Community monitoring of health services in India in context of National Rural Health Mission

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When those with power lack motivation …

Then those with motivation must become empowered
How did Community based monitoring emerge in context of NRHM?

- Health rights and accountability activities ongoing in various areas since late 1990s
- Union Health Ministry supports project on ‘Empowering rural poor for better health’ in 1999-2000 in 7 blocks in 6 states
- Jan Swasthya Abhiyan Right to Health care campaign 2003-04
- NRHM task force on District health planning 2006 – section on CBM drafted and included in NRHM framework
- AGCA submits proposal for pilot of CBM in late 2006, approved and supported by MOHFW from mid-2007
Community based monitoring—Democratising the public health system

• The Public health system runs with public funds but functions as a top-down, centralised bureaucracy with hardly any accountability

• Very little space for users, community members and local organisations to voice their experiences, opinions, suggestions

• Panchayat members are not adequately informed and involved in real decision making

• Frontline employees are also disempowered
People need to reclaim the public health system

- Need to break through current alienation and bureaucratisation of PHS through systematic social action at various levels
- Community based monitoring and planning is one key intervention to reclaim public health systems
- Raised awareness about rights and entitlements; processes for regularly collecting evidence on health system functioning; spaces for regular dialogue and feedback; improved accountability and dialogue between people, local organisations and providers
National pilot phase of CBM 2007-09

States selected for first phase (June 2007 – Mar. 2009)

• Assam
• Chhattisgarh
• Jharkhand
• Karnataka
• Madhya Pradesh
• Maharashtra
• Orissa
• Rajasthan
• Tamil Nadu
Geographical coverage in Pilot phase

<table>
<thead>
<tr>
<th>Level of coverage</th>
<th>Number</th>
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<tbody>
<tr>
<td>States</td>
<td>9</td>
</tr>
<tr>
<td>Districts</td>
<td>36</td>
</tr>
<tr>
<td>Blocks</td>
<td>108</td>
</tr>
<tr>
<td>PHCs</td>
<td>324</td>
</tr>
<tr>
<td>Villages</td>
<td>1620</td>
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</tbody>
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Structure of CBM within each district

District

- Block 1
  - PHC 1
    - Village
  - PHC 2
    - Village
  - PHC 3
    - Village
- Block 2
- Block 3

Village

Village

Village

Village

Village
Levels of committees for Feedback & Action

- State Planning & Monitoring Committee
- District Monitoring & Planning Committee
- Block Monitoring & Planning Committee
- PHC Monitoring & Planning Committee
- Village Health, Water supply, Nutrition and Sanitation Committee
Composition of CBM committees

- Elected representatives – Panchayat members
- Public Health officials
- CBO / NGO representatives
- Non-official delegates from lower committees
Key processes in CBMP

- **Awareness generation** at community level through meetings and mobilisation
- **Formation and capacity building** of VHSC and monitoring committees
- **Data gathering and filling report cards** at village, PHC, Rural Hospital levels.
- **Dialogue with health functionaries** (Public hearings or mass dialogue)
- **Media coverage**
- **State level conventions and dialogue**
- **Continued coordination** among nodal NGOs at block, district and state levels
Significant positive processes and impacts in Pilot phase

• Improvements in ‘Good’ ratings of village and PHC health services over successive rounds seen in several states like Karnataka, Rajasthan and Maharashtra

• ‘Stories of change’ begin to emerge in several states with evidence of improved accountability, responsiveness of public health system

• ‘Jan samvads’ and ‘Jan sunwais’ proved to be effective forums for accountability

• Many innovations and alternative methods developed according to local situations
Some challenges noted by National review of CBM in 2009

- In many states, Health department wasn’t comfortable with term monitoring.
- Acceptance of process by officials at state level in most states, but limited acceptance lower down.
- Instances of adversarial positions emerging between local health department officials and NGOs.
- Instances where health department took offence after Jan Samvad
- Relations with PRIs have been weak in almost all states.
- Monitoring tool perceived to be complex, needs simplification and adaptation
- Late release of funds from GOI had an impact on the initiation of the process; need more human resources and adequate time
Post-pilot phase: 2009 onwards

Transfer to State NRHMs

- After March 2009, each state supposed to include CBMP in their annual PIP
- A few states continued and expanded CBMP though with degrees of resistance (Maharashtra, Tamil Nadu, Jharkhand)
- Some states discontinued based on administrative or procedural pretexts (Madhya Pradesh, Rajasthan)
- Some states either stalled (Odisha) or diluted while massively upscaling (Karnataka)
- Only major new state added until 2012 has been Bihar
Tamil Nadu

- CBMP started in five districts, 14 blocks, 450 panchayats
- Development of wide network with involvement of diverse groups and interaction with Health sector trade unions
- Innovative and highly visual tools developed at various levels
- Analysis of data on service delivery within village using caste as a stratifier
- SMS based data collation by activists using mobile phones
- Significant inputs for local health planning process
- Discontinuation of Jan Sunwais / Jan Samvads
- Now generalising to all villages in six districts
### Tamil Nadu

<table>
<thead>
<tr>
<th><strong>Tamil Nadu</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Image Description</strong></td>
</tr>
<tr>
<td>- A table or chart with various columns and rows, possibly indicating data or statistics related to Tamil Nadu.</td>
</tr>
</tbody>
</table>

**Note:** The image contains a table and a chart with data points, likely related to various aspects of Tamil Nadu. The specific details are not clearly visible due to the image resolution and angle.
Jharkhand

- 2011-12, 96 blocks in 24 districts (50 villages each) taken by Village Health Committee Sahiyya Resource Centre
- Central role of State training team and Block training teams (instead of nodal NGOs)
- Kala jathas organised on wide scale for community mobilisation and awareness
- Discussion on Report card in Gram Sabha
- Jan Samvads at block, distt and state level
Odisha

- In pilot phase CBMP in 4 districts, 12 blocks, 180 villages
- Name ‘Community Monitoring’ changed to ‘Community Action’
- Active State AGCA supported pilot phase activities
- However setback after 2008 with change of State officials
- With the change of leadership again at the Mission Directorate in 2010, efforts of SAGCA regained momentum

- Relaunching process as Gaon Swasthya Samikshya in 82 blocks of 5 districts
Maharashtra: Scale of community based monitoring & planning

13 districts: formation, orientation and activity of

- Over 600 Village Health Committees
- 35 Block Committees
CBMP in Maharashtra: some innovative and positive features

- Diversity of civil society organisations including ‘Jan sangathans’ involved
- Emphasis on state level processes including state ‘Jan sunwais’ and formation of state M&P committee
- Quarterly newsletter ‘Dawandi’ widely circulated across state
- Documentation of increase in service utilisation (Thane) and stories of change
- Emerging CBM of nutrition services
Jan sunwais: a forum for dialogue and accountability

- Report cards and cases of denial presented
- Health officials respond to issues raised by people
- Actions ordered regarding services at village, PHC and Rural hospital levels
- Nearly 200 Public hearings organised so far at PHC, block and district levels
Community based planning: Sharing power in the public health system

- Participation of CBMP representatives in RKS meetings to suggest community health priorities for facility based planning.
- CBMP committees develop annual block level PIP proposals.
- Major pro-people shifts in priorities for RKS based planning, in PHCs and CHCs leading to improved services.
Positive outcomes in states

• Enhanced trust and improved interaction between provider and community
  – Improvement in service delivery - ANC, PNC, immunization,
  – Responsiveness of provider to community needs
  – Improved provider attitude and behavior

• Community based inputs in planning and action
  – Active involvement of PRI members in planning and functioning of health facilities
  – Local need based planning, deprived groups / areas
  – Appropriate planning and utilization of untied funds at VHSC, PHC and CHC
Positive outcomes in states

• Reduction in out of pocket expenditure
  – Reducing demands for informal payments
  – Ensuring timely and full payments of Janani Surksha Yojana
  – Significant reduction of outside prescriptions

• Some improvements in service delivery and utilisation

• Creation of spaces for multi-stakeholder dialogue, empowerment of local activists, initiating ‘democratisation’ of public health system
Some key challenges in post-pilot phase

- CBMP accountability processes have met substantial resistance from State health departments in nearly all states.
- Control by State health departments over financial and administrative mechanisms has been major basis for constriction of CBMP processes; delayed fund flow, tedious reporting requirements, interruption of activities.
- Diluting role of NGOs or questioning their selection.
- Generally lack of institutionalised service guarantees, grievance redressal mechanisms.
Some key challenges in post-pilot phase

• Community based monitoring activities have been maximally effective regarding local health services whereas actions and decisions at higher levels (esp. State)

• Systemic problems have persisted such as staff vacancies, shortage of medicines due to procurement and distribution system

• Empowerment of actual community members and involvement of PRI members has been slower than expected, requires substantial efforts

• Tendency to ‘Karyakarta based’ or ‘Committee based monitoring’
National official environment: Positive words, sluggish actions

- MOHFW lost enthusiasm for CBMP after pilot phase, change of key officials
- Planning commission proposal to focus efforts in LWE districts, displaying problematic approach
- Since mid-2012, some revival of expression of support to CBMP by Ministry
- However AGCA proposal for system of ‘support units for community action’ yet to be responded to in effective manner
Need for two-track strategy at State level

- Continuing to utilise and expand officially recognised spaces created by CBMP
- Building social pressure for guaranteed health services, effective action on issues raised at various levels
- Expanding processes to newer areas in existing as well as new blocks / districts in voluntary, less intensive mode
- Developing wider constituency for CBMP incl. PRI members, media, social sector networks and campaigns
- Strongly promoting Health rights actions even beyond CBMP framework in campaign mode
Need for two-track strategy at National level

• Officially created frameworks like AGCA should be used to push for stronger mechanisms to support community action, despite certain limitations
• Need to demand more effective backing to CBMP by MOHFW, nationally defined entitlements and grievance mechanisms, financial guidelines for civil society organisations
• However wider, coordinated civil society activism is required even to raise profile of CBMP at national level and push for more receptive space for accountability processes
• Possibility of a national network to promote social accountability in health sector, synergistic with existing networks like JSA
Need to move from ‘project mode’ to ‘social process mode’

- Publicly funded CBM in project mode has enabled effective implementation of wide range of activities
- While some resources are necessary, certain problems are also coming up due to project mode
- Need to move towards less resource intensive, much more inclusive and generalisable model of community monitoring and planning
- Wherever local groups, social organisations are interested in facilitating Community monitoring activities they should be allowed space and mandate
- Limited resources may be provided for capacity building, organisation of events, regular meetings
- Such a model would allow wide generalisation and development of community monitoring across the state
When the public gives feedback and starts occupying centre stage, Public systems begin to change.