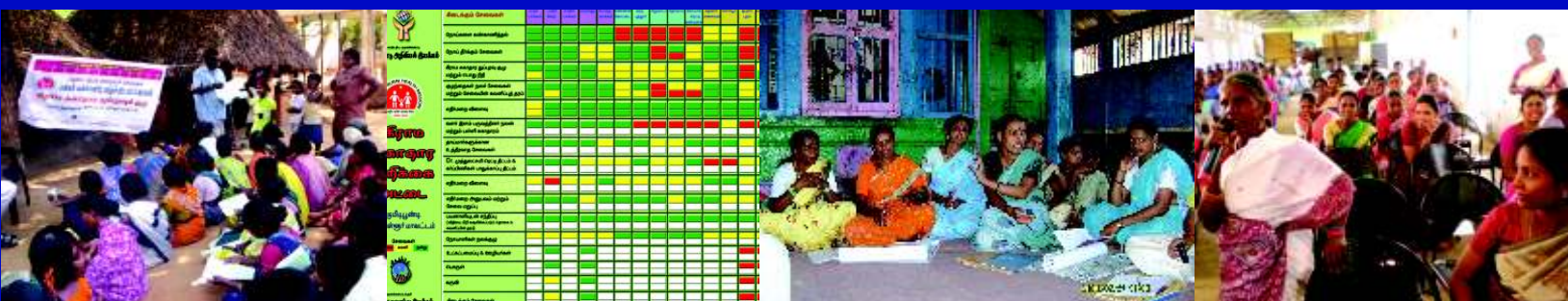


Reviving Hopes Realising Rights



A Report on the First Phase of Community Monitoring under NRHM



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A Report
on
the First Phase of
Community Monitoring under NRHM

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Preface

The first phase of community monitoring implemented across nine states in 2007 draws its basis from the NRHM Framework for Implementation. The nine states selected for the first phase effort were: Assam, Chhatisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu. In each state, three to five districts were selected considering the geographical spread, in each district three blocks, in each block three PHCs and in each PHC five villages were selected. The first round of community monitoring process thus covered over 1600 villages and 300 facilities.

The 18-month process involved capacity building of planning and monitoring committees at different levels for conducting enquiry into the functioning of different components of NRHM and the uptake of key services. It was an empowering process for the community because it provided community representatives' knowledge on different entitlements, service standards and service guarantees provided within the NRHM. It also gave an opportunity to discuss the status of health services delivery with healthcare providers and programme managers.

The process of writing the national report and compiling information from across nine states was a daunting exercise and would not have been possible without due support and guidance from various sources. The detailed process documentation and state reports gave us an insight into the efforts, challenges and lessons learned at the state level. These, and further information provided by the district/state nodal NGOs were the motivation to put together information and findings of the states. The state-level findings may not adequately reflect the intensity of the efforts, as the Section was solely dependent on information provided in reports or what was gathered from direct feedback. It is meant to give a glimpse of the immediate impact of the effort. There are state reports prepared by the state nodal agencies, which capture further details.

This Report consists of three sections. Section One talks about the overall process adopted, including activities undertaken at the National Secretariat level. Section Two draws upon the data and qualitative feedback collated from the states representing state-level findings and changes that took place over a period of time and innovations that each state has done. The Third section is based on the review that was done by an external review team.

We hope this Report will provide a comprehensive overview of the extensive process that was carried out in nine states. This Report, along with the manuals and materials produced under the first phase will be a useful resource for states to scale-up their efforts as also for other states to initiate community monitoring keeping in view the experiences from the first phase.

Acknowledgement

We wish to acknowledge our sincere gratitude for all the support, inputs and feedback that we have received.

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We would like to thank Mr. A R Nanda, Executive Director of Population Foundation of India (PFI) and Convener AGCA, for his excellent guidance and encouragement throughout the process. Without his leadership and inputs this process would not have been possible.

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And finally we would like to express our gratitude to all members of the Advisory Group on Community Action, State Mentoring Committees of concerned states and all state nodal organisations and district and block level NGOs. A special thanks to the citizens of India who were engaged in the process of community monitoring across nine states.

Contents

Preface	
Acknowledgements	
Glossary	
Section I	
Introduction	3
The Process	5
National Level Preparatory Phase	6
State Implementation Phase	8
Material Support	12
Section II	
Findings from the States: Some Immediate Outcomes	17
Maharashtra	17
Rajasthan	22
Jharkhand	24
Orissa	27
Madhya Pradesh	31
Assam	34
Chhattisgarh	36
Tamilnadu	38
Karnataka	43
Section III	
Review of Community Monitoring	49
Review Process	49
Summary of Findings	49
Key Findings on Process	50
Key Findings on Program Management	52
Gain from Community Monitoring	54
Equipped for Scale up - Recommendations	54
Reference	58
Annexures	
List of Material	62
Names of States, Districts and Blocks	64

Glossary

AGCA: Advisory Group on Community Action
 ANM : Auxiliary Nurse Midwife
 ASHA : Accredited Social Health Activist
 AWW : Anganwadi worker

BMO: Block Medical Officer
 BP: Blood Pressure
 BPHC: Block Primary Health Centre
 BPL: Below Poverty Line

CBM: Community Based Monitoring
 CBO: Community Based Organization
 CD: Computer Disc
 CEHAT: Centre for Enquiry into Health and Allied Themes
 CHC: Community Health Centre
 CHSJ: Centre for Health and Social Justice
 CINI: Child in Need Institute
 CM: Community Monitoring
 CMHO: Chief Medical and Health Officer
 CMO: Chief Medical Officer
 CMP: Community Monitoring and Planning
 CRP: Community Resource Person

DH: District Hospital
 DHO: District Health Officer

FLW: Front Line Worker

GoI: Government of India
 GKS: Gaon Kalyan Samiti

JSY: Janani Suraksha Yojana

ICDS: Integrated Child Development Service
 ID: Identity Card

MDGs: Millennium Development Goals
 MO: Medical Officer
 MoHFW: Ministry of Health and Family Welfare
 MPW: Multi Purpose Worker

NFHS: National Family Health Survey
 NGO: Non Government Organisation
 NHP: National Health Plan
 NHSRC: National Health Systems Resource Centre
 NRHM: National Rural Health Mission

OLAMP: Orissa Medical Research and Health Services
 OP: Out Patient
 OPD: Out Patient Department

PFI: Population Foundation of India
 PFI-RRC: Population Foundation of India - Regional Resource Centre
 PHC: Primary Health Centre
 PIP: Program Implementation Plan
 PRA: Participatory Rural Appraisal
 PRI: Panchayati Raj Institution

RCH: Reproductive and Child Health
 RKS: Rogi Kalyan Samiti
 RWSS: Rural Water Supply and Sanitation

SC: Schedule Caste
 SDM: Sub Divisional Magistrate
 ST : Schedule Tribe
 SW: Social Worker

TAG: Technical Advisory Group
 TOT: Training of Trainers

VHC: Village Health Committee
 VHN: Village Health Nurse
 VHND: Village Health and Nutrition Day
 VHSC: Village Health and Sanitation Committee

Section - I

Introduction

The National Rural Health Mission (NRHM) launched on April 12, 2005, aims to bring about significant improvement in healthcare delivery in rural areas of the country and in the health status of the people. The NRHM promises to provide universal access to equitable, affordable and quality healthcare, which is accountable and at the same time responsive to the needs of the people, especially those who are marginalised and live in rural areas.

Key objectives of the Mission are reduction in child and maternal deaths, population stabilisation and gender and demographic balance. The processes set to achieve the objectives of the Mission will help accomplish goals under the National Health Policy (NHP) and the Millennium Development Goals (MDGs).

The NRHM proposes an intensive accountability framework through a three-pronged process of community monitoring, external surveys and stringent internal monitoring. Facility and Household Survey, NFHS and RCH data would act as the baseline for the Mission against which the progress would be measured.

The adoption of a comprehensive framework for community monitoring and planning at various levels under NRHM is an extremely positive development. It can place centre-stage community members and beneficiaries, CBOs and NGOs working with communities and Panchayati Raj Institution (PRI) representatives and allow them to actively and regularly monitor the progress of NRHM interventions in their areas. Besides ensuring accountability, it would also promote decentralised inputs for better planning of health activities based on locally relevant priorities and issues identified by community representatives.

This framework is consistent with the 'Right to Health Care' approach mentioned in the latest NRHM framework document, since it places people at the centre of the process of regularly assessing whether health rights of the community are being fulfilled. It could also be a step towards "Bringing the 'Public' back into Public health" by allowing community members

and their representatives to directly give feedback about the functioning of public health services, including inputs for improved planning of the same.

The Ministry of Health and Family Welfare (MoHFW) has constituted the NRHM Advisory Group on Community Action (AGCA) with the mandate to provide guidance for community action under NRHM. To initiate the process of community monitoring as outlined in the implementation framework, the AGCA recommended the implementation of community monitoring in the states with support from the Government of India (GoI). Based on the AGCA recommendations, the GoI decided to support a first phase green field initiative in community monitoring with active role of AGCA and civil society organisations. A partnership between Health Department, community (CBOs and NGOs) and PRIs is envisaged, to realise the objectives of community monitoring. Community Monitoring, implemented as a first phase in nine states since 2007, draws its basis from the NRHM Framework of Action. Population Foundation of India (PFI) and Centre for Health and Social Justice (CHSJ) were designated the National Secretariat for the first phase effort supported by the MoHFW. The nine states selected for the first phase effort were: Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu. In each state, three to five districts were selected looking at the geographical spread, and three blocks were selected from each district. In each block, three PHCs and in each PHCs, five villages were selected.

Table 1: Geographical Coverage

	Particulars	Number
1	States	9
2	Districts	36
3	Blocks	108
4	PHCs	324
5	Villages	1620
6	VHSC formation	1620

The objectives of the first phase were:

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

To realise these objectives, facilitation by civil society, especially NGOs, has been the key element. The NGOs were to mobilise the community and enable a participatory process of monitoring by involving various stakeholders. The NGOs were also to represent

the community and be their spokesperson with the Health Department, as the communities and PRI members do not have such expertise. This, it was presumed, would help shift the locus of power gradually from the Health Department to the people. It is anticipated that the NGOs would bring in objectivity to the process, which may be missing if the process was anchored by the Health Department. The NGOs were to have three roles in community monitoring:

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

The Community Monitoring Project started in April 2007 and was completed in March 2009. The entire process was divided into three phases - the National Preparatory Phase, the State Preparatory Phase and the Implementation Phase. The documentation of the process was done concurrently and an external review was done in November - December, 2008.

The Process

Implementation Mechanism

The AGCA provided oversight and guidance to the entire process through the National Secretariat (PFI & CHSJ). A state nodal agency was identified for each of the nine states. State nodal agencies identified district and block nodal agencies in the selected districts and blocks.

Planning and Monitoring Committees were to be set up at PHC, block, district and state levels and at the village level, Village Health and Sanitation Committees (VHSC) were to be set up. The process was conceived as a three-way partnership between healthcare providers and managers of the health system, the community (including CBOs and NGOs) and the PRIs. The tiered mechanism of feedback in the monitoring process is illustrated in Figure 1 and 2.

Figure 1: Feedback Mechanism of Different Levels of Committees

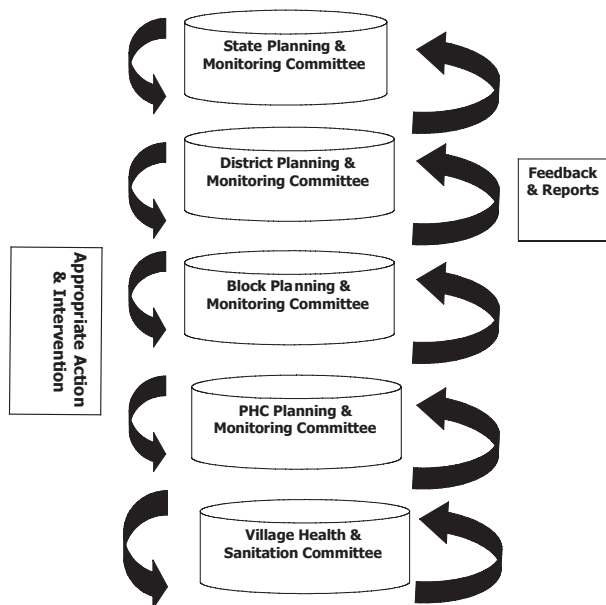


Figure 2: Feedback Mechanism at Different Levels

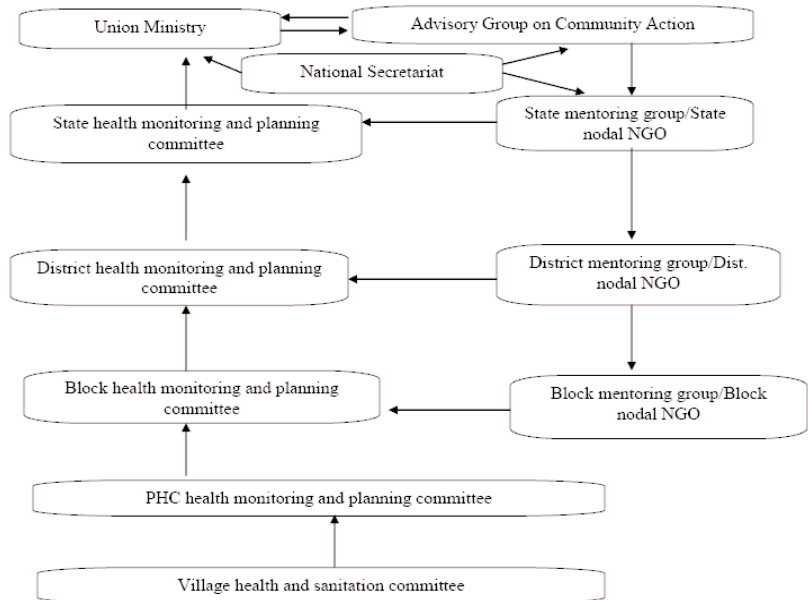


Table 2: Nodal NGOs identified for the nine first phase states

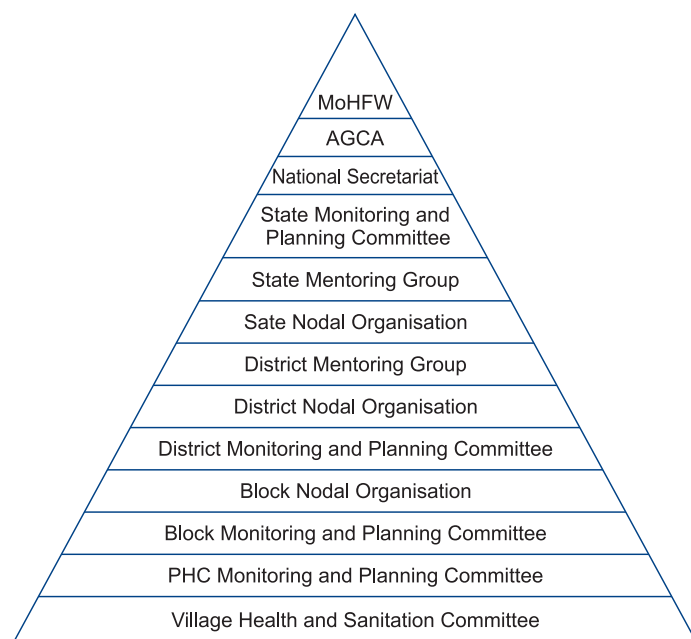
	Name of the States	Name of the State Nodal NGOs
1	Assam	Voluntary Health Association of Assam
2	Jharkhand	CINI
3	Rajasthan	PRAYAS
4	Tamilnadu	Tamil Nadu Science Forum (TNSF)
5	Chhattisgarh	State Nodal Consortium (SANDHAN Sansthan, Chattisgarh Voluntary Health Association and PFI-RR)
6	Karnataka	Karuna Trust
7	Madhya Pradesh	Madhya Pradesh Vigyan Sabha
8	Maharashtra	SAATHI-CEHAT
9	Orissa	KCSD- KIIT

National Level Preparatory Phase

The Preparatory Phase at the national level included setting-up a task group under the aegis of AGCA. The task group along with the National Secretariat was responsible for developing tools for community monitoring, a model curriculum for trainings, materials for trainings and workshops, design and content of workshops, awareness and promotional materials and documentation formats. The task group was also assigned the responsibility of establishing initial contact with State Health Secretaries; apprising them of the first phase initiative; setting-up the State Community Monitoring and Mentoring Group and identification of state nodal agencies.

AGCA members were assigned specific states to assist in setting the ball rolling for community monitoring in the state.

Figure 3: Organogram - Agencies & Committees at Each Level



It was recognised right at the outset that strategies, especially promotional materials and presentation of formats, would require adaptation at the state level, given the uniqueness of different communities, varying socio-political situations, local health profile specificities, characteristics of civil society organisations involved in the monitoring and the state of public health system. This was critical not only because healthcare needs of the people vary, but also because perceptions of people and their capacities to participate in health programmes also vary. Thus, while the National Secretariat developed the general guidelines and materials, these were tailored to specific contexts at the state and district levels.

Glimpse of material prepared at national level



State Mentoring Group

As a first step to implement the Project at the state level, a State Mentoring Group was formed with due involvement of the State Health Department and state level voluntary networks. Members of the Mentoring Group included designated representatives from the Health Department, civil society organizations and in some cases, other related department representatives such as Public Relation (PR) Department. The Mentoring Group had clearly spelt out responsibilities to lead community monitoring in the state during the first phase and beyond. In addition, the designated national AGCA members (as permanent invitees to the State Mentoring Group) provided required impetus to the effort.

State Nodal Organisation

The State Mentoring Group, in the first meeting itself identified one of the state-level organisations by consensus as the State Nodal NGO to implement the first phase. This State Nodal NGO worked under the direction of the State Mentoring Team with backstopping support from the National Secretariat.

The State Mentoring Group in coordination with the State Nodal NGO selected the districts and blocks for initiating community monitoring. Nodal NGOs for district and block levels were also selected based on a specific selection criteria initially proposed by the National Secretariat and modified/accepted at the state level by the mentoring group.

National Workshop

To begin with, a three-day National Workshop for Training of Master Trainers on Community

Monitoring was organised to orient the state nodal agencies and to prepare them to implement the community monitoring process in their respective states. The states were asked to nominate four master trainers from their respective states, who would work as resource persons and further train people. The workshop was used as a platform to share experiences and develop common working principles.

State-Level Workshop

A State-Level Workshop was subsequently organised by the State Mentoring Team, State Nodal Organisation and State Health Mission involving all stakeholders (State Mission officials, district health officials, PRI representatives from selected districts, NGO networks and civil society organisations from these districts). Representatives from NRHM, GoI and National Secretariat also participated. The activities of the first phase were shared and the process finalised. Detailed timetable for district-level meetings, formation and orientation of committees, conducting community monitoring and sharing of results at the PHC and block was worked out in this two-day state level workshop.

State-Level Training

The State Nodal Organisation under guidance from the State Mentoring Team conducted a five-day State-level Training of Trainers. The training was attended by district-level trainers who were responsible for facilitating the community monitoring process at the district level and below. The trainers were primarily the voluntary sector facilitators. However, state Health Department officials were also present and involved in these workshops, enabling them to actively participate in further such trainings.

State Implementation Phase

Activities carried out at the state implementation level could be divided into the following phases:

- Preparatory phase
- Training and workshop phase
- Formulation of community monitoring committee
- Monitoring phase
- Jan Samvad phase
- End phase.

Table 3 : Detail of Activities at the State Level

Phases	Activities
Training/ workshop phase	<ul style="list-style-type: none"> ● District workshop ● Block facilitators training ● Block providers training ● VHSC orientation workshop ● Orientation of different level of committees
Formation of Community Monitoring Committee	<ul style="list-style-type: none"> ● Village health and Sanitation Committee ● PHC Monitoring and planning committee ● Block Monitoring and planning committee ● District monitoring and planning committee
Monitoring phase	<ul style="list-style-type: none"> ● Community Mobilization ● Preparation of Village health profile ● Community enquiry ● Preparation of report card - Village, PHC and Block
Jan Samvad	Jan Samvad at PHC and Block level
End phase	State process documentation and state review workshop

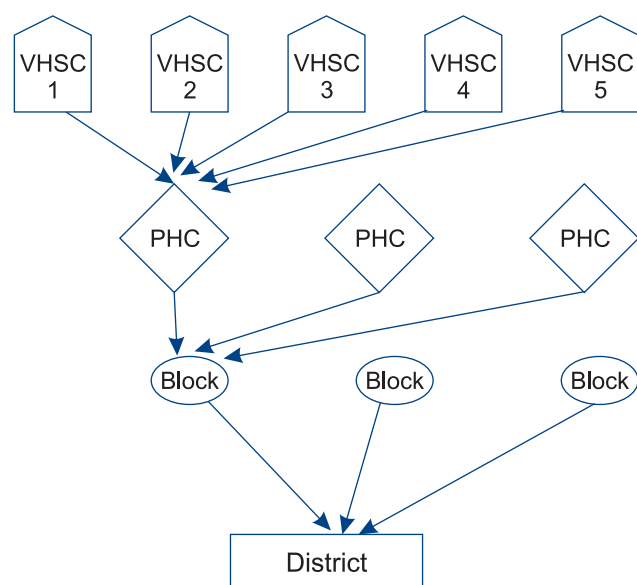
Once the district and block level facilitating organisations were selected and trained at the state level, the key activities shifted to the district and block levels. The activities at the district and block level proceeded in the following manner:

Setting the Stage

District processes were facilitated by district-level organisations taking responsibility in the first phase along with district health officials and PRI representatives. A District Mentoring Team (including representatives of each of the three groups) to facilitate the community monitoring process was put in place, which facilitated the orientation activities in this and subsequent stages. In each district, a civil society organisation was identified to take responsibility as the District Nodal Organisation. This NGO was assisted by other civil society organisations that would take specific responsibility in various blocks. The process started with a District Level Workshop to share the concept, identify blocks and PHCs and involve key district health officials, PRI members and civil society organisations. For each selected block, the block nodal organisations took up the responsibility of coordinating with the District Nodal NGO.

A Block Facilitator Training was conducted for at least a four-member Block Community Monitoring Facilitation Team, including at least two NGO/CBO members, with at least half the members being women. These Block Facilitation Team members were responsible for subsequent committee formation and orientation processes.

Figure 4: Organogram of Monitoring & Planning Committees



Formation of Committees

During the four months (Aug-Nov 2007), committees were formed at village, PHC and block levels in the selected blocks (in that order), along with primary orientation of their members. Formation of community monitoring and planning committees started from village committees, PHC, block, and then district committees. It was important to constitute the committees from village level upwards in an inclusive manner - hence a few members from VHSCs were included in the PHC committee. Similarly, a few PHC committee members were included in the block committee and so on. CBOs/NGOs and Panchayat representatives who had shown initiative in organising community monitoring activities at any level found representation in the next higher-level committee. Adequate representation of women, dalits and adivasis was ensured in the various committees.

Following committee formation at the peripheral levels, the District Level Committee was also finalised and became functional in November 2007. In the first phase, a provisional committee was formed at the state level in December 2007. This would be given final shape only after the next phase of 'Extended Implementation' is completed and at least, half of the districts of the state have Community Monitoring Committees in place, which could send representatives to the State Committee.

Community Mobilisation, Monitoring & Report Card Preparation

A process of raising awareness of community members regarding their health entitlements and significance of community monitoring was carried out in all villages, prior to formation/expansion of VHSCs. At least three meetings in each village were conducted for this purpose, and the final meeting was expected to be in the form of an 'official' Gram Sabha where the new VHSC members would be selected and formation/expansion of the VHSC would be declared. Posters related to people's health entitlements under NRHM were put up in the village as part of this process. Innovative strategies for community mobilisation were adopted by states such as use of folk form (Kala Jaththa), Chinaki (introduction) meetings, padyatras, involving children, youth parliament and social mapping etc.

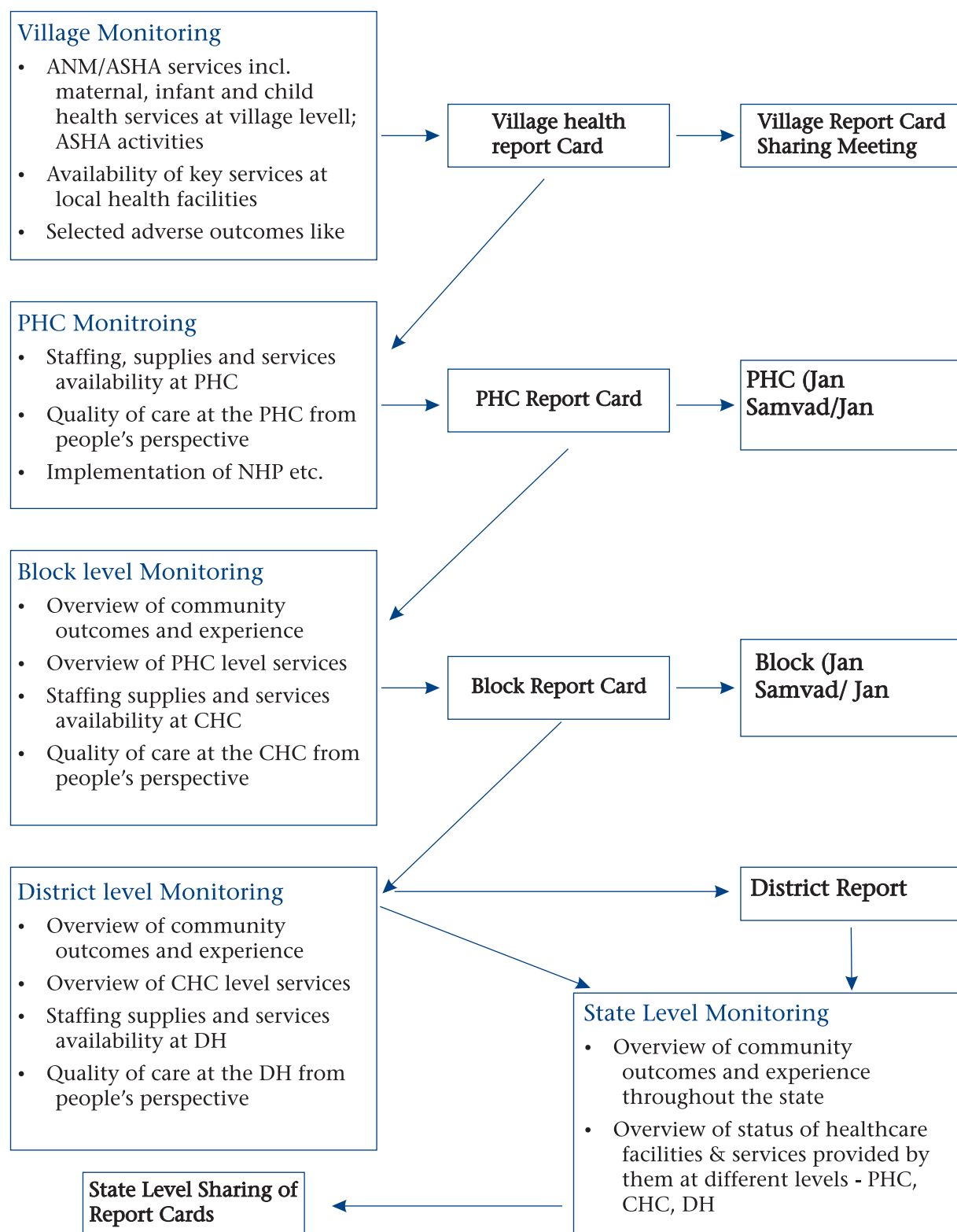
The community monitored the need, coverage, access, quality, effectiveness, behaviour, presence of healthcare personnel at service points, possible denial of care and negligence aspects. The monitoring process included outreach services, public health facilities and the referral system. These exercises aggregated information upwards as illustrated in Figure 4. The monitoring results were also shared at the village level, PHC and block level in the appropriate PRI fora. Some of the broad areas under the NRHM on which community monitoring was conducted were:

- Entitlements under Janani Suraksha Yojna (JSY)
- Roles and responsibilities of ASHA
- Indian Public Health Standards (IPHS) for different facilities like Sub-centre, PHC, CHC
- Concrete Service Guarantees
- Citizen's Charter

In the first phase, indicators for information collection at the village level and the PHC level were finalised, and accordingly tools for monitoring were formulated at the national level. It was also decided that frequency of the monitoring cycle in every village would be once in three months i.e. a report card of village would be prepared once every three months and submitted to the PHC monitoring committee. However, only one round of data collection was planned for the first phase. The exceptions were Karnataka, Rajasthan and Maharashtra where more than one round of data collection was done.

In each monitoring cycle at the village level, two group discussions were planned. One of these group discussions was with the general community, and one was exclusively with women. Similarly, at the PHC

Figure 5: Issues and Process of CM at different level



level, exit interviews of the OPD patients were to be conducted in each cycle. These group discussions and exit interviews were accompanied by a facility survey at the PHC and interview of the PHC MO. The block coordinators mainly conducted facility surveys and also exit interviews and interview of MOs.

PHC and block level community monitoring exercises included a public dialogue (Jan Samvad) or public hearing (Jan Sunwai) process. Here, individual testimonies and assessments by local CBOs/NGOs were presented. Individual testimonies were identified through the adverse outcome recording process. These public dialogues were moderated by the district and block facilitation groups in collaboration with PRI representatives and CBOs/NGOs working on health rights issues.

Monitoring committees reviewed and collated reports from committees at the unit level below them. The members did not rely on reports but also directly interacted in the field and got feedback. Firstly, each committee appointed a small sub-team drawn from its NGO and PRI representatives who visited a small sample of units (say one facility or two villages) under their purview on a regular basis and directly reviewed the conditions. This gave the committee a first-hand assessment of conditions in their area. For example, the PHC Committee representatives would visit two villages and conduct group discussions in each trimester, selecting different villages by rotation. Similarly, the Block Committee representatives would visit one PHC by rotation in each trimester.

Secondly, monitoring committees at PHC, block and district level would be involved in six-monthly or annual Jan Samvads or Jan Sunwai at their respective levels, where committee members would get direct feedback on the situation, including possible presentation of cases of denial of healthcare. Similarly, it is suggested that the State Health Mission could conduct an annual public meeting open to all civil society representatives where the State Mission report and independent reports would be presented and various aspects of design and implementation of NRHM in the state, including state specific health schemes, would be reviewed and discussed enabling corrective action to be taken.

Engaging Media

One of the key strategies in the first phase was to involve the media in creating public opinion about the existing state of the public health system and also to positively influence decision-makers.

Some of the strategies adopted for a wide and effective media coverage included:

1. **Appointing a state media consultant:** A working journalist with experience of facilitating media coverage of developmental and health issues was associated as a consultant with the entire process. This was an innovation which proved quite effective in involving senior media persons from multiple major newspapers, and ensured continuous following-up of involvement of the media at both state and district level, including the electronic media.
2. **Appointing and orienting media fellows:** Two media fellows were designated at the state level to cover the CM (Community Monitoring) activities. These journalists belonged to major dailies with multiple editions in various parts of the state to ensure adequate regional as well as state level coverage. Similarly, a media person at the block level was assigned to cover and report on CBM related block activities.
3. **State media workshop:** In this one-day workshop, media participants were familiarised with the process of community monitoring. In some states, this workshop was planned when the community monitoring data from villages was already available with the state nodal NGO. Preliminary analysis of this data was presented in the workshop. Attempt was made to ensure that senior government officials were also present for this workshop. This helped the media persons present in the workshop to get official perspective on the reported deficiencies from villages and also to understand specific issues associated with the quality of healthcare in the states.

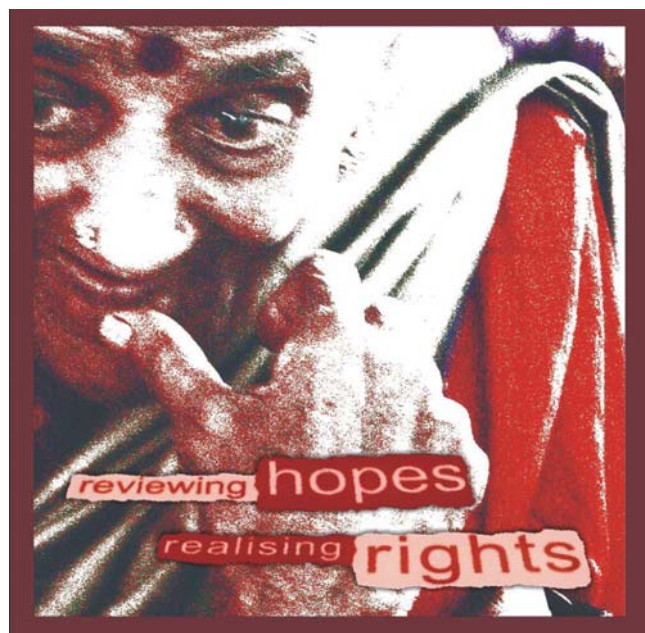
Material Support

One of the important preliminary tasks for the National Secretariat was to develop communication material to create awareness on various entitlements and schemes, service guarantees and provisions, community participation and framework for community monitoring under NRHM. Seven sets of brochures, six sets of posters and a booklet on Health Entitlements faced were developed. CDs of print-ready version of materials were sent to each state nodal agency to enable them to modify the materials as per their requirement and print in their state language. These materials were extensively used during community mobilisation and orientation of various committees on their role under NRHM.

In addition to the promotional materials, the National Secretariat with support from the task group developed three manuals 1) Manual for Managers, 2) Manual for Training and 3) Manual for Monitoring. These manuals together provide detailed guidelines on how to plan and implement community monitoring in the state.

A 30-minute documentary film produced towards the end of the first phase captured the process, immediate impact of the process in the field, and the lessons learned and challenges faced. The film, both training as well as advocacy tool highlights the potential of community monitoring as a community empowerment and democratisation process in the context of people's right to health.

CD Cover of CM Film



* copies available at CHSJ.

The film highlights the potential of Community Monitoring as a community empowerment tool and democratization process in the context of people's right to health. The film includes experiences and opinions of different stakeholders associated with the process at the national, state and local levels. It also reflects some of the activities that was carried out at different levels during this process.

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Produced on behalf of
Advisory Group on Community Action(AGCA)

By
National Secretariat on Community Action-NRHM



P F I

Online Edition

The National Secretariat developed a Community Monitoring website (www.nrhmcommunityaction.org) to enable online review of information related to community monitoring. The website contains general information such as definitions and explanations of community monitoring concepts under NRHM. The website contains the organogram of community monitoring, lists of AGCA members, TAG members, the National Secretariat on community action, broad description of Monitoring and Planning Committees at different levels, and mentoring teams at the state and district levels. Also included are details of nodal NGOs at the state level, information on the process of the Project, name and address of districts and blocks and geographical spread.

The website also has information and documents

related to government orders, progress made and state-specific toolkits. The national toolkit (Manager Manual, Training Manual and Monitoring Manual and other Publications) has been uploaded for wider circulation. State-wise newspaper clippings and photographs collated on various occasions by the state nodal agencies and during state visits by the programme officers have been uploaded as well. The national website is linked with state specific web pages. The states have control over these web pages and are provided with password and user ID so that they can upload information as per their requirement. A half-day intensive training was provided to the state technical person on how to maintain the web pages and upload information. The national website is linked with the Health Ministry's NRHM website.

A unique feature of the website is that it enables access to data till the village level. Report cards at

Screen Shot of National CM Website



village, PHC, block and district level can be viewed for each of the nine states. This enables reviewing the

data not just at the district level but also at the state and national levels at the click of a button.

Screen Shot of Report Card Generation Page

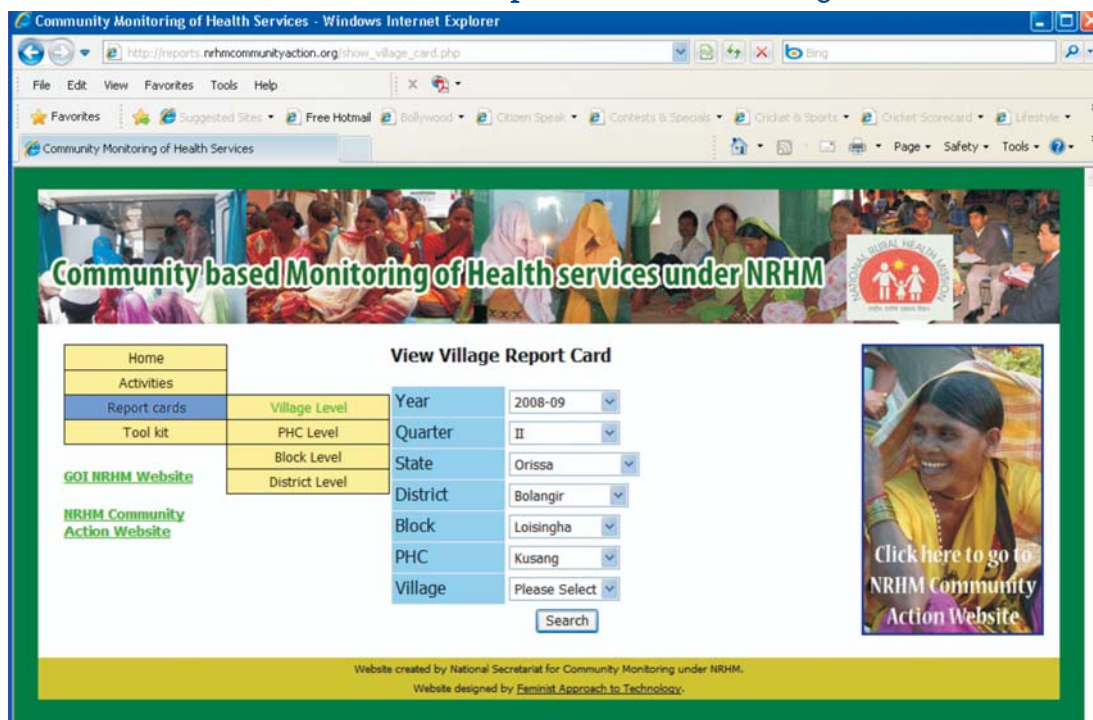


Table 4 - Example of a Village Health Report Card generated by the website

Village Level Report Cards			
Village Name	Lebeda	Year:	2008-09
Block Name	Muribahal	Quarter:	II
District Name	Bolangir		
Sl. no.	Issue	Score	
1	Maternal Health Guarantees	50	
2	Janani Suraksha Yojna	42	
3	Child Health	87	
4	Disease Surveillance	50	
5	Curative Services	96	
6	United funds	25	
7	Quality of Care	75	
8	Community perceptions of ASHA	100	
9	ASHA functioning	83	
10	Equity Index	100	
11	Adverse Outcome or experience reports	100	

Section - II

Findings from the States : Some Immediate Outcomes

The process of the first phase of Community Monitoring (CM) across nine states was implemented from March 2007 to March 2009. The monitoring process involved capacity building of planning and monitoring committees at different levels to conduct enquiry into the functioning of different components of NRHM and uptake of key services. It was an empowering process for the community because it provided the community representatives knowledge of different entitlements, services standards and services guarantees that are provided within the NRHM. It also provided an opportunity to discuss the status of service delivery with health care providers and managers.

The geographical coverage and pace of the monitoring process varied from state to state. While some of the states went ahead and completed the required activities within the set timeframe, others needed more time. The districts in the states were selected considering the geographical spread of the state. Thus, the number of districts varied from three to five across nine states.

The village was the main unit for community monitoring. The tools that were developed at the national level were adapted and modified at the state level. The score cards that had 11 parameters to assess the health situation of the village were based on the traffic lights. The report cards had three colour codes on the basis of the following parameters:

Green = 75% to 100%

Yellow = 50% to 74%

Red = 1% to 49%

As described in Section I, the process underwent several layers of interventions, which led to enormous learning, innovations, participation of different stakeholders, negotiations and challenges. One of the prime objectives of community monitoring was to show the way for communitisation, which was met by opening doors for dialogues between services providers and community and by reaching a consensus.

Jan Sunwai and sharing of village-level findings of monitoring made a great impact on the mindsets of providers, which resulted in better service delivery, ratification of the problems and in bringing local health providers and community on the same platform. The process also enhanced the level of ownership among community members.

This section describes the findings, innovations and impact of community monitoring that each state experienced during the process. It is based on data and documents that the state nodal agencies provided, interviews with community organisations and community leaders and case studies shared by district nodal agencies during the CM process.

MAHARASHTRA

The first phase of community monitoring was carried out in five districts (Nandurbar, Pune, Amaravati, Osmanabad and Thane) of Maharashtra. The state has so far completed three rounds of monitoring at village, PHC and rural hospital levels. The first round of data was collected between July-Aug 2008, the second round between Mar-Apr 2009 and the third round between Oct-Dec 2009. Though the project ended in March 2009, The State collected an additional round of data during Oct-Dec 2009. The monitoring took place in 220 villages, 40 PHCs and 15 blocks. The state has observed significant improvements in certain services from July 2008 to Dec 2009, mainly due to combination of two factors - NRHM 'supply side' inputs and 'demand side' push by CM.

The positive impact of community monitoring in the state was based on two important aspects: responsiveness of state government officials, adequate supply of funds and relevant decisions by officials as well as sustained push by various communities, NGOs and people's organisations. While availability of finance, supportive directions and untied funds from NRHM give the basic inputs for improvement, the CM process provides a matching yet critical 'push from

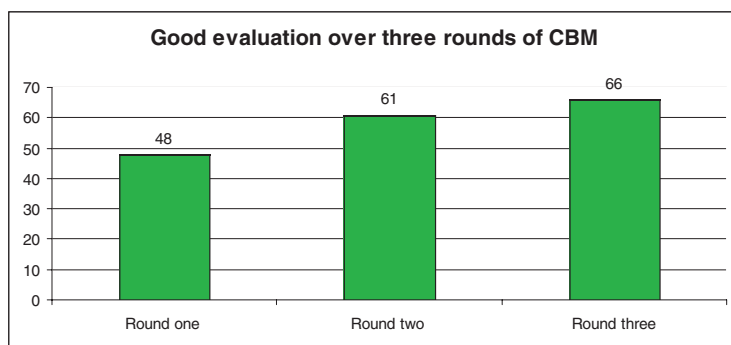
below' to help ensure that desired changes are actually implemented.

Village-level Health Services: Visible Improvements

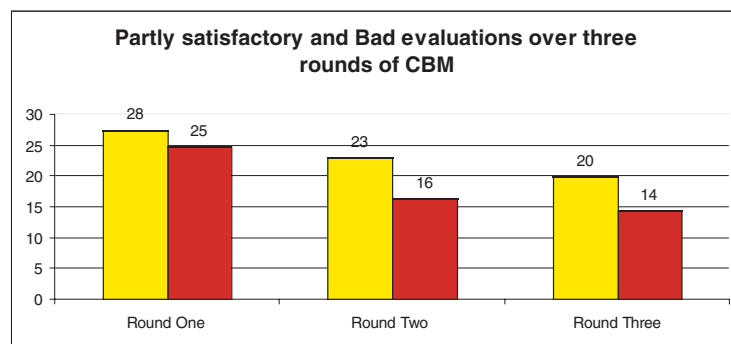
The village health report cards covered nine key health services and these were rated by Village Health Committee members as either 'Good' (Green) 'Partly Satisfactory' (Yellow) or 'Bad' (Red). This information was collected from 220 villages. Graph 1 shows the trend of good ratings for these services across five districts in Maharashtra covering three rounds of CM. While 48 per cent of the services were given 'Good' rating in round one, it increased to 61 per cent in round two and further to 66 per cent in round three. Thus, there has been a consistent overall improvement in village health services in the CBM covered villages.

Similarly, Graph no. 2 shows the concurrent reduction in 'Partly Satisfactory' and 'Bad' ratings of services in these five districts over three rounds of CM. Services rated as 'Bad' have reduced from 25 per cent in the first round to 14 per cent in the third round.

These changes, while generally being in a positive direction, have varied from district to district. An aggregate 'Good' evaluation trend for each district over the three rounds of CM is shown in Graph no. 3. In three districts (Amaravati, Pune and Thane) there is a

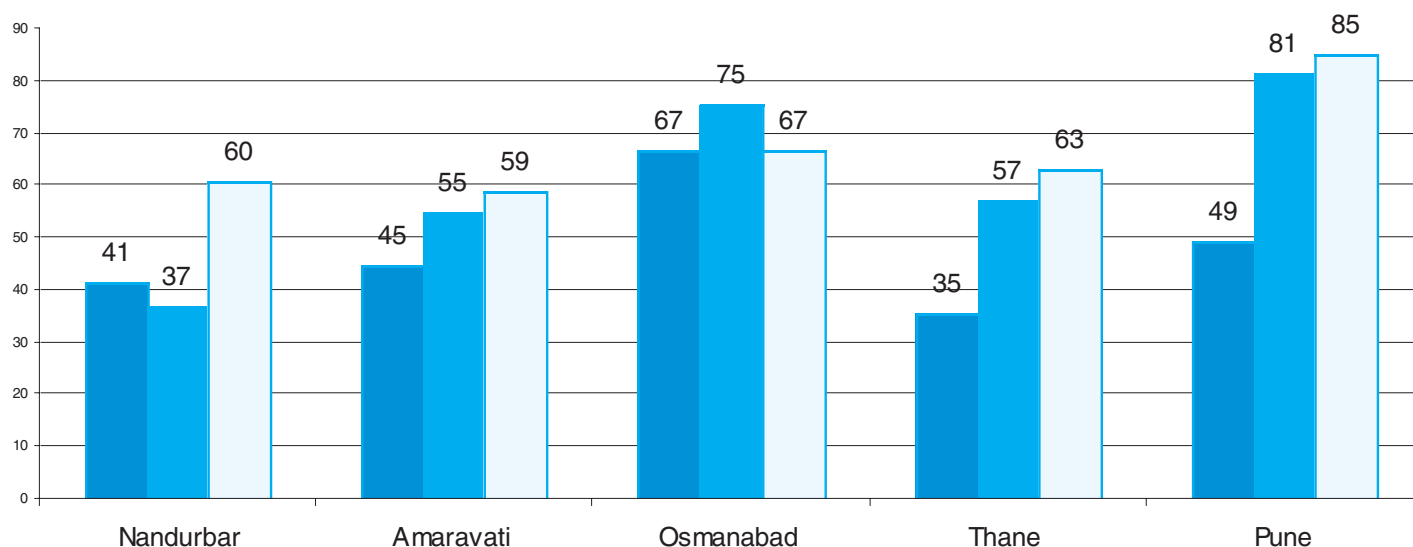


Graph 1



Graph 2

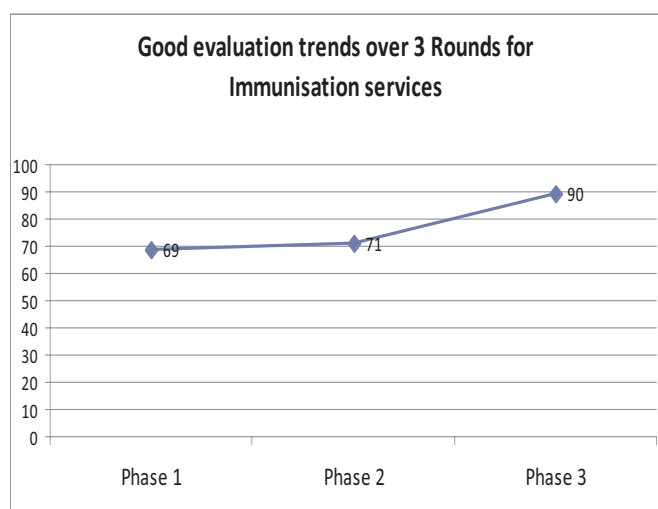
District Trends over three rounds of CBM



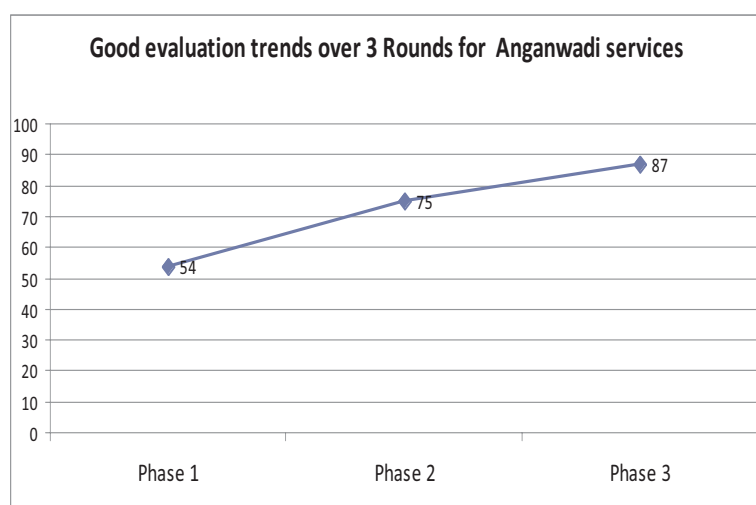
Graph 3

significant improvement between Round one and Round two, although between Round two and Round three the improvement is more gradual. In Nandurbar, ratings remained poor between Round one and Round two, but improved significantly by Round three. The ratings for Osmanabad improved slightly between Round one and two, but returned to initial levels by Round three.

Certain health services have shown high and consistently improving 'Good' ratings across the five CBM districts over three phases. At the end of Round three, 90 per cent of districts received a rating of 'Good' for immunisation services and 87 per cent of districts received a rating of 'Good' for Anganwadi services. The following graphs (Graphs 4 and 5) display trends for these services.



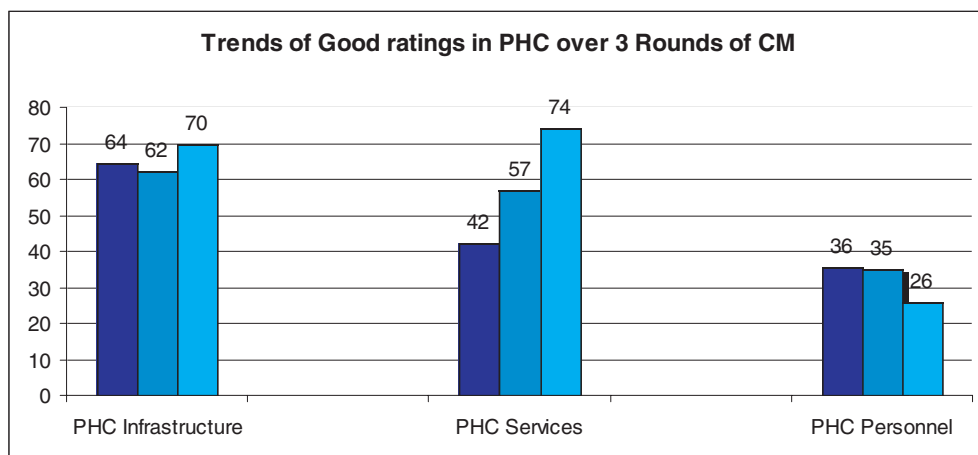
Graph 4



Graph 5

Health Facility Level: Evident Impact

The facility monitoring was done keeping four parameters in mind namely, infrastructure, services, personnel and medicines. From Round one to three, significant changes have been observed in the first two parameters.



Graph 6

Glimpses of Change

Following are some examples of qualitative improvements, which have resulted from each of these issues being raised through the CM process. These kinds of improvements have been observed generally in several blocks being covered by the CM process.

- PHC doctors in one of the districts used to prescribe medicine from private shops. This issue was raised through CM and subsequently the practice was stopped. Some of the required medicines, which are unavailable, are now purchased from the RKS funds. A suggestion box for patients has been placed in the PHC due to recommendation of PHC Committee.
- Due to efforts of CM, utilisation of the village untied funds for purchasing furniture for Anganwadis in some blocks has stopped. Funds are now used for other 'more relevant' health-related activities.
- The laboratory facilities that were not functional in some districts have now started to work twice a week. In one of the blocks a non-functional Sub-centre started to function regularly after the CM process.
- The number of people availing services from certain PHCs, now has increased after the CM process. In some PHCs, the number of patients availing these services doubled after CM shifted from private to public health system.
- Now most of the public health facilities have displayed the "Citizen Health Charter" as well as information related to ambulance services.
- In a significant innovation linked to CM, adolescent representatives (12-17 yrs) in two blocks have been included in the VHSCs so that issues of children and adolescents could be raised and addressed adequately in the meetings.
- In one of the adivasi blocks, land has been sanctioned and a new PHC building is now under construction as a special case. A mobile unit has been started at the Sub-centre level based on demand from the community. A mobile medical unit has also been approved at one of the PHCs.
- Implementation of Janani Suraksha Yojana (JSY) has improved and beneficiaries are getting benefits more regularly in one of the districts.
- Frequency of visits of ANM and MPWs in villages has improved leading to improved village health services in several blocks; there is definite improvement in immunisation coverage in these villages.
- One of the Sub-centres now has a residential medical officer as this centre covers a population of around 7000.
- Interaction between local health care providers and community has improved in most of the blocks; villagers in one area have taken initiative for giving protection to the ANM as her quarter is on the periphery of the village.

The major role of Jan Sunwais in inducing these improvements needs to be emphasised; many of these issues were raised in such hearings and effectively addressed. As part of the CM process around one hundred Jan Sunwais at PHC and district levels have been organised so far in Maharashtra.

Innovations that 'Made a Difference'

Specially designed, simplified pictorial VHSC tools have been designed and used particularly in Thane, Nandurbar and Amravati districts keeping in mind the adivasi population and low literacy levels.

Village, PHC and rural hospital report cards have been published in a poster format. These large-size posters

are displayed publicly in the village or facility, allowing all villagers and health functionaries to see the results.

A regular 24-page state-level newsletter in Maharashtra, on community monitoring titled 'Dawandi' (public proclamation) is being published with news items, interviews, photographs, articles, instances and examples of people's positive and negative experiences at health facilities and positive stories of field-level health workers who have done praiseworthy work.

In the expanded phase, PRI members in many blocks who had been appointed as panelists during the Jan Sunwais have been made members of committee sub-groups to investigate specific health services in Pune. This has led to their increased participation.

Arogya Jagruti Diwas has been organised in villages of Thane district with mass participation and

community mobilisation followed by data collection and report card preparation. Part of the day is also used to undertake constructive work such as cleaning a well, digging soak pits etc. Such activities create broader ownership of the community monitoring activity beyond VHSC members.

'Open' trainings in Dahanu and Murbad blocks imply that VHSC trainings are open for not only VHSC members but for all other interested community member. This has created a facilitative environment promoting high social recognition of the programme.

The village health services calendar has been used in some blocks to inform the community as well as monitor regular outreach visits of ANMs and MPWs.

'Jahir Arogya Sabhas' were organised at village level in Purandar block with the PHC medical officer visiting each CM village and conducting a village level discussion on improving health services. Panchayat representatives and community members also

participated in the meetings.

Active participation of people's organisations (Sanghatanas) in the entire CM process in Maharashtra is a major highlight of the state. Many of the innovations took place in areas where such organisations are active because some of the earliest experiments in Maharashtra on rights-based mobilisation of community on health issues had taken place in these areas.

State level review and culmination workshops have been organised in November 2008 and April 2010 with participation of all concerned PHC Medical Officers, Taluka Medical Officers, DHOs and Civil surgeons or representatives, all block and district nodal NGOs and state nodal NGO representatives, NRHM Mission Director, state-level NRHM and Directorate of Health Services officials for comprehensive review of issues emerging through the CM processes in each district. These major events provided a platform for systemic and policy level issues related to public health system to be discussed.

Testimony of a PHC Doctor during Jan Sunwai - An interesting aspect of the community monitoring process

The Amaravati district Jan Sunwai in Oct. 2008 was unusual, because it was the first time in a CM-related public hearing that a PHC MO came to present her own grievance. Her testimony exemplifies the difficulties faced by well-intentioned and sincere officers in the health bureaucracy.

Dr. Miraj Ali had been working as a PHC MO in Dhamangaon Gadhi for the last one-and-a-half years. People have reported that she has been instrumental in improving the health services of the PHC. This was by no means a small achievement considering the fact that the same PHC was almost dysfunctional before she was appointed there. She had been staying in the PHC from the day of her appointment and naturally, the number of OPD patients, especially women patients, had increased significantly.

In the Jan Sunwai around 20 men and women, including one Zilla Parishad representative, travelled all the way from their village to Amaravati town and strongly protested against her unjustified transfer by the DHO. However, the DHO of Amaravati who was present in the Jan Sunwai was quite dismissive and non-committal. Around 325 people residing in Dhamangaon had signed a petition to reinstate Dr. Ali, and the Zilla Parishad member from Dhamangaon had also endorsed this demand. This petition was presented in the Jan Sunwai.

What was striking was the way ordinary women from Dhamangaon supported Dr. Ali. CM organisers still remember a frail looking woman who came to the Sunwai at her own expense and warned the DHO not to play with the sentiments of the people in Dhamangaon since every house in the village knows about the contribution and commitment of Dr. Ali.

RAJASTHAN

In the First phase of monitoring four districts were chosen, Alwar, Chittorgarh, Jodhpur and Udaipur in Rajasthan. The CM process was carried out in 180 villages, 36 PHCs and 12 blocks. Although the process of community monitoring started in the State from September 2007 but the course of report card preparation took place from September 2008.

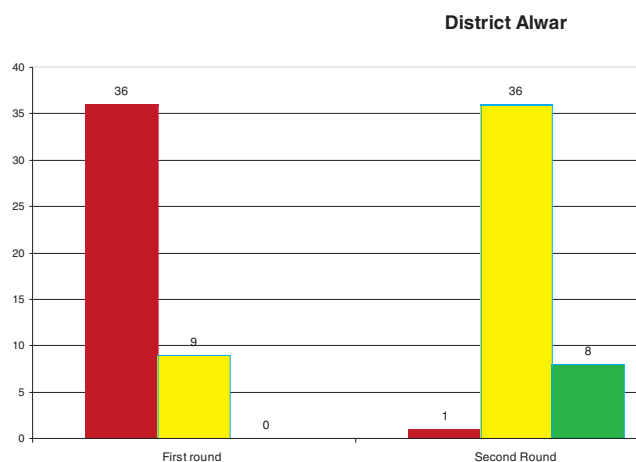
From Sept 2008 to Nov 2009, the state underwent three rounds of monitoring and saw a considerable shift in color codes of score cards. The report under submission used data from two rounds of community monitoring from Sept 2009 and Nov 2009.

Significant Improvements

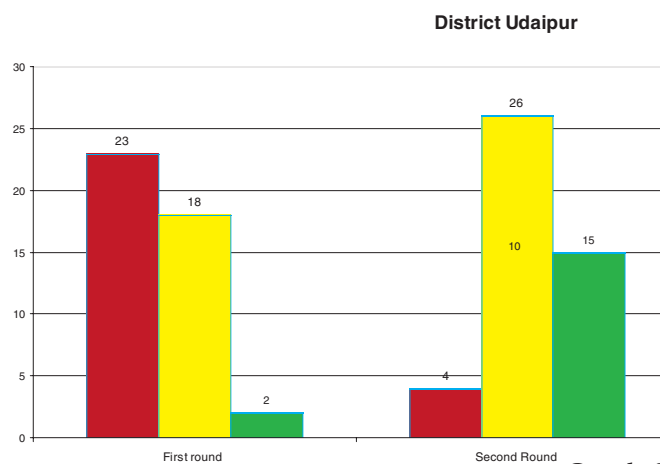
In a short span of time, the State saw significant changes and improvements. In districts of Alwar and Udaipur, the process of monitoring not only helped in increasing the utilisation of vaccination services but

also motivated ASHAs to visit door-to-door for service provision on a regular basis. The process also helped in effective utilisation of public health services by the community due to which the attendance of patients increased. The doctors and other paramedical staff became more regular and devoted more time. The health facility eventually became more regular and organised in terms of services provided.

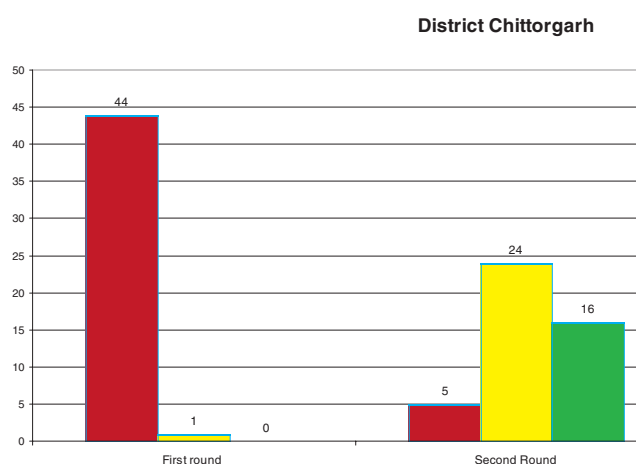
After the first round of monitoring exercise (Sept 2008), 138 villages out of a total 180 villages scored red, 37 villages were yellow and only five villages were green. The second round of monitoring experienced shift in colour score, which was carried out in Oct 2009. A substantial shift was seen from red to yellow and yellow to green. In the second round, out of 137 villages (which were observed red in the first round) 76 villages shifted to yellow colour score and 12 villages scored green colour, also showing an increase from the first phase where only 3 villages scored green colour. Graph 7, 8, 9 and 10 depict shift in colour codes during two rounds of CM.



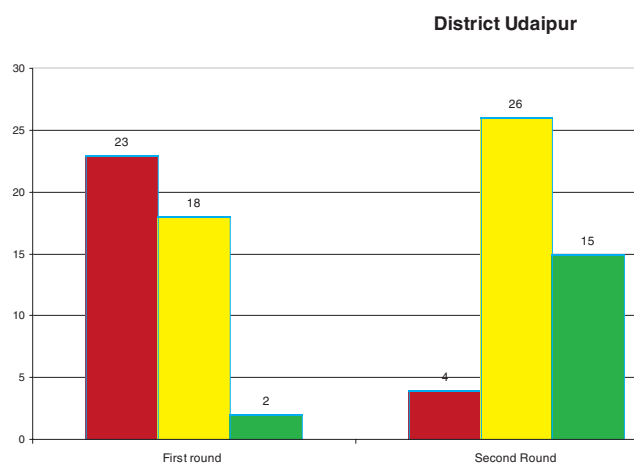
Graph 7



Graph 8



Graph 9



Graph 10

The active involvement of different levels of committees gave leverage to the members to demand better and effective services, facilities and human-

power. Some of the changes at the village, PHC and block level took place due to the hard work of the committees.

Glimpses of Change

- In Pachla PHC of District Jhodpur, the post of Medical Officer (MO) was vacant for a long time but due to the efforts of committee members, an MO was appointed.
- At Cherai PHC of district Jhodpur, a case of corruption was noticed where one of the nurses was taking bribe from pregnant women to provide them private quarters. Mismanagement of JSY money was also reported. Due to constant pressure from the committee the nurse was transferred.
- At the Bomboli PHC of Udaipur district, there was corruption in disbursement of JSY money to beneficiaries and BPL card holders faced problems in availing free medicines. With the continuous efforts of committee members these reported problems got solved.
- The committee members ensured ANM's presence in VHSC meeting.
- PHC MOs ensured training of ANMs on the use of BP machine and haemoglobin meter.

Prior to initiation of community monitoring process most of the VHSCs had already been formed in the State but when members of civil society groups enquired about the roles and responsibilities of VHSC members, it was found that only the Sarpanch and Anganwadi worker (who together are joint signatories for the untied grant) were aware of these committees and their roles and responsibilities. Other members who were also part of the committees did not have any idea about the committee. The feedback of this enquiry was given to the Chief Medical Officer (CMO), based on which a special order was issued to restructure these committees. Following the restructuring of VHSC, the meetings conducted at the village level with PRI members helped evoke increased interest in community monitoring.

Community Ensures Recognition for ANM: Benefits From Community Monitoring

The community monitoring process in Umed Nagar village was initiated in Sept. 2008. The VHSC was formed through the process of CM and meetings had been held regularly. In Jan Samvad, corruption in JSY scheme in this area was brought to light and it was also found that women have to go to CHC Mathaniya for delivery which is quite far.

Rukhsana Begam, the ANM of Umed Nagar under CHC Mathania in Osian block is a very dynamic member of VHSC. She has been trained in conducting safe delivery but due to unavailability of necessary

equipment at Sub-center, deliveries could not be performed there. The community had raised this issue in the VHSC meeting and had demanded necessary equipment. Their repeated efforts bore results, when the govt. declared it as a model Sub-center and also gave permission for conducting deliveries. However, they faced another problem of arranging a separate room and quarter for the ANM. The VHSC again demanded the same from the Panchayat and succeeded. Currently, all the deliveries in the area are performed at this Sub-center and women receive JSY benefit within a day or two from the delivery.

During the period January-December 2009, Rukhsana conducted 244 deliveries at her Sub-center which is indeed praiseworthy. She resides in the village which makes it easier for her to provide qualitative services.

The VHSC has nominated her for Excellent Service Performance Award and she has been rewarded for her commitment and efficiency at district level on the occasion of Republic Day.

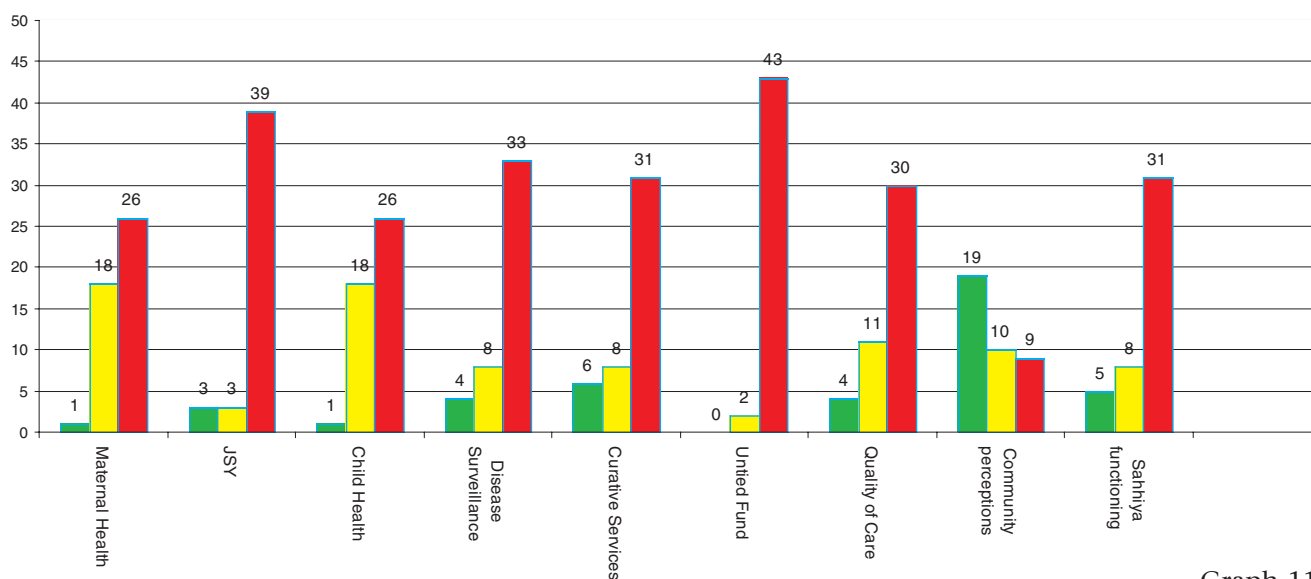


JHARKHAND

The CM was carried out across three districts of Jharkhand. The process covered 135 villages, 27 PHCs and nine blocks. The CM exercise in the State has enabled community and community-based organisations to monitor demand/need, coverage,

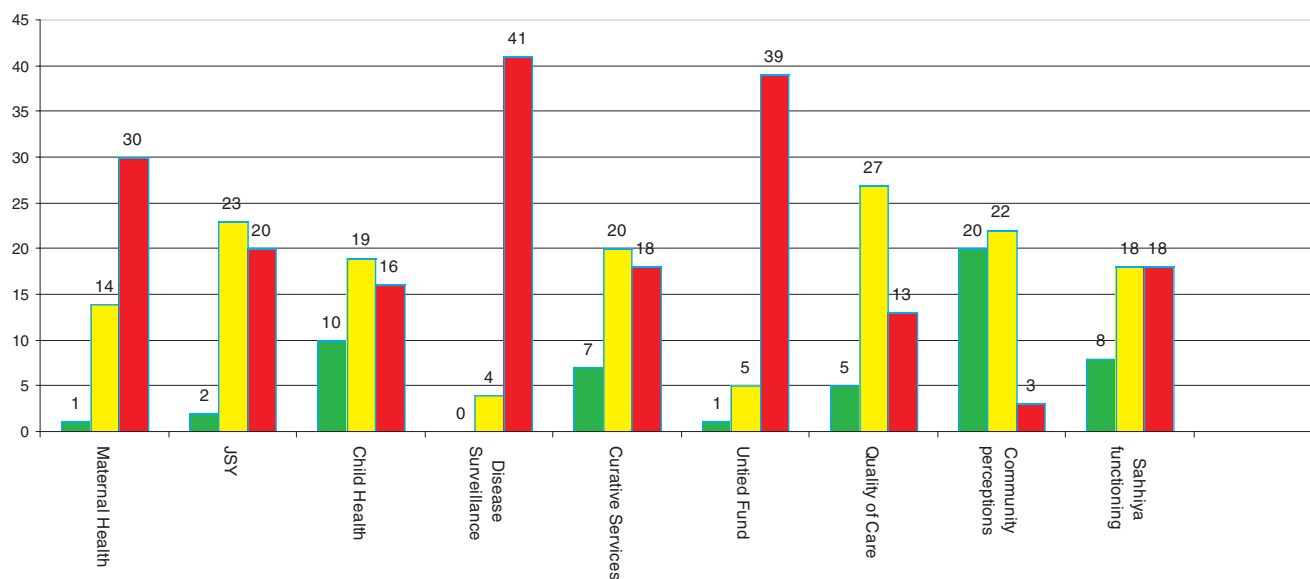
access, quality, effectiveness, behaviour and presence of healthcare personnel at service points and to trace possible denial of care and negligence. The State underwent a round of monitoring and for this purpose it undertook a few innovations to make CM effective and significant. The graphs (11, 12, & 13) below shows district-wise status:

Dist Palamu

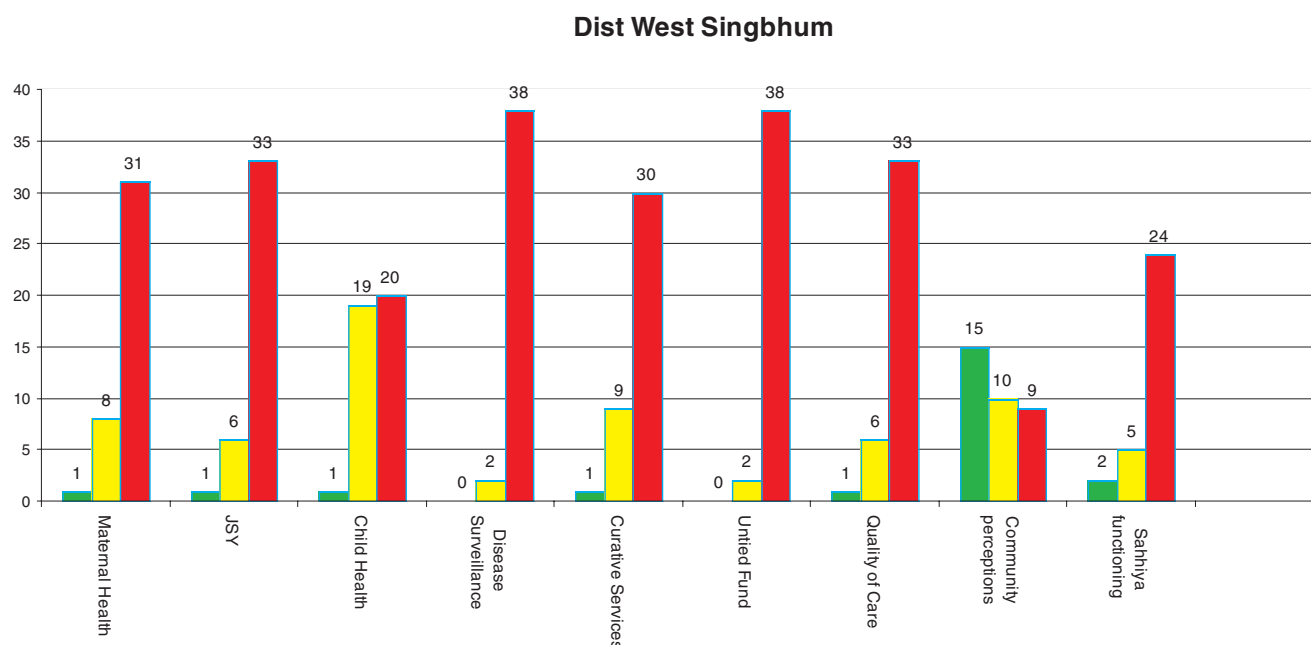


Graph 11

Dist Hazaribagh



Graph 12



Graph 13

Prior to CM, the Village Health Committee Members and Sahiyya (In Jharkhand ASHAs are called as sahiyya) were not well-versed with their role in the community and there was a lack of motivation for participation among them.

Breaking the Ice: Orienting Community Members:

The orientation had great impact on the mindset of members; it contributed in grooming VHC members after which they were well-informed and sensitised. Members are now more empowered and aware about the purpose of being part of the Committee and their roles and accountability towards the community. After CM, most of the VHCs conduct meetings on a regular basis and issues related to maternal and child health and disease control are now being discussed and raised in the proper forum. Most of the VHCs have developed a sense of ownership for the community and are taking action to address health issues and advocating with health service providers for the same. Sahiyya earned the community's acknowledgement and an identity of its own. The community knows about its presence and purpose in the community.

Regular dialogue with officials at the block, district and state levels during the process has in fact, broken a barrier between the community and government functionaries. Officials in the State and district levels helped in getting cooperation from government functionaries and are now willing to take

the process forward in the whole State.

The most important outcome of this process was the initiation of dialogue between the community and the health system. As such the word 'monitoring' or 'nigrani' was not considered appropriate. Instead, it was replaced by the word 'Action' and the word Samwad (dialogue) was used in place of Sunwai (hearing). This was done because the purpose was to ensure the quality of services in the State and not find faults. Moreover, the community and government health functionaries were part of the process together.

After sharing of report card at the village level, most of the VHCs have prepared the village health plan based on gaps and have started negotiation with FLWs. The VHCs in some of the blocks are supporting service providers in VHND.

Following the orientation of Media Fellows, regular news on CM is now being covered, which is helping in ensuring quality of health services at the village level.



Innovative Treatment Bears Fruit

Involvement of a street play group in **Kala-Jaththa** (theatre-based awareness campaign) was an interesting and innovative initiative. The performance of Kala-Jaththa helped in mobilising and sensitising the community. It has been used successfully in the past in other social programmes like education but it was being used for the first time on a large-scale within a health intervention. Training of street play groups ensured that



the performance did not lose focus, scripts were appropriate and right messages were given.

Village Health Register: State has come up with an idea of a village health register to keep records of proceedings and meetings. Now every VHSC has a village health register in order to maintain records.

जबारा का स्वास्थ्य		जबारा के हाथ	
<h1>ग्राम स्वास्थ्य समिति</h1> <h2>बैठक - बही</h2>			
ग्राम :		
पंचायत :		
प्रखण्ड :		
जिला :		
			

Sample of Village Health Register

Media plays its Part

Sensitising media on public health issues, especially maternal and child health was important to ensure dissemination of such information to sensitise community and to strengthen advocacy with service providers. A Media Fellowship was given to eight media persons from Hazaribag, Palamu, West Singhbhum and Ranchi to ensure improved participation of media in sensitising the community and health service providers about entitlements and facilities guaranteed under the National Rural Health Mission.

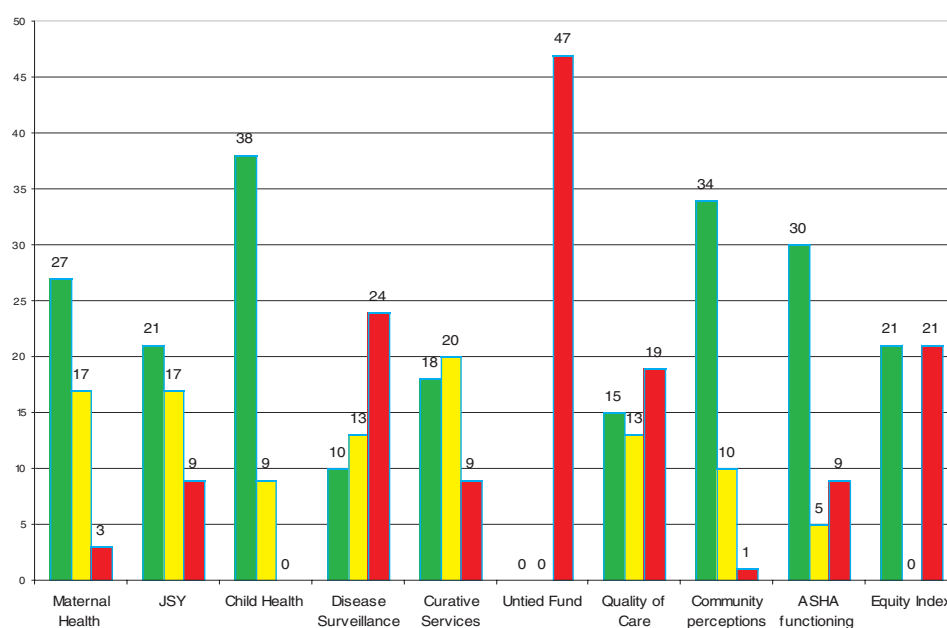


ORISSA

The process of community monitoring in Orissa, started in April 2007 in four selected districts-Bolangir, Kendrapara, Mayurbhanj and Nabarangpur. The CM activity was carried out across 180 villages, 36 PHCs and in 12 blocks of the State. The State underwent a round of monitoring and gained vital learning through the process. The success of CM was due to active

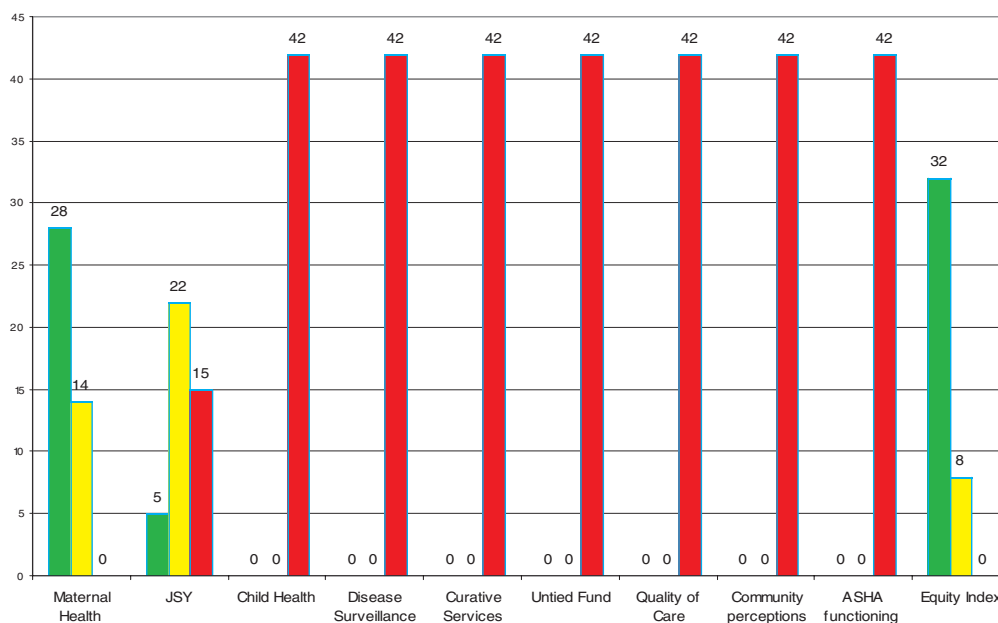
participation of districts and blocks in orientation programmes, trainings, workshops, planning and review meetings and individual sharings. The State underwent regular internal planning, review, monitoring of activities, problem solving, learning lessons and incorporating the same in the process for minimising risks and successfully implementing the CM. District wise findings of CM are shown in the graphs (14, 15, 16 & 17) below.

Dist Bolangir



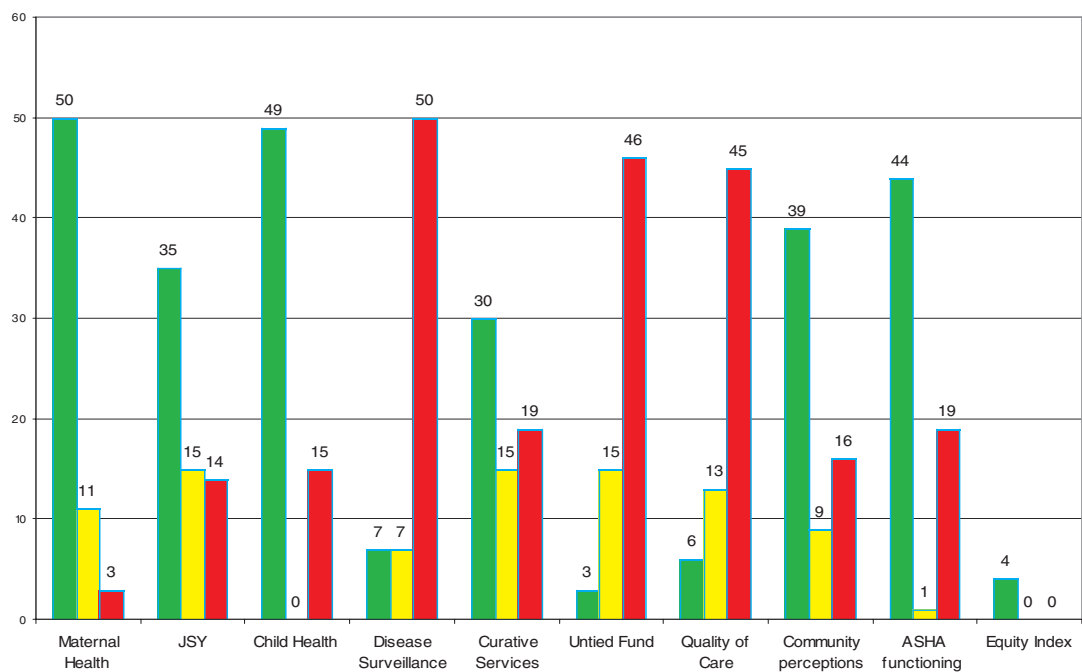
Graph 14

Dist Nawarangapur



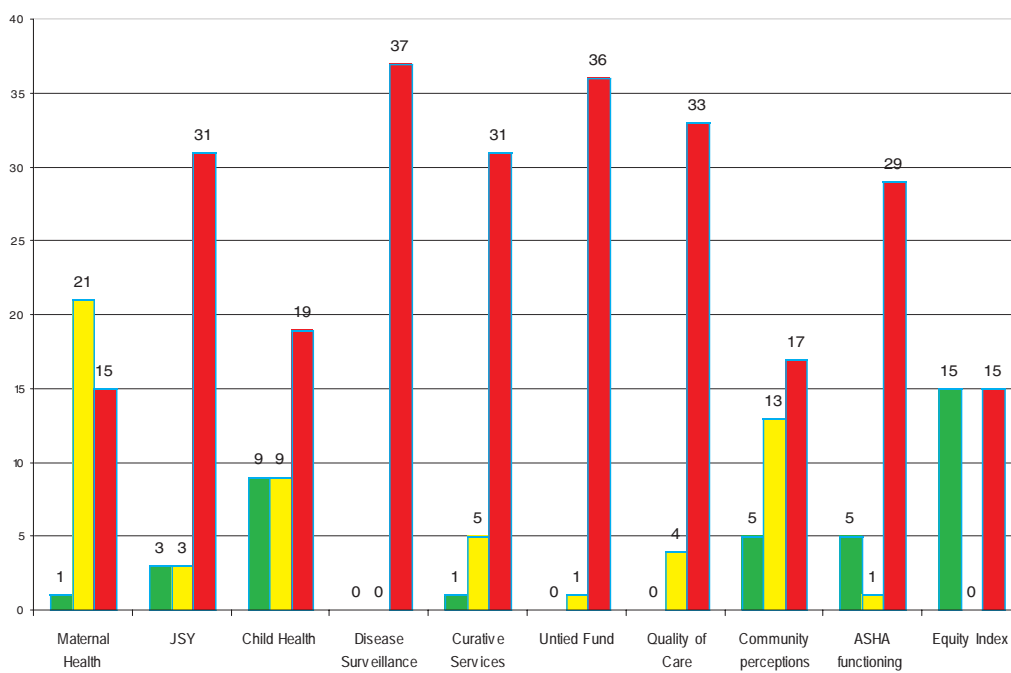
Graph 15

Dist Mayurbhanj



Graph 16

Dist Kendrapara



Graph 17

Triggering a Change

The orientation process helped in increasing awareness on different health entitlements of VHSC members, which brought about positive changes in perception of the members and resulted in increased demand for service facilities.

In addition, the process empowered VHSC members to the extent that VHSC members prepared the health action plan and started working as per the plan even though the VHSC had not received money from the government.

The process also helped in regularising disbursement of JSY funds and facilitated in releasing the JSY benefits.

The process improved ownership among ANMs, AWWs and ASHAs and increased better coordination among them. The CM empowered the ASHAs, as they witnessed that people at higher level responded to their grievances and welcomed suggestions from them and acted on the information provided by them.

Glimpses of Change

A contractual doctor appointed in one of the PHCs was not visiting the PHC regularly. During the public sharing meeting, the villagers complained about this and a new doctor was appointed within three months.

An AWW in one of the PHCs used to charge Rs 50 from the women to make JSY cards for them. A complaint was filed at the district headquarter after which she stopped taking bribes.

ANMs and AWWs are demanding training due to the CM process which in turn helps in imparting health-related information to the community and also in providing services.

The CM process in Orissa has sensitised service providers and beneficiaries. The community has realised that it is wrong to bribe ANM, ASHA or doctors for getting JSY benefits. Most of the women who delivered in hospital before CM faced harassment in order to get the JSY benefits. Now due to strong opposition from villagers, the harassment has stopped and nearly 80 per cent of corruption has been dealt-with by the community at the PHC and CHC level.

Doctors, pharmacists and other staff have now become regular in Badapada PHC due to their involvement in community monitoring process and public scrutiny of their performance. More importantly, a friendly and effective relationship has now developed among various stakeholders.

The PRI members for the first time realised that it is their duty to see that villagers get quality health service at the Sub-center, PHC and CHC levels. Previously, they were under the impression that providing quality health services is only the duty of doctors and their involvement is limited only to construction of road and digging ponds. Now they are taking interest in solving problems related to health services. They are even lobbying for better facilities for doctors and other medical staff like provision of quarters, drinking water and better sanitation facilities.

The score cards helped service providers to understand the actual health situation in their areas which they tried to improve.

Doctors and medical staff are now gradually becoming aware that denial of health services can be made public and disciplinary actions may be taken. They realise that they are accountable for the patients.

Doctors and staff exercise self-restraint in taking money from patients after being involved in the community action process.

Changes at Gaon Kalyan Samiti (GKS) level

The GKS (in Orissa VHSCs are called GKS) formed and oriented under Community Action are self-managed, self-driven, self-reliant and more effective in addressing health issues than other GKS. They work as a team with the principle of cooperation, mutual understanding and support. They have a sense of ownership for the GKS.

The GKS formed and oriented under community monitoring are maintaining proper records of untied funds and their utilisation. They maintain appropriate resolution books and accounts and adopt a democratic process in deciding actions for which funds are to be spent and that it is accountable for. However, in other cases, several irregularities were also noticed when the GKS was not formed in the right process and had not received adequate training.

CM has provided a good platform to promote health rights. The community and committee members at various level now understand that health is their right. So there is effective demand for better health services and at the same time, mutual cooperation between service providers, PRIs, community leaders and other stakeholders.

Some GKS are now preparing their own action plan in order to plan and spend untied fund money. It is also involved in raising more funds that has given them a leverage to spend on the health of the community.

Reaching Out through Media

The Community Monitoring Media Fellowship Programme was instituted to provide prospective to media journalists with an opportunity for reflection, codification and discussion on specific NRHM issues. The objective of the programme was that this would contribute to strengthening of NRHM programmes by



enhancing capacities at all levels. Central to this, the objective was to facilitate individual and organisational learning (block nodal NGOs, district nodal NGOs) involved in community action process and by feeding localised knowledge into state, regional and national processes, and vice versa. Media fellows were selected in each selected district as well as at the state level.

VHSC Resolves Fluoride Problems: Ms. Sanjukta Basa, Secretary, OLAMP; Mayurbhanj

Kurkutia village under Kusumbandh PHC has excessive fluoride in water and nearly 70 per cent people suffer from kidney and liver related problems. Although several complaints were made to higher authorities, nothing much happened. During one of the VHSC meetings I called reporters from the

television channel ETV and apprised them about the situation. Next day the reporters visited the village and saw the problem themselves. Soon after this, I wrote a letter to the District Collector, Executive Engineer RWSS and CDMO of the district and told them about the fluoride contaminated water and how the villagers were unable to use the tube well. The District Collector appointed a health team to investigate the matter. The team found that the problem was serious. After receiving the report the Collector gave instructions to the Executive Engineer RWSS to supply water tankers to the villagers. The district authority is also laying down a water pipeline to the village. The district authority also deactivated the tube wells to prevent people from using the contaminated water. The district authorities sprung into action largely due to the efforts of CM.

Empowered VHSC Tackles Superstition: Ms. Manorama Dey, Block Coordinator, Unnayan Rasgobindpur

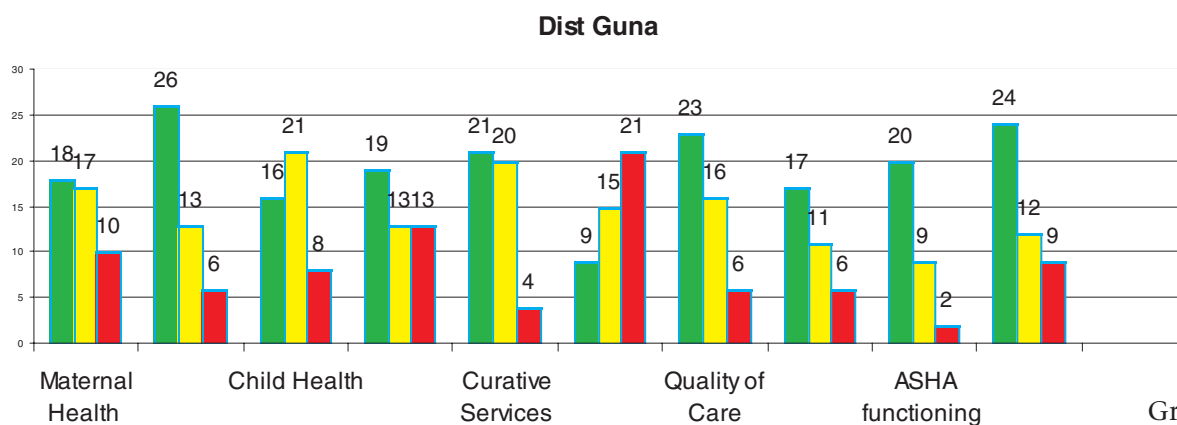
The CM has made a great impact on the mindset of the people. Training and knowledge imparted under the CM has brought about positive changes in the society. In one of the villages of the block, a small boy was bitten by a snake after which the family took him to the local/traditional healer. When the VHSC members of the village came to know about the incident they immediately reached the scene and rushed the boy to the nearest government hospital. The boy was treated for three to four days after which he was discharged.

In another incident, a malaria patient from village was taken to the traditional healer as the family was very poor and couldn't afford to take the patient to the hospital. The VHSC members upon learning about the case arranged transport for the patient to be taken to the hospital. They used the RKS fund for the treatment. They also made the traditional healer to understand that serious cases of malaria need to be treated in hospitals. A change in attitude and perception was felt after the process of CM as the Committee members, with their autonomy and decision-making power were more empowered.

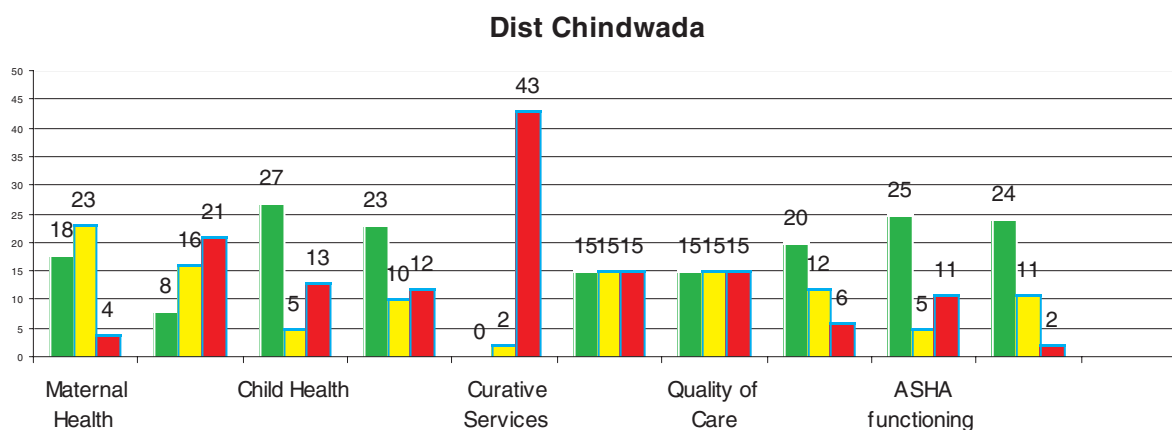
MADHYA PRADESH

A total of five districts were selected for CM In Madhya Pradesh: Guna, Chindwada, Sidhi, Badwani, and

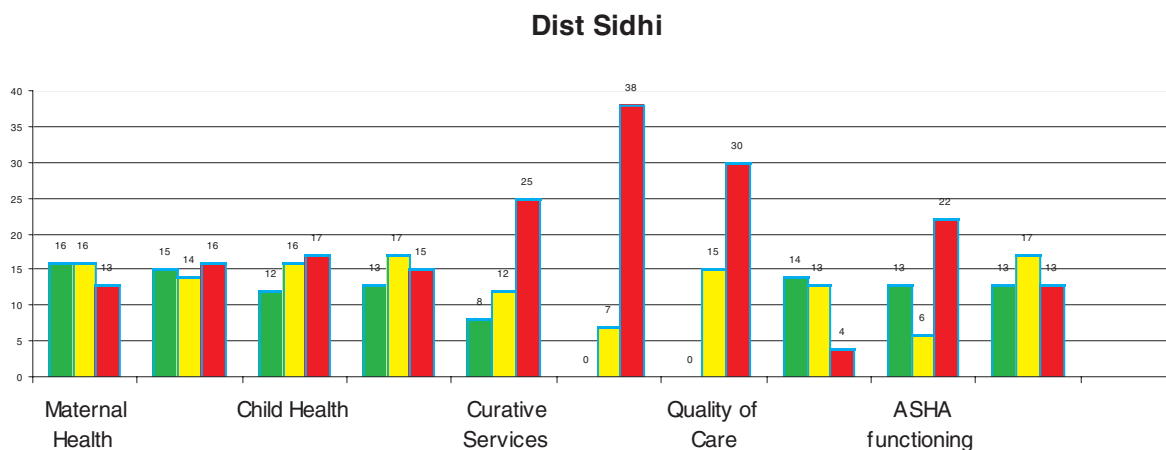
Bhind. The monitoring was undertaken across 225 villages, 41 PHCs and 15 blocks. District wise findings of CM is shown in the graphs(18, 19, 20 , 21 & 22) below:



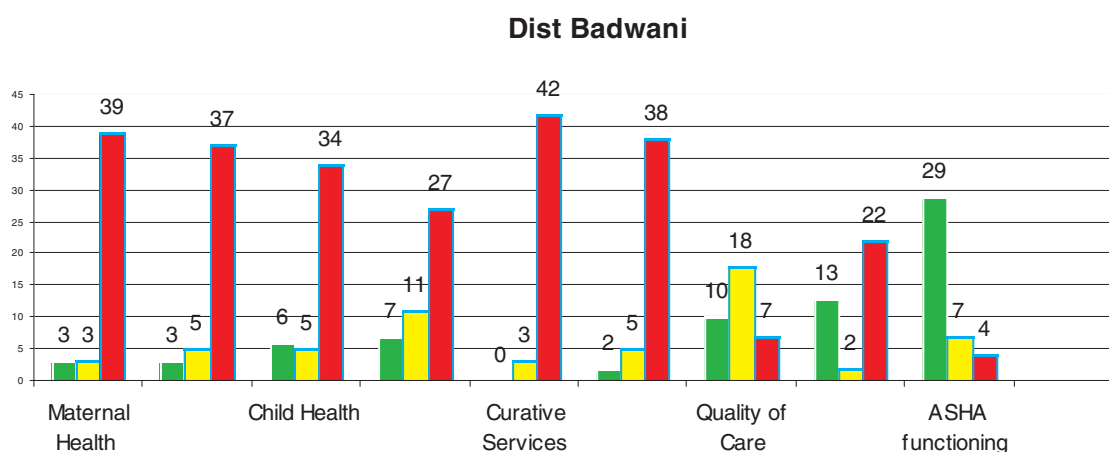
Graph 18



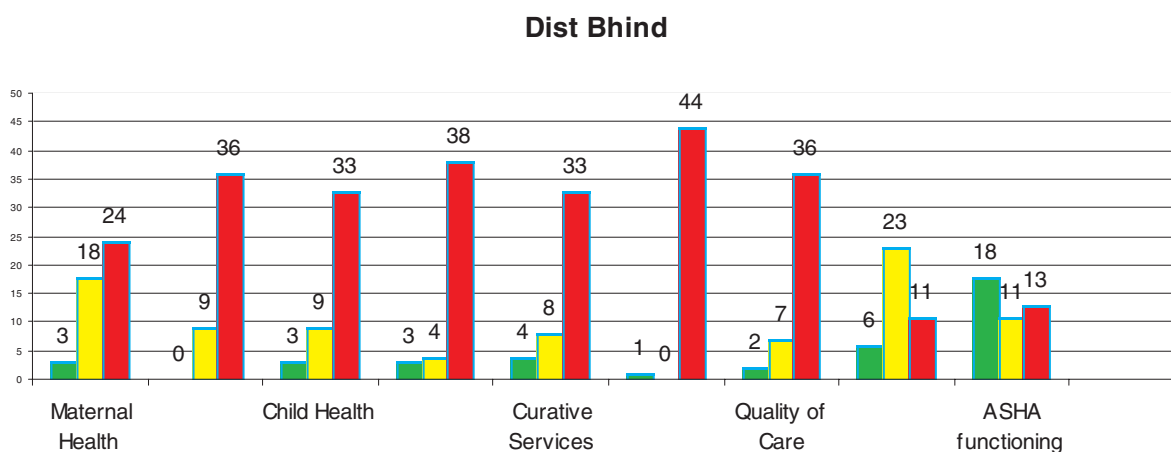
Graph 19



Graph 20



Graph 21



Graph 22

Glimpses of Change

Three days of continuous monitoring of the CHC in Pati block was undertaken after the VHSC was orientated. A dialogue on effective delivery of health services was initiated with the BMO during the period.

The following decisions were taken after the interaction:

- Not to prescribe drugs from private medical stores.
- Making the ambulance available for all patients.
- Starting Janani Express Yojana in the block.
- Not charging anything extra from patients.
- No charges for BPL card holders for treatment during admission in the hospital.

Doctors posted in PHCs, the CMO and the BMO are appreciative of the demand generated for health

services after community monitoring.

Substantial Change Observed in Attitude & Behaviour of Public Health Providers.

There was no doctor posted at Bhuimad PHC of Sidhi district. The compounder, who visited the PHC did not reside at head quarter and was irregular in attending the PHC. However, the community members ensured that the compounder visits the PHC regularly. During Jan Samvad it was reported that no vaccination was being conducted in the Bhuimad area. Post community monitoring, the CMHO himself visited the PHC for three regular months and monitored the vaccination.

Since it was a malaria endemic area, a malaria check-up camp was organised after the Jan Samvad in which more than 1000 patients were examined and treated. Medicine stock was also increased as existing supply of medicines was inadequate.

Baigas are a primitive tribal group who have not received BPL cards on the basis of which they could avail various entitlements and benefits under the Deen Dayal Antyodaya Upchar Yojana Card and receive treatment up to Rs 20,000. The matter was brought to the notice of health officials and it immediately instructed to issue BPL cards along with the Deen Dayal Antyodaya Upchar Yojana cards also to the Baigas. As a result the tribe members were successful in getting the said cards. .

The doctor posted in the PHC said during the Jan Samvad that he could not reside in the head quarter due to non-availability of quarter in the PHC. The villagers discussed the issue during the hearing and took the initiative of arranging a house for the doctor.



In Guna District, the CMHO is highly motivated after the community monitoring programme. He has attended all the district level trainings and visited Block and PHC committees. He has also released the VHSC untied fund and given the responsibility to PHC Committees for supporting them.

Improving Client-Provider Interaction

Gaildubba village, Chhindwara- villagers reported about the ANM not visiting the village to BMO which resulted in regular visits of the ANM. They are also undertaking other sanitation related activities in the village after discussing it in VHSC meetings like cleaning of wells before rainy season etc.

Markadhana village, Chhindwara-villagers put up the ANM visit chart in the Anganwadi centre and monitored the same. They reported to BMO that ANM was irregular. An action was taken against her. In this village also, sanitation activities were undertaken as decided during the VHSC meeting.

Palwat village Badwani - After the delivery of a VHSC member's wife in the government hospital the nurse refused to vaccinate the newborn baby and prepare the card as she was not given money demanded by her for the services. Villagers placed their complaint to the BMO and as a result she came to the village to vaccinate the child and prepared the card.

Ubad garh village, Badwani: The ANM was not coming regularly to the village. In order to monitor ANM performance, VHSC members gave BMO a list of women who didn't received ANC and children who were not vaccinated. The BMO instructed the ANM to visit the villages regularly and meet VHSC members. She responded positively and her visits became more frequent and regular.

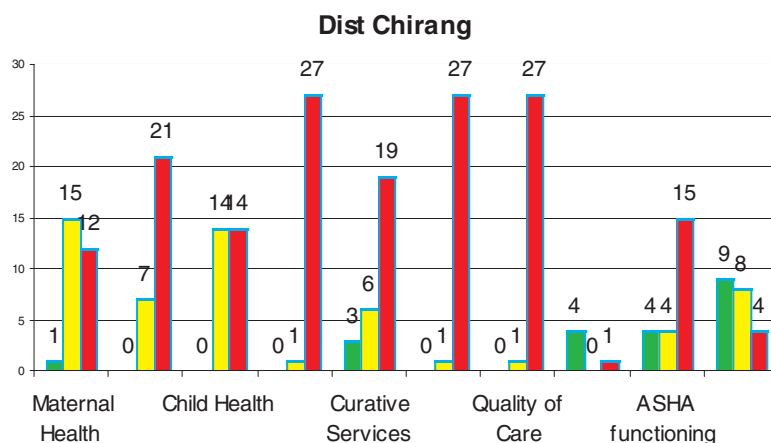
Kandara, Limbi, Berwada, Gudi villages, Badwani the ANM was not regular in these villages. The VHSC took the initiative and wrote to the BMO after which the ANM has started visiting the villages regularly. In case of absence, she informs the same to ASHA or VHSC members. This step taken by her enabled the members to communicate her visit plans to the villagers and save them from inconvenience.

A total of 220 ASHAs in Gohad Block, Bhind district have formed the AHSA Adhikar Samiti for addressing their problems. They submitted memorandum to the SDM, CMHO for timely release of JSY incentives, which is released regularly now.

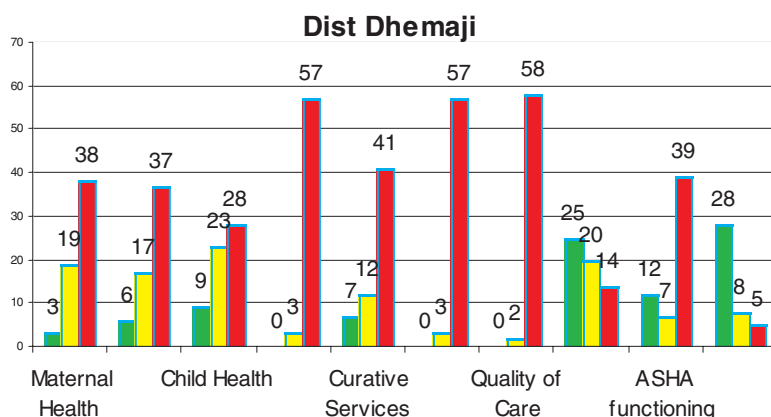
ASSAM

For the first phase of the community monitoring three districts Chirang, Dhemajee and Kamrup Rural were chosen in the state. The monitoring was carried out

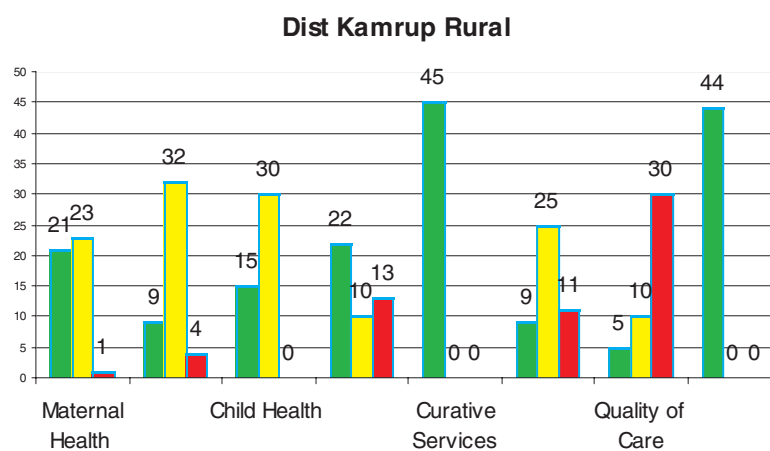
across 135 villages, 27 PHCs and 9 blocks. The state underwent one round of monitoring. District wise findings of CM is shown in the graphs (23, 24 & 25) below:



Graph 23



Graph 24



Graph 25

Community monitoring processes have started empowering people in the state. After the process of CM was initiated in the state, people have started speaking out what they like and what they do not. Due to initiatives taken up in the process, people are now aware about their health rights, what has to be done when there is a denial of services which is violation of their health rights. The process has made community aware about how best they could cooperate with the health service providers.

Another significant achievement is that after the initial progress of CM in three districts, the state NRHM has proposed to integrate the process in two more districts and has included in the state PIP.

Desired changes have taken place

After the first phase of CM positive changes have been seen in the community as well as in the functioning of the Sub-centre at Ratanpur under Jonai BPHC in Dhemaji District.

The Community now feels that having good health is their right and assured service guarantee should be in place. The people of Ratanpur now can access health services at the newly constructed, well-equipped Sub centre, which earlier was in a dilapidated condition. The community monitors working of SW, MPW, reports to MO and looks after cleanliness of the Sub-centres.

As shared by Mr Nirmal Doley (Ward Member) President, VHSC; Ms Premolota Pegu (ASHA worker) Secretary, VHSC; and Mr. Nava Deori, Community Member - the Community has come to know about the responsibilities of ASHA as well as ANM which has improved registration of the pregnant women. The untied fund of the VHSC has now been used more appropriately, e.g. cleanliness of the village, awareness generation programme on Malaria, Diarrhoea, Nutrition Public Health and Sanitation.

Increase in registration of birth and death has also been seen. Village Health and Nutrition Day is now observed in the villages with active participation of the ASHA, AWW, ANM and villagers.

People now have easy access to modern Family Planning Methods (FPM) (Oral Contraceptive Pills and Condoms) Iron Folic Acid tablets from the ASHA and they now don't hesitate to ask and enquire about the FPM in meetings and women also take part in this kind of discussion. Women are now more concerned about their health which is a positive sign for the community.

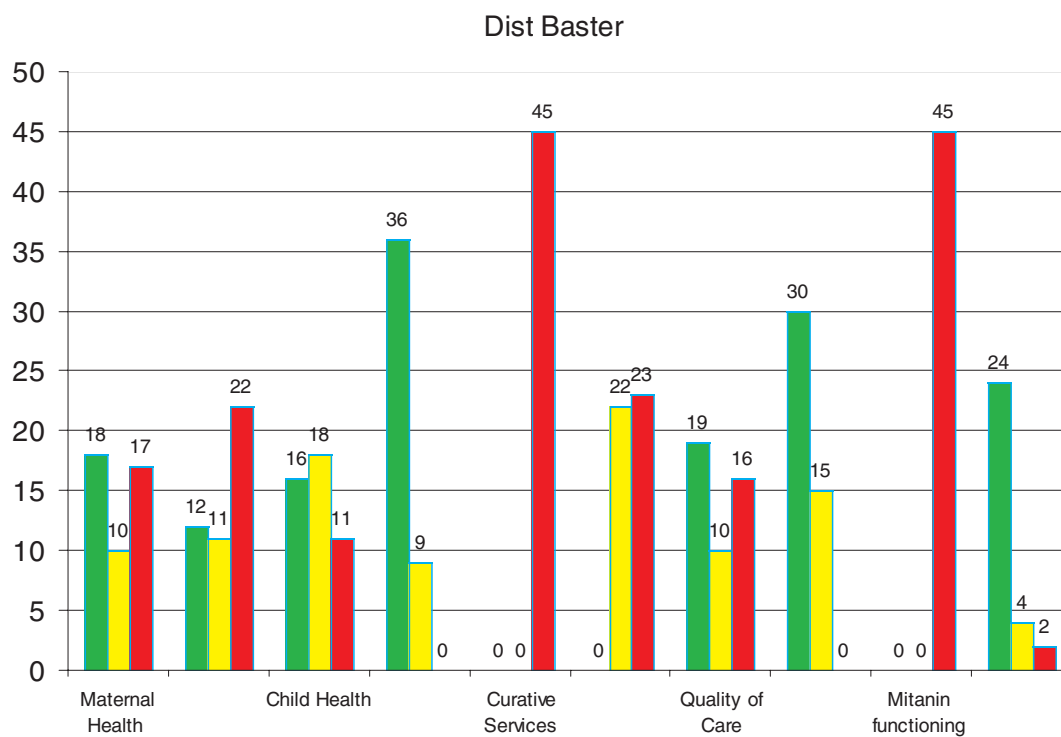
What is more encouraging to note is that though the process is still at a nascent stage, it has not only enhanced the accountability of service providers but also kindled the sense of ownership amongst people which is undoubtedly a core essence of community monitoring process.



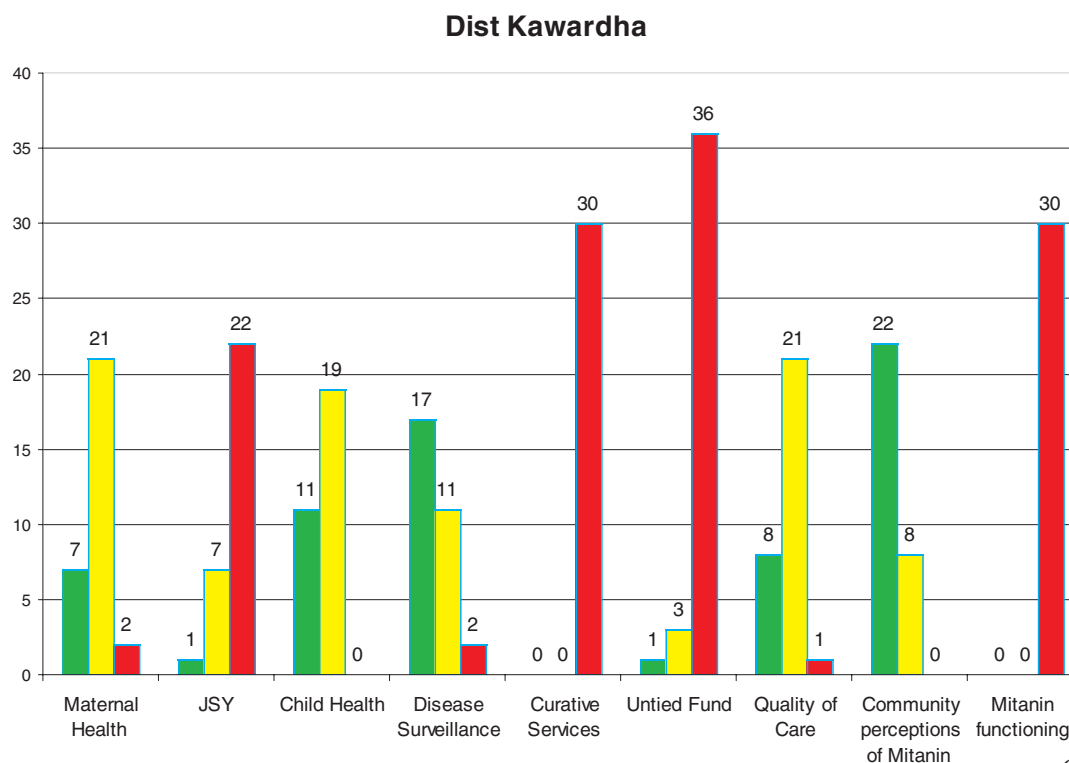
CHHATTISGARH

The state of Chhattisgarh undertook three districts for CM. The CM activity was done across 115 villages, 27

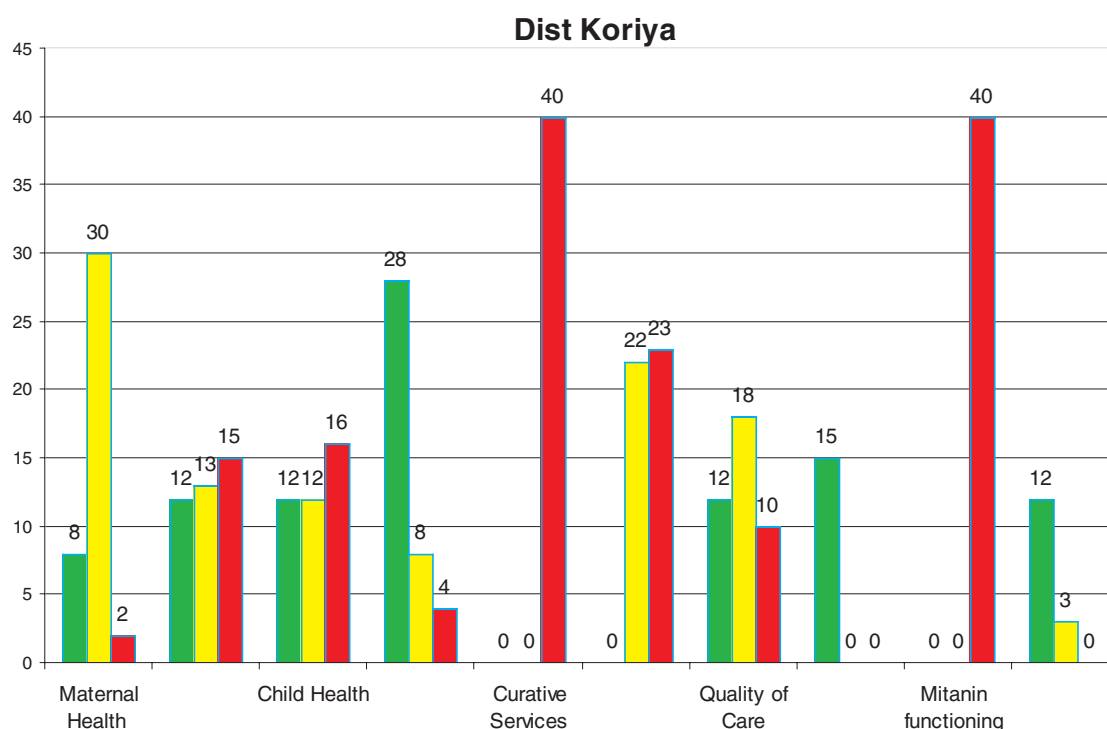
PHCs and nine blocks. The state underwent a round of monitoring. District wise findings of CM is shown in the graphs (26, 27 & 28) below.



Graph 26



Graph 27



Graph 28

VHSC members take charge of health

Bastar Samajik Jan Vikas Samiti, Darva Bastar

This incident occurred nearly 15 days after the formation of VHSC in Bispur village under CM. It was revealed during one of the meetings that adequate and sufficient medicines were not available at the Sub-centre. Several community members also spoke about the irregularity of hospital staff. The meeting was attended by all health workers and health department staff. Soon after the meeting, the VHSC members continued to monitor the health related problems in the village due to which the situation improved. The stock of medicine at the Sub-centre increased and importance was given to hygiene and sanitation issues in the village. The areas around boring wells were thoroughly cleaned. The VHSC members in four villages through their proactive approach not only enhanced the quality of health services in the villages

but raised awareness on CM in the community.

Community Monitoring helped in getting human resource and infrastructure

A meeting was organised at the PHC in Koleng village under CM. While reviewing the health delivery status from the rural community members, it was found that there was a great need of a lady ANM, lady doctor and also of ambulance service. When asked whether the community members were paying any sort of bribe to health personnel or if the doctor was being irregular in his visit, the villagers replied in the negative. They said that they have never paid money to health officials and that they were quite happy with the performance of the existing doctor, Dr Sharma, who had been visiting the Centre regularly and treating people well. Now efforts are being made through the VHSC members to appoint lady health staff at the Centre and also to acquire an ambulance for the PHC.

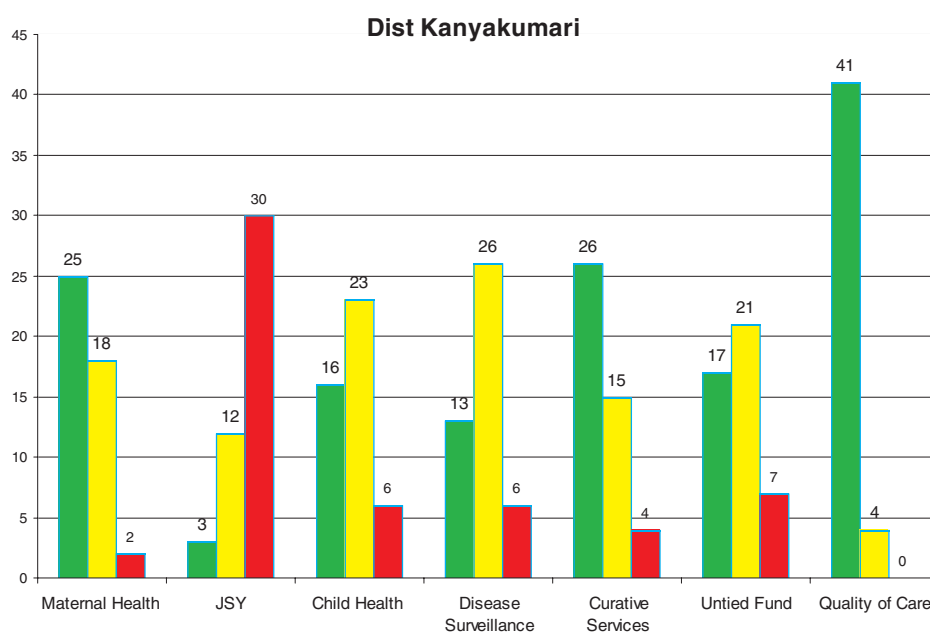
TAMIL NADU

CM in the State has been effectively on ground for about 18 months. For the first phase, the State chose five districts: Dharmapuri, Kanyakumari, Perambalur, Thiruvallur and Vellore. The monitoring was carried out in 225 villages, 45 PHCs, and in 15 blocks.

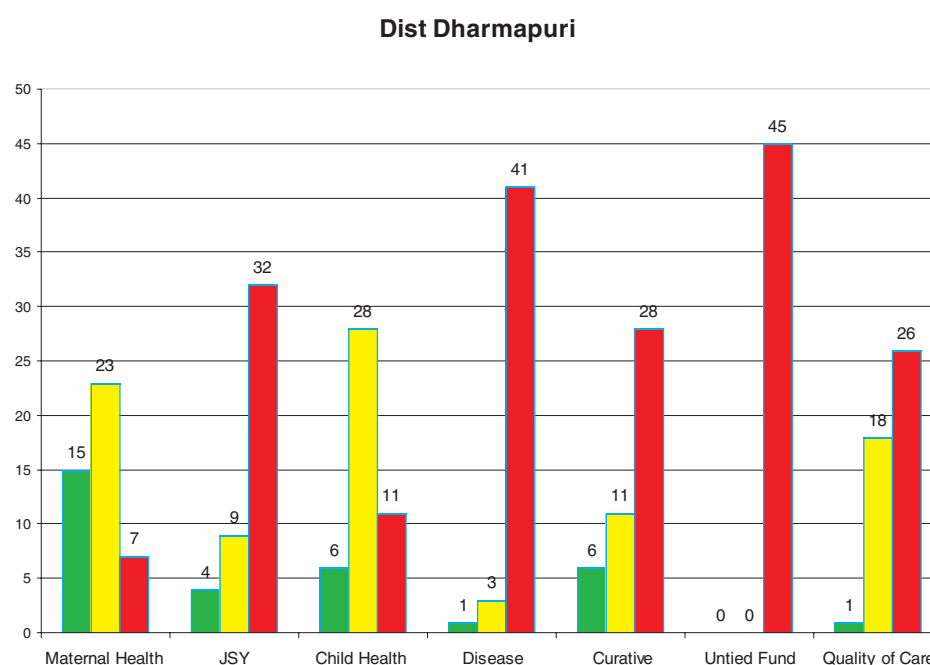
The CM process in the State has set in motion efforts to bring the community to the centre-stage in health delivery. The VHSCs have given voice and visibility to the community and thereafter people have

a better sense of their entitlements and hence their expectation from the public health system has increased. They have also begun to understand the constraints of the Health Department, especially those of the frontline workers. It has not only enabled a better linkage between the community and the Health Department but also enhanced accountability of the Department in engaging with the community and in responding to the community.

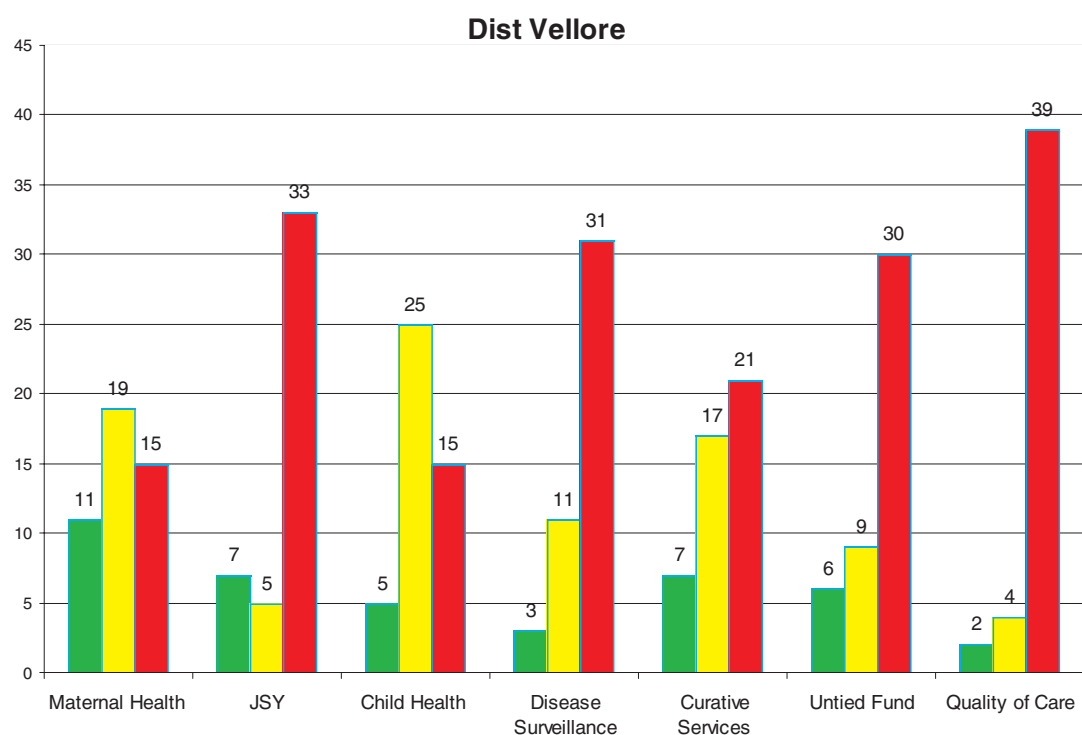
District wise findings of CBM is shown in the graphs (29, 30, 31, 32 & 33) below.



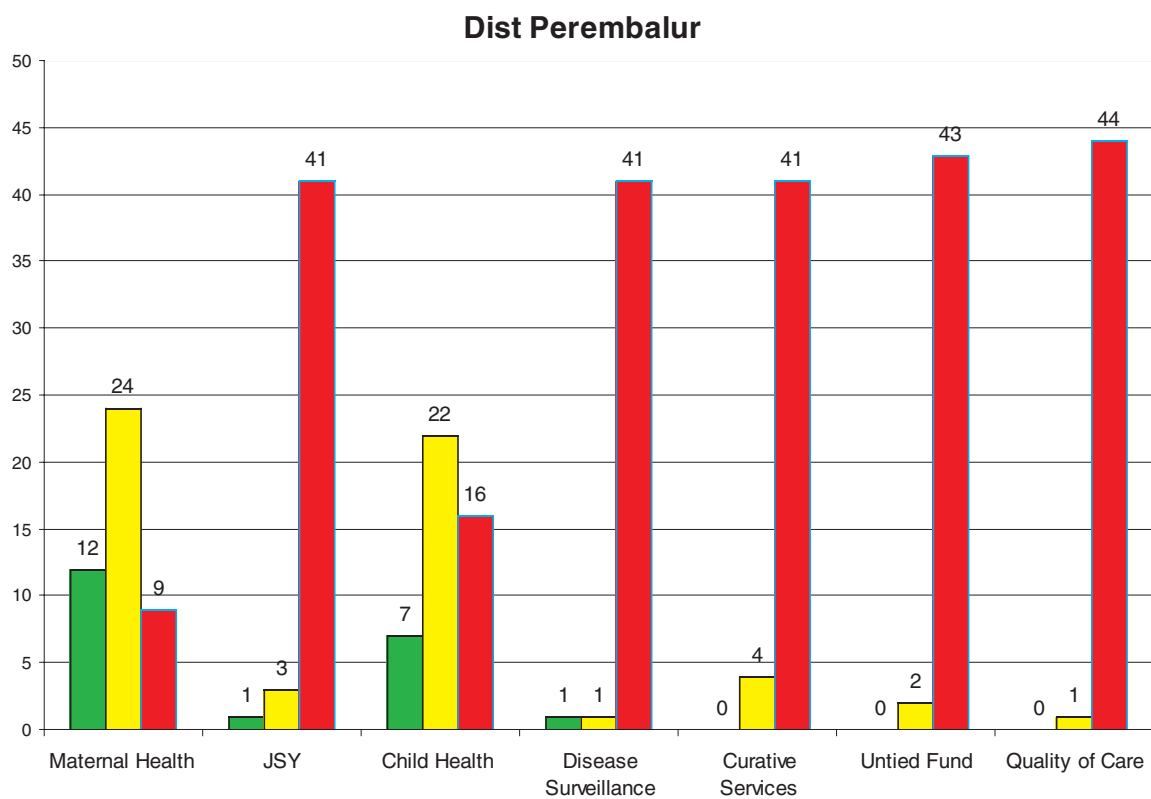
Graph 29



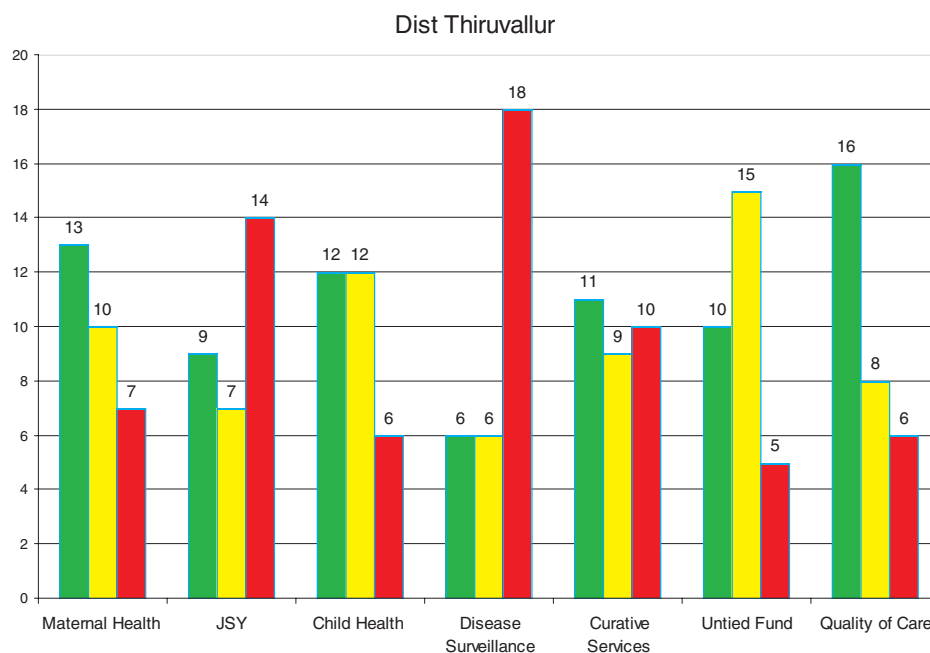
Graph 30



Graph 31



Graph 32



Graph 33

Glimpses of positive changes

In the State, the changes brought about after the first phase activities can be classified at a systemic and community level.

Meeting Demands from an Enlightened Community:

The members of VHSC in one of the districts played a proactive role, thanks to the orientation and training provided to them. The training helped them to access health care services as per their needs and they felt the requirement of a sub-centre in their village. They collected all relevant information from the facilitators and the local health staff after which they approached the appropriate health authorities and followed-up on the issue till the sub-center was actually established much to the surprise and joy of the villagers. This infused the VHSC members with a huge amount of confidence.

It was only after the orientation and training of community members and VHSC members in one of the blocks that they realized that all services of Village Health Nurse (the ANM is called VHN in Tamil Nadu) should be available free of cost. In their particular area, which is very remote, the VHN was actually staying in the village. She was treating simple illnesses at the village level by giving injections and tablets wherever necessary, but she was charging for these services. The

VHSC members discussed this with her. She mentioned that the medicines she was using were bought from the market and that she was merely charging the market price. The VHSC members then approached the MO who then called the VHN and explained to her that people are better aware now and that she should change her old practice. The VHN subsequently stopped charging for her services. She also stopped stocking injections and medicines bought from the market. Despite these positive outcomes, however, some people feel the VHN has now stopped providing health services especially during emergency situations which is a loss.

Ensuring Rights

Despite the fact that there are no user fees for out-patient services in Tamil Nadu, one of the PHCs was charging a small amount for registration and making the Out-patient (OP) ticket. During the orientation and training sessions when the VHSC members were told that this was not a standard practice and that they were entitled to free services, they decided to do something about it. The VHSC members approached the MO and raised the issue pointing out that they were well aware now of the illegality of this fee. The MO immediately took steps to make sure that no money was collected from the patients for what is supposed to be a free service.

During the public hearing in one district, the people raised the issue that in one of the PHCs there was lack of privacy especially for women patients. The Deputy Director immediately ordered that simple partitions be purchased and installed so that privacy for women patients during simple procedures and while taking injections is maintained. This was greatly welcomed by the people in that area.

Long-term Impact through Systemic Changes

Besides these motivating examples of local change brought about during the pilot phase, some of the most significant changes have also been brought about at the systemic level.

- It is for the first time that the Health Department officials and the people met as part of a systemic mechanism and discussed issues from people's point of view. This led to a huge positive feeling among the people.
 - One of the major benefits of the process was that people recognised the various constraints which front-line health staff have to face during the course of their work. This occurred thanks to the fact that the people, now as committee members, raised various issues regarding service availability and quality directly with frontline workers for the first instance. This gave them a chance to understand various issues from the systemic point of view. Similarly, the system began to appreciate the needs and priorities of people and gaps in the system as perceived by people, thanks to these discussions.
 - Thanks to the various changes brought about in the health system and to the CM process; especially public hearings and face-to-face meetings of senior health officials with the people, community members have now begun to perceive the health system as being responsive. It was felt that this was the first step towards full ownership of the healthcare system by the people.
 - As per the Tamil Nadu Government rules, the VHSC consists of 5 members - three of whom (VHN, AWW and Health Inspector) are government staff. It was pointed out at the beginning of the Project that to function as a people's committee there had to be greater community representation in the committee.
- However, it was only after demonstrating the feasibility of formation of such committees during the first phase and continued interaction with higher officials, that there was a consensus that there needs to be a change in the composition. As a first step, a larger group of people at the village level will receive orientation and training in the ongoing VHSC training initiative by the government.
- The potential role of civil society groups in the field of health is being increasingly recognised. Both state and district level officials of the public health system are more open to interaction with civil society-based groups.
 - One of the major outputs from the process has been the publication and release of a document entitled "Community Monitoring and Planning First Phase in Tamil Nadu: A Joint Learning Process." This was co-authored by Mission Director, State Rural Health Mission, Director of Public Health and Preventive Medicine and representatives of civil society of the State Mentoring Committee of the first phase. This paper was a collation of various discussions between the government and civil society groups on various steps/stages and dimensions of the first phase. This paper was released as a background paper during the state-level dissemination workshop. It formed the basis for discussion during a half-day session where various stakeholders, including Deputy Directors, Medical Officers, village health nurses, NGO directors, academics, and project facilitators discussed it. The participants came up with further recommendations for each of the issues raised and discussed in the joint paper. This comprehensive document forms the basis of the next phase of the project.
 - Due to the CM process, the visit of VHN has become regular. Many instances of denial where people were asked to buy syringes have now been resolved. The duty roster, timings and mobile numbers of the VHN are now displayed on walls of the health facility.
 - One of the PHCs of Tiruvellore district used to be often closed and it had no proper transport access. Following the CM, the PHC is now open and the MO visits the PHC regularly.
 - The VHNs are now aware about the availability of untied funds and request for allocation from the MOs. The process of empowerment of VHNs is also believed to be happening.

Innovative Alliances

One of the interesting initiations that the State undertook was to involve VHN associations in the CM process. The involvement with the VHN Association helped to allay their fears about the process as they initially perceived the process as a fault-finding initiative. The President of the VHN Association participated in the state-level meeting, and extended her support to the process.

Children and youth parliament were organised to mobilise the elders in a district. The church too, played a role in mobilisation in certain villages. The Nursing College in the district was roped in to spread information about NRHM and CM.

Folk media and handbills were also used for spreading awareness and mobilisation. These handbills

provide details of the functioning of Sub-centers and the services provided in them; facilities in a PHC and services provided in a PHC; details of duty time of doctors, nurses and VHNs, other staff, and the citizen's charter. This is one of the major outputs of the process. The presence of volunteers from the literacy movement - Valar Kalvi Thittam (Continuing Education Programme) is a significant strength in a few districts. They helped to mobilise the community in many villages. In fact, these volunteers took the lead in preparing score cards in villages where they were present.

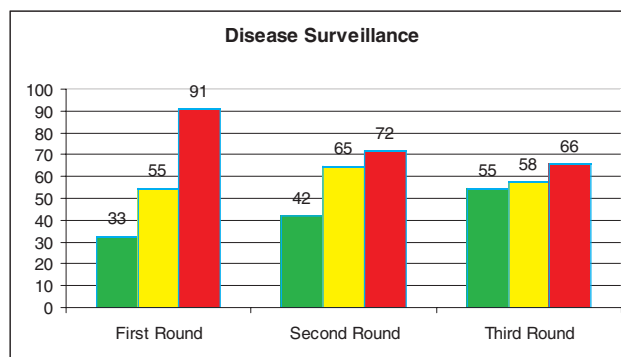
Another small but significant initiative undertaken in Dharmapuri district was issuing of ID cards for VHSC Members so as to ensure that they are recognised and accepted by the Health Department.

KARNATAKA

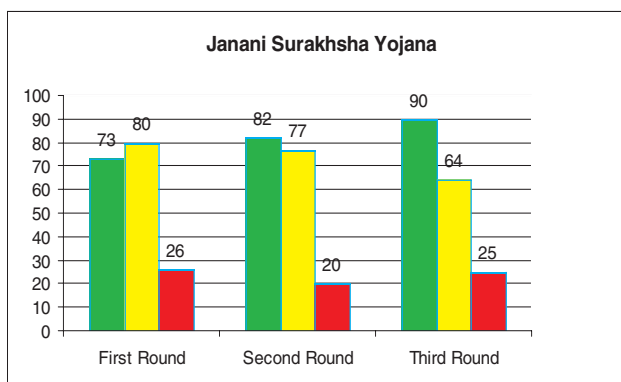
For the first phase of CM in Karnataka, four districts were selected with a target to cover 180 villages across the State. Karnataka was included in the CM process quite late but it managed to form 562 VHSC which was way above the original target of 180 across four districts. The State gradually increased the number of villages as it undertook rounds of monitoring. The State underwent three rounds of monitoring over a six months period and witnessed significant changes. Four districts, 52 PHCs and 12 blocks were taken for this process.

Visible Difference

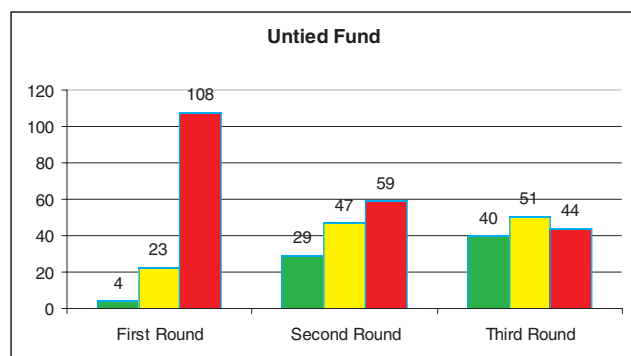
Analysis of the score cards shows that the perception of community members on various health and health service parameters has changed. All the parameters over the project period show differential degree of progress (red signs decrease while yellow and green signs increase). Round wise findings of CBM is shown in the graphs (34, 35, 36, 37, 38 & 39) below.



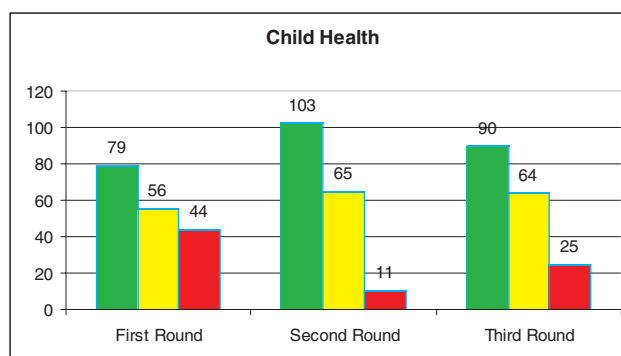
Graph 36



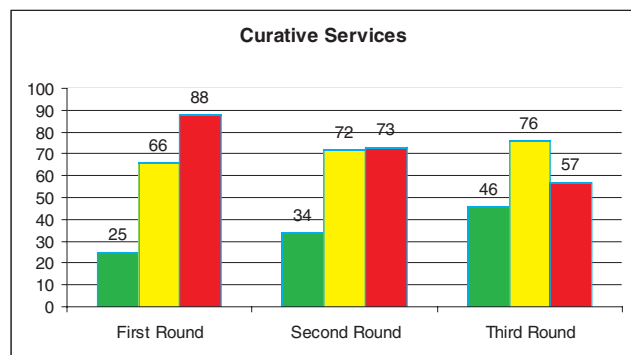
Graph 37



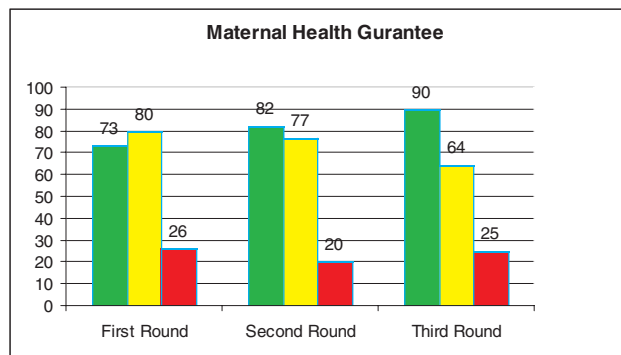
Graph 34



Graph 38



Graph 35



Graph 39

Glimpses of Change

Jan Samvads resulted in action being taken in some areas - such as use of untied funds at PHC and SC level for repairs of infrastructure and equipment or posting of health personnel in some cases.

The process has also resulted in more accurate reporting of deaths. For instance, in the last six months, in one Taluka alone, the VHSC process identified six infant deaths and one maternal death, which were not picked up by the system earlier.

The State Government took strong ownership of the programme and worked in close partnership with civil society organisations. State Mentoring and Monitoring group (SMMG) included key officers from the state Health Department and the NGOs that shared a common vision and commitment. The SMMG facilitated coordination at state and district levels and significantly influenced the outcomes.

A common focus across districts on the high level of investment in village processes including three member CRP team to (i) mobilise community, (ii) form VHSC, (iii) train VHSC members and (iv) facilitate score card filling - have resulted in strong VHSCs.

The CM process worked as an agent to bring together ICDS and AWW and helped them perform better in the absence of ASHAs (Karnataka has no provision of ASHA). In some of the CBM villages, convergence between health and ICDS was further strengthened as the AWW took a leadership role as a co-convenor, and in many instances she served as the de facto convenor.

Innovative Deviations

Karnataka chose to make two significant deviations from the national design. One was to expand the process to "planning and monitoring" instead of just "monitoring." Thus, the initiative in Karnataka is referred to as Community Planning and Monitoring of Health Systems (CPHMS).

The second was in terms of geographic coverage. The departure from national guidelines of covering five villages in each PHC area to attempt universal coverage of all villages in the PHC area resulted in 80-100 per cent coverage of villages under each PHC.

Kala Jaththa as a prelude/precursor to VHSC formation served to mobilise communities and facilitated acceptance of marginalised groups by general community. Kala Jaththa performances also



facilitated acceptance of marginalised groups by the general population.

The state undertook the Participatory Rural Appraisal (PRA) techniques to mobilize community, the method was used for formation of VHSCs and developing village action plan.

Another initiative that resulted in high community acceptance of the process was a series of meetings held with different caste groups prior to the VHSC training. Appointing ten Community Resource Persons (CRP) at Taluka level to create VHSC was a critical measure in achieving scale with quality. The CRP invested substantial time in working with all sections of the community in these areas (where



casteism is high) to ensure appropriate representation on VHSC.

In all districts of first phase, the district coordinator networked with the local media to enable periodic articles in the regional language press about the process and ensuring coverage in the Jan Samvad. This yielded results, particularly the publicity in regional language newspapers.

However, the coverage varied across the districts.

Several variations from national guidelines in capacity building process strengthened it. Also, the State organised a district level TOT for nodal NGOs rather than one common state level TOT in order to provide more focused and high level mentoring and support to the district NGOs.

A Transformed PHC

A Success story by Community Health Cell, Bangalore - Nodal Organisation for Raichur District -

Gunjalli is a village situated at a distance of 22 km from Raichur district headquarters, covering a population of 35,000 in 20 villages within its jurisdiction.

Before the CM, it was a very low-performing PHC with less than 40 per cent immunisation coverage. Though VHSCs were formed the members did not know about their roles and responsibilities, with zero utilisation of untied funds. Most of the deliveries were taking place at home. After the intensive process of CM training, Jan Sunwais and follow-up during the CM process, the atmosphere in the PHC and in the villages taken for CM was transformed.

Activated VHSCs: Ten VHSCs were revitalised and started functioning. The village health plans made included addressing health and hygiene issues. In the villages, Unradoddi and Gunjalli, the area around bore wells did not have any drain and hence was dirty due to accumulation of waste water causing unhealthy atmosphere for school children. The VHSC had soak pits dug (filled with coal and sand) and the place was covered with granite stones. Another VHSC cleaned gutters in these villages, with the help of women Self Help Groups. This added to the cleanliness of the villages. Though NRHM started in 2005, till the CM in 2008, the amount under JSY was not distributed at all. At the Jan Samvad, 189 women were given their dues for the first time. The disbursement of JSY started then is now happening regularly.

- The PHC untied fund was not utilised at all till 2008. During the CM, in the months of Jan-Feb 2009 the PHC building was painted and renovated, filtered drinking water unit was installed, the hitherto unusable toilets were repaired and were tiled, a TV was installed for patients to watch in the waiting area. Patients and pregnant women had to sit on the floor or stand in the waiting area. So, chairs (20) were made available at the reception. The area around the PHC, which was earlier filled with waste and bushes got cleaned and a compound wall was erected around the PHC. The loads of red soil around the PHC not only helped in filling all the uneven places, but also enhanced the look of healthy atmosphere giving it a new and clean look.
- Though the PHC was declared 24 x 7 functioning PHC in 2006 itself, it had only one staff nurse and a doctor. With the pressure of people and the influence of Jan Samvad two more nurses were posted. This resulted in the increase in immunisation coverage to 80 per cent from the earlier 40 per cent.
- Institutional delivery saw a rise even up to 35 deliveries a month. On an average, about 25 deliveries have been conducted every month during and after the CM.

Dr. Anil Kumar, the Medical Officer, was extremely cooperative with the process. In the entire process, the involvement and participation of people around the villages has significantly increased. "Due to people's involvement and doctor's cooperation we saw a transformation in this PHC", say Shivram Reddy and Tarakeshwari of Roovari (NGO) who were involved in the process of CM.

Section - III

Review of Community Monitoring

The first phase of the community monitoring process was implemented in nine states of India. The process went through several challenges and invited both admiration and critique. The AGCA wanted to conduct a rapid assessment/review of the first phase of CM to identify key achievements and challenges to make recommendations for further scaling up. The AGCA suggested that the review must be conducted in a participatory manner, and must be steered by a three-member team in each state. The review was proposed for all the nine states to assess, if the objectives of community monitoring were fulfilled to identify key learnings and challenges and to highlight successful innovations. This section has been drawn from the National Review Report (Coordinated and written by S. Ramanathan) submitted by the review team.

The review was undertaken with the following objectives:

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

Methodology - Ensuring Field Rigor:

The review was conducted by external consultants (Dr. Ashok Dyalchand in Maharashtra and Rajasthan, Ms. Rajani Ved in Karnataka, Mr. S. Ramanathan in Orissa and Tamil Nadu, and Ms. Renu Khanna in Madhya Pradesh) along with representatives from the National Secretariat and State Mentoring Groups. The National Health Systems Resource Centre (NHSRC) undertook the review in three states (Assam, Chattisgarh and Jharkhand).

The field visit in each state was for six days. As one of the objectives of the review was to identify lessons for scaling -up, a middling district was identified to learn what worked and what did not. Three days were spent in the field and three days at the state level. The first

two days at the state level were spent on interviewing/meeting government officials, members of the State Mentoring Group, state Nodal NGO, NGO representatives from other districts, media representatives and development partners. In the field interviews were held with MO, ANM/VHN, ASHAs, AWWs, Sarpanch and representatives of NGOs at the district, block and village levels, and group discussions were organised with members of various committees. The final day of the review was spent on presenting preliminary findings of the review and filling gaps, if any.

The review covered wide range of issues like national and local context of the state, institutional arrangements such as different levels of committees and mentoring team, the process of CM in the state including selection criteria for nodal NGOs and capacity building, monitoring and reporting, and engagement with media and linkages with other processes of communitisation.

Ready for Roll-out - Summary of Findings:

In period of 18 months, only one cycle of monitoring was done. Hence, the review team felt that it was too early to assess the outcomes of the process. However, there had been significant gains. The gains include:

- Preparation of national and state level resource materials.
- Formation of over 2000 VHSCs in nine states
- Preparation of report cards in all VHSCs
- Organising Jan Samvads/Jan Sunwai
- Completion of one cycle of monitoring

The gains are reflective of the commitment and passion of all stakeholders - GOI, state governments, NGOs and communities. The crusader approach and the spirit of volunteerism are abundantly evident in the way community monitoring was implemented in the nine states. The review does indicate that with the implementation of community monitoring, the promise of communitisation articulated in the NRHM

Framework is beginning to be fulfilled. Therefore, it is imperative that the first phase is expanded forthwith and sustained to ensure that this promise is realised.

There had been rapid acceleration in the implementation of the community monitoring in the last six months of the first phase; building upon the strong preparatory phase of the Project. During the review, it was found that a few states had begun the process to include it in the Annual State Program Implementation Plan (PIP) for the year 2009-10. Karnataka had committed Rs 25 crores for implementation in the next year. Maharashtra, Orissa, Rajasthan, and Tamil Nadu had initiated steps for inclusion of community monitoring. Other states are in process to do so.

Key Findings on the Process

Selection process:

The criteria for the selection of the districts varied across states. The presence of civil society organizations and regional representation were some of the considerations in the choice of districts and blocks within them. The NGOs did the first -level identification of districts. The selection of the districts was discussed with the State Governments and in almost all the states, the Government modified the selection.

In nearly all the states, Government largely did not interfere in the selection of district and block nodal NGOs at any level. They accepted the choice made by the state nodal NGOs.

Community Mobilisation

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

Village meetings coupled with home visits to socially excluded groups, especially Dalit hamlets and women, was the major strategy in almost all the states.

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

In many states, getting Government Order (GO) issued for formation of VHSCs proved time-consuming. In Orissa, the guidelines for VHSC formation kept changing. While this reflects an evolution in the process of forming them, constant changes reduced the project period available for mobilisation and the process was hurried through. In one block in Rajasthan, it was observed that the mobilisation depended on political affiliation - the Ruling Party representatives were not keen on forming VHSCs or in convening the meetings, whereas the representatives from the Opposition Party were very keen. Communal divide is said to have hindered mobilisation in parts of Rajasthan.

Committee Formation

VHSCs: The VHSCs were reconstituted in Tamil Nadu and in few villages of Madhya Pradesh, where VHSCs already existed. They were reconstituted, given the NRHM guidelines. In the remaining states, new committees were formed. In Madhya Pradesh, the reconstituted VHSCs were approved by the Panchayats in the Gram Sabha. This was also done in two districts of Tamil Nadu. In Maharashtra, Gram Sabhas could not be convened in all villages; hence, VHSCs were formed by convening small group meetings.

The VHSCs reflect a significant social capital and they have to be nurtured to strengthen communitisation in NRHM. While the community mobilisation and the formation of VHSCs has increased knowledge about entitlements and rights in the community, it is still limited. There is a need for more orientation and strengthening of the VHSCs.

It was observed in Orissa that women outnumbered men in almost all the VHSCs. On an average, the ratio of women to men representation was 3:1. Many see participation of women as advantageous as this is expected to lead to a better health status in the household. However, from the interactions with the women during the review, it

emerged that they did not have much freedom to decide on any issue. Any decision taken by them needed the approval of men. In Tamil Nadu too, men rarely attended the meetings.

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

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

In almost all states, there is no significant participation of health officials in the formation of committees above village level. Even the PRI representatives rarely participate. The objective of bringing together the Health Department, civil society and PRI representatives to mentor and support the process is not realised. It is important that Health Department convenes these committees. This is essential to ensure that these are not seen as NGO committees.

The review felt a need for orienting and building capacity of the members of these various committees above the village level.

Report Card Preparation

Village Report Cards: The process for preparation of Report Cards is uniform across all states. The NGO facilitators mostly prepare the report cards. The VHSC members find the preparation of the report cards very complex. The review also indicates that even NGO facilitators found the report card preparation process and tool to be difficult. For e.g. there is confusion in marking, especially on marking negative responses. In Tamil Nadu, the NGO facilitators took nearly three months to internalise the tools.

Sharing village report cards: In Tamil Nadu and

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

In almost all the states, some officials of the Health Department are aware of the score cards but the knowledge of score cards overall within the Department is still limited.

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

One key issue that emerges from the review is the need for simplification of the tool as the current tool is complex. This view emerges from all the states.

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

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

Jan Samvad/ Jan Sunwai

Jan Samvad is an important process for sharing the report cards. The objective of Jan Samvads was to create a common understanding of key health issues among the community; to review the current

implementation and to prepare action plans for improving NRHM implementation. The Samvad is also an opportunity for dialogue between the community and the Health Department.

The Report Cards were the basis for Jan Samvad. In some instances, case studies were prepared and shared in the Jan Samvad. The process of Jan Samvad was intense in terms of mobilising communities and service providers.

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

However, the Samvads, have also raised the ire of service providers, in some instances. In Rajasthan, the issues raised in the Jan Samvad led to conflict between the community and service providers at the lower levels. In Chattisgarh, a Medical Officer said that Jan Samvads should also highlight the conditions prevalent in the facilities - lack of water, equipment, schooling and quarters for the staff and not just issues of service denial. Following Jan Samvad in Maharashtra there was opposition from field workers and resistance at the block and district levels. Service providers observe that Report Cards and Jan Samvads do not highlight the efforts by the health workers. They only highlight service gaps, deficiencies and denial of rights and entitlements.

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

Engaging the Media

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

Media has played an important role in highlighting community monitoring and being its advocate in some instances. Reports were written in national newspapers such as 'The Hindu' (The Times of India) and in local dailies.

However, in several instance the media tended to sensationalise the issues. They disproportionately highlighted issues of denial and weaknesses in the Health Department pointed out during the Jan Samvads. Following the media highlight, there is a sense of fear, resistance and an increase in the adversarial position from the Health Department.

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

Key Findings on Programme Management

Capacity Building

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

The capacity building was done in a cascading manner in almost all the states, following the pattern recommended by the National Secretariat. In almost all states, besides classroom teaching, field visits were organised to provide hands-on training in filling report cards and in mobilisation.

The first phase has created a resource pool of trainers at the state and sub-state levels. This resource

pool should be nurtured and upgraded.

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

There was no significant participation of health officials in the trainings. This is despite the efforts of few states to break the training to phases to ensure their participation. The health officials cited other responsibilities as the reason for non-participation. One of the main learnings from the first phase is that capacity building of the health officials from conceptualization to details of community monitoring and action is as important as capacity building of community and civil society groups.

A more regular process of orientation on-job support and supportive supervision and handholding could have helped the process. In Karnataka, besides the training, a very high degree of on-job support and handholding is provided by the district NGOs. This had a significant impact on the implementation. The handholding by district facilitators is also evident in Bolangir district of Orissa. Few members of the State Mentoring Team in Tamil Nadu backstop the process in a significant manner. Whereas places where such continued on-job support is provided, it has made a difference in implementation.

Relationships and Convergence

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

The Health Department in many states appear uncomfortable with the term "monitoring." The term "nigrani" was not well accepted as the officials felt that the purpose of community monitoring is to ensure quality service rather than finding faults. They felt that the process is more of an action than monitoring. They renamed the process as community action. Karnataka decided to amplify the process to include planning as well.

While the acceptance at the state level was mixed, the acceptance at sub-state levels in almost all states was low. In Orissa and Tamil Nadu, the health officials lower down often refused to acknowledge letters issued by state officials. They provide support only if there is a direction from the district officials. In Karnataka also, where there was a high level of acceptance at the state level, it does not translate into any effective cooperation at the sub-state levels. In Maharashtra, NGOs had to depend on administrative orders from higher authorities to enforce attendance at meetings at lower levels. Despite the high acceptance at the state level in Rajasthan, the relation between NGOs and health providers was adversarial in the PHCs visited for the review.

The review felt that it was important to overcome this and engage the Health Department as a partner in the process. It is important to ensure that the health officials do not feel intimidated or threatened and perceive the VHSCs and NGOs as adversaries. To enable the acceptance it may be helpful if data generated by the community monitoring is used in planning, implementing, improving services, concurrent monitoring, rather than merely to find fault. It is important that the threat perception is removed and the link between planning and monitoring is established. This has been done in a few states and this needs to be done in other states as well.

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

Relation with PRIs: This is one of the weakest links in almost all states. In Maharashtra, the PRIs are indifferent to the process. Their non-involvement has an impact on community mobilisation and in identification of persons as members of the VHSCs. In Karnataka, the PRIs are yet to be engaged in the process. Although the PRI members largely head the VHSC in Orissa, they rarely turned up for the meetings. However, the participation of PRIs in Orissa as compared to other states appears to be better.

Relation between NGOs: Majority of the NGOs involved in the pilot phase in most of states are a part of other networks. Most work together on rights-based issues. Many are affiliated to the Jan Swasthya

Abhiyan. Their membership in a pre-existing network and a shared value and commitment helps to smoothen the process of working together. Hence, there is harmony between the NGOs involved in community monitoring. Some however, are new to this arrangement. Decisions are taken in a participatory manner in most states, which help to strengthen the collective. The formation of network of NGOs on community monitoring is an important output too. The network could be a source of support when the process is scaled-up in the respective states.

Short Term Gains

The gains are impressive, despite the short implementation time. The most significant gain from community monitoring is the active engagement between the community and the Health Department. It is enabling the community to be in centre-stage and making them a significant stakeholder in the management of public health system. It is empowering too, as the VHSCs have given a sense of identity and voice to community. Given the project duration, the work done on formation of various institutional arrangements to facilitate community monitoring across the nine states is commendable. The VHSCs and various committees above the village level reflect a significant social capital and they should be strengthened, nurtured and sustained to contribute to the communitisation process in NRHM.

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

Gains on Gaps

There have been gains from an equity perspective too. Community monitoring has involved the excluded

and the marginal groups in the process. There was an affirmative approach to ensure that the Dalits, the ST and the women were involved. Steps were taken, in many states to ensure that women, Dalit and ST members headed the VHSCs. This is an important gain from the process.

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

Equipped for scale-up

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

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

Key Recommendations

- The Review Team strongly recommends continued support from the MoHFW for the process. The process still needs significant nurturing and direction from MoHFW. There is a need for technical and financial support to ensure that the process continues to be implemented in the first phase states as well as initiated in other states.
- To ensure this, there is a need to build ownership of the process by the respective State Governments. The process of building ownership should continue in the first phase states and the process should to be initiated in the remaining states. The AGCA with support from MoHFW and

various NGOs, who were a part of the first phase should enable this. As a start, the review recommends a dissemination meeting of the first phase experience and exposure visits by teams from Health Departments of different states. The capacity building of Health Department personnel for communitisation and community monitoring has to be a key result area.

- Community monitoring should be anchored within the larger communitisation process of the NRHM; and within an existing arrangement in the Health Department. This is essential to ensure acceptance of the process by the health officials and to ensure that the process is scaled-up. However, while the implementation role is anchored in an existing arrangement in the Health Department, the oversight role should be kept separate. The oversight committee at different levels should have representatives of government and civil society.
- The Review Team recommends that community monitoring be linked to village level planning. Monitoring, after all, is a post-facto exercise. In addition, community may monitor a programme that is top-driven and framed, without a concern for their needs. Community ought to have a control over what is implemented too. To enable the link between planning and monitoring, it is recommended that ASHA be involved in the process. ASHA could assess the health needs and the VHSCs prepare a health plan based on those needs. This could be incorporated as a part of the district plan by due process. On a monthly basis, ASHA will report to the VHSC if the health needs are being addressed. This process will enable planning, implementation and monitoring too. It could also facilitate triangulation of data. If after this collaborative effort, there are still gaps in service provision and denial of services, it could be resolved in Jan Samvads held at regular intervals. The Review Team believes that this strategy could be replicated and likely to be more acceptable to health providers, administrators and policy makers.
- The NGOs, who are part of the first phase at various levels, should be involved as resource

centres and provide technical support to the process - in developing training materials, training VHSCs and health officials, on-site support for the VHSCs, monitoring and in process documentation. Community monitoring, when scaled-up, should involve mother NGOs SHGs, women Panchayat members' collectives and PRIs. Efforts should be made to strengthen the role of PRIs in collaboration with Rural Development Department.

- It is essential to ensure that both the process and tools for monitoring are simple and adapted to local needs. Hence, it is recommended that the processes and the tools followed in the pilot phase be simplified. The review also recommends an incremental approach. To begin with, monitoring be done with few indicators and gradually expanded to both build the capacity of the community and acceptance by the Health Department. Initially, monitoring could be limited to mortality and this could be linked with planning. Gradually, other indicators could be added.
- The Jan Samvad is currently seen as being led by the NGOs. It is important that the process gradually becomes a community led process. This is important to ensure community involvement and accountability of the Health Department.
- The process, when up-scaled, should not be limited to a one-year cycle in the manner in which the pilot phase was done. The process needs significant nurturing. It should be supported for a minimum of three years to ensure that the institutional arrangements are functional and mature before a decision is taken to restructure or revamp the process.
- The first phase has been largely supported by volunteerism on the part of NGOs. This may not occur when the process is scaled -up. Hence, it is important that a realistic assessment of the human resource requirement is done and budgeted for.
- The review recommends that adequate budgetary support be provided for community monitoring to realize the promise of communitization, under NRHM.

Innovations in the Process

Selection

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

Community Mobilisation

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

VHSCs

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

Report Cards and Tool

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

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Annexures

Annexure I: List of Materials

S/N	Particular	Language	Description
	Brochure		
1	Apne adhikar janiye	Hindi	Services given by ASHAs, JSY scheme, ANMs, PHCs and Sub Centers under NRHM.
2	What is Community based monitoring	English	What is first phase of Community monitoring, process of community monitoring, initiating community monitoring, role of civil society organizations in community monitoring, activities within community monitoring and timeline of activities.
3	What is Community based monitoring	Hindi	Translated from English version.
4	What is Gram Swasthya Samiti (VHSC)	Hindi	What is the VHSC, members of VHSCs, role and responsibilities of VHSC and untied funds.
5	Swasthya evam Poshan Diwas (Health and Nutrition Day)	Hindi	About Health and nutrition day, preparation before organizing the day, facility available, suggestions, information and referral.
6	Prathmic Swasthya Kendra (Primary Health Center)	Hindi	Services available at PHC.
7	Upkendra ko milne wali mukta va anudan rashi	Hindi	How to utilize untied fund at the sub centre, dos and dongs of untied fund.
	Poster		
1	Upkendra (Untied fund and Sub Centre)	Hindi	Utilization of untied fund money.
2	Garbhawati Stri ko Milne Wali Suvidha (Free services for pregnant women)	Hindi	Facilities for pregnant women, right to health care.
3	Gram Swasthya va Swachhata Samiti (Village health and Sanitation Committee)	Hindi	VHSC's role and responsibility
4	Janani Suraksha Yojana	Hindi	JSY scheme and benefits
5	Prathmic Swasthya Kendra Se Milne Wali Suvidhayen?	Hindi	Concrete service guarantee at PHC level.
6	Samudayik Nigraani	Hindi	What is community monitoring and component of community monitoring

	Entitlement kit		
1	Community Entitlement	English and Hindi	Introduction to NRHM, service guarantees scheme and provision under NRHM, community participation in NRHM, and Framework for community monitoring.
	Manuals		
1	Managers Manual	English	Introduction of NRHM, Community Monitoring under NRHM, first phase of community monitoring, implementation of first phase of CM, Organizational responsibility.
2	Training Manual	English	How to conduct - state level, state managers' orientation, district level, and block providers' workshop. How to train different levels of committees.
3	Monitoring Manual	English	What are health rights, health systems in India, communitisation of health services, what is community monitoring, introduction to NRHM, frameworks for community monitoring in NRHM, mobilizing community and formation of VHSCs, conducting community monitoring at the village and facility level, compiling village and facility level score card, sharing the results and conducting Jan Samvad.

Annexure II: Name of States, Districts and Blocks

S/N	Name of the state	Name of District	Name of Blocks
1	Assam	Chirang	Sidli
			Borobazar
		Dhemaji	Jonai
			Sissiborgaon
			Dhemaji
			Bordoloni
		Kamrup Rural	Rangia
			Kamalpur
			Boko
2	Chhattisgarh	Baster	Tokapal
			Badekilepal
			Darbha
		Kawardha	Kawardha
			Bolda
			Shaspur (Lohara)
		Koriya	Khadgwan
			Manendargarh
			Janakpur
3	Jharkhand	Palamu	Patan
			Chainpur
			Lesliganj
		West Singbhum	Chakradharpur
			Manoharpur
			Tonto
		Hazaribag	Churchu
			Katkamsandi
			Ichak
4	Karnatka	Gadag	Gadag
			Rona
			Mundaragi
		Chamarajnagar	Kollegal
			Yelandur
			C.R.Nagar
		Tumkur	Gubbi
			Madhugiri
			Pavagada
		Raichur	Raichur
			Devadurga
			Manvi
5	Madhy Pradesh	Guna	Guna
			Raghogarh
			Bamouri
		Chindwada	Tamia
			Parasiya
			Junnardev
		Sidhi	Sidhi
			Macholi
			Kusmi

		Badwani	Pati
			Bansemal
			Badwani
		Bhind	Bhind
			Gohad
			Mehgaon
6	Maharashtra	Amaravati	Dharni
			Chikhaldara
			Achalpur
		Nandurbar	Akkalkuwa
			Dhadgaon
			Shahada
		Osmanabad	Osmanabad
			Tuljapur
			Kalam
		Pune	Velhe
			Purandar
			Khed
		Thane	Dahanu
			Jawhar
			Murbad
7	Orissa	Bolangir	Loisingha
			Muribahal
			Patnagarh
		Kendrapara	Patamundai
			Rajnagar
			Derabisi
		Mayurbhanj	Rasgobindpur
			Bahalda
			Bangiriposi
		Nawarangapur	Nawarangpur
			Tentulikhunti
			Raighar
8	Rajasthan	Jodhpur	Luni
			Mandor
			Osiyan
		Chittorgarh	Bhainsroagarh
			Chittorgarh
			Kapasan
		Udaipur	Kotda
			Gogunda
			Sarada
		Alwar	Laxmangarh
			Umrain
			Ramgarh
9	Tamil Nadu	Dharmapuri	Harur
			Nallampalli
			Kariyamangalam
		Kanyakumari	Agasteeswaram
			Kuruthancode
			Killiyoor

		Perambalur	Perambalur
			Andimadam
			Tirumanur
		Thiruvallur	Gumidipoondi
			Meenjur
			Poonamalli
		Vellore	Kandhili
			Pernampet
			Kaniyampadi



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