Does Community Monitoring Improve Delivery of Maternal Health Services?

Examining the Role of VHSC in Mayurbhanj District, Orissa

10 CHAPTER

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INTRODUCTION

Community-based monitoring (CBM) is a form of public oversight, ideally driven by local information needs and community values, to increase the accountability and quality of social services. Within the CBM framework, members of a community affected by a social programme generate demands, suggestions, critiques and data that they then feed back to the organization implementing the programme or managing the environmental change. CBM aims not only to generate the appropriate information for high quality service delivery but also seeks to strengthen local decision-making, public education, community capacity and effective public participation in local government. Ultimately, CBM is a tool to facilitate more inclusive decision-making on issues deemed important to members of a community with respect to public service delivery.[1]

Community Monitoring has been included as an accountability mechanism in the Indian government's National Rural Health Mission (NRHM) launched in 2005, to ensure that

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the services reach those for whom they are meant, especially for those residing in rural areas, the poor, women and children.[2] The whole framework of Community Monitoring aims at placing various groups such as community members and beneficiaries, community-based organizations and NGOs working with communities, along with panchayat representatives, at the centre-stage, allowing them to actively and regularly monitor the progress of NRHM interventions in their areas. Community monitoring is also seen as an important aspect of promoting community-led action in the NRHM and Village Health and Sanitation Committees (VHSCs) are one such tool to monitor health services at the village level. Separate committees are constructed to monitor public health services at the Primary Health Centre (PHC), block and district levels. VHSCs meet to monitor and plan public health services at the village level. It is assumed such feedback from direct users will lead to improved accountability, increased utilization of services and ultimately affect health outcomes.

VHSCs are composed of (a) members of local government (Gram Panchayat), (b) community health workers (Accredited Social Health Activists orASHAs) (c) outreach functionaries of the public health system (Auxiliary Nurse Midwives (ANMs), Multi-Purpose Workers (MPWs) and preschool/nutrition workers (Anganwadi workers)) and (d) representatives from community groups. In certain places, NGOs have been given responsibility to form the VHSCs. According to the NRHM guidelines, there is also provision of untied grants up to Rs.10,000 per year for the VHSC for use by the committee for household surveys, health camps, sanitation drives, revolving funds etc. The role of the VHSC is to create awareness about essentials of health programmes with focus on people's knowledge of entitlements to enable their involvement in the monitoring and to develop a village health plan based on the village situation and priorities identified by the community. It is also responsible for maintenance of village

health register and ensuring that the ANM/MPW visit the village on the fixed health days (FHD) and perform antenatal and postnatal check up and counselling on supplementary nutrition.

The Context

The Advisory Group on Community Action (AGCA— a standing committee of the NRHM) coordinated the first phase of Community Monitoring in nine States of the country during the period 2007–2009[3]. Community Monitoring was also initiated in Orissa as part of this initiative and Society of Development Action (SODA) was involved in implementing this programme in 15 villages under three PHCs in Bangriposi block in Mayurbhanj district. Training of VHSC members about NRHM-mandated health entitlements and mechanisms were crucial components in empowering VHSCs to their roles within the community monitoring methodology. This study was initiated to understand how the functioning of trained VHSC influences the functioning of the ANMs, and the delivery of MCH services. With regard to MCH services, an ANM is supposed to perform the following tasks: registering pregnancies, providing TT injections, conducting

Table 1: Rural Mayurbhanj: Some Sociodemographic data

Characteristic	%age
Literate population (7+)	62.7
Have access to toilet facility	14.7
Use piped drinking water	2.6
Have a BPL card	62.1
Girls marrying before 18 years	38.4
Use of any contraceptive method	48.6
Mothers with 3ANC in last pregnancy	64.9
Mothers receiving PNC visit within 48 hours of last delivery	95.7
Children (12–-23m) fully immunized	55.3

Source: (from: DLHS 3, 2008-09)

antenatal and postnatal health check up, dispensing iron, folic acid and chloroquin tablets, in addition to providing advice for rest and food and so on during pregnancy. She is also supposed to advise pregnant women about various services available for delivery, Postnatal care and new-born care.

Mayurbhanj district is one of the backward districts of Orissa. Of the 593 districts studied under the District-level Household and Facility survey, Mayurbhanj district ranked 397.[4] According to DLHS – 3 survey, full immunization coverage of children aged 12–23 months, one of the important functions of ANM was found to be between 45 to 60 percent only.[5] Bangriposi block where the study was conducted is one of the tribal blocks in Mayurbhanj district. Sixty-eight percent of the population is tribal. The literacy level is 38 percent only.

The Objective

The objective of the study was to understand whether functioning VHSCs affect or influence service delivery by ANMs especially in the context of maternal health services. The important task in this study was to set criteria for functioning VHSCs, and then compare service delivery for maternal health in villages with a functioning VHSC with those without a functioning VHSC. This would provide a comparison of services provided by ANMs working in villages covered under community monitoring with those that are not covered under community monitoring. In effect, the study was meant to provide an understanding of how community monitoring could possibly affect service delivery.

METHODOLOGY

The study had three discrete components, and used both quantitative and qualitative methods. The first section

comprised selecting the seven villages with functioning VHSCs (intervention arm) and seven comparison villages where VHSCs were not functioning. In the second component, 20 women who had delivered in the last three months from each set of villages were interviewed to obtain information about the services they had utilized during their pregnancy, delivery and post-partum period. In the third part of the study, 14 Fixed Health Days were observed by the study team in each arm of the study (two in each of the cluster of seven villages) to directly note the MCH services being provided in these camps.

Sample selection: There are 96 villages in Bangriposi block, of which 81 didn't have VHSCs at the time of the study and 15 had VHSCs formed and trained as a part of the first phase of the Community Monitoring process. From the villages where there are VHSCs, seven villages were selected using a scale to score the VHSC functioning (See Box 1 for the criteria of VHSC functioning used in this scale). For villages where there are no VHSCs, all

Box 1: Criteria of VHSC Functioning

- The VHSCs, which are already formed and are functioning for at least a period of 3 months.
- Have adequate number of members as per NRHM guideline, i.e., ANM, ASHA/AWW as Convener, PRI member as Secretary, PTA/MTA member, SHG leader, CBO representative and user groups representation.
- Members were sensitized about their roles.
- The VHSC is conducting a meeting of its members at least once in a month.
- The ANM/ASHA/AWW are present in the meeting.
- Have prepared village health register and updating it periodically.

villages having a common ANM with the intervention arm villages were eliminated. In order to reduce chances of contamination, those villages adjoining the intervention villages were also removed. Also those villages having the same health day for health camps were eliminated for logistic purposes. A set of seven villages were then randomly selected from the remaining villages using the lottery method.

After selecting the villages, a list was drawn up of all women who had delivered in the last three months and from among these, two lists of 20 women each were selected randomly from VHSC villages and non-VHSC villages who have delivered in the last three months for interview. So a total of 40 women were interviewed.

For the final component of the study, two consecutive fixed health days were observed by the field researchers in all the 14 villages for noting service delivery through this mechanism.

Data Collection

Three different methods were used for the three different components of the study. In order to score and rank VHSCs, interviews were conducted with mothers, members of VHSCs and ANMs. Verification of VHSC records was also undertaken for scoring the functioning of VHSCs. A 69-point scale covering the different criteria for VHSC functioning was drawn up. The highest score was 41 (59%) and lowest score was 19 (28%) and those selected for the study had scores in the range 33–41.

In-depth interviews were conducted with the forty women from the 14 villages using interview guides and checklists. Direct observations with checklists and detailed field notes were used for fixed health day visits. The data was collected by a team comprising the first and second author and five field investigators.

FINDINGS

The findings from interviews are summarized below:

Antenatal Care

> NRHM service guarantee – In order to reduce maternal and child mortality, NRHM standards indicate that all pregnant women should be registered in first trimester by the ANM with support from the ASHA.

The study reveals that in functioning VHSCs where community monitoring has taken place, 70 percent women (14 out of 20) were registered within 12 weeks of pregnancy compared to none in the non-VHSC villages. According to the mothers, it was the AWW who was registering the pregnancies in most of the villages. Further analysis of different types of services that women received during their pregnancy reveals that except for TT injections and IFA tablets, other antenatal care (ANC) services like BP measurement, weight measurement, abdomen check-up, medical advice, VHSC villages were better served than non-VHSC villages (See Table 2). When ANMs from non-VHSC villages were asked about this difference, in most of the cases they said that the BP instrument was out of order. In VHSC villages, 18 women (90%) received advice about common problems during delivery from ANM, and of them 10 were advised

Table 2: Antenatal Services Received

Service Status (n= 20 for each)	VHSC Villages	N- VHSC Villages
No BP exam	0	14
BP exam 3 times	19	3
No Abdomen exam	2	17
Abdomen twice	14	2
Weight taken twice	19	0
IFA 100tabs given	20	20
TT 2	20	20

to seek medical attention during delivery. In comparison, in non-VHSC villages, no woman was given any advice about delivery care by the ANM.

Intranatal Care

The study found that in both types of villages institutional delivery took place among 60 percent women (12 women in each group). The ASHA accompanied the women to the institution in all cases in both sets of villages. As far as ANM attendance during home delivery is concerned, out of the eight women who delivered at home, three women (37.5%) from VHSC villages were attended by the ANM during deliveries, whereas, in the case of non-VHSC villages none of the eight women who delivered at home received any assistance from the ANM.

NRHM service guarantee – NRHM is promoting institutional delivery through the Janani Suraksha Yojana which provides a financial incentive of Rs.1400 to women to deliver in institutions. The ASHA also received performance based incentive of Rs.600 for accompanying the woman to the institution. It also guarantees skilled attendance at home deliveries as and when called for as well as appropriate and prompt referral.

Postnatal care

It was found that in the VHSC villages the ANM had visited 65 percent (13 women) of the women interviewed after delivery whereas, in the non-VHSC villages it was only 20 percent (4 women). While women from VHSC villages reported that they received advice for early breast-feeding, personal hygiene and on diets, on the other hand, none of the women from non-VHSC villages reported receiving any such advice.

NRHM service guarantee – In order to reduce maternal mortality, NRHM guarantees a minimum of two post-partum visits by ANM.

Neonatal Care

With regard to neonatal care, 19 women (95%) from the VHSC villages said that the ANM had advised them about maintenance of temperature of the new born where as in the non-VHSC villages the advice was given to only two women (10%). Only three women (15%) from non-VHSC villages reported receiving advice on exclusive breastfeeding, as against almost all women (95%) from VHSC villages receiving such advice.

NRHM service guarantee – In order to reduce child mortality and morbidity, NRHM guarantees counselling on diet and rest, hygiene, contraception, essential new born care and breast feeding practices.

Regarding immunization, the study reveals that 18 women (90%) from VHSC villages received advice on complete immunization compared to six women (30%) from non-VHSC villages. It was also found that despite ANMs from VHSC villages informing the mothers about the immunization schedule, they themselves were not able to stick to the schedule while administering OPV and DPT vaccines because of lack of supply of vaccines. From VHSC villages, 14 women (70%) reported that their child got BCG within 45 days, as against only two mothers (10%) from non-VHSC villages.

Maternal Health Services Scores

In order to understand the difference in services received by the women in the two sets of villages, each mother was given a score depending upon the number of services she had received. The different services which were included in each score is given in Box 2. Each of the antenatal, intranatal, postnatal and neonatal service score was converted to a ten-point scale in order to facilitate comparison. An average score was computed for each of these service aspects for the women from VHSC and

non-VHSC villages. The difference in average scores between the two groups was found to be 1.4 times for antenatal services, 2.1 times for intranatal services, 20 times for post natal services and 5.6 times for neonatal services.

Box 2: Maternal Health Services Scores

Services included to compute each score

- ANC score – Registration, ANM checkup, Weight check, Blood Pressure check, Abdomen, TT 2, IFA, ANM advice.
- INC score – Institutional Delivery, Delivery advice, ASHA accomp, risk related counselling, ANM advice.
- PNC score – PNC check, Number of checks, ANM counselling, Diet counselling, rest counselling, Hygiene counselling, Contraceptive counselling
- NNC score – Temperature related, breast feeding related counselling and BCG, Polio and DPT vaccine received.

Findings from observations of FHD camps are summarized below:

Attendance of Personnel and Women

From the observations of 28 FHDs in 14 villages, it was found that in both the VHSC and non-VHSC villages the attendance of ANMs, AWWs and ASHAs was universal in all camps. The ICDS supervisor was present in three FHDs in VHSC villages and members from SHG, PRI, or VHSC were present at least for sometime in all the FHDs in VHSC villages. In contrast,

Table 3: Attendance at the 28 FHDs Observed

	VHSC	non VHSC
Children 0–1	200	175
Children 1–5 years	753	707
Pregnant women	101	111
Lactating women	103	106

from non-VHSC villages, neither the ICDS supervisor nor any members from SHG/PRI were present in any of the FHDs. The total attendance of women and children in all the camps is summarized in Table 3. A total of 28 and 39 women received ANC services in VHSC and non-VHSC FHDs respectively, while 30 women from VHSC villages received PNC services compared to 16 from non VHSC villages.

Antenatal, Postnatal and Neonatal Care and Counselling Services

A larger range of services were provided in FHDs held in VHSC villages compared to non-VHSC villages. It was found that most of the women who attended FHDs of VHSC villages received BP examination, weight and abdominal check-ups. Of the 14 FHDs from seven VHSC villages, counselling of pregnant women was done in six FHDs, but it was not done in any of the FHDs from non-VHSC villages. Only with regard to TT injections, IFA and chloroquine tablets, one did not notice much of a difference between the FHDs conducted in the two types of villages. On an average a woman from the VHSC villages received six out of seven types of services available at the FHD compared to the non-VHSC villages where a woman received only three out of these seven services.

In all the 14 FHDs of VHSC villages, women received PNC services, but PNC services were hardly available in FHDs of non-VHSC villages. PNC services observed at VHSC FHD were dietary counselling, rest counselling, hygiene counselling, contraceptive counselling, newborn care counselling, feeding counselling as well as RTI/STI and HIV related counselling. In only one FHD from non-VHSC villages did women receive some information on newborn care and STI/RTIs. For PNC and neonatal counselling, the women from VHSC villages on an average received five out of eight services made available. No such average could be arrived at for non-VHSC women because such services were barely available in non-VHSC villages.

CONCLUSION

The study was conducted in a very small sample of 14 villages in one block, and by the same agency that did the intervention, which is an important limitation of the study. However, at the same time a rigorous selection procedure was used both for the intervention and comparison arm of the study to avoid selection bias. The findings from both sources — interview with women who have undergone delivery as well as the observation of FHDs are consistent, lending additional weight to the conclusions of the study. While no generalization can be attempted about the extent of change that is possible through VHSC training, because the quality and content of VHSC training may differ from place to place, the study findings are significant. The study reveals that the presence of VHSC has had an overwhelmingly positive influence on the delivery and utilization of maternal and child health services provided by ANMs in these villages. Villages without a VHSC hardly received any PNC or neonatal care services. The aspect of counselling was not noticed at all in non-VHSC villages.

The impact of VHSC training that is evident at the village level may be influencing this change in service delivery behaviour of the frontline workers and the concomitant improvement in the utilization of services by women could possibly be happening in the following way.

a) The formation of VHSC in the village and training them about NRHM entitlements and their roles and responsibilities is promoting the presence of SHG, PRI and VHSC members during FHDs.

b) Presence of trained VHSC members is acting as a positive feedback to service providers like ANM, AWW and ASHA and has improved the range of services being provided during the FHDs.

c) Women from villages with trained VHSCs are being encouraged to receive NRHM-mandated services and are

not only coming in greater numbers to FHDs but are also receiving substantially more services — especially, with regard to PNC and neonatal care, an important component for reducing maternal and neonatal mortality.

Based on the experiences of the study, the following recommendations are being made:

- Formation of VHSC should be done soon in other villages.
- There is a need to ensure proper composition of VHSC members, and their training should include a clear articulation of their roles and responsibilities at the community level for promoting community action and involvement in NRHM services. The criteria for selection and training should follow the pattern suggested by the first phase of the community monitoring process.
- VHSC meetings should include the presence of PRI, ANM and SHG members and they should all be present at FHDs and represent the community interests.

The selection and training of VHSCs in this case followed the template developed by the AGCA and which has been subsequently adopted by the Government of India. The states have been recommended that they adapt it to their realities, so such a template is available for use by other states and agencies. It is hoped that the findings from this study gives further fillip to the process of communitization within NRHM and strengthens the role of VHSCs within its overall framework.

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NOTES

1. Adapted from: The Ecological Monitoring and Assessment Network Coordinating Office and the Canadian Nature Federation (2003): "Improving Local Decision-Making through Community Based Monitoring: Toward a Canadian Community Monitoring Network." http://www.ccmn.ca/english/library/ccmn.pdf
2. National Rural Health Mission: "Community based Monitoring of Health services under NRHM," http://www.nrhmcommunityaction.org
3. For further details of the implementation of the first phase please see www.nrhmcommunityaction.org
4. http://www.jsk.gov.in/indices%5Corrisa%5Corrisa_Mayurbhanj.pdf
5. http://www.jsk.gov.in/dlhs3/orissa.pdf