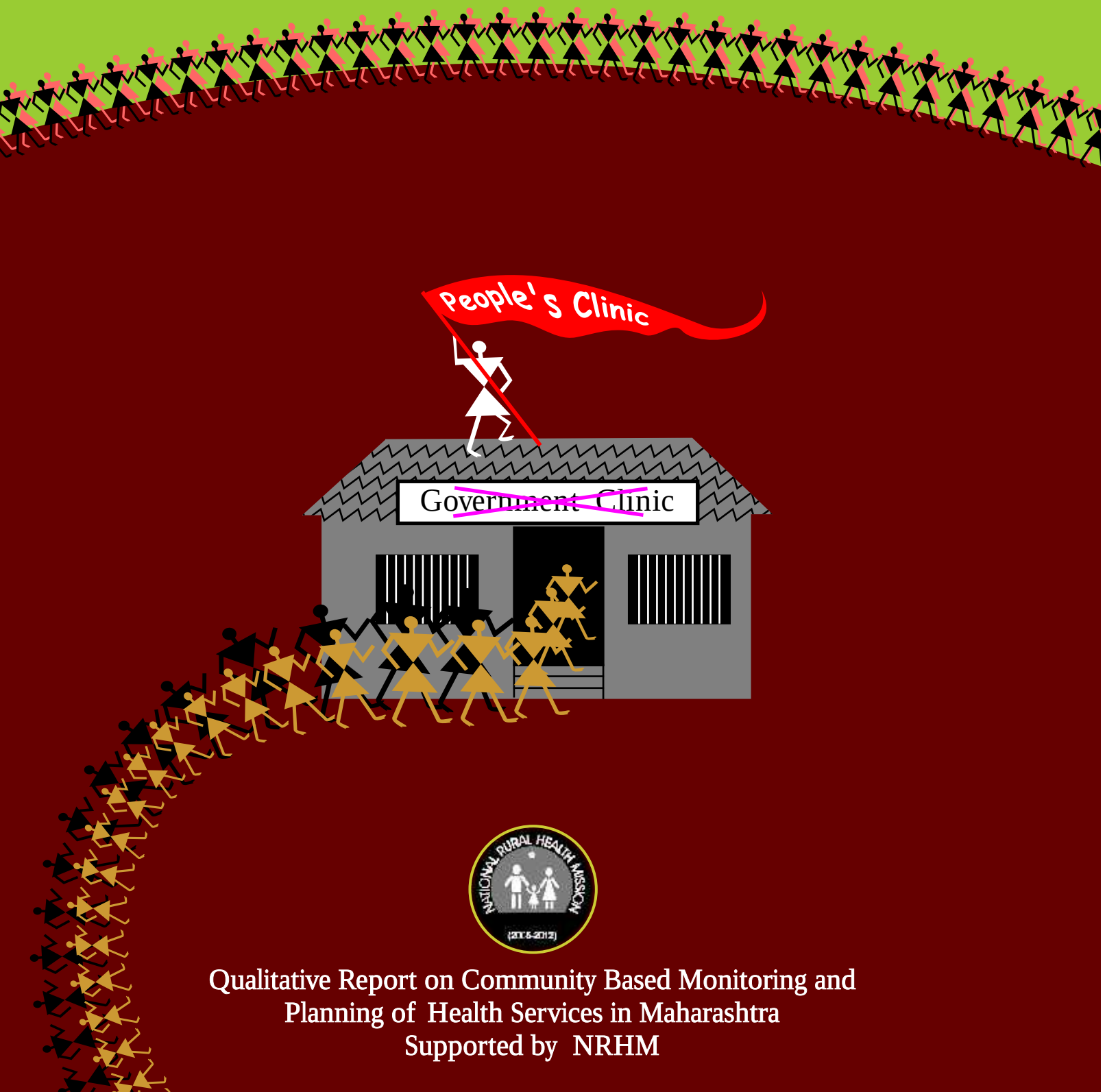
People
are reclaiming the
Public health system...



Qualitative Report on Community Based Monitoring and Planning of Health Services in Maharashtra
Supported by NRHM

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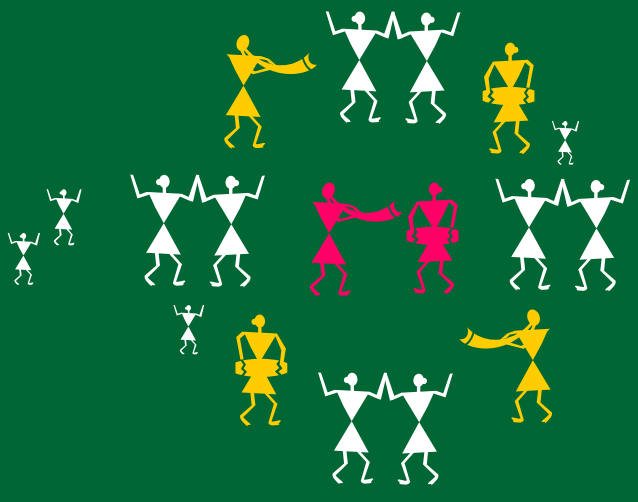
  The process of community based monitoring has become a reality because of efforts of NGOs/CBOs from across thirteen districts of Maharashtra, State NRHM and Health department officials, Health workers from different levels in the state and PRI members. This book is a product of all these efforts. The CBMP activity is part of the National Rural Health Mission framework and is financially supported by NRHM.

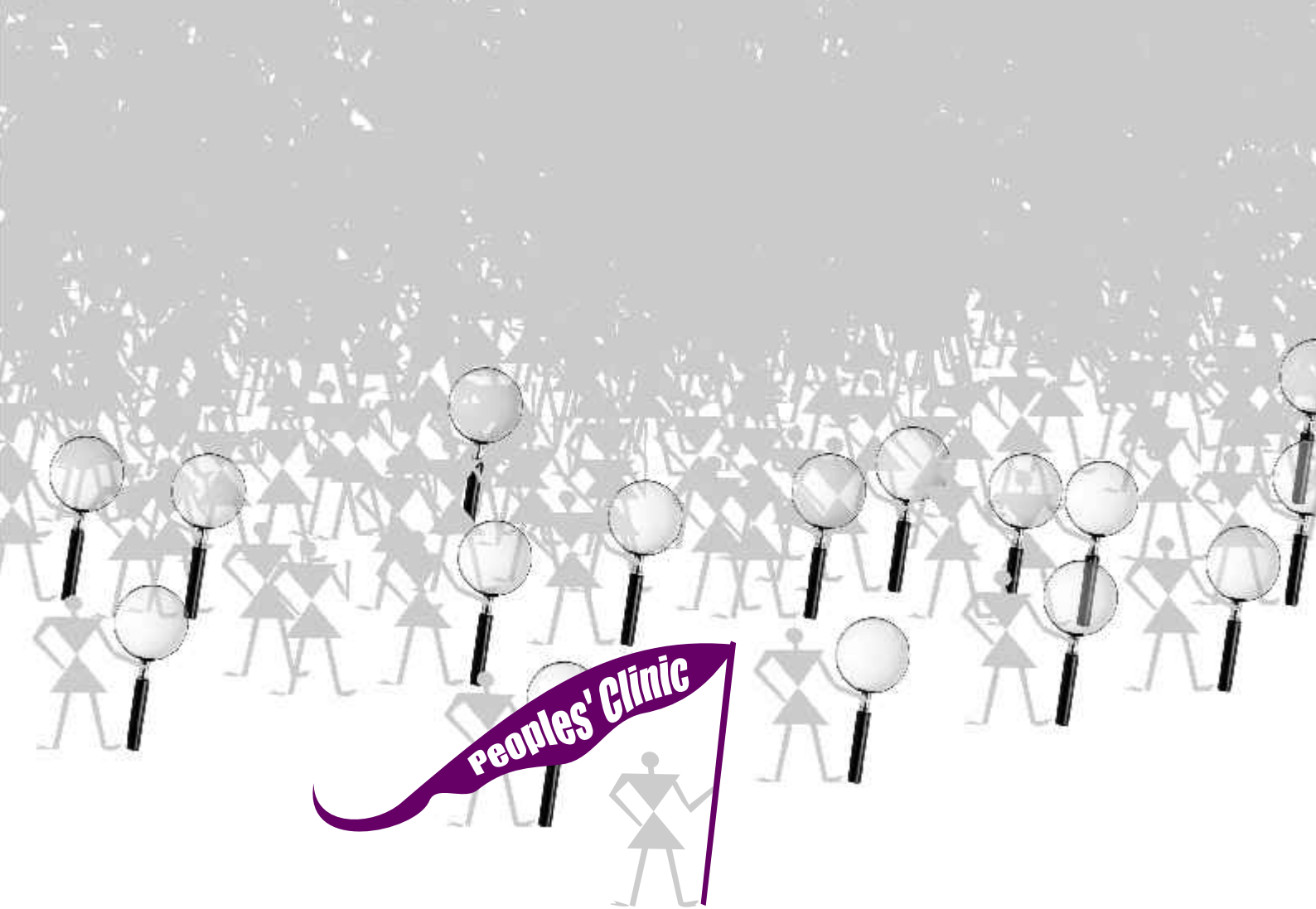
- For Private Circulation
- March 2012

About the English translation

This English booklet is translated from the original Marathi report 'Ata Sarkari Davakhana Hotoy Janatecha' based on processes and experiences of Community based monitoring and planning in Maharashtra. The Marathi booklet was published in 2011, whose title means “The 'Government' clinic is now becoming a 'People's' clinic”.

This qualitative process documentation presents ground realities, experiences and ideas of stakeholders across various districts involved in the CBMP process. These peoples' voices give an authenticity to the document and make it live and readable. We had received a very positive response to the original book, but due to language constraints it was difficult to take this rich document beyond the Marathi reading public. Hence in order to share these experiences more widely, we decided to translate this Marathi booklet into English for a broader audience. While doing the translation, we deliberately chose to retain the regional flavor of the original while making the content accessible for English readers. We hope this effort will be found useful.





Qualitative Report on
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People are reclaiming the Public health system ...

What is this document about?

An account of a collective process to revitalise health services...

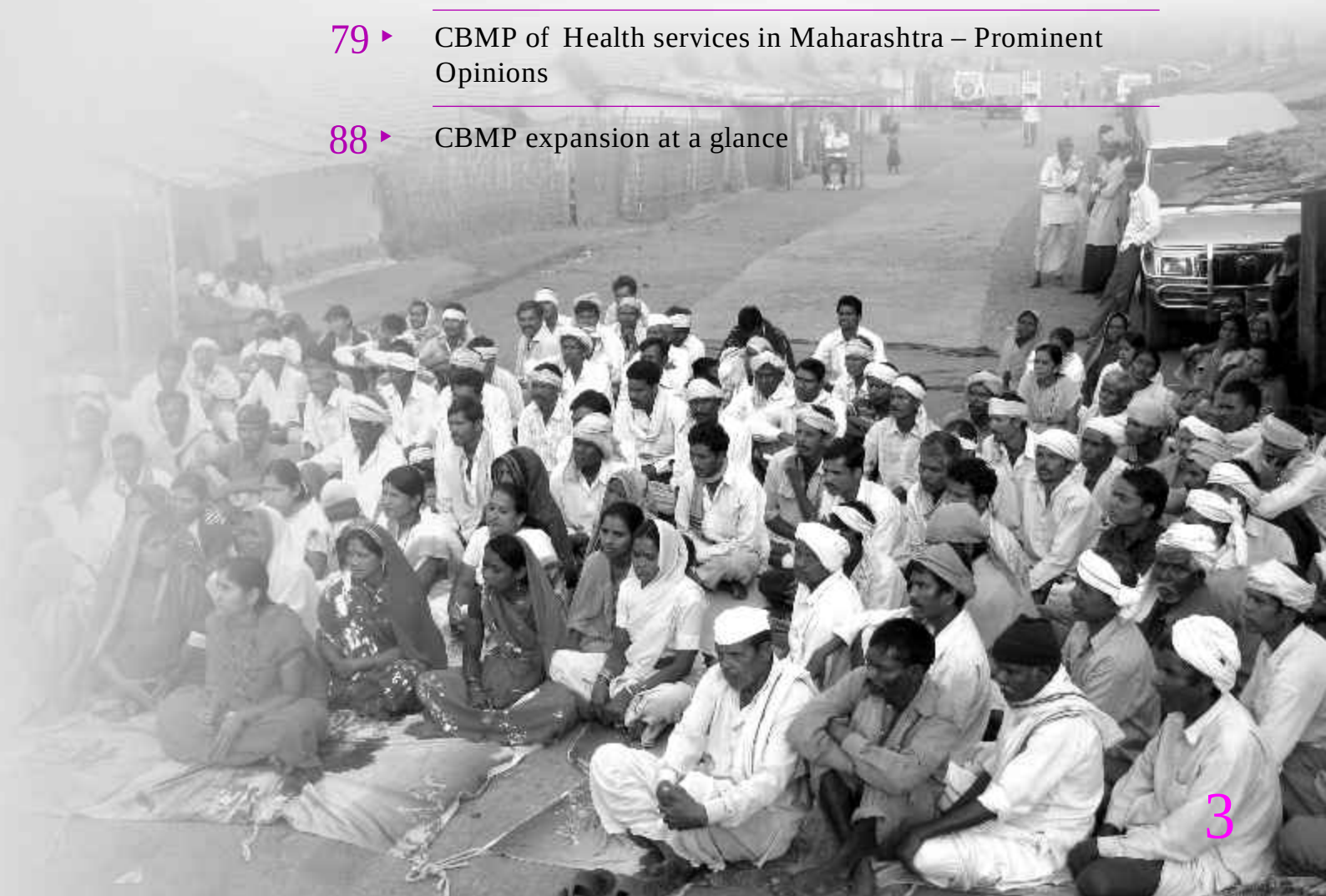
The general perception is that nothing can happen smoothly and efficiently in public systems. While people often complain about delays and problems they experience in Government offices, they exhibit indifference towards this system at the same time. The public health system is no exception to this prevalent sense of apathy. Usually people are least concerned about the state of health services, as they consider it as a government function. Nevertheless, this apathy, as this document presents, can be turned into concern and action.

This document presents the process of implementing 'Community Based Monitoring and Planning' (CBMP) in Maharashtra that has been initiated with support from the 'National Rural Health Mission'(NRHM). The CBMP experience shows that people's indifference is waning and 'government' clinics are becoming 'peoples' clinics. This document explains the emergence, scope, impact and future challenges of this innovative concept, and also presents views and opinions of various stakeholders, such as a member of National Planning Commission, noted social activists, senior media persons, Health officials from state and district levels, NGO and CBO activists, village level health functionaries and community members, about CBMP.

NRHM, among other things, aims to bring down maternal and child mortality, provide quality health services in remote areas and increase community participation in planning of health services by taking people's views into account. NRHM is being implemented across the country, while CBMP in Maharashtra started on pilot basis in five districts – Amravati, Pune, Nandurbar, Thane and Osmanabad. CBMP processes and experiences in these five districts are covered in this document. We hope that the content and presentation will be a useful resource in scaling up and universalization of this unique concept.

CBMP has instigated a process of change. People identifying gaps within the health system, and then taking initiative to correct them is unprecedented. Through this effort the public health system is becoming accountable. Moreover, government acknowledgment and support makes this entire effort even stronger.
Such a remarkable process should be scaled up widely, and we hope this book will contribute towards this goal.

Contents



An Appropriate Solution to a problem …

> The biggest problem we are encountered with is inadequate implementation. The schemes which are very well developed at higher levels in the Government of India are not implemented appropriately at grassroots levels. The schemes are very well fleshed out but not found efficacious as they should be at the ground level. Hence there is lot of dissatisfaction about health programs all around.
>
> So, what I found useful in the CBM program is that the most disempowered people actually started monitoring the program. They are coming on a platform and having dialogue about health issues with health functionaries and officials. CBM is a tool by which we can achieve inclusive growth.
>
> - Dr. Syeda Hameed
> Member, Planning Commission, GoI

In this document, read about…

Community Based Monitoring and Planning of Health Services

Its meaning, emergence, nature, scope, effects and outcomes...

What is meant by 'Community Based Monitoring and Planning of Health Services'?

'People don't do what you expect, they do what you inspect'

Any system responds to what is directly inspected rather than what is expected of it. This management rule aptly denotes the human psyche. What applies to people also applies to systems. Community based monitoring is a method which is used to get beneficiary feedback about a particular service. Community based monitoring enables us to know people's feelings and satisfaction levels about the service and accordingly explore necessary areas for improvements to satisfy them.

Every system seeks to know whether it functions effectively or not and adopts various methods towards this end. One of the prevalent methods is to appoint an independent agency to undertake review and monitoring. Regular periodic reporting by the staff and officers in charge at various levels is also used to review progress achieved through the work. These two standard methods have oft been used to monitor functioning and impact of health services. However, the opinions of the people who use these services have not been systematically taken into account so far. CBMP bridges this gap by involving community members in the assessment of services in order to improve them. It is a kind of social audit of public health services, which serves to facilitate active participation of people who are otherwise indifferent towards the state of affairs in the health system.

What are the key elements in implementation of CBMP?

CBMP implementation covers the following;

- ✓ Initiative of community members to access regular and good quality health services
- ✓ Taking concrete steps to increase out reach of public health services and disseminating information about schemes and health services meant for community members.
- ✓ Monitoring by villagers to ensure availability of local health services.
- ✓ Collecting information and feedback about available health services from its beneficiaries
- ✓ Presenting key community health issues based on compiled information.
- ✓ Deliberating upon local issues through public dialogue (*Jan Samvad*), public hearing or similar methods in order to address and resolve them.
- ✓ Communicating people's opinions to decision makers.
- ✓ Increasing people's participations at various stages of planning of health services

Community Based Monitoring and Planning

How did the concept emerge?

According to the directive principles in the Indian Constitution, the government is responsible to promote public health. However, the health sector in India is plagued with numerous problems. Some of the critical areas of concern include inadequate budgetary provisions, enervated public health system, proliferation of profit seeking private medical sector, insensitivity of the medical profession towards health needs of common people, and poor implementation of services meant for underprivileged sections. All these critical concerns have been raised often by health rights activists. The national campaign platform for health rights – *Jan Swasthya Abhiyan* – has frequently raised these and other concerns at the state and national levels. Upholding the right to health care, JSA has strongly advocated for improvements in and strengthening of public health system. The CBMP process is linked with years of work by JSA members who have been doing advocacy on health rights.

As part of these efforts, in 2004 JSA in collaboration with National Human Rights Commission organised a series of Public Hearings at regional levels with an aim to establish the right to health care. These public hearings, organised in various parts of the country, brought forth a range of critical issues pertaining to the state of public health services. Taking serious note of the situation, NHRC endorsed the concept of 'Community Based Monitoring', as a methodology to ensure social accountability of health services and also as a measure to ensure realization of people's right to health care. NHRC forwarded its recommendations to the Health Ministry, which included community based monitoring.

Subsequently public health system reforms set in after NRHM was initiated in 2005. NRHM aimed at bringing down extent of maternal and child mortality and providing quality health services to the underprivileged rural population. Likewise, it was decided to increase budgetary provisions for public health. However, the administration was aware that the desired goals would not be reached without effective community participation. People's involvement became an essential factor also to monitor utilization of funds, especially those meant for marginalized sections. NRHM enhanced the availability of resources in terms of funds and facilities. However, it was equally important to have a mechanism in place to ensure that these resources are utilized properly, effectively and for the benefit of all people. How to ensure that people are getting quality health services? How to assess whether or not they are satisfied with the service? The government reports alone are insufficient to get a comprehensive picture. In this context, the idea of collecting people's experiences about health services, as evidence of responsiveness of the services, was conceptualized.

With this background, the Health Ministry established a task force on 'District Health Planning'. Some of the JSA activists, who were part of the task force, urged adoption of community based monitoring. Later their suggestions got incorporated in the NRHM framework.

The National Advisory Group for Community Action (AGCA) that was formed as part of NRHM further explored ways to ensure community participation. Their deliberations led to formulation of the CBMP framework in its present form with approval from NRHM.

The actual implementation of Community Based Monitoring and Planning of Health Services began in 2007. Total 35 districts from 9 states were identified for the pilot phase, including Maharashtra where CBMP was initiated in 5 districts – Amravati, Nandurbar, Pune, Thane and Osmanabad.

As the evolution process indicates, CBMP was conceived in order to promote people's right to health care.

Scope of Community Based Monitoring & Planning in Maharashtra

Based on approval by NRHM at national level, the process of CBMP implementation began in all pilot states including Maharashtra. The responsibility for implementation was entrusted to civil society organisations.

SATHI shouldered the responsibility for state level implementation as the state nodal organisation in Maharashtra.

The process began in five districts on a pilot basis. These are - Amaravati, Nandurbar, Pune, Thane and Osmanabad.

A District nodal organisation was selected in every district.

Three blocks in every district were selected with a block implementing organisation in each.

The CBMP process was initiated in 3 PHCs and 15 villages in each block.
Later the scope of work further expanded.

Community Based Monitoring & Planning in pilot districts of Maharashtra now includes...

5 districts | 21 blocks | 71 PHCs | 440 Villages

and is carried out by 14 grassroots NGOs and people's organisations.

All were united by a common objective.

Public health officials and health workers, NGOs and people's organisations, elected representatives of local self governing bodies, community members and media personnel all have come onto a common platform for the first time to discuss health issues, and improve health services.

Our mission is to establish people's Right to Health...

Who were involved in CBMP implementation and where was it implemented?

- Maharashtra State Nodal Organisation – SATHI, Pune
- Pune District and Purandar and Daund Blocks Nodal Organisation – MASUM (Mahila Sarvangin Utkarsh Mandal), Pune
- Velhe and Bhor Blocks Nodal Organisation – Rachana
- Khed and Junnar Blocks Nodal Organisation – Chaitanya
- Amaravati District and Chikhaldara and Chandurbajar Blocks Nodal Organisation – Khoj, Amravati
- Achalpur and Anjangoan Blocks Nodal Organisation – Mamta Bahuuddeshiya Society
- Dharni Block Nodal Organisation – Apeksha Homio Society
- Nandurbar District and Shahada Block Nodal Organisation – Janarth Adivasi Vikas Sanstha, Nandurbar
- Akkalkuwa and Taloda Blocks Nodal Organisation – Loksangharsh Morcha
- Dhadgoan Block Nodal Organisation – Narmda Bahao Aandolan
- Thane District and Murbad and Shahapur Blocks Nodal Organisation – Vanniketan, Thane
- Dahanu and Mokhada Block Nodal Organisation – Kashtakari Sanghtana
- Javhar Block Nodal Organisation – Dr. Manibhai Desai Adivasi Mahila Sangh
- Osmanabad District Nodal Organisation – Lokpratishthan (Kalamb and Osmanabad Blocks) and HALO Medical Foundation (Tuljapur Block)

Now, community monitoring gets an official sanction!

"In 1999-2000 *Kashtakari Sanghatana* implemented a project titled 'Empowerment of rural poor for better health' in Dahanu block. With guidance from SATHI we carried out specific activities to increase social accountability of health workers. As part of it, the community openly discussed the responsibilities of health workers with them, recorded health workers' village visits on a specially designed calendar, and also monitored implementation of local health programmes. This process got further extended and expanded into a process of community monitoring.

Now, NRHM has supported CBMP. Community members are entrusted with responsibility to monitor performance of the health system. NGOs and people's organisations are also part of this effort. This is a promising process. We have ample evidence to infer that Adivasi communities are far more effective than the government systems in protecting forests. Similarly, now we can say communities are competent in fostering health services."

- Brian Lobo, Kashtakari Sanghatana, Thane

Community Based Monitoring and Planning

From Village level to the State level…

Although the actual process of CBMP started in 2007, the preparatory process was going on at different levels for some time in a collaborative manner involving NRHM, State Health Ministries and voluntary organisations.

A coordinating mechanism is essential if government and NGOs are to work together. Independent forums were formed for the purpose of facilitating the process, specifically in terms of organizing meetings, taking decisions and issuing official orders, to disseminate them and provide overall guidance for the work. Coordinating structures were formed at the national, state as well as district level.

National level

National Advisory Group for Community Action (AGCA)

At the national level, the Advisory Group for Community Action has been formed by NRHM to ensure people's participation in health sector reform processes. Committed experts who have contributed to public health for many years were invited to become AGCA members. This group assumed a 'parental' role to the CBMP at the national level.

State level

State Mentoring Committee

The state level mentoring committee was formed to facilitate the process within the state. The committee members include State Health Officials and persons experienced in public health & community health.

District level

District Mentoring Committee

A district mentoring committee was formed in all districts where the CBMP process was implemented. The committee has been responsible to take review of district level processes and their outcomes, to issue relevant orders at the district level for the success of the project, to have regular quarterly meetings to review and plan the process.

How were the Monitoring and Planning Committees formed?

Translating a plan on paper into reality is not a simple task. Besides, CBMP was not implemented just at the village level, but at various levels from village to PHC, block and district. The implementation districts were also geographically and culturally diverse. In spite of these complexities a structure that would be commonly applicable was evolved.

All stakeholders at various levels were brought together in a phased manner. Village health committees were expanded first, followed by formation of PHC level committees. After processes were initiated at these levels, block and then district level committees were constituted. All the committees were connected through a representative structure, which means some representatives from Village committees were members in the PHC committee, similarly PHC committee members were represented in Block committees and District committee had representatives from Block committees. All

committees functioned at their respective levels and were engaged in various activities such as back and forth communication, follow up to get essential government orders, training of volunteers, conducting village meetings and making field visits. Persistent efforts of various committees, from state to village level, at their respective levels and in coordination with each other, have given required momentum to the CBMP process.

Community based monitoring is a good concept. It has not just been on paper but since last few years we are making efforts to implement it on the ground. There are definitely some changes taking place. People are now increasingly availing public health facilities. The community monitoring process is making them aware of their rights and steps they need to take to attain their rights. The health system is also becoming more responsive and accountable towards people.

I have specific observations to share from State Mentoring Committee meetings. We need to be careful and conscious in our approach. Particularly, the health officials and functionaries in the health system should properly understand the core of the process. At first, they might have felt the process to be troublesome, with people pointing out their faults and complaining against them. However, it should be kept in mind that the process is ultimately aimed at improving the system and therefore requires to be looked at with a positive attitude.

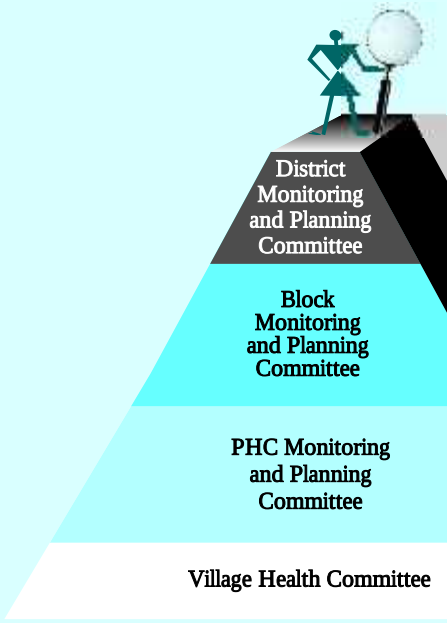
A number of organisations are involved in this effort. They also need to be cautious about not misusing the 'power' that they have been accorded. It should be kept in mind that monitoring is a social responsibility given to these organisations in the public interest, for raising relevant problems within the community and it should not be misused for personal gains.

Lastly, along with monitoring we all should be aware of the planning component integral in this process. Planning process has two approaches-first, needs based planning and second, planning by the government. Just the latter is never enough. For effective and meaningful planning, both approaches should be combined. Local needs should be prioritized. The state and district committees will always extend their fullest support to facilitate such pro-people planning process.

> “Planning only at the government level does not suffice …”

-Vikas Kharge,
Director, NRHM,
Maharashtra State.
Member, State Mentoring Committee

Structure and Constituents of CBMP Committees



Proportion of Representation in the Committees

Proportion of Representation in the Committees from PHC level and above –

- Representation of elected members of local government bodies–30%
- Representation of medical officers – 20 – 30%
- Representation of NGOs/CBOs – 15 – 20%
- Representation of RKS members – 10%

In addition, members include heads of health committees in *Zilla Parishad* and *Panchayat Samiti*, District Medical Officer and Nodal NGO representative.

Gram Panchayat members, ASHA volunteers, Anganwadi worker, SHG members, representatives of local community groups .

A crucial phase in the CBMP process is formation of committees. A Government Order was necessary to initiate the process, however it was a tough task to get it issued. We already had Village Health, Nutrition, Water Supply and Sanitation Committees and RKS committees in place. The question that we were confronted with was, why these new monitoring and planning committees and that too why in five identified districts? Some officials opined that the responsibility of monitoring should be handed over to the already existing RKS committees.

> "Only alert members can bring about the change"

-Dr. Nitin Jadhav
State Coordinator,
CBMP, SATHI,
State Coordinating Organisation,
Pune

Time was taken to convince them that existing RKS committees are for guiding implementation, and implementing committees by their very nature are unable to do independent monitoring as well.

After the order was issued, the process of committee formation started. The existing village health committees were mostly inactive to begin with. Hence we started with awareness, expansion and activation programmes. Conscious efforts were made to ensure representation of women, dalit and physically challenged people in the committees. We faced opposition in Pune and Thane districts in involving representatives from marginalized communities. However, the nodal organisations remained firm on this issue and ensured their participation.

For effective interlinkages, some non-government members from each committee were included in higher level committees, to enable posing of problems not being addressed locally, at the higher level. For instance, Village health committee members in Purandar block noticed substandard quality of food provided in some schools. The problem was not solved locally, so they raised it at PHC level and pursued till it got resolved.

Training programmes for committee members have been important, including exposure visits and dialogue with medical officers. If committees are formed without members being effectively trained, the committees exist only on paper. However, proper training has inculcated awareness and capabilities among CBMP committee members.

What exactly did the CBMP committees do?

After a variety of efforts the monitoring and planning committees were formed. These committees were given specific roles. The process of community based monitoring and planning of health services evolved with a clear methodology as follows.

Village Health, Nutrition, Water supply, and Sanitation Committee (VHNWSC)

a. Maintaining Village Health Register and reviewing work of health functionaries
b. Preparing a village health report card by compiling information about village level health services
c. Taking initiative to organize health related programmes at the village level
d. Visiting PHC and Rural Hospital to get information about the services and to have a dialogue with respective medical officers.

PHC Monitoring and Planning Committee

a. Visiting PHC, preparing a PHC report card by compiling information and addressing problems identified through this process. Organizing PHC level public hearings.
b. Presenting problems indentified through the monitoring process in the RKS meetings.
c. Preparing a health plan at the PHC level

Block Monitoring and Planning Committee

a. Visiting Rural Hospital, preparing a RH report card by compiling information and addressing problems identified through this process. Organizing block level public hearings.
b. Presenting suggestions in the RKS meetings.
c. Preparing a health plan at the block level

District Monitoring and Planning Committees

a. Discussing issues related to health services at various levels in the district and pursuing concrete actions.
b. Organising district level public hearings.
c. Visiting Civil / District and Sub-District Hospitals and reviewing the services therein.
d. Presenting suggestions for the health plan at the district level

How can common people give their feedback about health services?

NRHM clearly delineates health services people are entitled to get at various levels in the health system. Indian Public Health Standards (IPHS) have outlined minimum standards for quality health care. Health system has suo moto decided a definite time frame to attain these standards. The government has guaranteed health services at village, block and district levels in various facilities such as Sub-center, PHC and Rural Hospital.

Although NRHM has guaranteed health services, it is necessary to check to what extent this commitment is being fulfilled. CBMP provides an opportunity to know whether or not these services are actually available for common people.

People often complain about the state of public health services in their informal talks. However, such feelings and remarks have little relevance for monitoring purposes. Therefore a systematic methodology is adopted in CBMP to get people's objective feedback about the services they get or do not get. Specific issues have been identified for information compilation at every level.

Three key sectors for Monitoring and Planning-

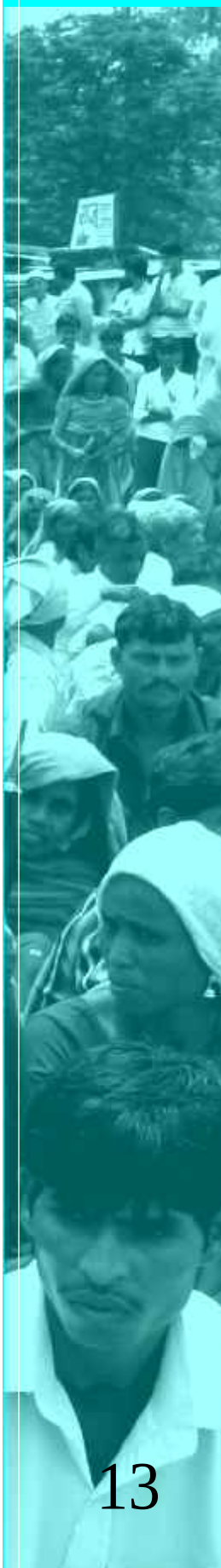
- Availability of Health services guaranteed by the government
- Availability of resources such as infrastructure, humanpower, medicines
- Utilization of funds

For village level health services information on following parameters was collected

- Maternal and child health services (Both ante-natal and post-natal care and immunization)
- Village level disease surveillance services
- Curative services at the village level
- Anganwadi (ICDS) services
- Regularity and quality of services available at PHC and peoples experiences of these
- Utilization of village level untied fund provided through NRHM
- Adverse outcomes such as maternal death, infant deaths and denial of health services.

For PHC level health services information on following parameters was collected

- Infrastructure: Availability and situation of electricity, water supply, toilet facility, labor room, IPD section and situation of laboratory
- Services: OPD and IPD services, delivery services and referral services (availability of ambulance) etc.
- Human resources: Availability of Medical officer, ANM, Pharmacist, Driver etc.
- Availability of essential medicines: Checking whether the essential medicines are available in adequate quantity as per the list of essential medicines prepared by DHS.
- Exit interviews of patients: Information about quality of health services, behavior of health facility staff, illegal charges etc.



Barometer of people's satisfaction - Health Report Cards

An easy to use yet effective tool was necessary to enable rural people to monitor government services. We are generally familiar with report cards of school children. A village heatlh report card was developed on similar lines and villagers were asked to fill it up with necessary details in their community meetings. But the village is not a homogenous unit and experience of marginalized people and those residing in outskirts or remote hamlets can be different from the people living in main village. In order to get opinion of the marginalized groups, separate meetings were organised with these groups who are likely to get excluded due to social or physical constraints.

Members of social organisations played a crucial role in coordinating the process. This facilitated open discussion among committees at various levels. Community members also considered views of medical officers and health workers before recording their remarks in the prescribed color code- red, yellow and green.

The reports were finalized as 'Good', 'Partially satisfactory' or 'Bad' by calculating the total of marks for each category of services.

Color code ranking for health services :
● Red – Serious/Bad, ● Yellow – Partially Satisfactory, ● Green - Good

In the first report card of Nasrapur PHC, it emerged that the situation was quite bad. This PHC caters to a population of 51,000 but has only one medical officer, who remained frequently absent. He was not even available when we first visited the PHC to fill the report card. Vilas Borge, CBMP Committee President and Panchayat Samiti member, contacted the doctor on phone. It was the weekly market day and large number of patients were waiting for the doctor. Once the doctor arrived, we told him to check the patients first and later we discussed points in the report card. He avoided giving information of fund utilization, saying that the accountant was on leave.

Earlier we had spoken to some women in delivery ward, who complained about rude behavior of staff and unhygienic condition of toilets. We raised these issues in our discussion with the doctor. We had three women in our committee- a Sarpanch and two Grampanchayat members. They asked about blood pressure of pregnant women not being checked. We also discussed about unavailability of quarters for the doctor. All in all, given the situation we all decided to give 'Serious' ranking to the PHC.

In our subsequent visit we invited the Block level Medical officer and recalled the previous remarks on the report card. Clearly the staff was uneasy with the entire process, but we knew that the process will ultimately be helpful to them also, and we continued the discussion further. Subsequently, the behavior of the staff changed. Now printed case-papers are available, medicine supply has improved and ASHA volunteers get honorarium regularly. But the post of second MO was still vacant. After we warned that we would go on a protest fast, a temporary appointment was made immediately. Clearly, our report card invoked much needed action.

"We prepared a report card and the action started..."

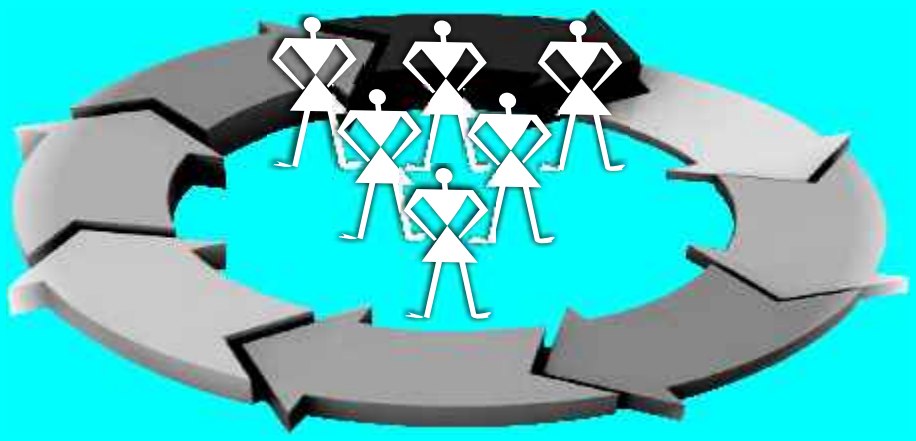
Rajendra Rankhambe
Coordinator Bhor Block,
CBMP Project
(Rachna Sanstha), Pune

Innovative methods to promote
people's participation
in the public health system like-

Public hearings,
public dialogue,
Village Health meetings
Village health awareness day,
and
Involvement of Media

These have helped people to speak up about
their health issues
and

now the health services have started
becoming more sensitive and responsive
towards people's needs...

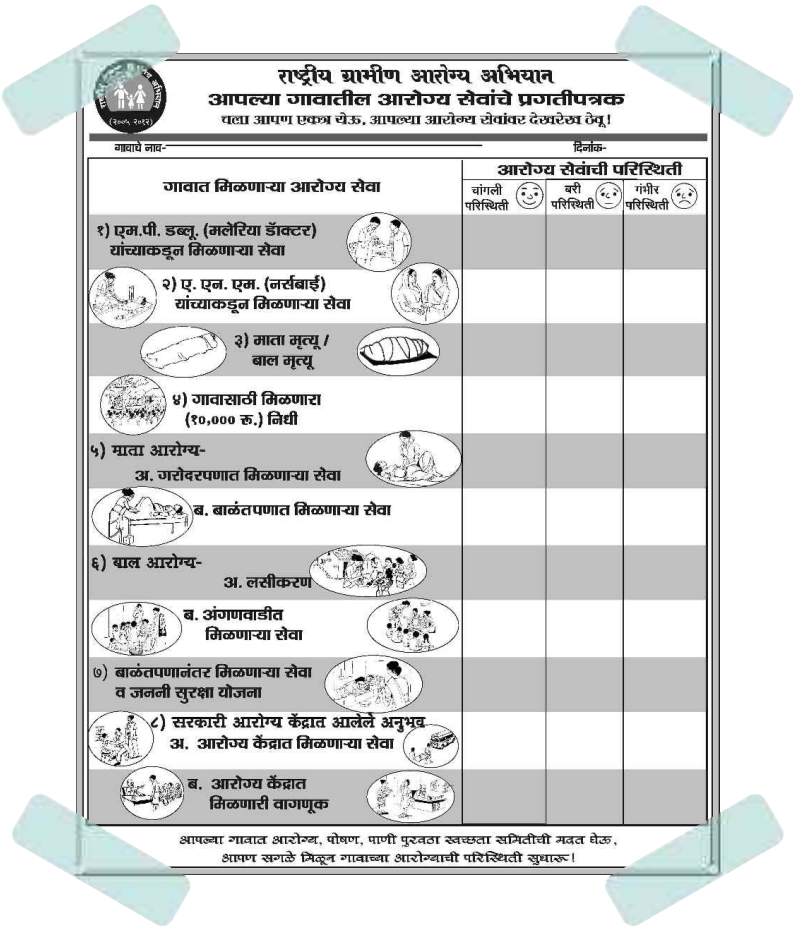


Innovative methods used in the CBMP process

Community Based Monitoring & Planning aims to enable common people to intervene in the health system to ensure social accountability. Various tools that are easy to use and are based on objective principles have been developed for this purpose.

Health Report Cards

The health report card serves as an assessment tool for the monitoring process. Separate report cards are need at village, Sub-centre PHC and Rural Hospital level. It is a pictorial tool that can be used in a participatory manner.



राष्ट्रीय ग्रामीण आरोग्य अभियान
आपल्या गावातील आरोग्य सेवांचे प्रगतीपत्रक
चला आपण एकत्र येऊ, आपल्या आरोग्य सेवांवर देखरेख ठेवू!

गावाचे नाव- दिनांक-

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१) एम.पी. डब्लू. (मलेरिया डॉक्टर) यांच्याकडून मिळणाऱ्या सेवा			
२) ए. एन. एम. (नर्सबाई) यांच्याकडून मिळणाऱ्या सेवा			
३) माता मृत्यू / बाल मृत्यू			
४) गावासाठी मिळणारा (१०,००० रु.) निधी			
५) माता आरोग्य- अ. गरोदरपणात मिळणाऱ्या सेवा			
ब. बाळंतपणात मिळणाऱ्या सेवा			
६) बाल आरोग्य- अ. लसीकरण			
ब. अंगणवाडीत मिळणाऱ्या सेवा			
७) बाळंतपणानंतर मिळणाऱ्या सेवा व जननी सुरक्षा योजना			
८) सरकारी आरोग्य केंद्रात आलेले अनुभव अ. आरोग्य केंद्रात मिळणाऱ्या सेवा			
ब. आरोग्य केंद्रात मिळणारी वागणूक			

आपल्या गावात आरोग्य, पोषण, पाणी पुरवठा स्वच्छता समितीची मदत घेऊ,
आपण सगळे मिळून गावाच्या आरोग्याची परिस्थिती सुधारू!

Public Hearings

Nearly 200 public hearings have been conducted across five districts till March 2012 at various levels such as PHCs, blocks, districts. These hearings are attended by large numbers of local community members, people's organisations, NGOs, government officials and prominent persons from the region. In public hearings, community members report their experiences of health services and denial of care, as well as findings included in the health report cards. The authorities present are then expected to respond to these testimonies, stating how the problems will be addressed.

For all the public hearings dates were decided well in advance, so that enough time is available to collect necessary evidence and testimonies. Initially the medical officers did feel offended and some even opposed it, however, soon they realized its long term significance. It can be inferred that public hearings have been well established as a medium of community monitoring in these five districts.

Public Dialogues

In the first phase of the CBMP process, during public hearings mostly problem areas were highlighted, and some medical officers and health workers were not satisfied with the process. The origin of problems sometimes lies in policy level issues, and medical functionaries at lower levels cannot do much about such issues. Rather they themselves are unable to work properly because of inadequate resources and infrastructure. Realizing these systemic constraints, now 'Public Dialogue' has evolved as a medium to deepen communication with health service providers, especially to understand their problems and policy matters impinging on the implementation process.

Through the medium of Public Dialogues, community members engage in a discussion with the service providers about ways to address various problems and implement changes. This approach promotes assertive yet constructive dialogue, instead of just confrontation without outcome.

Village Health Awareness Day

The concept of 'Village Health Awareness Day' emerged from an experiment in Thane district. All villagers got together on a specific day in these villages. Village level health service providers, i.e. ANM and MPW were also invited to explain their roles and responsibilities to people. Then people would present key health problems in the village, followed by a discussion over possible solutions and planning for its execution, where people proposed decisions. The day used to start with *shramdan* (collective voluntary work) such as cleaning public spaces and drains in village. It was realized that this event brought people closer to service providers and they all worked together for improving the health conditions in the village.

People in Murbad block further improvised this concept and called all villagers together in the *Anganwadi* Center on a specific day. People checked the Anganwadi register, verified weight records of children by actually weighing them, assessed the number of women, adolescent girls and children getting nutritious diet from the center. This public assessment brought in transparency and underlined the significance of these services. People's awareness about local health services has increased through such programmes, according to the local activists.

Involvement of Media

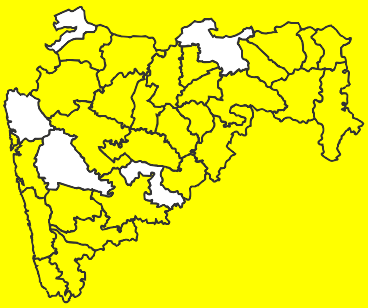
Journalists primarily rely on information that becomes available to them, and are always in search of newer sources for this purpose. Their quest for information brought them closer to the committees and organisations involved in CBMP process, who were able to share facts and ground realities with them. This was helpful in getting media coverage regarding health issues. Issues like poor medicine availability in public health facilities and inadequacies in providing health services at local level were taken up by the media, and it helped solving the issues to a significant extent. Both the print and television media helped to give visibility to these problems and stressed their importance.

We have also started a quarterly newsletter '*Dawandi*', which means proclamation or public announcement. This is perhaps the only state level newsletter in the country which is devoted to CBMP processes. The newsletter presents various problems related to health system, while also giving adequate acknowledgment to positive efforts by persons in the system. Thus the newsletter is now read and recognized by common people as well as health functionaries. Interestingly, this newsletter is much in demand in districts even beyond the CBMP districts, especially by the health functionaries. *Dawandi* has attained popularity among health activists and health workers in just a few years of publication.

Other awareness materials on Health rights include wall posters, booklets, poster exhibitions and audio-visual presentations; all of these contribute to building understanding and preparedness of participants for the CBMP process.

Districts chosen in the first phase for initiating the process of community based monitoring and planning of Health Services …

Thane, Nandurbar, Amaravati, Osmanabad and Pune

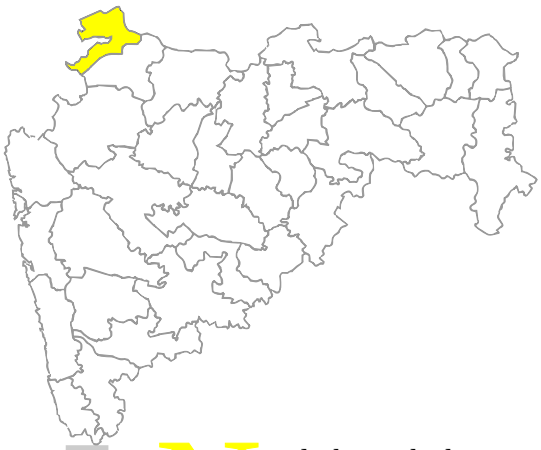


What has been happening in these five districts?

These five districts have distinct background characteristics. Some are predominantly tribal, some have rural areas with minimal tribal population. Each district has a unique geographical and social constitution. Yet similar processes were organised in all the five, with a common goal of improving Health Services.

The perspectives varied between districts but outcomes were similar :

'With peoples action, Health services are beginning to improve, slowly but surely.'



Nandurbar district

Process of Community Based Monitoring and Planning of Health Services

These changes are invaluable …

Nandurbar, which is a predominantly adivasi district, fares poorly on all human development indices. Majority of adivasis are marginal farmers and laborers, due to poverty they would prefer public health facilities. However, misconceptions about the government health services and the inadequacies in government health facilities are widely prevalent, therefore people turn to 'quack' doctors who have proliferated in this area.

Most people live in remote hilly areas and need to walk upto 10 kilometers to reach a main road. Does the health system reach out to such people? The public health staff also works in adverse conditions, but they are so overwhelmed with 'targets' imposed from above that they hardly make efforts required to reach out to people.

However, a change process has begun due to implementation of CBMP. To begin with people were skeptical about this process. I remember, people hardly shared any complaints when the report cards were filled for the first time in villages. Later, based on compiled information, we organised a public hearing. Gradually people realized that their real experiences are actually discussed in public meetings, and problems are getting addressed. This process encouraged them and made them examine health services carefully. Therefore, as compared to the first time, there were more negative remarks in the second round of filling cards since people were now more vocal about their health related problems.

Although people became aware, the local association of doctors took this as an initiative to find fault with them. Basically they did not like the idea of people questioning them and making them answerable. However, our aim to improve health services was clear and we persisted. Gradually the misunderstanding among the doctors also got cleared. So much so that Dr. Dani, MO in Shahana PHC, strongly urged us to initiate the CBMP process in his work area.

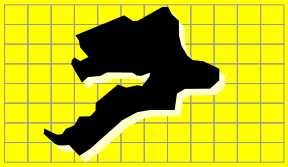
CBMP has led to several changes. Pimprani, Chirde, Langdi, Ghotali are some of the most remote villages in our areas. Earlier they were even deprived of immunization services. Now not only regular immunization sessions are organised, but the vacant posts are also filled. Practice of 'quack' doctors and some private practitioners was in full swing in villages like Rampur, Kansai, Kudawad, Chandsaili and Vadgaon. But

Ranjana Kanhere,
Janarth Adivasi Vikas Sanstha,
District Nodal Organisation,
Nandurbar

now villagers in these areas have become aware about public health services and prefer to use them. As a result private and 'quack' doctors are running out of business. Dr. Rajesh Patil is a very active Medical Officer in Kusumwada, one of the PHCs involved in the CBMP process. The OPD turnout in 2008 was around 900 per month, which is higher compared to other centers, the credit goes to Dr. Patil. With CBMP the attendance almost doubled to become 1300 – 1800 per month by 2010, with people turning more to the public health system. A competent MO backed by watchful and aware people led to increased utilization of the facility.

When we earlier checked the number of patients given referral services in Wagharde and Kusumwada PHCs, the numbers were 34 and 21 respectively. Since the issue of people paying out of pocket for transportation was taken up in the CBMP process, the number of people receiving referral services has increased. We observed that now on an average 100 patients get referral services from a PHC annually. Earlier patients had to spend Rs. 600-900 towards fuel cost of the vehicle in case they get a referral service. Now RKS funds are made available for this. If we assume a modest figure of 100 referrals per year in these PHCs, people have saved upon expenses of Rs. 60,000 to 90,000 in a year towards required transportation. This is quite significant. Overall, we are convinced about continuing to pursue this process of change which is indeed, invaluable.

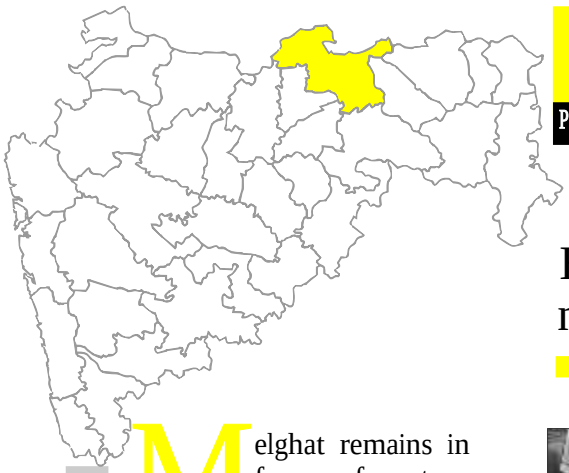
Scope of CBMP in Nandurbar district



- Blocks : 4 blocks -Akkalkuva, Taloda, Shahada, Dhadgoan
- Villages : Total 90 villages
- Primary Health Centers : 18 PHCs (Telkhedi, Mandavi, Son, Aadgoan, Padalda, Sulwada, Somval, Valheri, Pratappur, Moramba, Horaphali, Khapar, Bilgoan, Chulwad, Roshmal, Kusumwada, Shahana, Wagharde)

Some Significant changes

- Medicine stock in public facilities is now displayed on the board. Therefore everybody has access to the information about availability and quantities of medicines at a given point of time.
- As a special case, land was allotted to Ohava PHC and construction has started.
- Patients now get all medicines from the health facility itself. Out of stock medicines are purchased from RKS funds.
- Benefits of *Janani Suraksha Yojana* are now regularly distributed among the genuine beneficiaries.
- Behavior of the PHC staff towards patients has improved considerably.
- Regular village level services by ANM and MPW has started and coverage of immunisation has increased.
- Previously non-functional Bijari sub center in Dhadgaon block became functional after the pressure exerted though community based monitoring.



Amaravati district

Process of Community Based Monitoring and Planning of Health Services

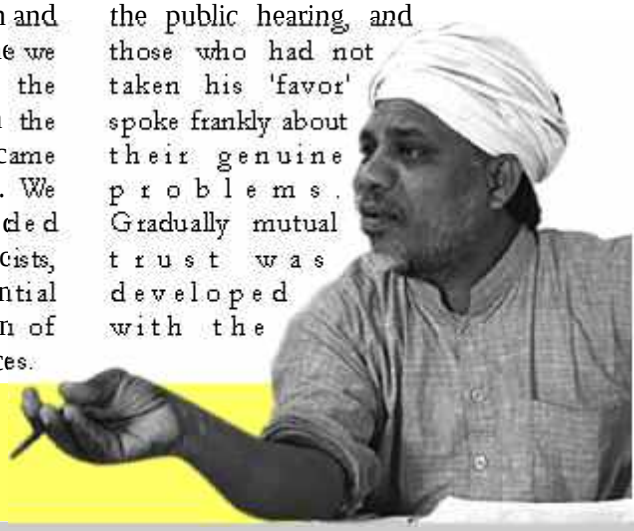
Health Services are no longer dysfunctional!

Melghat remains in focus for two reasons; one is the Melghat Tiger Reserve, the other is the serious problem of malnutrition and child mortality in this area. Melghat is a cluster of over 320 villages, situated on the border of Maharashtra and Madhya Pradesh which is predominantly populated by Korku adivasis.

Ever since the Tiger Project started in 1972, people in the area are on the verge of being displaced. Living with this insecurity, they are neither displaced nor rehabilitated, which has become an excuse for the administration to not develop basic infrastructure. People are asked, 'Why do you need amenities when you are going to be displaced anyway?' Tar roads are not constructed as tiger foot prints won't be traceable on these roads, hence local people have to bear with rough roads. It is very difficult to take a pregnant woman to hospital for delivery in timely manner, the roads are so bumpy that she might deliver on the way. Given this context, health workers used to complain that 'people don't use public health facilities', hence they used to close down the health facilities by noon. The CBMP process started with this kind of background.

This process has enhanced our own understanding. Earlier, in order to improve health services, we used to demand appointing a pediatrician and obstetrician. At that time we were 'outsiders' for the system. However, with the CBMP process, we became involved in the system. We now also demanded appointment of pharmacists, availability of essential medicines and provision of ANMs and their services. As we understood the situation comprehensively, our demands became specific.

Initially we faced opposition by certain health service providers. Prior to one public hearing, the MPW feared that people would speak against him, so he tried to lure a few people by offering them alcohol. But many more people gathered for the public hearing, and those who had not taken his 'favor' spoke frankly about their genuine problems. Gradually mutual trust was developed with the



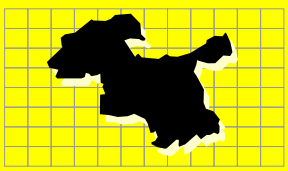
- Bandya Sane
Khoj,
District Nodal
Organisation, Amaravati

service providers.

Government employees are usually reluctant to work in this area and want an immediate transfer. In fact, public health workers complained to us about the District health officer demanding money for transfers. We submitted this information to higher authorities. Investigation was done by the anti-corruption squad, but it was all 'managed' and no action was taken. We raised this problem again in the State level hearing, which created necessary pressure that finally resulted in transfer of that corrupt official. In this process, a relationship of trust has been built between local health workers, the social organisation and community members. People have become vocal about their problems, utilization of public services has increased and problems that could be addressed locally got solved.

But policy level issues persist. Medical officers shirk their duties and take another posting by paying rupees 5-6 lakh. The post of the Medical Officer is often only filled temporarily for 11 months. Nevertheless, some positive changes are evident in health facilities, for example they do not close down at noon, some provider is present 24x7. People visiting the health facility at any point of time do not go back without treatment. At least the health centers are now open and are willing to function round the clock. ●

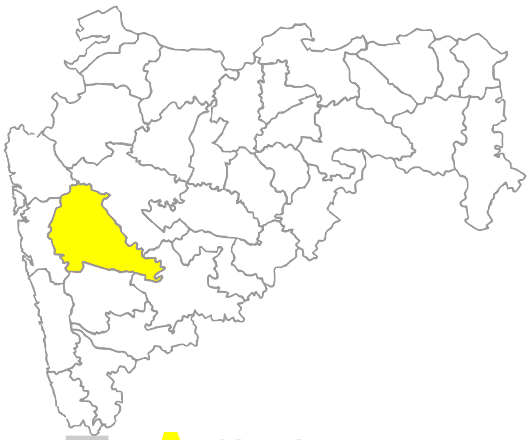
Scope of CBMP in Amaravati district



- Blocks : 5 blocks - Dharni, Chikhaldara, Achalpur, Chandurbajar, Anjangoan
- Villages : Total 90 villages
- Primary Health Centers : 18 PHCs (Dhulghat-Railway, Harisal, Sadrawadi, Bijudhavadi, Kalamkhar, Bairagad, Salona, Tebrusonda, Semadoh, Patrot, Yesurna, Dhamngoan-gadhi, Brahmanwada Thadi, Asegoan Purna, Karasgoan, Kokarda, Sategoan, Kapus Talani)

Some Significant changes

- The nonfunctional Sub Center falling under Bihali PHC became active after the public hearing.
- Dhamangaon-gadhi PHC got an ambulance.
- The residential ANMs in Gaurkheda, Kumbhi and Malhar Sub-Centers began staying at the centers.
- Hot water facility was started in Dhamngoan-gadhi and Patrot PHCs.
- Health Rights Charter was displayed in a prominent place in Gaurkheda, Kumbhi and Malhar Subcenters.
- The number of institutional deliveries went up significantly in Achalpur block.
- As a special case, a doctor was appointed sometime ago at Sindhi Subcenter that covers around 7000 population. However, people did not benefit since the doctor was irregular and supply of medicines was inadequate. Now, as a result of community based monitoring, the medical officer joins duty in time and people get required treatment.
- As JSY incentive women used to receive only Rs. 500, but now they receive the complete amount of Rs. 700.
- Patients are no longer asked to buy medicines from outside.
- Mobile units in Harisal PHC and Nimdari Subcenter have started because of people's initiative.
- Process of birth and death registration got regularized in Sadrawadi village after proper coordination among ANM, MPW, ICDS worker and ASHA was established.
- Behavior of the staff to the patients has improved considerably in Dhulghat Railway PHC in Dharni block.
- The Community Monitoring and Planning Committee members in Dharni Block organised a meeting of private vehicle drivers and made them aware about their important role in making health services accessible for people. Now a ready list of drivers is available and patients are able to get a referral on time.



Pune district

Cooperation and dialogue make it possible to achieve our goals

Although Pune is one of the developed districts of the state, it has many remote adivasi hamlets and villages that are far from the glare of development. Majority of the rural population are compelled to use private health services, although they cannot afford them, because the public health services are not working properly. Due to lack of facilities, the health workers also are also not enthusiastic about fulfilling their duties. In this context, it was challenging to convince people about their right to health care. It took some time to make them realize the need to use public services and to improve them through community monitoring.

Initially, elected Panchayat representatives were not cooperative and government functionaries found this process to be insulting. One of the health officials remarked, "How can the illiterate villagers do monitoring, when even college graduate clerks are unable to write properly?" Some found the term 'monitoring' objectionable. However, the real purpose is to ensure services, which is certainly people's prerogative as they are the end users. If the people are not getting services they are entitled to get, they have a right to know its reasons from the concerned officers. When we explained the concept of CBMP to service providers, they understood its significance and have gradually accepted the process.

We have several positive stories to share. In some villages the ANMs now plan their village visits with the help of villagers and according to people's convenience. An ANM in Pariche PHC openly appreciates initiative of the Village health committee: "Since they informed me about diarrhea patients, early intervention became possible." The ANM in Velhe PHC did not have a proper toilet unit and faced difficulties, particularly in monsoon. When the problem was presented before the BDO through the CBMP process, it was constructed within 6 months.

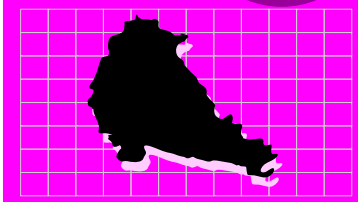
The CBMP process got a real boost after the first District level public hearing. The issue of patients being asked to buy medicines from outside was discussed in this public hearing, and as a result this practice was stopped. In one village the newly constructed Sub-center was awaiting formal inauguration by the local leader, which now became functional due to people's demand. The CBMP process has enabled people to speak about their problems before concerned officers, and to fearlessly present testimonies of malpractices or denial of health care in public system.

Our consistent efforts led to an enquiry of health facility staff in Rural Hospital in Saswad by an independent committee. The problem of water scarcity in Rural Hospital at Velhe was solved. As problems were resolved, it

Dr. Hemlata Pisal
District Coordinator,
MASUM, Pune

led to increased participation by not only the community but also by the Panchyat Samiti members. The PHC at Belsar was running in a small hired place since several years. With CBMP, the newly elected Sarpanch Nilesh Jagtap followed up the long awaited proposal for construction of PHC building, and got it sanctioned. Regarding space for Sarola Subcenter, the Sarpanch announced in the Village health committee meeting to give his own plot for construction. The Grampanchayat at Nhavi decided to set up a solar lamp at the Sub-center. Due to efforts by Sambhaji Holkar, chairperson of the Health Committee of the Zilla Parishad and Dr. Sangde, funds became available for repairing of Subcenters in Bhatti, Kuran Khurd and Kodapur. A boat-based health unit facility was made available to Bhutonde Subcenter in Jogwadi. Zilla Parishad member Bhausaheb Devade assured in one of the public hearings that a 'suggestion box' will be placed in Aptale and Inglun PHCs in Junnar. People then demanded in the district level public hearing to have such a box in all PHCs.

The sense of mutual cooperation among the villagers, elected representatives and public service providers has been enhanced and can be claimed as the major achievement of the CBMP process. ●



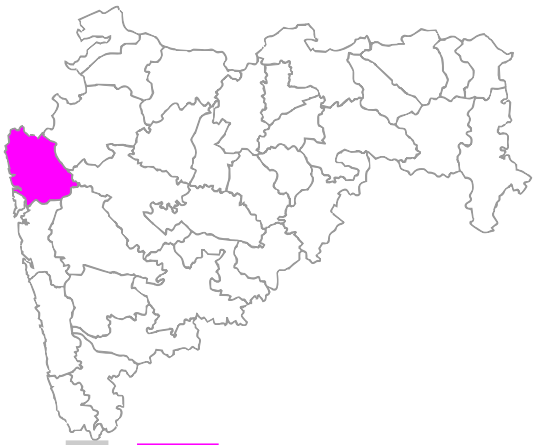
Scope of CBMP in Pune district

- Blocks : 5 blocks -Velhe, Purandar, Daund, Bhor, Junnar
- Villages: Total 75 villages
- Primary Health Centers: 15 PHCs

(Velhe, Panshet, Pasli, Malshiras, Belsar, Parinche, Kedgoan, Nandgoan, Varvand, Bhogvali, Nasrapur, Jogwadi, Aaptale, Yenere, Inglun)

Some Significant changes

- OPD attendance in several PHCs has increased and has even doubled.
- Health Rights Charter is now displayed at all facilities.
- Information boards about referral services are displayed in all facilities.
- Behavior of the staff has considerably improved in many centers.
- Vacant posts of ANMs and MPWs are now filled up in many places.
- Considerable improvement in availability of medicines.
- Mahur (Parinche-Purandar) Subcenter became functional.
- Under Panshet unit, construction has been started for Ruley Subcenter.
- Patients in Malshiras PHC are no longer given prescriptions to buy medicines from outside.
- RKS funds were sanctioned for Panshet unit in Velhe block.



Thane district

People have stepped forward, now is the turn of the Health System...

Thane is an adivasi dominant district situated close to Mumbai and its suburbs. The district has hilly and forest areas with many remote tribal hamlets. The population is quite scattered in areas like Mokhada, Dahanu, Palghar, Shahapur and Murbad, while it is dense in parts close to urban areas. Major inequity is apparent across the district and the health system also reflects this disparity. Private health services are available in urban areas and poor people there at least have some access to health services by less qualified doctors, compared to their rural counterparts. Villagers have no option except 'quack' doctors since the public health system is weak and often inaccessible. In fact, they need the public services the most, but these are often not within easy reach due to lack of proper roads and transportation. Therefore the health system should reach people through an efficient network of outreach workers. Prior to initiation of CBMP process, the outreach services were quite irregular. Health workers were not willing much to reach out to remote hamlets and villages. Being part of a lackadaisical system, they cannot be blamed entirely for poor service delivery. They had no sense of accountability since people were indifferent and hardly aware of their right to health care and there was no public demand for improving public health services.

Some blocks in Thane district are Scheduled tribe areas which get special funds for health and other services from Tribal Development Department, but these benefits do not reach people. In fact, there are special allowances by the government for health staff working in tribal areas and there are additional resources and provisions like special health squads for remote areas. But not much actually reaches people at ground level. Under such circumstances we initiated CBMP and informed people about their entitlements, in particular guaranteed services, outreach services and provision of funds. We shared focused and specific information that they could benefit from.

Earlier people were aware of the ANM's visits: that she visits occasionally at the Sarpanch's place, spends some time in ICDS center; that's all they knew. Through our information sharing they realized what is she actually supposed to be doing during visits, services expected of her, ANC check up and its significance. Now people became more precise in their communication with ANM and other providers, and after people began to interact, the ANM became responsive and particular about her work and records. For instance, she

Indavi Tulpule
Van Niketan
(Shramik Mukti Sanghtana),
District Nodal
Organisation, Thane

started carrying ANC cards and maintained records of weight and other check ups. Sometimes the communication turned into confrontations. Health functionaries complained that people are making unnecessary allegations against them. However, all their claims were proved wrong when the records were assessed as part of the community monitoring process. For instance, health records showed all pregnant women having the same hemoglobin count and BP, which is practically impossible. People raised questions on the basis of such issues identified by them.

After people realized the importance of services given by the health workers, many questions were raised. For example, in a public hearing it was asked that if MPW posts are vacant in many villages, the existing workers would have extra workload. In this case, how would they be able to provide all the services? Moreover, people realized the importance of health services like ANC check-up and its importance in ensuring a safe delivery and healthy baby. Once people related the significance of health services to their own lives, they began to access services more often and demand for services increased.

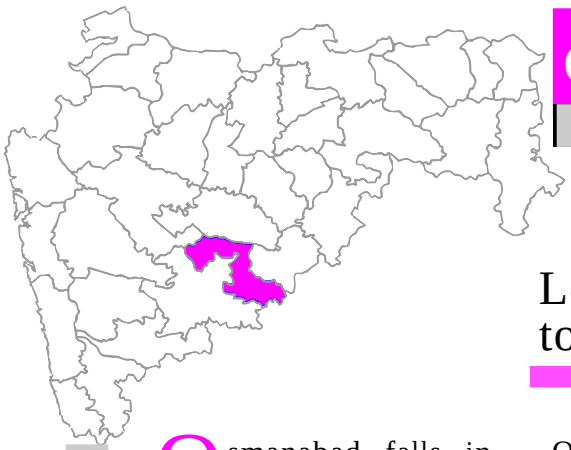
Now community members and service providers are working together to strengthen the health system. Changes are evident locally, but structural problems persist at the higher levels despite repeated follow up. Finally, I would like to note that while people in Thane district now have CBMP as a tool to improve health services, this process should be expanded to other areas of the state, which would certainly make its impact felt more strongly. ●

Some Significant changes

- Now medical officers and staff do not charge for injections.
- Patients are no longer prescribed to buy medicines from outside.
- Behavior of health facility staff towards patients has generally improved.
- Village health fund is used for all health needs, which was earlier spent only on ICDS center
- Now weight records of malnourished children in Murbad block are not manipulated, underreporting of malnutrition has been checked.
- OPD attendance has increased in all health facilities where community monitoring is being implemented.
- Frequency and regularity of village visits by ANMs and MPWs has increased considerably.
- Institutional deliveries have increased in all health facilities where community monitoring is being implemented.

Scope of CBMP in Thane district

- Blocks : 4 Blocks – Dahanu, Murbad, Shahapur, Mokhada
- Villages : Total 60 villages
- Primary Health Centers : 12 PHCs (Dhundalwadi, Saivan, Ganjad, Dhasai, Shiroshi, Dolkhamb, Vashind, Takipathar, Khodala, Vashala, Aase)



Osmanabad district

Local Solutions to Universal Problems

Osmanabad falls in Marathwada region which is one of the more backward regions of Maharashtra; feudal traditions and caste hierarchies remain strong here. Due to traditional cultural practices and gender discrimination, proportion of atrocities against women is also disturbingly high.

As often experienced, efficiency of the government system depends on the leadership. The system works well when there are sensitive, efficient officers at the helm, and it collapses to its prior lethargic mode when the concerned officer is transferred.

When CBMP commenced, the Osmanabad district administration was headed by a competent and active officer, hence response of the health system was somewhat positive, even though there were many gaps and problems. Later the officer was transferred and party leadership within Zilla Parishad also changed, which adversely impacted the spirit and situation in the health system.

We used to encounter several problems. ANMs and MPWs did not stay at the Sub center. Village visits by medical officers remained on paper. In PHCs patients were asked to buy medicines from outside. Women who went to Naldurg PHC for delivery were unnecessary referred to other facilities, falsely informing that there is high risk. JSY incentives were delayed without due reasons in Salgara PHC. In one instance the MO regularly came on duty heavily drunk.

As part of the CBMP process, we highlighted all these problems with evidence and testimonies, in public hearings. We also addressed problems at respective PHC levels, however initially we did not get desired response. Public hearings and village meetings helped in increasing awareness among people. Media follow up helped to create necessary pressure. As a result additional MOs were appointed in three PHCs – Andur, Salgara and Naldurg. Itkal Sub center was earlier not equipped to handle

Changes are evident at all levels

Dr. Smita Shahapurkar
President, Lokpratishthan,
Co-Coordinator,
Osmanabad

We are seeing concrete changes due to the CBMP process.

Village committee members are now aware about utilization of the village untied fund. Earlier it was used to buy furniture, or for repairing the Anganwadi center. However, now it is rightly utilized for health related activities, such as referral for poor pregnant women or maintenance of

Some Significant changes

- Number of village visits by ANMs and MPWs have increased in Kalamb and Osmanabad blocks.
- Appointment of only one medical officer in Ter Rural Hospital was a cause of concern among people and they raised this issue in public hearing. As a result a second doctor has been appointed resulting in increase in IPD admissions.
- List of PHC Monitoring and Planning Committee members is displayed in all PHCs.
- Health Rights Charter has been displayed in prominent areas of PHCs, as was decided by PHC level committees

Scope of CBMP in Osmanabad district

- Blocks: 3 blocks – Osmanabad, Tulajapur, Kalamb
- Villages: Total 125 villages
- Primary Health Centers: 9 PHCs (Jagji, Yedshi, Pohner, Anadur, Naldurg, Salgara, Moha, Shiradhon, Itkur)

normal deliveries; the relatives had to carry lantern, water and bedding with them while admitting their patient there. After people pointed out this problem through community monitoring, all these necessary provisions were made. Residential quarters for ANMs were in awful condition in Umaraga (Chiwari), Shahapur and Keshegoan Subcenters, which have now been repaired. Due to public pressure, unnecessary referrals and prescribing medicines for purchase have almost stopped. Ambulances in all three PHCs have been repaired and are now in use.

72 Bharat Vaidyas (village health workers) of HALO foundation are actively involved in the CBMP process. Our village level health activists have also become part of village health committees and have a say in the committee's functioning. We hope, in future CBMP would certainly contribute to make further substantial changes in the health system in Tuljapur. ●

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borewell. Awareness programmes are now being organised on the Village Health Day. In Vadgaon village in Kalamb block, the Health committee organised a hemoglobin check up camp for 230 women on the Village health day. Frequency of visits by ANMs and MPWs has increased and Health committee members have started monitoring quality of food distributed by Anganwadis.

The problem of water scarcity in some Sub-centers was resolved by respective Gram Panchayats, by making water facility available. The Block health officer set up solar lights in Hasegoan Sub-center after follow up by the committee members. The ambulance in Shirdhon PHC was not being used since one year because of want of new tyres. After presenting this problem in a public hearing, the District health officer immediately sanctioned necessary funds and the vehicle is now functional. Most vacant posts in PHCs have been filled as a result of people's pressure in Yedshi, Jagji, Pohner in Osmanabad block and Shirdhon, Moha, Itkur in Kalamb block.

The severe shortage of medicine supply in Rural Hospital has been rectified after the committee members pointed out the problem. A committee member took photographs of the unhygienic condition of Ter Rural Hospital and cleanliness improved after these were shown to the Civil Surgeon. ●

The emerging process of Community Based Planning

In continuation of the process of Community based monitoring, to help tackle various local and facility level issues, promotion of decentralized community based planning of health services has been initiated in 5 districts since 2011. It was observed that Hospital development committees (Rogi Kalyan Samitis - RKS) were formed for various health centers, however most of the members were not aware of their responsibilities and functions, or about their expected role in deciding about utilization of flexible funds related to NRHM. Owing to lack of guidance, even the doctors and staff in the health center were often found to be ill equipped for proper management of these flexible and untied funds. In this context, workshops for Monitoring and Planning Committee members including Panchayat representatives as well as RKS members on community based planning were organised at various levels. Frontline health staff, such as ANMs and MPWs, were also involved in such workshops. Guidelines, a poster and a booklet were widely circulated on how flexible funds should be used for genuine patient welfare (Rogi Kalyan). Broad based workshops and meetings were organised to formulate proposals based on issues identified in the CBMP process, for inclusion in the annual block and district level PIPs (Project Implementation Plans). This has led to a greater level of awareness among various stakeholders and receptivity of officials towards addressing issues emerging from community based monitoring, and taking up suggestions given by CBMP committee members, exemplified by Nasarapur PHC.

From 'official based planning' to 'community based planning' in Nasarapur PHC

In Nasarapur PHC in Bhor block of Pune district, NRHM flexible funds were being used even without getting sanction by the RKS committee. RKS members revealed that no committee meeting had been called so far, and doctors themselves were taking all the decisions on utilization of funds. Following CBMP orientation programmes Shivaji Konde, President RKS, spoke to doctors and insisted for regular convening of planning meetings by the RKS and circulation of decisions of each meeting to all members. Civil society representatives of the Block Monitoring and Planning committee were invited for the first time to the RKS committee meeting on 12th December 2011 where they actively participated and made several proposals, which led to the RKS committee taking a number of positive decisions for improving the PHC. As a result of these decisions, within a few months the following changes have taken place:

- *There was no board displaying the name of the PHC and it was difficult for any new patient to find the facility which is located in an old building. Now through RKS funds a board has been prepared and put up in a prominent location.*
- *There was a serious problem of water which was pointed out. Now four water tanks have been installed, to provide drinking water as well as to other parts of the PHC.*
- *The toilets were non functional and cluttered with materials, due to lack of water. Now these have been cleaned up and have become functional.*
- *In order to make the laboratory more functional, a tank for water storage was purchased, a cupboard and new pipe line for laboratory was installed, making the lab fully functional.*
- *The post of sanitation worker is vacant in Nasarapur PHC, leading to lack of cleanliness. So the RKS has appointed a worker on contract basis which has led to regular cleaning of the PHC premises.*
- *A workshop on role of adolescents in the development of village health was conducted for school children from two villages through the RKS fund.*

Another similar incident is from Velha Rural Hospital (RH), where the RKS members, which included the BDO, Tehsildar and Private doctors, had never been called for meetings. The CBMP nodal civil society organisation called a meeting, inviting all RKS members as well as elected representatives like Chairperson and Deputy Chairperson of the Panchayat Samiti to discuss the need for effective planning. It was reported that almost 60% funds for the financial year 2011-12 remained unutilized although ten months had already passed. After learning about this, the RKS members listed down key problem areas and needs in the RH. After taking a round of the hospital they prioritized feasible action areas, such as setting up an independent room to stock medicines, appointment of staff, strengthening ambulance service etc. They also asked to include certain proposals in next year's PIP and asked the Block Medical Officer to do

the follow up.

Similar experiences are now being reported from several CBMP areas. Thus, it is becoming evident that through the CBMP process, information generated through community monitoring is now being contributed to enhance popular participation in the local health planning process. Through this process, the health system is also realizing that ordinary people can come up with relevant innovative ideas to improve the health system.