCs were all completed within one month, in most instances. For instance, for one NGO implementing community monitoring in Bolangir district, 13 out of the 15 villages are new ones. In other words, they have prior involvement in only two villages. Hence, its knowledge about the conditions prevalent in the villages is still limited.

There are few innovations in mobilising the community. The NGO Palli Niketan in Bolangir distributed a leaflet on community monitoring. They also organised a kalajatha to spread the information on community monitoring and to mobilise the community.

The guidelines for VHSC formation kept changing. While this reflects, an evolution in the process of forming them, constant changes reduced the project period available for mobilisation and the process was hurried through.

In almost all the districts, the process for the formation of the GKS appears to have begun in early 2008 and completed by April-May 2008¹⁸. There was an attempt to register the GKS with the Registrar of Societies. The process could only be completed in Nabarangpur district, as the district administration, gave its support to enable the registration. The process of registering was very time consuming mired in red-tapism. Hence, a decision was taken by the health department not to register the GKS.

¹⁸ The State NGO Coordinator wrote the CDMOs of the four selected districts, on April 24, 2008 emphasising the need to complete the process of formation of VHSCs.

On an average, the formation of GKS appears to have taken about a month. Though

Issues discussed in Village Meetings: Case of Phalsamal Village, Bolangir District			
S.No	Date	Topics Discussed in village meeting	No. of participants
1	October 3, 2007	VHSC formation and role of members	22
2	November 4, 2007	Sanitation in village, Joint pass book for VHSC	17
3	December 1, 2007	Village survey & village health problems	17
4	January 5, 2008	Health plan preparation and health awareness	16
5	February 3, 2008	Sanitation	14
6	March 3, 2008	On MMR & IMR	15
7	April 1, 2008	On Malaria	13
8	May 5, 2008	On VHSC Training	16
9	June 7, 2008	On community action in NRHM	15
10	July 4, 2008	On Typhoid and Malaria	12

formed, majority of the GKS have not received the untied funds due to them. The GKS have to open a bank account to enable the money to be deposited in the name of the GKS. However, no bank is willing to open an account on zero balance. Efforts are on to resolve this issue and the funds would be transferred only after this. This has limited the ability of GKS to initiate local actions.

In the villages visited for the review in Bolangir district, the process of VHSC formation had happened during this year. The block Nodal NGO had meetings with key persons in the village. The ASHAs were requested to inform every one in the village to convene for the formation of the VHSCs. The meetings were held in a common location- either a school or Panchayat office, depending on availability. The number of participants often numbered about 30 persons. The number varied, depending on how many persons ASHAs informed and community interest. The meetings often lasted for about four hours and the representatives were selected at the end of the meetings. In these villages, following the formation of GKS, there have been three meetings¹⁹.

The recent guideline, which renamed VHSCs as Gaon Kalyan Samities (GKS), has designated the PRI representative as its head²⁰. The guidelines have also specified the official representatives in GKS. Besides the PRI representative, it includes ANM, AWW

¹⁹ Some NGOs have had a meeting per month (as seen in the table above) where as others haven't been so active. The meetings were used to discuss health issues- such as JSY, hygiene and also the planning for health.

²⁰ In Bankel village, Sambu Bhai, a ward member from the ST community was made the President of GKS. The Sarpanch, a lady, said that she should have been made the President. She raised this issue in a meeting that we had in the village. However, the others in the village said that they wanted the GKS to be headed by an ST- as they were a majority in the village.

and ASHA. The non-official representatives include members from the VEC and SHG. While the selection of the official representatives was easy enough, the selection of the non-official representative often depended on who could spare the time to participate in the meetings.

The women outnumber the men in almost all the GKS. On an average, the ratio of women to men representation is 3:1. Participation of women is seen as advantageous by many as they feel that if women are involved then it has a better impact on the health status in the household. While this is undoubtedly true, the freedom that the women would have to take decisions is often limited. The men often do not participate in the meetings, citing other important engagements and ask the women to continue with the meetings. The women often, go through the motions of the meetings, as any decision taken by them needs the approval of the men²¹. Is the process being seen as non-important by the men? Would this be a potential casualty because the men do not consider it important enough to provide time to it?

IV.c Committee formation at other levels

All the committees have been formed at the higher levels. However, no significant reports of their role came through during the review.

IV.d. Report Card Preparation

The preparation of the village health profile- as a base line for the process- happened between October-November 2007. The health officials were of the view that score card is useful to assess services and to plan for change. One health official said that the score card helps us to know what has happened, why a certain thing has not happened and what can be done to make it happen.

In most villages visited for the review, few of the GKS representatives were aware of the score cards, the colouring codes and their implication. However, many were unable to explain how they are derived. Calculation of percentages is complicated, for many. The process is managed by the NGOs and not by the community. For the NGO representatives too, the preparation of the report card is complex and many did not understand it. In fact, in the state sharing workshop, the presentation on the consolidated score card indicated the red as low utilisation. For instance, if the JSY was red, it was being mentioned as low utilisation of JSY whereas, it reflects the perception of what percent of those who were interviewed knew about JSY and whether they received the funds or not.

To ensure that the community has a complete control over the process, there is a need to simplify the process.

²¹ For instance, in one of the village, the PRI representative, who headed the VHSC said he didn't know what happens in the meetings as he is not informed. He said that the women conduct all the meetings. When he was confronted with the details of requests made to him to convene the meetings and how he always cited other engagements and didn't participate in the meetings, he changed his version.

There is very little sharing of the score cards at the community level. Only a few in the community are privy to the details. This has to change. There is a need for the larger community to be aware of the outcome of the process. Some officials of the health department are aware of the score cards but overall the knowledge of the score cards within the health department is still very limited.

IV.e. Jan Samwad

The process of organising Jan Samwads in each PHC happened around October-November 2008. While the Jan Samwad is more a platform for sharing the output of the process of monitoring, the focus has tended to be more on denial of services, adverse outcomes and issues related to lack of effective service. For instance, the Jan Samwad organised by the Palli Niketan in Bolangir district highlighted about 41 instances of denial of services and adverse outcomes. The Jan Samwad also raised the issue of the non-availability of the MO at Kusmel PHC. The MO, who was posted in the Kusmel PHC and present in the Jan Samwad, promised the community that he would henceforth be regular and will be available in the PHC.

IV. f. Engaging the Media

Media has been involved in community monitoring. The process of engaging the media has been through many ways: there have been media workshops in both the districts and the state. Media fellowships were given to select journalists to be involved in the process of community monitoring. There were press reports on the community monitoring in the newspapers.

There were media fellowships given at the State and district level. However, no significant details of their role, other than a few press reports and participation in media workshops, came through.

Key Issues

- Selection of districts was done on a regional basis. The district officials did have a role in the selection of blocks.
- NGO had submitted EOI and their capacities were assessed based on the profile submitted by them and cross checking details through field visit and by seeking opinions of district officials. The PHC MOs were often involved in the choice of villages.
- Mother NGOs, who could have contributed to the process, were left out. Many new NGOs, who had no prior involvement in health issues, were engaged. They took time to understand the functioning of the health department. For some NGOs, the villages chosen for community monitoring were new and they needed time to understand village dynamics, prior to the formation of the GKS.
- Often, the process of community mobilisation was limited to few meetings. The member selection was already framed by the guideline from the Government. Only the selection of non-official members from the VEC and SHG were issues to be resolved at the village level.

- The participation in most meetings was limited to about 30 plus numbers. Rarely, did large number of people gather for the meetings.
- Most PRI representatives, do not attend the GKS meetings. The women representatives often outnumbered the male representatives by 3:1. However, the women appear to have had no power to take decisions and they went through the motions of the meeting.
- Report cards are prepared in all villages. However, while some in the community are aware of the cards and the colour codes, majority are not aware of it. There is a need to simplify the card and ensure that the community has a control over it.
- No significant details emerged about Jan Samwad.
- Media played a role but no significant details of their involvement came through.

Programme Management

V.a. Capacity Building

The process of capacity building for community monitoring is detailed in the Table below.

S.No	Date	Activity	Output
1	July 14, 2007	1 day state level orientation	Selected NGOs oriented on NRHM & CM and process of developing action plan initiated.
2	July 19-21, 2007	3 day National TOT	4 district coordinators, 1 SAGCA member & Govt. personnel (?) trained as state trainers
3	July 24, 2007	State workshop	Orienting various stakeholders on CM & roles & responsibilities of different committees
4	October 11-13, 2007	3 day State TOT	Training key functionaries of district & block NGOs who will implement/ facilitate implementation of CM
5	November 2007	District Orientation	Orientation of key stakeholders from the districts- officials, PRIs & NGOs
6	January 29, 2008	1 day consultation of block NGOs	To re-orient the block NGOs given the gap between the training and the initiation of the process of CM.
7	March-April 2008	5 days- 3 phase Block Nodal NGO training	Training Block NGO facilitators on understanding CM in the context of rights framework, understanding the functioning of public health systems, preparing score cards, field visits
8	April- May 2008	1 day Block health providers training	Orienting health providers on CM, their role in CM, health service guarantees, preparation of score cards.
9	July-August 2008		Orientation of district level Planning & Monitoring Committee members
10	April-May 2008	2 day training	Orientation of the block PHC Planning & Monitoring Committee members on NRHM & community monitoring
11	April-May 2008	2 day orientation	Orientation of PHC Planning & Monitoring Committee members on NRHM and community monitoring
12		Orientation of VHSC members	VHSC members trained in phases on rights, NRHM, service guarantees, service availability in each level of health services, CM, roles & responsibilities of VHSCs,

			preparation of village health profile, preparation of score card
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The 3 day state TOT organised in October 11-13, 2007 was a modification of the national guideline, which had suggested a 3 day training followed by two days of field visit. In Orissa, the block NGOs were requested to visit a village, a SC, PHC and CHC in their respective blocks, collect preliminary information based on a check list.

<p>Training of Block Facilitators</p> <p>The training of block facilitators was broken down into three phases.</p> <ul style="list-style-type: none"> • First Phase: One day- a general introduction to CM and an assessment of needs and preparation of village profiles. • Second Phase: three days – community mobilisation, formation of VHSCs, training on data collection, preparation of score cards, documentation • Third Phase: One day – how to organise Jan Samwad. <p>The training spread over 3 phases was undertaken in March-April 2008. One reason for the division into phases was to enable the participation of the Government functionaries. Since, they couldn't stay away from their posts for 5 days at a stretch the training was broken down into phases</p>
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However, the participation of the health officials in the orientation was not regular despite it being

broken down into three phases. Their argument is that they have many other responsibilities²². Majority of the front line workers, who were interviewed, were unable to recall the topics discussed during the training. They said that while issues seemed very clear during the training, subsequently, they faced difficulties in recall. Hence, there was a suggestion for regular process of capacity building. Many expressed the need for more training on developing the score card, as they felt that it was complicated. In fact, many front line workers were unable to derive percentages and the colour codes based on it. They also felt that they needed more training on community mobilisation.

NGOs gained on four aspects from the training. They are knowledge on health issues, skills in monitoring, building relation and documentation. However, the field personnel of these NGOs need continuous support to ensure a proper implementation of the community monitoring.

The participants of the various training/ orientation at different levels felt that while lectures were adequate for orientation of health staff, the field visits and practical work were more appropriate for training on developing score cards.

One of the NGO in Bolangir had taken a lead in translating and preparing training materials based on the national guidelines and materials. Despite the availability of the materials, it appears that the process of translating was done again at the state level.

²² Some people mentioned that while they listened to the health officials, the health officials never listened to them.

This NGO had also developed some posters to depict roles and entitlements of the community in a pictorial form. These could have been adopted for the rest of the state too. The process of enabling cross-learning and sharing across the different partners has to be enabled.

V.b. Support, Monitoring and Reporting

The State Nodal NGO for community monitoring was Kalinga Centre for Social Development (KCSD). However, most of those who were associated with KCSD eventually moved to another organisation. Nonetheless, they continued to provide support for the pilot phase. In Orissa, significant support for the process came from the District Nodal NGOs, who literally held the process together. The Nodal NGO appeared to be more involved in liaison at state level. The SAGCA members provided initial support for the process- in finalising the blocks and NGOs.

There were visits by the officials of the National Secretariat, who provided support at various times.

The format for reporting was provided by the National Secretariat. In Bolangir, it was observed that the reports are nearly the same. It appears that the reports are merely cut-paste jobs, to fulfil the requirement of reporting.

V.c. Financial Management

Besides delay in availability of funds, no specific issues related to financial management came through during the review.

Key Issues

- The training done in a cascade, did not lead to any significant capacity building. Many are unable to recall the issues discussed during the training. The trainees requested continued support and more training in preparation of report cards and on community mobilisation.
- The district Nodal NGOs almost entirely hold the process together. The State NGO is more involved in liaison at the state level. Support is provided by the personnel from the National Secretariat.
- Reporting appears to be more a cut paste, to fulfil the requirement.

V. Relation to other communitisation process

No significant details of convergence with other communitisation process emerged during the review. In states where ASHA has been engaged, she is a part of the VHSC. This one aspect needs strengthening in the next phase of up-scaling.

VI. Potential Outcomes

Effectively, the community monitoring has been in place for about 18 months. Only one cycle of monitoring has been completed in the state. Hence, it is too early to assess outcomes. Only an indicative description is made here based on anecdotes.

A lot of ground work has been done during this period, which would make the process of up-scaling simpler. The achievement in the state reflects the work of all the stakeholders involved in this process.

The community monitoring has initiated the process of empowering the community. The VHSCs have given a sense of identity to community. In Orissa, it is observed that there is a greater degree of involvement of the community in the process. Most VHSC members, save the men, are aware of the process and are contributing to it. Many do perceive GKS as an institution, which could help to articulate their views and help address issues. The process is enabling a better understanding by the community of their entitlements from the health system. Hence, their expectation has increased. To that extent, it has initiated the process of bringing in the community centre stage.

Community monitoring is enabling the community to understand better their entitlements from the health system. However, in most instances, the knowledge of entitlements is limited to JSY.

Community monitoring has improved accountability. There are instances of MOs being changed based on reports from the community. Actions are also taken on reports about non-regularity of visits of ANMs. Importantly, the process has enabled the community to understand the roles of health functionaries and their constraints as well. The community monitoring process has also enabled the front line workers to articulate their constraints. There has been a greater acceptance by the community of the difficulties that the front line workers face. In many villages, this has brought a sense of connect between them.

The women and Scheduled Tribe have a greater presence in the Gaon Kalyan Samities. However, there are no significant details of whether the process has improved equity in services.

Over and above, for the NGOs, this has provided an opportunity to bridge community and health service providers. There is an increased acceptance of their role in articulating the voice of the community. There are difficulties too, when issues are highlighted in the Jan Samwad and through the media. This is more so, when issues of corruption are highlighted.

The process in Orissa appears to have engaged the PRIs. Their involvement is still mixed but discussion with the PRI representatives does indicate that they will be happy to anchor this process as a part of the Panchayat system. In fact, some of the PRI representatives were keen that this is discussed in the Panchayat meetings too. The PRIs could be an important ally for the community monitoring in Orissa.

There is a need for a better sharing and cross learning between the various NGOs engaged in the process. In addition, there appears to be a need for consensus on perspectives within the SAGCA, if this process is to move forward. The diverse perspectives have the potential of derailing the process in the state.

VII. Recommendations for scaling up

The community monitoring has initiated the process of empowering the community. This will make a significant change on the health outcome in the state. The process should continue and eventually cover the entire state. The social capital created through the GKS and other institutional arrangements should be nurtured.

The process could be initiated in stages: First, all the villages under the 36 PHCs could be covered. Next, all the villages in the four districts and eventually the entire state, could be covered. This would help in learning the lessons and gradually build capacity to scale-up in the entire state. A full scale expansion may put significant pressure on the existing institutions and they may not be able to deliver good quality result.

The PRIs and the SHGs could be allies for the scaling-up. The potential of Mother NGOs could be considered too during the expansion phase.

However, for this to happen, it is essential to simplify the tool. The existing tool is complex. The community will require external help to use the tool. Before scaling-up, it is recommended that the tool is simplified and state specific tool is developed. It is also recommended that the issues to be monitored be increased in an incremental manner. This would help to build the capacity of the community and acceptance from the health department.

It is recommended that planning and monitoring go together. There is a need to combine these two processes. ASHA could assess the village needs and based on the assessment, she and the VHSC could prepare a village plan. This is transmitted to the ANM and higher levels. The VHSC could monitor if the plan is being implemented. This would also enable triangulation of data.

Annexe 1: Details of Meetings held at State Level

S No	Date	Details of meeting	Outputs
	April 11, 2007	Consultation on community monitoring	<ul style="list-style-type: none"> • Discussion on CM • CM Mentoring group- discussion on its formation, criteria for selection of members • Decision on state secretariat • Decision on districts • Identifying members to meet health secretary
	April 19, 2007	1 st Meeting of Community Monitoring Mentoring Group (CMMG)	<ul style="list-style-type: none"> • Sharing of outcome of meeting with Mission Director & Health Secretary • Developing a framework & plan of action for CM • Preliminary identification of blocks • Roles & responsibilities of state secretariat • Resource mapping & capacity building of NGOs
	May 29, 2007	2 nd meeting of CMMG	<ul style="list-style-type: none"> • Discussion on planning for state workshop
	June 4, 2007	1 st Community Monitoring Advisory Group meeting	<ul style="list-style-type: none"> • Finalisation of districts • Formation of sub committees to discuss with districts & finalise blocks and select NGOs • Decision on district facilitators from AGCM
	June 20, 2007	3 rd internal meeting of AGCM (CSOs)	<ul style="list-style-type: none"> • Discussion on forming district level advisory group for community monitoring • Reporting on the visit of the 2 sub-committees to the districts for finalisation of blocks and initial meeting with NGOs
	July 3, 2007	4 th internal meeting of AGCM (CSOs)	<ul style="list-style-type: none"> • Final selection of block NGOs • Finalisation of draft agenda for state level workshop
	July 9, 2007	5 th internal meeting of AGCM (CSOs)	<ul style="list-style-type: none"> • Decision on splitting state workshops into two separate ones • Finalising agenda for state workshop • Discussion on orientation materials for workshop
	August 14,	7 th internal	<ul style="list-style-type: none"> • Decision on pruning State TOT from

2007.	meeting of CSO Members AGCM	5 days to 3 days	<ul style="list-style-type: none"> • Discussion on district orientation workshops • Adding Dr M K Mohanty from KCSD and Dr Krishna Patnaik from NIAHRD as members of SAGCA.
September 28, 2007.	8 th internal meeting of AGCM (CSOs)		<ul style="list-style-type: none"> • Decision on state level TOT
October 8, 2007.	9 th internal meeting of AGCM (CSOs)		<ul style="list-style-type: none"> • Finalisation of tools to be shared with block NGOs during TOT • Discussion on the role of the district facilitators and block NGOs in undertaking activities at the PHC & block level, given the availability of personnel in respective institutions. • Discussion on district level orientation
December 26, 2007	10 th internal meeting of AGCA		<ul style="list-style-type: none"> • Discussion on role of district nodal agency • Discussion on representation of members- individual vs. organisational affiliation of the members
January 18, 2008	11 th Internal meeting of AGCA (CSOs)		<ul style="list-style-type: none"> • Concern of members over behaviour of some members & role of secretariat • Organise one day meeting of Block Nodal NGOs to keep up momentum in view of delay in disbursement of funds
January 29, 2008	12 th meeting of AGCA		<ul style="list-style-type: none"> • Discussion on routing of funds- in districts facilitated by organisation, funds to be routed thru the NGO. In districts, facilitated by individuals, funds to be routed thru KCSD • Finalisation of agenda for block nodal NGO meeting
March 4, 2008	13 th internal meeting of AGCA		<ul style="list-style-type: none"> • Discussion on formation of VHSCs in districts • Discussion on finalising district action plans • Discussion on allocation of funds to block NGOs
June 14,	14 th AGCA		<ul style="list-style-type: none"> • Discussion on proposal to be

	2008	Meeting	<p>submitted to Govt. for community action in PIP, formation of VHSC</p> <ul style="list-style-type: none"> • Discussion on functioning of block NGOs
	September 11, 2008	15 th internal meeting of CSO members AGCM	<ul style="list-style-type: none"> • Discussion on State Media Workshop held on September 19, 2008. • Discussion on score cards that were prepared and deficiencies that were noted. • Discussion on media fellowships.
	October 27, 2008.	16 th internal meeting of CSO members AGCM	<ul style="list-style-type: none"> • No-cost extension of project up to December 31, 2008. • Discussion on progress in districts • Status of Jan samwads • Discussion on external review

Annex 2: Schedule of Visits and Meetings

Date	Place	Details
Nov 06, 2008	Bhubaneshwar	Meeting with SAGCA members
Nov 07, 2008	Bhubaneshwar	Meeting State NGO Coordinator
		Meeting State Programme Manager NRHM
		Meeting with Media Fellows
		Field Visit to Anganadavalasai village
Nov 08, 2008	Bolangir Dist.	Field visit to Muribahal Block
		Meeting with PHC MO (i/c) Muribahal
		Visit to Bamkel village
Nov 09, 2008	Bolangir Dist.	Visit to Gudighat village.
		Visit to Chalki village
		Meeting with Block NGO representatives
Nov 10, 2008	Bolangir Dist.	Meeting with District Facilitators
		Meeting with DPM, NRHM
		Meeting with CDMO
		Meeting with Zilla Parishad Chairperson
		Meeting with representatives of all block NGOs of Bolangir district.
Nov 11, 2008	Bhubaneshwar	Presentation of field visit report to SAGCA and Development Partners
		Meeting with PD, NRHM
Dec 17, 2008	Bhubaneshwar	State Sharing Meeting

Annex 3: Documents Consulted

SAGCA, Community Action in Orissa, Process and Progress, up to September 15, 2008.

SAGCA, Report of the District Media Workshop held on 31st October 2008 on Community Action, Nabarangpur

SAGCA, Community Monitoring, Process Documentation, Kendrapara district

SAGCA, Community Monitoring, Final Report, Nabarangpur

SAGCA, Proceedings of First Community Monitoring Meeting, June 2007

SAGCA, Proceedings of NGO Orientation, July 2007.

SAGCA, Minutes of the Consultation on Community Monitoring, April 2007.

SAGCA, Minutes of the 16 meetings of SAGCA

SAGCA, Report of the State Level TOT on community monitoring

SAGCA, State Media Workshop, August 2008.

**National Rural Health Mission
Community Monitoring Review in Rajasthan
A. Dyalchand & P. Shirsat**

b. Background

National Rural Health Mission: The National Rural Health Mission (NRHM) strives to provide effective healthcare to the rural population throughout the country, with a special focus on the states that have poor health indicators and/or a weak health infrastructure. NRHM undertakes a structural correction of the health system and effective integration of health services through decentralized management at various levels, in order to improve access to health care for rural people. It seeks to provide universal access to equitable, affordable and quality health care, responsive to the needs of the people.

NRHM proposes an intensive accountability framework through a three pronged process of community based monitoring, external surveys, and stringent internal monitoring. As envisaged in the Right to Information Act, NRHM has made it mandatory for health institutions to prominently display information regarding grants received, medicines and vaccines in stock, services provided to the patients, and user charges if any.

Objectives of Community Based Monitoring²³

- Conducting community needs assessment
- Generating information about health services
- Providing feedback of generated information to health care institutions
- Providing feedback on the status of the fulfillment of entitlements, functioning of the public health system, and identifying gaps in demand and supply
- Enabling the community to become equal partners in the health planning process
- Improving responsive functioning of the health system

The institutional framework for community monitoring:

Village health and sanitation committees have been freshly established or reactivated at village level, health monitoring and planning committees have been formed at PHC, Block, District and State levels to ensure regular community based monitoring of activities at the respective levels. Periodic public hearings or dialogues Jansunwai / Jansamvad are being organized to provide a forum for a dialogue between civil society and health providers and strengthen the accountability of the Health system to the community and beneficiaries.

Community Monitoring Initiatives in Rajasthan:

Rajasthan has a rich history of initiatives of participation of civil society in monitoring the work of the public sector. The Right to Information and NREG are two initiatives that originated in Rajasthan. In the health sector there have been similar attempts at participation of civil society.

²³ Das A et, all - A promise to better health care services for the poor/ community entitlement book – national secretariat on community action NRHM

In 2001, starting with the Medical Relief Societies (MRS) the State Government of Rajasthan began to impart varying degrees of autonomy to Government hospitals (Community Health Centres and larger hospitals). The main task of the society was to receive, account for, and spend, user-fee collections.

Apparently, the State Government was encouraged by the outcome of the initial steps towards hospital autonomy (Rajasthan Medicare Relief Societies or RMRS), and decided to extend the concept of autonomy to the management of the Health and Family Welfare sector at the district level. The devolution of power to Panchayat Raj Institutions (PRIs) was also considered by a committee headed by a senior state officer Mr. Mahendra Surana, Special Secretary.

Given the formulation for decentralization in the National Health Policy 2002, under the European Commission (EC)-assisted Sector Investment Programme; District Health and Family Welfare Agencies were established in pilot districts of Barmer and Jalore, in Rajasthan, in 2002. SIP stressed a systems approach focusing attention to *decentralization / devolution* and clear *delineation of roles and responsibilities*. Other key areas were optimum use of resources (*particularly Workforce and Infrastructure*), and better *financial systems*.

A prime aim of establishing District Health Societies was to make decision-making democratic and more effective through decentralisation, enabling them to handle both technical and managerial issues locally. The next planned step was to decentralise up to the level of PHCs and PRIs and Village Health Committees. Even as back as 2001, every Gram Panchayat has a village health committee (VHC) which had not become active.

The other important initiative was the WHO supported initiative in 1999, known as “Empowerment of the rural poor for better health care. The experiment was undertaken by ‘Prayas’ in a few villages of Rajasthan. Under this programme village health committees were established and tools were developed for the monitoring of health providers and Primary health centres. Several of the mechanisms and tools designed in 1999, under this project have been modified for use in the present CBM initiative.

b. Executive Summary

Several qualitative rapid assessment methods were used for reviewing the Community Monitoring component of NRHM in the State of Rajasthan.

Through the involvement of NGOs at the State, District and block levels, Village Health and Sanitation Committees have been established in 180 villages. Committees at the PHC, block and district levels have been established but are not functioning effectively.

Prayas a long standing NGO in Rajasthan was selected to implement the community monitoring process in the State. Twelve organizations were identified for implementing CBM in the State, on the basis of their rights based ideology, and experience in public health.

The organizations involved in CBM were active in Jan Swasthya Abhiyan and were linked with each other through a network called the Peoples Rural Health Watch. Membership in a pre-existing network, and a shared ideology, provided an enabling environment for effective coordination among the NGOs at various levels.

The community mobilization process was undertaken over a period of three days through small group meetings. Only three members from each VHSC could be trained. Their skills in community monitoring are limited and the CBM process is still heavily dependant on NGOs.

The focus of CBM is on attendance of providers and maternal health services at the village level. The data mostly highlighted grievances and denials, shifting the focus more towards curative health needs. No attempt was made at triangulation of data.

Data collected were used to prepare a report card for the village. The main use of the report cards was for the Jansunwai / Jansamwad that followed the data collection. Report cards were prepared with the aim of emphasizing gaps in service delivery, deficiencies in performance of workers and denial of rights and entitlements. The manner in which Jansunwais were conducted has not been appreciated by Government workers and in some places there have been conflicts.

Community based monitoring is an effective strategy for achieving rapid and large health benefits. An 'Action Taken Report' to be submitted by health providers must be instituted if the CBM process is to be sustained. Equity needs to be a priority objective for CBM in future.

It should be made mandatory for health providers to present a report of their performance to the VHSC. Data being collected through CBM are subjective, based on people's perception. Primacy is being given to denial of services and rights. The process so far has resulted in providing a forum for grievance redressal. CBM data should be used for planning, provision of services, monitoring, and grievance redressal, to bring about a systemic change in the health delivery system. Media need to be involved through a sustained campaign to improve the health delivery system. Grievance redressal through the media should be restricted to cases of very serious denials.

To promote sustainability, GOI and the state government must ensure continuity of support. The engagement between NGOs, VHSCs and health providers needs to continue. CBM should be scaled up to cover entire PHCs rather than 15 villages per PHC and bring about a change in the health system because of which denial of rights occurs. Only then will a sustainable and replicable model emerge from this initiative.

The present CBM strategy is not replicable, it needs to be redesigned. The CBM should function in a collaborative mode with health providers to improve the health delivery system and if that does not work Jansunwai and media should be used to advocate change.

c. Methodology

Several qualitative rapid assessment methods were used for reviewing the Community Monitoring component of NRHM. Information on all relevant issues was collected from representatives of all the districts.

Information collected by one set of stakeholders was shared with other stakeholders that were involved in the CBM process in the State. The conclusions of the reviewers were based on a process of triangulation of information collected from various individuals that participated in the review process.

The key methods used for the assessment were:

- f. In-depth interviews of key actors
- g. Focus group discussions with VHSC members, AWWs, PHC staff, NGO staff
- h. PRA tools such as listing and ranking
- i. SWOT analysis was conducted using the PARC method developed by IHMP, Pachod
- j. Triangulation of data collected from various sources.

Refer Annexe 1 for details of persons interviewed, meetings conducted and schedule

d. Institutional Mechanisms

Village Health and Sanitation Committees: Village health and sanitation committees were established by the block level NGO. The most important challenge face by the facilitators while establishing committees was community mobilization. The process was perceived by the community as a NGO project. The communal divide in the community was the most important hindering factor to bring people together to form a committee. People had an apathetic attitude toward the formation of committees, based on their previous experience with formation of similar committees in the past. The fact that village health and sanitation committees were established in villages where NGOs have been working since several years and had an established rapport with the communities in those villages made the task feasible in the stipulated amount of time.

Health Monitoring and Planning Committees at the PHC Level: PHC committees have been established in the PHCs included in the CBM process. The PHC committees are expected to monitor the performance of sub-centers and primary health centers. They are responsible for consolidating village health plans and developing the PHC plan and they initiate action in cases where services are denied. In the PHC that was visited during the evaluation it was found that committee meetings had been organized and VHSC members took active part in bringing gaps and denials to the attention of the PHC staff. However, PHC committees have not yet got involved in preparing PHC level plans.

State Nodal NGO: The State Nodal NGO is expected to provide support for the process of community monitoring at the district and block levels. Such support includes human resources, logistics and administrative set-up for the community monitoring program.

Selection of the State Nodal Organization: Prayas published a booklet in the year 2005, emphasizing the need for a structural change in the current health system in Rajasthan. Prayas was also involved in the process of policy formulation of NRHM at the central level. During the planning phase of NRHM several Non Government Organizations expressed an interest in supporting the Government to achieve the goals of NRHM and submitted a proposal to that effect. In an AGCA meeting it was decided to develop community based monitoring as a component of NRHM, based on the experiences of the Jan Swasthya Abhiyan. It was decided that the process would be facilitated and coordinated by the Population Foundation of India, New Delhi. Prayas took an active part in designing the community monitoring process. Being one of the authors of the concept of community monitoring, Prayas got the responsibility of implementing the community based monitoring component of NRHM in the state of Rajasthan. In a meeting, organized under the chairmanship of the mission director, NRHM and Secretary Health and family welfare, Government of Rajasthan, Prayas was selected as the Nodal NGO for implementing the community based monitoring in the state of Rajasthan on May 8, 2007. Prayas

was formally confirmed as the State Nodal Agency through an official letter issued by the State nodal officer on May 10th, 2007.

Formation of the State Mentoring Committee: The state mentoring committee was set up by the state nodal officer in consultation with the mission director, NRHM. The State Nodal Agency provided necessary guidance for formation of the State Mentoring Committee. The state mentoring committee has seventeen members. It was chaired by the mission director, NRHM and co-chaired by the state nodal officer and a representative of civil society. The Government order regarding the same was issued by the mission director, NRHM on September 11th 2007. The State Mentoring Group actively and successfully lobbied for creation of VHSCs at every revenue village level instead of earlier policy of the state government to have it at panchayat level. State Mentoring Group regularly met and reviewed the progress.

Selection of Districts: A three member committee was formulated to select districts for implementation of the project. Norms for the selection of districts were formulated at the national level, and in the first phase of Community Monitoring, 30 districts were sanctioned in the 8 selected states. The key criteria were regional diversity and the presence of credible district level NGOs which could implement CBM. In accordance with these norms, 4 districts; Jodhpur, Chittorgarh, Udaipur and Alwar were identified for the implementation of the pilot phase in the State of Rajasthan.

Table 1: District selected for community monitoring:

Sr. No.	District	Nodal Organization
1	Chittorgarh	Prayas
2	Udaipur	ARTH
3	Jodhpur	GRAVIS
4	Alwar	IBTADA

Identification of District Nodal Agencies

The state nodal organization received a notification from the government of Rajasthan to select the nodal agencies at the district and block levels. On the basis of this notification the process of selecting the district and the block nodal organizations was initiated. A three member committee chaired by the Director RCH was formulated to select district nodal agencies for the implementation of Community based monitoring. Criteria were developed for the selection of district nodal agencies at a state level meeting.

The key criteria for selection of the district nodal agencies were – physical location in the district, experience in the field of public health, organizations having a right based approach and the organizations having medical personnel. The administrative capacity and leadership skills of these organizations to take responsibility of functions at the district level were also taken into consideration. Four districts - Jodhpur, Chittorgarh, Udaipur and Alwar were identified, on the basis of the given criteria, for the implementation of the first phase of Community Based Monitoring. The organizations were selected from the existing network of NGOs involved in Jan Swasthya Abhiyan and Peoples Health Watch. In case of Alwar district the selection of the NGO

was done with the assistance of ARAVALI²⁴. Information regarding the selection of the district nodal agencies was conveyed to the chief medical and health officer of the concerned district. The selection was finalized by the state mentoring committee. The selected NGO's were expected to follow the framework of community based monitoring prescribed by NRHM, GOI. Hence, the selected NGOs were not asked to submit any proposal for community based monitoring.

Since Prayas had implemented the WHO supported initiative on "Empowerment of the rural poor for better health" in 1998-99, and had also conceptualized the community monitoring framework at the GoI level, they were considered appropriate for implementing the process in two blocks of Chittorgarh district.

Selection of the Block Nodal NGOs: The secretariat set up by the state nodal agency identified the blocks in which organizations were working in the Jan Swasthya Abhiyan. In order to save time no screening was done to select the block level implementing agencies.

"The process of screening was not done; we already knew the organizations working in the field of public health. If we would have got in to the process of screening and selection it would have taken lot of time" - state nodal agency representative

The basic criteria for selection of the organizations were grassroots presence, experience of working in the field of health and involvement in Jan Swasthya Abhiyan. The decision regarding selection of block implementing agency was taken in consultation with the district nodal agency and the chief medical and health officer of the concerned district. This selection was later approved by the state level mentoring group in its first meeting.

Table 2: Selected blocks and organizations for implementation of 1st phase of community monitoring:

District	Block	Organization
Jodhpur	Luni	Meera sansthan
	Mandoor	Bhagawan Mahavir sansthan
	Osiyan	Gravis
Chittorgarh	Bhainsrogh	Nav nirman sanstha
	Chittorgarh	Prayas
Udaipur	Kapasana	Navchar sanstha
	Kotda	Sewa Mandir
	Gogunda	ARTH
Alwar	Sarada	MRAKVS
	Lakshmanagarh	BGVS
	Umrain	MMSVS
	Ramgarh	IBTADA

Three PHC's per block and two villages in each PHC were the norm set for village selection. The villages for community based monitoring were selected by the block level implementing

²⁴ NGO set up by the government of Rajasthan

organizations. The villages selected by these organizations were ones where they had been working over the last several years.

Establishment of District Mentoring Group (Zilla Jan Swasthya Bhagidari Samiti): The decision to establish a District Mentoring Group (Zilla Jan Swasthya Bhagidari Samiti), in each district where community monitoring was being implemented, was taken in the meeting of the state mentoring group. This committee was expected to provide support to the process and ensure smooth implementation in the district. Necessary instructions were issued by the MD, NRHM to the CHMOs of the concerned districts to establish a district mentoring group. District mentoring groups were formed by the CHMOs with the help of the district nodal NGOs in the month of October 07. The district mentoring group is chaired by the CMHO of the district and a representative from the district NGO is the member secretary of the group.

Linkages and Relationships

NGO network: After the selection of organizations, at all levels, for implementing the community based monitoring programme, twelve organizations came together to form a network. For the first time in Rajasthan a wide network of organizations came together to work with the government health care system. Through the process of community monitoring, independent, autonomous NGOs came together to form a strategic partnership with the government. The NGO's identified at the state, district and block levels were active in the field of health. The main basis of selection of these organizations was their ideological perspective. These organizations were active in Jan Swasthya Abhiyan and were linked with each other through a network called People's Rural Health Watch. These organizations were already monitoring health services through the Peoples Rural Health Watch campaign, in their respective areas. A pre-existing network, experience in public health and a shared ideology, provided an enabling environment for effective coordination among NGOs at various levels. This network provided an opportunity for strengthening the capacity of the grassroots organizations. Collective decision making and the adoption of a participatory approach contributed to the motivation of workers at the grassroots. The network of organizations has provided a platform for sharing experiences, and developing a sense of collective ownership of the programme.

The organisations involved in the process of community monitoring represent the interests and needs of the community in their area. According to representatives of the district nodal agencies the network created a space for lobbying with government health providers. The network had enabled NGOs to liaise with government officials from village to the state level.

Despite ideological similarity the NGOs have adopted different strategies and methods of functioning. There was a diversity of understanding about the process of community monitoring in different organisations which has influenced coordination and created a spirit of healthy competition among the organisations.

NGO Relationship with the Government: The relationship between the NGO network and the Government has been successful at the policy and administrative levels because of the personal equation between Prayas and the respective Government officials. Rajasthan Government state health officials have shown exemplary commitment towards the process of CBM. There is a genuine belief among Government officials in Rajasthan that Community based Monitoring can yield results. They have requested the NGO network to include indicators such as coverage with maternal health services; contraceptive use and immunisation coverage so that quantitative and qualitative outcomes can be demonstrated through community based monitoring. The Government has begun replication of the CBM process in 41,000 villages of Rajasthan. There

was no evidence provided to the reviewers that the Government has reviewed the pilot phase of CBM and has incorporated the best practices and lessons learnt from this initial experience.

NGO Relationship with Health Providers: The relationship between NGOs and health providers was found to be adversarial in the PHCs visited by the reviewers. The Jansunwai at the PHC level has created a passionate opposition among some of the government health workers and to some extent a similar resistance at the block and district levels. In one of the PHCs that were reviewed, where VHSC and PHC committee members had been invited to interact with the reviewers, emotions ran high and the PHC workers alleged that NGOs are bribing community members to speak against them. Reviewers were requested by PHC workers to witness how monetary incentives were being paid to committee members for speaking against them. It turned out that the NGO was paying TA DA to the committee members who had attended the meeting as per the norms stipulated by the AGCA. Staff in the same PHC refused to share information from JSY records even with the State government official who was accompanying the reviewers.

NGO Relationship with VHSCs: VHSC and PHC committee members were very vociferous about their demands and in pointing out the gaps and denials in the provision of health services. However, there is inadequate understanding among VHSC and PHC committee members and hence community representatives are able to articulate demands that are limited to their understanding of the primary health care system. Most of the issues raised by the VHSC and PHC committee members are not resolvable at the village or PHC level. NGOs must ensure that issues are raised at the appropriate level, which includes – Village, Sub-centre, PHC, CHC, block, district and state. Village Health and Sanitation Committees were established by block level NGOs. CBM is, therefore, perceived by the community as an NGO project. This perception needs to be changed if CBM is to be institutionalized.

Relationship between VHSCs and PRIs: PRI members have participated in the CBM process. Several village Pradhans attended the meeting held at one of the PHCs and appeared well informed and interested in the CBM process. It was difficult to assess how generalizable this observation is and to what extent their participation can be sustained.

a. Processes and their Implementation

Community mobilization for establishment of VHSC's

Objective of community mobilization:

- To make the communities aware of their health related entitlement within NRHM.
- To have a shared understanding of the health issues of the community.
- To facilitate the formation or expansion of the Village Health and Sanitation Committee.
- To build ownership about public health service.
- To develop awareness about determinants of health.

Community mobilization was conducted over a period of three days in each village. On the first day discussions were held with the community on various health issues in small groups. On the second day social mapping and community mapping of the village was done by the facilitators

with the participation of the community. Community members were sensitized for community based monitoring and issues related to institutions providing health care.

A procession (padyatra) was taken out in some places and posters were put up at the PHC and Sub-centers. Village meetings were organized on the third day during which people suggested the names of the individuals to form the VHSC. The criteria and guidelines for selecting VHSC members were provided by the AGCA. Individuals who were willing to volunteer their services and devote time for community monitoring were selected. Members were selected from the Gram panchayat, marginalized section of the community and from self help groups (CBO's).

Training of VHSC members: A training programme, of five days duration, was conducted at the block level to build capacity of the VHSC members. Three members from each VHSC were selected for the training. The objective of the training was; to enable VHSC to review village health register, performance of ASHA, ANM and MPW and could send the three monthly reports to the primary health centre. The training curriculum was split into 3 and 2 days according to the AGCA guidelines. In first three days of training the trainees were oriented to NRHM and community monitoring. For the next two days the participants were given field training for skills development. The focus of the training was on sensitizing the participants to the issue of health in the context of NRHM, roles and responsibilities of VHSC, and rights and entitlements. The participants were trained in using the tools for data collection, collecting data for community monitoring and presentation of the data.

Few of the trained members could recall the training content. None of the VHSC member interviewed could recall details about NRHM. The VHSC members could only tell about the monitoring of the ANM's and AWW's work. According to most of the VHSC members the objective of the committee is to monitor providers at the village level. VHSC members participated in the process of data collection and preparation of the village health cards. Committee members were able to understand the colour code in the report cards that were given to the village and facility. Most of the members were enthusiastic about issues raised in the Jansunwai. Some of the VHSC members demanded formal recognition through registration of the committee. The NGO's were not confident about the VHSC's capacity to take the process further on their own. Block facilitators were not satisfied with the time given to formulate the committees. Some of them expressed concern about the communal divide in the community. In Rajasthan, factions in the community on the basis of class and caste make it difficult to mobilize the community - *representative from district nodal agency*. The NGO facilitators were also apprehensive about government providers being members on the committee. According to them health providers could create biases and influence the result of community monitoring.

Data collection by the VHSC: Data collection was carried out by the block level NGO facilitators with VHSC members. They undertook the first round of monitoring by conducting beneficiary interviews, provider interviews, exit interviews, focus group discussions and observations. Information was collected from the interview of beneficiaries of various groups (different sections of community open category, dalit women and minorities). Inferences were based on the perceptions of the respondents and VHSC members. No attempt was made at triangulation of the data.

At the end of the first round of data collection a report card and a cumulative report card is generated at each level. To understand the health status of the village colour codes were used where green suggests good performance for the indicator, yellow suggests there is a cause for

concern and red suggests that the performance for that indicator is poor. On the basis of the cumulative information the village was given a colour code.

There was poor understanding of the data at the level of VHSC members and community. The understanding of the data and its implications was not satisfactory at the level of the NGOs either. In Rajasthan, the score card was very different from the one being used in Maharashtra. A more complicated scoring system has been adopted for measuring each indicator (refer appendix 2 for score card).

Indicators used to collect data at village level

1. Guaranteed health services through NRHM
2. Janani Suraksha Yojna (JSY)
3. Child health
4. Incidence of the diseases in the area
5. Curative services
6. Untied fund
7. Quality of the services
8. Peoples perception about ASHA and her work
9. Equity (services provided to general category women and to women belonging to minority)
10. Adverse consequences

Indicators used for monitoring the primary health centre

1. Availability of staff compared to the sanctioned positions
2. Equipments
3. Availability of services
4. Quality of services
5. Actions taken by Rogi Kalyan Samiti and implementation of the actions

Preparation of report Cards: The indicators at the village level were evaluated on a point scale ranging from 0 to 24. Indicators at the PHC level were measured as a proportion of services available compared to expected services in the primary health care centre. Guaranteed health services and Janani Suraksha Yojna were evaluated on the basis of the proportion of eligible beneficiaries that received services. The focus of the whole exercise was on availability of services and presence of service providers. Greater importance was given to the attendance of the provider. Data collected were consolidated to prepare the report card for each village. These report cards were prepared by the NGO facilitator with the participation of VHSC members. Report cards, in the form of posters, were displayed at the Jansunwai and at primary health centres.

The report cards were used for:

- ❖ Discussions conducted in Jansunwai
- ❖ Sharing with government officials
- ❖ Dissemination to media

During the review and assessment process, the evaluators found that only a few VHSC members understood the report card. The scoring system was not understood by the NGO facilitators or the VHSC members. The report cards were not used for planning health services in any of the villages or PHCs that were visited during the assessment. The main use of the report cards was for the Jansunwai / Jansamwad. **(Refer Annexe 2 for filled report card)**

The staff of the PHC and CHC was completely unaware about service guarantees (citizens charter of health) and the communitization process under NRHM. At the grass root level ANM's were directly involved in the CBM process as members of the VHSC. ANM's participated in the process of data collection and preparation of the village health cards. According to the NGO facilitators most of the ANM's are active and willing to improve their performance.

Jansunwai conducted at primary health centre

Jansunwai was conducted at each primary health centre where the community monitoring process was implemented. The community was mobilized for Jansunwai through pamphlets and VHSC meetings. Information was given to the health care providers at the village, PHC and district levels by the block level NGO. Jansunwai was conducted in presence of community members, VHSC and different CBO's, health care providers.

The process included

- Presentation of Cumulative Village Report Card & Facility Report Card
- Presentation of Denial of Care / Adverse Outcomes
- Discussion on implementation of outreach services, improving utilization of facility level services and addressing cases of denial of care/adverse outcomes.

Major issues raised during Jansunwai

- Absenteeism of health care providers
- Demand of money by health providers
- Private practice by the government health care providers
- Cases of denial of services
- Untied funds
- Regularization of the services provided by sub-centre and primary health care centre
- Non availability of the service provider
- Lack of guaranteed services and medicines at the primary health centre and sub-centre
- Denial of benefit of Janani Suraksha Yojna
- Behavior of the service providers

During Jansunwai most of the issues raised were related to denial of services. The focus was also on apparent deficiencies in health facilities. Jansunwai provided an effective platform for grievance redressal. There is little focus on health service provision and quality of health services. Jansunwai has had an effect on the performance of grass root level workers especially ANM and MPW's. There was no evidence of any impact of Jansunwai on health providers working at primary health centres. It has provided a platform for dialogue between different stakeholders. It has created space and scope for improvement in the delivery and quality of services as well as awareness and participation from community. It has created demand for services. It has given stakeholders other than VHSCs, such as CBO's and NGO's to inquire into the health system. The process of Jansunwai was found to be time intensive as it took a long time to mobilize and organize communities as well as providers. NGOs have nurtured a few individuals who are very vocal to speak during Jansunwai's. Their understanding of the process of CBM appeared limited. People who were vocal dominated the process to make their point which reduced space for others to express their views. The grievances raised in the Jansunwai have created a conflict between the community and health providers in several PHCs. The inability of the health providers to respond and take action on the issues raised in Jansunwai has

led to several conflict situations. There appears to be no mechanism in place for conflict resolution. The skepticism of some health providers concerning Jansunwai has led to reluctance and resistance. Poor follow up and absence of grievance redressal is breeding disinterest and frustration in the community about the process. Reviewers came to the conclusion that PHCs that are well functioning are less intimidated by Jansunwai and have attempted to improve their performance. In the poorly functioning PHCs health workers have become defensive and have resisted all attempts at improvement. The response of the NGOs has been belligerent occasionally as they were of the opinion that the power of the Government was behind them. District level committees were formed and district health officials participated in the meetings. However, it appears that after formation of the committee (Zilla jan swasthya bhagidari samiti) no efforts were made to review the progress of CBM. Orders were issued to the concerned staff to attend meetings and Jansunwais by the CHMO but no efforts were made to ensure their participation. This has led to an unnecessary strain between civil society representatives and the health officials. On one occasion people demanded that the CHMO be present for a Jansunwai. Since he had other important commitments he delegated his assistant to attend. The VHSC members locked the PHC and demanded the presence of the CHMO for taking on the spot decisions that he said could not have been taken at his level in any case.

Flow of information

Information collected from all five villages in one primary health center area was collated using the village report cards. This information was used to prepare the PHC card which was disseminated during the Jansunwai. At the Jansunwai this information was shared with the district and block level officials and disseminated to the media.

There is inbuilt mechanism of monitoring the progress of the performance in the health system. This administrative monitoring is ongoing on monthly basis at primary health center, district and state level. A very detailed formal Management Information System (MIS) is in place in the State but it has not been able to make health providers accountable as the data is not used for supervision and monitoring at the local level. Community monitoring has given scope to the community to monitor the health system at the local level. Despite the community based nature of the monitoring process it has not as yet ensured that those in need of primary health services receive those services on a timely basis. Nor is there any attempt at triangulation between the data collected through the formal MIS and the Community monitoring data.

Role of media

Media

formal agreement with the media, nor were any media fellowships. In Jansunwai the State and district level NGOs would prepare and send formal engagement, involvement of media appeared to be a crucial process. Media played an important role in taking the issues of community monitoring to a large scale audience creating awareness on health issues and health facilities. Media was able to draw attention of health officials at the district and PHC levels. Publicity given to the issues of Jansunwai in the media created pressure on the health service providers. The pressure created by the media had different outcomes at various levels. According to block level facilitators some women received benefits of JSY immediately after the media coverage. The print media tended to sensationalize news related to the community monitoring process highlighting the denial of entitlements, deficiencies in health facilities and cases of corruption. Hence, media coverage intimidated service providers and health officials resulting in several conflict situations.

f. Programme Management

Mission Director, NRHM: Timely decisions were taken and orders were issued by the State to the district level. This process was facilitated by the state nodal organization. The result is that committees stipulated at various levels were formed. However, the lack of formal meetings of district mentoring committees was a major gap that affected implementation of the process. The other important officials implementing NRHM especially DPM was unaware of the process.

State level workshop: As per the AGCA guidelines a state level workshop was organized at the state institute of health and family welfare in the month of August 2007. In this workshop 50 participants were present, including the CMHO's and DPM's of the concerned districts and representatives of civil society organizations. The purpose of this workshop was to sensitize providers and introduce providers and civil society organization representatives to each other.

State mentoring group: A state mentoring group comprising of seven members was formed and was chaired by the mission director, NRHM and co chaired by state nodal officer. State nodal officer for community monitoring facilitated the formation of the group with suggestions from the state nodal organization.

"The State Mentoring Group was established by government orders; Prayas made suggestions and the government accepted our suggestions" - state nodal agency representative

An official order regarding formation of the group was issued by the mission director NRHM in September 2007.

The State mentoring committee was formed collectively by the state nodal NGO and officials from the government. Frequent meetings of the state mentoring committee were held. The CBM process was reviewed periodically and appropriate actions were initiated. To conduct most of the state level meetings necessary support was provided by the department of health. There was frequent communication between state health authorities and the state nodal NGO. The participation and the support provided by the officials at the state level indicated effective coordination between the NGOs, the department of health and the State NRHM. This coordination is imperative for CBM to be effectively implemented in the State.

State level training of trainers: A five days training was organized at Jaipur. The workshop was organized by Prayas in coordination with ministry of health and family welfare, Government of India. Thirty five participants from various organizations participated in this training, which included district and the block level coordinators.

District level workshop: In the selected districts workshop were organized at the district level in the month of September, November and December 2007. Participants for this workshop were health providers from the private sector, CHMO, DPM and elected representatives from Panchayat raj institutions. The objective of this workshop was to sensitize the health care providers and members of panchayat raj institutions.

Training of block facilitators: Three days training of the block facilitators was conducted in the month of December 2007. The training was conducted on the basis of the curriculum developed by the AGCA. The focus of the training was on cognitive and practical skills. The methodology used to impart the training was classroom teaching, group work, discussion and games. Objective of the training was to develop understanding of NRHM, the process of community monitoring, tools of community monitoring, establishing VHSCs and roles and responsibility of VHSC.

g. Relation to Other Processes of communitization

The existing network of the peoples rural health watch has already established a rapport in the community. These connections were helpful for the NGO's to mobilize the community. The linkages between self help groups and the NGO's facilitate the process of community mobilization. The process of community mobilization and formation of VHSC's was carried out

with the help of Self Help Groups. Membership of self help group was one of the criteria for selecting VHSC members. There was active participation from SHG's in data collection and Jansunwai. There was no separate strategy adopted to sensitize PRI institutions. The existing strategy of training was unable to provide necessary inputs to sensitize PRI institutions. Few PRI members who were part of monitoring committees took interest in the process.

h. Potential Outputs and Outcomes

It is too early to assess the outputs and outcomes of community based monitoring, but certain trends and potential results are obvious even at this stage. There is consensus that the attendance of health workers has improved, thereby improving the availability of primary level health services. There are several instances where Jansunwai and media involvement have been successful in redressal of grievances. However, several factors are impeding the implementation of CBM. There is a paucity of human resource (vacant posts), which are not being filled despite demands by the community. Similarly, there are glaring deficiencies of equipment, drugs and supplies. In the light of such scarcity, health care institutions are not able to cater to the demands generated by the CBM process.

i. Conclusions and Recommendations

CBM is a highly commendable initiative taken by the Government under NRHM. It has the potential of yielding results that can lead to rapid and large health benefits. The Government needs to be commended for creating a space for the participation of civil society to ensure that the basic health rights of the community are addressed efficiently. It is strongly recommended that this initiative be continued.

Community participation: The participatory nature of the CBM process is its biggest strength. Inclusion of community mobilization in this process provides an opportunity to sensitize the community about its rights as well as its responsibilities. It is a unique initiative in that space has been created for dialogue between the community and health providers. CBM has the potential to create awareness about health services and generate demand. Community involvement in health care services is one of the prominent features of the National Rural Health Mission and the process of community based monitoring is the best avenue for achieving this.

The process involved, and the time allocated for community mobilization will most certainly not be sufficient if NGOs are asked to replicate this process in villages where they have no previous contact. It is recommended that more time and resources be allotted for this important process.

Establishment of VHSCs: AHSAs or AWWs should be instructed to ask every 20 to 40 households to nominate their VHSC representative.

Prime Responsibility for Ensuring Effective CBM: Block NGO facilitators performed most of the roles expected from VHSC members. There is no evidence that the VHSC can function independently, which needs to be rectified in future.

Linkages between the Government and the NGO Sector: Some NGOs have adopted a confrontationist approach, advocating immediate change in a system that has functioned lackadaisically for decades. A more gradual and systematic approach needs to be adopted that will bring about sustainable change. The State Nodal Agency should moderate the functioning of such NGOs.

Rajasthan has included community monitoring in the State PIP. It has decided to replicate the process in 41,000 villages. The State must ensure the participation of Government staff in the context of CBM. The State must also ensure that there is a measurable response by health providers to the demands made and gaps identified by CBM. In conjunction with the CBM report card a concomitant 'Action Taken Report' (ATR) by health providers must be instituted if the motivation of VHSC members in the CBM process is to be sustained.

Relationships and Linkages: Even with a limited number of NGOs there have been ideological differences, variations in strategies, and in the capacity to undertake this initiative. When the CBM initiative is scaled up, the challenge will be to find more NGOs who have the required combination of shared values and expertise. Finally, CBM needs to be implemented in 41,000 villages. Considering the limited reach of the NGO sector their future role needs to be reviewed. Instead of being implementers they should undertake the responsibility of introducing the best practices identified at the pilot level, in the scaling up initiative being undertaken by the State.

Presently, the demand for change is coming from NGOs who are acting as spokespersons for the community. VHSCs are not empowered enough to act independently. However, if the participation of civil society is institutionalized and sustained, it will ultimately lead to VHSCs taking the responsibility of ensuring the health rights of the community.

Constitution of VHSCs: The key responsibility of village health and sanitation committees is to ensure accountability of health care providers in the delivery of health services. Therefore, health providers themselves should not be members of the committee. On the contrary, it should be made mandatory for health providers (ANM, MPW and AWW) to attend the monthly VHSC meeting and present a report of their performance to the VHSC.

Monitoring Process: Primacy is being given to denial of services and rights. The quality of data needs to be reviewed so that it can be used for health micro-planning. There is a potential for the CBM data being used for preparing village, sub-centre and PHC plans.

Monitoring Indicators: The data being collected are subjective, based on people's perception. The monitoring indicators for CBM need to be objective and verifiable. The CBM data should permit triangulation. Since data are subjective, there is resistance and non-acceptance of the findings by health providers, especially at the level of Primary and Community Health Centers. This also indicates a communication gap between the NGO facilitators and health service providers. This needs to be rectified and opportunities should be sought to make the process more inclusive and collaborative.

Tools and Report Cards: The tools for collecting monitoring data need to be revised urgently. Using simple quantitative data, such as beneficiaries covered versus beneficiaries not covered, can be incorporated to make it more objective.

Jansunwai: Data collected through the CBM were used during Jansunwai, and focused mostly on denial of services and entitlements. The process so far has resulted in providing a forum for grievance redressal for individual cases of denial of service, rather than any attempt to address systemic problems. The denial of Janani Suraksha Yojana (JSY) money to eligible pregnant

women is a case in point why a change in strategy is required in order to make CBM outcomes systemic. JSY payment was a repeated issue that was raised in Jansunwais conducted at the village level. The CBM succeeded in getting some of the women reimbursed; however, the operational system for JSY payment, with all its glaring gaps, remains unchanged. The evaluators concluded that, while CBM has succeeded in rectifying denials and in grievance redressal at an individual level, there is little change in the health systems because of which these denials result.

Grievance Redressal Mechanism: Establishing a separate and enduring grievance redressal mechanism, where denial of rights and entitlements can be recorded and addressed, should be made mandatory for all PHCs and sub-centres. Then, it will not be necessary to use Jansunwai as the forum for grievance redressal, and it can be used for introducing sustainable systemic change in the health system. This can happen only if CBM is implemented through a health systems approach.

Involvement of the Media: The role of media needs to be reconsidered. Media need to be involved through a sustained campaign to improve the health delivery system. Grievance redressal through the media should be restricted to cases of very serious denials that defy rectification through other means.

Outcome of the Monitoring Process: It is recommended that CBM information be first used for planning of services at the village, sub-centre and PHC levels. Following this, the information should be used for monitoring the provision of services in collaboration with health providers. Following these collaborative actions, if service provision is lacking, the issues can be taken to the level of Jansunwai and media intervention.

Community Health Needs: There is meagre evidence that the CBM system is assessing the health needs of the community. It is recommended that this should be undertaken.

Triangulation – Data Validity: There is no evidence of triangulation of data. The reason why triangulation is not possible is because of the nature of data being collected under CBM. It is recommended that more objective information be collected which lends itself to triangulation.

Coverage and Equity: At present, CBM does not have the capacity to address issues related to coverage and equity. Data collected under CBM should be redesigned to ensure better coverage, including coverage of marginalised households and individuals.

Entitlements: There is evidence that VHSCs have some knowledge of entitlements, but this does not exist as yet at the community level and hence requires greater importance.

Accountability: There is evidence that this process will bring about accountability of the service providers. The CBM needs to be redesigned so that this outcome is strengthened.

Service Guarantee: As mentioned earlier, CBM is at present giving primacy to grievance redressal and individual denial of rights. To some extent CBM is also addressing availability of

services. However, CBM needs to be strengthened so that it can address issues related to accessibility and quality of services.

Sustainability: The engagement between NGOs and VHSCs on the one hand, and health providers on the other, needs to continue. This engagement is threatened because health providers are feeling intimidated. Health providers perceive NGOs and VHSCs as adversaries. This can be reversed if health providers are encouraged to use CBM data for demand generation, micro planning, implementation, concurrent monitoring, and supervision. If health providers find that the data are of use to them in improving their performance, the threat element will be removed. In order to sustain the process, it is highly recommended that CBM be scaled up to cover entire PHCs rather than 15 villages per PHC. Only then will a sustainable and replicable model emerge from this initiative.

Replicability: At every level, which includes NGOs, district and state level health administrators, the perception was that the present CBM strategy is not replicable suggesting that the CBM strategy needs to be redesigned. A possible alternative strategy is that ASHA becomes the ears and eyes of the VHSC. She should assess the health needs of her community on a monthly basis (200 houses @ 10 houses a day) and give her assessment to the ANM. The ANM must provide primary level services on the basis of the needs assessment done by ASHA. On a monthly basis, ASHA must report to the VHSC if the health needs assessed by her were addressed by the ANM, and the PHC, including institutional deliveries and referrals. This way the CBM will be used for health planning and implementation. This will also ensure triangulation of data. If after this collaborative effort, there are still gaps in service provision and denial of services, these can be taken up in a Jansunwai. It is believed that the change in strategy recommended above will create a more replicable model of CBM, and will be much more acceptable to health providers, administrators and policy makers.

Another innovation that was suggested by the reviewers and was received well by health officials in Rajasthan was that the Government makes it mandatory for the ANM and MPW to get their MPRs certified by the VHSC. Certification of MPRs prepared by ANM, MPW and the PHC on basis of CBM conducted by ASHA would automatically ensure triangulation of data. If at the time of certification there are gaps and denials, those can get taken up during periodic Jansunwais. Additionally, the PHC should be required to maintain Action Taken Reports which they should send to district officials so that gaps and denials identified during CBM are addressed on a timely basis.

VHSC members did not have the necessary cognitive or practical skills to undertake community monitoring independently. When implemented at a State level, the present strategy of capacity building does not appear replicable. It may not be possible to orient all VHSC members from 41,000 villages in the State. It is recommended that CBM be included in the curriculum for the induction training of ASHA. In addition to ASHA, only one person from each VHSC, preferably the chairperson or secretary should be invited for training in CBM.

Review of Community Monitoring in Tamil Nadu: A Report

Executive Summary

The community monitoring in the state has been effectively on ground for about 18 months. Despite this short period, there have been significant gains from it. These include the translation of materials for orientation and training, forming committees at different levels, undertaking capacity building through training and orientation, mobilising the community, preparing report cards, organising Jan Samwads, engaging the media, organising advocacy with key stakeholders in the government, and preparing for the scaling up.

The gains have been impressive, given the time and the intensive effort required for these tasks. The spirit of volunteerism, commitment and passion that has gone into the process is also commendable. Community monitoring has set in motion the efforts to bring the community centre-stage in health delivery. VHSCs have given voice and visibility to the community. Communities have a better sense of their entitlements and hence their expectation from the public health system has increased. They have also begun to understand the constraints of the department, especially the front line workers. It has enabled a better connect between the community and the health department. It has also enabled a better accountability of the department- in engaging and in responding to the community.

The Review recommends the continuation and scaling up of community monitoring in the entire state.

However, it is recommended that the scaling up be done in an incremental manner to build capacity of the community and acceptance by the department. It recommends that planning and monitoring go together. While scaling up, the Review recommends a substantial simplification of the tool and the processes. It is recommended that community monitoring be anchored in an existing arrangement in the health department to ensure buy-in by the health department. The oversight responsibility however, should be separate and this could include representatives from the government and civil society. To ensure success, the process should go through a minimum of three cycles, before a decision on restructuring and revamping is taken. The State Mentoring Team, Resource Team and the various arrangements at the district level, ought to be the resource pool to facilitate scaling up.

II. Background

Tamil Nadu is ranked as a high performing state, based on human development index, literacy, low fertility and mortality rates. The state has witnessed a medium growth in the last few years. The sharp decline in fertility, the high literacy rate and many innovative social development programmes have focussed attention on some of the best aspects of the state.

However, many issues in the state need attention too. Majority of the work force in the state is involved in agriculture. Yet, the agriculture sector has more or less been stagnant. The development in the state is said to be uneven- both geographically and across groups. There is still significant rural poverty and the decline in rural poverty has been much slower. Nearly 20 percent of women still marry before 18 years. In districts such as Dharmapuri, about 39 percent of the girls marry below the legal age. About 40 percent of married women experience spousal violence. A significant number of children (about 33 percent) of less than three years are underweight. Majority of the pregnant women undergo ANC and the institutional delivery is over 90 percent. Yet, only less than 50 percent consume IFA and about 50 percent of the pregnant women are anaemic.

In other words, despite the many shining aspects of Tamil Nadu, many issues need attention, too.

The state has a good coverage by health care services. The public health system provides preventive, promotive, curative and rehabilitative health services. The State also has undertaken many innovations in the health sector; such as, the Tamil Nadu Medicine and Supplies Corporation. There have been partnerships between the health department and NGOs, more specifically, for service delivery.

However, the pilot initiative on community monitoring, under NRHM, engages NGOs not to provide services but to partner with the department to address issues of accountability, quality and in ensuring that community receive their entitlements. To that extent, this is a unique initiative.

III. Review Methodology

The review in Tamil Nadu was part of a countrywide review of the process in nine states. The Terms of Reference (TOR) and the methodology were common for all nine states. The review team included Suresh from the State Nodal NGO, Ameer Khan from the State Resource Group and S Ramanathan (External Consultant).

The external consultant is in Tamil Nadu hence, the review process was staggered. He had earlier participated in a one-day sharing meeting held in August 2008, independent of the review, which had provided an overview of the issues. For the review, three-day field visit was undertaken in Vellore district. The field visit included visits to villages, SCs, PHCs. In the meetings at villages, discussions were held with VHN, Panchayat Presidents, and members of the VHSCs. A meeting at the district level in Tirupathur on November 19, 2008 enabled meeting with all the NGOs implementing community monitoring in Vellore district and meeting with the officials of the health department, including the Deputy Director, Tirupathur. One day meeting at the State level was organised to meet the representatives of the NGOs from the other districts. The External Consultant also participated in two meetings held with the Mission Director, to discuss the expansion phase of community monitoring. This provided an opportunity to discuss the issues with her. The State Nodal Officer, health department, was interviewed separately for the review. The representatives of the State Nodal NGO were also interviewed.

Details of persons met and places visited are in the Annexe. The External Consultant also conducted a desk review of key documents provided by the National Secretariat and the state and district nodal NGOs. The list of documents reviewed is listed in the annex.

VIII. Institutional Mechanisms:

III.a. State level Institutional Arrangement

The State Mentoring Team consists of 14 members. The State Mentoring Team is a broad based one representing Government, implementing NGOs, human rights groups, academic institutions, medical profession, civil society networks, marginalised sector and the national AGCAⁱ. A State Resource Team of ten members also, provides support for the process. Majority of these resource persons are drawn from the State Mentoring Team and from the districts.

The State Nodal Officer, appointed by the health department is the point of contact between NGOs and the health department. The nodal officer's role is to provide technical support and in passing information from the department to the NGOs.

The state has followed the national guidelines for the formation of the institutions at the district, PHC and VHSCs. The details of the institutions formed are in the table below.

Table: Institutions formed in Tamil Nadu

State	VHSCs	PHC committee	Block Committee	District Committees
Tamil Nadu ⁱⁱ	225	45	15	5

The State Mentoring Group team has met four times. The representatives of the health department did not attend any of the meetings. Even, some of the civil society representatives are inactive and did not attend the meetings. Few members of the State Mentoring Group and State Resource Team, provide substantial support and hold the process together.

The Tamil Nadu Science Forum (TNSF) is the State Nodal NGO. TNSF has a presence in 29 districts in the state. Its presence, however, is quite strong in about 10 districtsⁱⁱⁱ. Earlier, it had played a major role in the literacy and post-literacy movements. It has many volunteers and is strong in mobilisation^{iv}. For the pilot phase of the community monitoring, however, TNSF appeared to have more restricted its role to providing administrative and financial support.

III.b Relationships and Convergence

Relation with the health department:

The process of engaging the health department began with the meeting of Health Secretary and Joint Secretary on May 30, 2007. A representative of National AGCA along with few state representatives met them. On the suggestion of the Health Secretary, a meeting with the Director, Health was also organised. However, subsequent to the meeting, it took nearly four months for the health department to issue the Government Order (GO), to initiate the pilot phase. At the state level, there is more acceptance of the process by the current Mission Director, NRHM though, the Director, Public Health has his reservations.

A representative of the Medical Profession, in the State Mentoring Group, has a good rapport with many of the officials^v. The health department, too, as mentioned above, has appointed a Nodal Officer, to provide the link between NGOs and the health department.

A key initiative in the state was to involve the VHN Association in the process. The discussion with the VHN Association helped to allay their fears about the process and to seek their cooperation. The President of the VHN Association participated in the state level meeting, and extended her support to the process. However, despite this, the involvement of the VHNs varies across districts. In Perambalur district, VHNs do not cooperate with the project implementation. In Dharmapuri, VHNs are reported to question the credentials of the NGOs to monitor them^{vi}. Many VHNs also think that the process is meant to spy on their work and report to the higher authorities. Some also see this as a nuisance^{vii}.

The relation with VHNs is symptomatic of the relation with the health department. The relation varies across districts. While the relation is good in a district like Vellore, where the Deputy Directors are proactive, it is not very smooth in other districts^{viii}. In Perambalur, reports indicate that the Medical Officers and service providers are unhappy with the formation of the VHSCs. The Deputy Director did not attend the workshop despite invitation and requests. Hence, most of the activities of community monitoring are implemented without their support. In Dharmapuri, the relation became slightly adversarial, after the media highlighted instances of non-payment of Muthulakshmi Reddy scheme funds to the women. They are also queries in some districts on why the NGOs monitoring only the health department and not the other departments. The relation also goes through swings depending on official transfers^{ix}.

In the committees formed in the district and PHCs, the participation of the health officials is rare. There are instances of the MO's agreeing to participate but not attending the meetings. The health department appears to view the process more as a NGO initiative rather than a partnership between health department and civil society. There is also the view that process is more of faultfinding than an effort to help the department to improve its services. This perspective, that the health department in the state is strong and does not need monitoring either by the PRIs or by the civil society, did emerge too.

One aspect that emerges clearly is that, without the acceptance of the process by the district officials, it will be very difficult to implement it. The officials lower down in the districts do not accept the authority of the letters issued either from the national or state level. They would allow access, only if, the Deputy Director at the district level issues a letter^x. Hence, the acceptance at the state level alone is not sufficient. There has to be a buy-in by the officials in the district. If the Deputy Director is convinced^{xi} and willing to implement the process then it is relatively smooth to implement^{xii}.

Relation with ICDS:

Besides the membership of the Anganwadi worker in the VHSC, no other significant details of the convergence and rapport with the ICDS emerges both at the state level and at the districts.

Relation with PRIs:

At the state level, there is hardly any relation with the Panchayati Raj department. According to the State Nodal NGO, initial meetings were organised with the Panchayat Department but the department evinced no significant interest. The representatives of the department and the PRI representatives did not join the state workshop^{xiii}.

There are pockets of good relations with the PRIs in the districts, but overall, the relation is not significant. In Vellore district, the PRI representatives at the district level are involved to an extent^{xiv}. However, in the same district, the PRI representatives, who headed the VHSC, often do not attend the meetings^{xv}. In one of the block in Vellore district, despite the long presence of the nodal NGO, it is very difficult to get the support of the PRIs and meetings are often held without their participation^{xvi}. There are also instances of PRI representatives who resisted the process^{xvii}. In Perambalur, PRIs are reportedly not interested. The District President did not attend the district workshop, despite invitation and requests. Some attend the meetings, but they are often not regular. In Dharmapuri, the PRIs wanted sitting fees to participate in the meetings. On the contrary, in Tiruvellore district, PRIs learnt about NRHM and the details of the untied funds through community monitoring. Hence, they are appreciative of the process.

In Vellore, few PRI representatives^{xviii}, who were interviewed, said that Panchayats do not have any authority to monitor the functioning of the health department. Hence, they do not evince any interest in its functioning^{xix}. They however, felt that it is important for the PRIs to monitor the health department. Some were willing to consider discussing the report cards at the Panchayat meetings.

Relation between NGOs:

One of the key aspects of the initiative is the spirit of volunteerism by most of the NGOs involved in community monitoring. They are very keen, egged more by their desire to ensure that the community receives its entitlements. There is harmony between all the NGOs who are working on this initiative. For almost all the organisations, the process is new and they had to first learn, internalise it before they embarked on it with the community. Many find the process intensive, but they also have learnt from it. Many of the organisations have come together for the first time. There are also opportunities for cross learning across NGOs. Few NGOs are unable to deliver. In Tiruvellore district, one NGO has done mobilisation in only 50 percent of the villages. The quality of work of few NGOs is also reportedly poor^{xx}.

Key Issues

- All institutional arrangements as proposed by the National guideline are in place.
- The State Nodal NGO is more involved in providing administrative and financial support.
- Few members of the State Mentoring Group and State Resource Group provide substantial support and hold the process together.
- The relation with health department varies. There are pockets of good relations, but at an overall level, the acceptance of the process by the health department is not significant.
- The support of the district health officials appears crucial for the acceptance of the process by the health department.
- The relation with PRI, too, is not very significant.
- The process, seen more as an NGO initiative, does not appear to have enabled any significant partnership between health department, civil society and PRIs.
- There is a significant spirit of volunteerism among the NGOs and harmony between them. There are opportunities for cross learning between them.

IX. Process

IV.a Selection process: geographical and institutional

In the state meeting held on May 30-31, 2007, a tentative listing of districts was done. The Director Health, however suggested the inclusion of Dharmapuri district (which was not in the original list) and suggested that districts other than Kanyakumari and Tiruchirapalli be included. Following this suggestion, Dharmapuri was included. However, Kanyakumari was retained and instead of Tiruchirapalli, Perambalur was included. Hence, it was decided to have five districts, instead of the four suggested by the national guideline.

Following the finalisation of the districts, the choice of blocks was determined more by the availability of the NGOs. The choice was often made by the NGOs themselves^{xxi} and the health department was informed. The health department was invited in a few districts, when the selection was made, but often, they did not participate in the meetings. The selection of the blocks and the NGOs happened in September-October 2007. Once the blocks were finalised, the PHCs and the villages were chosen by the NGOs. In the selection of the villages, there were consultations with the health department in some instances^{xxii}. PRIs were consulted in some instances. In Kanniambadi block, TNSF convened a meeting of all Panchayat Presidents on December 22-23, 2007, to finalise villages. In this meeting, the villages which were backward and had SC population in majority were chosen. Though the villages are spread, they were chosen, with an intent to learn, how the process rolls out in different parts of the block.

In selecting NGOs, the emphasis was on institutions, which had a history of working on right based issues or working for the betterment of the marginal groups. TNSF was chosen as a State Nodal NGO, in a two-day meeting of the civil society organisations and AGCA member held on May 30-31, 2007. The selection of district nodal NGOs was easy but the selection at the block level proved more difficult. The selection of the NGOs in the block was done by the district Nodal NGOs. For some of the NGOs, this was the first time that they were getting involved in health activity. Hence, many had to understand health issues and the functioning of the health department before they began work with the community.

TNSF besides being a State Nodal NGO implements the activities in three other blocks. It is also the district nodal NGO in Thiruvallur block. CHAT is the district Nodal NGO in Perambalur although, it does not implement community monitoring in that district. It however, implements community monitoring in one block in Kanyakumari district. DCBR is the nodal NGO in Vellore district. The representatives of DCBR and TNSF are represented in the State Mentoring Committee.

One aspect that needs mention is that the roles of implementation and oversight appear blurred in the current arrangement. TNSF is a State Nodal NGO and implements activities as a district Nodal NGO also and implements activities in few blocks. In this arrangement the distinction between implementation and oversight, appears blurred. It appears to have had a bearing on monitoring and course correction during the

implementation. It appears that issues, which could have been picked up during routine monitoring and corrected, were not addressed. For instance, during a visit to a village for review, it was found that the community was hardly aware of the details of the process. A state representative who was present observed that if we had known this was the status, then, we could have put in more effort to improve their understanding and deferred the preparation of the report cards. In other words, issues that should have come up during routine monitoring became evident during the review. From a governance perspective, the Review Team suggest that there ought to be a separation of the oversight and Implementation roles.

In Dharmapuri district, a NGO federation Dhvani, is the district nodal NGO. In this district, there are three NGOs, who are responsible for the implementation of community monitoring in each block. This is different from other districts where one NGO is responsible for the entire block. One of these NGOs is designated as the block nodal NGO. The idea is to involve more partners so that they feel involved. In Perambalur too, in Andimadam block, three NGOs are involved in implementation. The details of the nodal NGOs are given in the Table below.

Involving More NGOs

In Dharmapuri district, 3 NGOs are involved in each block, unlike other places where a single NGO implement the process in the entire block. This is done in Andimadam block in Perambalur district too. This would be very helpful when the process is scaled up, as there would be more NGOs, who would be able to support this process.

State Nodal NGO: Tamil Nadu Science Forum (TNSF)			
District	District Nodal NGO	Block	Block Nodal NGO
Dharmapuri	Dharmapuri District Voluntary Agencies Network Initiatives (DHVANI)	Harur	Community Rural Development Society (CRDS)
		Nallampalli	SEEDS
		Kariyamangalam	Rural Development Society (RDS)
Kanyakumari	Voluntary Health Association of Kanyakumari (VHAK)	Agasteeswaram	VHAK
		Kuruthancode	Catholic Hospital Association of Tamil Nadu (CHAT)
		Killiyoor	TNSF
Perambalur	Catholic Hospital	Perambalur	Dawn Trust

	Association of Tamil Nadu (CHAT)	Andimadam	Gandhi Gramodhaya Trust
		Tirumanur	Udhaya Trust
Thiruvallur	TNSF	Gumidipoondi	TNSF
		Meenjur	Jeeva Jothi
		Poonamalli	Pasumai Trust
Vellore	Darulselvi Community Based Rehabilitation (DCBR)	Kandhili	DCBR
		Pernampet	Voice Trust
		Kaniyampadi	TNSF

IV. b Community Mobilisation

The community mobilisation is an intensive work and involved substantial time of the NGOs^{xxiii}. The process of community mobilisation followed the meetings held at district head quarters to train the NGOs. The NGO facilitators were trained on mobilisation processes and in forming groups. Community were mobilised primarily through meetings. Separate meetings were held in the Dalit hamlets. There are some innovations too. In Kanyakumari district, children's and youth parliament was utilised to mobilise the elders. Church too, played a role in mobilisation in certain villages^{xxiv}. The Nursing College in the district was roped in to spread information about NRHM and on community monitoring. Handbills and folk media were also used for mobilisation. The presence of volunteers from the literacy movement - Valar Kalvi Thittam (Continuing Education Programme) is a significant strength in a few districts. They helped to mobilise the community in many villages. In fact, in villages where they are present, these volunteers took the lead in preparing the score cards.

Innovations in community mobilisation

- In Kanyakumari district, children's and youth parliament mobilised the elders.
- Church also played a role in mobilisation in certain villages in Kanyakumari district.
- Nursing College roped in to spread information
- Handbills and folk media were also used
- Volunteers from literacy movement enabled mobilisation in few districts.

To enable people to understand their entitlements and to spread awareness on the functioning of the health department, the NGOs have printed handbills. These bills provide details of the functioning of the sub-centres and the services provided in a SC; facilities in a PHC and the services provided in a PHC; details of the duty time of the doctors, nurses and VHNs, other staff, and the citizen's charter. This is a very useful output of the process.

Handbills informed People on

- Facilities and services provided in a Sub Centre (SC)
- Facilities and services provided in a PHC
- Duty time of doctors, nurses and VHNS, other staff
- Citizen's Charter.

In few villages, the VHSC also organised monthly meetings to discuss various health issues. The number of participants varied depending on interest and the time available with the community. In Vellore, according to the NGO representatives, there was poor turn out of the community for the village meetings. Based entirely on the few villages visited in Vellore district, it appears that the level of community involvement is not significant. Except the volunteers of the literacy movement, the rest community do not have much knowledge on rights, NRHM, VHSC and community monitoring. Even some of the volunteers lack complete understanding.

The point that the review would like to reiterate is that it is not just the inability of VHSC members to prepare the score cards; many VHSC representatives, lack understanding of the issues such as rights and the role of VHSCs. In fact, some of the VHSC members were not aware of their own role in it^{xxv}.

Evidently, the mobilisation in these villages needs more effort^{xxvi}.

The other aspect is that, in the villages, there are on an average, about four meetings in a month- SHG meetings, health meeting and PTA. There is a sense of fatigue too, for those, who are to participate in these meetings.

IV.c Committee formation

As mentioned above, the committees at different levels, as proposed in the national guideline are formed.

The VHSCs were formed in Tamil Nadu under the NRHM, prior to the start of the community monitoring programme. The VHSC were primarily involved in the management of the untied funds, provided under NRHM^{xxvii}. The VHSCs, were recast, by including more members and this process was done during March - May 2008. The Panchayats approved the reconstituted VHSCs, in the Gram Sabha and issued a letter of approval in two districts. Besides revenue villages, VHSC were formed in the hamlets, too. During this period, the orientation of the VHSCs was also undertaken. On an average, 2 to 5 meetings were held with each VHSC to orient them and training was provided to equip them for data collection and preparation of report cards.

Approval from Panchayats

Panchayats approved the reconstituted VHSCs in the Gram Sabha and issued a letter of approval. This was done to ensure that VHSCs are not disbanded once the President demits the office. This was done in Vellore and Dharmapuri districts.

The reconstituted VHSCs consists of 10 plus members. The number of members varies across villages, depending on the various stakeholders who are to be represented. Typically, a VHSC is headed by the Panchayat President or the PRI representative, it includes the VHN, the deputy leader of the Panchayat, ward members, representatives from NGOs/ literacy movement, Anganwadi worker, representative of Parent-Teacher Association (PTA) and a representative of the SHGs. Although, emphasis is on ensuring equity, in few of the villages, the Scheduled Caste is not represented in the VHSC^{xxviii}.

In most villages, visited for the review, it was observed that the women outnumber men as representatives in the VHSCs. The response from the village is that the men are busy eking a livelihood and do not have time for the meetings. This is said to be the pattern in the other districts too^{xxix}. A question that arises is: Do the men consider the process as unimportant and relegate the responsibility to the women? Is there a danger that the process may weaken as men do not get involved. The NGO representatives, however, see a merit in the involvement of the women. According to them, it is important to engage women to ensure that they begin to decide on health issues. This issue is open and needs further examination.

Issuing ID card for VHSC Members

Innovation undertaken in Dharmapuri district to ensure their recognition and acceptance by the health department.

The formation of the various committees, above village level, happened around July-August 2007. These institutions have members from the health department, PRI and civil society representatives. The representatives of the health department hardly attend the meetings. The PRI representatives, too, do not evince much interest. In some districts, NGOs, who are not involved in implementation, are not keen to be in the mentoring group. Some NGOs opted out, as there is no financial gain from participating in these meetings.

In these committees formed in the district and PHCs, the participation of the health officials is rare. There are instances of the MO's agreeing to participate, but not attending the meeting. Even the PRI representatives rarely participate. The objective of bringing together the health department, civil society and the PRI representatives to mentor and support the process, seldom happens. These forums are more or less limited to participation of the NGO representatives alone.

Consequently, these committees are not realising the purpose for which they are formed., namely, bringing together the health department, PRIs and civil society. These committees are almost entirely NGO led. Besides, these committees did not consolidate the report cards from the facilities/ villages lower down. None appears to have undertaken any field visit or monitor the progress of the implementation. To that extent, there is no significant value realised from the formation of these committees.

IV.d. Report Card Preparation

Prior to the preparation of the report card, a village profile was prepared around February 2008 in all the villages. The profile was prepared based on discussions with the community. The profile was shared in village meetings. The preparation of the report cards began in mid-2008, following the training of the VHSCs. Subsequent to this, the preparation of the facility level report cards in PHCs were prepared and consolidated by August 2008.

A comprehensive tool book for the preparation of the report card has been put together in the state. This book is a very useful document and a source of reference for field-workers.

The report cards are prepared either by the volunteers of the literacy movement or the NGO personnel. One of the reasons for this is the complexity of the tool. In Perambalur and in Dharmapuri, the people did not understand the questions. Hence, sub-questions were prepared to elicit information. According to some NGO representatives, it took about three months for them to internalise the tools. According to them, only those who are literate, with a minimum of 10th class literacy, would be able to fill the report cards. There are difficulties in calculating percentages. One district, also mentioned that repeating the same question to a general group and to the disadvantaged group, is often, monotonous. There is also some confusion on marking negative responses.

To prepare report cards, people have to be met, many times. Frequent visits in the morning and in the evening are necessary to elicit the information. Many of the respondents are not too keen to answer the questions. The volunteers and NGO representatives often, go as a group to gather the information as people do not answer when approached by an individual person. Besides, people are not too keen to talk about the bad experiences. They do not want to report about the MOs or the VHN for fear of reprisals from them. In fact, some reportedly, withdrew from the process.

PRIs too, in many villages are not too keen on the process.

There are instances where the VHN refused to show the records and reports. The verification of reports, therefore, could not be done, in many instances.

One of the important aspects in the state is the sharing of the report cards in the village meetings. The sharing, of the village report cards, was done during August- September 2008. This is an important step as it enabled the people to know the status of the various issues and to discuss how the village can help in moving the red to yellow and the yellow to green. Thus, the first tentative steps for village planning were made in these meetings. This needs to be taken forward.

- The tool adapted in Tamil is a good reference on issues of entitlements and rights and useful for the field personnel.
- Sharing of the report cards in village meetings, initiated the process for village planning

The preparation of the facility report cards are done mostly by the PHC and block coordinators. Few representatives of the VHSCs were part of the team to assess the facilities. However, even the coordinators had difficulties in understanding different types of instruments. They had to rely on what the officials of the health department told them. The purpose of checking the availability of whether there is Boyle's apparatus and whether there is forceps etc is not clear from a community monitoring perspective. This adds to the complexity of the tool.

Cumulating the report cards is done entirely by the NGOs and is more a centralised process.

IV.e. Jan Samwad

Jan Samwads were done in September-October 2008. Hearings were organised in the PHCs besides the districts.

The forum usually highlighted the deficiencies in services, such as non-visit of VHNs, non-availability of ambulance services, lack of clean facilities, poor referral services and fee collection in certain facilities. The community requested more human resources, especially a Gynaecologist, more medicines, X-ray and scanning facilities and ensuring a good referral services. In some instances, the community requested that the out-patient clinic be kept open twice daily.

There were some changes following the Jan Samwad. In some districts, the visits of the VHN became regular^{xxx}. The practices of making patients buy medicines and syringes stopped in some facilities^{xxxi}.

The officials of the health department are not too keen to attend the meeting. There are some instances of disputes occurring between PRIs, health officials and NGOs. An MO (i/c) of PHC in Vellore district was of the view that instead of open meetings, it would be helpful if the issues were discussed with the health department. Subsequently, it could be raised in an open forum.

IV. f. Engaging the Media

Media workshops in all the districts were held around August – September 2008. The media was informed of the activities of the community monitoring and some of the results of the process. No significant details of engaging the media emerged during the review.

Key Issues

- Community mobilisation is an intense process. Meetings are the dominant mode for mobilisation.
- There are some innovations in mobilisation. Children's, youth groups and nursing students were used to mobilise community in one district. Handbills and folk media are also used.

- VHSCs were already formed under NRHM and they were reconstituted. VHSCs are also formed in hamlets.
- In districts like Vellore and Dharmapuri, the Panchayats approved the reconstituted VHSCs in the Gram Sabha.
- In one district, ID cards are issued to VHSC members to ensure their recognition and acceptance by the health department.
- The level of knowledge on rights, NRHM and community monitoring is very limited. Majority of the VHSC representatives interviewed during the review did not have much knowledge on these issues.
- In some of the villages, the members are not aware of the role of the VHSC and their own role in it.
- Only some the volunteers from the literacy movement and the NGO personnel are able to explain these issues.
- A few in the community are able to explain the significance of the colours in the report card.
- The report cards are complex and difficult to internalise even for the NGO volunteers. Preparing the report cards takes time. The volunteers from the literacy movement or the NGOs prepare the cards. The purpose of questions on apparatus at the facility level is not clear.
- However, the sharing of the report card in the villages and discussion around it is helpful. It could lead to the next stage., namely., village health planning.
- The tool adapted in Tamil is a good reference on issues of entitlements and rights and useful for the field personnel.
- The Jan Samwads were held in all the PHCs and districts. These Samwads were more a forum to highlight deficiencies in services and requesting more facilities. Some changes occurred post Janwad but no significant outcome is evident following Jan Samwads.
- No significant involvement of the media emerged too.

X. Programme Management

V.a. Capacity Building

The capacity building is done in a cascade^{xxxii}. The State Training fed into the districts and lower down.

Between May to November 2007, when the formal order of the Government was issued, the State Mentoring Group had series of meetings at the district level. They had organised two-day meetings in all the districts to orient the various stakeholders on NRHM and on community monitoring. Meetings were held with various government officials too.

In view of this, instead of the State Workshop and a 5-day state TOT as suggested in the National Guidelines, it was decided to combine the workshop along with the TOT and confine the TOT to three days, with a brief inaugural session. It was felt that it may be difficult to organise a five-day TOT. Following the State TOT, it was decided to have 2 days TOT at the district level and one day in each of the block. This process was to minimise the transmission loss in cascade training ensuring an effective capacity building. More importantly, the process was to ensure a greater ownership at the district level.

Besides class room lectures, in some instances, such as at the PHC level, the training included field visits. During visits, the participants visited facilities, such as, Anganwadi centres, Sub Centres and other health facilities; meet persons who had availed services and persons denied services.

For the NGOs, the process has helped to improve their knowledge and skills. The various coordinators at the block and PHC level felt that the process has helped them to learn about team work, how to interact with the community, develop skills of public speaking, and an ability to understand the problems of the community and address it.

Although, an attempt was made to reduce the transmission loss, many at the village level are still unable to recall the issues discussed during the training. Many VHSC members are not aware of community monitoring or their role in it^{xxxiii}. In fact, some NGO volunteers too had difficulty in recall of issues discussed during the training.

V.b. Support, Monitoring and Reporting

Besides the State Mentoring Group, there is also a ten member State Resource Team, to provide support for the process. Few of the members of the State Resource Team, provide significant support for the implementation and capacity building. There was support from the National AGCA in the initial phase. The State Nodal NGO appears to have been more involved in administrative support- in ensuring reports, and in financial aspects. From the State Nodal NGO, two persons were designated- one as a Project Coordinator and the other as Joint Coordinator. The Joint Coordinator appears, to take on more of the role of the point person, on behalf of TNSF.

In the districts, the pattern is one district coordinator, one block coordinator, three PHC coordinators and then NGO volunteers / staff at the village level. The PHC coordinators are responsible for managing the process in all the five villages in each PHC. In Vellore, it was found that while the block and PHC coordinators are paid, the village volunteers are not. The latter, undertake the bulk of the activity at the village level. It may be useful to consider an honorarium for them when the process is scaled up.

The District Coordinator convenes coordination meetings and this helps as a forum to share and to monitor progress. The coordinator is also responsible for documentation and reporting. The district Nodal NGO is responsible for routing of funds and for financial reporting.

The reporting gives the impression of being a cut-paste job. They do not reveal much. The review did not come across any monitoring or field visit reports of the coordinators from the State Nodal NGO or the resource team. It would help if the monitoring systems are more effective

There is some good documentation of the initial processes at the state level. In few districts such as Vellore and Perambalur the reviewer came across documentation of the process. While effort is made to document the process, it could have helped if the documentation is consistent. Some meetings are described, but for others, there is only the participant list. Capacity building for process documentation would help the process.

There are some concerns that the reporting requirements keep changing. It is felt that it would help if the reporting requirements are clear from the beginning so that the data required for reporting are collected. Some NGOs mentioned that some new reports are requested in the middle of the process and the NGOs have difficulty responding to it, as they are not collecting the data on those aspects.

V.c. Financial Management

The fund allocated for four districts is spread over five districts. To that extent, there is less money available across the entire activity. Consequently, there is more voluntary effort of the NGOs to ensure that the programme is implemented. There are some issues that allocation of funds for the workshops was not adequate. However, according to the State Nodal NGO, at an overall level, there are no major issues on finance.

Key Issues

- Capacity building is done in a cascade. The national guidelines on training are modified. The State TOT was reduced to three days and more time was given for orientation at the district and block levels.
- Besides class room lectures, field visits were also organised to build capacity.

- There is transmission loss in the cascade training. Majority of the VHSC representatives are unable to recall the issues discussed in the training or, on issues of rights, community monitoring, role of VHSCs and their own roles in it.
- The process has helped to build capacity of the NGOs.
- The support for the process is provided through State Mentoring Team, State Resource Team and the State Nodal NGO. There were also visits of AGCA members in the initial phase and visits from the National Secretariat.
- In each district, besides the mentoring teams at different levels, there are district coordinators, block and PHC coordinators to provide support to the process.
- The review did not come across any monitoring reports of the coordinators from the State Nodal NGO or the resource team. It would help if the monitoring systems are more effective.
- The reporting gives the impression of being a cut paste job. Documentation is attempted but, was often patchy. It would help to have a better documentation of the community monitoring, which is so process intensive. A better reporting and process documentation is required.
- There are no specific issues on financial management. However, since the funds are spread over five districts, many provided voluntary support for the pilot phase. While this is commendable, it is not sustainable. This needs to be taken care of when the process is up-scaled.

XI. Relation to other communitisation process

There is no ASHA in Tamil Nadu and hence the relation with ASHA does not merit an attention. However, no significant issue of involvement with the Rogi Kalyan Samiti also emerged during the review. It would help to build in and strengthen the relation with other communitisation process.

XII. Gains so far and Moving Towards...

In the limited time of 18 months, that the pilot phase has been effectively on ground, there have been many outputs. These include the translation of materials for orientation and training, forming committees at different levels, undertaking capacity building through training and orientation, mobilising the community, preparing report cards, organising Jan Samwads, engaging the media, organising advocacy on the process with key stakeholders in the government, and preparing for the up-scaling of the process.

Given the effort required for these tasks, the attainment has been very significant. More so, as a lot of volunteerism, commitment and passion has gone into the process and this is a commendable. It would be easy to build on this process for scaling up.

However, given the duration that the process has been on ground and given the fact that only one cycle of monitoring has been done, it is too early to assess the outcomes. A broad sweep, indicating what could be the potential outcomes from the process is described.

The process of bringing in the community to be in the centre-stage in health delivery has begun. It has made them a significant stakeholder in public health system. VHSCs have given voice and visibility to the community. Communities have a better sense of their entitlements and hence their expectation from the public health system has increased. This is evident from the issues raised in the Jan Samwad. People are also beginning to perceive the health department as being responsive. In Kanyakumari district, where the private health facilities dominate, people are willing to consider reverting to the public health facilities, if the quality improves.

More importantly, the process had enabled an inter-face between the community and the health department.

The process of community monitoring has also thrown up number of issues that need rectification too. There are many instances of VHN not staying in the SCs^{xxxiv}. Most do an up down to the SC and the communities face a problem in accessing her. In districts, like Tiruvellore, the poor infrastructure was found to be the reason why VHNs do not stay. This has also had some positive impacts. Panchayats, in some instances, have come forward to improve the SCs to ensure the VHN stays in them, for instance in Kanyakumari district.

The process has helped to improve accountability. The department has begun to engage the community and to respond to its requests. In Pernampet, consequent to the process, the visit of VHN has become regular. Many instances of denial where the people were asked to buy syringes have now been resolved. The duty roster and timings of the VHN are displayed now. The SCs now have a board, which indicates the roster of visits of the VHN. The mobile number of the VHN is also displayed in few of the SCs so that she could be contacted. One of the PHC in the interior of the Gummdipoondi block, Tiruvellore district was often closed as it is an interior one and

has no proper transport access. The MO, travelled from Chennai every day. Following monitoring, the PHC is kept open and the MO visits the PHC regularly.

The interesting aspect is also that the VHNs have come to learn about the availability of untied funds and now request for the allocation from the MOs. The process of empowerment of VHNs is also believed to be happening.

The Review recommends the continuation of the process in the state.

XIII. Recommendations for scaling up

While recommending the continuation of the process and its scaling up, it is suggested that the process be done in an incremental manner. It may be helpful to first expand the process to all the villages under the 45 PHCs where the community monitoring is being implemented. Then the process could be expanded to cover all the villages in the five districts and then eventually taken forward for the entire state. This would help to build capacity of the community and enable acceptance of the process by the health department.

The review suggests that planning and monitoring go together. The community ought to undertake a need based village plan and it should monitor whether the plans are being implemented.

The review recommends a substantial simplification of both the tool and the process for implementation. The current tool, although useful in many ways, is very complex and would need an elaborate institutional arrangement for it to be prepared, collated and put together. Hence, to enable the up-scaling, the process needs to be simplified. There is a need to recognise the value of community time too.

It may be useful to anchor this process within an existing arrangement in the health department to ensure buy-in by the health department. As mentioned earlier, the acceptance by the district official is vital for the implementation of this process. To enable this acceptance, the process has to be anchored in an arrangement, which is acceptable to the health department.

However, while the implementation could be anchored in an existing arrangement in the health department, the oversight responsibility should be kept separate. The oversight committee at the state and districts should have representatives of government and civil society.

The process, when scaled-up, should not be limited to a one-year cycle, in the manner in which the pilot phase was done. The process needs significant nurturing. It should go through a minimum of at least two to three cycles, before a decision on restructuring and revamping is taken.

The State Mentoring Team, Resource Team and the various arrangements at the district level, ought to be the resource pool to facilitate the implementation.

Annex 1: Schedule of Visits and Meetings

Date	Place	Details
Nov 03, 2008	Chennai	Meeting with PD NRHM
Nov 18, 2008	Tirupathur	Meetings with District Nodal NGO
		Field Visit to Narianeri village
		Meeting with PHC MO (i/c)Gajala Naicken Patti
		Field Visit to Anganadavalasai village
Nov 19, 2008	Tirupathur	Field visit to Jalliyur village
		Meeting with PHC MO (i/c) Kunichi PHC
		Meeting with Volunteers, block coordinator & District Coordinator & members of block Nodal NGO
Nov 20, 2008	Tirupathur	Meeting with block Coordinators of Vellore District
		Meeting with Health Department officials, Deputy Director, Tirupathur
Nov 30, 2008	Chennai	Meeting with District Coordinators of 4 districts
Dec 11, 2008	Chennai	Meeting with State Resource Team
		Meeting with PD, NRHM and DPH
Dec 12, 2008	Chennai	Meeting with State Nodal Officer, Community Monitoring
Dec 13, 2008	Chennai	Meeting with State Nodal NGO

Annex 2: Documents Consulted

TNSF, Booklet on Tools (in Tamil)

TNSF, Booklet on Rights and Entitlements (in Tamil)

TNSF, Community Monitoring and Planning: An Interim Report

Documentation Reports of Kaniyambadi, Tirupathur, Pernambut blocks.

Documentation Reports of Perambalur

ⁱ The Government representatives were the Mission Director, NRHM and the State Nodal Officer appointed by the health department to coordinate the activities of community monitoring.

ⁱⁱ In Tiruvellore taluk, the activities are done only in eight villages and during review, it was mentioned that the NGO has not completed the activities. However, the data from the national secretariat indicates that VHSCs have been formed in all the villages.

ⁱⁱⁱ Interview, TNSF, December 13, 2008.

^{iv} TNSF had published booklets on health and with the support of Department of Science and Technology had implemented a project to monitor child health. For this project, which was implemented in seven

districts, they had a volunteer for every 200 households to monitor the growth of the child. TNSF also formed SHGs and as a part of the SHG intervention they addressed women's health, specifically, the issue of anaemia.

^v In her earlier role as Professor in the Medical College, she had taught many of the officials of the health department and they respect her.

^{vi} State level Review Meeting held on August 7, 2008.

^{vii} Interview with NGO representative, Voice Trust at Tirupathur on November 19, 2008.

^{viii} However, even in Vellore, the level of involvement varies. In one of the PHC, the MO (i/c) said while she meets the Panchayat President during her field visit, she is not aware of the VHSCs (Interview with MO on November 18, 2008 in Tirupathur block). In a meeting held on November 19, 2008 at Tirupathur one of the Health Inspector, said that it was important to ensure that correct information was provided to the community by the NGOs. He led in criticising the entire approach and questioning some of the information provided. The other officials from the health department, who were present at the meeting, kept quiet neither confirming nor contradicting, what he said. Few of the VHNS who were present in the meeting, said that they are aware of the process.

^{ix} In Kaniambadi block, Vellore District, in one of the up-graded PHC the MO (i/c) refused to share any information despite letters from the Deputy Director. After her transfer, the relation is better. Interview with NGO Representative on November 19, 2008.

^x The MO (i/c) in one of the PHC said that she allowed access for the PHC monitoring team to visit the PHC, as there was a letter from the Deputy Director, who said that this was an activity under the NRHM. Otherwise, she said that she would not have allowed any one to access the PHC.

^{xi} The Deputy Director of Tirupathur concluding the meeting held on November 19, 2008 said that there is a need to view this process as expressing a felt need of the community. He said that this is not an audit of the department but more a tool to assess its strength and weakness. He expressed his support for the process.

^{xii} A Deputy Director observed that that if instances of corruption are highlighted, then there is bound to be an adversarial reaction. He said that there is a need for a judgement call on what is the larger objective of the process. If the process is meant to show the department in poor light then, he felt that this is a very short term approach, which could kill the process. On the contrary, if the process, perseveres and gradually builds the capacity of the community to engage with the health department then, this would help both the community and the department. In the long run, the community could begin to address issues of corruption and ensure accountability of the department to the community, once, the capacity of the community to address such issues is strengthened.

^{xiii} Interview with Representatives of State Nodal NGO on December 13 2008.

^{xiv} One of the reasons is the respect that many have for a member of the State Mentoring Team, who is from this district. In Kaniambadi block owing to the long involvement of TNSF, there is rapport with the PRIs but even here, it is reported that PRIs never turned up and the meetings are often conducted without their presence.

^{xv} The PRI representatives often suggest that the meeting be held in their absence. Members of the VHSCs mentioned this during the review process.

^{xvi} Interview with Block Coordinator, Kaniambadi block on November 19, 2008 at Tirupathur.

^{xvii} A Panchayat President was not keen to have SC representatives in the VHSC and he had to be persuaded to do so. Another Panchayat President wanted to know the process by which the village, he represents, was chosen. He does not attend any meetings and is reported to be telling the health department that the community monitoring is against the health department.

^{xviii} Interview with PRI Representatives on November 18, 2008

^{xix} The Panchayat according to the Panchayat President of Anganadavalasai, in Vellore district spends more time discussing issues related to light, water, road and check dams.

^{xx} This was mentioned on few occasions by the representative of the State Nodal NGO and further reiterated during the interview on December 13, 2008.

^{xxi} In the meeting of the NGOs held on July 30, 2007 at Perambalur district, the 13 NGOs who had come for the meeting decided on the blocks and the NGOs who would undertake the community monitoring. The same meeting also finalised the members of the District Mentoring Committee, Report of the Mentoring Committee Meeting, CHAT, Perambalur district, July 30, 2007.

^{xxii} The MO in Additional PHC of Gajala Naicken Patti in Vellore district said that there was no discussion with her on village selection. The NGO representative, who was present in the meeting agreed and said that it was lapse on their part. However, in Kunichi PHC the MO (i/c) said that she was consulted on village selection.

^{xxiii} TNSF had been working in Kaniyambadi block, Vellore district, for many years, undertaking various activities. Yet, according to the representative of the Kaniyambadi block, it took them about 3 days to mobilise the communities in each village. Interview with Kaniyambadi Block Coordinator on November 19, 2008 at Tirupathur.

^{xxiv} In villages where the Christian population is in a majority, the church has to be consulted on most issues. Once an issue is discussed with church officials then, it is announced during the Mass. In these villages, there is also a federation of sorts- called the Anbiyam, which is a cluster of 30 families who belong to the larger Peravai (federation). Thus, the process of mobilisation and forming community groups has already occurred in these villages and hence mobilisation was easier. Interview with representatives of Kanyakumari district on November 30, 2008.

^{xxv} The Panchayat President in Anganadavalasi, Vellore district, only knew that she also heads the VHSC on the day the review team went to her village on November 18, 2008. In the same village many of the VHSC members did not know what is the role of the VHSC and their own role in it. In a village under Kunichi PHC too, neither the community nor the VHSC members knew much.

^{xxvi} One of the state representative present during the review mentioned that if we had known this was the status then we could have put in more effort to improve their understanding and deferred the preparation of the report cards. In other words, the issues that should have come up during the process of routine monitoring became evident during the review.

^{xxvii} Majority of them are probably dormant too. Even the PRI representatives are not aware that such committees exist in the village. In May 2008, the Panchayat President of Edaiyakurichi village, in Perambalur district, said that until that day, she was not aware about a VHSC and its roles and responsibilities.

^{xxviii} In Narianeri village, Kandili block, Vellore district, there are no SC representative. The SCs are not represented in the Panchayat too.

^{xxix} Interview with District Representatives on November 30, 2008 at Chennai

^{xxx} This is said to have occurred in Kanyakumari district, following a Jan Samwad, Interview with representatives of Kanyakumari district on November 30, 2008.

^{xxxi} This was observed in Kanyakumari district, Interview with representatives of Kanyakumari district on November 30, 2008.

^{xxxii} A State Level Workshop on Community Monitoring was organised from December 3, 2007. About 70 persons participated in the workshop. The State Mentors, Government officials and representatives from the five districts participated in the workshop. Following the workshop, a two-day State TOT was organised on December 4-5, 2007. The district workshops were organised in end December 2007 in all the districts. The participants were from the blocks and the district officials and NGO representatives.

^{xxxiii} In the villages visited for the review in Vellore district, except the volunteers from the literacy movement, other members often didn't know the role of the VHSCs, their own role in it and about community monitoring.

^{xxxiv} One of the issues in many of the SCs is that the VHN rarely stays in them. For instance in Vellore, in one block, the VHN stayed in only four SCs out of the 15 villages under community monitoring. This was observed in Dharmapuri district too.