

Review* of Pilot Phase of Community Monitoring: A Report

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Contents

Executive Summary

Acronyms

I. Background

II. Review Methodology

III. Process

- III. a Selection process: geographical and institutional
- III. b Community Mobilisation
- III. c Committee formation at other levels
- III. d Report Card Preparation
- III. e Jan Samwad
- III. f. Engaging the Media

IV. Relation to other communitisation process

V. Programme Management

- V.a. Capacity Building
- V.b. Support, Monitoring and Reporting
- V.c. Financial Management

VI. Institutional Mechanisms

- VI. a. National level arrangement
- VI. b. State level arrangement
- VI. c Relationships and Convergence

VII. Potential for sustainability and scaling up

VIII. Recommendations for scaling up

IX. Conclusion

X. Annexure

- 1. Report Card Preparation: Process and Outputs
- 2. Institutional Arrangements
- 3. Documents Referred
- 4. State Reports
 - Assam
 - Chhattisgarh
 - Jharkhand
 - Karnataka
 - Madhya Pradesh
 - Maharashtra
 - Orissa
 - Rajasthan
 - Tamil Nadu

Executive Summary

The implementation of community monitoring though initiated in early 2007, effectively began in August 2007. A review of the pilot phase was proposed to assess, if, the objectives of the community monitoring were fulfilled, to identify key learning and challenges and to highlight successful innovations. The review was undertaken in all the nine states where the pilot phase was implemented. This National Report is a consolidation of the State Reports besides covering the national level issues.

The pilot phase has been effectively implemented for about 18 months. In this period, one cycle of monitoring has been done. Hence, it is too early to assess the outcomes of the process. However, there have been significant gains. The gains include:

- Preparation of national and state level resource materials. These materials are now available in public domain.
- Formation of over 2000 VHSCs in nine states.
- Preparation of report cards in all VHSCs.
- Organising Jan Samwads.
- Completion of one cycle of monitoring.

The gains are reflective of the commitment and passion of all stakeholders- GOI, state Governments, NGOs and communities. The crusader approach and the spirit of volunteerism are abundantly evident in the way community monitoring is implemented in the nine states. The review does indicate that with the implementation of community monitoring, the promise of communitisation, articulated in the NRHM Framework, is beginning to be fulfilled. Therefore, it is imperative that the pilot phase is expanded forthwith and sustained to ensure that this promise is realised.

There has been a rapid acceleration in the implementation of the community monitoring in the last six months; building upon the strong preparatory phase of the project. Few states have already begun the process to include it in State PIP for the year 2009-10. Karnataka has already committed Rs 25 crores for the implementation in the next year. Maharashtra, Orissa, Rajasthan, and Tamil Nadu have initiated steps for the inclusion of the community monitoring. Other states are yet to do.

The gains are impressive, despite the short implementation time. The most significant gain from community monitoring is the active engagement between the community and the health department. It is enabling the community to be in centre-stage and making them a significant stakeholder in the management of the public health system. It is empowering too, as the VHSCs have given a sense of identity and voice to community. Given the project duration, the work done on the formation of the various institutional arrangements, to facilitate community monitoring, across the nine states is commendable. The VHSCs and the various

committees above the village level, reflect a significant social capital and they should be strengthened, nurtured and sustained to contribute to the communitisation process in NRHM.

Community mobilisation is a key element of the community monitoring and it received high level of attention, from the NGOs. The community mobilisation, the VHSCs, the monitoring tool, the report cards, the Jan Samwads, which are the various elements of the community mobilisation process, have increased knowledge about entitlements and rights in the community. Consequently, as mentioned above, the process is empowering. Changes have been effected in many instances, following a Jan Samwad and this has led to the perception that the health department is responsive and accountable. This has the potential to move the community, back to the under/unutilised public health facilities; leading to an improvement in health and nutrition outcomes.

There have been gains from an equity perspective too. Community monitoring has involved the excluded and the marginal groups in the process. There was an affirmative approach to ensure that the Dalits, the ST and the women were involved. Steps were taken, in many states, to ensure that women, Dalit and ST members headed the VHSCs. This is an important gain from the process.

Community monitoring has also enabled a better connect between the front line service providers and the community, in some instances. The community has begun to appreciate the constraints of the front line providers. There are instances where, the community has begun to address some of the constraints faced by the front line workers.

The sharing of the report cards in the villages, besides empowering the community is also paving the way for the next stage- the village level plans. This would facilitate a need based village-level planning and deepen the process of decentralisation- a key objective of the NRHM.

Various institutional arrangements have been formed at the national, state and sub-state levels to implement community monitoring. These arrangements reflect a significant social capital and should be utilised as technical resource agencies when the process is scaled up, in the country. Quality training materials and modules have been prepared at national level and adapted at state levels. There is also a sizeable resource pool of trainers that has been created by the process. These will facilitate a smooth roll out when the process is scaled up.

The review strongly recommends the continuation and support of the process, with some modifications.

The Review Team strongly recommends for continued Government of India support for institutionalising community action within NRHM. GoI/ MoHFW should support community action including community monitoring to ensure that it is

scaled up in the pilot states and initiated in the remaining states. This would require developing an institutional/technical support mechanism with advice of the AGCA, support of those who have been part of the pilot programme and greater ownership and resource commitment by the state governments.

However, the Review suggests that community monitoring is anchored as a part of the larger communitisation effort of NRHM and with in an existing arrangement in the health department. At present, there is no significant convergence with other communitisation process and there is a need to build this in, when the process is scaled up.

It is recommended that the Planning and Monitoring go together at the village level. ASHA should provide the link between monitoring and planning at the village level. The process and tools should be simplified, to enable its use by the community. The tool should also be locally adapted. The review recommends an incremental approach – the issues to be monitored should be gradually increased to ensure that the capacity of the community is built and there is acceptance from the health department. The Jan Samwads should gradually become a community led process to enable community involvement and accountability. The review recommends a three-year cycle for the process. The pilot phase was largely supported by volunteerism. This may not be feasible when the process is scaled up hence, a realistic assessment of the human resource requirement should be made. A realistic assessment of financial requirement and allocation should be made to realise the NRHM promise of communitisation.

Acronyms

AGCA	: Advisory Group on Community Action
ANM	: Auxiliary Nurse Midwife
ASHA	: Accredited Social Health Activist
AWW	: Anganwadi worker
CBM	: Community Based Monitoring
CBO	: Community Based Organisation
CHSJ	: Centre for Health and Social Justice
GO	: Government Order
GOI	: Government of India
JSY	: Janani Suraksha Yojana
MoHFW	: Ministry of Health and Family Welfare
NGO	: Non Governmental Organisation
NHSRC	: National Health System Resource Centre
NRHM	: National Rural Health Mission
PHC	: Primary Health Centre
PFI	: Population Foundation of India
PFI-RRC	: Population Foundation of India – Regional Resource Centre
PIP	: Programme Implementation Plan
PRI	: Panchayati Raj Institution
SC	: Scheduled Caste
ST	: Scheduled Tribe
TAG	: Technical Advisory Group
TOT	: Training of Trainers
VHN	: Village Health Nurse (in Tamil Nadu)
VHSC	: Village Health and Sanitation Committee

I. Background

National Rural Health Mission (NRHM) was conceptualised and implemented to bring about fundamental changes in the delivery of health care, in the rural areas of the country. It is an integrated expression of the Government's commitment to improve effective access and provide services of good quality to the people, especially the marginalised groups. The NRHM interventions are expected to improve health outcomes.

One of the key elements of the NRHM is its emphasis on accountability¹. Community monitoring, with in the larger context of communitisation process of NRHM, is expected to enable this. The NRHM Framework outlines the objectives of Community Monitoring². The key aim is to place the community at the centre of health interventions. To initiate the process of community action as outlined in the implementation framework, the AGCA recommended the implementation of community monitoring in the states with support from Gol. Based on the AGCA recommendations, Gol decided to support a pilot green field initiative in community monitoring with active role of AGCA and civil society organisations. A partnership between the health department, community (CBOs and NGOs) and PRIs is envisaged, to realise the objectives of the community monitoring. The Community Monitoring, implemented as a pilot in nine states since 2007, draws its basis from the NRHM Framework of Action.

A pilot was proposed, to pool available expertise to steer the process and ensure a successful roll out. The intention is to learn the lessons first, before replicating it across the country. Lesson learning, is important as this is the first time that the health department is considering the institutionalisation of community monitoring of health services, across the country³. The process is perceived as being delicate, needing careful nurturing. The "spirit of fact finding and not fault finding" is emphasised.

The Advisory Group on Community Action (AGCA) forwarded a proposal, to pilot community monitoring, to the MoHFW in early 2007. This proposal was based on discussions in AGCA since June 2006⁴.

The objectives of the pilot phase are:

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

To realise these objectives, the facilitation by the Civil Society, specifically the NGOs, is the key element. The NGOs are to mobilise the community and enable a participatory process of monitoring by involving the various stakeholders. The NGOs are also to represent the community and be their spokesperson with the health department, as the communities and PRIs do not have such an expertise. This will help to shift the locus of power, gradually, from the health department to the people. It is anticipated that the NGOs would bring in objectivity, to the process, which may be missing if the process was anchored by the health department⁵.

The community monitoring was to start in April 2007 and was to be completed in 11 months. The entire process was divided into three phases- the National preparatory phase, the State preparatory phase and the implementation phase. The documentation of the process was to be done concurrently and a review was expected in January 2008. However, for various reasons, the effective start of the Project was in August 2007, which pushed the deadline first to September 2008 and eventually to March 2009.

The pilot phase of community monitoring is implemented in nine states. The states are Assam, Chattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu. In these nine states, the pilot phase is implemented in 36 districts. In each district, three blocks each are chosen (108 blocks) and in each block three PHCs are chosen (324 PHCs) and in each PHC 5 villages are chosen (1620 villages) for the pilot.

II. Review Methodology

The AGCA, with the oversight responsibility for the pilot phase, decided to conduct a review of the pilot phase on its completion. The review is to be conducted, for each state and compiled to prepare the national report.

The objectives of review are:

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

The review was conducted by external consultants along with representatives from the National Secretariat and the State Mentoring Groups. Four external review members were identified and the NHSRC was engaged as an institution for the review. NHSRC undertook the review in three states- Assam, Chattisgarh and Jharkhand through their state representatives. Two external review members did two states each and the other two members did one state each.

The external review team participated in the TAG/AGCA meeting held at New Delhi on September 17-18, 2008. This helped to orient the team and to meet the representatives from the nine states. Following this, a two-day methodology workshop was held at New Delhi on October 20-21, 2008. The first day was used by the external review team to refine the review tools and protocols and the second day was used to discuss and finalise the review tools with the other team members, state representatives and to finalise the logistics and other details. The review tools were finalised in consultation with the states.

The field visit in each state was for six days. In these six days, it was decided to focus on one district, rather than spend time in travel. As one of the objects of the review was to identify lessons for scaling up, a middling district was identified to learn what worked and what did not. Three days was spent in the field and three days at the state level. The first two days at the state level was spent on interviewing/ meeting the government officials, members of the State Mentoring Group, state Nodal NGO, meeting NGO representatives from the other districts, media representatives and development partners. Following this, the review team spent three days in the field. In the field, at the district, block and villages levels, interviews were held with the Medical Officers, ANM/VHN, ASHAs, AWWs, Sarpanch and representatives of NGOs and group discussions were organised with the members of the various committees. The final day of the review was spent on presenting the preliminary findings of the review, and filling the gaps, if any.

Few of the external consultants, also met key officials of MoHFW in Delhi during December 22-24, 2008 and interviewed key persons in the AGCA and specifically from the National Secretariat. Meeting was also held with NHSRC to understand their perspective on communitisation.

As mentioned above, the review had three objectives. The review reports, both national and states describe in detail whether the objectives of the community monitoring were met. The reports also highlight the key learning and challenges in implementing the community monitoring. The successful innovations are described in the reports.

This national report, which is a consolidation of state reports, highlights the innovations and deviations, if any, from the national guidelines and key issues, if any, across the states. If the implementation has been according to the prescribed norm and similar across states then, it is not highlighted in the national report. Readers interested in detailed state specific reports are requested to read the reports, given as annexe to this report. The report also highlights few national level issues.

This report is divided into 9 sections, besides the Executive Summary. The first section provides the Background; the second section is on review method; the third section describes the process- the process of selection, community mobilisation, report card preparation, Jan Samwad and engaging the media. The fourth section is on relation to other communitisation process; the fifth section is on programme management- capacity building, support and monitoring and financial management. The sixth section details the institutional mechanism- the national and state level arrangements and the convergence and relations between institutions; the seventh section describes the potential for sustainability and scaling up and the eighth section lists the recommendations for scaling-up. The last section concludes the review.

III. Process

III.a Selection process: geographical and institutional

The criteria for the selection of the districts varied across states. The presence of civil society organisations and regional representation were some of the considerations in the choice of districts and blocks within them. The NGOs did the first level identification of districts. The selection was discussed with the State Governments and in almost all the states, the Government modified the selection. In Orissa, Karnataka and Madhya Pradesh, the Government made few changes in the districts, chosen for the pilot. In Tamil Nadu⁶ and Maharashtra, the pilot is implemented in five districts, following the suggestion of the Government. In Chattisgarh, the health department and NGOs jointly finalised selection of districts.

Once the districts were finalised, the selection of blocks, PHCs and villages were done in that order. The availability of the NGOs was the predominant criteria, for the selection of the blocks. The role of the health officials, in the selection, varied across states. In Chattisgarh, Madhya Pradesh, Orissa and Tamil Nadu⁷ there were consultations between the NGOs and the health officials. PRIs played a role too, in one block, in Tamil Nadu. The NGO presence again, determined more, the choice of villages. There are instances of NGOs implementing the pilot in new villages, where they had no presence earlier. The review did come across instances where villages are scattered and not contiguous⁸.

The State Nodal NGOs were chosen, in the initial meeting held around May 2007. The National AGCA members were present in these meetings. The criteria adopted to select the State Nodal NGO are not evident from any document. The selection appears to be influenced by the prior experience of NGOs and their membership in the Jan Swasthya Abhiyan network. In Karnataka, Maharashtra and Rajasthan, the NGOs headed by the representatives in the National AGCA are the State Nodal NGOs.

The Table provides the details of the State Nodal NGOs

S No	State	State Nodal NGO
1	Assam	Voluntary Health Association, Assam
2	Chattisgarh	Sandhan Sansthan
3	Jharkhand	Child in Need Institute (CINI)
4	Karnataka	Karuna Trust
5	Madhya Pradesh	Madhya Pradesh Vigyan Sabha
6	Maharashtra	SATHI-CEHAT
7	Orissa	Kalinga Centre for Social Development (KCSD)
8	Rajasthan	Prayas
9	Tamil Nadu	Tamil Nadu Science Forum (TNSF)

The National Secretariat had developed a format to identify civil society organisations for implementing community monitoring⁹. This format appears to

have been rarely used. Orissa used a format to rank the NGOs in the districts. They also assessed the NGOs, through field visits or by cross-checking with Government officials. In Rajasthan, a three member committee chaired by Director, RCH framed the criteria for selection of districts and nodal NGOs.

Since the emphasis was on choosing NGOs, involved in rights-based work, many, who were identified, had no prior involvement in health issues. While they probably had capacity in mobilising the community, they possessed little knowledge of the functioning of the health department. Hence, many had to understand the functioning of the health department, before they began communicating with the community.

Although, the national guideline mentioned that the focus should not be only on “mother NGOs”, by default, except in Chattisgarh where the PFI-RRC was involved, the “mother NGOs” were kept out in almost all states. In Orissa, the national guideline was cited as the reason for excluding the NGOs, identified by the NGO Programme of the health department. In states such as Orissa, the pilot initiative could have benefited from the strong NGO Programme of the health department¹⁰.

In almost all states, Government largely did not interfere in the NGO selection at any level. They accepted the choice made by the nodal NGOs.

One aspect that needs mention is that the roles of implementation and oversight appear blurred in the current arrangement. In three states, members of the AGCA head the State Nodal NGO. Another AGCA member heads a district Nodal NGO, in one state. There is an instance of a State Nodal NGO, which is a district Nodal NGO also and implements activities in few blocks. While, this arrangement might have infused the process with “passion” of the committed persons and the “crusader approach” in implementation, it blurs the distinction between implementation and oversight. It appears to have had a bearing on monitoring and course correction during the implementation. From the records and discussions with key persons, it appears that a review of the performance of the State Nodal NGOs was rarely done at the national level. It also appears that issues, which could have been picked up during routine monitoring and corrected, were not addressed¹¹. From a governance perspective, the Review Team suggest that there ought to be a separation of the oversight and Implementation roles.

Key Issues

- The criteria for district selection varied across states. The State Government did modify the first level of identification made by the NGOs, in almost all the states.
- The State Governments largely did not interfere in the NGO selection at any level.

- The emphasis was on selecting NGOs working on rights based issues. This ensured that new NGOs, who had no previous involvement in health, were engaged, too. However, wherever the MNGO programme was strong, the strength of such NGOs under the MNGO programme could have been utilised.
- The roles of oversight and implementation appear blurred in the current arrangement. From a governance and accountability perspective, the Review Team suggests that the roles of implementation and oversight are kept separate.

III. b Community Mobilisation

This is one of the key processes. It received a high level of attention from the NGOs. In some states, there were already village committees existing and these were reconstituted, given the national guidelines for the VHSCs. In other states, fresh committees were formed. It involved, getting the requisite permission/orders issued by the health department for the recasting/ formation; organising village meetings for the formation; identifying the members for the committee; building their capacity; and ensuring that the meetings of the VHSCs are held. This took considerable time and effort for almost all the NGOs involved in the process.

Village meetings coupled with home visits to the socially excluded groups, especially the Dalit hamlets and meetings with women, was the major strategy in almost all the states. This process helped in inclusion of the marginalised groups and in enabling equity. In Madhya Pradesh and Orissa, emphasis was placed on having an SC/ST PRI representative as the head of the VHSCs. Meetings were also organised with Sarpanch and other local leaders, in almost all the states. On an average, about three to five meetings were held in villages, in all the states, to mobilise the community and to identify members for the VHSC. Posters prepared at the national level were adapted and used in mobilisation.

Few states innovated in community mobilisation. Karnataka¹² and Jharkhand¹³ used *Kala Jatthas* to generate awareness in the community. *Kala Jattha* was also used in one block in Orissa¹⁴. In Chirang district, Assam, NGO volunteers stayed in the villages to build rapport and to hold *Chinaki* (introduction) meetings. Karnataka used PRA to enable mobilisation and to form committees. In Rajasthan, Padayatra was taken out in few locations. In Kanyakumari district, Tamil Nadu, the children's parliament was used as a forum to mobilise parents¹⁵. Handbills were used in few states to mobilise the community¹⁶. In Karnataka, ten community resource persons (CRP), appointed at the Taluka level, mobilised the community and formed the VHSCs. This initiative helped in achieving scale with quality, in the state¹⁷.

The preparation of the Village Health Profile for each village, apart from being a baseline, also enabled the mobilisation. The village profile is also meant to enable the block facilitator and the VHSC members to familiarise themselves with

the issues in the village¹⁸ before the start of the monitoring process. Participatory process, such as, mapping exercises by the community, was done in few states, such as Karnataka and Rajasthan. In Orissa, in one block, the health profile was found to be a mere cut paste job, only details such as distance and population varied. Hence, their utility both as a baseline and in identifying issues is compromised.

In many states, getting GO (Government Order) issued for formation of VHSCs proved time consuming. In Orissa, the guidelines for VHSC formation kept changing¹⁹. 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 through²⁰. In Rajasthan, in one block, it was observed that the mobilisation depended on the political affiliation- the ruling party representatives were not keen on forming VHSCs or in convening the meetings whereas, the representatives from the opposition party were very keen²¹. Communal divide is said to have hindered mobilisation in parts of Rajasthan.

There is an assumption that NGOs are better skilled at mobilisation. Hence, it was probably assumed that NGOs would mobilise communities, in villages, where they had no prior presence. This assumption is not borne out in all instances. In one block in Orissa, of the 15 villages, the NGO had prior involvement only in two villages. This severely limited their ability to mobilise the community. Understanding village dynamics and rapport building took time. In Tamil Nadu, MP and other states, too, in the villages visited for review, it is observed that mobilisation needs more effort. In these villages, the VHSC representatives are not entirely aware of the role of the VHSCs, their own role in it and on rights and entitlements.

Key Issues

- Community mobilisation is a key process and it received a high level of attention from the NGOs.
- There are some innovations, but largely village meetings and home visits, especially, to socially excluded groups is the predominant strategy for mobilisation.
- Village health profile, apart from being a baseline is also an instrument for mobilising the community. While it helped the NGOs and community members, to understand the issues, there are instances of profile being more a cut paste job, compromising its role as a baseline.
- Substantial time of NGOs was spent in getting the orders issued from the government for the formation of committees. Given the time bound nature of the pilot phase, this reduced the project period available for mobilising the community.
- Mobilisation needs more effort, especially, in villages where the NGOs have had no prior presence.

III.c Committee Formation

VHSCs: The VHSCs were reconstituted in Tamil Nadu and in few villages of Madhya Pradesh, where VHSCs already existed. They were reconstituted, given the NRHM guidelines. In the remaining states, they were formed new. In Madhya Pradesh, the reconstituted VHSCs were approved by the Panchayats in the Gram Sabha. This was also done in two districts of Tamil Nadu²². In Maharashtra, Gram Sabhas could not be convened in all villages; hence, VHSCs were formed by convening small group meetings²³. As mentioned above, in almost all states, substantial time was spent in getting the GO for the reconstitution/ formation of VHSCs.

The VHSCs reflect a significant social capital and they have to be nurtured to strengthen communitisation in NRHM. While the community mobilisation and the formation of the VHSCs, has increased knowledge about entitlements and rights in the community, it is still limited. As the various state reports indicate, there is a need for more orientation and strengthening of the VHSCs. VHSCs are yet to be conversant of their roles, the purpose of community monitoring and on the issue of rights and entitlements.

In Orissa, it was observed that the women outnumber the men in almost all the VHSCs. On an average, the ratio of women to men representation was 3:1. Many see participation of women as advantageous, as, this is expected to lead to a better health status in the household. This is no doubt true. However, from the interactions with the women during the review, it emerged that they did not have much freedom to decide on any issue. Any decision taken by them needs the approval of the men²⁴. In Tamil Nadu too, men rarely attended the meetings. Is the process, not seen as important by the men? Would this be a potential casualty because men do not consider it important enough to provide time for it?

There is variation in community involvement across states. For instance, in Orissa, it appears that there is a greater level of community involvement compared to, say, Tamil Nadu. In Tamil Nadu, except for the volunteers of the literacy movement, no significant involvement of the community is evident in the villages visited for review. In Tamil Nadu, there are so many committees at the village level, that villagers are confused at times. This observation is however, based on field visit to few villages.

Committees above village level: All the committees above the village level- in PHCs, block and districts are formed in all the states. In Jharkhand, a Sub Centre Planning and Monitoring Committee, too, was formed²⁵. In Maharashtra, district monitoring committees were formed earlier when Jan Arogya Abhiyan had initiated monitoring in few districts. The composition of these committees was modified based on national guidelines.

However, unlike the VHSCs, these bodies are not vibrant due to lack of time for providing training and supervision of functioning of the committees²⁶. The committees at each higher level are to prepare a cumulative card of the reports from below along with a facility report card at their level. This hardly happens. One of the reasons for this is the complexity of the reporting format, which is not understood, even by many of the NGO facilitators. There is hardly any review of the process by the Mentoring Teams at the district, block and PHC level.

In the committees formed above the village level, in almost all states, there is no significant participation of the health officials. 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, is not realised. In addition, as mentioned above, these committees did not consolidate the report cards or undertake any field visit, as proposed in the guideline. To that extent, the programme was able to only form these committees, and unable to devote significant attention to their orientation and supervision.

One of the reasons, for their dormant status, is the lack of clarity about their roles. Although, their roles are mentioned in the guidelines, in practice, there is a lack of clarity on what issues need to be addressed at each level and what should be sent to the higher level. For instance, the posting of health providers, cannot be addressed, if raised, in the PHC committee. This issue has to be sent up to the higher level, specifically the state level for resolution. Should this be done? If yes, how is to be done and who would follow up on this issue, are issues on which there is a need for clarity.

It is important, that health department convenes these committees. This is essential to ensure that these are not seen as NGO committees.

There is also a need for orienting and building capacity of the members of these various committees above the village level.

Key issues

- VHSCs were reconstituted in few states, but were formed new in many states. The VHSCs reflect a significant social capital. They are to be supported and nurtured to strengthen communitisation in NRHM.
- In few states, the participation by women is higher in the VHSCs. While this is beneficial, it needs to be examined, whether men consider the process as unimportant and whether there is a danger of it being subverted, if, only women continue to manage the process.
- There is variation in community involvement across states.
- The various committees above the village, although formed, are not active, compared to VHSCs.
- These committees rarely prepared the cumulative report or undertook monitoring/ field visits.

- One of the reasons for the dormant status appears to be the lack of clarity on their role. There is a need for clarity on what issues could be addressed at their level, what needs to be sent to a higher level and how this process ought to be managed.
- There is poor engagement of the officials from the health department and PRIs in these committees. These committees are almost entirely NGO led.
- It is important that the health department convene these committees. This would ensure that these are not seen as NGO committees.
- There is a need to orient and build capacity of all the members in these committees.

III.d. Report Card Preparation

This is the main output of the process of community monitoring. The process and the expected outputs are depicted in the diagram given in Annex 1²⁷.

Village Report Cards: The process for preparation of Report Cards is uniform across all states. At the village level, it consists of in-depth Interviews with ASHA, AWW, pregnant and lactating mothers and women from marginalised section. At the SC level, besides in-depth Interview with the ANM, the facilities in the SC are assessed based on a check list. In the PHCs, there are exit interviews with the patients, a facility check list and interview with the MO (i/c).

The NGO facilitators prepare the report cards, in almost all instances. The VHSC members find the preparation of the report cards very complex. Even NGO facilitators found the report card preparation process and tool to be difficult e.g. there is confusion in marking, especially, on marking negative responses. In Tamil Nadu, the NGO facilitators took about three months to internalise the tools. Only persons with a minimum of 10th class literacy can fill the report cards. Most VHSC members, understand the colour codes, but are unable to explain the tool or, how the ranking is derived²⁸. None from the VHSCs is able to explain the equity index. The index is also wrongly reported in almost all instances.

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. In few states, people are reluctant to talk about the bad experiences with the health department. Some do not want to respond for fear of reprisals from the health department. In Tamil Nadu, a District NGO coordinator mentioned that repeating the same question to a general group and to the disadvantaged group, is often monotonous.

Sharing village report cards: In Tamil Nadu and Maharashtra, the report cards are displayed and shared in village meetings. The sharing of the report cards generates discussions about how to make the red to amber and amber to green, paving the way for village health plans. No significant details of sharing of the report cards, with the community are available from other states. In our view, the community should be aware of the output of the process.

In almost all states, 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.

Report cards at facilities above village level: As mentioned earlier, the committees above the village level do not undertake any independent assessment. The field workers said that this is not possible given the project period. While details of village report cards and facility reports at PHCs are available, no significant reports of Facility Card preparation at the block and district level emerged during the review. Besides, as mentioned earlier, the preparation of the cumulative report cards, at the next higher level, i.e. PHC, block and district is rarely done by the committees.

Tool for preparing report card: The tool, it needs mention, help in increasing the awareness of the communities on their entitlements and rights²⁹. However, two indicators that receive greater attention from the community in almost all the states are the attendance of the service providers and the provision of JSY.

One key issue that emerges from the review is the need for the simplification of the tool. The current tool is complex. This view emerges from all the states. The tool seems well beyond the capacities of the communities and in many instances even the NGO facilitators. For instance, the reporting on equipment in health facilities needs a higher level of knowledge and training. However, there are attempts to simplify the tools. In Maharashtra, specially designed pictorial tools are used in Thane, Nandurbar and Amravati districts, where the tribal populations predominate and literacy levels are low.

To ensure that the communities³⁰ have a control over the process, the Review suggests an incremental approach. To begin with, there should be few indicators³¹. For instance, initially the community monitoring could be limited to mortality indicators. The issues to be monitored should be gradually increased, as the community gains experience and the health system becomes responsive to the process.

Triangulation of data: There are some concerns whether the tool will facilitate triangulation. In no state, triangulation appears to have been done. There is a view that the data collected through community monitoring is not comparable with the information collected through the routine HMIS. There are also concerns that the data is subjective and reflects perceptions. Hence, there is some resistance from the health department in accepting the data. To ensure that the triangulation occurs, the tool has to be modified in consultation with the health department and mechanisms to enable triangulation put in place.

Key Issues

- The tool has helped in enabling the community to learn about their entitlements and rights.
- Sharing of the report cards in the villages is helpful. It helps to move the process to next stage- village level plans.
- However, the tool is complex. It took substantial time even for the NGOs to internalise. It is time consuming to collect the information specified in the tool.
- Most VHSC members, understand the colour codes, but are unable to explain the tool or, how the ranking is derived. Most VHSC members are unable to explain equity index.
- The Review Team suggests an incremental approach. The issues to be monitored should be gradually increased, as the community gains experience and the health system becomes more responsive to the process. To begin with, it is suggested that the community monitoring be limited to monitoring mortality and gradually expanded to cover other aspects.
- There are issues with respect to triangulation of data. It is held that the data collected through the process do not lend themselves to triangulation. This need to be rectified in consultation with the health department and a mechanism for enabling triangulation should be put in place.

III.e. Jan Samwad

Jan Samwad is an important process for sharing the report cards. The objective of the Jan Samwads is to create a common understanding of the key health issues among the community; to review the current implementation and to prepare the action plans for improving NRHM implementation³². The Samwad is also an opportunity for dialogue between the community and the health department.

The Report Cards are the basis for the Jan Samwad. In some instances, case studies are also prepared and shared in the Jan Samwad. The process of Jan Samwad is an intense one, both, in mobilising the communities and the service providers.

Jan Samwad has been beneficial in many ways. It has raised expectations of the people and it has led to changes. There are instances of change that happened subsequent to a Samwad. There are reports, of Medical Officers being changed, visits of front line workers becoming regular, drugs and syringes being given to the people, JSY money being paid to the beneficiaries, and instances of money deducted from JSY being paid back to the community³³. The availability of the untied funds has enabled the health department to address few of the needs articulated in the Samwads. Consequently, in such instances, community have begun to perceive the health department, as responsive. More importantly, the process is empowering the community, as it has made them aware of their entitlements and their rights as citizens.

Jan Samwads have also provided, in some instances, an opportunity to peripheral health care providers to articulate their problems and to elicit the support of the community. This has helped to place their problems at the higher levels, for resolution.

However, the Samwads, have also raised the ire of service providers, in some instances. In Rajasthan, the issues raised in the Jan Samwad have led to a conflict between the community and the service providers at the lower levels. In Chattisgarh, a Medical Officer said that Jan Samwads should also highlight the conditions prevalent in the facilities- the lack of water, equipments, schooling facilities and quarters for the staff and not just the issues of denial. In Maharashtra, following Jan Samwad, there is some opposition from the field workers and resistance at the block and district levels. Service providers observe that Report Cards and Jan Samwad do not highlight the efforts by the health workers. They only highlight service gaps, deficiencies and denial of rights and entitlements. In fact, few health officials in Maharashtra perceive the Jan Samwad as “kangaroo courts” and are unsure whether this could be sustained. In Orissa, a block PHC (i/c) who was very enthusiastic of the process when interviewed for the review has apparently become its bitter critic following the Jan Samwad.

The issue is that NGOs are seen as leading the process of Jan Samwad. The community is in the background in the process. The health officials, resent being accountable, to NGOs. Hence, it is important to gradually ensure that the process is led by the community. This would ensure the accountability of the health department to the community

It is important that the protocol on Jan Samwad is followed and there is adequate preparation for it. It is also important to ensure that the health department is a partner in the process and not an adversary³⁴. The Samwad should not become a forum for conflict with the health department³⁵. It would be helpful to discuss the issues with the health department before the Samwad is organised. Also, as originally conceived, the objective of the Samwad, should be more towards planning rather than only highlighting denial of services.

Importantly, there is a need for an adequate follow up and responsiveness following a Jan Samwad. The action taken on issues raised during the Samwad has to be communicated to the community. In Rajasthan, poor follow up and absence of a mechanism for redressing grievance is leading to disinterest and frustration in the community. In Assam, people said that while the Samwad raised their hope by emphasising service guarantees, there was no action taken on specific instances of denial, and hence they feel that their efforts are in vain. In Maharashtra, it is observed that scepticism might seep in, if there are no measurable changes in health delivery and service quality.

Key Issues

- Jan Samwads are empowering the community, as it has made them aware of their entitlements and their rights as citizens.
- Changes were initiated consequent to Jan Samwad. This has led to a perception that health department is responsive.
- There are also instances, where the Samwads have raised the ire of the health department. It would help to engage the health department as a partner in the process.
- Jan Samwads also have the potential to make peripheral health care providers, partners in the process for systems change.
- At present, NGOs are leading the process of Jan Samwad. Health officials resent being held accountable by the NGOs. It is important to ensure that the Samwads are community led to ensure accountability to the community.
- There is a need for post Jan Samwad follow-up and action taken on issues raised during the Samwads has to be communicated to the community. This is essential to ensure that the community does not become sceptical of the process.

III. f. Engaging the Media

Engaging the media is an important activity in community monitoring. However, the manner in which media is engaged, varies across states. In few states, there were media workshops in both the districts and the state; in many states media fellowships were given to select journalists in state and districts; and in some, the media merely covered the events. In Maharashtra, a State Media consultant is also appointed. The media workshops, helped to orient the media on covering health issues.

Media has played an important role in highlighting community monitoring and being its advocate, in some instances. Reports were written in the National Newspaper, such as The Hindu and in the vernacular dailies.

However, in many contexts, media had tended to sensationalise issues. They disproportionately highlighted the issues of denial and weaknesses in the health department mentioned during the Samwads. Following the media highlight, there is a sense of fear, resistance and an increase in the adversarial position from the health department. This could derail the process of community monitoring.

While recognising the media as an important ally, the review emphasises the need to explore further, how media could be involved in community monitoring.

Innovations in the Process

Selection

- Format to screen NGOs and field visits to assess NGO capacity in Orissa
- A three member committee headed by Director, RCH to identify NGOs in Rajasthan

Community Mobilisation

- Use of folk form *Kala Jatthas* in Karnataka, Jharkhand and Orissa
- Padyatras in Rajasthan
- *Chinaki* (introduction) meetings in Assam
- Organising meetings in Dalit hamlets and separate meetings with women groups in many states.
- Use of children and youth parliament to mobilise adults in Tamil Nadu.
- Appointment of 10 Community Resource Persons per taluk in Karnataka for mobilisation
- Use of PRA, social mapping and community mapping to prepare health profile in Rajasthan and Karnataka.
- Involving VHN Association in Tamil Nadu
- Organisation of conventions and mass participation in districts and state level in Maharashtra.

VHSCs

- Provision of ID card to all VHSC members in one district in Tamil Nadu, to ensure their recognition by health department
- Approval from the Gram Sabha for the reconstituted VHSCs in Tamil Nadu and Madhya Pradesh to secure their tenure.
- Ensuring that SC/ST PRI representatives head the VHSCs to ensure equity in a few states.

Report Cards and Tool

- Pictorial tools for tribal regions of Maharashtra
- Tool, published as a booklet, a reference document on rights and entitlements in Tamil Nadu.
- Sharing of the Village Report Cards in Tamil Nadu and Maharashtra, in villages, ensuring accountability and enabling the next step in preparing village plans.

IV. 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. The linkage with the larger communitisation process, such as Rogi Kalyan Samiti (RKS) is yet to be built into the process.

Across states, there is a variable understanding of the link between community monitoring and other communitisation process. Some see the community monitoring as a vertical process whereas, others, emphasise the linkages. It would help, if the link between community monitoring and the larger communitisation process under NRHM, is articulated.

V. Programme Management

V.a. Capacity Building

The National Secretariat has prepared training materials of good quality to enable training and orientation. The training materials detail the issue of rights and entitlements, the process of community mobilisation and committee formation and preparation of report cards. These are translated and adapted at the state level. No significant changes are made in training materials in any state. The Secretariat has also prepared elaborate guidelines, for organising the trainings. These guidelines are modified in few states.

The capacity building is done in a cascade manner in almost all the states, following the pattern recommended by the National Secretariat. There are minor variations- some broke the training into shorter durations to ensure the presence of government officials. Karnataka innovated by having a district level TOT rather than a state level TOT. In almost all states, besides class room teaching, field visits were organised to provide hands-on training in filling report cards and in mobilisation.

The pilot phase has created a resource pool of trainers, at the state and the sub-state levels. This resource pool should be nurtured and upgraded.

There is transmission loss in the cascade training. Many VHSC members are unable to recall the issues discussed during the training³⁶. VHSC members and some NGO facilitators, said that while issues seemed clear during the training, they were unable to recall them, later. Many felt the need for more training on preparing the score card, as it is complicated.

There was no significant participation of the health officials in the trainings. This is despite the efforts of few states, to break the training to phases, to ensure their participation³⁷. The health officials cited other responsibilities, as the reason for non-participation. Learning, from the pilot phase is that capacity building of the health officials, to the concept of communitisation and the details of community monitoring and action, is as important as the capacity building of the community and civil society groups. Mindsets, about communitisation and its critical role in democratisation and governance have to be reoriented.

For the NGOs, the process helped to improve their knowledge on health issues, skills in monitoring, building relation and in documentation. However, many NGO coordinators mentioned the need for continued support and hand holding.

A more regular process of orientation, on-job support and supportive supervision and handholding could have helped the process. In Karnataka besides the training, a very high degree of on the job support and handholding is provided by the district NGOs. This has a significant impact on the implementation. The handholding by the district facilitators is also evident in Bolangir district in Orissa.

Few members of the State Mentoring Team in Tamil Nadu backstop the process in a significant manner. Where such continued on-job support is provided, it has made a difference in implementation.

Key Issues

- Training materials of good quality are prepared at the national level and adapted at the state level.
- The national guidelines on training are modified in some instances.
- The resource pool of trainers at various levels should be nurtured and upgraded.
- There is transmission loss in knowledge in the cascade training.
- More on-job support, supportive supervision and handholding is required. This has made a difference in implementation where it is provided.
- There is no significant participation of the government functionaries in the capacity building.
- Capacity building of health system personnel around the concept of communitisation is vital for its success.

V.b. Support, Monitoring and Reporting

The support from the National AGCA members to the state processes is at two levels:

- a) Direct involvement of AGCA members in states where the NGOs they head/ associated with are the state nodal NGOs. This is observed in Rajasthan, Maharashtra and Karnataka.
- b) Support from four AGCA members to the remaining six states, which has no representation in the AGCA.

In these six states, the AGCA members provided substantial support in the initial phases. They were involved in the initial meetings, which set off the process.

The National Secretariat has three programme personnel- two at CHSJ and one at PFI. These three persons provide support to the states:

- To identify and select NGOs,
- As resource persons in state workshops/training programmes
- Facilitate district and block level meetings.

They also undertake monitoring visits to the states to update physical progress and help in process documentation.

The personnel in the National Secretariat play a larger role, than originally visualised, in mentoring, monitoring and support roles. The three persons at the Secretariat are new to the process. They need capacity building to provide support to the states. They, bear most of the day-to-day management of the process with the states, and often, with very little support from the AGCA members. It appears that their task will be much easier, if there is more clarity on their roles.

In few states, State Nodal NGOs confine their role to administrative and financial support. It appears that in few states, State Nodal NGOs, lack capacity to anchor such a process, and provide technical support. There are however, exceptions. In Karnataka, the state nodal NGO coordinator undertakes regular field visits to provide support and monitor implementation. The role of few members of the State Mentoring Group and Resource Team in Tamil Nadu and Madhya Pradesh was mentioned earlier. In Orissa, the district Nodal NGOs hold the process together.

There are also significant delays in reporting. The reporting formats are designed at the national level. Often, the reports appear to be cut-paste job, more done to fulfil the requirements of reporting. There is a need to strengthen the monitoring systems at the state level. As mentioned elsewhere, issues, which should be picked up during routine monitoring and corrected, seem to be missed out. A robust monitoring system is essential when the process is scaled-up.

The process documentation, in almost all the states, is patchy and uneven. Given the very process intensive nature of the activity, it would have helped if the process documentation is done in a better manner³⁸.

Key Issues

- The National AGCA members provided support in initial phases.
- The three Program personnel in the National Secretariat play a much larger role than visualised in mentoring, monitoring and support.
- This is a new initiative. Besides, for many actors, this is their first involvement in a process of such nature. Hence, the support required is high. The process would benefit, if higher level of support is provided.
- There are delays in reporting from the states. Most reports, give the indication of being cut-paste job, undermining the purpose of reporting.
- There is need to strengthen the monitoring systems in the states, to ensure mid-course corrections.
- The process documentation is patchy. Given the process intensive nature of the activity, good quality documentation of the process should be done.

V.c. Financial Management

The review team did not look at the financial management in detail. The financial management is only reported here, to the extent that, it affected the implementation. The fund flow to the State Nodal NGO is from the National Secretariat, which in turn receives the funds from MoHFW.

A proposal was sent to the MoHFW in early January 2007. The formal approval for the whole programme was only received in May 2008. In the interim, MoHFW released funds in instalments to facilitate implementation- Rs 10 lakhs as 1st Instalment in March 2007, Rs 75.2 lakhs as second instalment in July 2007, Rs 3.05 crores as third instalment in January 2008 and the fourth instalment of Rs 3.15 crores in March 2008. The first instalment in early 2007 helped to develop

the tools and form state level committees. As the bulk of the funds were received late, this delayed the start of the activities in the states. In the absence of a formal approval of the programme right in the beginning including the budget the implementation and release of funds to states was based on each instalment released which led to difficulty in smooth implementation and fund flow for the programme.

Roughly, about 86 percent of the budget or about Rs 5.55 crores is allocated to the states. PFI- functioning as a National Secretariat- routed the funds to the states in three instalments³⁹. As the entire proposal was not approved at one go in the beginning, for each instalment, an MOU was signed between PFI and the respective State Nodal NGO⁴⁰.

The budget is uniform across all states and these were worked out in consultation with most partners. For states, which are resource poor, the expenditure on many activities such as hiring space, materials and even in getting personnel are much higher compared to states, which are better endowed.⁴¹ The budget could have been framed based on needs, rather than, a uniform one across all states had the formal approval was given in toto at the beginning itself..

The human resource requirement also appears understated, given, the complex tasks to be undertaken and the intensity of the process. This should be addressed when the process is scaled up.

The review team is also of the view that the time frame for implementation at the state level - 3 months for preparatory phase and 6 months for implementation - was very short. For this very process intensive activity that involves, diverse sets of stakeholders and importantly mobilising the community, the budgeting of time is inadequate. The state implementation phase, should have been longer, so that the process could have gone through at least a minimum of two cycles of monitoring

Key Issues

- The release of funds in August 2007 from MoHFW delayed the start of the process at the state level.
- Rather than a uniform budget, it would have helped if the budget is based on state needs.
- The human resource requirement is understated given the tasks and the intensity of the process.
- The period for the state level implementation is very short. A longer implementation phase for at least two cycles of monitoring would have helped the process.

VI. Institutional Mechanisms

VI.a. National level Arrangement

The Advisory Group for Community Action (AGCA), constituted in October 2005, is a standing committee within NRHM, to support and advise the MoHFW in developing strategies for involving the community in NRHM. The TOR for the group includes the following:

- To advise on ways of developing community partnership and ownership for the Mission.
- To advise on the community monitoring of the various schemes taken up by the Mission.

A Sub-Committee of AGCA, formed in June 2006 suggested steps for the operationalisation of the community monitoring⁴². A National Secretariat⁴³ for Community Action was formed and located at Population Foundation of India (PFI, Delhi), in December 2006. The AGCA has taken on both mentoring and partial implementation role in community monitoring. Few of the AGCA members, are involved in implementing community monitoring, through their NGOs, both at the national and state levels. The AGCA provided mentoring support to the state teams for the roll out of the process⁴⁴. A Technical Advisory Group- a Sub Group of AGCA formed in February 2007 is responsible for providing technical support and direction to this effort⁴⁵.

On February 24, 2007, it was decided to have a Secretariat located at both PFI and CHSJ. This is a modification of the decision of December 2006, to house the national secretariat at PFI. PFI is responsible for financial management and CHSJ is responsible for providing the technical support.

VI.b. State level Arrangement

The NRHM implementation Framework has outlined the various institutional arrangements, to be formed, at the state and sub-state levels, for community monitoring. The institutions are:

- Village Health Committees (subsequently renamed as VHSCs)
- PHC Planning and Monitoring Committee
- Block Planning and Monitoring Committee
- District Planning and Monitoring Committee
- State Planning and Monitoring Committee

Since community monitoring is implemented in select villages in the pilot phase, a representative Planning and Monitoring Committees cannot be formed at the block, district and state levels. Hence, to kick start the process, Mentoring Teams are formed at both state and district levels and a Community Monitoring Facilitation Team formed at the block level. Eventually, these institutions will be subsumed into the Planning and Monitoring Committees, when ever they are formed at different levels. For the villages and the PHCs, the institutional

arrangement proposed by the NRHM is utilised, as these are stand-alone arrangements. The above mentioned, institutional arrangements are to provide oversight, mentor and implement the process.

Besides these, to facilitate the process, a hierarchical arrangement of NGOs at the state, district and block levels, also exists. The funds from the National Secretariat are routed to the State Nodal NGO, which is responsible for disbursing funds and reporting for the state. It is also responsible for coordinating with the health department at the state level. The District Nodal NGO is often the first among the equals, as one of the NGO from the block is designated as the district Nodal NGO. The block NGOs, facilitate community monitoring in the villages.

The organisational arrangement as proposed by NRHM and the arrangement for the pilot phase, as proposed by AGCA is depicted in Annex 2.

Almost all states have adopted this arrangement, with minor variations, either in nomenclature or in membership or additional arrangements to help in implementation. For instance, a few states have formed additional arrangements, to provide support. Jharkhand⁴⁶ has constituted a State Advisory group and in Madhya Pradesh⁴⁷ and Tamil Nadu, a State Level Resource Group/ Team has been formed. Few states have modified the arrangements, based on their need for support. In Assam, ANT, a district Nodal NGO, provides technical support to Assam Voluntary Health Association, which is the State Nodal NGO, to implement community monitoring. In Chhattisgarh, a consortium of NGOs function as Nodal agency⁴⁸. In Madhya Pradesh, two NGOs function as state nodal NGOs⁴⁹. In Chattisgarh, two resource persons each from the State Mentoring Group have been attached to the District Nodal NGOs, to provide support.

The role of the State Mentoring Committee varies across states. In Karnataka, Maharashtra and Rajasthan there is participation of the Government officials and decisions are taken jointly. On the contrary, in Tamil Nadu and Orissa, there is no participation of the Government officials, reducing the effectiveness of Mentoring Committees. In both these states, NGO representatives provide support. In Tamil Nadu, few NGO representatives of the Mentoring Committee hold the process together. In Orissa, the NGO members were active in the initial phase and they visited districts, and helped in selection of blocks and NGOs. In Madhya Pradesh, the State Mentoring Group and Advisory body are not effective. No significant details of support from the State Mentoring Group have emerged for the other states

The effectiveness of State Nodal NGOs, too, varies across states. In Karnataka, the Nodal NGO is proactive in pushing the process and it has expanded the implementation, beyond the norm. In most states, besides the initial support in the form of training and material development, State Nodal NGOs, appear to

have more restricted their role in providing administrative support and liaison with state Government. No significant details of field visits and supportive supervision by the coordinators from the State Nodal NGOs, emerged during the review.

Except Madhya Pradesh, which is yet to form a few committees at the PHC, block and district levels; in other states, all committees have been formed. The Table below provides details of the committees formed. As mentioned earlier, the committees above the village level are not very vibrant. NGOs seemed to have focussed more attention on forming and strengthening the VHSCs, given the time available in the project. As mentioned earlier too, these committees above the village level need clarity about their roles. Hence, these committees, undertake no significant activity. Even, VHSCs, as observed earlier, need support to monitor on their own. The committees at all levels need significant support and nurturing to enable them to play their roles.

As mentioned earlier, the institutional arrangements of community monitoring also appear disassociated from the larger communitisation process of NRHM. There is need to link these arrangements with Rogi Kalyan Samities, to enable this.

Table: Institutions formed in different states

State	VHSCs	PHC committee	Block Committee	District Committees
Assam	135	27	9	3
Chattisgarh	135	27	9	3
Jharkhand	135	27	9	3
Karnataka ⁵⁰	180	36	12	4
M.Pradesh	225	41	11	4
Maharashtra	225	45	15	5
Orissa	180	36	12	4
Rajasthan	180	36	12	4
Tamil Nadu	225	45	15	5
Total	1620	320	104	15

However, despite the limitations, these institutions have facilitated the implementation of the pilot phase. Substantial efforts have gone into establishing them in all the states. Importantly, the committees, such as the VHSCs, have involved the excluded and the marginal groups, in decision making. This is a major change. These committees reflect a significant social capital at different levels. These institutions could contribute to the communitisation process envisaged in the NRHM. There is a need to support and nurture these institutions.

Key Issues

- Given the project duration, the formation of all the institutional arrangements across the nine states is commendable.

- These institutions reflect significant social capital and they have to be strengthened and nurtured to contribute to the larger communitisation process of NRHM.
- Committees, such as VHSCs, have involved the excluded and the marginal groups, in the decision making process. This is a major change.
- The committees need support and those above the village level, need a better clarity of their roles.
- The effectiveness of State Nodal NGO varies across states. While some are proactive others, are content to provide administrative and liaison support.
- The ownership and support from the members of the state mentoring groups is mixed.

VI.c Relationships and Convergence

Relation with the health department: The relation with the health department varies across states. While there is a better ownership of the process in Karnataka⁵¹, Maharashtra and Rajasthan⁵² at the state level, there is indifference in states like Madhya Pradesh and Assam. The remaining states fall between these two levels. In Karnataka, Maharashtra and Rajasthan, the state officials participate in all the state mentoring committee meetings. The relation at the state level also varies depending on who is at the helm.

The Health Department in many States appear uncomfortable with the term “monitoring”. In Jharkhand, the term *nigrani* is not well accepted as the officials feel that the purpose of community monitoring is to ensure quality service rather than find faults⁵³. They feel that the process is more of an action than monitoring. In Orissa too, this is the view. They renamed the process as community action. Karnataka decided to amplify the process to include planning as well⁵⁴.

In Madhya Pradesh, except for one meeting of the State Mentoring Group, no other meetings were convened. The state Nodal Officer has not evinced any interest in the process and government representatives are not keen to participate in the meetings. Some officials question the mandate of State Mentoring Group. In Orissa and Tamil Nadu, except for one meeting, there has been no participation of state officials. In Maharashtra, despite the acceptance at the state level, there were delays in issuing orders for the formation of the committees at PHC, block, district and state levels⁵⁵. In Tamil Nadu also, there were delays in getting orders issued, despite approval of the Health Secretary. In Orissa, while the Mission Director, NRHM is supportive, there is hardly any buy in by the Director Health and the officials in the districts⁵⁶. In Tamil Nadu, while the current Mission Director appears supportive, the Director, Public Health, has his reservations.

While the acceptance at the state level is mixed, the acceptance at sub-state levels, in almost all states is low. In Orissa and Tamil Nadu⁵⁷, often, the health officials lower down refuse to acknowledge letters issued by state officials. They

provide support only if there is a direction from the district officials⁵⁸. In Karnataka also, where there is a high level of acceptance at the state level, it does not translate into any effective cooperation at the sub-state levels. In Maharashtra, NGOs have to depend on administrative orders from higher authorities to enforce attendance at meetings at the lower levels. In Rajasthan, too, despite the high acceptance at the state level, the relation between NGOs and the health providers is adversarial in the PHCs visited for the review⁵⁹. There are also instances, where officials said that this is an initiative of the NGO and they have nothing to do with it. The Joint Director of Health Services, in a district in Assam, laid the entire responsibility on the district nodal agency. He said he has no role.

Interestingly, in Madhya Pradesh there appears to be a better support from the lower level officials in few blocks, despite disinterest at the state level. The Medical Officers from few blocks attended Jan Samwads and some even gave letters of appreciation for the process.

In Chhattisgarh⁶⁰, Madhya Pradesh and Orissa, the frequent transfer of officials affected the implementation. It nullified the entire rapport built earlier and the rapport building has to begin ab initio with the new incumbent. However, the interest of the official varies and this has an impact on the implementation.

There are instances where the relation between the health department and the NGOs became adversarial, especially at the lower levels of the bureaucracy, consequent to this process. In one district in Assam, after convening a District Workshop on March 10, 2008, the district administration is not keen to convene any other meeting. The District Planning and Monitoring Committee are not formed in the district. In Maharashtra, the Jan Samwad at the village and PHC level led to resistance from the health workers from district to the village level. Some of the health officials lower down, especially the front line providers appear intimidated by the process and by the formation of the VHSCs and the community monitoring. In Tamil Nadu, in one of the district, the officials who are unhappy with news reports on the non-payment of Muthulakshmi Reddy Scheme payment to the pregnant women have begun to resist the process⁶¹. The resistance from the district is transmitted upwards and there is reluctance at the state level to continue with the process. In Rajasthan, there are instances where the health officials lower down, became defensive and resistant following Jan Samwad.

It is important to overcome this and engage the health department as a partner in the process. It is important to ensure that the health officials do not feel intimidated or threatened and perceive the VHSCs and NGOs as adversaries. To enable the acceptance, it may be helpful if the data generated by the community monitoring is used in planning, implementing, improving services, concurrent monitoring, rather than merely to find fault. It is important that the threat perception is removed and the link between planning and monitoring is

established. This has been done in a few states and this needs to be done in other states as well.

Relation with ICDS: At the village level, there is convergence in many states as AWW are a part of the VHSC. In Karnataka, AWW take on the leadership role in the VHSC. In Orissa, AWW being senior to ASHA, take a lead in the VHSC activities. In Orissa and Rajasthan, ICDS is represented in the state Mentoring Committee. No significant issues of relation with ICDS emerged from any state. This aspect needs to be addressed.

Relation with PRIs: This is one of the weakest links in almost all states. In Maharashtra, the PRIs are indifferent to the process. Their non-involvement has an impact on community mobilisation and in identification of persons as members of the VHSCs. In Karnataka, PRIs are yet to be engaged in the process. In Orissa, although the PRIs head the VHSC, majority, rarely turned up for the meetings. The participation of the PRIs in Orissa however, compared to other states, appears better.⁶² In Madhya Pradesh, few of the PRIs attended the Jan Samwads and were appreciative of the process. The involvement of the PRIs in Tamil Nadu⁶³ and Rajasthan too, is not very encouraging. In Tamil Nadu, there are instances where the PRIs did not want the process to be implemented⁶⁴.

Relation between NGOs: Majority of the NGOs involved in the pilot phase, in most states, are a part of other networks. Most work together on rights based issues. Many are affiliated to the Jan Swasthya Abhiyan. Their membership in a pre-existing network and a shared value and commitment helps to smoothen the process of working together. Hence, there is harmony between the NGOs, who are involved in community monitoring. Some however, are new to this arrangement. Decisions are taken in a participatory manner, in most states, which help to strengthen the collective. The formation of network of NGOs on community monitoring is an important output, too. The network could be a source of support when the process is scaled up in the respective states.

It needs mention that in a few states, there is high degree of volunteerism exhibited by most of the NGOs, who are part of the network. Most are motivated and are egged by their desire to ensure that the community receive their entitlements. A spirit of healthy competition also, has occurred between the NGOs in the network. There is diversity in the way they implemented community monitoring.

There are a few incidents of disagreement between NGOs especially between the State Nodal NGO and the District Nodal NGOs. There is also an instance of lack of harmony between NGOs, who are members of the State Mentoring Group. This could affect the implementation.

While in a few states, opportunities are created for cross learning and sharing between NGOs, it is lacking in other states.

No significant issues of relation between the State Nodal NGOs and the National Secretariat emerged during the review.

The relation between the two institutions, who are the national secretariat for the community monitoring- one, providing the financial support and the other providing technical support, is harmonious. There are irritants, which are a part of the course of working together. However, the bifurcation of the financial reporting and reporting on activities to two different agencies causes slight dissonance. There is a view that it is difficult to monitor the financial reporting without understanding the implementation of the activities.

Key Issues

- In many states, the health department is not comfortable with the term monitoring.
- There is mixed acceptance of community monitoring at the state level, across the states.
- However, there is low acceptance at the sub-state levels in almost all the states.
- The buy-in by the health department at various levels, is essential, to ensure a successful implementation of community monitoring.
- The participation of the officials from the health department varies across states.
- Instances of adversarial positions emerging consequent to community monitoring between the health department and the NGOs.
- It is important to manage this, and there is a need to ensure that the health department is not viewed as an adversary. This is essential for the continuation of the process.
- There is convergence with the ICDS at the village level. No significant details of convergence at other levels, is evident.
- Relation with PRIs is weak in almost all states.
- There is harmonious relation between NGOs in almost all the states.

VII. Potential for sustainability and Scaling up

The Review strongly recommends the continuation of the process and its scaling up both, in the pilot states and in other states as well. However, there are some concerns on sustaining this process and in scaling it up.

The pilot phase has been given a no-cost extension by the MoHFW until March 2009. However, from the next year, the MoHFW has been categorical that community monitoring would continue only if the State Governments include it in the State PIP. The response from the State Governments to this has been mixed. Karnataka has already committed about Rs 25 crores to continue implementation beyond April 2009. Maharashtra, Orissa, Rajasthan, and Tamil Nadu have included it in the PIP for the next year. Other states are yet to do so. Hence, the continuation of the process beyond March 2009 is in question in these states.

There are also few states such as Gujarat, which are not part of the pilot phase and are considering inclusion of the community monitoring in their PIP. These states have to be supported and helped in kick-starting the process.

There is a concern that scaling up in some of the pilot states is being done without considering the lessons learnt from the pilot phase. It is imperative that the lessons learnt from the pilot phase are take due cognisance when the process is scaled up in the pilot states.

As evident from the review, there are some components of the approach adopted in the pilot phase, that may not lend themselves easily to scaling up. There is a need to re-look at the monitoring tool, the capacity building processes, the role of the NGOs, etc. Each state needs to undertake a review to identify lessons learnt, modifications required, before scaling-up.

VIII. Recommendations for scaling up

1. The Review Team strongly recommends continued support from the MoHFW for the process. The process still needs significant nurturing and direction from MoHFW. There is a need for technical and financial support to ensure that the process continues to be implemented in the pilot states as well as initiated in other states.
2. To ensure this, there is a need to build ownership of the process by the respective State Governments. The process of building ownership should continue in the pilot states and the process should to be initiated in the remaining states. The National AGCA, with the support of MoHFW and the various NGOs, who were a part of the pilot phase should enable this. As a start, the Review recommends a dissemination meeting of the pilot phase experience and exposure visits by teams from health departments of different states. The capacity building of the health department personnel for communitisation and community monitoring has to be a key result area.
3. Community monitoring should be anchored within the larger communitisation process of the NRHM; and within an existing arrangement in the health department. This is essential to ensure acceptance of the process by the health officials and to ensure that the process is scaled up. However, while the implementation role is anchored in an existing arrangement in the health department, the oversight role should be kept separate. The oversight committee at different levels, should have representatives of government and civil society.
4. The Review Team recommends that community monitoring be linked to village level planning. Monitoring, after all, is a post-facto exercise. In addition, community may monitor a programme that is top-driven and framed, without a concern, for their needs. Community ought to have a control over what is implemented too. To enable the link between planning and monitoring, it is recommended that ASHA be involved in the process. ASHA could assess the health needs and the VHSCs prepare a health plan based on those needs. This could be incorporated as a part of the district plan by due process. On a monthly basis, ASHA will report to the VHSC if the health needs are being addressed. This process will enable planning, implementation and monitoring too. It could also facilitate triangulation of data. If after this collaborative effort, there are still gaps in service provision and denial of services it could be resolved in Jan Samwads held at regular intervals. The Review Team believes that that this strategy could be replicated and likely to be more acceptable to health providers, administrators and policy makers.

The NGOs, who are part of the pilot phase, at various levels, should be involved as resource centres and provide technical support to the process- in

developing training materials, training VHSCs and health officials, on-site support for the VHSCs, monitoring and in process documentation. Community monitoring, when scaled-up, should involve Mother NGOs, wherever the scheme is working well and the SHGs, women Panchayat Members Collectives and PRIs. Efforts should be made to strengthen the role of PRIs in collaboration with Rural Development Department.

5. It is essential to ensure that both the process and tools for monitoring are simple and adapted to local need. Hence, it is recommended that the processes and the tools followed in the pilot phase be simplified. The review also recommends an incremental approach. To begin with, monitoring be done with few indicators and gradually expanded to both build the capacity of the community and acceptance by the health department. Initially, monitoring could be limited to mortality and this could be linked with planning. Gradually, other indicators could be added.
6. The Jan Samwad is currently seen as being led by the NGOs. It is important that the process gradually becomes a community led process. This is important to ensure community involvement and accountability of the health department.
7. The process, when up-scaled, 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 be supported for a minimum of three years to ensure that the institutional arrangements are functional and mature, before a decision is taken to restructure or revamp the process.
8. The Pilot phase has been largely supported by volunteerism of the NGOs. This may not occur when the process is scaled up. Hence, it is important that a realistic assessment of the human resource requirement is done and budgeted for.
9. The Review recommends that adequate budgetary support be provided for community monitoring to realise the promise of communitisation, under NRHM.

IX. Conclusion

The National AGCA, proposed a review of the Pilot Phase of the Community Monitoring with three objectives. The review was to assess if the objectives of the community monitoring were fulfilled in each state, to identify key learning and challenges and to highlight successful innovations.

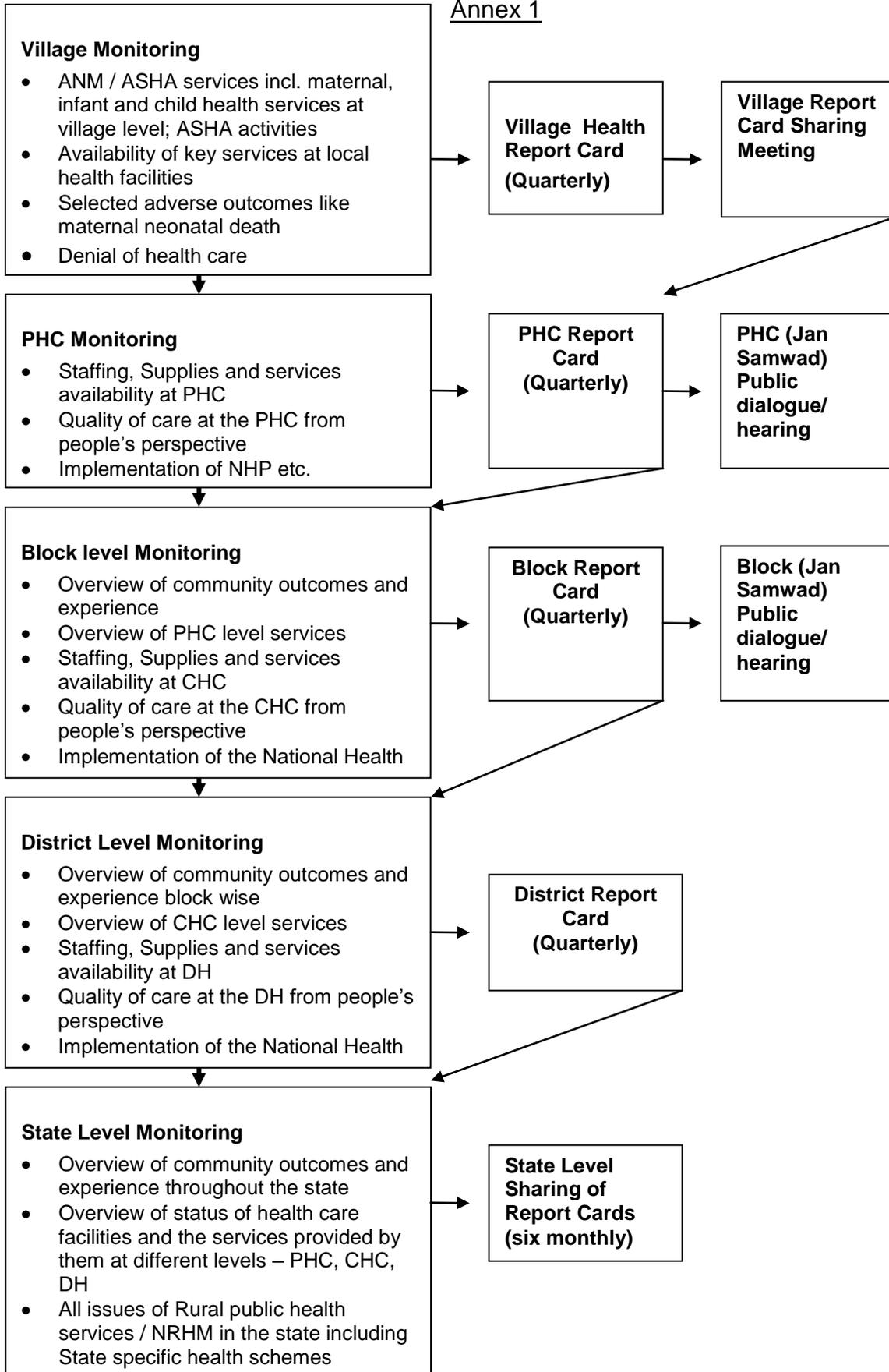
The review covered all the nine states, where the pilot phase was implemented. Based on the National Report and the State Reports, annexed to the National Report, it is evident that the objectives of the pilot phase of community monitoring, have been realised substantially.

The Pilot phase has demonstrated that it is feasible to establish a common mechanism for implementing community monitoring on a large scale and through building relationship between civil society, citizens and government. As mentioned in the Reports, institutional arrangements at the national and state level are established and these have ensured the implementation of the community monitoring. These institutions are a significant social capital and there is a need to strengthen and nurture these institutions. A comprehensive toolkit was developed and adapted for implementing community monitoring. As the Review indicates, the tool has helped to improve knowledge on entitlements and rights. However, the tool is complex. There is a need to simplify the tool and there is a need for an incremental approach to community monitoring. The tool and the mechanisms have enabled the generation of feedback from the community and there has been local corrective actions initiated in many instances, based on the feedback. However, the process of generating feedback and initiating local corrective action through Report Cards and Jan Samwads is still largely NGO led. There is a need to ensure, gradually, that the process is community led. This will ensure that the health department is accountable to the community.

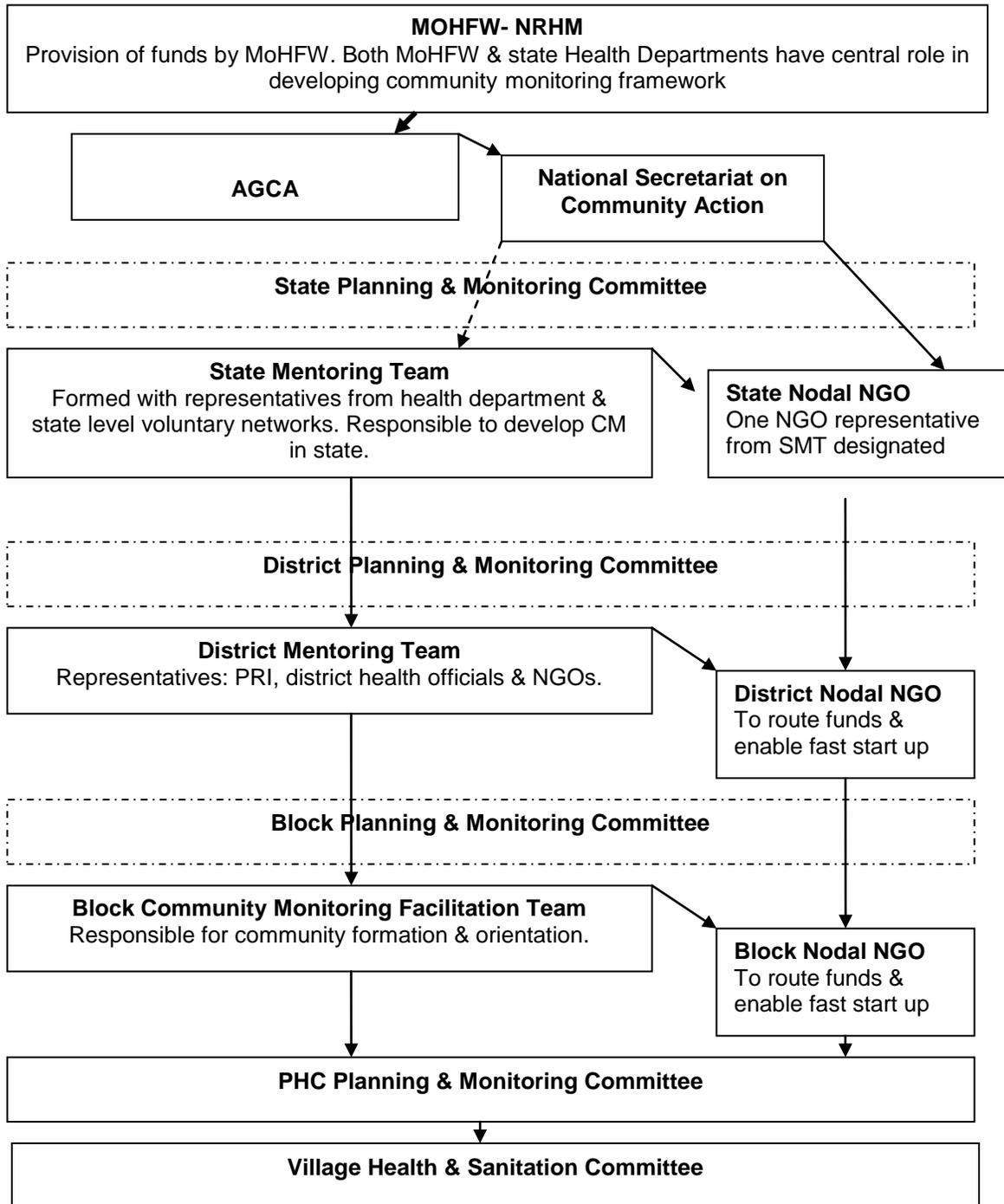
The Reports also highlight the various innovations that have been attempted by the States, in implementing the Pilot Phase. The learning is also highlighted in the reports.

The Review, strongly recommends the continuation of the support from the MOHFW and scaling it up for the entire country. As the Report highlights, with the implementation of the community monitoring, the promise of communitisation of NRHM, is beginning to be fulfilled. Continued support of all the stakeholders is essential to ensure that this promise is realised.

Annex 1



Annex 2



Annex 3

Documents referred

AGCA, 2007. Proposal to facilitate on a pilot basis Community based monitoring of Health services under NRHM

AGCA; Minutes of the Meetings

CINI, 2008; Community Based Monitoring of Health Services under NRHM in Jharkhand (a pilot initiative) - A Report, 2007-8

Implementers Handbook for Community Monitoring To Improve Health Services

MOHFW, National Rural Health Mission: Meeting people's health needs in rural areas Framework for Implementation 2005-2012

Task Force on Community Monitoring; A Summary of Community Entitlements and Mechanisms for Community Participation and Ownership for Community Leaders.

Task Force on Community Monitoring; Community Monitoring of Health Services under NRHM Handbook for Trainings and Workshops

Task Force on Community Monitoring; Manual on Community based Monitoring of Health services under National Rural Health Mission; Drawing from NRHM Framework of Implementation

¹ The NRHM Framework for implementation mentions, "...the process of communitisation of the health institutions itself would bring in accountability" (P31). The "basic change" that the NRHM intended to bring in the monitoring framework "is to involve local communities... to move towards a community based monitoring framework that allows continuous assessment of planning and implementation of NRHM" (P96).

The Framework further mentions that "Health Monitoring and Planning Committees would be formed at PHC, Block, District and State levels to ensure regular community based monitoring of activities at respective levels, along with facilitating relevant inputs for planning. Organisation of periodic Public hearings or dialogues would strengthen the direct accountability of the Health system to the community and beneficiaries" (P31).

The Framework also mentions that the "sharing of all data and discussion at habitation/village level to ensure full transparency; display of agreed service guarantees at health facilities, details of human and financial resources available to the facility; and public reporting of household and health facility findings and its wider dissemination through public hearings and formal reporting" (pp. 32-33).

² The objectives mentioned are (NRHM Framework for Implementation, p97):

- It should provide regular and systematic information about community needs, which would guide related planning.
- It should provide feedback according to the locally developed yardsticks for monitoring as well as key indicators. This would essentially cover the status of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.
- It should enable the community and community-based organisations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system. The community should emerge as active *subjects* rather than passive *objects* in the context of the public health system.
- It could be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

³ There have been a few initiatives earlier too, that attempted community monitoring and they were limited in their scope. A WHO supported initiative in 1999, led to the formation of the village health committees, and tools were developed for monitoring health providers and Primary health centres in Thane, Aurangabad Chamrajnagar and Chittorgarh districts. Kashtakari Sangathan, Institute of Health Management, Pachod, Karuna Trust and Prayas undertook this initiative. The Jan Swasthya Abhiyan advocated strongly for the formation of the village health committees. In 2004, the Government of Maharashtra passed a resolution leading to the formation of village health committees in the entire state (Maharashtra Report, p.2). In Chattisgarh too, the monitoring of health services began with the start of the Mitandin programme (Chattisgarh Report)

⁴ The first discussion on community monitoring was done in the 3rd AGCA meeting held on June 27, 2006. In the subsequent meeting of the AGCA held on July 27, 2006, the Sub Committee made a presentation. In their presentation, they suggested a three-phased approach- the national preparatory phase, the state preparatory phase and the pilot phase in select blocks. It was also mentioned that the monitoring should be done at village, facility and district levels by building upon existing structures such as the Gram Sabha, RKS etc but also involve the diverse grass roots organisations in the country too. The recommendation of the sub committee was that the AGCA should actively facilitate this process.

⁵ The NGOs were to have three roles in community monitoring:

- As members of monitoring committees
- As resource groups for capacity building and facilitation
- As agencies helping to carry out independent collection of information.

⁶ The Director Health, Tamil Nadu had suggested the inclusion of Dharmapuri district (which was not in the original list) and suggested that districts other than Kanyakumari and Trichy be included. Following this suggestion, Dharmapuri was included. However, Kanyakumari was retained and instead of Tiruchirapally, Perambalur was included. Hence, the pilot was implemented in five districts, instead of the four suggested by the national guideline.

⁷ In Tamil Nadu, the availability of NGOs determined the choice of the blocks. The health department was invited for meetings in some districts but the officials did not attend. In Vellore District, one MO said that there was no discussion with her on village selection. The NGO representative too agreed to her statement. However, in another PHC, in the same district, the MO said, she was consulted on village selection.

⁸ In one block, in Tamil Nadu, a deliberate choice was made to select few remote villages to implement the pilot. In Orissa, in one block, the villages chosen were scattered. This had an impact on provision of support and in the organisation of training activities.

⁹ The civil society organisations were to be screened based on their activity profile, their expertise in community mobilisation, women's empowerment activities and right based activities. It was also suggested that the participation be not limited to NGOs but involve CBOs and people's organisations. It further suggested that the selection should not focus only on 'mother NGOs', which may not be very objective in monitoring as they themselves are involved in implementation. It suggested that the organisations with experience of rights based and accountability enforcing activities be given adequate space and responsibility at all levels.

¹⁰ In Orissa, there was no involvement of the State NGO coordinator in the entire process.

¹¹ In Tamil Nadu, 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 present during the review 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 the process of routine monitoring became evident during the review.

¹² The *kala jatthas* organised in every single village in Karnataka appears to have stimulated community mobilisation and engagement with the process. In each district, a team of 10-12 artists was selected and trained on issues related to community monitoring at a state level workshop. Five teams were formed to conduct *kala jatthas* 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 *kala jattha*.

¹³ In Jharkhand, the *kala jattha* artistes from the three districts were trained during March 4-7, 2008. Scripts were also prepared and songs in different local dialects were written. Subsequent to this, the *kala jattha* teams performed in the pilot blocks in May 2008 to spread information on community monitoring, entitlements and about NRHM.

¹⁴ One NGO in Bolangir district prepared a leaflet and distributed it to the community members. They also organised a *Kala Jattha* to spread the information on community monitoring and to mobilise the community.

¹⁵ Church too played a role in mobilising the communities in few villages in Kanyakumari district.

¹⁶ In Tamil Nadu, handbills were used to spread awareness on entitlements and the functioning of the health department. These bills provided details of the functioning of SC and services provided by it; facilities in a PHC and the services provided by it; details of the duty time of the doctors, nurses and VHNs, other staff, and the citizen's charter

¹⁷ The CRPs invested substantial time in working with all sections of the community in the areas where casteism is high to ensure appropriate representation on VHSC. The presence of the CRPs helped them to vary from the national guideline. Karnataka undertook a universal coverage of all villages in each PHC. Hence, they formed 567 VHSCs as against the 180 that they were mandated to form.

¹⁸ NRHM suggests a mapping process culminating in the preparation of a health profile for the village. It had suggests the use of participatory rapid assessment, involving the entire community to ascertain the major health problems and health related issues in the village. This would throw light on the annual expenditure incurred by people for management of all the morbidities, the health resources available and the unhealthy influences within village boundaries. The health profile is expected to be both quantitative and qualitative data providing village information

(number of households – caste, religion and income ranking, geographical distribution, access to drinking water sources, status of household and village sanitation, physical approach to village, nearest health facility for primary care, emergency obstetric care, and transport system) and the morbidity pattern (p. 100).

¹⁹ In Orissa, the process of registering the VHSCs was time consuming- in chasing the various officials who were not sure who was responsible for their registration. Following this experience, the state Government gave up the emphasis on registering the VHSCs.

²⁰ In Maharashtra too, it was observed that the project period available for mobilisation was limited, Maharashtra Review Report, p. 10.

²¹ One of the authors observed this during a visit to Udaipur, unconnected with the review process.

²² In Dharmapuri district of Tamil Nadu, the VHSC members were issued an ID card, to ensure their recognition and acceptance by the health department

²³ In some villages, the Gram Sevaks prepared the list of the members and handed it over to the NGOs. Interestingly, in Maharashtra, there is a perception, among NRHM officials, that it is not the mandate of NGOs to form VHSCs; they, only can make them operational Maharashtra Report, p. 10.

²⁴ For instance, in one village, the PRI representative, who headed the VHSC said he did not know what happens in the meetings, as he is not kept informed. He said that the women conducted 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 stayed away from the meetings, he changed his version.

²⁵ This is an addition from the national guideline. The members were five Sahiyyas, five VHC Presidents, five VHC members, 1 ANM and 1 ICDS Supervisor. The role of the Committee is to review and collate collected reports from CBM teams; visit SCs and review records and discuss with ANM and other SC personnel and send reports to the Block Planning and Monitoring Committee

²⁶ In Tamil Nadu and Orissa, no significant details of their role emerged during the review. In Rajasthan, there were no formal meetings of the district mentoring committees. More so, the DPMs were not aware of the process, Rajasthan Report, p.13.

²⁷ The proposal submitted to the GOI had envisaged the following:

- The committee at each level reviews and collates the records from the committees immediately below it. This helps to assess the situation in all the units under its purview, and to make a report at its level. Restated, the PHC committee will collate all the report cards of the villages under its purview.
- The committee at each level (save the last one) also appoints a small sub-team drawn from its members, who will visit a small sample of units (say one facility or two villages every trimester) under their purview and review them. This is to give a first hand assessment of conditions and not just rely on secondary information. In other words, PHC committee representatives would visit villages in rotation, every quarter. Similarly, the higher-level committees would undertake visits in the lower level.
- In addition, the committees at each level would assess the functioning of the health facilities at their level. Thus, the monitoring committee at PHC level would assess the health facilities at PHC and similarly the committees at higher level would do so.
- The reporting period for every level except the state was quarterly. State reports were to be prepared every six months.

The Expected Outputs were:

- A village report card
- A cumulative report card of all villages
- An independent assessment of sample villages
- A PHC Report card
- A cumulative Report Card of all PHCs
- An independent assessment of few PHCs

- CHC Report Card
- Cumulative Report Card of all CHCs
- An independent assessment of few CHCs
- A District Report Card
- A State Report Card.

²⁸ This was evident in all the states. See Rajasthan Report, p.10 and p.11; Tamil Nadu Report, p. and Orissa Report, p. Rajasthan apparently used a more complicated scoring system for measuring each indicator. See Rajasthan Review Report, p.10.

²⁹ In Tamil Nadu, the tool was printed as a book with detailed instructions. The booklet also served to inform the community about NRHM, their rights and entitlements and it served as a useful reference material for the NGO facilitators too.

³⁰ There is an element of confusion in the NRHM framework too. At one point, it mentions, “we must be realistic in setting indicators and planning activities. Communities need few and simple indicators for monitoring, and the time devoted by members, especially community representatives involved in various committees must be utilised optimally” (p 99). Subsequently, however, the Framework mentions “the community and community-based organisations should monitor demand /need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. This should be monitored related to outreach services, public health facilities and the referral system” (p 100). How the Framework intended to manage these two aspirations- to ensure few and simple indicators for monitoring and to expect communities to monitor demand, coverage, quality, effectiveness, behaviour, denial of services etc., is not very clear.

³¹ Due to the multiple issues that are monitored, communities miss out many important aspects, death for instance. In Assam, in Nizlaguri village under Sidli Block PHC, during review it was observed that four children had died within 45 days of birth. However, this issue was never discussed in the VHSC meeting.

³² Implementers Handbook for Community Monitoring to Improve Health Services, p 70

³³ Information shared with Ram by one of the NGO in Rajasthan.

³⁴ The Review in Rajasthan observed that the NGOs were occasionally belligerent during the Jan Samwad, as they felt that they had the power of Government behind them, Rajasthan Report, p.12.

³⁵ On one occasion in Rajasthan, people demanded that the CHMO be present for a Jan Samwad. Since he had other important commitments, he had delegated his assistant to attend. The VHSC members locked the PHC and demanded the presence of the CHMO to decide on issue raised during the Jan Samwad. The CHMO said that it is not possible for him to take spot decision, as many issues cannot be resolved at his level. Rajasthan Report, p.13.

³⁶ This is observed in Rajasthan, Rajasthan Report, p.10. In Tamil Nadu, in one village, the Sarpanch came to know only during the review that she was the President of the VHSC. In the villages visited for the review in Tamil Nadu, except few volunteers from the literacy movement, other members of the VHSC did not know the role of the VHSCs, their own role in it and about community monitoring.

³⁷ In Orissa, the orientation was broken down into three phases to ensure participation of Government officials.

³⁸ In Tamil Nadu, there is good documentation of the initial processes at the state level. In districts such as Vellore and Perambalur, while there is documentation, it is not consistent. It describes few meetings in elaborate detail where as, for few meetings; the details are limited to names of participants. Capacity building for process documentation could have helped. In Orissa, documentation is done two districts. There is no significant documentation observed at the state level or in the other two districts in Orissa.

³⁹ The first instalment of money was given to the states, except Karnataka in August 2007. The second instalment was given to six states in February 2008 and this included Karnataka. The details of the third instalment have not been made available.

⁴⁰ Although the MOU was signed with all states in August 2007, one district Nodal NGO in Assam reported that they got the formal approval for incurring expenditure only in January 2008. In fact,

there were some issues as the district NGO had spent from their resources and began to implement activities before the formal approval was given.

⁴¹ The NGO in Assam said that the allocation for training is inadequate. In Assam, there are hardly any facilities in the villages and materials have to be transported to the villages, considerably increasing the cost of training. Similarly, it is difficult to hire personnel at the salary provided in the budget. Based on telephone conversation with Sunil Kaul by Ram on December 31, 2008.

⁴² In the 3rd AGCA meeting held on June 27, 2006, where the issue of community monitoring was first raised, it was decided to constitute a sub-committee of the AGCA, to suggest steps for the operationalisation of the community monitoring.

⁴³ In the 5th meeting of the AGCA, held on December 20, 2006, it was decided to establish a National Secretariat for Community Action to be located at PFI, Delhi. Its roles and responsibilities are

- Coordinating activities of the national preparatory phase, which includes developing tools, model curriculum, workshops, awareness materials and documentation formats for the programme.
- Assist the AGCA members and the state NRHM Directorates and NGO networks for the state preparatory stage.
- Facilitate process documentation and review of the pilot implementation phase in consultation with AGCA members.
- Develop a website on community based monitoring of processes and access to services under NRHM
- Manage the financial responsibility of the pilot programme
- Prepare progress reports, field visits and the national dissemination workshops of the programme at the national level
- Conduct quarterly review of AGCA for review of the pilot programme

⁴⁴ In the same meeting, AGCA members who would mentor the nine states for the roll out of the community monitoring was also identified. The meeting also decided to constitute a State Mentoring Group, consisting of representatives from the National AGCA, State Government Representatives and representatives of NGOs from the state to implement the pilot programme on community monitoring in the nine states.

⁴⁵ 6th meeting of AGCA on February 24, 2007.

⁴⁶ The members of the group are from field of public health and academics. From the reports, it appears that the members of the State Mentoring Group and State Advisory Group are entirely different. CINI, 2008, Community Based Monitoring of Health Services under NRHM in Jharkhand (a pilot initiative) - A Report, 2007-8, (p 8-9?)

⁴⁷ In Madhya Pradesh, the group consists of 14 members, and of these, four provide support during the training.

⁴⁸ The Chattisgarh Voluntary Health Association, PFI- RRC and Sandhan Sansthan formed a coalition with the head of the Sandhan Sansthan as its convener

⁴⁹ However, it appears that MPVS undertakes more of the coordination role whereas; SATHI CEHAT is more active in one district. The latter also liaises with the state health department.

⁵⁰ The final consolidated data provided by the National Secretariat only mentions 180 VHSCs whereas the Karnataka Report mentions that 567 VHSCs have been formed.

⁵¹ The Government of Karnataka has already committed about Rs 25 crores to continue the programme beyond April 2009 (see Karnataka Report).

⁵² Rajasthan Government has also allocated Rs. 29.05 lacs for the continuation of activity until March 31, 2009 (communication from Narendra, Prayas).

⁵³ Jharkhand also found it appropriate to use the term *Samwad* rather than *Sunwai* as it felt that the focus ought to be on dialogue to rectify problems. In Chattisgarh, the term Sunwai is more associated with the naxal movement and hence they prefer the term Samwad (Chattisgarh Report, p.21)

⁵⁴ This emerges from the belief of an AGCA member from Karnataka that community should be empowered to undertake community action, which included planning, implementation and

monitoring. The entire process of community monitoring should be to empower people, ensure, and enable weaker sections of the community to participate in the process. He disagrees with the process where community monitoring came first and then planning came next; (Minutes of the 7th AGCA meeting held on June 14, 2007).

⁵⁵ One reason cited for this is the perception among officials that the earlier initiative to establish village health committees did not yield much. They also felt that even if the community monitoring process was effective, there is little scope for taking disciplinary action against erring medical officers and health workers (Maharashtra Review Report, p. 8).

⁵⁶ In the state sharing meeting held on December 17, 2008 the Mission Director, NRHM, Orissa, participated in the inaugural session only. No other official from the health department participated in the meeting. The Director, Health was not aware of the community monitoring and in fact, despite request, he did not attend the state sharing meeting. Except one State AGCA meeting, in the remaining meetings, no health official participated.

⁵⁷ 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 the access.

⁵⁸ In Tamil Nadu, it is evident that without the acceptance of the process by the district officials, it will be very difficult to implement community monitoring.

⁵⁹ In one of the PHCs, in a meeting organised for the review, emotions ran high and the PHC workers alleged that NGOs are bribing community members to speak against them. The payment of TA and DA, paid as per the rules, was shown as evidence of monetary incentives being paid to committee members for speaking against them. Staff in the same PHC refused to share information from JSY records even with the State government official who was accompanying the reviewers, Rajasthan Review Report, p.8.

⁶⁰ One Collector had made the Zilla Saksharata Samiti a member of the District Mentoring Group, but his successor, decided that they had no role in health and removed them

⁶¹ A Deputy Director in Tamil Nadu said 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. Is the process meant for short-term gratification of painting the department in black, which he felt could kill the process or whether we persevere and build the capacity of the community to engage with the department and a build a rapport between them, after which, the community can begin to address such issues.

⁶² The Zilla Parishad Chairperson from Bolangir district takes interest in the issues and attends meetings. In fact, her enthusiasm is evident from the fact that she participated in the state-level sharing meeting for the entire day on December 17, 2008. She is also keen to have the score cards discussed at the Zilla Parishad meetings. The Panchayat Samiti members, in the state, too, have been taking an interest.

⁶³ In Tamil Nadu, even the officials of the Panchayati Raj Department at the state level did not evince any interest in the process.

⁶⁴ 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.