NATIONAL RURAL HEALTH MISSION
(2005-2012)

MANAGERS' MANUAL

Community Monitoring of Health Services Under NRHM

Managers' Manual on Community based Monitoring of Health services under National Rural Health Mission

Drawing from
NRHM Framework of Implementation

Prepared by
Task force on Community Monitoring
Of Advisory Group on Community Action

Based on the Proposal sanctioned by Mission Directorate of NRHM, MoHFW, Government of India

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Preface

The National Rural Health Mission (NRHM) was launched on the 12 April 2005, with the goal of improving the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. To ensure that the services reach those for whom they are meant, the NRHM proposes an intensive accountability framework that includes community-based monitoring as one of its key strategies.

The NRHM Framework for Implementation outlines the composition and broad roles of monitoring and planning committees at various levels. These outlines were to be subsequently elaborated for developing the process of community monitoring. The Advisory Group for Community Action (AGCA) is a standing committee within the NRHM, constituted to support and advise the MoHFW in implementation and review of the NRHM across the country. The AGCA took a lead in initiating discussions with the MoHFW to develop a detailed proposal on how "Community Monitoring" could be rolled out in a phased manner across the country. Through a process of discussions and deliberations, the AGCA developed a comprehensive proposal for decentralised 'Community Monitoring" with the active partnership of the Department and civil society institutions. The proposal was then forwarded Union Ministry of Health and Family Welfare (MoHFW) for implementation on a national scale. The MoHFW has approved this first phase of the "Community Monitoring" proposal and has suggested the AGCA for a special Task Group for overseeing the implementation.

The AGCA has established a Task Group for technical support and oversight in implementing the project and it is being chaired by Mr. A R Nanda of PFI, the convenor of AGCA. A Secretariat has also been established jointly by Population Foundation of India (PFI) and Centre for Health and Social Justice at New Delhi (CHSJ).

This Manual is based on project proposal that has been approved for different stakeholders in the community.

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Mr V. Srinivas Mission Director, NRHM, Government of Rajesthan.
Dr Pradeep Kumar Singh Mission Director, NRHM, Government of Jharkhand.
Mr Nilay Mitash Mission Director, NRHM, Government of Karnataka.

All members of the Advisory Group on Community Action.
All members of the Technical Advisory Group of AGCA.
All members of State Mentoring Committee of concerned states.
All State Nodal Organisations.
All District and Block level NGOs.
All Health Providers and Managers at District, Block, PHC and community level who were associated with the process.
Members of the different Panchayati Raj Insititutions in the nine states.
Members of the different level of Monitoring and Planning Committees in the nine states.
Members of the Village Health and Sanitation Committees.

And

Citizens of India who were engaged in this process across the nine states.

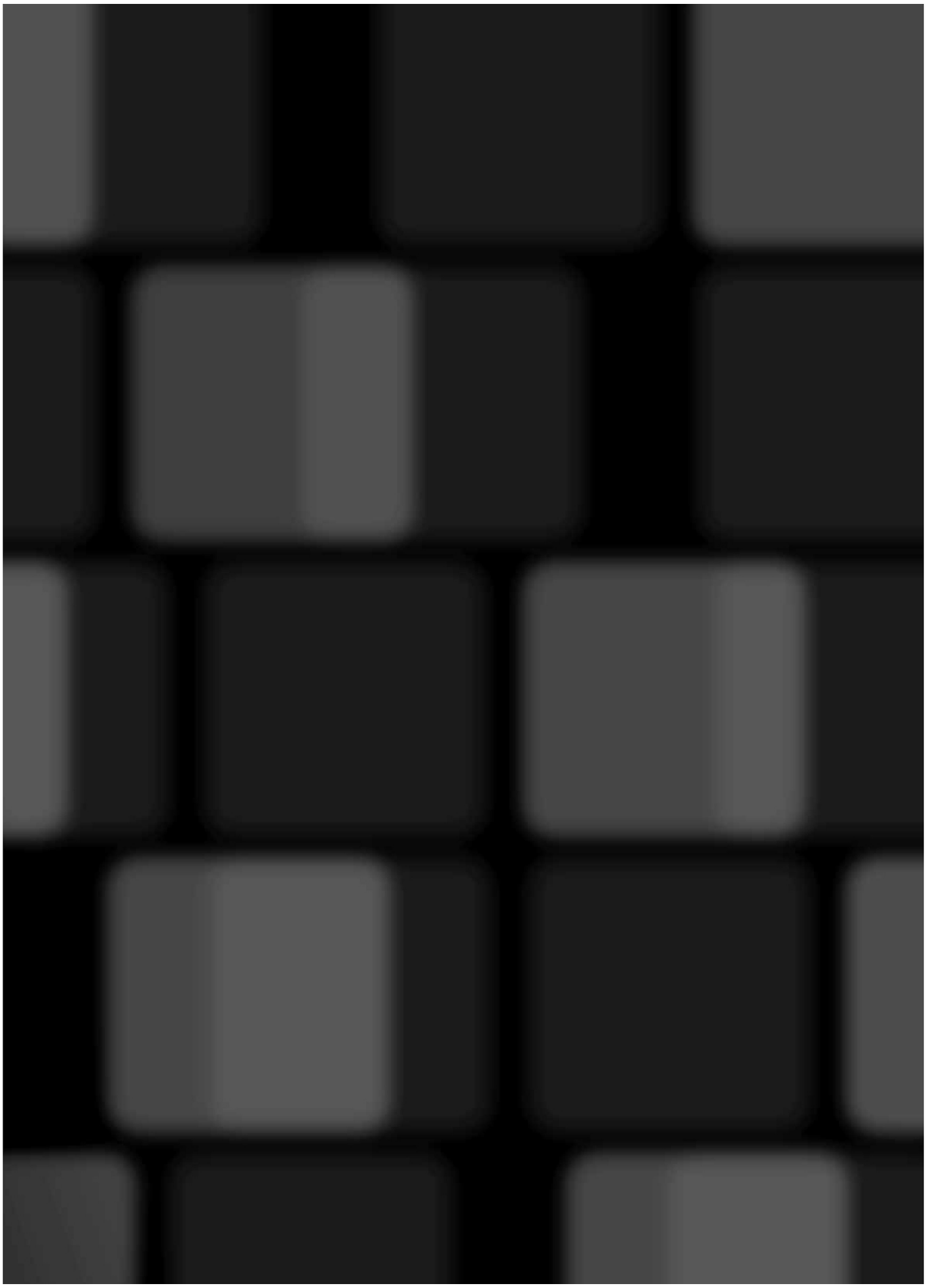
Contents

Enclosed in CD-ROM - Managers' Manual, Training Manual, Monitoring Manual, format of Process Documentation and other related materials.

Glossary

AGCA	Advisory Group for Community Action
AYUSH	Ayurveda Unani Siddha Homeopathy
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
AIDS	Acquired Inmmuno Deficiency Syndrome
APL	Above Poverty Line
BPMC	Block Planning and Monitoring Committee
CHSJ	Centre for Health and Social Justice
CHC	Community Health Centers
CBOs	Community Based Organisations
CSO	Civil Society Organisations
CM	Community Monitoring
CMO	Chief Medical Officer
CMHO	Chief Medical Health Officer
DOTS	Directly Observed Treatment, Short Course Chemotherapy
DHO	District Health Officer
DH	District Hospital
DPMC	District Planning and Monitoring Committee
FGD	Focus Group Discussion
GoI	Government of India
GDP	Gross Domestic Product
HIV	Human Immuno-deficiency Virus
HO	Health Officer
IPHS	Indian Public Health Standards
IMR	Infant Mortality Rate
MoHFW	Ministry of Health and Family Welfare
MDGs	Millennium Development Goals
MTA	Mother Teacher Association
MPW	Multi-Purpose Worker
MMR	Maternal Mortality Rate
MO	Medical Officer
MLA	Minister of Legislative Assembly
MLC	Minister of Legislative Council
NRHM	National Rural Health Mission
NHP	National Health Programmes
NHRC	National Human Rights Commission
PFI	Population Foundation of India
PRIs	Panchayati Raj Institutions
PTA	Parent Teacher Association
PHC	Primary Health Centre
PPMC	PHC Planning and Monitoring Committee
RKS	Rogi Kalyan Samiti
RTI	Reproductive Tract Infection
SHG	Self Help Group
SHC	Sub- Health Centre
SC	Scheduled Caste
ST	Scheduled Tribe
STI	Sexually Transmitted Infections
TOT	Training of Trainers
TAG	Technical Advisory Group
VHSC	Village Health and Sanitation Committee
VHC	Village Health Committee


NATIONAL-RURAL-HEALTH-MISSION



SECTION-I

Introduction to NRHM

There is an increasing recognition that despite significant improvements in health parameters like life expectancy at birth of and the reduction of infant mortality, there are large parts of the country where people continue to have very poor access to health care services and their health status continues to be abysmal. A high proportion of the population continues to suffer from and die of preventable conditions like maternal deaths, malaria and tuberculosis. Persistent malnutrition and high levels of anaemia amongst children and women is widespread. Due to the poor status of public health systems people are also facing poverty and indebtedness from the costs incurred in seeking health care. Public spending on health in India, especially on preventive and promotive health is also very low in India. On the other hand, private and out of pocket, expenditure on health is very high, about three times higher than the public expenditure. Thus, there is an urgency to deal with multiple health related crisis that the rural poor in the country are faced with. There is also the need to transform the health system into an efficient, transparent and accountable system delivering affordable and quality services.

The National Rural Health Mission has been conceptualised and is being implemented to bring about these fundamental changes in the way health

GOALS

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR).
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary healthcare.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH.
- Promotion of healthy life styles.

THE VISION OF THE MISSION

To provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

18 special focus states are Arunachal Pradesh, Assam, Bihar, Chattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur , Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa , Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

To raise public spending on health from 0.9% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling.

To undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.

To revitalize local health traditions and mainstream AYUSH into the public health system.

Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.

Address inter State and inter district disparities.

Time bound goals and report publicly on progress.

To improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.

there is an urgency to deal with multiple health related crisis that the rural poor in the country are faced with

care services are being delivered to the rural poor. The goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable, at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilisation, gender and demographic balance. In this process, the Mission would help achieve goals set under the National Health Policy and the Millennium Development Goals (MDGs).

In order to achieve its goals and objectives the Mission seeks to forge effective partnerships between the Central, state and local governments. There are flexible mechanisms built into the Mission so that local needs and priorities can be identified and addressed and local initiatives promoted. Intersectoral convergence is also seen as a key strategy of the Mission for improving interventions in preventive and promotive health. The Panchayati Raj Institutions (PRIs) and the community have been given key roles in the management of primary health care programmes as well as infrastructure.

Some of the key areas that have been identified for concerted action within the NRHM framework of action are as follows:

Well functioning health facilities

Quality and accountability in the delivery of health services.

Taking care of the needs of the poor and vulnerable sections of the society and their empowerment.

Prepare for health transition with appropriate health financing.

Pro-people public private partnership.

Convergence for effectiveness and efficiency.

Responsive health system meeting people's health needs.

The expected outcomes from the Mission are:

Reduction of Infant Morality rate to 30/1000 live births by 2012.

Reduction of Maternal Mortality to 100/100,000 live births by 2012.

Reduction of Total Fertility Rate to 2.1 by 2012.

Reduction of Malaria Mortality Rate by 50% up to 2010 and an additional 10% by 2012.

Reduction of Kala Azar Mortality Rate by 100% by 2010 and sustaining elimination until 2012.

Reduction of Filaria/Microfilaria Rate by 70% by 2010 by 80% by 2012 and elimination by 2015.

Reduction of Dengue Mortality Rate by 50% by 2010 and sustaining at that level until 2012.
Increasing Cataract operations to 46 lakh until 2012.
Reducing Leprosy Prevalence Rate from 1.8 per 10,000 in 2005 to less that 1 per 10,000.
Maintain 85% cure rate in the Tuberculosis DOTS series through the entire Mission Period and also sustain planned case detection rate.
Upgrading all Community Health Centers (CHC) to Indian Public Health Standards (IPHS).
Increase utilisation of First Referral Units through increased bed occupancy by referred cases from less than 20% to over 75%.
Engaging 4,00,000 female Accredited Social Health Activists (ASHA).

At the community level it is expected that:

There will be increased awareness about preventive health including nutrition.
There will be a trained worker available at the community level with a drug kit for common ailments.
A monthly Health Day will be organised where services related to maternal and child health, for ex. immunisation, ante-natal check-ups and nutritional services will be available.
Generic drugs for common ailments will be available at the sub centre and good hospital care will be assured through availability of doctors, drugs and quality services at PHC/CHC level.
There will be improved facilities available for institutional deliveries and the Janani Suraksha Yojna will also provide opportunities for subsidised hospital care for those below the poverty line.
Mobile medical units will ensure availability of services to remote underserved areas.
There will be provision of safe drinking water and household toilets.

To ensure that these outcomes are achieved, and quality and accountable health services which are responsive and take care of the needs of the poor and vulnerable sections of the society are attained — community ownership and participation in management is seen as an important pre-requisite within NRHM. Thus, community monitoring is an important component for achieving these results.

community ownership and participation in management is seen as an important pre-requisite within NRHM

HOW TO TRIGGER COMMUNITY ACTION?

Through household and health facility survey that involve Village Health Teams and discuss findings locally.

Through Health Camps that bring a range of health services to the community and makes them aware of their entitlements.

Through "Public Hearings" or Jan Sunawai oganized periodically where people share their experience of seeking health care. Such Jan Sunwais may be organized twice a year, or at least once a year at PHC, block and district levels.

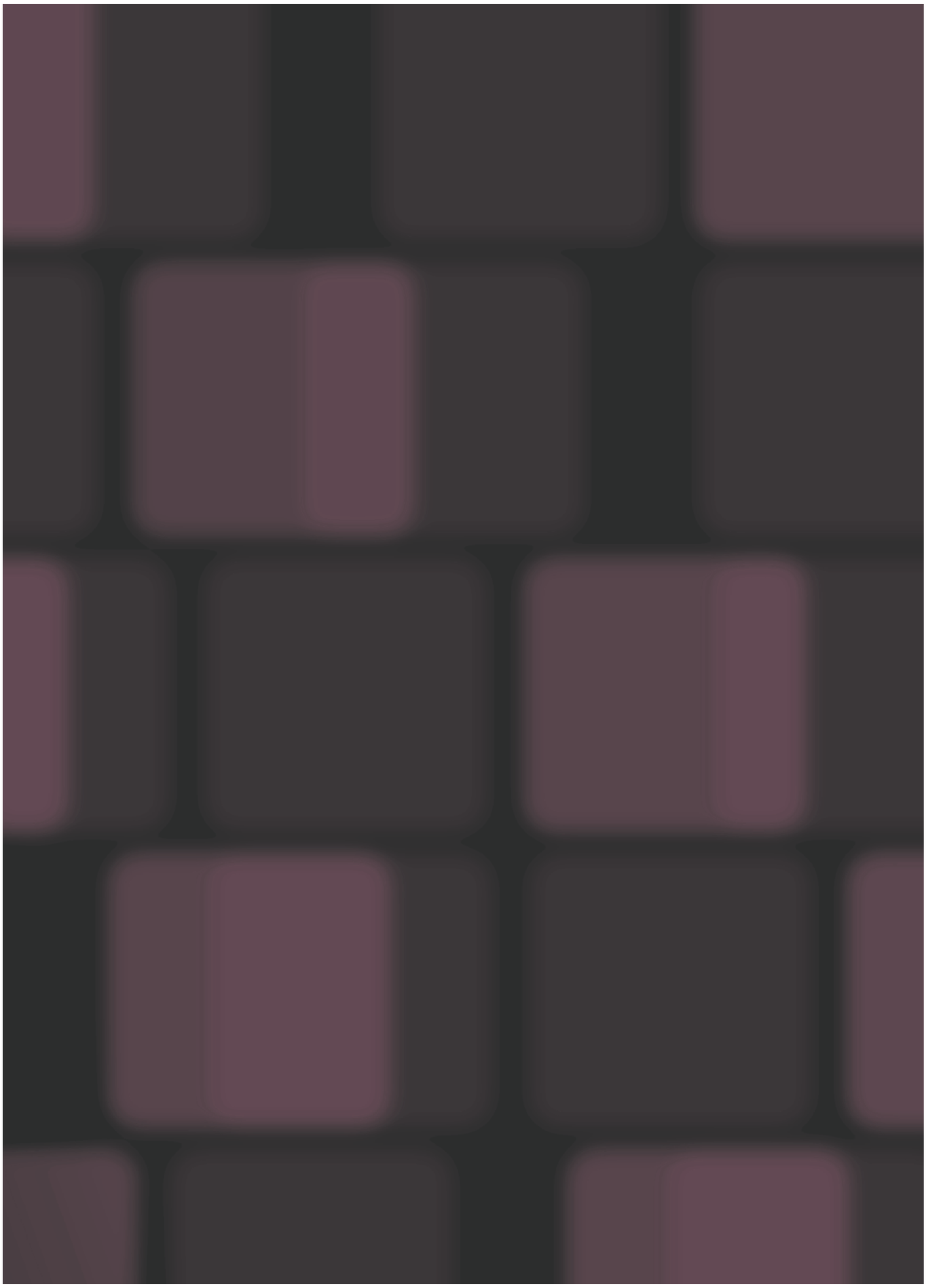
Through training and orientation of village Health Teams for community action.

By building team of Community Workers like Aangan Wadi Sevika , ASHA, School Teacher, Mahila Samakhya worker, PTA/MTA' members, etc.

By involving group like SHGs, Community based organizations, MTAs, PTAs, literacy volunteers, Containing Education Centre volunteers, etc. who have motivation for Community action.

By making local level health functionaries visit households frequently.

By making Block and District level Health Mission teams, including NGOs, organize a series of activities like health camps, public hearings, etc.



SECTION-II

Community Monitoring in NRHM

Introduction to Community Monitoring

The accountability framework proposed in the NRHM is a three-pronged process that includes internal monitoring, periodic surveys and studies and community based monitoring. Community monitoring is also seen as an important aspect of promoting community led action in the field of health. The provision for Monitoring and Planning Committees has been made at PHC, block, district and state levels. The adoption of a comprehensive framework for community-based monitoring and planning at various levels under NRHM, places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.

The community monitoring process involves a three way partnership between health care providers and managers (health system); the community, community based organisations and NGOs and the Panchayati Raj Institutions. The success of the community monitoring process will depend upon the ownership of the process by all three parties and a developmental spirit of 'fact-finding' and 'learning lessons for improvement' rather than 'fault finding'.

The objectives of community based monitoring are as follows:

It will provide regular and systematic information about community needs, which will be used to guide the planning process appropriately.

It will provide feedback according to the locally developed yardsticks, as well as on some key indicators.

It will provide feedback on the status of fulfilment of entitlements, functioning of various levels of the public health

system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.

It will enable the community and community-based organisations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system. The community should emerge as active subjects rather than passive objects in the context of the public health system. It can also be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

Process of Community Monitoring

The exercise of community monitoring involves drawing in, activating, motivating, and capacity building and allowing the community and its representatives e.g. Community Based Organisations (CBOs), people's movements, voluntary organisations and Panchayat representatives, to directly give feedback about the functioning of public health services, including giving inputs for improved planning of the same. The community and community-based organisations will monitor demand/need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. The monitoring process will include outreach services, public health facilities and the referral system.

the provision for Monitoring and Planning Committees has been made at PHC, block, district and state levels

The key Institutions for Community Monitoring as laid out in the Framework of Implementation are:

Village Health and Sanitation Committee (VHSC).

The PHC Planning and Monitoring Committee.

The Block Planning and Monitoring Committee.

The District Planning and Monitoring Committee.

The State Planning and Monitoring Committee.

Guidelines regarding the composition, roles and powers of these committees have been laid out in detail in the Framework of Implementation and are reproduced in Annexure 4.

The monitoring process will begin with a village report card being prepared by the Village Health and Sanitation Committee after consulting village records (ex. ASHA records or ANM records or the Village Health Register) and also by conducting interviews and meetings with potential beneficiaries (like women who are pregnant or have undergone childbirth in the recent past, or those with small children) to understand the community members' experiences and problems faced, as well as assess the extent to which key services are being delivered effectively. The Monitoring Committee at each subsequent level would review and collate the reports coming from the committees dealing with units immediately below it. For example, Block Committee will receive and review the VHSC reports while the District Committee would receive and review the reports from all Block Committees. However, the monitoring committees would not only rely on reports, but would also make their own independent observations on selected key parameters. Each committee would appoint a small team drawn from among its civil society and PRI representatives who would visit on a quarterly/six-monthly basis, a small sample of units (say one facility or two villages) under their purview and directly review the conditions.

This will enable the committee to not just rely on reports but to also have 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. The monitoring committees at

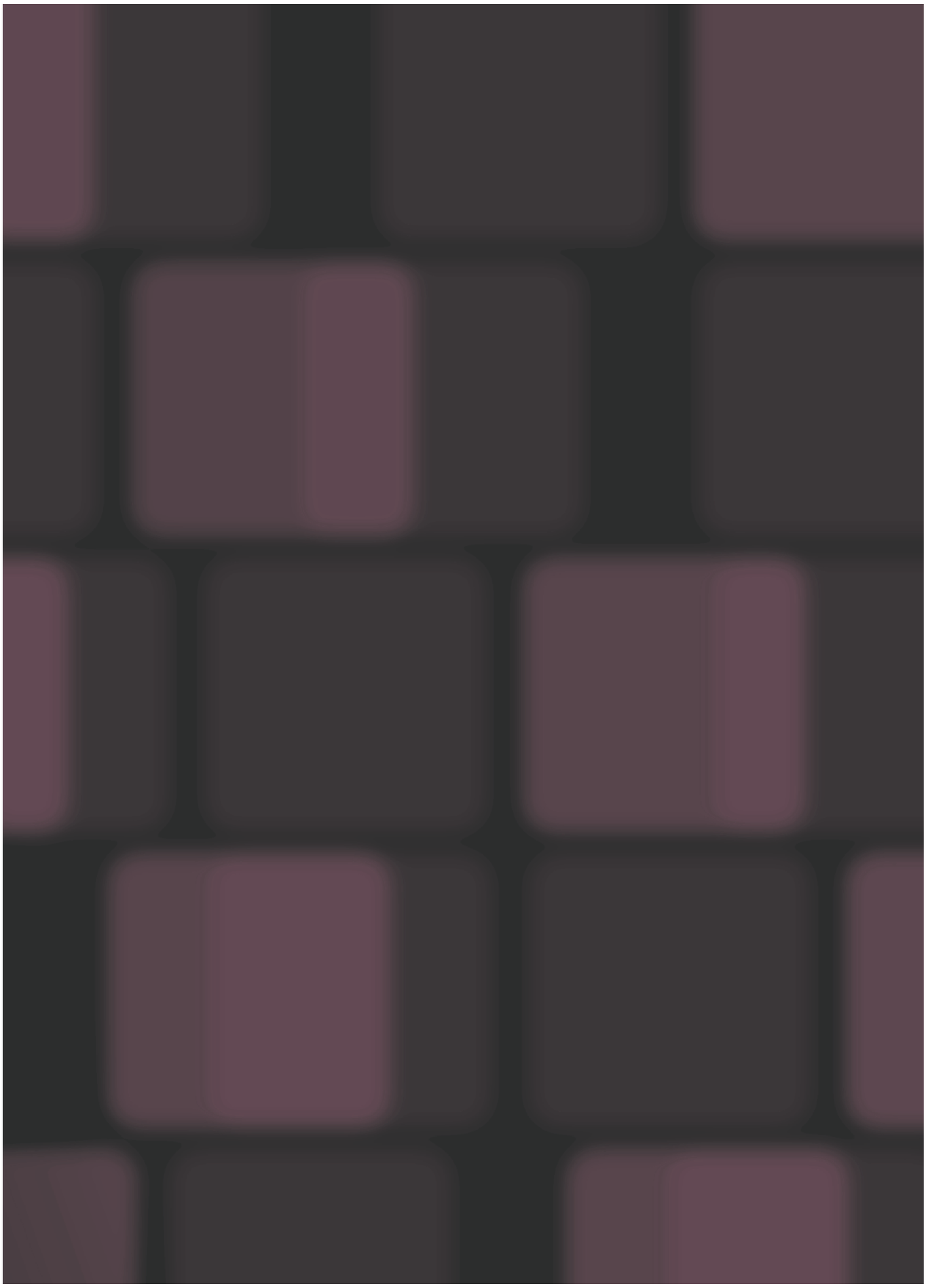
PHC/Block/District levels will be responsible for making an assessment of the functioning of the major health care facility at their respective level (PHC/CHC/District Hospital).

Sharing of the findings of monitoring committees will not only take place through the periodic report submitted to the next level of monitoring committee, but also through periodic public sharing. Monitoring committees at PHC, Block and District level will be involved in six-monthly or annual Jan Samvads or public hearings at their respective levels, where committee members would share the results of their findings and also get direct feedback of the situation, including possible presentation of cases of denial of health care. Similarly, the State Planning and Monitoring Committee will conduct an annual public meeting open to all civil society representatives where the State Mission report and independent reports will 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.

A broad outline of the ambit and scope of community monitoring at different levels is given in the Table below

Table-1 Ambit & Scope of Community Monitoring at Different Level

Community Monitoring Committee	Periodicity of Monitoring	Activities to be undertaken
Village Health and Sanitation Committee	Quarterly	a. Reviews Village Health register, Village health calendar. b. Reviews performance of ANM, MPW, ASHA. c. Reviews communities own experiences as beneficiaries of services. d. Sends brief three monthly report to PHC committee.
PHC Monitoring and Planning Committee	Quarterly	a. Reviews and collates reports from all VHSCs. b. An NGO / PRI sub team conducts FGDs in three sample. villages under PHC. c. Visit PHC, review records, discuss with RKS members. d. Send brief three monthly report to Block committee.
Block Monitoring and Planning Committee	Quarterly	a. Reviews and collates reports from all PHCs. b. NGO / PRI sub team visits at least one PHC of the block, conduct interviews with MO and make observations. c. Visit CHC and review records, discuss with RKS members. d. Send brief three monthly report to District committee.
District Monitoring and Planning Committee	Quarterly	a. Reviews and collates reports from all Blocks. b. An NGO / PRI sub team visits at least one CHC of the District, conducts interviews with Incharge, meets Block committee members and RKS members, makes observations c. Visits District hospital and reviews records, discuss with RKS members. c. Send brief three monthly report to State committee.
State Monitoring and Planning Committee	Quarterly	a. Reviews and collates reports from all Districts. b. An NGO / PRI sub team visits 3 to 5 Districts, conducts interviews with DHO and District Committee members, makes observations on DH. c. Sends six monthly report to NRHM / Union Health Ministry.



SECTION-III

First Phase of Community Monitoring

The outlines of community monitoring process provided within the Framework of Implementation have been developed and elaborated upon by the Advisory Group on Community Action (AGCA). The first phase was seen as a learning phase because no similar community monitoring activity, either in the health sector or in other social sectors has been implemented on a countrywide scale before. Thus in the first phase the implementation was supervised at a national level by a specially constituted National Secretariat and Task Group constituted under the supervision of the Advisory Group. It was decided that the first phase would be of eleven months (March 07-Jan 08), which got extended till December 2008 and covered nine states.

Some reasons because of which it was desirable to start with a learning phase, are as follows:

Learning from experiences and mistakes on a smaller scale, then moving to a larger scale: This is probably the first time in the country that the official health system is institutionalising community monitoring of health services on a major scale. There is scope for many kinds of experiences and even deviation from objectives, so it is thought to be desirable to try out the process on a smaller scale and make corrections before moving to a statewide scale.

The need to pool expertise and build an initial critical mass: The number of organisations with experience in rights-based and accountability-oriented work related to the Health sector may not be very large in many states. Similarly, expertise and commitment related to this activity within Health departments may also be limited to begin with. It would be desirable for facilitating agencies both within and outside the Health department to come together,

share expertise, help launch pilots in a few areas, and analyse experiences, before going to scale at the state level. This would also strengthen ownership of the process within the Department. Starting directly with a widely generalized model would demand very extensive involvement of comparatively few facilitators from day one; they would have to immediately spread themselves thin – not allowing much space for initial development of methodologies and building a critical mass.

The process of developing community monitoring is a delicate process that needs to be handled carefully. Community mobilisation experiences in the Health sector show that the initial response of community representatives is often to assertively point out a whole range of problems, deficiencies, gaps and even alleged cases of denial of health care which may be quite difficult for the Health officials to digest and take in the right spirit – which could even at times, lead to a virtual breakdown of dialogue. Maintaining the vitality and authenticity of the process, but not allowing complete polarisation, which would disrupt the dialogue and convergence process itself is a delicate task. Starting by launching the community monitoring process all over the state on a large scale may conceivably lead to potentially disruptive situations and even demotivation of Health functionaries which could be avoided by first working out the process in pilot areas and building appropriate checks and balances in the methodology before moving to generalisation.

no similar community monitoring activity, either in the health sector or in other social sectors has been implemented on a countrywide scale before

Scale of Implementation of the First Phase

The first phase of the community monitoring component of NRHM was implemented in 36 selected districts of 9 states of the country. These are

- Assam
- Chhattisgarh
- Jharkhand
- Madhya Pradesh
- Maharashtra
- Orissa
- Rajasthan
- Tamil Nadu
- Karnataka

In each of these states a number of districts were selected (between three and five depending upon the number of districts in the state) on the basis of regional diversity as well as the presence of a credible district level NGO/ Civil Society Organisation, which can facilitate the implementation. In each of these districts three blocks were chosen for the first phase, and from among these three blocks the operational area of three PHCs were selected. Five villages were selected for initiating community monitoring in each of the three PHC areas. The total numbers of districts, blocks, PHCs and villages is summarised below:

For States with 15 to 29 districts: three pilot districts were selected.

For States with 30 to 39 districts: four pilot districts were selected.

For States with 40 and above districts: five pilot districts were selected.

This will lead to a total of 36 districts spread across these nine states. In each district, three blocks were identified giving a total 108 blocks. In each of these blocks, three PHCs were identified giving a total 324 PHCs. In each PHC area, five revenue villages were identified giving a total 1620 villages.

Need for involving Civil Society Organisations/ NGOs in the First Phase

NGOs or Civil Society Organisations have been given crucial roles in the NRHM. It is envisaged that besides providing services in selected areas, they will not only be members in institutional arrangement at all levels, but will also act as resource organisations and provide support for evaluation, monitoring and social audit. These organisations had a crucial role to play in the first phase of community monitoring to ensure its success. Although state Health Departments would play an extremely important role in developing community monitoring activities, however the facilitation of community based monitoring was not left to state Health Departments. Some of the reasons for this are as follows:

Figure-1 Geographical Spread

It is largely the Health Department functionaries themselves who would be monitored; hence for the monitoring to be robustly independent, it is not sufficient to leave the entire task of developing the monitoring framework to the Health department alone.

For effective community monitoring, capacity building of a whole set of actors like beneficiary representatives, CBOs, people's movements, voluntary organisations and Panchayat representatives - who will eventually do the monitoring - is imperative. Hence, involvement of networks, organisations and individuals with experience of community mobilisation and community based monitoring to facilitate involvement in the health system of this whole new set of actors is needed.

To facilitate change in the balance of power in the health sector, in favour of people. The exercise of community monitoring carries meaning only if ordinary people and their spokespersons in form of both Panchayat representatives and CBOs, gain a degree of authority to identify gaps and correspondingly propose priorities and influence decision making regarding the health system.

The kind of capacity required to develop a participatory community monitoring system is quite different from programme implementation and training usually conducted by the Health Department; hence involving voluntary sector agencies with some experience of accountability building and health rights work would be desirable to help facilitate this process.

facilitate change in the balance of power in the health sector, in favour of people

Role of Civil Society Organisations in the First Phase

Civil Society Organisations i.e. Community Based Organisations (CBOs) and Non Governmental Organisations (NGOs) have three kinds of roles in the process of community based monitoring:

Members of monitoring committees: Social organisations working in close, regular contact with communities on health related issues, especially from a rights-based perspective, would be able to present in various monitoring committees the community concerns, experiences and suggestions regarding improving public health system functioning.

Resource groups for capacity building and facilitation: NGOs and CBOs will have the responsibility for overall facilitation of the initial process of committee formation and capacity building of community monitoring committee members about the process of community based monitoring. It includes the roles of members at different levels, including peripheral committees at PHC and village levels. Based on national model material, training modules and materials for orientation of community monitoring committee members would be adapted and published at state level and used for this capacity building process. All three types of members – Panchayat representatives, civil society organisations and health system functionaries would benefit from such capacity building.

Agencies helping to carry out independent collection of information: NGOs and CBOs would contribute to the collection of information relevant to the monitoring process at all levels from the village to state level. In these processes, an element of community mobilisation may be involved. Specific teams would dialogue with communities and would collect and process community-based information. These teams could be sub-groups drawn from the larger monitoring committee at specific levels, but could also include some persons from beyond the monitoring committee. Formation of such teams should be encouraged especially at the PHC and block levels. Each team should include members from one or more facilitating NGOs and PRI members, and could also include representatives from among the health care providers. Such teams should undergo a short orientation exercise before they undertake the community monitoring exercise.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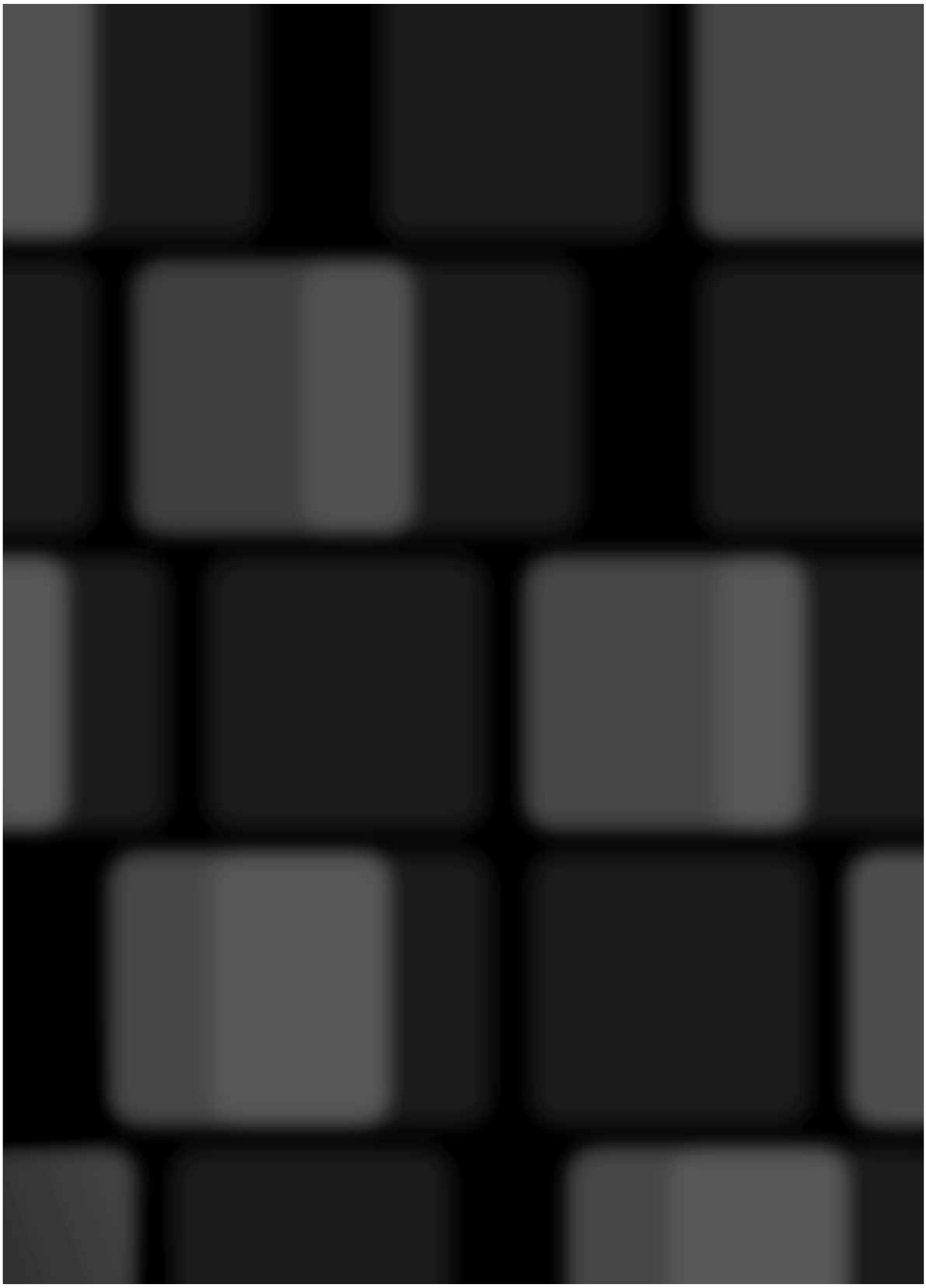


SECTION-IV

Implementing the first phase of Community Monitoring

The first phase of the community monitoring process was implemented under the overall supervision of the specially constituted Task Group of the Advisory Group on Community Action. A National Secretariat was set up in Delhi through the collaboration of Population Foundation of India and Centre for Health and Social Justice.

PREPARATORY PHASE

The activities that were undertaken during the first phase and the persons responsible at each level are given in the table below. The preparatory phase lasted from March 2007 to June 2007.

State Mentoring Group

The State Mentoring Group was formed involving representatives of the state Health Department and state level health sector voluntary networks. Based on experience and demonstrated interest, the State Mission Director and the state designated AGCA members suggested names for this mentoring team. This team had definite responsibilities to develop community monitoring in the state during the first phase and beyond, which was clearly spelt out. This team had seven to eleven members, of which at least four to seven were civil society representatives. In addition, the designated national AGCA members were permanent invitees to the State Mentoring Team.

State Nodal Organisation

One of the state level NGOs with membership in the State Mentoring Team was selected to work as the state nodal NGO during the first phase. This state nodal NGO worked under the direction of the State Mentoring Team.

Table-2 Activities in the Preparatory Phase

Activity	Responsibility	Support from
Setting up Task Group.	AGCA	MoHFW, GOI
Setting up National Secretariat.	AGCA- Task Group	
Contacting State Secretaries in the 9 states.	MoHFW, GOI	
Contacting Civil Society Organisations in the 9 states.	Task Group	
Preparation of necessary Materials, Curricula and Modules.	National Secretariat	Task Group
Meeting with state CSOs and identifying State Nodal organization.	AGCA- Task Group	National Secretariat
Meeting with State Health Secretary and NRHM Directorate and setting up State Community Monitoring Mentoring Group.	AGCA- Task Group	National Secretariat

Other state level activities that were carried out in the preparatory phase are as follows:

A State Level Workshop was organised by the State Mentoring Team, State Nodal Organisation and State Health Mission involving all stakeholders (State Mission officials, District Health officials and PRI representatives from selected districts, NGO networks and civil society organisations from these districts) along with NRHM GoI representatives. The activities of the first phase were shared and the process finalised. Detailed timetable for district level meetings, formation and orientation of committees was worked out in this two-day state level workshop.

A State level Training of Trainers for the facilitating teams from all pilot districts was conducted. It was held primarily by voluntary sector facilitators in the first phase, since government officials may not have adequate experience in community monitoring activities. However state Health Department officials were present and involved in these workshops, enabling them to actively participate in further such trainings.

Table-3 State Level Activities in the Preparatory Phase

Activity	Responsibility	Support from
Selection of districts and blocks for implementing the project.	State C M Mentoring Group.	Task Group. National Secretariat.
Selecting organizations which will be implementing activities at the district and block level.	State C M Mentoring Group.	Task Group. National Secretariat.
State level workshop to finalise the districts and modalities of district and block level activities.	State C M Mentoring Group.	Task Group. National Secretariat.
State level TOT.	State C M Mentoring Group.	Task Group. National Secretariat.
Adapting and translating materials, curricula and modules for the state.	State C M Mentoring Group.	Task Group. National Secretariat.

Outcomes of the Preparatory Phase:

National Secretariat was established.

State Community Monitoring Mentoring Groups were established in all nine states.

State Nodal Organisations were established in all nine states.

State level workshops were organised in all states.

State level TOT was organised in all states.

Draft of materials, curriculum and modules were prepared.

State level adaptation of the publications was begun.

DISTRICT LEVEL IMPLEMENTATION PHASE

Once the district and block level

facilitating organisations were selected and traind, the key activities shifted to the district and block levels. The time allocated for these activities was July 2007 to December 2007 in the first phase.

The activities at the district and block level proceeded in the following manner:

Getting Ready for Community Monitoring

District processes were facilitated by NGOs taking responsibility in the first phase districts along with the 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, one NGO was needed to take responsibility as the District Nodal NGO. 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

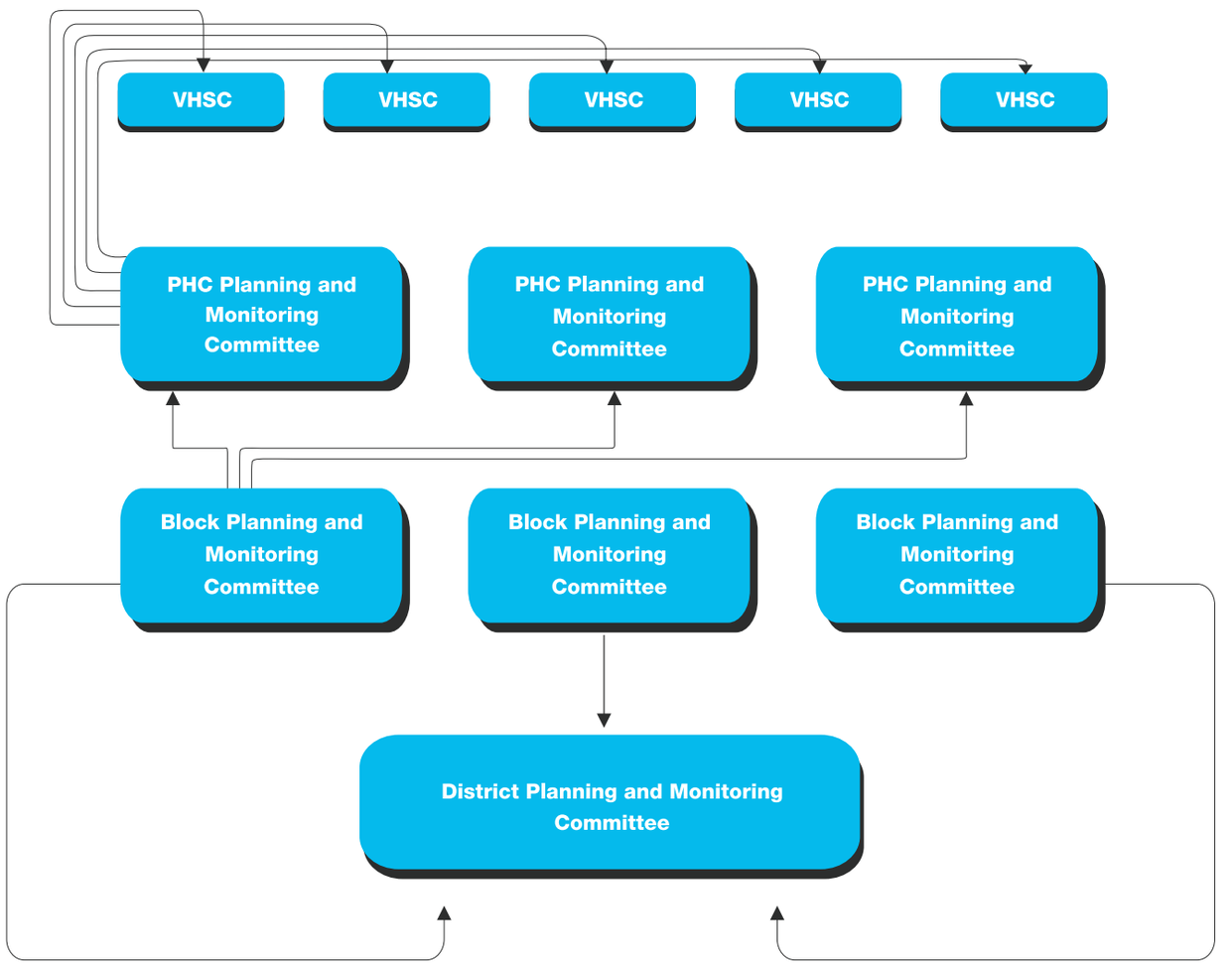


Figure- 2 Organogram of Monitoring & Planning Committees

blocks and PHCs, involving key District Health officials, PRI members and civil society organisations. Three blocks within the district were selected for pilot implementation. Block nodal civil society organisations took up the responsibility for specific blocks in coordination with the District Nodal NGO.

There was need to conduct a block level training for at least a four member Block Community Monitoring Facilitation Team, including at least two NGO/ CBO members and half women. These Block Facilitation Team members were responsible for the subsequent committee formation and orientation processes. It was anticipated that these activities would be completed in the month of July 2007.

Formation of Committees

During the next four months (Aug– Nov 2007), there was formation of committees at village, PHC and block levels in the selected blocks (in that order), along with organising primary orientation of their members. Formation of community monitoring committees started from village committees, PHC, block, and then district committees. A few members from VHCs were included in the PHC committee; similarly a few PHC committee members were included in the block committee. Therefore it was important to constitute the committees from village level upwards in such a sequential order. CBOs/NGOs and Panchayat representatives who had shown leading initiative in organising community monitoring activities at any level found representation in the next high-level committees. Adequate representation of women, dalits and adivasis was ensured in various committees.

Following committee formation at the peripheral levels, the District Level Committee was also finalised and became functional by November 2007. In the first phase, at the state level, a provisional committee was formed by 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 the Community Monitoring Committees in place, which could send representatives to the State Committee.

Community Monitoring

The community monitored need, coverage, access, quality, effectiveness, behaviour, presence of health care personnel at service points, possible denial of care and negligence. The monitoring process included outreach services, public health facilities and the referral system. The community monitoring exercises and collation of information was organised village wise, PHC wise, block-wise and district wise. In this way, these exercises aggregated information upwards. The monitoring results were also shared at the village level, block and district level in the appropriate PRI fora. Some of the frameworks on which community monitoring may be done, and which are included within the NRHM are as follows:

Village Health Plan, District Health Plan.
Entitlements under the Janani Suraksha Yojna.
Roles and responsibilities of the ASHA.
Indian Public Health Standards for different facilities like Sub Centre, PHC, CHC.
Concrete Service Guarantees.
Citizen's Charter and so on.

Activities that was undertaken at the village level for community monitoring has already been outlined in Table 1- Section II, Page 9.

PHC and block level community monitoring exercises included a public dialogue ('Jan Samvad') or public hearing ('Jan Sunwai') process by December 2007. 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/facilitated by the District and Block Facilitation Groups in collaboration with Panchayat representatives and CBOs/NGOs working on the issue of health rights.

The monitoring committee at each level

the monitoring results were also shared at the village level, block and district level in the appropriate PRI fora

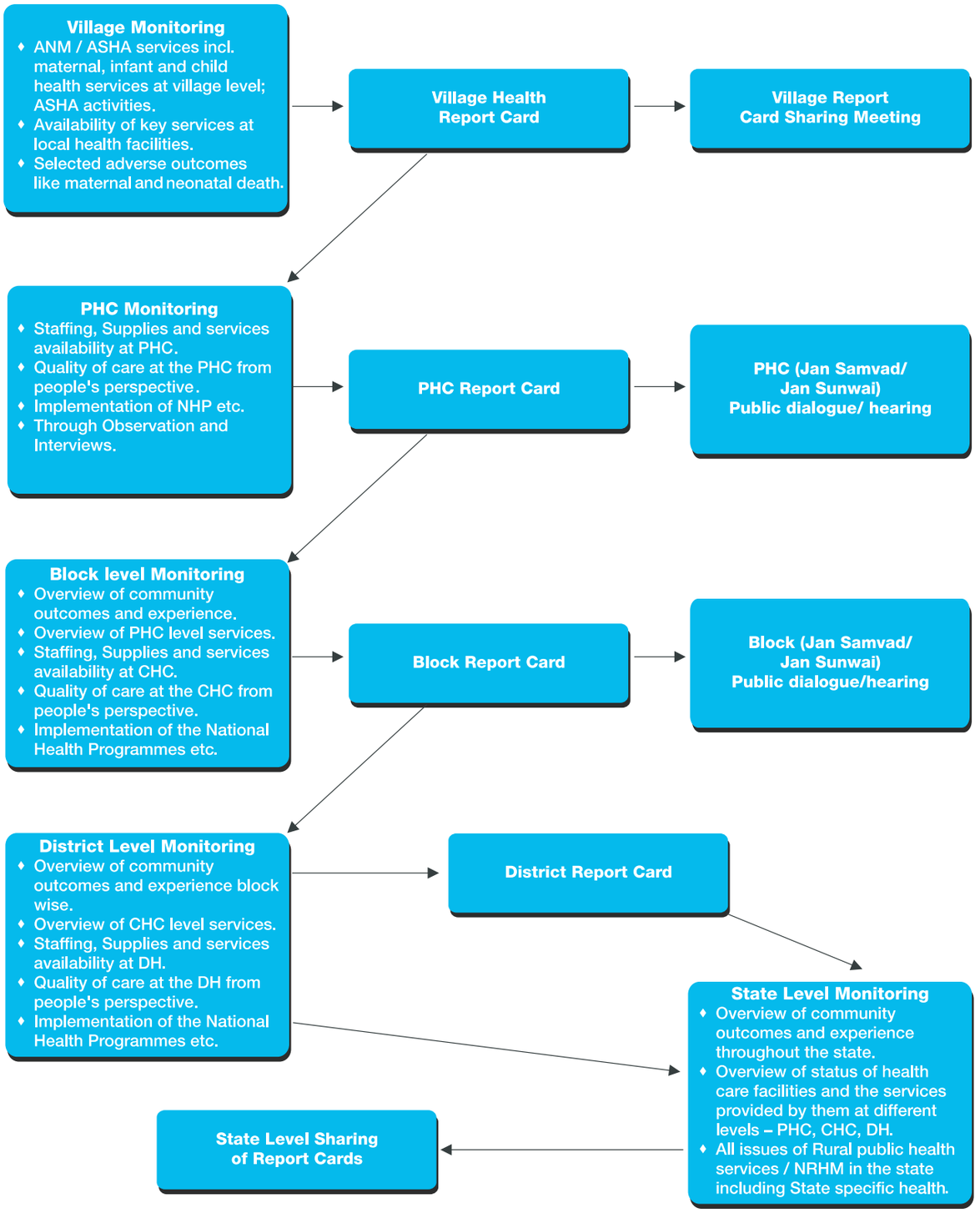


Figure- 3 Process of Monitoring

reviewed and collated the summary reports from the committees dealing with units under it. This enabled it to make an assessment of the situation prevailing in all the units under its purview, and to make a report at its level. For example, the District Committee would receive and review the reports from all block committees.

However monitoring committees did not only rely on reports, but also directly interacted in the field situation and got feedback. Firstly, each committee appointed a small sub-team drawn from its NGO and PRI representatives who visited on a regular basis, a small sample of units (say one facility or two villages) under their purview and directly reviewed the conditions. This enables the committee to not just rely on reports but to also have 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 Public hearings at their respective levels, where committee members would get direct feedback of the situation, including possible presentation of cases of denial of health care. 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.

Screening Civil Society Organisations for involvement in Community Monitoring

In order to screen civil society organisations for their capacity to partner in community monitoring activities, and to participate in monitoring committees at various levels, a simple questionnaire was used. Such organisations may include CBOs (including Self-Help Groups and people's organisations) as well as NGOs working at the respective level, with documented activity in the area since at least three years. In addition to other questions about the organisation, the following issues will be included in the questionnaire.

On the basis of their responses to their questionnaire, the following screening table will be used and any organisation having at least one entry in all the four aspects (with brief report of the activity carried out in that aspect) may be considered as having qualified. Any organisation with demonstrated experience of monitoring public services; organising public dialogues or public hearings should be given priority to participate in the community monitoring committees.

monitoring committees did not only rely on reports, but also directly interacted in the field situation and got feedback

Table-4 Criteria for NGO selection

Activity Profile	Community Mobilisation	Women's Empowerment Activities	WomeRights based Activities
A1- Income Generation A2 - Environment / Natural Resource Mgmt A3 - Education A4- Health	C1- Self Help Groups C2- Village Level Committees C3- Federations C4- Community Leadership training C5- Work with PRIs C6 – Village based organisation and mobilisation on specific issues	W1- Village level women's groups W2 – Women's leadership development and training W3 – Women and PRI	R1- Right to Healthcare R2- Right to Food R3- Right to Information R4- Right to Employment R5- Livelihood rights e.g. rights related to Forest, Land, Wages, Displacement etc. (specify)

Table-5 Format for NGO Selection

Name of CSO	Activity Profile				Community Mobilisation Activities					Women's Empowerment Activities			Rights based Activities		
	A1	A2	A3	A4	C1	C2	C3	C4	C5	W1	W2	W3	W4	W5	W6

Key Considerations during Selection

To ensure wide participation, diverse group of civil society networks and organisations involved in promotion of health rights and monitoring should be involved at various levels.

The process of selecting civil society organisations to be involved in monitoring committees at all levels could be facilitated by the mentoring team of the respective level, with guidance from the mentoring team of the higher level. For example, the District Mentoring Team could suggest the names of civil society organisations to be involved in the District Monitoring Committee, with inputs from the State Mentoring Team as relevant. This should be a participatory process including various civil society networks and organisations. It should not be limited to NGOs, and should also definitely involve CBOs and people's organisations

Civil society involvement in monitoring should not be focussed only on 'mother NGOs' which are often deeply involved in implementation and who may not always be the most objective monitors of work which they themselves are involved in implementing. Particularly for the community monitoring process in NRHM, it is imperative that the idea is not confined to just 'leave it to mother NGOs.' Rather, organisations with experience of rights based activities and accountability enforcing activities should be given adequate space and responsibility at all levels.

Process Documentation and Review

Since the first phase of the community monitoring process was a learning phase, it included process documentation and review as an important component. This included the following three distinct stages:

Process Documentation

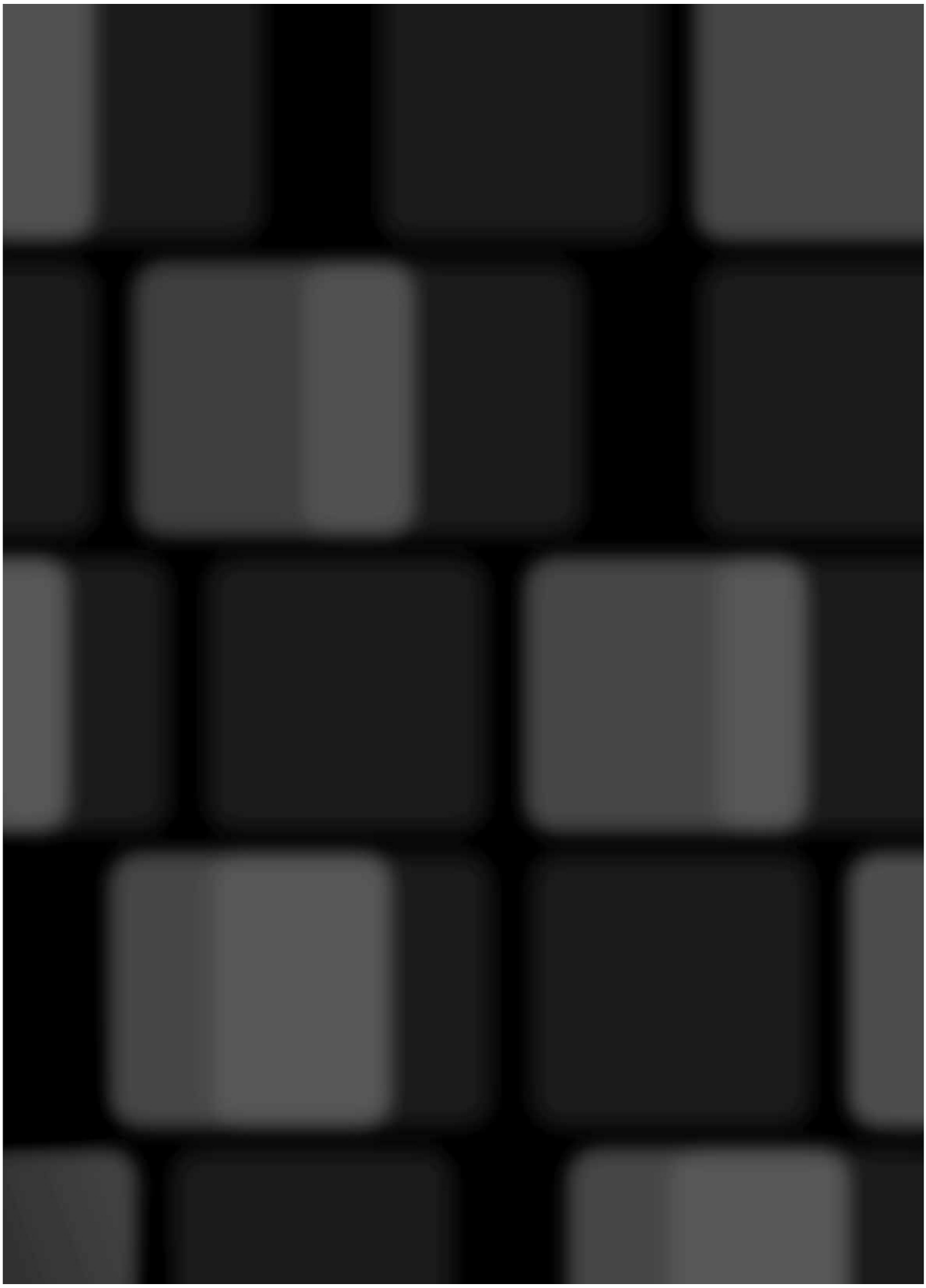
To ensure uniformity of recording the activity, each activity of the project that has been mentioned above included a documentation procedure. These documents were filled in by the responsible agency at different levels and collated at the state level. The State Mentoring Team was responsible for analysing these documents and prepared a review report on the state implementation, reporting what interventions worked and why and suggesting changes.

Evaluation of the State Level Intervention

There was an independent evaluation of the different interventions and their impact on different stakeholders by a team of five experts. The evaluation included review of the documentation process, interviews with different stakeholders, including members of the community in a limited number of locations across each of the nine states.

State Level Review Workshops

The third component of the review process comprised of an end line workshop with those involved in implementing the first phase to review the process in each state.



SECTION-V

Organisational Responsibilities

The entire range of activities during the first phase were needed to be supported by NRHM Mission Directorate from the Union Health Ministry level for rapidity of execution, given the compressed timeframe available. Responsibilities for handling funds and ensuring activities at various levels were allocated as follows:

NATIONAL LEVEL

At the national level, the Task Group of the Advisory Group on Community Action (AGCA) facilitated the entire process of community action in consultation with the Ministry of Health and Family Welfare. The Population Foundation of India is the Secretariat for the AGCA.

AGCA-TAG (Sub-group of AGCA)

Conceiving and planning the entire intervention.

Periodic review.

Support the relationship building with

Table 6: Organisational Responsibilities at Different Levels

Level	Responsibility
National	Overall facilitation by AGCA (in consultation with NRHM officials). Financial responsibilities and coordination handled by AGCA Secretariat along with sub-group of AGCA.
State	State Nodal NGO under guidance of State Mentoring Team (which would include State Mission Director).
District	District nodal NGO under guidance of District Mentoring Team (which would include District Health Officer).
Block and below	Block nodal civil society organisation (in coordination with District Nodal NGO).

the state government.
Support the formation of State CM Mentoring Group.
Identify State Level Nodal Organisation.
Technical inputs.
Generate training designs.
Framing Community Monitoring Protocol.
Jan Samvad protocols etc.
Distil lessons learnt.

National Secretariat on Community Action – NRHM

A National Secretariat was set up under the leadership of PFI along with Centre for Health and Social Justice at New Delhi. The Secretariat undertook special facilitation of the community monitoring process at the national level in consultation with the MoHFW and NRHM Mission. The National Secretariat functioned within the framework formulated by the AGCA for community based monitoring of programmes under NRHM.

The National Secretariat had the following roles and responsibilities:

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

Staffing: The National Secretariat was managed by two programme officers responsible for the overall programmatic and financial coordination of the programme. The officers reported to the Task Group of AGCA.

a National Secretariat was set up under the leadership of PFI along with Centre for Health and Social Justice at New Delhi

STATE LEVEL

At the state level, there was the State Community Monitoring Mentoring Group, State Resource Pool and the State Nodal Agency.

State CM Mentoring Group

Coordinate with the State Government.
Prepare state level plan/design and budgets.
Identify districts and blocks.
Identify NGOs for district and block level.
Review progress at the state level.
Distil lessons learnt from the state level experiences.

State Resource Pool

Adaptation of manuals, protocols and materials for the state level situation.
Translation of materials, manuals and protocols.
Provide training and facilitation support for events – trainings and workshops.

State Nodal Agency

Assist in implementing the decisions taken at the CM Mentoring Team.
Arrange for technical and resource support to district/block level NGOs.
Support the process of adaptation, translation and publication state level materials/manuals.
Supervise community level documentation processes.
Maintain documentation of state level processes.
Provide progress, process and financial reports and documents to the National Secretariat on a regular basis.
Financial support and disbursement to district level and block level processes.
Maintain state level accounts.
Supervise progress and support processes/activities at the district, block and community levels.

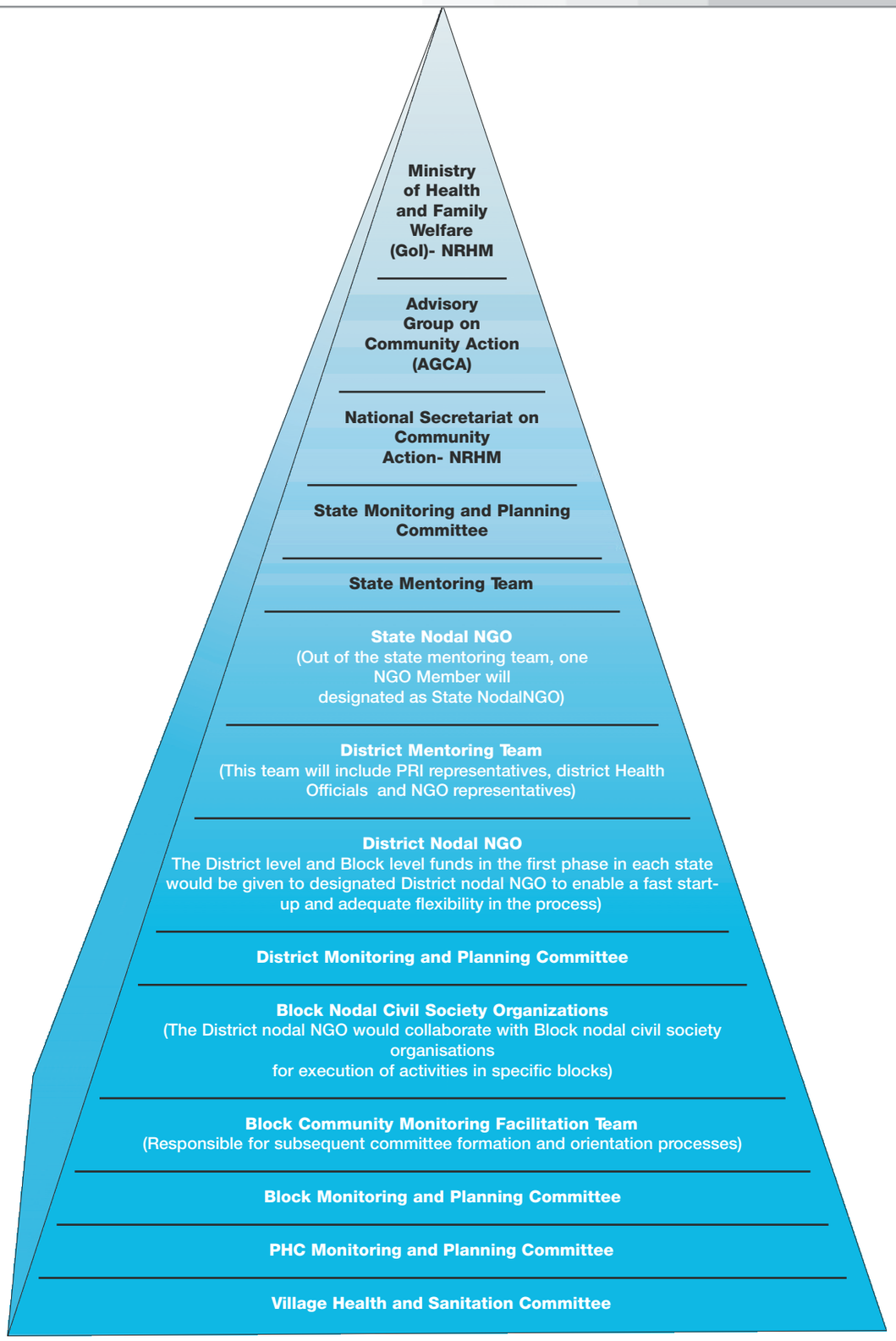


Figure-4 Organogram

DISTRICT LEVEL

At the district level, there is the District Community Monitoring Mentoring Group and the District Nodal Agency.

District CM Mentoring Group

Coordinate with the State and district level government.
Prepare district level plan/design and budgets.
Coordinate with blocks and provides technical support.
Review progress at the district level and below.
Distil lessons learnt from the district level and below experiences.
Identify NGOs for district and block level for implementing the community monitoring programme.

District Nodal Agency

Assist in implementing decisions taken by mentoring group.
Arrange for technical and resource support to district/ block level NGOs.
Support process of adaptation, translation and publication state level materials/manuals.
Supervise community level documentation processes.
Coordinate with State Nodal Agency.
Coordinate with district officials - Chief Medical Officer; Zilla Parishad, District Mentoring Team.
Mobilisation and capacity building at district level.
Collation of records and reports.
Financial management.
Mobilisation and capacity building at district and block level.
Facilitate balance of power between stakeholders - liaison with different stakeholders.
Declaring, dissemination - health entitlements within rights based approach.
Reflect community/spokespersons of community concerns, experiences.
Form committees at the village, PHC and block if such committees have not been formed.

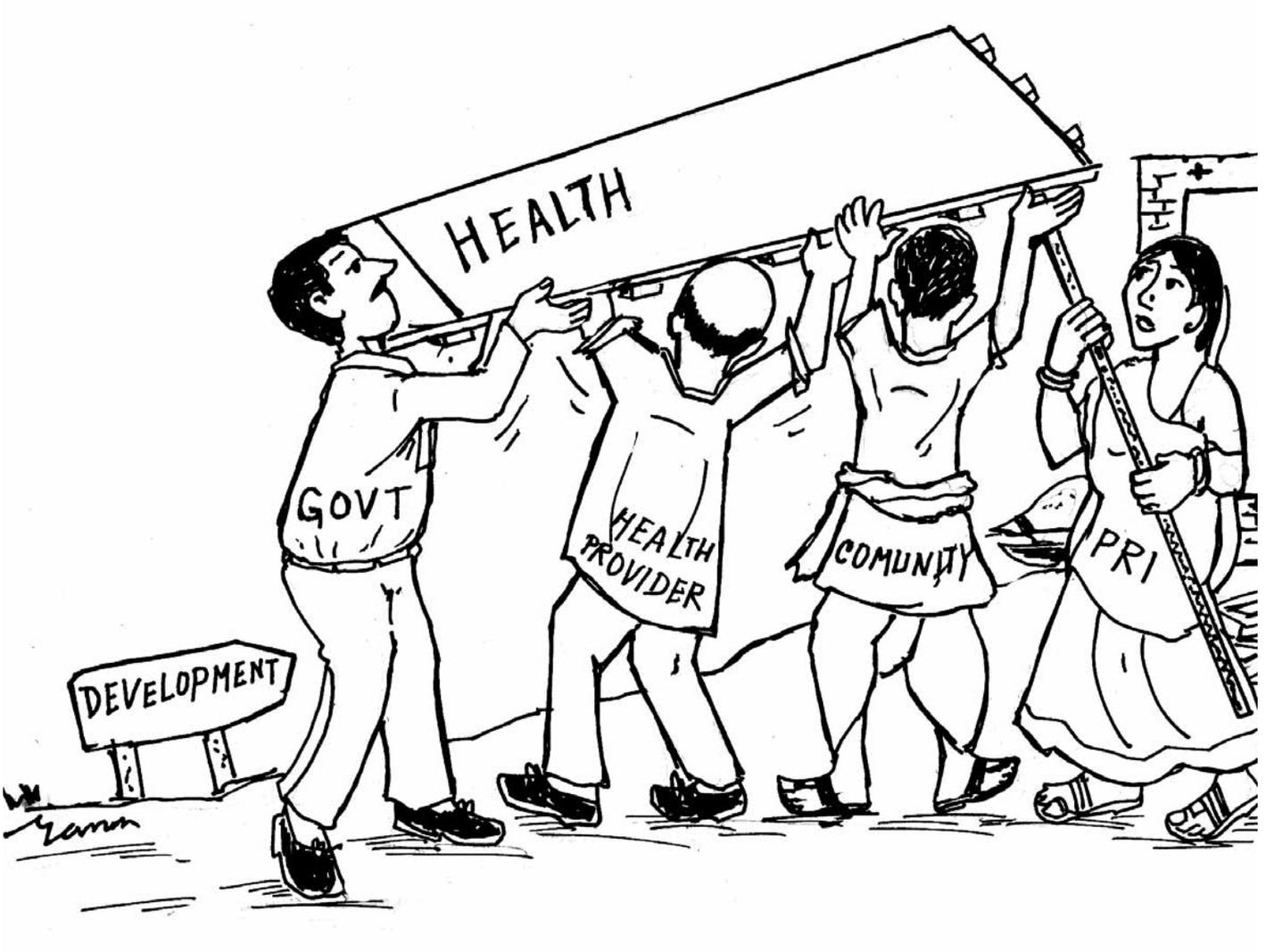
BLOCK LEVEL AND BELOW

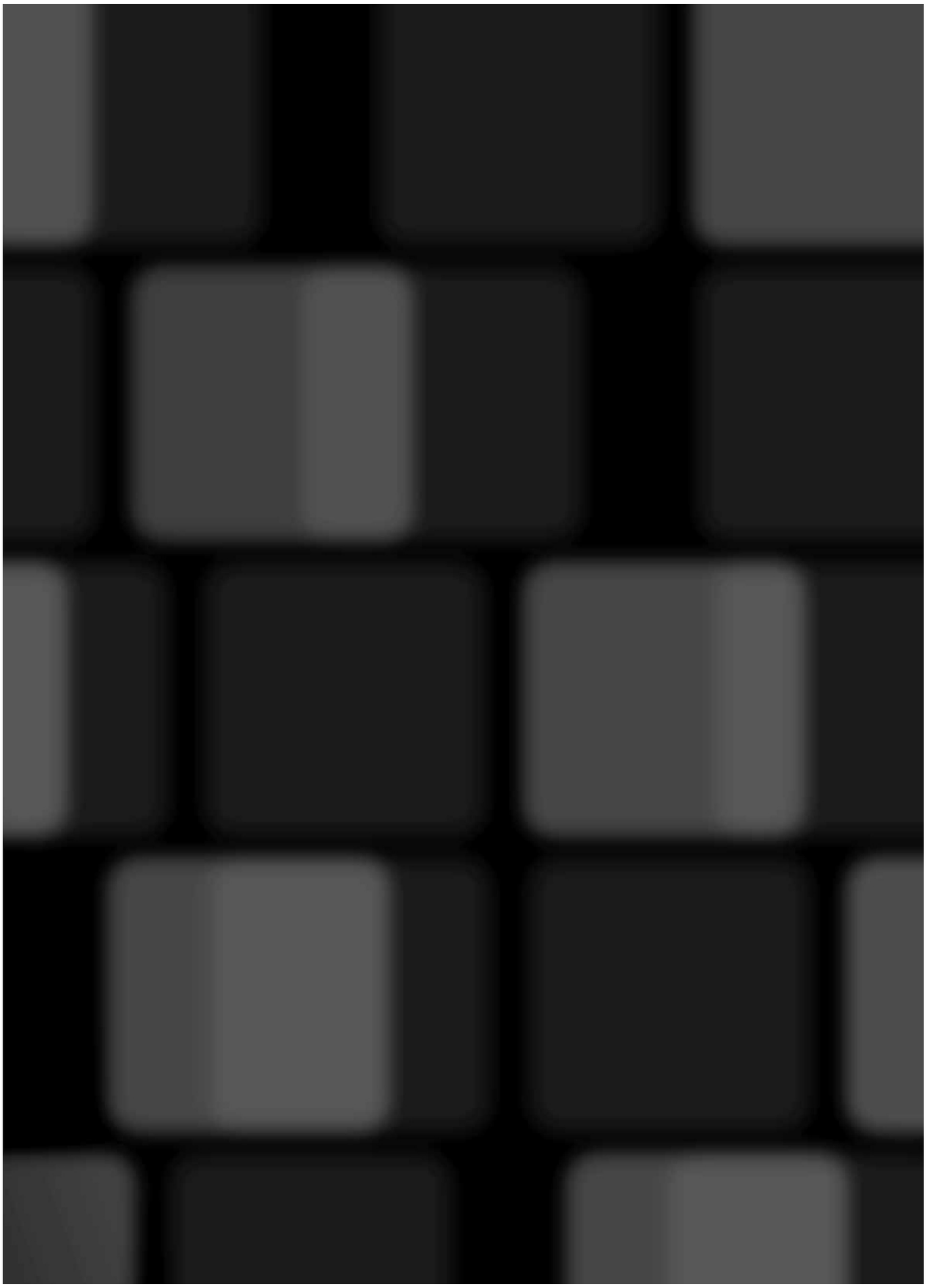
At the block level, there is a Block Nodal Agency in coordination with District Nodal NGO. The block level NGOs will appoint block facilitators for the execution of community monitoring.

Block Nodal Agency

Collaborate with District Nodal Agency for execution of activities in block.
Mobilisation and capacity building at block level.
Form committees at the village, PHC and block if such committees have not been formed.
Coordinate with- Block Medical Officer; village Panchayat, Panchayat Samitis, District Mentoring Team.
Supervise block facilitators for the execution of the Community Monitoring at block and village level.
Community mobilisation at village level.
Financial management at the block level.
Encouraging participation of all stakeholders in community monitoring process.
Conduct Jan Samvad at village, PHC and block level.
Supervise community level documentation processes.
Organise VHSC trainings.

Handholding of VHSC members for community inquiry and preparation of report card


HEALTH
GOVT
HEALTH PROVIDER
COMUNITY
PRI
DEVELOPMENT



Annexures

ANNEXURE I: NRHM STRATEGIES

(a) Core Strategies:

Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.

Promote access to improved healthcare at household level through the female health activist (ASHA).

Health Plan for each village through Village Health Committee of the Panchayat.

Strengthening sub centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).

Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).

Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.

Integrating vertical Health and Family Welfare programmes at national, state, block, and district levels.

Technical support to National, State and District Health Missions, for public health management.

Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.

Formulation of transparent policies for deployment and career development of human resources for health.

Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.

Promoting non-profit sector particularly in under served areas.

(b) Supplementary Strategies

Regulation of private sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.

Promotion of Public Private Partnerships for achieving public health goals.

Mainstreaming AYUSH -revitalising local health traditions.

Reorienting medical education to support rural health issues including regulation of medical care and medical ethics.

Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

ANNEXURE 2: MONITORING AND EVALUATION

Health MIS to be developed upto CHC level, and web-enabled for citizen scrutiny.
Sub centres to report on performance to Panchayats, hospitals to Rogi Kalyan Samitis and District Health Mission to Zila Parishad.
The District Health Mission to monitor compliance to Citizen's Charter at CHC level.
Annual District Reports on People's Health (to be prepared by Govt/NGO collaboration).
State and National Reports on People's Health to be tabled in Assemblies, Parliament.
External evaluation/social audit through professional bodies/NGOs.
Mid-course reviews and appropriate correction.

(From: NRHM Mission Document)

Monitoring Outcomes of the Mission

Right to health is recognised, as inalienable right of all citizens as brought out by the relevant rulings of the Supreme Court as well as the International Conventions to which India is a signatory. As rights convey entitlement to the citizens, these rights are to be incorporated in the monitoring framework of the Mission. Therefore, providing basic Health services to all the citizens as guaranteed entitlements would be attempted under the NRHHM.
Preparation of household specific health cards that record information on: Record of births and deaths, record of illnesses and disease, record any expenditure on health care, food availability and water source, means of livelihood, age profile of family, record of age at marriage, sex ratio of children, available health facility and providers, food habits, alcohol and tobacco consumption, gender relations within family, etc, (by ASHA/AWW/Village Health Team).
Preparation of habitation/village health register, on the basis of the household health cards (by the Village Health Team).
Periodic health facility survey at SHC, PHC, CHC, district levels to see if service guarantees are being honoured (by district/block level Mission Teams/research and resource institutions).
Formation of Health Monitoring and Planning Committees at PHC, block, district and State levels to ensure regular monitoring of activities at respective levels, along with facilitating relevant inputs for planning.
Sharing of all data and discussion at habitation/village level to ensure full transparency.
Display of agreed service guarantees at health facilities, details of human and financial resources available to the facility.
Sample household and facility surveys (by external research organisations/NGOs).
Public reporting of household and health facility findings and its wider dissemination through public hearings and formal reporting.

(From: NRHM Framework for Implementation)

ANNEXURE 3: COMMUNITY MONITORING FRAMEWORK

We have discussed the overall monitoring framework in an earlier section (IV). The basic change that NRHM wishes to bring about in the monitoring framework is to involve local communities in planning and implementing programmes with a framework that allows them to assess progress against agreed benchmarks. While external institutions will also assess progress, they will do so on benchmarks that have been agreed with local communities and health institutions. The intention is to move towards a community based monitoring framework that allows continuous assessment of planning and implementation of NRHM. Besides the issues already mentioned earlier on the monitoring framework, the broad principles for community based monitoring are listed below:

Given the overall objective that people should have complete access to rational, appropriate and effective health care, community based monitoring should preferably fulfil following objectives:

It should provide regular and systematic information about community needs, which would guide related planning.

It should provide feedback according to the locally developed yardsticks for monitoring as well as key indicators. This would essentially cover the status of entitlements, functioning of various levels of the public health system and service providers, identifying gaps, deficiencies and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.

It should enable the community and community-based organisations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system. The community should emerge as active subjects rather than passive objects in the context of the public health system.

It could be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

Ownership of Community Monitoring Process

The Health Department functionaries need to be involved in the preparation and mobilisation phase of the initiative so as to enable 'ownership' of the process and outcomes among the providers and users.

PRIs, community based organisations and NGOs, along with Health Department functionaries should be involved in the preparation and mobilisation phase of the initiative so as to enable ownership of the process and outcomes among the providers and users.

The government can enable such interactive processes through issuing relevant Government Orders, and by ensuring effective communication to all levels of public health functionaries.

All the members of any committee that is formed (for example the Village Health Committee) must have their roles and responsibilities clearly defined and articulated.

Power(s) and Capacity Building

The committees that are formed at various levels must have concomitant authority i.e. they must have the power to initiate action. The capacities of the members of a village level committee have to be built continuously for them to be able to function effectively. This would require allocation of resources and capacity building inputs. This process must begin with full and ready access to information.

The intent of the newly launched NRHM as mentioned in the core strategy is that it will promote community ownership and decentralised planning from village to district

level. This is supposed to be through participatory processes, by strengthening evidence based effective monitoring and evaluation. In order to actually do so it will be imperative that:

The government should enable such interactive processes by issuing relevant Government Orders. One example of such orders is the one passed by the Government of Rajasthan for the formation of Convergence Committees at the district and PHC level. A similar example is the response of the Gujarat Government to the National Human Rights Commission, wherein coordination bodies at various levels of the Public Health System are proposed for operationalising a state level health services monitoring mechanism.

All the members of any committee that is formed must have their roles and responsibilities clearly defined and articulated.

Effective and quality monitoring requires institutional mechanisms at various levels beginning at the community and going upwards. Adequate investment (time and resources) must be made in capacity development at various levels.

Analysis of the collected information must be undertaken at various levels so as to enable prompt action and corrections. The committees that are formed at various levels must have concomitant authority i.e. they must have the power to take action.

The monitoring system must be directly linked to corrective decision making bodies at various levels. The information and issues emerging from monitoring must be communicated to the relevant official bodies responsible for taking action (from PHC to state level) so that monitoring results in prompt, effective and accountable remedial action.

Overall Points to be Considered

Effective community monitoring would change the status of community members from passive beneficiaries to active rights holders, enabling them to more effectively access health services.

One must be realistic in setting indicators and planning activities. Communities need few and simple indicators for monitoring, and the time devoted by members, especially community representatives involved in various committees, must be utilised optimally.

Community monitoring must be seen as an integral part of the Public Health System at all levels and for all activities, and not as a stand-alone process.

Panchayati Raj Institutions are not synonymous with the community. For community ownership and effective monitoring, even if PRI representatives are involved, one still needs to involve user groups and beneficiaries, and to include CBOs.

Involvement of the General Public by Means of Regular 'Public dialogue' or Public hearing (Jan Samvad / Jan Sunwai)

Most of the public participation in the monitoring process would be mediated by representatives of the community or community-linked organisations. However, to enable interested community members to be directly involved in exchange of information, and to improve transparency and accountability of the health care system, 'Public dialogues' (Jan Samvad) or Public hearings ('Jan Sunwai') would be need to organised at regular intervals (once or twice in a year, depending on the initiative of the local organisations) at PHC, block and district levels (see section IV page 21).

What Should the Community Monitor?

The community and community-based organisations should monitor demand/ need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. This should be monitored related to outreach services, public health facilities and the referral system.

ANNEXURE 4: COMPOSITION, ROLES AND RESPONSIBILITIES OF MONITORING COMMITTEES

Village Health Committee

This Committee would be formed at the level of the revenue village (more than one such villages may come under a single Gram Panchayat).

Composition

The Village Health Committee would consist of:

Gram Panchayat members from the village.
ASHA, Anganwadi Sevika, ANM.
SHG leader, the PTA/MTA Secretary, village representative of any Community Based Organisation working in the village, user group representative.

The chairperson would be the Panchayat member (preferably woman or SC/ST member) and the convener would be ASHA; where ASHA not in position it could be the Anganwadi Sevika of the village.

Roles and Responsibilities

Create public awareness about the essentials of health programmes, with focus on people's knowledge of entitlements to enable their involvement in the monitoring.
Discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community.
Analyse key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present an annual health report of the village in the Gram Sabha.
Participatory Rapid Assessment to ascertain the major health problems and health related issues in the village – Estimation of the annual expenditure incurred for management of all the morbidities may also be done. The mapping will also take into account the health resources and the unhealthy influences within village boundaries. Mapping will be done through participatory methods with involvement of all strata of people. The health mapping exercise shall provide quantitative and qualitative data to understand the health profile of the village. These would be village information (number of households – caste, religion and income ranking, geographical distribution, access to drinking water sources, status of household and village sanitation, physical approach to village, nearest health facility for primary care, emergency obstetric care, and transport system) and the morbidity pattern.
Maintain village health register and health information board/calendar – The health register and board, put up at the most frequented section of the village will have information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc. Similarly, dates of visit and activities expected to be performed during each visits by health functionaries may be displayed and monitored by means of a Village health calendar. These will be the most important document maintained by the village community about the exhibition of health status and health care services availability. This will also serve as the instrument for cross verification and validation of data.
Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW.
Obtain a bi-monthly health delivery report from health service providers during their visit to the village. Discuss the report submitted by ANM and MPW and take appropriate action.

Consider the problems of the community and the health and nutrition care providers and suggest mechanisms to solve it.
Discuss every maternal death or neonatal death that occurs in their village, analyse it and suggest necessary action to prevent such deaths. Get these deaths registered in the Panchayat.
Manage the village health fund.

Power (s) of the Committee

The convener will sign the attendance registers of the AWWs, Mid-Day Meal Sanchalak, MPWs, and ANMs.
MPWs and ANMs will submit a bi-monthly village report to the committee along with the plan for next two months. Format and contents of the bi-monthly reports would be decided village health committee.
The committee will receive funds of Rs.10, 000 per year. This fund may be used as per the discretion of the VHC.

Yardsticks for Monitoring at Village Level

Village Health Plan.
NRHM indicators translated into Village health indicators.

Tools for Monitoring at Village Level

Village Health Register.
Records of the ANM.
Village health calendar.
Infant and maternal death audit.
Public dialogue (Jan Samvad).

PHC Health Monitoring and Planning Committee

The PHC Health Committee would function as the health monitoring and planning arm of the Panchayats coming under the PHC area. It is recommended that the PHC Committee have the following broad pattern of representation, including members from Panchayats, health care service providers and civil society:

Composition

30% members should be representatives of Panchayat Institutions (Panchayat Samiti member from the PHC coverage area; two or more sarpanchs of which at least one is a woman).
20% members should be non-official representatives from the village health committees, coming from villages under the jurisdiction of the PHC, with annual rotation to enable representation from all the villages.
20% members should be representatives from NGOs/CBOs and people's organisations working on Community health and health rights in the area covered by the PHC.
30% members should be representatives of the health and nutrition care providers, including the Medical Officer – Primary Health Centre and at least one ANM working in the PHC area.

The chairperson of the PHC committee would be one of the Panchayat representatives, preferably a Panchayat Samiti member belonging to the PHC coverage area. The executive chairperson would be the Medical officer of the PHC. The secretary of the PHC committee would be one of the NGO/CBO representatives.

Roles and Responsibilities

Consolidation of the village health plans and charting out the annual health action plan in order of priority. The plan should clearly lay down the goals for improvement in health services and key determinants.

Presentation of the progress made at the village level, achievements, actions taken and difficulties faced followed by discussion on the progress of the achievements of the PHC, concerns and difficulties faced and support received to improve the access to health facilities in the area of that particular PHC. The discussion could include:

- Sharing of reports of Village Health Committees.
- Reports from ANM, MPW about the coverage of health facilities.
- Any efforts done at the village level to improve the access to health care services.
- Record and analysis of neonatal and maternal deaths.
- Any epidemic occurring in the area and preventive actions taken.

Ensure that the **Charter of citizens' health rights** is disseminated widely and displayed out side the PHC informing the people about the medicine facilities available at the PHC, timings of PHC and the facilities available free of cost. A suggestion box can be kept for the health care facility users to express their views about the facilities. These comments will be read at the coordination committee meeting to take necessary action.

Monitor physical resources like, infrastructure, equipments, medicines, water connection etc at the PHC and inform the concerned government officials to improve it.

Discuss and develop a PHC Health Plan based on an assessment of the situation and priorities identified by representatives of village health committees and community based organisations.

Share information about any health awareness programme organised in the PHC's jurisdiction, its achievements, follow up actions, difficulties faced etc.

Coordinate with local CBOs and NGOs to improve the health scenario of the PHC area.

Review functioning of sub-centres operating under jurisdiction of the PHC and taking appropriate decisions to improve their functioning.

Brief minutes of the meeting at the end of the meeting along with the action plan emphasising the actions to be taken by different committee members, which will be shared at the District Level Committee. The minutes will also serve as a reference point, while sharing the progress done between two committee meetings.

Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The report may become a part of the performance appraisal of the concerned staff member. The committee may recommend corrective measures to the next level (block/district). The decisions taken in the committee need to be forwarded to higher concerned officials and a copy to the corresponding health committee of that level who will be responsible to take necessary decision for action to be taken on the inquiry within a period of three months.

Power(s) of the committee

Contribute to annual performance appraisal of Medical officer/other functionaries at the PHC.

Take collective decision about the utilisation of the special funds given to PHC (say Rs.25, 000) for the repairs, maintenance of equipments, health education etc and any other aspects, which will facilitate the improvement of access to health care services. The MO can utilise this fund after the discussion and approval from the committee.

Yardsticks for Monitoring at PHC level

Charter of Citizens Health Rights.

IPHS or similar standards for PHC (this would include continuous availability of basic

outpatient services, indoor facility, delivery care, drugs, laboratory investigations and ambulance facilities).
PHC Health Plan.

Tools for Monitoring at PHC level

Village health registers / calendars.
PHC records.
Discussions with and interviews of the PHC committee members.
Public dialogue (Jan Samvad) or Public hearing (Jan Sunwai).
Quarterly feedback from village Health Committees.
Periodic assessment of the existing structural deficiencies.

Block Health Monitoring and Planning Committee

The committee constituted at the block level would be consistent with CHC. This committee would have members drawn from service providers, representatives of VHSCs and PPMCs, representative of panchayts. A local civil society organization will serve as its member secretary. The block CMO & HO will be the convener of this committee and it will be chaired by the Pradhan of Panchayat Samiti.

Composition

30% members should be representatives of the Block Panchayat Samiti (Adhyaksha/ Adhyakshika of the Block Panchayat Samiti or members of the Block Panchayat samiti, with at least one woman).
20% members should be non-official representatives from the PHC health committees in the block, with annual rotation to enable representation from all PHCs over time.
20% members should be representatives from NGOs / CBOs and People's organizations working on community health and health rights in the block, and involved in facilitating monitoring of health services.
20% members should be officials such as the Block Medical Officer, the Block Development Officer, selected Medical Officers from PHCs of the block.
10% members should be representatives of the CHC level Rogi Kalyan Samiti. The chairperson of the Block committee would be one of the Block Panchayat Samiti representatives. The executive chairperson would be the Block medical officer. The secretary would be one of the NGO / CBO representatives.

Roles and Responsibilities

Consolidate PHC level health plans and charting out of the annual health action plan for the block. The plan should clearly lay down the goals for improvement in health services.
Review progress made at the PHC levels, difficulties faced, actions taken and achievements made, followed by discussion on any further steps required to be taken for further improvement of health facilities in the block, including the CHC.
Analyse records on neonatal and maternal deaths; and the status of other indicators, such as coverage for immunisation and other national programmes.
Monitor physical resources like, infrastructure, equipments, medicine, water connection etc at the CHC; similar exercise for the manpower issues of the health facilities that come under the jurisdiction of the CHC.
Coordinate with local CBOs and NGOs to improve the health services in the block.
Review functioning of sub-centres and PHCs operating under jurisdiction of the CHC and taking appropriate decisions to improve their functioning.
Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee; initiate an enquiry if required and table report

within two months in the Committee. The Committee may also recommend corrective measures to the district level.

Power(s) of the committee

Contribute to annual performance appraisal of Medical officer/other functionaries at the PHC and CHC.

Take collective decision about the utilisation of the special funds given to CHC for the repairs, maintenance of equipments, health education etc and any other aspects, which will facilitate the improvement of access to health care services. The CMO can utilise this fund after the discussion and approval from the committee.

Yardsticks for Monitoring at Block level

IPHS or similar standards for CHC (this would include continuous availability of basic outpatient services, indoor facility, community outreach services, referral services, delivery and antenatal care, drugs, laboratory investigations and ambulance facilities).

Charter of Citizens Health Rights for CHC.

Block Health Plan.

Tools for Monitoring at Block level

PHC and CHC records.

Discussions with and interviews of the CHC RKS members.

Report of Public dialogue (Jan Samvad).

Quarterly feedback from village and PHC Health Committees.

Periodic assessment of the existing structural and functional deficiencies.

District Health Monitoring and Planning Committee

The committee constituted at the district level would contribute to the development of District Health Plan. This committee would have members drawn from service providers, representatives of VHSCs, PPMCs, BPMCs and representative of panchayts. The chairperson of the District Committee would be one of the Zilla Parishad representatives, preferably convenor or member of the Zilla Parishad Health committee. The executive chairperson would be the CMO/CMHO/DHO or officer of equivalent designation. The secretary of the PHC committee would be one of the NGO/CBO representatives.

Composition

30% members should be representatives of the Zilla Parishad (esp. convenor and members of its Health Committee).

25% members should be district health officials, including the District Health Officer/Chief Medical Officer and Civil Surgeon or officials of parallel designation, along with representatives of the District Health Planning Team including management professionals.

15% members should be non-official representatives of block committees, with annual rotation to enable successive representation from all blocks.

20% members should be representatives from NGOs/CBOs and people's organisations working on Health rights and regularly involved in facilitating community based monitoring at other levels (PHC/block) in the district.

10% members should be representatives of Hospital Management Committees in the district.

Roles and Responsibilities

Discuss on the reports of the PHC health committees.

Financial and solving blockages in flow of resources if any.

Assess infrastructure, medicine and health personnel related information and

necessary steps required to correct the discrepancies.
Review progress report of the PHCs emphasising the information on referrals utilisation of the services, quality of care etc.
Contribute to development of the District Health Plan, based on an assessment of the situation and priorities for the district. This would be based on inputs from representatives of PHC health committees, community based organisations and NGOs.
Ensure proper functioning of the Hospital Management Committees.
Discuss on circulars, decisions or policy level changes done at the state level; deciding about their relevance for the district situation.
Take into cognisance of the reported cases of the denial of health care and ensure proper redressal.

Yardsticks for Monitoring at District Level

Charters of Citizens Health Rights.
District Action Plan.
NRHM guidelines.
Indian Public Health Standards.

Tools for Monitoring at the District Level

Report from the PHC Health committees.
Report of the District Mission committee.
Public Dialogue (Jan Samvad).

State Health Monitoring and Planning Committee

The committee constituted at the state level would contribute to the development of State Health Plan. This committee would have members drawn from service providers, representatives of VHSCs, PPMCs, BPMCs, DPMCs and representative of panchayts. The chairperson would be one of the elected members (MLAs). The executive chairperson would be the Secretary Health and Family Welfare. The secretary would be one of the NGO coalition representatives.

Composition

30% of total members should be elected representatives, belonging to the State legislative body (MLAs/MLCs) or Convenors of Health committees of Zilla Parishads of selected districts (from different regions of the state) by rotation.
15% would be non-official members of district committees, by rotation from various districts belonging to different regions of the state.
20% members would be representatives from State health NGO coalitions working on Health rights, involved in facilitating community based monitoring.
25% members would belong to state Health Department.
Secretary Health and Family Welfare, Commissioner Health, relevant officials from Directorate of Health Services (incl. NRHM Mission Director) along with technical experts from the State Health System Resource Centre / Planning cell.
10% members would be officials belonging to other related departments and programmes such as Women and Child Development, Water and Sanitation, Rural development.

Roles and Responsibilities

Discuss the programmatic and policy issues related to access to health care and to suggest necessary changes.
Review and contribute to the development of the State Health Plan, including the plan for implementation of NRHM at the state level; the committee will suggest and review priorities and overall programmatic design of the State Health Plan.

Discuss Key issues arising from various district health committees, which cannot be resolved at that level (especially relating to budgetary allocations, recruitment policy, programmatic design etc) and initiate appropriate action initiated by the committee. Also discuss administrative and financial level queries, which need urgent attention.
Institute a health rights redressal mechanism at all levels of the health system, which will take action within a time bound manner. Review summary report of the actions taken in response to the enquiry reports.
Operationalise and assess the progress made in implementing the recommendations of the NHRC, to actualise the right to health care at the state level.
Take proactive role to share any related information received from GOI and will also will share achievements at different levels. The copies of relevant documents will be shared.

Power(s) of the committee

Ensure that the different levels committees are properly constituted and they meet regularly and transact their mandates in letter and spirit

Yardsticks for Monitoring at State Level

NHRC recommendations and National Action Plan on Right to Health Care; responses of state Health Departments and actions to which the State Government has committed itself.
NRHM state level plan and the State Health Mission guidelines.
IPHS.

Tools for Monitoring at State Level

Reports of the district health committees.
Periodic assessment reports by various taskforces/ state level committees about the progress made in formulating policies according to IPH Standards, NHRC recommendations and its implementation status etc.

ANNEXURE 5: CONCRETE SERVICE GUARANTEES

Concrete Service Guarantees that NRHM will provide:

Skilled attendance at all births.

Emergency obstetric care.

Basic neonatal care for new born.

Full coverage of services related to childhood diseases/health conditions.

Full coverage of services related to maternal diseases/health conditions.

Full coverage of services related to low vision and blindness due to refractive errors and cataract.

Full coverage for curative and restorative services related to leprosy.

Full coverage of diagnostic and treatment services for tuberculosis.

Full coverage of preventive, diagnostic and treatment services for vector borne diseases.

Full coverage for minor injuries/illness (all problems manageable as part of standard outpatient care upto CHC level).

Full coverage of services inpatient treatment of childhood diseases/health conditions.

Full coverage of services inpatient treatment of maternal diseases/health conditions including safe abortion care (free for 50% user charges from APL).

Full coverage of services for blindness, life style diseases, hypertension etc.

Full coverage for providing secondary care services at sub-district and District Hospital.

Full coverage for meeting unmet needs and spacing and permanent family planning services.

Full coverage of diagnostic and treatment services for RI/STI and counselling for HIV – AIDS services for adolescents.

Health education and preventive health measures.

*visit*www.nrhmcommunityaction.org

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