NATIONAL RURAL HEALTH MISSION
(2005-2012)

TRAINING MANUAL

Community Monitoring of Health Services Under NRHM

Community based Monitoring of Health services under National Rural Health Mission

MANUAL FOR TRAININGS AND WORKSHOPS

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Preface

Community based monitoring is an important component of the accountability framework as well as the community ownership processes envisaged within the National Rural Health Mission (NRHM). The process of community based monitoring is supervised by a series of community planning and monitoring committees from the village level upto the state level. These committees have been entrusted with the responsibility of understanding the current status of health care services delivery and providing feedback to improve the system at different levels. To fulfill this, it is necessary for the community planning and monitoring committees from the Village Health and Sanitation Committee (VHSC) upwards, to understand the developmental spirit of the process, gather and analyse information sensitively and suggest areas for improvement.

The providers also need to be sensitive to the need for receiving community feedback and be aware of the role of such community based monitoring in improving the overall quality and utilisation of services. Thus, the community based monitoring process includes a series of enquiries and sensitive negotiations between the civil society and health system actors to improve the health care delivery system.

This Training Manual is a collection of training modules and session plans aimed at different stakeholders who are supposed to participate in the range of capacity building programmes from the state to the village level. The Manual is a compendium of session plans and resource materials that the trainers will find useful in training members of the Village Health Sanitation Committees as well as in the orientation of providers. The community based monitoring process involves the participation of and facilitation by civil society facilitators at different levels and the Manual also includes workshop designs for such organisations. Each session plan is carefully described and also includes all necessary support materials like copies of presentations and hand-outs.

The Training Manual has been finalised through a process of implementation across nine states that were part of the First phase of the community based monitoring processes. Feedback was taken from the trainers who implemented the various sessions in the field and incorporated into this version. It is hoped that this Manual and the accompanying CD will prove useful in the roll-out of the community based monitoring component of NRHM across the country. We encourage practitioners to adapt the modules, session plans and resources to suit their needs.

Acknowledgements

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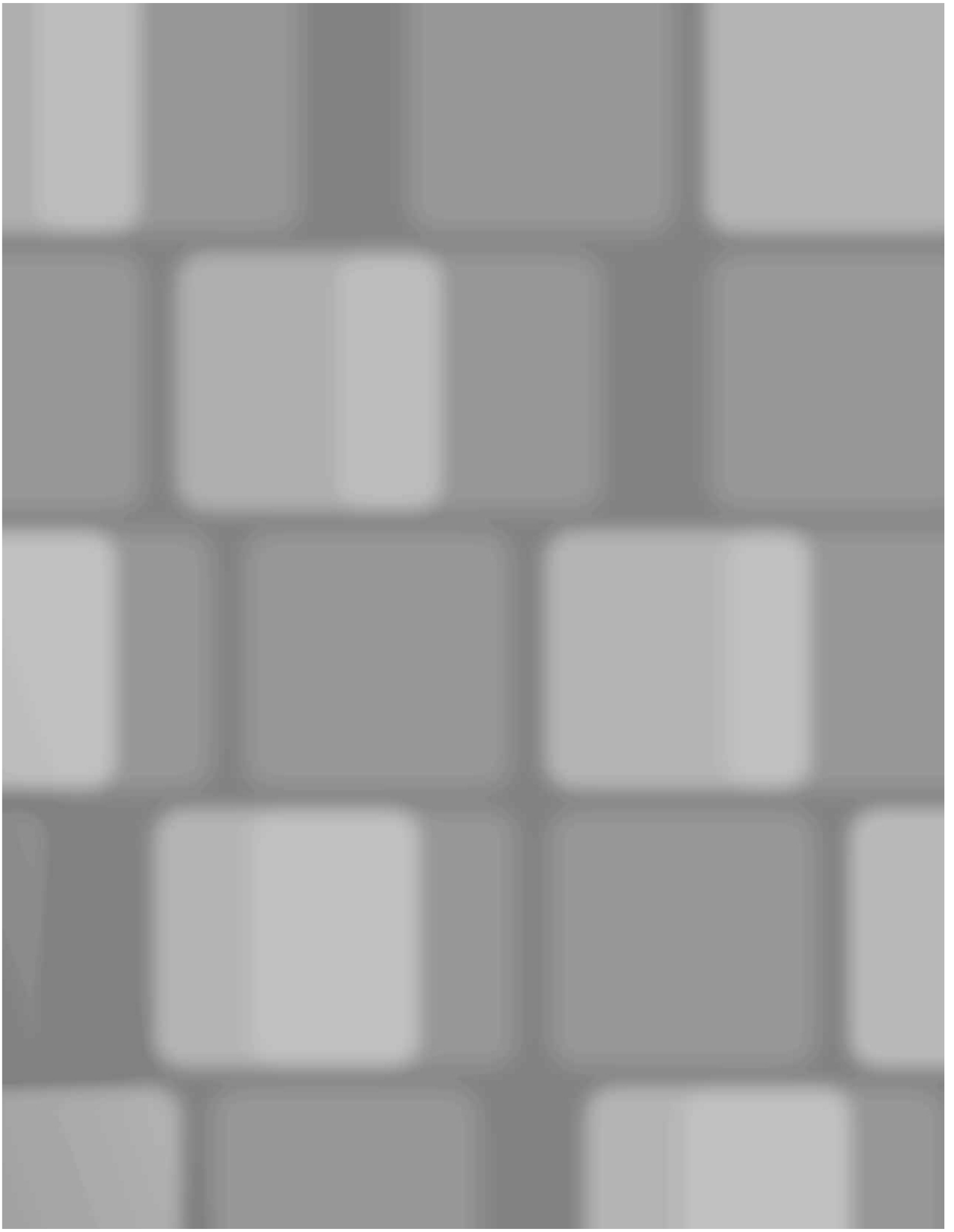
Contents

RESOURCE CD Enclosed

Glossary

AGCA	Advisory Group for Community Action
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
CM	Community Monitoring
CMO	Chief Medical Officer
CHC	Community Health Centre
CO	Chief Officer
DPM	District Programme Manager
DM	District Magistrate
DG	Director General
DOTS	Directly Observed Treatment Short course
FGD	Focus Group Discussion
FIR	First Information Report
GoI	Government of India
IPHS	Indian Public Health Standards
IV	Intravenous
JSA	Janani Suraksha Yojana
LHV	Lady Health Visitor
MPW	Multi-Purpose Worker
MPC	Monitoring and Planning Committee
MLA	Minister of Legislative Assembly
NRHM	National Rural Health Mission
NGO	Non-Governmental Organisation
PRI	Panchayati Raj Institution
PHC	Primary Health Centre
PS	Police Station
SP	Superintendent of Police
SDM	Sub-Divisional Magistrate
TAG	Technical Advisory Group
VHSC	Village Health and Sanitation Committee



CHAPTER 1

State Level Workshop

Organised by: State mentoring team, State Health Mission, State nodal NGO, supported by AGCA -TAG and National Secretariat.

Objectives(s)

1. To brief participants about the NRHM process.
2. To locate community monitoring in the larger framework of community participation and ownership in Comprehensive Primary Health Care.
3. To update participants about community monitoring process under NRHM to be implemented in the state.

Schedule

S/L	Programme	Method	Time	Facilitator
1.	Welcome, Context and Objectives		15 mins	
2.	Introduction		15 mins	
3.	Inaugural Address		15 mins	
4.	Introduction to NRHM and Communitisation	Presentation and Discussion	45 mins	
5.	Process of Community Monitoring in NRHM & Key Achievements in other States	-do-	1 hour	
6.	Roles & Responsibilities of Key Stakeholders & Organogram of Community Monitoring	-do-	1 hour	
7.	Developing a Broad Work Plan & Time Frame of Activities		1 hour	
8.	Valedictory	Plenary Discussion		

4 To explain the process of implementation at different levels, the financial flow and the organisational set up.
5 To prepare a work plan for the state.

Participants

State Mission officials.
State mentoring team members.
Health officials from selected districts.
PRI representatives from selected districts.
NGO networks and civil society organisations from selected districts and the state nodal NGO.
NRHM, GoI and AGCA representatives.
Other representatives from reputed academic institutions.
JSA members involved in People's Rural Health Watch in the state.

Expected Outcomes

A shared understanding of the community monitoring process under NRHM.
Stakeholders' commitment to work together for the project.
Clarity of government and NGO's role and degree of involvement in the process.

One day (5-6 hours)

Materials Required

Overhead/LCD projector
Projector screen
Registration forms
Flip charts and chart papers
Markers and sketch pens

Participant Kit

Travel reimbursement form
Notepad
Pen
File cover
Brochure on Community Monitoring under NRHM
Community Entitlement Book
Hard copies of all the presentations

Presentations (Annexure IV)

Introduction to NRHM & Communitisation
Community Monitoring under NRHM
Roles and Responsibility of Different Stakeholders & Organogram of CM

Reference:

Managers' Manual
NRHM Documents(NRHM Framework for Implementation etc.)
Monitoring Manual

SESSION PLAN

1. Introduction to NRHM and Communitisation

Objective(s): To give a brief outline on NRHM and its emphasis on communitisation.

Process: The presentation titled, 'Introduction to NRHM & Communitisation' in Annexure IV to be shown to participants.

The facilitator is required to be familiar with NRHM documents before the Session (refer CD).

2. Process of Community Monitoring & Experience in other States

Objective(s): To gain understanding on community monitoring, its need and framework, to outline the various activities envisaged in the community monitoring process and experience from other states.

Process The presentation titled, 'Community Monitoring under NRHM' in Annexure IV is to be shown and followed by discussion.

The facilitator is required to read the NRHM documents, Manager's Manual and Monitoring Manual. The presentation can be updated with slides on different experiences of community monitoring from the states.

3. Roles and Responsibilities of Key Stakeholders and other Agencies

Objective(s) To identify the actors of community monitoring and clarify their roles.

Process The presentation titled, 'Role of stakeholders & Committees at Different Levels' in Annexure IV is to be explained using chart/overhead projector or black/white board and followed by discussion.

The facilitator is required to be familiar with NRHM documents

(NRHM Framework for Implementation), Manager's Manual and Monitoring Manual (refer CD).

4. Sharing of District Plan and Clarification of Pending Issues that may remain in the Plenary

Objective(s): To share the plan of action and flag the issues.

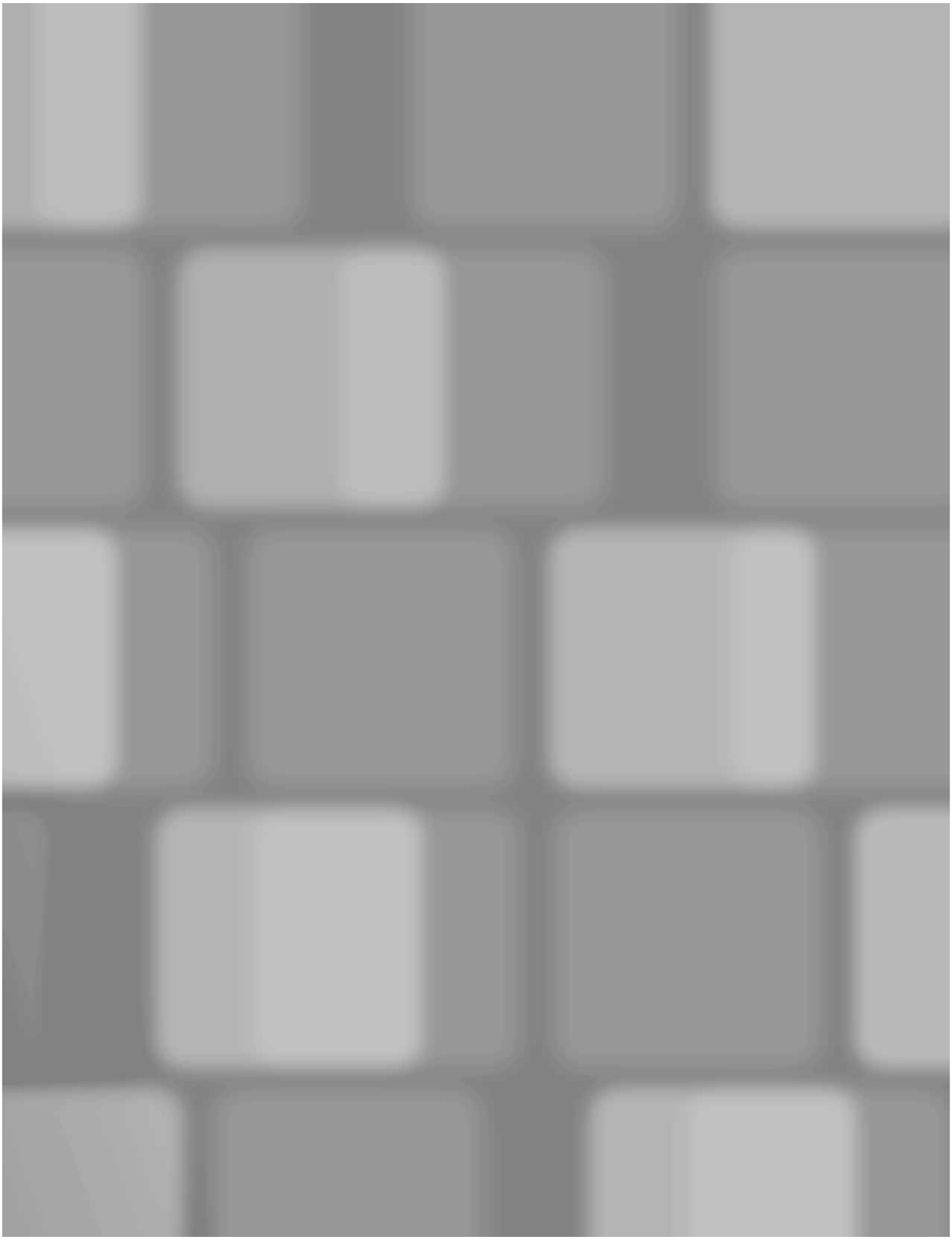
Process: Participants can be divided in groups and should be provided with chart papers. Each group should discuss the plan of action needed to be carried out in the district and the challenges they might face during its implementation.

Note: The facilitators need to help them layout the activities required for the plan of action. Each group should present its plan of action followed by open discussion.

A template for discussing the broad framework of work plan is given below which can be modified according to individual state's requirements:

Format 1

S/ N	Activities	Timeline	Responsibility
1.	**Activities at the State Level**		
a.	State Manager's Workshop		
2.	**Activities at the District Level**		
a.	Selection of Blocks		
b.	Formation of District Mentoring Group		
c.	District Workshop		
d.	Formation of District Committee		
3.	**Activities at the Block level**		
a.	Selection of Block Facilitators		
b.	Block Facilitator's Training		
c.	Formation of Block Committees		
d.	Orientation of Block Committees		
4.	**Activities at the PHC**		
a.	Formation of Committee		
b.	Orientation of Committee		
c.	Jan Samvad		
5.	**Activities at the Village Level**		
a.	Formation/activation of VHSC		
b.	VHSC Orientation Workshop		



CHAPTER 2

State Managers' Orientation Workshop

Organised by: State mentoring group and State nodal NGO.

Objective(s)

1. To locate community monitoring within the larger NRHM implementation framework.

Schedule

Activity	Method	Time	Facilitator
Day 1			
Introduction & Expectation Setting		45 mins	
Barriers to Health & Health Rights	Exercise/Case Study	90 mins	
Rights Based Approach & Community Monitoring in NRHM	Exercise /Presentation/ Open House Discussion	90 mins	
Introduction to NRHM, Service Guarantees, IPHS Standards & Community Monitoring	Open House Discussion & Presentation	30 mins	
Organogram of Community Monitoring			
& Role of Different Stake Holders	Presentation & Discussion	1 hr	
Introduction to Various Activities within Community Monitoring Process	Presentation & Discussion	90 mins	
Day 2			
Recap of Day One	Discussion	30 mins	
Administrative Mechanisms & Documentation & Reporting	Discussion	1 hr	
Budget & Financial arrangements	Discussion	1 hr	
Selection of Block, PHC, Villages	Discussion	1 hr	
Action Plan & Follow-Up	Discussion	1 hr	
Valedictory Session			

Expected Outcomes

Detailed district level workplans will be prepared for community mobilisation and for formation of monitoring groups at all levels.
A time line of activites at the state and district level will be prepared.
A follow-up plan with responsibilities will be prepared.

Two days (11-12 hrs, residential for outstation participants)

Materials Required

Over head/LCD projector
Projector screen
Registration forms
Pin-up boards, Thumb pins
Chart papers, Flip charts
White/black board, Bold markers
White board markers/chalk
Copies of the four case studies

Participant Kit:

Notepad, Pen, File cover
Travel reimbursement form
Brochure on Community Monitoring under NRHM
Community Entitlement Book
Hard copies of all the presentations
Copy of Manager's Manual

Presentations: (Refer Annexure IV)

Rights & Rights based Approach.
Community Monitoring under NRHM.
NRHM, Service Guarantees, IPHS, Charter & CM.
Role of Different Stakeholders & Organogram of CM.
Community Monitoring Process under NRHM.

Case Studies: (Refer Annexure I)

Drawya Kumari, Gonda
Nankai, Lucknow
Lakshmi's Story
Champa of Nupur Village

Reference:

Manager's Manual
Community Entitlement Briefing Book
Monitoring Manual
NRHM Documents(NRHM framework for Implémentation etc.)
Process Documentation Performa

2. To share process of implementation at different levels, the financial flow and the organisational set up.
3. To finalise blocks and the corresponding civil society facilitating organisations
4. To develop a realistic time plan for implementation in the state given agricultural/monsoon and festival cycles.
5. To chart out the specific expectations, commitments, roles and responsibilities of various stakeholders involved at various levels.

Participants

Director, Health Dept/Nodal officer.
State AGCA members.
Mentoring group members.
Resource group members.
CMOs of selected districts.
DPM's of the selected districts.
State officials of Panchayat and Social Welfare Dept. etc.
Chairperson of Zilla Parishad.
Health Sub-Committee of selected districts.
Representative of state nodal NGO.
District nodal NGO coordinators.

SESSION PLAN

DAY 1

1. Introduction

Objective(s): Participants to get an opportunity to know each other.

Process: This could be done in an innovative way with which the training organisers are comfortable, provided participants get enough time to understand each other, including their skills.

An easy and conventional way of conducting introductions is as follows:

Match the pair

Write words such as: pen, paper, needle, thread, coffee, tea, black, white, sun, moon, day, night, sweet, salty, iron tablet, anemia, diarrhea, ORS, green leafy vegetables, vitamins on small chits. Fold the chits and put them in a box.
Each participant takes one chit and finds his/her partner. So pen and paper, needle and thread, coffee and tea, black and white, sun and moon, day and night, sweet and salty etc can be various pairs. Ask pairs to learn as much as possible about one another (name, profession, skills, place of origin, etc). Give them 10-15 minutes. Ask each participant to introduce very briefly the person she or he has been paired with in the last 5-10 minutes.

Facilitator may find out how the different skills of participants could be utilised during the training. If there are members from the marginalised and vulnerable groups as participants, do not introduce them as members of those communities.

2. Expectation Setting

Objective(s): To list out training objectives and clarify scope of training.

Process: The facilitator asks the participants to write their expectations from the workshop in a small chit or on a whip card. The facilitator is expected to collect all the cards from the participants and sort them out. Similar expectations are grouped and categorised. Stick all responses on the wall or on a board. Read the categorised list of expectations. After this exercise, facilitator clarifies which among these expectations are going to be met and which ones are not going to be met. This Session should conclude by explaining the learning objectives of the workshop written on a chart or board.

3. Barriers to Health and Rights based Approach

Objective(s): To bring out the details of barriers to health and enable participants to start thinking on 'how to address such barriers' in their area.

Guidelines for Facilitator

It is better to take a case study related to barriers to health in the area where the trainees belong to. While listing out barriers, it is important to see that the analysis of barriers is not confined to general issues like poverty, illiteracy etc. only.
The analysis should use an 'onion peel approach' by which the specific barriers to health are identified. Or it could be done through asking each participant 'Why?'

Process: Participants are divided into four groups. Each group selects a moderator and a reporter. The facilitator provides copies of four different case studies (refer Annexure I) to members of the four groups. The moderator reads out the case study and then facilitates a discussion.

Discussion points (30 minutes)

1 What do you feel about the experiences of the main characters in the case study?
2 Do you think they deserve to go through such experiences?
3 What are the different barriers that are present in the case study which hinder good quality service delivery and good health outcomes?
4 List number of barriers on health.

II. Ask each group to present the results of their discussion by turn - one barrier of each kind, which emerges from the case study from each group. The subsequent groups could then discuss the remaining barriers till all barriers are exhausted. (30 minutes)

III. Write down the responses of the groups in the following format:

Personal & Community Level Barriers	Health System Level Barriers	Provider Attitudes & Behaviour

IV. Understanding Rights

Ask the Participants to identify right that are being violated at different levels referring to the list of barriers. List the barriers and rights in the following format. (15 minutes)

Barrier	Right

Talking points for facilitator

The rationale for community monitoring lies in adopting a rights based approach as it raises questions about responsibilities and accountability of development agencies.

Ask the participants to define what they mean by a 'right' (Plenary Discussion). Consolidate the participant's definitions into an acceptable definition of rights. (15 minutes)

The facilitator can then go into the next session on "Rights and right's based approach."

4. Rights and Rights Based Approach

Objective(s): To know what rights and rights based approaches are, from where rights emanate from and how human rights are integrally related to community monitoring.

Process: Distribute a sheet with five scenarios' (Refer Annexure II) to each of the participants or read them aloud one by one. Let the participants know that they will have to think about two questions;

1. From a 'rights' perspective what do you think is wrong in each of these situations?
2. Why do you think the person concerned does not react/respond?

Once there is a discussion on these two questions, ask the group what could be some of the strategies to change the situation so that the rights of the person concerned is not violated.(The facilitator is required to be familiar with Chapters 1 and 3 (Health Care is our Basic Rights and Communitisation of Health Services) of the Monitoring Manual). (Refer CD)

Rights based action includes:

a. Rights promoting activities

Rights/entitlement awareness.
Rights education- Community and providers, community mobilisation/organisation, leadership development, building evidence, case studies, primary research, secondary data etc.
Sharing information - briefing kits, fact sheets, pamphlets, plays.
Media advocacy - press conference, stories, opinions, editorials.

b. Claiming health rights

Asking for services, respecting the rules.
Dialogue with providers/managers/legislators.
Asking for grievance redressal/compensation.
Legal action.
Filing complaints/making suggestions.
Representation, delegation.
Public hearing, social audit.
Direct action - protests, demonstrations.

The discussion can be summed up by making the presentation titled 'Right's & Right's Based Approach' in Annexure IV.

5. Introduction to NRHM (Entitlements, IPHS, Charters) and Community Monitoring

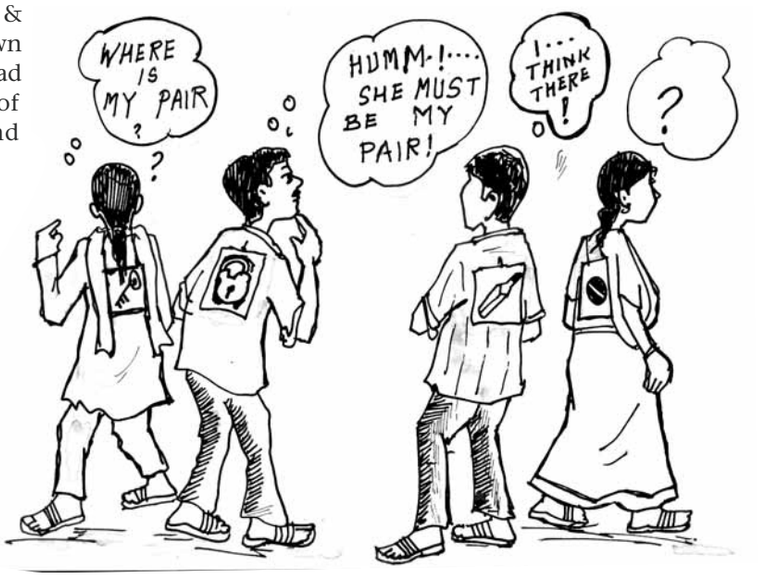
Objective(s): To demonstrate the rights based framework of NRHM and specify the need, objectives and advantages of community monitoring.

Process: The presentation titled 'NRHM, Service Guarantees, IPHS, Charter & CM in Annexure IV is to be shown. The facilitator has to read the NRHM documents (NRHM Framework for Implementation etc.), Managers' Manual and Monitoring Manual. The Entitlement Briefing Book brought out by the National Secretariat can also be referred.(Refer CD).

6. Organogram of Community Monitoring & Role of Different Stakeholders

Objectives(s): To identify the actors of community monitoring and clarify their roles.

Process: The presentation titled 'Role of stakeholders & Organogram of CM' in Annexure IV is to be shown followed by open discussion. The facilitator has to read the NRHM documents (NRHM Framework of Implementation etc.), Managers' Manual and Monitoring Manual. (Refer CD).



7. Introduction to various activities within Community Monitoring Process

Objective(s): To outline the various activities envisaged in the community monitoring process so the managers get an overview of the level of input required from their organisations.

Process: The presentation titled 'Community Monitoring Process under NRHM' in Annexure IV is to be shown followed by discussion. The facilitator has to read the NRHM documents (NRHM Framework of Implementation etc.), Managers' Manual and Monitoring Manual. (Refer CD).

DAY 2

1. Administrative Mechanisms, Documentation and Reporting

Objective(s): To familiarise the managers with the administrative set up and reporting and documenting mechanisms.

Process: Different roles of different agencies at various levels can be discussed. The facilitator should be familiar with the process documentation Performa (refer CD for process documentation format) and the Managers' Manual.

2. Budget and Financial Arrangements

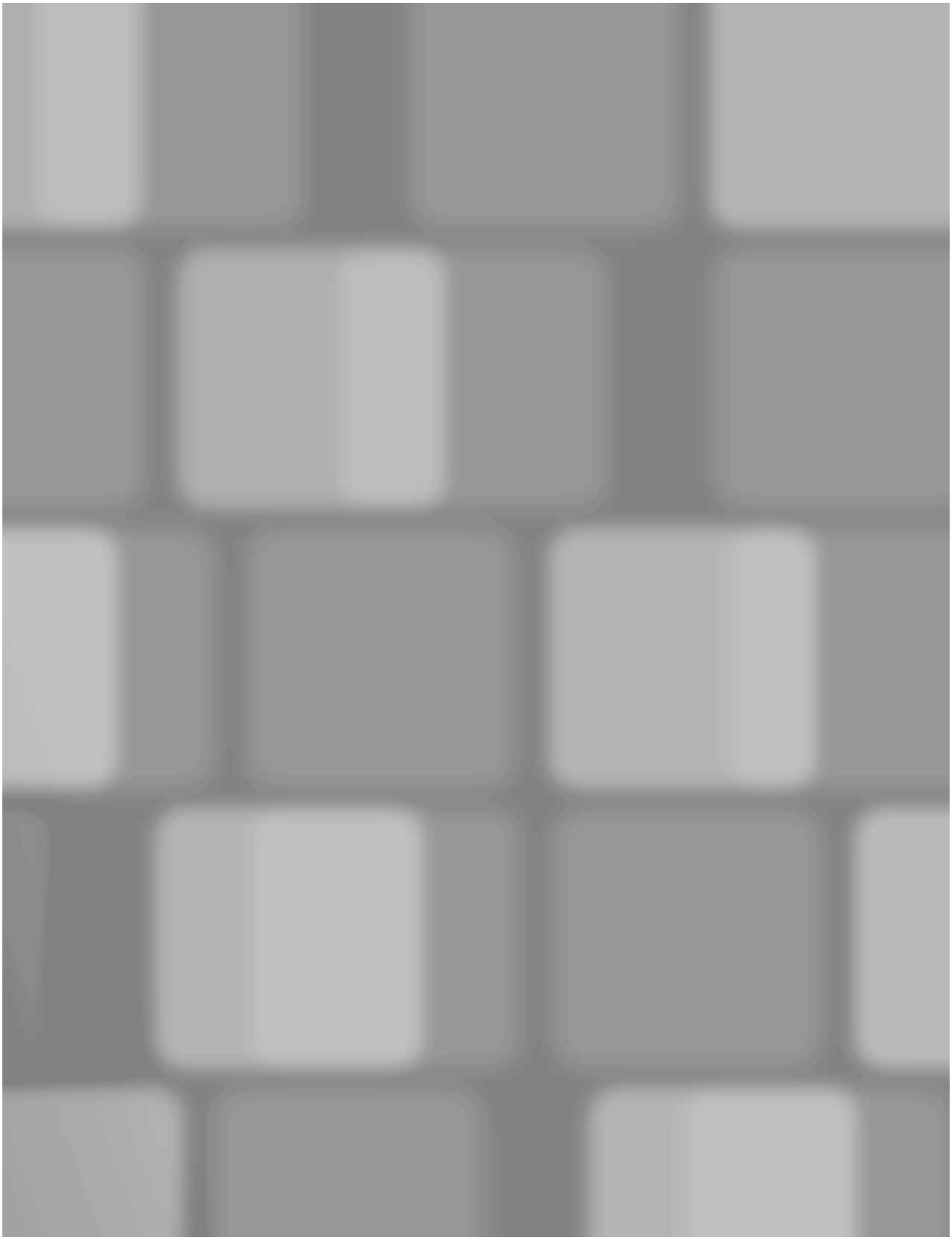
Objective(s): To brief the managers about financial arrangement of the project.

Process: Share the copy of the budget and have an open discussion. The facilitator should have clarity regarding the budget.

3. Selection of Blocks/PHCs/Villages and Follow-up Planning

Objective(s): To develop a work plan of the community monitoring project in the state.

Process: The planning can be done district wise. A tentative timeline of activities can be drawn.



CHAPTER 3

District Level Workshop

Organised by: District nodal NGO & district mentoring Group.

Objective(s)

1 To brief participants about the NRHM process.
2 To locate community monitoring in the larger framework of community participation and ownership in Comprehensive Primary Health Care.

Schedule

Programme	Methodology	Time
Welcome, Context and Objectives		15 mins
Round of Introduction		15 mins
Inaugural Address		15 mins
Introduction to NRHM and Commnitisation	Presentation	20 mins
Community Monitoring under NRHM	Presentation & Discussion	30 mins
Community Monitoring Process & Experience in other States	Presentation & Discussion	45 mins
Role of Stakeholders & Organogram of Community Monitoring	Presentation & Discussion	1 hr
Sharing of District Plan & Clarification of	Moderated	30 mins
Pending Issues in the Plenary	Discussion	
Valedictory		15 mins

3 To update participants about the community monitoring process under NRHM to be implemented in the state.
4 To explain the process of implementation at different levels and the organisational set up.

Expected Outcomes

A shared understanding of the community monitoring process under NRHM.
A resolve of the stakeholders to work with together for this project.
The government is clear on its involvement and its role in this process.

Participants

District Mission officials.
District level health officials.
District level PRI representatives.
NGO networks and civil society organisations working in the district.
Representatives from state nodal NGO.
Other individuals who can be helpful in the process.

One day (5-6 hrs)

Materials Required

Over head/LCD projector
Projector screen
Registration forms
Flip charts
Chart papers
Bold markers

Participant Kit

Notepad
Pen
File cover
Travel reimbursement form
NRHM Brochure on Community Monitoring
Community Entitlement Book
Hard Copies of all the presentations

Presentations (Refer Annexure IV)

Introduction to NRHM and Communitisation
Community Monitoring under NRHM
Community Monitoring Process under NRHM
Roles and Responsibility of Different Stakeholders & Organogram of CM

Reference

Managers Manual
Community Entitlement Briefing Book
NRHM Documents

SESSION PLAN

1. Welcome, Context and Objective

Objective(s): Participants will get know about the context of the project, the process at the national and state level and objectives of the workshop.

Process: The facilitator should welcome to the participants followed by laying down the background of the workshop. An update of activities done till date at the state level and objectives of the workshop should be given.

2. Introduction to NRHM

Objective(s): To demonstrate the rights based framework of NRHM and specify the need, objectives and advantages of community monitoring.

Process: The presentation is to be shown to the participants.

The facilitator is required to be familiar with the NRHM documents, Managers' Manual and Monitoring Manual. The Entitlement Briefing Book brought out by the National Secretariat can also be referred (refer CD).

3. Community Monitoring under NRHM

Objective(s): To specify the need, objectives and advantages of community monitoring.

Process: The presentation titled 'Community Monitoring under NRHM in Annexure IV is to be shown to the participants.

The facilitator is required to be familiar with the NRHM documents, Managers' Manual and Monitoring Manual (refer CD).

4. Process of Community Monitoring & Experience in other States
Objective(s): To outline the various activities envisaged in the community monitoring process and experience from other states.

Process: The presentation is to be shown followed by discussion. The presentation can be updated with slides on different experiences of community monitoring from the states.

The facilitator is required to be familiar NRHM documents, Managers' Manual and Monitoring Manual (refer CD).

5. Role of Stakeholders and Organogram of Community Monitoring
Objective(s): To identify the actors of community monitoring and clarify their roles.

Process The presentation titled 'Role of stakeholders & Organogram of CM' in Annexure IV is to be made using chart/overhead projector or black/white board and followed by discussion.

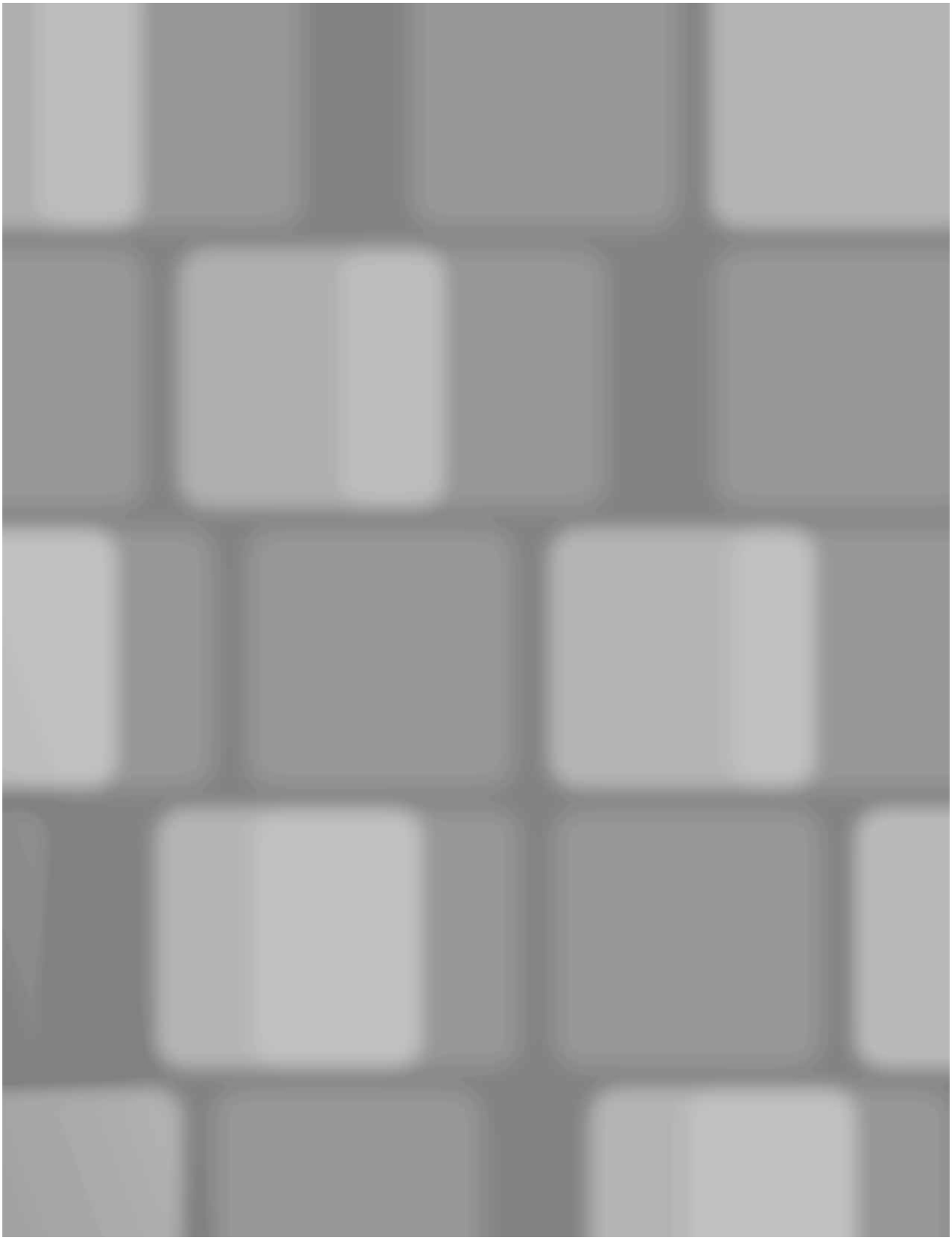
The facilitator is required to be familiar with NRHM documents, Manager's Manual and Monitoring Manual (refer CD).

6. Sharing of District Plan & Clarification of any Pending Issues in the Plenary

Objective(s) To share the plan of action and flag the issues.

Process: Participants can be divided in groups and should be provided with chart paper. Each group should discuss the plan of action that need to be carried out in the district and identify the challenges that may arise during implementation.

Note: The facilitators need to help them layout the activities required for the plan of action. Each group should present its plan of action followed by open discussion.



CHAPTER 4

Block Providers' Orientation Workshop

Organised by: District nodal NGO and Block nodal NGO.

Objective(s)

1 To orient about NRHM and service guarantees at various levels.
2 To brief about different stakeholders and committees in the community monitoring process at various levels.
3 To highlight the providers' role and importance in the community monitoring process.

Programme	Methodology	Time	Facilitator
Welcome , Objectives & Introduction		15 mins	
NRHM, Community Monitoring & Service Guarantees at various levels (Context, Objectives of the Project)	NRHM Quiz, Presentation Discussion	15 mins	
Determinants of Health & Health Outcomes	Power Walk & discussion	15 mins	
Different Stakeholders and Committees in the Community Monitoring Process at Various Levels	Presentation & Discussion	20 mins	
Community Monitoring Process	Presentation & Discussion	30 mins	
Jan Samvad	Presentation & Discussion	45 mins	
Thanks			

Expected Outcomes

Knowledge gained about NRHM and service guarantees about importance and functioning of committees at different levels.
Understanding of role of block providers.
Familiarisation with community monitoring process and Jan Samvad.

1 Day (5-6 hours)

Materials Required:

- Over head/LCD projector
- Projector screen
- Registration forms
- Pin-up board
- Thumb pins
- Flip charts
- Chart papers
- Bold markers
- White/black board
- White board markers/chalk

Participant Kit:

- Notepad
- Pen
- File cover
- NRHM Brochure on Community Monitoring
- Community Entitlement Book
- Print-out of all the presentations

Presentations:

- NRHM, Service Guarantees, IPHS, Charter & CM
- Role of Stakeholders & Committees at Different Levels
- Community Monitoring Process under NRHM
- Jan Samvad

Reference:

- Monitoring Manual
- Managers' Manual
- Community Entitlement Briefing Book
- NRHM Framework for Implementation

4 To familiarise participants with the community monitoring process and Jan Samvad.

Participants

ANM, MO, Health workers, MPW, LHV, Staff Nurse etc.

SESSION PLAN

1. Welcome and Objectives

The facilitator welcomes the participants and explains the purpose of the workshop. He/she thanks all the participants for attending for the workshop.

2. Introduction

Objective(s): Participants to get an opportunity to know each other.

Process: A participant can introduce his/her name and work. The second person has to tell his/her name and work followed by the first person's name and work. The third person will tell his/her name and work followed by second and first person's name and work and so on till all participants are covered. In between many will forget the chain and this can be an occasion for some light-hearted humor.

3. NRHM, Community Monitoring (including first phase) and Service Guarantees at Various Levels (Context, Objectives of the Project)

Objective(s): To orient participants about NRHM, community monitoring (including first phase) and importance of community monitoring under NRHM and service guarantees that has been promised at the various levels.

Process: Start with a small quiz about NRHM. After the quiz, summarise NRHM with the presentation, focusing on community level service guarantees.

The presentation titled 'NRHM, Service Guarantees, IPHS, Charter & CM' in Annexure IV is to be made using chart, overhead projector or black/white board.

The facilitator can refer to the NRHM Framework of Implementation, Monitoring Manual and Entitlement Book (refer CD).

4. Determinants of Health and Health Outcomes

Objective(s): To build perspective essentials for fulfillment of right to health care, access to food, water, adequate sanitation, employment, health care facilities. Why gender, class and caste issues are important with respect to right to health? And what providers can do to see these barriers are addressed during service delivery.

Process: This session can have an exercise called Power walk (see

details below). After the exercise, participants will brainstorm on "how social exclusion and other determinants can adversely impact access?"

Power Walk

1. Facilitator should prepare cards with names of different categories of population. The names of population categories written on the card are -

Tribal man
Tribal woman
Physically challenged woman
Female vegetable seller
Landless daily wage earner - male
Mother of 3 daughters
Father of three daughters
Rickshaw driver - male
Shop owner - male
Bank officer - male
Street beggar - female
Widow (housewife)
Widower
School teacher (woman)
School teacher (man)
Business person (man)
Business person (woman)
Domestic servant (female)
Domestic servant (male)
Doctor
Agriculture laborer (female)
Agriculture laborer (male)
Illiterate manual worker (male)
Illiterate manual worker (female)

2. Participants are asked to stand in a single row and the cards are distributed to all the participants. During the exercise, everyone should try to get into the roles of those categories mentioned in the card and should act as instructed by the facilitator.

3. The facilitator then reads out certain statements (see below) and if a participant agrees to the statement, she/he should take one step ahead from where they stand and if a participant disagrees to the statement she/he should take one step backward from wherever they are. Read the statements slowly, giving the participants time to listen, understand and then respond. The statements to be read out are:

I can read daily newspaper every day morning.
I can complete my school education.
I will be received at a hospital/clinic with respect and dignity.
I can purchase a contraceptive whenever I want.
I have passed Class X.
I can go out in the evening at dusk without fear of being molested.
I can negotiate with my partner with regard to the number of children I would like to have.
If I am tired and do not feel like doing the housework I would be able to let it be.
If I am hungry and nobody else in the house had eaten I will be able to eat.

4. After reading out all the statements and participants taking their positions, participants will be asked to disclose their identities and look at where they are and also explain to others why they moved backward from

where they were or why they moved ahead. What are the factors, which do not let them take a step forward? The facilitator asks the group who among these people are possibly the least healthy and needs health care services most? What barriers do these people have to access services?

5. Different Stakeholders & Committees in the Community Monitoring Process at various levels

Objective(s): To clarify the purpose, actors and activities of community monitoring.

Process: This Session carries forward the discussion of the previous session through discussion and presentation. First, the facilitator asks the providers to list steps that can be taken at the level of the service provider or the facilities to improve service provision and steps that need to be taken at the level of individual and community to improve service provision keeping in mind the situation that was discussed in the earlier session.

Next, the facilitator asks the providers how the community will come to know what the providers want to do and how will they communicate with the community what they expect from the individual and the community? The facilitator will move the discussion towards the need for dialogue based on evidence around NRHM related services and their uptake.

Once this discussion has been completed, the facilitator makes a short presentation titled 'Different Stakeholders and Committees at Different Levels' in Annexure IV demonstrating the Community Monitoring Framework and the role of the providers.

The facilitator is required to be familiar with NRHM documents, Managers' Manual and Monitoring Manual. (Refer CD)

6. Community Monitoring Process

Objective: Familiarisation with community monitoring process regarding tools, data gathering, analysis of the responses (brief overview), collation of data and score card.

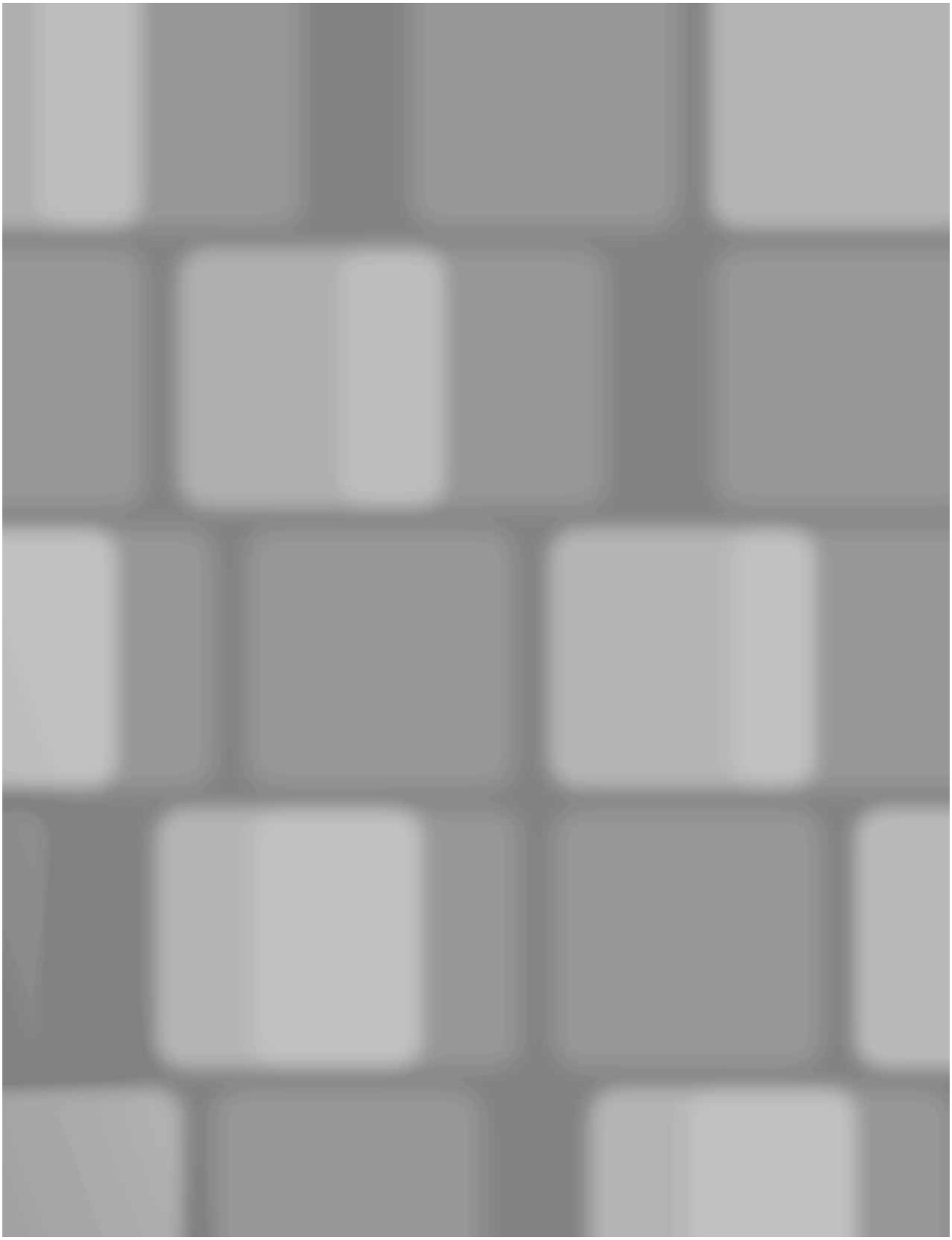
Process: Use presentation titled "Community Monitoring Process under NRHM" in Annexure IV. With the help of presentation give overview of how many tools would be used for the purpose of community monitoring, the process of data collection, collation of data at different level and scorecard. Focus on the role of the providers in facilitating the community monitoring process.

Read Chapters 8 and 9(Conducting Community Monitoring at the village levels and Compiling village and facility level score cards) of Monitoring Manual. (Refer CD)

7. Jan Samvad

Objective: To describe the process of PHC and block level sharing and its importance.

Process: The presentation is to be made using charts/overhead projector or board. The facilitator should read Chapter 10 (Sharing the results and conducting Jan Samvad) of the Monitoring Manual.



CHAPTER 5

Block Facilitators' Training

Organised by: District nodal NGO with support from state nodal NGO.

Objectives(s)

1. To increase knowledge about NRHM, especially on entitlements and mechanisms for community participation and ownership.
2. To develop an understanding on community monitoring within a framework of health rights.
3. To develop skills in applying tools for community monitoring.
4. To prepare an action plan for implementing the community monitoring programme.

Participants:

Block facilitators, block coordinators, state nodal NGO representatives and district coordinators.

Schedule

Programme	Methodology	Time
Day 1		
Context Setting		30 mins
Introduction	In Pairs	45 mins
Expectation Setting	Cards	45 mins
Understanding Health Services System		45 mins
Universal Access & Social Exclusion	Game & Discussion	60 mins
Understanding Barriers to Health	Case Studies & Discussion	45 mins
What is Right & Rights based Approach	Exercise & Discussion	60 mins
Introduction to Community Monitoring	Film Show & Discussion	45 mins

Programme	Methodology	Time
Day 2		
Recap of Day 1		
Introduction to NRHM (Entitlements, IPHS, Charters)	Presentation &Discussion	30 mins
Community Monitoring in NRHM	Presentation & Open Discussion	30 mins
Role of Stakeholders & Organogram of Community Monitoring	Presentation & Open Discussion	30 mins
Composition & Role of District, Block & PHC Level Committees	Group Work	40 mins
Community Mobilisation, Formation, Roles, Responsibility of VHSC	Presentation & Discussion	60 mins
Day 3		
Review of Day 2		
Community Monitoring Tools	Presentation & Discussion	45 mins
Practicing the Tools & Formation of Report Card & Score Card at Village Level & Collation of the Score Card at PHC & Block	Group Work	90 mins
Division of Group for Field Work		
Day 4		
Field Trip		
Preparation of Field Trip Report		
Day 5		
Review of Day 4		
Presentation of the Report Card & Score Cards		
Jan Samvad		
Planning for Community Monitoring: Next Steps	Group Work	
Evaluation of the Workshop		
Valedictory Session		

SESSION PLAN

DAY 1

1. Introduction (45 minutes)

Objective(s): Participants to get an opportunity to know each other.

Process: This could be done in an innovative way with which the training organisers are comfortable, provided participants get enough time to understand each other including their skills. An easy and conventional way of conducting introduction is as follows:

Match the pair

Write words such as: pen, paper, needle, thread, coffee, tea, black, white, sun, moon, day, night, sweet, salty, iron tablet, anemia, diarrhea, ORS, green leafy vegetables, vitamins on small chits. Fold the chits and put them in a box.

Each participant takes one chit and finds his/her partner. So pen and paper, needle and thread, coffee and tea, black and white, sun and moon, day and night, sweet and salty etc can be various pairs Ask pairs to learn as much as possible about one another (name, profession, skills, place of origin, etc). Give them 10-15 minutes. Ask each participant to introduce very briefly the person she or he has been with in the last 5-10 minutes.

Facilitator may find out how the different skills of participants could be utilised during the training. If there are members from the marginalised and vulnerable groups as participants, do not introduce them as members of those communities.

2. Expectation setting (45 minutes)

Objective(s): To list out training objectives and clarify the scope of the training.

Process: The facilitator asks the participants to write their expectations from the workshop in a small chit. Stick all responses on the wall or on a board. Similar expectations can be grouped. Read the list of expectations when it is complete. After this exercise, facilitator clarifies which among these expectations would be met and which ones would not be met. This Session should conclude by explaining the learning objectives of the workshop written on a chart or on a board.

3. Understanding Health Services System of the State (45 minutes)

Objective(s): To give clarity regarding the structure and functions of health system at micro and macro level. Participants will know the nuances of the entity, which they would monitor later.

Process: The facilitator needs to develop a clear understanding of the healthcare system in the country from Chapter 2 (Health System in India) of the Monitoring Manual. (Refer CD).

The Session can start with a short quiz. For quiz questions, please refer to Annexure III. After the quiz make a short presentation titled "Indian Health System" in Annexure IV using charts or board to explain the health system mechanism.

4. Understanding Universal Access (60 minutes)

Objective(s): To understand the various levels of social stratification existing in the society and how such stratification and social exclusion limits universal access to health.

Process: This session can have an exercise called Power walk (see

Expected Outcomes

Increase knowledge about NRHM, especially on entitlements and mechanisms for community participation and ownership.
Develop an understanding on community monitoring within a framework of health rights.
Develop skills in applying tools for community monitoring.
Prepare an action plan for implementing the community monitoring programme.

5 days

Materials Required:

- Over head/LCD projector
- Projector screen
- Registration forms
- Pin-up board, Thumb pins
- Flip charts, Chart papers
- Bold markers, White/black board
- White board markers/chalk
- Copies of the 4 case studies (Refer Annexure I)
- Copies of the situations (Refer Annexure II)
- Desktop/ laptop or TV

Participant Kit:

- Notepad, Pen, File cover
- Travel reimbursement form
- NRHM Brochure on Community Monitoring
- Community Entitlement Book
- Hard copies of all the presentations
- Monitoring Manual, Pamphlets

Presentations:

- Indian Health System
- Rights & Rights Based Approach
- Role of Stakeholders & Organogram of Community Monitoring
- Community Mobilisation & Formation of VHSC
- Community Monitoring Tools

Case Studies: (Refer Annexure I):

- Drawya Kumari, Gonda
- Nankai, Lucknow, Lakshmi's Story
- Champa of Nupur Village

Reference:

- Managers' Manual
- Monitoring Manual
- NRHM Framework for Implementation

d. Community Entitlement Book

details below). After the exercise, participants will brainstorm on "How social exclusion and other determinants can adversely impact access?"

Power Walk

1. Facilitator should prepare cards with names of different categories of population. The names of population categories written on the card are -
2. Participants are asked to stand in a single row and the cards are distributed to all the participants. During the exercise, everyone should try to get into the roles of those categories mentioned in the card and should act as instructed by the facilitator.

Tribal man
Tribal woman
Physically challenged woman
Female vegetable seller
Landless daily wage earner - male
Mother of 3 daughters
Father of three daughters
Rickshaw driver - male
Shop owner - male
Bank officer - male
Street beggar - female
Widow (housewife)
Widower
School teacher (woman)
School teacher (man)
Business person (man)
Business person (woman)
Domestic servant (female)
Domestic servant (male)
Doctor
Agriculture laborer (female)
Agriculture laborer (male)
Illiterate manual worker (male)
Illiterate manual worker (female)

3. The facilitator then reads out certain statements (see below) and if a participant agrees to the statement, she/he should take one step ahead from where they stand and if a participant disagrees to the statement she/he should take one step backward. Read the statements slowly, giving the participants time to listen, understand and then respond. The statements to be read out are:

I can read daily newspaper every day morning.
I can complete my school education.
I will be received at a hospital/clinic with respect and dignity.
I can purchase a contraceptive whenever I want.
I have passed Class X.
I can go out in the evening at dusk without fear of being molested.
I can negotiate with my partner with regard to the number of children I would like to have.
If I am tired and do not feel like doing the housework I would be able to let it be.
If I am hungry and nobody else in the house had eaten I will be able to eat

4. After reading out all the statements and participants taking their positions, they would be asked to disclose their identities and look at where they are and also explain to others why they remained where they were or why they moved ahead. What are the factors, which did not let them take a step forward?

5. The facilitator asks the group who among these people are possibly the least healthy and needs health care services most? What barriers do these people have to access services?

6. After returning to their seats the participants can further share their thoughts in the whole group regarding various levels of social stratification existing in society and how it leads to social exclusion and marginalisation and finally restricts their access to health services, information and commodities.

7. Facilitator should conclude the discussion by providing a definition on universal access. Universal Access can

be defined as a situation in which the services of an organisation reaches the poor, marginalised, socially excluded and underserved groups living within a defined geographical/administrative boundary.

5. Understanding Barriers to Health (45 minutes)

Objective(s): To bring out the details of the barriers to health and enable participants to start thinking on how to address such barriers in their area.

Process:
I. Participants are divided in four groups. Each group selects a moderator and a reporter. The facilitator provides copies of four different case studies to members of each group. The moderator reads out the case studies and then facilitates a discussion.

Guidelines for Facilitator

It is better to take a case study related to barriers to health in the area where the trainees belong. While listing out barriers, it is important to see that the analysis of barriers is not confined to general issues like poverty, illiteracy etc. only.
The analysis should use an 'onion peel approach' through which specific barriers to health are identified.

The case studies are available in Annexure I

Discussion points (30 minutes)

What do you feel about the experiences of the main characters in the case study?
Do you think they deserve to go through such experiences?
What are the different barriers that are present in the case study which hinder good quality service delivery and good health outcomes?
List number of barriers on health.

II. Ask each group to present the results of their discussion by turn - one barrier of each kind, which emerges

Personal & Community Level Barriers	Health System Level Barriers	Provider Attitudes & Behaviour

from the case study from each group. The subsequent groups could then discuss the remaining barriers till all barriers are exhausted.

III. Write down the responses of the groups in the following format:

Barrier	Right

IV. Ask the participants to identify rights that are being violated at different levels referring to the list of barriers. List down barriers and rights in the following format. (15 minutes)

V. Ask the participants to define what they mean by a 'right' (Plenary Discussion). Consolidate the participants' definitions into an acceptable definition of rights. (15 minutes)

VI. The facilitator can go into the next session on rights and right's based approach.

Talking Points for Facilitator

The rationale for community monitoring lies in adopting rights based approach as it raises questions about responsibilities and accountability of development agencies.

6. Rights and Rights Based Approach (60 minutes)

Objective(s): To know what are rights and rights based approach, from where rights come from and how human rights are integrally related to community monitoring.

Process: Distribute a sheet with five different scenarios (refer Annexure II) to each of the participants or read them aloud one by one. Let the participants know that they have to think about two questions:

1. From a 'rights' perspective what do you think is wrong in each of these situations?
2. Why do you think the person concerned does not react/respond?

Once there is a discussion on these two questions, ask the group what could be a few strategies to change the situation so that the rights of the person concerned is not violated.

The facilitator is required to be familiar with Chapters 1 and 3 (Health Care is our Basic Right and Communitisation of Health Services) of the Monitoring Manual. (Refer CD).

Rights promoting activities

Rights/Entitlement Awareness.
Rights education - community and providers, community mobilisation/ organisation, leadership development, building evidence - case studies, primary research, secondary data etc.
Sharing information - briefing kits, fact sheets, pamphlets, plays etc.
Media Advocacy - press conference, stories, opinions, editorials etc.

Claiming health rights

Asking for services, respecting the rules.
Filing complaints/making suggestions.
Dialogue with providers/managers/legislators.
Representation, delegation.
Asking for grievance redressal/compensation.
Public hearing, social audit.
Legal action.
Direct action - protests, demonstrations.

The discussion can be summed up by making the presentation titled "Rights & Rights Based Approach" in Annexure IV.

7. Understanding the Concept of Community Monitoring (45 minutes)

Objective(s): To clarify the needs, advantages, objectives and actors of community monitoring. It would also give participants an opportunity to see how a pioneering attempt at social audit was made with people's participation within the framework of inclusiveness and accountability.

Process: The Session should begin with screening of a documentary film (refer CD) of a social audit.

This is about a social audit conducted by an NGO social movement named Mazdoor Kisaan Shakti Sangathan

(MKSS) in India. After screening the movie participants would be asked to share their feelings about the movie. From the feedback of participants and through brainstorming, the facilitator will be able to explain the characteristics and advantages of community monitoring.
The facilitator needs to read beforehand and develop an understanding from the Managers' Manual. The presentation can be done using charts or board (refer CD).

DAY 2

1. Introduction to NRHM (Entitlements, IPHS, Charters)

Objective(s): To give an overview of NRHM and elaborate on its rights based approach.

Process: The presentation can be done using charts or board. The facilitator has to read the NRHM documents, Managers' Manual and Monitoring Manual. The Entitlement Briefing Book brought out by the National Secretariat can also be referred (enclosed in CD).

2. Community Monitoring under NRHM

Objective(s): To outline the various activities envisaged in the community monitoring process.

Process: The presentation titled 'Community monitoring under NRHM' present in Annexure IV can be done using charts or black board followed by discussion. The facilitator has to read the NRHM documents (NRHM Framework for Implementation), Monitoring Manual and Managers' Manual (refer CD).

3. Role of Stakeholders & Organogram of Community Monitoring

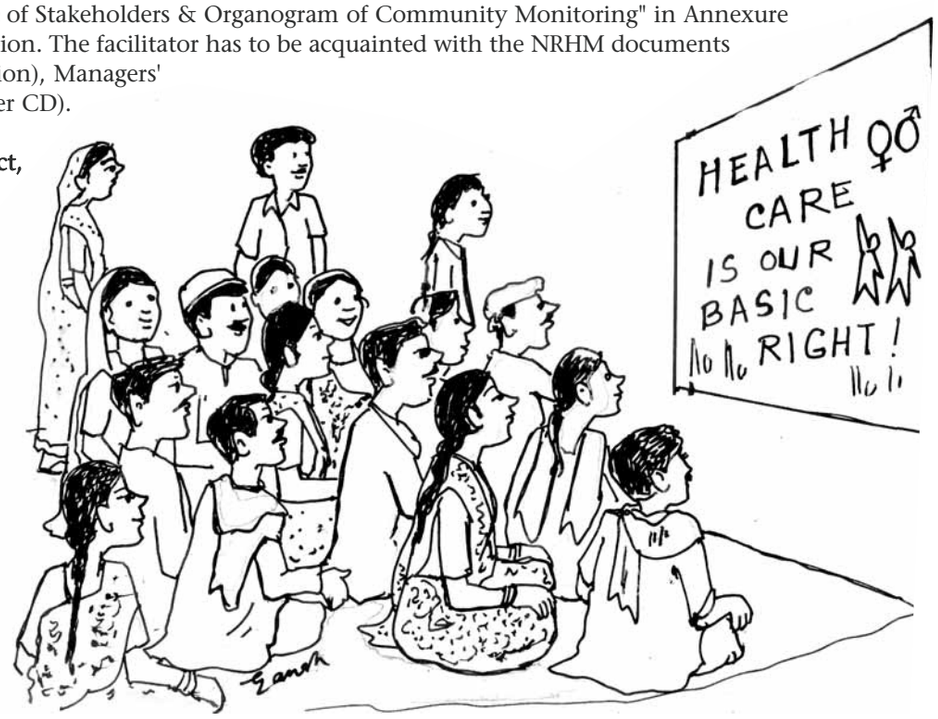
Objective(s): To clarify the actors of community monitoring and their roles.

Process: The presentation titled "Role of Stakeholders & Organogram of Community Monitoring" in Annexure IV is to be shown followed by discussion. The facilitator has to be acquainted with the NRHM documents (NRHM Framework for Implementation), Managers'
Manual and Monitoring Manual (refer CD).

4. Composition and Role of District, Block & PHC level Committees

Objective(s): To understand the composition and role of the various committees at different levels.

Process: The participants can be divided into three groups. The role and composition of the District, Block and PHC level committees can be discussed in each group separately. The Community Entitlement Briefing Book in the participant's kit can be referred(in CD) for the group discussions. The groups would present the composition and roles of each committee one by one.



5. Community Mobilisation and Formation of VHSC

Objectives: To get acquainted with the process of community mobilisation and the formation of VHSC.

Process: The presentation titled "Community Mobilisation & Formation of VHSC" in Annexure IV can be shown followed by a discussion.

The facilitator should be familiar with Chapter 7 (Mobilising the Community and Formation of VHSC) of the Monitoring Manual. (Refer CD)

DAY 3

1. Community Monitoring Tools

Objective(s): To get familiarised with the tools.

Process: The presentation titled "Community Monitoring Tools" in Annexure IV can be shown. The Monitoring Manual can be referred and each tool can be discussed.

The facilitator should read Chapters 8 and 9 (Conducting Community Monitoring at the Village and Facility Levels and Compiling Village and Facility level Score Cards) of the Monitoring Manual. (Refer CD)

2. Practicing the Tools and Formation of Report Card & Score Card at Village Level & Collation of the Score Card at PHC and block

Objective(s): To familiarise the members with methods of data collection, how to analyse the responses and how to collate the date and fill it in the report card. The aim is also to acquaint participants how to develop cumulative sub centre, village and PHC report card.

Process: The participants should be divided in groups. The role-play method could be adopted where one group can do a mock FGD, another can take the interview and the third group can practice observation.

For collation, the facilitator can demonstrate how to prepare a report card. The participants can then go back to their groups. Each group can take up one activity. It could be either Block Report Card or PHC Cumulative Report Card or Sub centre Cumulative Report Card or Village Report Card.

The facilitator should be familiar with Chapters 8 and 9 (Conducting Community Monitoring at the Village and Facility Levels and Compiling Village and Facility level Score Cards) of the Monitoring Manual. (Refer CD)

DAY 4

1. Field Work

Objective(s): To get hands-on experience on data gathering.

Process: Each group is to visit the designated areas and use tools to collect data.

One group can conduct FDG with community, another can visit PHC, CHC and Sub Centre for observation purpose and third group can conduct interview with women, ASHAs etc. After field visit each group can present their experience and can discuss problem faced in the filed and how to over come. This will give

opportunity to learn from each other and also each group will get feel of each setting. Later on group can practice to develop the score card and can present it front of other group.

The process will give confidence to present the findings in Village Health Day and Jan Samvad.

DAY 5

1. Jan Samvad

Objective(s): To demonstrate the need, method and advantages of Jan Samvad.

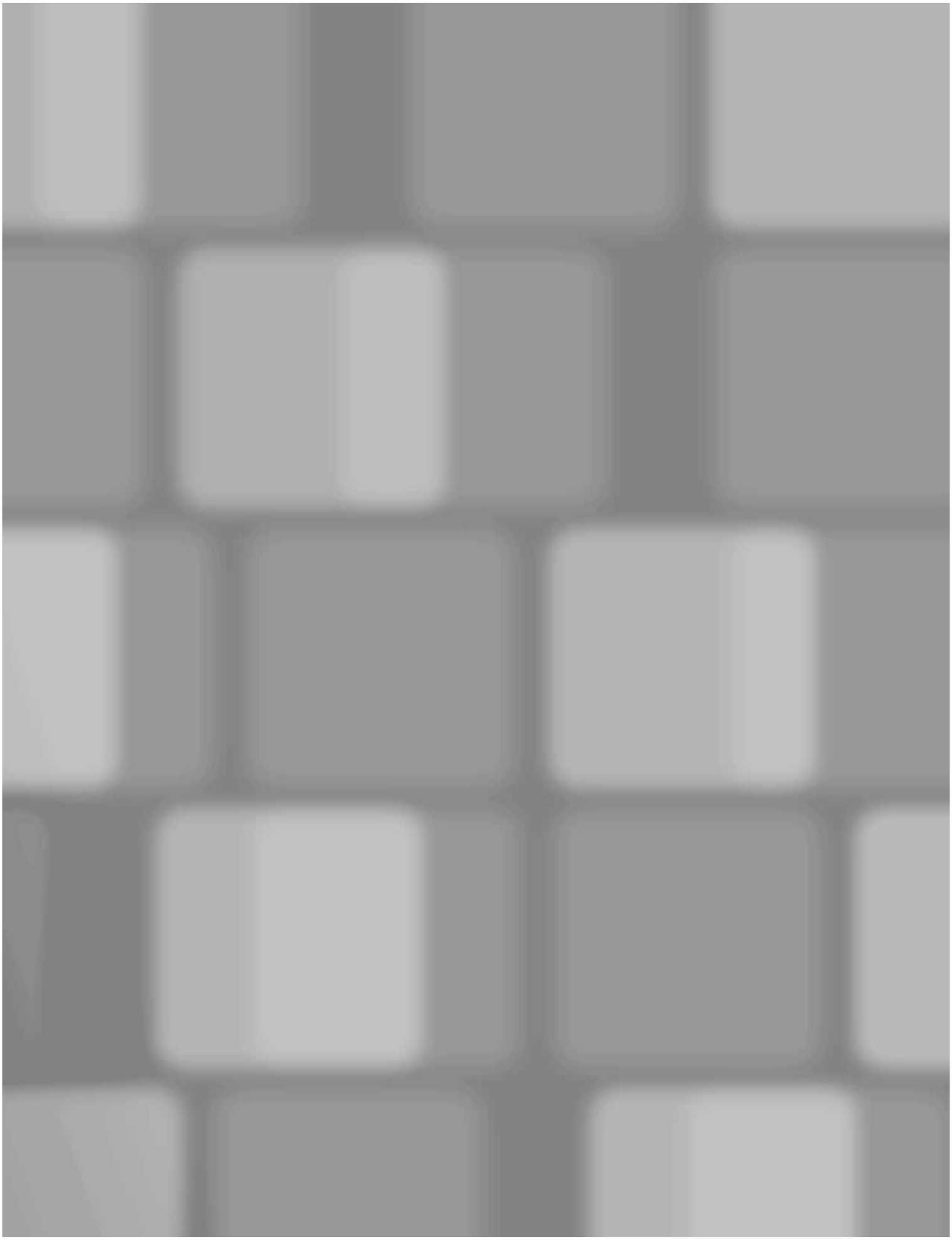
Process: The presentation can be made using charts or black board followed by discussion. The facilitator should demonstrate the process of conducting and facilitating Jan Samvad and explain the issues to be discussed. In addition, the process of presenting personal testimonies in Jan Samvad and techniques for presenting scorecard should also be explained. Dummy score cards prepared by participants after field visits could be used for this purpose.

2. Planning for Community Monitoring

Objective(s): To develop a work plan of the community monitoring process in the block.

Process: The planning can be done block wise. A tentative timeline of activities could be drawn. The following format could be used for this purpose;

S/L	Name of district	Name the block	Name of PHC under each block	Name of the activity under each level	Timeline



CHAPTER 6

VHSC Orientation Workshop

Organised by: District nodal NGO and block nodal NGO

Schedule

Programme	Methodology	Time
Day 1		
Introduction		
Health Rights & its Relevance	Activity, Discussion & Presentation	45 mins
NRHM and Service Guarantees at Various Levels	Presentation & Discussion	30 mins
Different Stakeholders and Committees in the Community Monitoring Process at Various Levels	Presentation & Discussion	40 mins
Importance and Functions of VHSC	Presentation & Discussion	30 mins
Determinants of Health	Activity & Discussion	45 mins
Day 2		
Different Levels of the Public Health System	Presentation & Discussion	30 mins
Know our work - ANM, MPW, ASHA, AWW	Discussion	45 mins
Mapping Village Health Resources	Presentation & Discussion	40 mins
Issues for Monitoring at the Village Level & how to Monitor	Presentation & Discussion	45 mins
Preparation of the Village Health Report Card	Group Work	1 hr
Day 3		
Field Visit		4 hrs
Analysis of the Responses, Collation of Data & Filling a Score Card.	Group work	1 hr
Village Sharing	Presentation & Discussion	30 mins
Preparing Work/ Time Plan for the Community Monitoring Process	Discussion	45 mins

Expected Outcomes

Knowledge gained about health rights, NRHM and service guarantees.
Clarity about importance and functioning of VHSC.
Able to use the community monitoring tools, collation and sharing format.
Work/time plan for community monitoring process.

3 Days

Materials Required

Over head/ LCD projector
Projector screen
Registration forms
Pin-up board, Thumb pins
Chart papers, Flip charts
Bold markers
White/ black board
White board markers/chalk

Participant Kit

Notepad, Pen, File cover
Travel reimbursement form
NRHM Brochure on Community Monitoring
Community Entitlement Book
Hard copies all the presentations
Managers Manual, Pamphlets
Monitoring Manual

Presentations (Refer Annexure IV):

Introduction to NRHM, Service Guarantees, IPHS Standards and Community Monitoring.
Role of Different Stakeholders & Committees at Different Levels.
Importance & Functions of PHC MPC.
Rights and Rights Based Approach.
Indian Health System.
Issues for Monitoring at the PHC level and how to Monitor.
Jan Samvad.

Reference

Community Entitlement Briefing Book
Monitoring Manual
NRHM Documents

Objective(s)

To orient about NRHM and service guarantees at various levels.
To orient about health rights and the relevance.
To brief participants about different stakeholders and committees in the community monitoring process at various levels.
To outline the importance and functioning of VHSC.
To broaden the knowledge about the determinants of health.
To familiarise the participants with community monitoring tools, collation and sharing formats.

Participants

Village Health and Sanitation Committee (VHSC) members.

SESSION PLAN

DAY 1

1. Introduction

Objective(s): Participants to get an opportunity to know each other.

Process: This could be done in an innovative way with which the training organisers are comfortable, provided participants get enough time to understand each other including their skills.

An easy and conventional way of conducting introductions is as follows:

Match the pair

Write words such as: pen, paper, needle, thread, coffee, tea, black, white, sun, moon, day, night, sweet, salty, iron tablet, anemia, diarrhea, ORS, green leafy vegetables, vitamins on small chits. Fold the chits and put them in a box.
Each participant takes one chit and finds his/her partner. So pen and paper, needle and thread, coffee and tea, black and white, sun and moon, day and night, sweet and salty etc can be various pairs.
Ask pairs to learn as much as possible about one another (name, profession, skills, place of origin, etc). Give them 10-15 minutes.
Ask each participant to introduce very briefly the person she or he has been paired with in the last 5-10 minutes.

Facilitator may find out how the different skills of participants could be utilised during the training. If there are members from the marginalised and vulnerable groups as participants, do not introduce them as members of those communities.

2. Health Rights and its Relevance

Objective(s): To know what are rights and rights based approach, from where rights come from and how human rights are integrally related to community monitoring.

Process: Distribute a sheet with five different scenarios (refer Annexure II) to each of the participants or read them aloud one by one. Let the participants know that they would have to think about two questions.

1. From a 'rights' perspective what do you think is wrong in each of these situations?
2. Why do you think the person concerned does not react/respond?

Once there is a discussion on these two questions ask the group what could be a few strategies to change the situation so that the rights of the person concerned is not violated.

The facilitator has to be familiar with Chapters 1 and 3 (Health Care is our Basic Right and Communitisation of Health Services) of the Monitoring Manual (refer CD).

Rights based action includes:

Rights promoting activities.
Rights/ Entitlement Awareness.
Rights education - community and providers, community mobilisation/ organisation, leadership development, building evidence - case-studies, primary research, secondary data etc.
Sharing information - briefing kits, fact sheets, pamphlets, plays.
Media Advocacy - press conference, stories, opinions, editorials.

Talking Points for Facilitator

The rationale for community monitoring lies in adopting rights based approach as it raises questions on responsibility and accountability of development agencies.

Claiming health rights

Asking for services, respecting the rules.
Filing complaints/making suggestions.
Dialogue with providers/managers/legislators.
Representation, delegation.
Asking for grievance redressal/compensation.
Public hearing, social audit.
Legal action.
Direct action - protests, demonstrations.

The presentation titled "Rights & Rights Based Approach" in Annexure IV can be used to sum the discussion.

3. NRHM and Service Guarantees at Various Levels

Objective(s): To orient participants about levels of the public health services, related service guarantees and responsible public health functionary.

Process: The presentation is to be made using chart or black/white board. The facilitator can refer the Entitlement Book (enclosed in CD).

4. Different Stakeholders & Committees in the Community Monitoring Process at Various Levels

Objective(s): To identify the actors of community monitoring and clarify their roles.

Process: The presentation is to be made using chart or black/white board and followed by discussion. The facilitator has to be familiar with NRHM documents (NRHM Framework for Implementation), Monitoring Manual and Managers' Manual (refer CD).

5. Importance and Functions of VHSC

Objectives(s): To share common understanding about the function of VHSC and related responsibility of the

VHSC members with emphasis on monitoring function. The aim is also to elaborate on community monitoring of health services and its advantages.

Process: The presentation is to be made using chart or black/white board and followed by discussion.

6. What are the Determinants of Health?

Objective(s): To build perspective essential for fulfillment of right to health care, access to food, water, adequate sanitation, employment, health care facilities. Also to make the participants aware as to why gender, class and caste issues are important with respect to right to health.

Process: This session can have an exercise called Power walk (see details below). After the exercise, participants will brainstorm on "how social exclusion and other determinants can adversely impact access?"

Power Walk

1. Facilitator should prepare cards with names of different categories of population. The names of population categories written on the card are:-

Tribal man
Tribal woman
Physically challenged woman
Female vegetable seller
Landless daily wage earner - male
Mother of 3 daughters
Father of three daughters
Rickshaw driver - male
Shop owner - male
Bank officer - male
Street beggar - female
Widow (housewife)
Widower
School teacher (woman)
School teacher (man)
Business person (man)
Business person (woman)
Domestic servant (female)
Domestic servant (male)
Doctor
Agriculture laborer (female)
Agriculture laborer (male)
Illiterate manual worker (male)
Illiterate manual worker (female)

2. Participants are asked to stand in a single row and the cards are distributed to all the participants. During the exercise, everyone should try to get into the roles of those categories mentioned in the card and should act as instructed by the facilitator.

3. The facilitator then reads out certain statements (see below) and if a participant agrees to the statement, she/he should take one step ahead from where they stand and if a participant disagrees to the statement she/he should take one step backward. Read the statements slowly, giving the participants time to listen, understand and then respond. The statements to be read out are:

I can read daily newspaper every day morning.
I can complete my school education.

I will be received at a hospital/clinic with respect and dignity.
I can purchase a contraceptive whenever I want.
I have passed Class X.
I can go out in the evening at dusk without fear of being molested.
I can negotiate with my partner with regard to the number of children I would like to have.
If I am tired and do not feel like doing the housework I would be able to let it be.
If I am hungry and nobody else in the house had eaten I will be able to ea.t

4. After reading out all the statements and participants taking their positions, they would be asked to disclose their identities and look at where they are and also explain to others why they moved backward from where they were or why they moved ahead. What are the factors, which did not let them take a step forward?

5. The facilitator asks the group who among these people are possibly the least healthy and needs health care services most? What barriers do these people have to access services?

6. After returning to their seats the participants can further share their thoughts in the whole group regarding various levels of social stratification existing in society and how it leads to social exclusion and marginalisation and finally restricts their access to health services, information and commodities.

7. Facilitator should conclude the discussion by providing a definition on universal access. Universal Access can be defined as a situation in which the services of an organisation reaches the poor, marginalised, socially excluded and underserved groups living within a defined geographical/administrative boundary.

DAY 2

1. Different Levels of the Public Health System

Objective(s): To give clarity with regard to the structure and functions of health system at micro and macro level. Participants will know the nuances of the entity, which they would be monitoring later.

Process: The facilitator needs to gain knowledge and develop an understanding of the healthcare system in the country from Chapter 2 of the Implementers' Handbook. The presentation can be done using charts or board.

2. Know our Work

Objective(s): To gain understanding about the importance and functions of ANM, AWW, MPW, ASHA.

Process: The ANM, AWW, MPW and ASHA will briefly present the work they do. The presentations need to be facilitated by the facilitator along with other inputs if any. This can be done in an innovative way by asking participants about their knowledge of roles and responsibilities of the said health providers. Later on, the inputs on roles and responsibilities can also be presented.

3. Mapping Village Health Resources

Objective(s): To identify Health service providers, communication and transport facility, state of drinking water sources, state of village health sanitation.

Process: The village health services profile given in Chapter 7 (Mobilising the Community and Formation of VHSC) of the Monitoring Manual is to be utilised for this purpose. The facilitator needs to present the village health services profile and explain the process of filling and also the PRA techniques used to fill the profile (refer CD for PRA technique manual and other materials).

4. Issues for Monitoring at the Village Level and how to Monitor

Objective(s): To familiarise the VHSC members with the monitoring tools and issues.

Process: Detailed discussion on each monitoring tool and the report card. The presentation titled "VHSC issues and Monitoring Process" in Annexure IV can be used.

The facilitator needs to be familiar with Chapter 8 and 9 of the Monitoring Manual (Conducting Community Monitoring at the Village and Facility levels and compiling village and facility level Score Cards).

DAY 3

1. Field Visit

Objective(s): To provide first hand experience of filling the tool and preparation of report card.

Process: The VHSC members will be taken to a nearby government health facility to use the monitoring tools.

Block coordinator, facilitators should accompany VHSC members for field work. While one group can conduct FDG with the community, another can visit PHC, CHC and Sub centre for observation purpose. The third group can conduct interviews with women, ASHAs etc. After the field visit, each group has to present its experience from the field and discuss problem faced in course of data collection and how to overcome them.

This will give an opportunity to learn from each other and get a feel of each situation. Later, each group can practice preparation of the score card and present it to other groups.

The process would give confidence to the participants in presenting the findings during Village Health Day and Jan Samvad.

2. Village Sharing

Objective(s): To describe the process of village level sharing and its importance.

Process: The presentation is to be made using charts or board

and the formats for village sharing should be discussed. The facilitator should explain the participants the process of conducting village sharing meeting and the issues need to be discussed. The format of dummy score cards can be used to demonstrate the way it is to be shared in meetings.

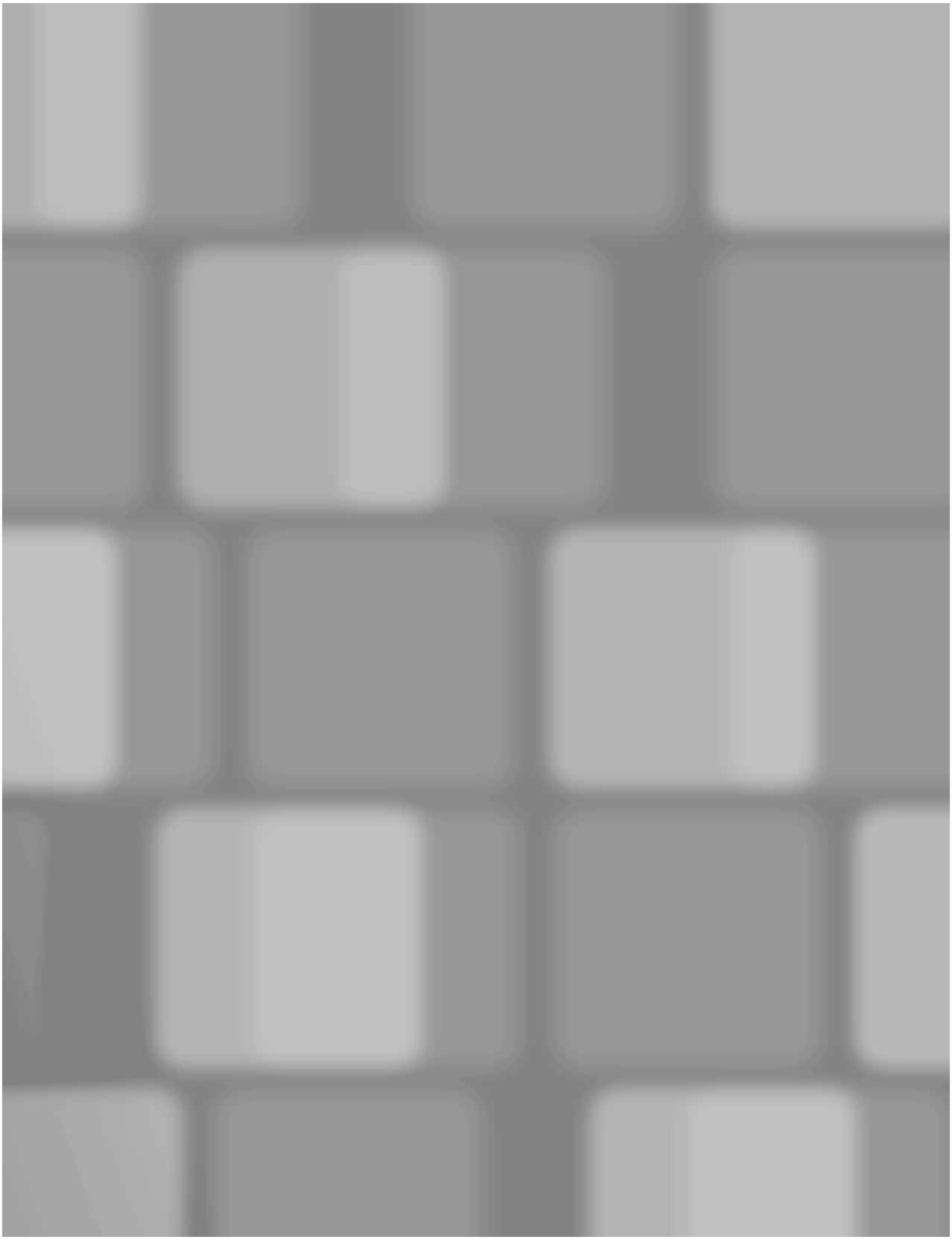
The facilitator should be familiar with Chapter 10 (Sharing Results and Conducting Jan samvad) of the Monitoring Manual. (Refer CD)

3. Planning

Objective(s): To possess a work plan for the community monitoring process.

Process: The group can collectively discuss on how and when to do the actual monitoring. The selection of VHSC members for representation in the PHC planning and monitoring committee can also be decided. Following format could be used for this purpose;

S/L	Name of district	Name the block	Name of PHC under each block	Name of Village under each PHC	Name of the activity under each level	Timeline



CHAPTER 7

PHC MPC Orientation Workshop

Organised by: District nodal NGO and block nodal NGO.

Schedule

Programme	Methodology	Time
Day 1		
Introduction		30 mins
NRHM, Community Monitoring & Service		
Guarantees at Various Levels		
(Context, Objectives of the Project)	Presentation & Discussion	30 mins
Different Stakeholders & Committees in the		
Community Monitoring Process at Various Levels	Presentation & Discussion	40 mins
Importance & Functions of PHC MPC	Presentation & Discussion	30 mins
Health Rights & its Relevance	Activity, Discussion & Presentation	45 mins
Determinants of Health	Activity & Discussion	45 mins
Indian Public Health System	Quiz, Presentation & Discussion	30 mins
Day 2: VISIT TO A PHC FOR PRACTICE		
Issues for Monitoring at the PHC Level & How to Monitor	Presentation & Discussion	45 mins
Practice of Data Collection, Analysis of the Responses,		
Collation of Data & Filling a Score Card	Group work	1 hrs
Preparation of the PHC Report Card and Cumulative Report Card	Group Work	1 hr
Jan Samvad		1 hr
Future Planning		1 hr
Vote of Thanks		15 mins

Expected Outcomes

Knowledge gained about Health rights, NRHM and service guarantees.
Clarity about importance and functioning of PHC MPC.
Able to use the community monitoring tools, collation and sharing format.
Work/time plan for community monitoring process.

2 Days (8-9 hrs)

Materials Required

Over head/LCD projector
Projector screen
Registration forms
Pin-up board, Thumb pins
Chart papers, Flip charts
Bold markers, White/black board
White board markers/chalk
Copies of the 4 case studies (Refer Annexure)

Participant Kit

Notepad, Pen, File cover
Travel reimbursement form
NRHM Brochure on Community Monitoring
Community Entitlement Book
Hard copies of all the presentations
Managers' Manual, Pamphlets

Presentations (Refer Annexure IV):

Introduction to NRHM, Service Guarantees, IPHS Standards and Community Monitoring.
Role of Different Stakeholders & Committees at Different Levels.
Importance & Functions of PHC MPC.
Rights and Rights Based Approach.
Indian Health System.
Issues for Monitoring at the PHC level and How to Monitor.
Jan Samvad.

Reference

Community Entitlement Briefing Book
Monitoring Manual
NRHM Documents

Objective(s)

To orient about NRHM and service guarantees at various levels.
To orient about health rights and their relevance.
To brief about different stakeholders and committees in the community monitoring process at various levels.
To outline the importance and functioning of PHC MPC.
To broaden knowledge about the determinants of health.
To familiarise participants with community monitoring tools, collation and sharing formats.

Participants

PHC Monitoring and Planning Committees members.

SESSION PLAN

DAY 1

1. Introduction

Objective(s): Participants to get an opportunity to know each other.

Process: This could be done in an innovative way with which the training organisers are comfortable, provided participants get enough time to understand each other including their skills.

An easy and conventional way of conducting introductions is as follows:

Match the pair

Write words such as: pen, paper, needle, thread, coffee, tea, black, white, sun, moon, day, night, sweet, salty, iron tablet, anemia, diarrhea, ORS, green leafy vegetables, vitamins on small chits. Fold the chits and put them in a box.
Each participant takes one chit and finds his/her partner. So pen and paper, needle and thread, coffee and tea, black and white, sun and moon, day and night, sweet and salty etc can be various pairs.
Ask pairs to learn as much as possible about one another (name, profession, skills, place of origin, etc). Give them 10-15 minutes.
Ask each participant to introduce very briefly the person she or he has been paired with in the last 5-10 minutes.

Facilitator may find out how the different skills of participants could be utilised during the training. If there are members from the marginalised and vulnerable groups as participants, do not introduce them as members of those communities.

2. Health Rights & its Relevance

Objective(s): To know what are rights and rights based approach, from where rights come from and how human rights are integrally related to community monitoring.

Process: Distribute a sheet with five different scenarios (refer Annexure II) to each of the participants or read them aloud one by one. Let the participants know that they would have to think about two questions;
1. From a 'rights' perspective what do you think is wrong in each of these situations?
2. Why do you think the person concerned does not react/respond?

Once there is a discussion on these two questions ask the group what could be a few strategies to change the situation so that the rights of the person concerned is not violated.

The facilitator has to be familiar with Chapters 1 and 3 (Health Care is our Basic Right and Communitisation of Health Services) of the Monitoring Manual. (Refer CD)

Talking Points for Facilitator

The rationale for community monitoring lies in adopting rights based approach as it raises questions on responsibility and accountability of development agencies.

Rights based action includes:

Rights promoting activities.
Rights/ Entitlement Awareness.
Rights education - community and providers, community mobilisation/ organization, leadership development, building evidence - case-studies, primary research, secondary data etc.
Sharing information - briefing kits, fact sheets, pamphlets, plays.
Media Advocacy - press conference, stories, opinions, editorials.

Claiming Health rights

Asking for services, respecting the rules.
Filing complaints/making suggestions.
Dialogue with providers/managers/legislators.
Representation, delegation.
Asking for grievance redressal/compensation .
Public hearing, social audit.
Legal action.
Direct action - protests, demonstrations.

The presentation titled "Rights & Rights Based Approach" in Annexure IV can be used to sum the discussion.

3. NRHM, Community Monitoring and Service Guarantees at Various Levels

Objective(s): To orient participants about NRHM, community monitoring and importance of community monitoring under NRHM and service guarantees as has been promised at the various levels.

Process: The presentation titled "NRHM, Service Guarantees, IPHS, Charter & CM" in Annexure IV is to be made using chart, overhead projector or black/white board. The facilitator can refer to the Framework of Implementation and Entitlement Book (enclosed in CD).

4. Different Stakeholders & Committees in the Community Monitoring Process at Various Levels

Objective(s): To identify the actors of community monitoring and clarify their roles.

Process: The presentation titled "Role of Stakeholders & Committees at Different Levels" in Annexure IV is to be made using chart/overhead projector or black/white board followed by a discussion.

The facilitator has to be familiar with the Entitlement Book, Managers' Manual and Monitoring Manual. (Refer CD)

5. Importance and Functions of PHC MPC

Objective(s): To share common understanding about the function of PHC MPC and related responsibility of

the PHC MPC members with emphasis on monitoring function. This session will also elaborate on community monitoring of health services and its advantages.

Process: The presentation titled "Importance & Functions of PHC Monitoring & Planning Committee" in Annexure IV is to be made using chart/overhead projector or black/white board and followed by discussion.

6. What are the Determinants of Health?

Objective(s): To build perspective essential for fulfillment of right to health care, access to food, water, adequate sanitation, employment, health care facilities. Also to make the participants aware as to why gender, class and cast issues are important with respect to right to health.

Process: This session can have an exercise called Power walk (see details below). After the exercise, participants will brainstorm on "How social exclusion and other determinants can adversely impact access?"

Power Walk

1. Facilitator should prepare cards with names of different categories of population. The names of population categories written on the card are:-

2. Participants are asked to stand in a single row and the cards are distributed to all the participants. During the exercise, everyone should try to get into the roles of those categories mentioned in the card and should act as instructed by the facilitator.

Tribal man	Widower
Tribal woman	School teacher (woman)
Physically challenged woman	School teacher (man)
Female vegetable seller	Business person (man)
Landless daily wage earner - male	Business person (woman)
Mother of 3 daughters	Domestic servant (female)
Father of three daughters	Domestic servant (male)
Rickshaw driver - male	Doctor
Shop owner - male	Agriculture laborer (female)
Bank officer - male	Agriculture laborer (male)
Street beggar - female	Illiterate manual worker (male)
Widow (housewife)	Illiterate manual worker (female)

3. The facilitator then reads out certain statements (see below) and if a participant agrees to the statement, she/he should take one step ahead from where they stand and if a participant disagrees to the statement she/he should move one step backward. Read the statements slowly, giving the participants time to listen, understand and then respond. The statements to be read out are:

I can read daily newspaper every day morning.
I can complete my school education.
I will be received at a hospital/clinic with respect and dignity.
I can purchase a contraceptive whenever I want.
I have passed Class X.
I can go out in the evening at dusk without fear of being molested.
I can negotiate with my partner with regard to the number of children I would like to have.

If I am tired and do not feel like doing the housework I would be able to let it be.
If I am hungry and nobody else in the house had eaten I will be able to eat.

4. After reading out all the statements and participants taking their positions, they would be asked to disclose their identities and look at where they are and also explain to others why they moved backward from where they were or why they moved ahead. What are the factors, which did not let them take a step forward?

5. The facilitator asks the group who among these people are possibly the least healthy and needs health care services most? What barriers do these people have to access services?

6. After returning to their seats the participants can further share their thoughts in the whole group regarding various levels of social stratification existing in society and how it leads to social exclusion and marginalisation and finally restricts their access to health services, information and commodities.

7. Facilitator should conclude the discussion by providing a definition on universal access. Universal Access can be defined as a situation in which the services of an organisation reaches the poor, marginalised, socially excluded and underserved groups living within a defined geographical/ administrative boundary.

7. Different Levels of the Public Health System

Objective(s): To give clarity regarding the structure and functions of the health system at micro and macro level. Participants will know the nuances of the entity, which they would be monitoring later.

Process: The facilitator needs to gain knowledge and develop an understanding of the healthcare system in the country from Chapter 2 (Health System in India) of the Monitoring Manual (refer CD). The presentation titled "Indian Health System" in Annexure IV is to be made using charts/overhead projector or board.

DAY 2

1. Issues for Monitoring at the PHC Level and How to Monitor

Objective(s): To familiarise the PHC MPC members with the monitoring tools and issues.

Process: Detailed discussion on each monitoring tool and the report card. The facilitator needs to be familiar with Chapters 8 and 9 (Conducting Community Monitoring at the Village and Facility Level and Compiling Village and Facility Level Score Cards) of the Monitoring Manual. (Refer CD)

2. Practice of Data Collection, Analysis of the Responses, Collation of Data & Filling a Score Card

Objective(s): To familiarise the members with methods of data collection, how to analyse the responses and how to collate the date and fill it in to report card.

Process: The participants should be divided into groups. The role-play method could be followed where one group can do a mock FGD, another can take the interview and other group can practice observation.

3. Preparation of the PHC Report Card and Cumulative Report Card

Objective(s): To familiarise the members how to prepare the PHC report card and how to develop cumulative sub centre and village report card.

Process: The participants should be divided into groups. They can be provided with dummy report cards and should be explained how to fill the report card at the PHC level and how to generate cumulative report card of sub centre and village level. Each group can present the score card to other groups. The process would give confidence to the participants in presenting the findings during Village Health Day and Jan Samvad.

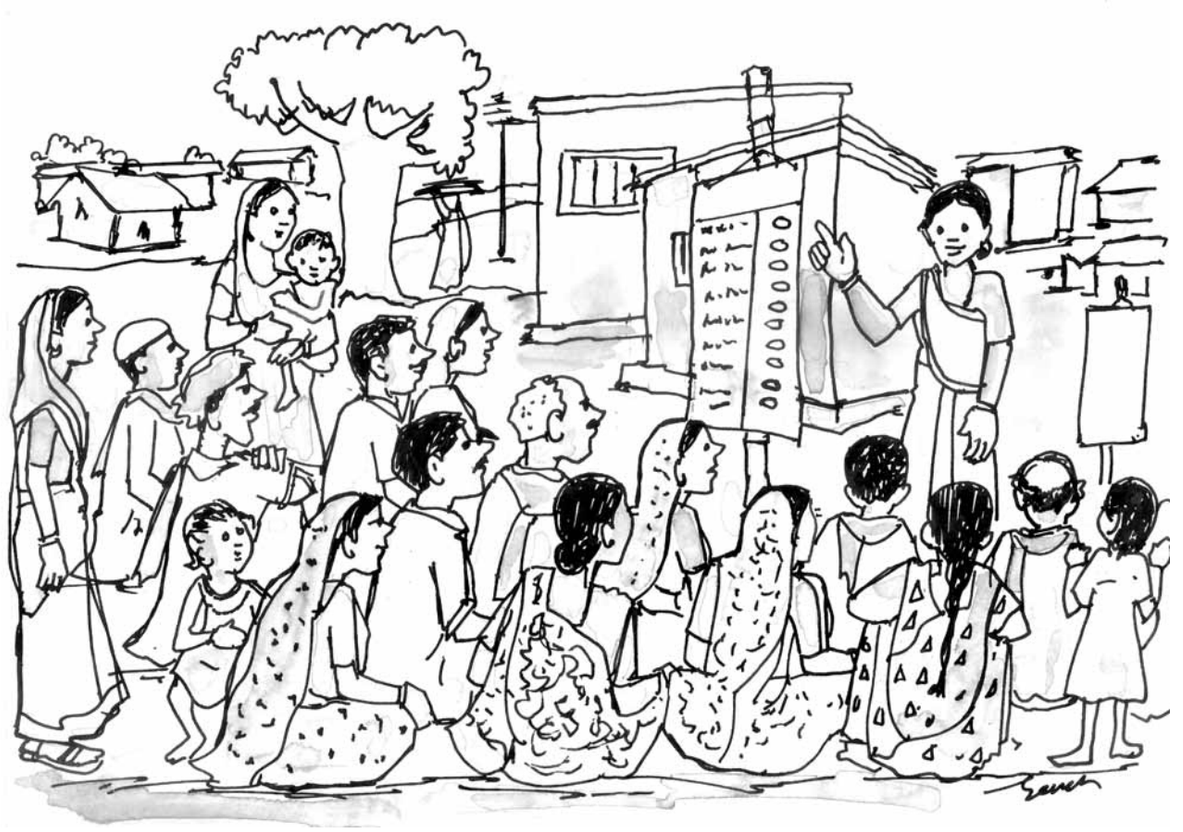
4. Jan Samvad

Objective(s): To describe the process of PHC level sharing and its importance.

Process: The presentation is to be made using charts or board. The formats for PHC level sharing should be discussed.

The facilitator should demonstrate the process of conducting and facilitating Jan Samvad and explain the issues to be discussed. In addition, the process of presenting personal testimonies in Jan Samvad and techniques for presenting scorecard should also be explained. Dummy score cards prepared by participants after field visits could be used for this purpose.

The facilitator should be familiar with Chapter 10 (Sharing the Results and Conducting Jan Samvad) of the Monitoring Manual.(Refer CD)

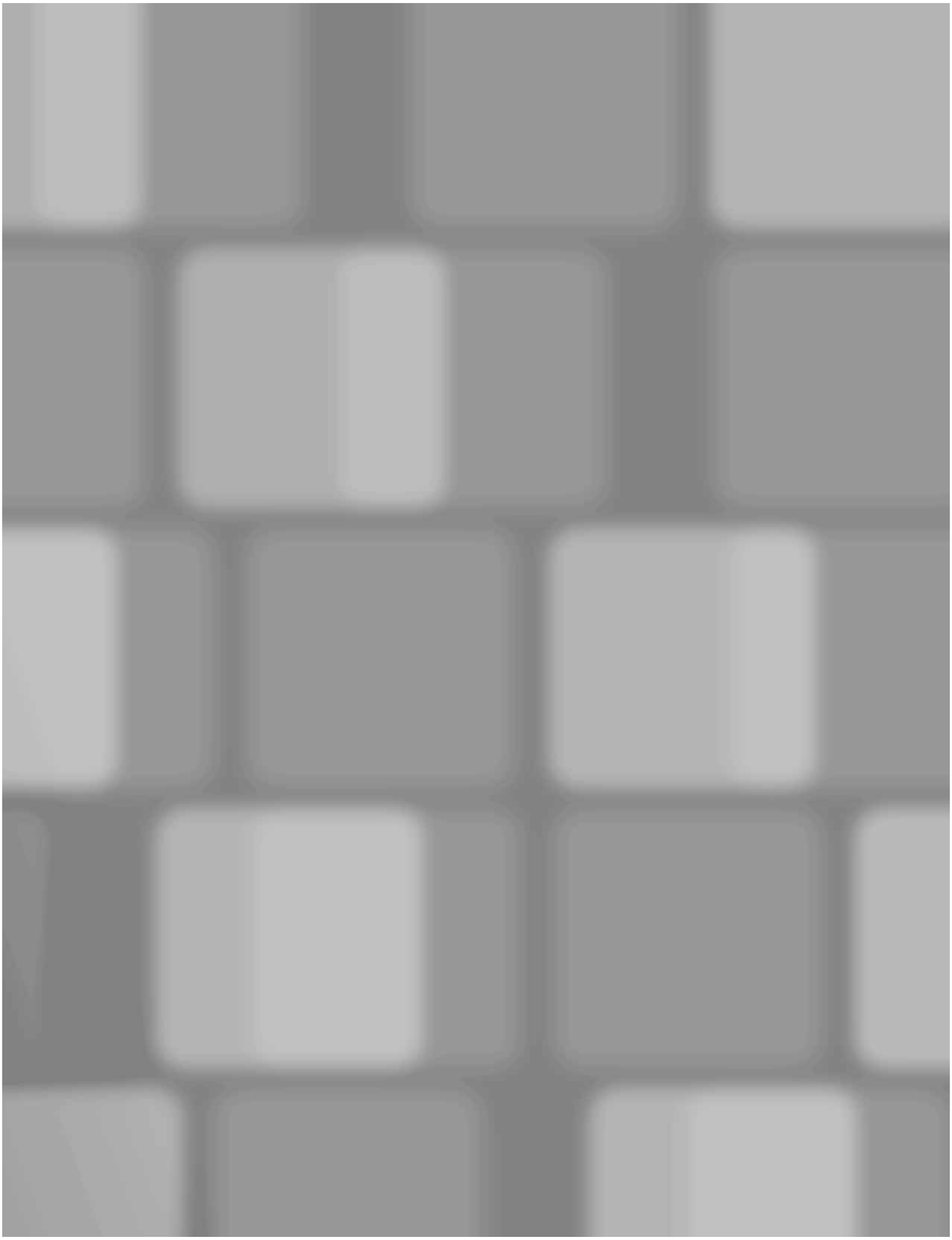


5. Future Planning

Objective(s): To possess a work plan for the community monitoring process.

Process: The group can collectively discuss on how and when to do the actual monitoring. The selection of PHC MPC members for representation in the block planning and monitoring committee can also be decided. Following format could be used for this purpose;

S/L	Name of district	Name the block	Name of PHC under each block	Name of Village under each PHC	Name of the activity under each level	Timeline



CHAPTER 8

Block MPC Orientation Workshop

Organised by: District nodal NGO and block nodal NGO

Objective(s)

1 To orient about NRHM and service guarantees at various levels.
2 To orient about health rights and the relevance.

Schedule

Programme	Methodology	Time
Day 1		
Introduction		30 mins
Health rights and its Relevance	Presentation & Discussion	45 mins
Importance and Responsibilities of Block MPC	Presentation & Discussion	30 mins
NRHM, Community Monitoring and Service Guarantees at Various Levels (Context, Objectives of the Project)	Presentation & Discussion	30 mins
Different Stakeholders and Committees in the Community Monitoring Process at Various Levels	Presentation & Discussion	40 mins
Determinants of Health	Activity & Discussion	45 mins
Different Levels of the Public Health System	Presentation & Discussion	30 mins

Programme	Methodology	Time
Day 2		
Issues for Monitoring at the Block Level and How to Monitor	Presentation & Discussion	45 mins
Practice of Data Collection, Analysis of the Responses, Collation of Data and Filling a Score Card	Group work (role play can be used)	1 hrs
Preparation of the Block Report Card and cumulative Report card	Group Work	1 hr
Jan Samvad (Process, Preparation, Report Generation, Further Planning)	Presentation & Discussion	1 hr
Future Planning		1 hr

3 To brief about different stakeholders and committees in the community monitoring process at various levels.
4 To outline the importance and functioning of Block MPC.
5 To broaden the knowledge about the determinants of health.
6 To familiarise participants with the community monitoring tools, collation and sharing formats.

Participants
Block Monitoring and Planning Committees members

SESSION PLAN

DAY 1

1. Introduction

Objective(s): Participants to get an opportunity to know each other.

Process: This could be done in an innovative way with which the training organisers are comfortable, provided participants get enough time to understand each other including their skills.

An easy and conventional way of conducting introductions is as follows:

Match the pair
Write words such as: pen, paper, needle, thread, coffee, tea, black, white, sun, moon, day, night, sweet, salty, iron tablet, anemia, diarrhea, ORS, green leafy vegetables, vitamins on small chits. Fold the chits and put them in a box.

Each participant takes one chit and finds his/her partner. So pen and paper, needle and thread, coffee and tea, black and white, sun and moon, day and night, sweet and salty etc can be various pairs.

Ask pairs to learn as much as possible about one another (name, profession, skills, place of origin, etc). Give them 10-15 minutes.

Ask each participant to introduce very briefly the person she or he has been with in the last 5-10 minutes. Facilitator may find out how the different skills of participants could be utilised during the training. If there are members from the marginalised and vulnerable groups as participants, do not introduce them as members of those communities.

2. Health Rights & its Relevance

Objective(s): To know what are rights and rights based approach, from where rights come from and how human rights are integrally related to community monitoring.

Process: Distribute a sheet with five different scenarios (refer Annexure II) to each of the participants or read them aloud one by one. Let the participants know that they would have to think about two questions;

1. From a 'rights' perspective what do you think is wrong in each of these situations?
2. Why do you think the person concerned does not react/respond?

Once there is a discussion on these two questions ask the group what could be a few strategies to change the situation so that the rights of the person concerned is not violated. The facilitator has to be familiar with Chapters 1 and 3 ((Health Care is our Basic Right and Communitisation of Health Services)) of the Monitoring Manual. (Refer CD)

Talking Points for Facilitator

The rationale for community monitoring lies in adopting rights based approach as it raises questions on responsibility and accountability of development agencies.

Rights based action includes:

Rights promoting activities.
Rights/ Entitlement Awareness.
Rights education - community and providers, community mobilisation/ organization, leadership development, building evidence - case-studies, primary research, secondary data etc.
Sharing information - briefing kits, fact sheets, pamphlets, plays.
Media Advocacy - press conference, stories, opinions, editorials.

Claiming health rights

Asking for services, respecting the rules.
Filing complaints/making suggestions.
Dialogue with providers/managers/legislators.
Representation, delegation.
Asking for grievance redressal/compensation.
Public hearing, social audit.
Legal action.
Direct action - protests, demonstrations.

The presentation titled "Rights & Rights Based Approach" in Annexure IV can be used to sum the discussion.

3. Importance and functions of Block MPC

Objective(s): To share common understanding about the functions of Block MPC and related responsibilities of Block MPC members with emphasis on monitoring function.

Expected Outcomes

Knowledge gained about health rights, NRHM and service guarantees.
Clarity about importance and functioning of Block MPC.
Able to use community monitoring tools, collation and sharing format.
Work/time plan for community monitoring process.

2 Days (11-12 hrs)

Materials Required:

1. Over head/LCD projector
2. Projector screen
3. Registration forms, Pin-up board
5. Thumb pins, Flip charts
7. Chart papers Bold markers
9. White/black board
10. White board markers/chalk
11. Copies of the 4 case studies (Refer Annexure I)
12. Copies of the situations (Refer Annexure II)

Participant Kit:

1. Notepad, Pen, File cover
4. Travel reimbursement form
5. NRHM Brochure on Community Monitoring
6. Community Entitlement Book
7. Pamphlets on Service Guarantees, VHSC, PHC & Sub centre
8. Hard copies of all the presentations
9. Monitoring Manual

Presentations (Annexure IV):

1. Health Rights and its Relevance
2. NRHM, Community Monitoring and Service Guarantees at Various Levels
3. Different Stakeholders and Committees in the Community Monitoring Process at Various Levels
4. Importance & Functions of Block MPC
5. Different Levels of the PHS
6. Issues for Monitoring at the Block Level and How to Monitor
7. Jan Samvad

Reference

a. Monitoring Manual
b. Community Entitlement Briefing Book
c. Monitoring Manual
d. NRHM Documents

Process: The presentation titled "Importance & Functions of Block MPC" in Annexure IV is to be made using either chart/overhead projector or black/white board and followed by discussion.

4. NRHM, Community Monitoring (including first phase) & Service Guarantees at Various Levels (Context and Objectives of the Project)

Objective(s): To orient participants about NRHM, community monitoring (including first phase) and importance of community monitoring under NRHM and service guarantees as has been promised at various levels.

Process: The presentation titled "NRHM, Community Monitoring & Service Guarantees" in Annexure IV is to be made using chart, overhead projector or black/white board. The facilitator can refer to the NRHM Framework for Implementation, Monitoring Manual and Entitlement Book (enclosed in CD).

5. Different Stakeholders in the Community Monitoring Process

Objective(s): To identify the actors of community monitoring and clarify their roles.

Process: The presentation titled "Different Stakeholders in Community Monitoring" in Annexure IV is to be made using chart/overhead projector or black/white board and followed by discussion. The facilitator is required to be familiar with NRHM documents, Managers' Manual and Monitoring Manual.

6. What are the Determinants of Health?

Objective(s): To build perspective essential for fulfillment of right to health care, access to food, water, adequate sanitation, employment, health care facilities. Also to make the participants aware as to why gender, class and cast issues are important with respect to right to health.

Process: This session can have an exercise called Power walk (see details below). After the exercise, participants will brainstorm on "how social exclusion and other determinants can adversely impact access?"

Power Walk

1. Facilitator should prepare cards with names of different categories of population. The names of population categories written on the card are :-

Tribal man
Tribal woman
Physically challenged woman
Female vegetable seller
Landless daily wage earner - male
Mother of 3 daughters
Father of three daughters
Rickshaw driver - male
Shop owner - male
Bank officer - male
Street beggar - female
Widow (housewife)
Widower
School teacher (woman)
School teacher (man)
Business person (man)
Business person (woman)
Domestic servant (female)
Domestic servant (male)
Doctor
Agriculture laborer (female)
Agriculture laborer (male)
Illiterate manual worker (male)
Illiterate manual worker (female)

2. Participants are asked to stand in a single row and the cards are distributed to all the participants. During the exercise, everyone should try to get into the roles of those categories mentioned in the card and should act as instructed by the facilitator.

3. The facilitator then reads out certain statements (see below) and if a participant agrees to the statement, she/he should take one step ahead from where they stand and if a participant disagrees to the statement she/he should take one step backward from wherever they are. Read the statements slowly, giving the participants time to listen, understand and then respond. The statements to be read out are:

I can read daily newspaper every day morning.
I can complete my school education.
I will be received at a hospital/clinic with respect and dignity.
I can purchase a contraceptive whenever I want.
I have passed Class X..
I can go out in the evening at dusk without fear of being molested.
I can negotiate with my partner with regard to the number of children I would like to have.
If I am tired and do not feel like doing the housework I would be able to let it be.
If I am hungry and nobody else in the house had eaten I will be able to eat.

4. After reading out all the statements and participants taking their positions, they would be asked to disclose their identities and look at where they are and also explain to others why they moved backward from where they were or why they moved ahead. What are the factors, which did not let them take a step forward?

5. The facilitator asks the group who among these people are possibly the least healthy and needs health care services most? What barriers do these people have to access services?

6. After returning to their seats the participants can further share their thoughts in the whole group regarding various levels of social stratification existing in society and how it leads to social exclusion and marginalisation and finally restricts their access to health services, information and commodities.

7. Facilitator should conclude the discussion by providing a definition on universal access. Universal Access can be defined as a situation in which the services of an organisation reaches the poor, marginalised, socially excluded and underserved groups living within a defined geographical/administrative boundary.

7. Different Levels of the Public Health System

Objective(s): To give clarity regarding the structure and functions of the health system at micro and macro level. Participants will know the nuances of the entity, which they would be monitoring later.

Process: The facilitator needs to gain knowledge and develop an understanding of the healthcare system in the country from Chapter 2 (Health Systems in India) of the Monitoring Manual (refer CD). The presentation titled "Indian Health System" in Annexure IV is to be made using charts/overhead projector or board.

DAY 2

1. Issues for Monitoring at the Block Level and How to Monitor

Objective(s): To familiarise the Block MPC members with monitoring tools and issues.

Process: The presentation titled "Issues & Process for Monitoring" in Annexure IV can be done using charts/ overhead projector or board. Detailed discussion on CHC checklist, exit interviews, MO interview formats and the report card (cumulative & block) is to be done.

The facilitator needs to be familiar with Chapters 8 and 9 (Conducting Community Monitoring at the Village and Facility Levels and Compiling Village and Facility Level Score Cards) of the Monitoring Manual. (Refer CD)

2. Practice of Data Collection, Analysis of the Responses, Collation of data and Filling a Score Card

Objective(s): To familiarise the members with methods of data collection, how to analyse the responses and how to collate the date and fill into the report card.

Process: The participants should be divided into groups. The role-play method could be followed where one group can do a mock FGD, another can do the interview and the third group can practice observation.

3. Preparation of the Block Report Card and Cumulative Report

Objective(s): To familiarise the members on how to prepare the block report card and how to develop cumulative sub centre, village and PHC report card.

Process: The facilitator to demonstrate how to make a report card. The participants can then be divided into groups. Each group can take up one activity. It can be either block report card or PHC cumulative report card or sub centre cumulative report card or village report card. Each group can present the score card to other groups. The process would give confidence to the participants in presenting the findings during Village Health Day and Jan Samvad.

4. Jan Samvad

Objective(s): To describe the process of block level sharing and its importance.

Process: The presentation titled "Jan Samvad" in Annexure IV is to be made using charts/overhead projector or board. The formats for block level sharing should be discussed. The facilitator should demonstrate the process of conducting and facilitating Jan Samvad and explain the issues to be discussed. In addition, the process of presenting personal testimonies in Jan Samvad and techniques for presenting scorecard should also be explained. Dummy score cards prepared by participants after field visits could be used for this purpose.

The facilitator should read be familiar with Chapter 10 (Sharing the Results and Conducting Jan Samvad) of the Monitoring Manual. (Refer CD)

5. Future Planning

Objective(s): To possess a work plan for the community monitoring process.

Process: The group can collectively discuss how and when to do the actual monitoring. The selection of Block MPC members for representation in the district planning and monitoring committee can also be decided. Following format could be used for this purpose;

S/L	Name of district	Name the block	Name of PHC under each block	Name of Village under each PHC	Name of the activity under each level	Timeline

Annexure I

CASE STUDIES

CASE STUDY 1

Drawya Kumari, Gonda

Drawya Kumari (also known as Mrida Kumari) aged 26 years and mother of three children, is a resident of village Kunwarpur, Amroha Tola, Nirjanpur, district Gonda. She was convinced by the local ANM, Shakuntala Singh, to go in for a sterilisation operation.

On 30th January 2003, she walked four km with her sister-in-law, Urmila, to the Halgharmau PHC for the Sterilisation Camp. In the first 20 minutes, the surgeon completed four cases. She was the fifth. It was 3.30 pm. According to Urmila, Drawya told the doctor "Mera dil ghabra raha hai" [I am feeling uneasy in my heart]. She was given two injections and the doctor, Dr. Alok Agarwal, made the incision.

He was about to insert the trocar when he found out that she was dead. Dr. Agarwal called it a "hysterical heart attack." There was no ambulance present and the oxygen cylinder had not been refilled as this can only be done in Lucknow. The surgeon said that he tried to resuscitate her, failing which he abandoned her and the camp. He left the PHC immediately "to report the matter to the Gonda CMO."

Meanwhile, the ANM informed her sister-in-law who went back to the village. When the shocked family arrived at the PHC at 5.30 pm, they found the entire place deserted. The body of Drawya Kumari was lying on a blood-soaked stretcher outside the PHC entrance.

Soon the police and SDM arrived and insisted on taking the body away for a post-mortem. At 9.30 pm, the CMO tried to pay the husband's younger brother Rs 10,000 in return for signing on a piece of paper. The local MLA was consulted on the phone, so he came over to see the paper. It was written in the paper that Drawya had come to the camp out of her own free will and had died as soon as she was lifted on to the stretcher. The family tore up the paper and refused the money offered.

The post mortem was done, but the Chief Medical Officer (CMO) withheld the copy of the report. He refused to provide a copy to the family. They were unable to even lodge an FIR until the local Block Pramukh (whose son was an MLA) intervened. Even then it took visits to the DM, SP and a wireless message to the CO before the FIR could be lodged on 5th February 2003. The CMO refused to share any report about the case to the documentation team, saying they would only be presented in court.

[1]Auxiliary Nurse Midwife working with the government

CASE STUDY 2

Nankai, Lucknow

Nankai (also known as Ramrati), a dalit woman of around 20 years, was pregnant with her first child. She came for the delivery to her mother Kalawati's home at village Karanpur, PS Nigohan, district Lucknow. Her mother got her checked up at a local clinic where they advised she should be taken to the Mohanlal Ganj Community Health Centre for delivery since they did not have the facilities.

On 29 July, at 3 pm, Nankai went into labour. After 12 hours, the family decided to take her to the hospital. They borrowed money and took her to the Mohanlal Ganj CHC around 7 am on 30 July 2004.

A woman staff met them at the hospital. She called three other women who took Nankai inside. According to Kalawati, they verbally and physically abused Nankai, despite her pleas not to hit her daughter. One of them called Kalawati aside and asked her to pay Rs.5000, which she did. After half an hour, they asked her for Rs. 10,000, saying 'the baby was stuck in the pelvis.' When she expressed her inability to pay, they taunted her and asked her to take her daughter elsewhere for delivery.

As Kalawati took her daughter out of the hospital gate, Nankai asked her mother for support as she felt the baby coming out. Almost at once, Nankai delivered her baby boy on the ground. The baby appeared normal to the grandmother but she was unable to make him breathe. She helped her daughter to expel the placenta, which came out normally.

Nankai's cries caused a crowd to gather around the scene. They created a commotion at the hospital and outside. At this a woman doctor came out and took Nankai inside the hospital to put on an I.V. drip.

In the evening, Nankai was discharged from the hospital and went home, although her abdomen and arms and chest still hurt from the blows of the hospital staff. An FIR was registered at the Mohanlal Ganj PS by Sunil Kumar Gautam, member of the Bahujan Samaj Party.

On 31 July, a three-member enquiry team of the Health Department visited Nankai, which included the Deputy CMO and a lady doctor, Dr. Indubala (Superintendent of Red Cross Woman and Child Hospital). Dr. Indubala examined Nankai and announced that she needed to be taken to a hospital. Nankai refused and some activists present also supported her refusal saying that she had no abnormal symptoms requiring hospitalisation.

According to Nankai and her mother, later in the day when everybody had left and again the next day, Dr. Indubala twice did a forcible PV (per vagina) examination of Nankai, which caused extreme pain: "She put her hand inside me and tore me (phad diya) right till my rectum." After that Nankai cried in agony, and was unable to sit or sleep for the next two days.

On 2 August, 2004, when activists visited her again, she was very ill but expressed fear of doctors, hospitals and medical examination. She was taken to Dufferin Hospital in Lucknow, where the doctors present for Emergency Ward duty refused to keep required records of medico-legal evidence unless they were asked to by the Police Department.

The DG, Medical Health, Dr. R.D. Tripathi had already been informed of her condition, and was requested to order the recording of proper medico-legal evidence. This was provided by the Medical Officer on duty at 1.30 a m on 3 August. In the medical report, it was mentioned that Nankai had a two-and-half-inch long tear from the vagina towards the rectum, which was infected. She was treated for infection at the hospital and discharged after almost a month.

CASE STUDY 3

Lakshmi's Story

Lakshmi belongs to a village in Jharkhand, located about 15 km from the district headquarters. She is 27-years-old, an agricultural wage labourer and belongs to the Scheduled Castes (SC).

Lakshmi grew up in another village. She was the first of four surviving children - three girls and a boy. Since her father had an affair with another woman, the family suffered. Lakshmi's mother had to go out to earn and Lakshmi was stopped from attending school after Class I. She would graze cattle and earn money, and when she was about 10 years old she started working as an agricultural labourer.

When Lakshmi was only 14, she was married off to her uncle's son, Ramu, because there would be no dowry involved. Ramu was 25 and was also an agricultural wage labourer without any property.

When they got married, Ramu told Lakshmi that times had changed, and that they should have only two children. If they had a boy and a girl, she should have an operation. But somehow, Lakshmi never conceived for two years. Her mother-in-law started abusing her.

Lakshmi conceived when she was 17 and her first pregnancy was very difficult. Her limbs and face were swollen and her vision was clouded. She would also vomit everything she ate daily. But she never visited a doctor for her problems. People told her that such symptoms were quite normal during pregnancy. A baby girl was born to her and after the delivery in a government hospital, Lakshmi's problems disappeared.

The second baby was also born in a hospital but he died in a few days. He vomited once in the morning, was taken to the hospital immediately but died. The third was a daughter, and she too died a few hours after birth. Some doctors said that the baby had a heart problem while others said Lakshmi was very weak. Few others opined that it was because Lakshmi had married a close relative. But the baby was tiny and with only skin and bones. Lakshmi was heart-broken.

After her third delivery, Lakshmi started having foul-smelling white discharge frequently. She did not get treated telling herself that this must be because of her weak health. Lakshmi started a vrat (religious fasting) once a week for a healthy baby the next time. Her fourth baby was born recently, and is a boy. Lakshmi wanted to have a family planning operation, and so did Ramu. But the doctors said that she was too weak and sent her home. They asked her to come back after her health improved.

Lakshmi is now desperate. She does not want to conceive immediately and wants to make sure that her son survives and grows into a healthy child. But knowing her husband, she thinks abstinence is not feasible. She is afraid that if she refuses, he too would start having an affair with another woman, just like her father did. Lakshmi wants her health to improve soon.

CASE STUDY 4

Champa of Nupur Village

If you come to Nurpur village from the city of Jaigarh, you first pass the village shop run by Moti and then come to Paschim Tola. The dalit families in this hamlet are the poorest in the village. There is a single hand pump in the middle of the Tola but since there is no drain the field around is always muddy. Most of the families who live in this Tola work as daily wage laborers in others' fields. Women also go and work as agricultural labourers in the peak seasons.

In the last one year, eight children were born in 16 homes of Paschim Tola, of whom one was born dead and two died within the first month. All the children were born at home and the dai was Rama Bai who also lives in Paschim Tola. The ANM does not come to this Tola and none of the 13 children who are now alive have received any injections. They have only been given polio drops when the polio team comes to the village from time to time. There was a measles outbreak 6 months ago and two children from this Tola died.

The pradhan of the village, Ram Swaroop, lives in Uttar Tola. The people staying in Uttar Tola are better off and belong to upper castes. Many of the Paschim Tola families work in the fields of the Uttar Tola families. Two families have tractors and there are motorcycles in three households. Ram Swaroop has a telephone in his house.

The daughter-in-law of Ram Swaroop, Munia, had a baby boy four months ago. The ANM, Saraswati, had come to the village for her delivery. Saraswati comes to Uttar Tola from time to time for vaccination of the little babies and pregnant women, but does not go to Paschim Tola. In the past one year, 12 children were born in Uttar Tola and only one baby died during the measles outbreak. This child had not had the measles tika because his mother had gone to her parent's house when Saraswati had come for the measles immunisation. Eight children have received all the immunisation shots while three have only received polio drops during the Polio Campaign.

At present, seven women are pregnant in the village - 3 in Uttar Tola and 4 in Paschim Tola. Among the women in Paschim Tola, only one woman - Champa - has had a pre natal check-up. Champa has studied up to Class 8. Her husband, Uday Lal, works in Chandigarh. When he came home from work he took her to Jaigarh for her check-up from a lady doctor. Champa was also given an injection. She knows she needs more check-ups, but without Uday Lal at home she does not have the money to visit the private lady doctor. She had gone to the government clinic once but the doctor shouted at her and she did not want to visit him again. Saraswati knows that Champa is pregnant but will never come to Paschim Tola. Champa wonders whether she should go to the pradhan's house when Saraswati comes there, but then she is also frightened because they are Brahmins and may not let her come in.

Annexure II

SITUATIONS

What is wrong?

1. Raja is a dalit man and he has a small shop selling pan and cigarettes. Every other day, three older men come to his shop and take three packets of cigarette and three pans and go away without paying. Raja does not protest.

2. Munni and Munna are twins and both study in the last year of junior school. When they come back from school, Munna takes his meal and then after a short nap goes to play with his friends. Munni helps her mother make papad for the local women's cooperative. In the evening, Munni helps with making dinner while Munna studies because he has to go to senior school next year. Munna gets better marks and lots of praises, and Munni doesn't mind.

3. Patlu earned rupees 50 for running a small errand. He was counting the five soiled ten rupee notes, when Bhola, the local goon, came up and snatched them away saying "what will you do with this money? It will be better spent by me." The police beat constable was sitting in the teashop and Patlu went up to him and said "Daroga saab, Bhola took away my money. Why don't you tell him to return it?" The policeman replied, "Why don't you take it back yourself? Don't you think I have better things to do?" Patlu slinked away because this policeman was known for his bad temper.

4. A group of tribal men were engaged in collecting kendu leaves from their local forest. They sold the leaves to the local leaf contractor at a rate, which the contractor had fixed for them. One of them went to the neighbouring town and came to know that the 'official' rate was 50% more than what they got. After coming back he told the members of the group about this and they spoke to the contractors' representative. The man came back with the message from the contractor that he was hurt that they did not trust him and they were free not to sell their leaves to him, but he could not raise the rate. The group of tribal men begged forgiveness for hurting the contractor and continued to sell leaves at the old rate.

5. Razia was pregnant with her fifth child when she felt the labour pains beginning. She had lost her last child, so she asked her husband to take her to the hospital immediately. When the nurse checked her, she felt that labour had not begun, though Razia kept feeling the pains. Razia asked the nurse to admit her. But the nurse was not willing because pains had not begun and she had plans to spend the night with her family ten km away. When Razia asked for the third time, why she couldn't be admitted, the nurse scolded her. Razia went back home with her husband.

Annexure III

Question Bank for Quiz

1. Which functionary in the health system is responsible for giving measles vaccination?
2. What is the name of the new village-level volunteer appointed through NRHM?
3. When a woman starts experiencing labour pain, which is the lowest level of government facility she should visit if she wants to deliver in a hospital?
4. Which of these services are provided in PHC?
   a. Immunisation for children
   b. Care of pregnant women
   c. Care of children with diarrhea
5. For which disease does a person need to take DOTS treatment?
6. What is the name of the scheme for pregnant women under NRHM?
7. What is the minimum number of antenatal check-ups that should be provided to the pregnant women?
8. In whose account is the untied fund for sub centre kept?
9. How many types of grants are given to the sub centre and what are the grants?
10. What is the function of Rogi Kalyan Samiti?
11. What is the annual maintenance grant given to PHC?
12. How much is the PHC untied fund?
13. What is the annual maintenance grant used for?
14. What is the area of coverage of a PHC?
15. Who is the chairperson of the VHSC?
16. How much grant does the VHSC receive annually?
17. How many minimum post partum home visits by the ANM are required?
18. How much is the annual maintenance grant for PHC?
19. How much is the untied fund for CHC?
20. How much is the annual maintenance grant for CHC?

For Answers

Please refer to the Community Entitlement Book and the NRHM Framework of Implementation for the answers.

Annexure IV

NRHM at Block Level,Community Monitoring & Service Guarantees

NRHM: A BOLD VENTURE

Launched on 12th of April 2005.
Seeks to provide universal access to equitable, affordable and quality health care, esp. to rural poor, women & children.
Aims to promote healthcare which is accountable and at the same time responsive to the needs of the people.
Help achieve goals set under the National Health Policy and the Millennium Development Goals.
Proposes an intensive accountability framework that includes community-based monitoring as one of its key strategies.

THE VISION

Seeks to provide effective health care to rural population throughout the country with special focus on 18 states (Arunachal Pradesh, Assam, Bihar, Chhattisgarh, HP, JH, J&K, Manipur, Mizoram, Meghalaya, MP, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand and UP), which have weak public health indicators and/or weak infrastructure.
Articulation of commitment of Govt. to raise public spending on health from 0.9% of GDP to 2-3% of GDP.
Key components include;

- Provision of a female health activist in each Village.
- Village health plan prepared through the Health & Sanitation Committee of the Panchayat.
- Strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS).
- Integration of vertical Health & Family Welfare Programmes and Funds for optimal utilisation of funds and infrastructure and strengthening delivery of primary health care.

Revitalise local health traditions and mainstream AYUSH into the public health system.
Effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for health.
Seeks decentralisation of programmes for district management of health and to address the inter-State and inter-district disparities, esp. among 18 high focus States, including unmet needs for public health infrastructure.
Define time-bound goals and report publicly on their progress.
Seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary health care.

ENVISAGED OUTCOMES AT NATIONAL LEVEL

Infant Mortality Rate reduced to 30/1000 live births.
Maternal Mortality Ratio reduced to 100/100,000.
Total Fertility Rate reduced to 2.1.
Malaria mortality reduction rate by 50% upto 2010, additional 10% by 2012.
Kala Azar mortality reduction rate by 100% by 2010 and sustaining elimination until 2012.
Filaria/Microfilaria reduction rate by 70% by 2010, 80% by 2012 and elimination by 2015.
Dengue mortality reduction rate by 50% by 2010 and sustaining at that level until 2012.

Japanese Encephalitis mortality reduction rate 50% by 2010 and sustaining at that level until 2012.
Cataract Operation: Increase to 46 lakhs per year until 2012.
Leprosy prevalence rate: Reduce from 1.8/10,000 in 2005 to less than 1/10,000 thereafter.
Tuberculosis DOTS services: Maintain 85% cure rate through entire Mission period.
Upgrade Community Health Centers to Indian Public Health Standards.
Increase utilisation of First Referral Units from less than 20% to 75%.
Engage 250,000 female Accredited Social Health Activists (ASHAs) in 10 States.

BROAD FRAMEWORK FOR IMPLEMENTATION

Among the other components

Institutionalising community led action for health.

- Involvement of PRIs in VHSCs, PHC monitoring & planning committees, etc.
- Amendments in Acts & statutes to fully empower local bodies.
- Provision of Untied Grant at various levels.
- To empower local monitoring committees for planning & conduction of Jan Samvads.

Monitoring/ Accountability Framework

An intensive accountability framework through a three-pronged process of community based monitoring, external surveys and stringent internal monitoring.

Communitisation of the health institutions;

- Compulsory for all the health institutions to prominently display information regarding grants received, medicines and vaccines in stock, services provided to the patients, user charges to be paid (if any) etc, as envisaged in the Right to Information Act.

Publication of Public Reports on Health at the State and the district levels to report to the community at large on progress made.

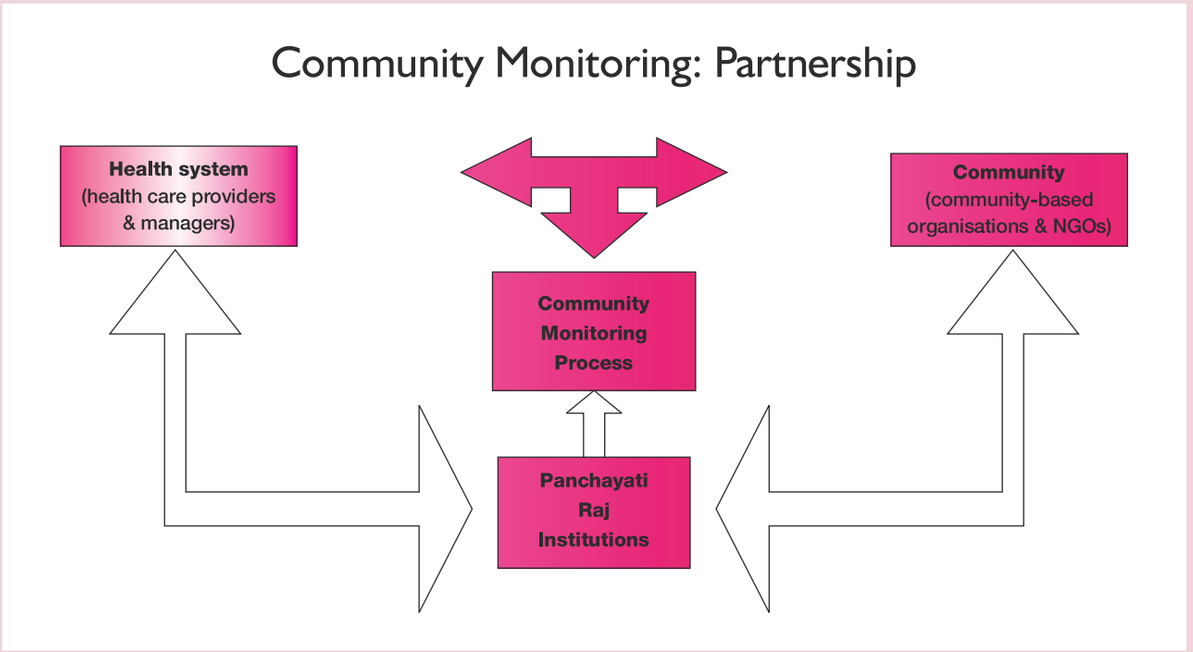
SERVICE GUARANTEES UNDER NRHM AT CHC LEVEL

Care of routine and emergency cases in surgery and medicine.
24-hour delivery services including normal and assisted deliveries.
Essential and Emergency Obstetric Care including surgical interventions .
Full range of family planning services.
Safe abortion services.
Newborn care and routine and emergency care of sick children.
Diagnostic services through the microscopy centers.
Blood storage facility.
Essential laboratory services.
Referral transport services.
All National health programmes should be delivered through the CHCs. E.g. HIV/AIDS Control Programme,National Leprosy Eradication Programme,National Programme for Control of Blindness.

COMMUNITY MONITORING UNDER NRHM

Part of three-pronged process of accountability framework proposed in NRHM that includes internal monitoring & periodic surveys/studies.
Seen as an important aspect of promoting community led action in the field of health.
Places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.
Provision has been made through Monitoring and Planning Committees at PHC, Block, District and State levels .

COMMUNITY MONITORING: PARTNERSHIP



OBJECTIVES OF COMMUNITY MONITORING

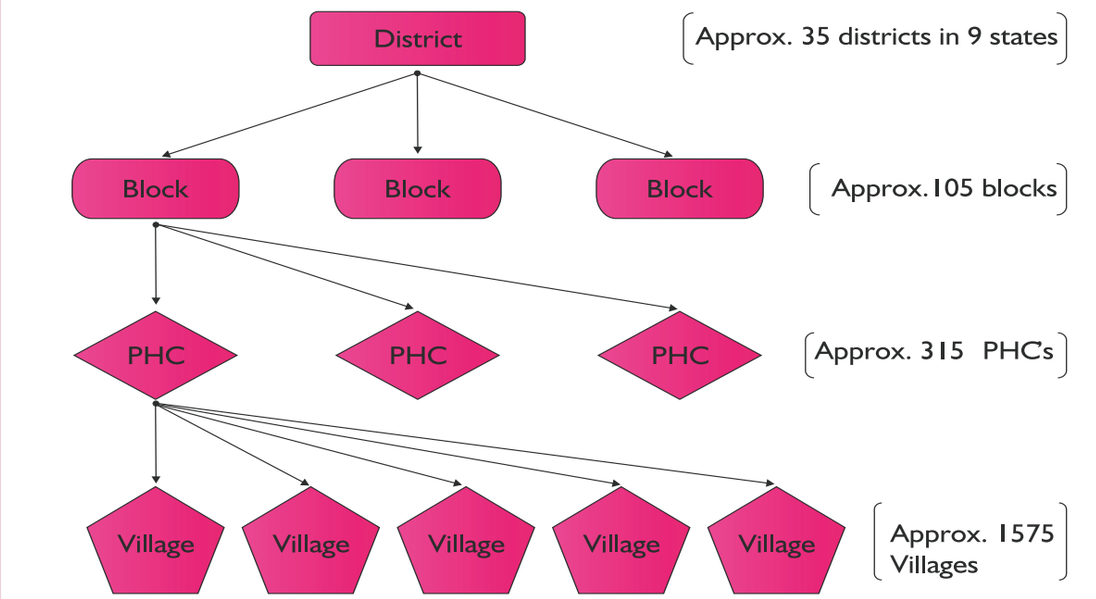
To provide regular and systematic information about community needs.
To provide feedback according to the locally developed yardsticks, as well as on some key indicators.
To provide feedback on the status of fulfillment of entitlements, functioning of various levels of the public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction.
To increase the community sense of involvement and participation to improve responsive functioning of the public health system.

FIRST PHASE: INITIATION

Outlines of Community Monitoring process provided within the Framework of Implementation developed and elaborated upon by the Advisory Group on Community Action (AGCA).
Supervised at national level by a specially constituted Secretariat and Task Group constituted under the supervision of the Advisory Group.
States: 9 states (Assam, Chhatisgarh, Jharkhand, Karnataka, MP, Maharashtra, Orissa, Rajasthan, Tamil Nadu).

FLOW OF REPORT/ FEEDBACK & NECESSARY ACTION

PLAN OF IMPLEMENTATION



COMMUNITY MONITORING: DESIRED OUTCOMES

Change of perception about health.
Greater utilisation of public health service.
Increased availability of services.
Improved quality of services.
Reduced overall health expense.
Increased participation of excluded groups.

ADVANTAGES OF MONITORING AND PLANNING BY COMMUNITY

Advantage for health system

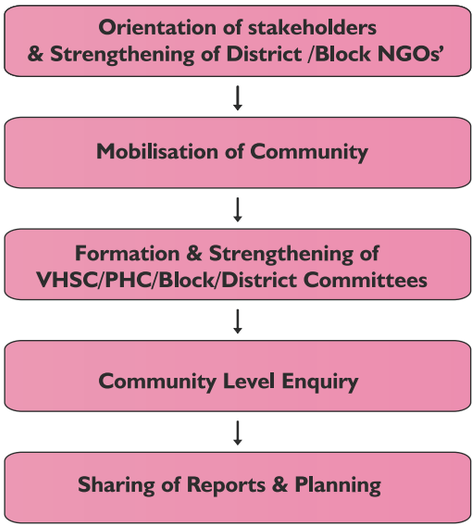
People's opinion/feedback on services provided can be taken into account.
It helps in providing health services to a wider number of beneficiaries.
A relationship of mutual understanding and cooperation is built between people and public health employees.
Review can be taken on the extent to which the objectives of the health services are achieved.
Obstacles in achieving the objectives of health services can be identified well in time.
Transparency in functioning becomes possible while providing health services. Employees and officers at all levels become proactive.

Advantages for people

People get an opportunity and space to put forth their complaints regarding health services and opinion on the health services they need.
Unnecessary expenses on private doctor are avoided as improved public services are utilised.
People learn in detail about the Government's health services and schemes. People do not remain mere beneficiaries of health services, rather they take on active role of participating in implementation of these services.
Certain health problems at the village level can be solved through everyone's co-operation.
The health system becomes accountable to the people.

Community Monitoring Process under NRHM

COMMUNITY MONITORING PROCESS



ORIENTATION OF STAKEHOLDERS & STRENGTHENING OF DISTRICT /BLOCK NGO'S

Orientation of Stakeholders;
- State Workshop
- State Managers Workshop
- District Workshop
- Block Providers Orientation Workshop
- Media Orientation Workshop

Strengthening of District /Block NGO's;
- Block Facilitator's Training

MOBILISATION OF COMMUNITY

Need

Familiarisation of the village health services.
Compilation of baseline information to compare after the community monitoring process.

Objectives of community mobilisation:

To make the communities aware of their health related entitlement within NRHM.
To have a shared understanding of health issues of the community.
To facilitate the formation or expansion of the Village Health and Sanitation Committee.

To build ownership about public health service.

Time: 3 days

Proposed Activities

(Assumption - the Block level organisation is familiar with the village)

Distributing pamphlets to literate people.

Putting posters in common meeting places of people (e.g. near temples, wells, market place, etc.).

Informal meetings with key people (leaders of CBOs, women leaders, Pradhan, in the village) to get an idea about;

- General layout of the village.
- Different social groups in the village and where they stay.
- Key health problems of the community.
- Key service providers of the area.
- Expense related to health problems.
- Communities' opinion and use of government health facilities and service providers.

Village meeting to share findings, share NRHM information and facilitate formation of VHSC

- Share the village health services profile in the village.
- Inform community of NRHM and community monitoring in NRHM (share pamphlets and posters and leave multiple sets behind in the community.
- Elicit interest from members of the community about formation of Village Health and Sanitation Committee.

Village Health Services Profile

Outcome of the Mobilisation Process.

Should be used by the facilitators and the VHSC members to familiarise themselves before they start with the monitoring process.

Shall help in comparing the changes that will be brought about after the community monitoring process.

Expected changes are improvement in services, increased utilisation of government services and decrease in health related expenditure.

FORMATION & STRENGTHENING OF VHSC/PHC/BLOCK/DISTRICT COMMITTEES

Formation of Committees

- VHC
- PHC M&PC
- Block M&PC
- District M&PC

Strengthening of Committees

- Orientation of VHC.
- Orientation of PHC M&PC.
- Orientation of Block M&PC.
- Orientation of District M&PC.

COMMUNITY LEVEL ENQUIRY

Outcomes

Village Health Report Card

Health Facility Score Card

Frequency

Village report card and facility score card will be produced once in every three months.

Who will do it

CBO/ NGO/ SHG representative in the extended Village Health and Sanitation Committee and one Panchayat member should be nominated for preparing the Village Health Report Card.
Village Health Report card would be prepared in a span of two days.
It is strongly recommended that at least for the pilot phase Block level coordinator should be present to demonstrate each monitoring activity.

COMMUNITY MONITORING ISSUES FOR VILLAGE HEALTH REPORT CARD

THEMES	SOURCE OF INFORMATION
Disease Surveillance	Group Discussion with community members
Curative Services	do
Untied funds	do
Child Health	Discussion with Women
Quality of Care	do
ASHA community perceptions	do
Adverse Outcome or experience reports	Interview and Group discussions
Maternal Health Guarantees	Interview with JSY beneficiary
Janani Suraksha Yojna	do
Asha functioning	Interview with ASHA
Equity Index (to find out if there is a difference in perception and service delivery among the two groups)	Discussion with women from general & Marginalised communities

COMMUNITY MONITORING ISSUES FOR FACILITY SCORE CARD

THEMES	SOURCE OF INFORMATION
Infrastructure and Personnel	Facility Check List
Equipment and Supplies	do
Service Availability	do
Unofficial charges	Exit Interview
Quality of Care	do
Functioning of Rogi Kalyan Samiti	Interview with MO

ACTIVITIES IN THE COMMUNITY MONITORING PROCESS

BENEFICIARY	COMMUNITY	PROVIDER	FACILITY
Five Interviews with women who have delivered in the last three months	One Group discussion with community members	One Interview with PHC Medical Officer	Observation of Sub centre using a checklist
	One Group discussion with women	One interview with CHC Medical Officer	Observation of PHC using a checklist
	One Group discussion with marginalised communities	Five Exit interviews of the PHC patients	Observation of CHC using a checklist
	One interview with the ASHA	Five Exit interviews of the CHC patients	

VILLAGE HEALTH REPORT CARD

S.No	Theme	Calculation	Score
1	Maternal Health Guarantee	Number of women * 10 = N	> 75 % of N 50 - 75% of N < 50 % of N
2	Janani Suraksha Yojana	Number of women * 8 = N	> 75 % of N 50 - 75% of N < 50 % of N
3	Child Health	Total Score - 20	16 - 20 10 - 15 0 - 9
4	Disease Surveillance	Total Score - 8	7 - 8 5 - 6 0 - 4

VILLAGE HEALTH REPORT CARD

S.No	Theme	Calculation	Score
5	Curative Services	Total Score - 8	7 - 8 5 - 6 0 - 4
6	United funds	Total Score - 8	7 - 8 5 - 6 0 - 4
7	Quality of Care	Total Score - 24	19 - 24 12 - 18 0 - 11
8	Community Perceptions of ASHA	Total Score - 16	13 - 16 8 - 12 0 - 7

VILLAGE HEALTH REPORT CARD

S.No	Theme	Calculation	Score
9	ASHA functioning	Total Score - 12	10 - 12 6 - 9 0 - 5
10	Equity Index	(Total score general community women)/ (Total score marginalized community women)	< 1 ⇨ Favorable to marginalised group 1 ⇨ No difference > 1 ⇨ Unfavorable to marginalised group
11	Adverse Outcome or experience reports	Total Score	

CUMULATIVE VILLAGE REPORT CARD

Theme	Villages	Villages	Villages
Maternal Health Guarantee			
Janani Suraksha Yojana			
Child Health			
Disease Surveillance			
Curative Services			
United funds			
Quality of Care			
Community Perceptions of ASHA			
ASHA Functioning			
Equity Index			
Adverse Outcomes			

FACILITY SCORE CARD

S.No	Theme	Calculation	Score
1	Infrastructure and Personnel	N=Maximum Score	75% of N 50-74% of N <50% of N
2	Equipment and Supplies	N=Maximum Score	75% of N 50-74% of N <50% of N
3	Service Availability	N=Maximum Score	75% of N 50-74% of N <50% of N

FACILITY SCORE CARD

S.No	Theme	Calculation	Score
4	Unofficial charges	Add points of all the persons interviewed (max 25)	= 19 13 - 18 = 12
5	Quality of Care	Add points of all the persons interview (max 35)	> 28 18 - 28 < 18
6	Functioning of Rogi Kalyan Samiti	Total Points scored	> 7 5 - 7 < 5

CUMULATIVE FACILITY SCORE CARD

Theme	Facility	Facility	Facility
Infrastructure and Personnel			
Equipment and Supplies			
Service Availability			
Unofficial charges			
Quality of Care			
Functioning of Rogi Kalyan Samiti			

REPORTS EMERGING FROM COMMUNITY MONITORING

Village Level

Village Report Card
Sub centre Report Card

PHC Level

Cumulative Village Report Card
Cumulative Sub centre Report Card
PHC Report Card

Block Level

Cumulative Village Report Card
Cumulative Sub centre Report Card
Cumulative PHC Report Card

SHARING OF REPORTS & PLANNING

Village Sharing Meeting

Village Score Card and key findings of the community monitoring exercise.
Adverse experiences and adverse outcome.
To improve service delivery & not finding fault with health care service providers.
To discuss key problems & suggest action points.

Jan Samvad (Public Dialogue)

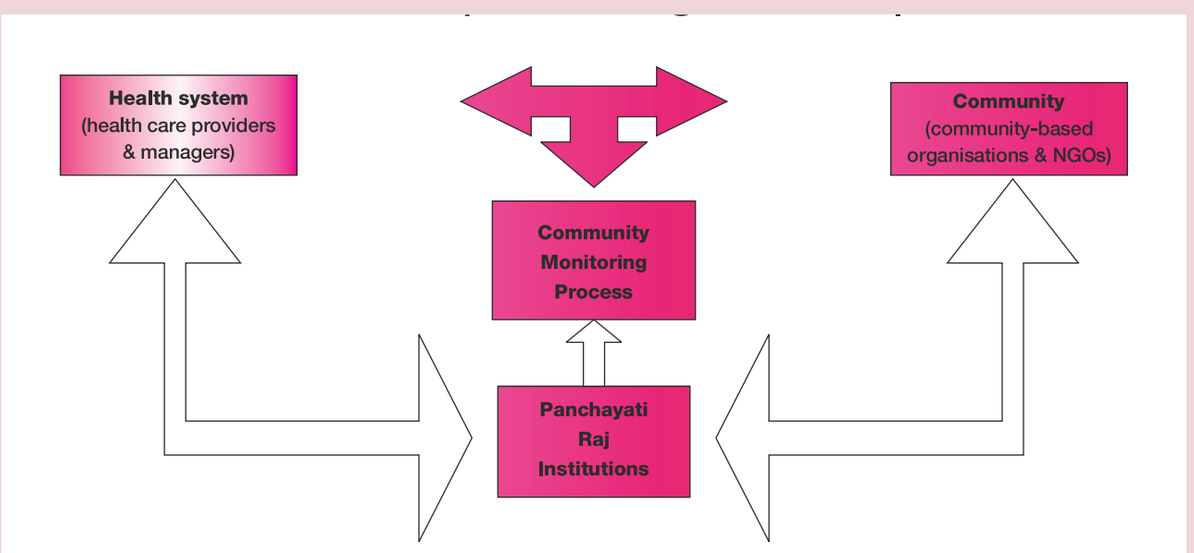
Conducted at Block and PHC level.
Presentation of Cumulative Village Report Card & Facility Report Card.
Presentation of Denial of Care/Adverse Outcomes.
Discussion on implementation of outreach services, improving facility level service utilisation & support to denial of care/adverse outcome cases.

Community Monitoring under NRHM

COMMUNITY MONITORING UNDER NRHM

Part of three-pronged process of accountability framework proposed in NRHM that includes internal monitoring & periodic surveys/studies.
Seen as an important aspect of promoting community led action in the field of health.
Places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.
Provision has been made through Monitoring and Planning Committees at PHC, Block, District and State levels.

COMMUNITY MONITORING: PARTNERSHIP



OBJECTIVES OF COMMUNITY MONITORING

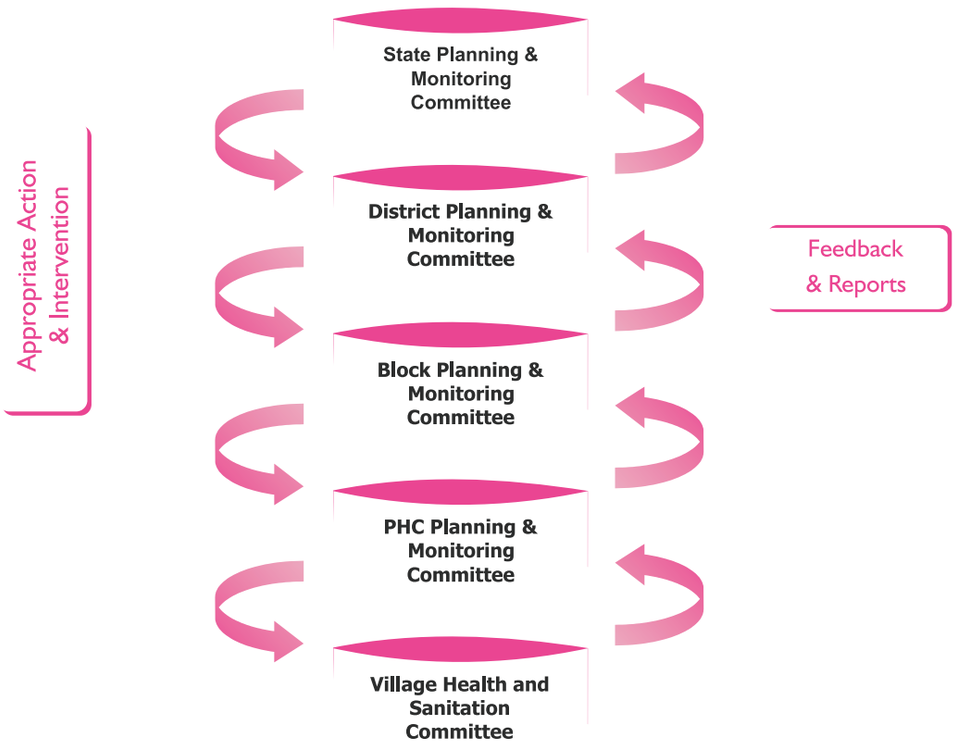
To provide regular and systematic information about community needs.
To provide feedback according to the locally developed yardsticks, as well as on some key indicators.
To provide feedback on the status of fulfillment of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction.
To increase the community sense of involvement and participation to improve responsive functioning of the public health system.

PROCESS OF COMMUNITY MONITORING

Involves drawing in, activating, motivating, capacity building and allowing the community and its

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.
Will also include monitoring of outreach services, public health facilities and the referral system.

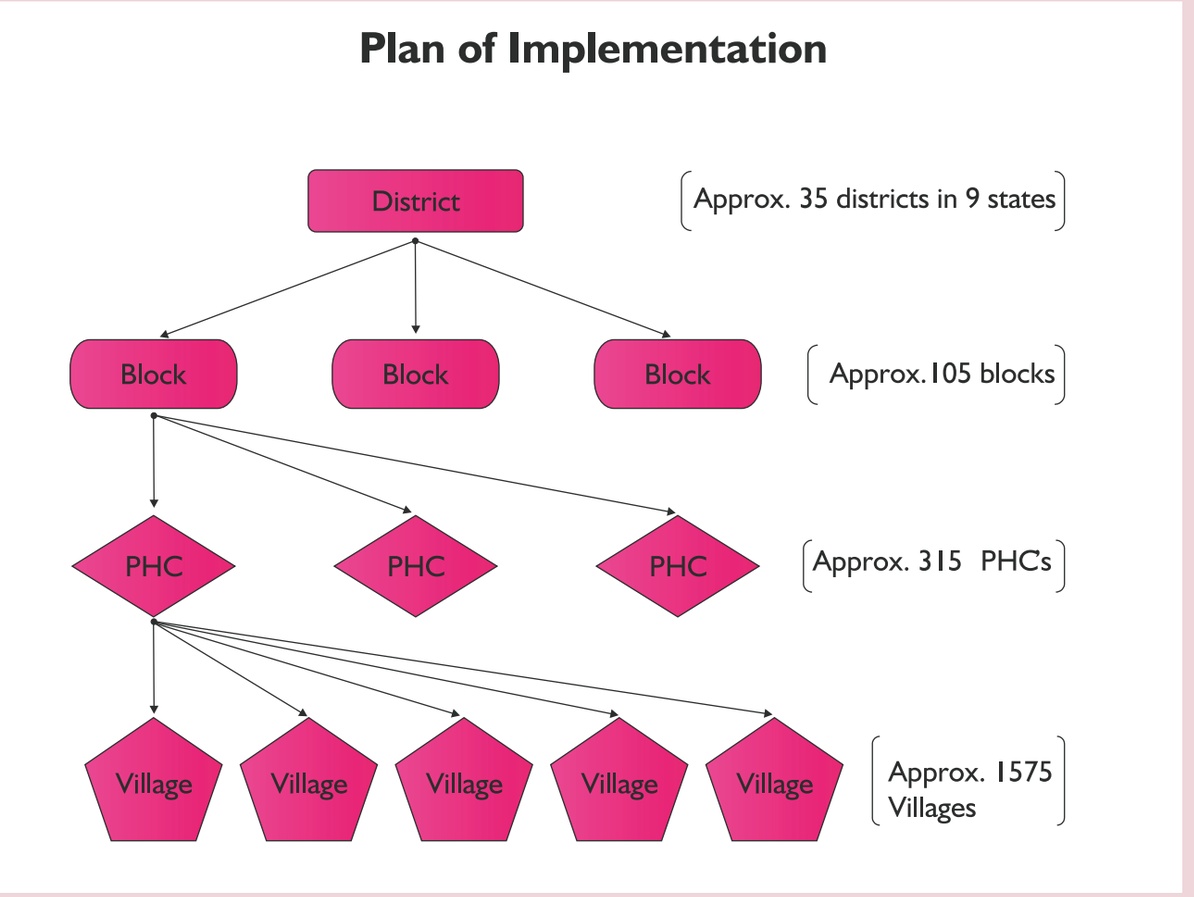
FLOW OF REPORT/FEEDBACK & NECESSARY ACTION



ROLE OF CIVIL SOCIETY ORGANISATIONS

Monitoring committees: As members esp. with a rights-based perspective to make the process more independent & robust.
Capacity building & facilitation: As resource groups to train people for them to gain a degree of authority to identify gaps and correspondingly propose priorities and influence decision-making.
Collection of info: As agencies contribute to info pool relevant to monitoring process at all levels - village to state level, in the process helping community mobilisation.

PLAN OF IMPLEMENTATION



ACTIVITIES AT VARIOUS LEVELS

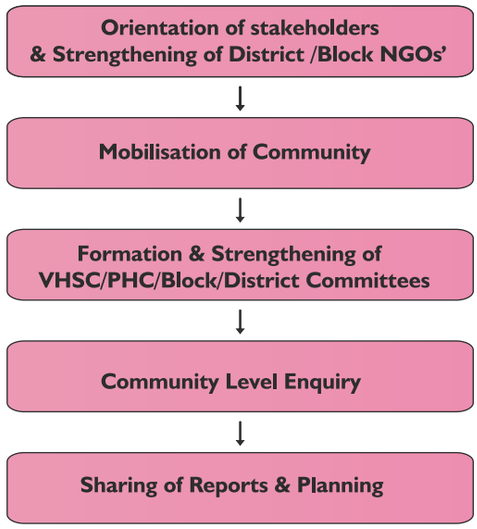
State

Setting up of the State Community Monitoring Mentoring Group.
Identifying state level secretariat and district level implementing NGOs that will facilitate the district level activities.

District

Setting up of District Community Monitoring Mentoring Group.
Identifying district level implementing NGOs that will facilitate the block level activities.

COMMUNITY MONITORING PROCESS



ORIENTATION OF STAKEHOLDERS & STRENGTHENING OF DISTRICT /BLOCK NGO'S

Orientation of Stakeholders
- State Workshop
- State Managers Workshop
- District Workshop
- Orientation of Block Providers

Strengthening of District /Block NGO's
- Block Facilitator's Training

MOBILISATION OF COMMUNITY

Need

Familiarisation of the village health services.
Compilation of baseline information to compare after the community monitoring process.

Objective

To make the communities aware of their health related entitlement within NRHM.
To have a shared understanding of the health issues of the community.
To facilitate the formation or expansion of the Village Health and Sanitation Committee.
To build ownership about public health service.
To develop awareness about determinants of health.

FORMATION & STRENGTHENING OF VHSC/PHC/BLOCK/DISTT COMMITTEES

Formation of Committees

VHC
PHC P&MC
Block P&MC
District P&MC

Strengthening of Committees

Orientation of VHC
Orientation of PHC P&MC
Orientation of Block P&MC
Orientation of District P&MC

REPORTS EMERGING FROM COMMUNITY MONITORING

Village Level

Village Report Card
Sub centre Report Card

PHC Level

Cumulative Village Report Card
Cumulative Sub centre Report Card
PHC Report Card

Block Level

Cumulative Village Report Card
Cumulative Sub centre Report Card
Cumulative PHC Report Card
CHC Report Card

District Level

Cumulative Village Report Card
Cumulative Sub centre Report Card
Cumulative PHC Report Card
Cumulative CHC Report Card
District Report Card

Sharing of Reports & Planning-I

Village Sharing Meeting.
Village Score Card and key findings of the community monitoring exercise.
Adverse experiences and adverse outcome.
To improve service delivery & not finding fault with health care service providers.
To discuss key problems & suggest action points.

SHARING OF REPORTS & PLANNING

Jan Samvad (Public Dialogue)
Conducted at PHC and Block level.
Presentation of Cumulative Village Report Card & Facility Report Card.
Presentation of Denial of Care/Adverse Outcomes.

Discussion on implementation of outreach services, improving facility level service utilisation & support to denial of care/adverse outcome cases.

COMMUNITY MONITORING: DESIRED OUTCOMES

Need

Familiarisation of the village health services.
Compilation of baseline information to compare after the community monitoring process.

Objectives

To make the communities aware of their health related entitlement within NRHM.
To have a shared understanding of the health issues of the community.
To facilitate the formation or expansion of the Village Health and Sanitation Committee.
To build ownership about public health service.
To develop awareness about determinants of health.

ADVANTAGES OF MONITORING AND PLANNING BY COMMUNITY

Advantage for health system

People's view point /feedback on services provided can be taken into account.
It helps in providing health services to a wider number of beneficiaries.
A relationship of mutual understanding and cooperation is built between people and public health employees.
Review can be taken on the extent to which the objectives of the health services are achieved.
Obstacles in achieving the objectives of health services can be identified well in time.
Transparency in functioning becomes possible while providing health services. Employees and officers at all levels become proactive.

Advantages for people

People get an opportunity and space to put forth their complaints regarding health services and to give their opinion about the health services they need.
Unnecessary expenses on private doctor are avoided as improved public services are utilised.
People learn in detail about the Government's health services and schemes. People do not remain mere beneficiaries of health services, rather they take on active role of participating in implementation of these services.
Certain health problems at the village level can be solved through everyone's cooperation.
The health system becomes accountable to the people.

IMPORTANCE & FUNCTIONS OF PHC MONITORING & PLANNING COMMITTEE

Community Monitoring Under NRHM

Consolidation of the village health plans and charting out the annual health action plan in order of priority.

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.

Ensure that the Charter of citizen's health rights is disseminated widely and displayed outside 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.

Monitoring of the physical resources like, infrastructure, equipment, 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 the 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 the functioning of Sub-centres operating under jurisdiction of the PHC 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

HEALTH SYSTEM

People, institutions and resources, arranged together to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill health.

CHARACTERISTICS & FUNCTIONS

Characteristics

Goodness: Improvement of health status.
Responsiveness: The extent to which health system meets a population's expectations of how they should be treated.
Fairness: Fairness in the distribution of resources and outcomes.

Functions

Delivering services: What services, delivered by whom and how.
Financing: Generation and allocation of funds for health systems.
Creating resources: Human resources, capital infrastructure, knowledge and technology, drugs and other consumables required to deliver services.
Stewardship: Oversight, setting the rules of the game, collating and collecting information, regulation, consumer protection.

LEVELS OF THE HEALTH SYSTEM

National level

Union Ministry of Health and Family Welfare.
Three departments, viz. - Health, Family Welfare & Indian System of Medicine and Homeopathy.

State level

State Department of Health and Family Welfare headed by Minister and with a Secretariat under the charge of secretary/Commissioner (Health and Family Welfare).

District level

District officers (DMOs and CMOs) are overall in-charge of the health and family welfare programmes. They are responsible for implementing the programmes according to policies laid down and finalised at higher levels, i.e. State and Centre.

Sub-divisional/Taluka level

Health care services are rendered through the office of Assistant District Health and Family Welfare Officer who is assisted by Medical Officers of Health, Lady Medical Officers and Medical Officers of general hospital.

Community level

One Community Health Centre (CHC) has been established for every 80,000 to 1, 20,000 population
Provides the basic specialty services in general medicine, pediatrics, surgery, obstetrics and gynecology.

PHC level

One Primary Health Centre covers about 30,000 (20,000 in hilly, desert and difficult terrains) or more population.

Each PHC has one medical officer, two health assistants - one male and one female, and the health workers and supporting staff.
It performs curative, preventive, promotive and family welfare services.

Sub-centre level

Most peripheral health institutional facility is the sub-centre manned by one male and one female multi-purpose health worker.
One sub-centre for about 5,000 populations (3,000 in hilly and desert areas and in difficult terrain).
Department of Family Welfare is providing 100% central assistance to all the sub-centres in the country since April 2002.

TYPES OF HEALTH CARE

Primary health care is the first point of contact a person encounters with the health services.
Secondary health care refers to those services particularly provided by hospitals.
Tertiary health care refers to those specialist services mostly provided by the medical profession.

PUBLIC & PRIVATE SECTOR

Public sector

All health care initiatives and providers financed and managed by government are in.

Private sector

Comprising all providers who exist outside the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat or prevent disease.

ASSESS PERFORMANCE OF HEALTH SYSTEMS

Responsiveness: Availability, access, acceptability and quality.
Efficiency: Value for money.
Equity: Wide range of meanings- investing on health problems of the poor; investing on increasing access to health services of vulnerable groups; narrowing the health gaps between the top and bottom deciles of population.

COMMUNITY MONITORING ISSUES

Overview of community outcomes and experience
Overview of PHC level services
Staffing, supplies and services availability at CHC
Quality of care at the CHC from people's perspective
Implementation of the National Health Programmes etc

METHOD OF DATA GATHERING

THEMES	SOURCE OF INFORMATION
Infrastructure and Personnel	CHC Check List
Equipment and Supplies	do
Service Availability	do
Unofficial charges	Exit Interview
Quality of Care	do
Functioning of Rogi Kalyan Samiti	Interview with MO

COMMUNITY LEVEL ENQUIRY

Outcomes

Cumulative Village Health Report Card
Cumulative Sub-centre Report Card
Cumulative PHC Report Card
Block Report Card

Frequency

Block Report card will be produced once in every three months.

Who will do it

CBO/NGO/SHG representative in the extended Block MPC and one Panchayat member should be nominated for preparing the Block report card.
Block report card would be prepared in a span of two days.
It is strongly recommended that at least for the pilot phase, block level coordinator should be present to demonstrate each monitoring activity.

Time

2 days

ACTIVITIES IN THE COMMUNITY MONITORING PROCESS

BENEFICIARY	PROVIDER	FACILITY
Five exit interviews of the CHC patients	One interview with CHC Medical Officer	Observation of CHC using a checklist

CUMULATIVE VILLAGE REPORT CARD

Theme	Villages	Villages	Villages
Maternal Health Guarantee			
Janani Suraksha Yojana			
Child Health			
Disease Surveillance			
Curative Services			
United funds			
Quality of Care			
Community Perceptions of ASHA			
ASHA Functioning			
Equity Index			
Adverse Outcomes			

CUMULATIVE SUBCENTRE REPORT CARD

Theme	Subcentre	Subcentre	Subcentre
Infrastructure and Personnel			
Equipment and Supplies			
Service Availability			

MULATIVE PHC REPORT CARD

Theme	PHC	PHC	PHC
Infrastructure and Personnel			
Equipment and Supplies			
Service Availability			
Unofficial charges			
Quality of Care			
Functioning of Rogi Kalyan Samiti			

BLOCK REPORT CARD

S.No	Theme	Calculation	Score
1	Infrastructure and Personnel	N=Maximum Score	75% of N 50-74% of N <50% of N
2	Equipment and Supplies	N=Maximum Score	75% of N 50-74% of N <50% of N
3	Service Availability	N=Maximum Score	75% of N 50-74% of N <50% of N

BLOCK REPORT CARD

S.No	Theme	Calculation	Score
4	Unofficial charges	Add points of all the persons interviewed (max 25)	≥ 19 13 - 18 ≤ 12
5	Quality of Care	Add points of all the persons Interview (max 35)	>28 18 - 28 < 18
6	Functioning of Rogi Kalyan Samiti	Total Points scored	> 7 5 - 7 < 5

Jan Samvad

OBJECTIVES

To create a common understanding among residents of a Block on the state of implementation of NRHM in their area.
To highlight key issues emerging from the current implementation status.
To review and prepare action plans for improving NRHM Implementation.

PREPARATORY PROCESSES

The process of village, sub centre & PHC levels community monitoring would have been complete and also preparation of village, Sub- centre & PHC level score cards should also have been complete.
The village level sharing meetings of the area would have been complete.
Screening of cases of denial of care for presentation.

Organiser - Members of Block Community Monitoring and Planning Committee.

Participants

Chief Medical Officer of the District or her/his representative.
Block Medical Officer.
Member of District Community Monitoring and Planning Committee.
Members of PRIs in the block.
Members of VHSCs.
Member of CBOs in the block.

CONDUCT OF JAN SAMVAD

Jan Samvad can take place in four parts

Introduction to the Jan Samvad - by Chair of the Organising Group.
Presentation of the Cumulative Village Report Card and discussion on implementation of outreach services in NRHM.
Presentation of Cumulative Sub-centre Report Card and discussion on improving Sub-centre level service utilisation.

Presentation of Cumulative PHC Report Card and discussion on improving PHC level service utilisation.
Presentation of Block Report Card and discussion on improving Block level service utilisation.
Presentation of Denial of Care/Adverse Outcomes - discussion on improving quality of care and support to cases.
Preparation of List of Recommendations for Providers, Facilities and Community.

PHC Issues & Process for Monitoring

COMMUNITY MONITORING ISSUES

Overview of community outcomes and experience.
Overview of PHC level services.
Staffing, Supplies and services availability at PHC.
Quality of care at the PHC from people's perspective.
Implementation of the National Health Programmes etc.

METHOD OF DATA GATHERING

THEMES	SOURCE OF INFORMATION
Infrastructure and Personnel	CHC Check List
Equipment and Supplies	do
Service Availability	do
Unofficial charges	Exit Interview
Quality of Care	do
Functioning of Rogi Kalyan Samiti	Interview with PHC MO

COMMUNITY LEVEL ENQUIRY

Outcomes

Cumulative Village Health Report Card
Cumulative Sub centre Report Card
PHC Report Card

Frequency

PHC Report card will be produced once in every three months.

Who will do it

CBO/ NGO/ SHG representative in the extended PHC MPC and one Panchayat member should be nominated for preparing the PHC report card.
PHC Report card would be prepared in a span of two days.
It is strongly recommended that at least for the pilot phase, Block level coordinator should be present to demonstrate each monitoring activity.

Time

2 days

ACTIVITIES IN THE COMMUNITY MONITORING PROCESS

BENEFICIARY	PROVIDER	FACILITY
Five exit interviews of the CHC patients	One interview with CHC Medical Officer	Observation of CHC using a checklist

CUMULATIVE VILLAGE REPORT CARD

Theme	Villages	Villages	Villages
Maternal Health Guarantee			
Janani Suraksha Yojana			
Child Health			
Disease Surveillance			
Curative Services			
United funds			
Quality of Care			
Community Perceptions of ASHA			
ASHA Functioning			
Equity Index			
Adverse Outcomes			

CUMULATIVE SUBCENTRE REPORT CARD

Theme	Subcentre	Subcentre	Subcentre
Infrastructure and Personnel			
Equipment and Supplies			
Service Availability			

PHC REPORT CARD

S.No	Theme	Calculation	Score
1	Infrastructure and Personnel	N=Maximum Score	75% of N 50-74% of N <50% of N
2	Equipment and Supplies	N=Maximum Score	75% of N 50-74% of N <50% of N
3	Service Availability	N=Maximum Score	75% of N 50-74% of N <50% of N

PHC REPORT CARD

S.No	Theme	Calculation	Score
4	Unofficial charges	Add points of all the persons interviewed (max 25)	≥ 19 13 - 18 ≤ 12
5	Quality of Care	Add points of all the persons Interview (max 35)	>28 18 - 28 < 18
6	Functioning of Rogi Kalyan Samiti	Total Points scored	> 7 5 - 7 < 5

Role of Stakeholders & Committees at Different Levels

MAJOR STAKEHOLDERS

Accredited Social Health Activist (ASHA)
Auxillary Nurse Midwife (ANM)
Anganwadi Workers (AWW)
Panchayati Raj Institutions (PRI)
Non-governmental Organisations (NGO's)
District Administration
State Governments

ASHA

Health activist in community.
Counsel women on birth preparedness.
Mobilise community & facilitate them in accessing health & health related services available at Anganwadi/sub-centre/primary health centers.
Depot holder for essential provisions like ORS, IFA, chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.
Receive performance-based incentives for promoting universal immunisation, referral and escort services for Reproductive & Child Health (RCH) and other health care programmes & construction of household toilets.

ANM

Act as resource persons for initial & periodic training & also ensure that during training ASHA gets compensation for performance & also TA/DA for attending training schedule.
Hold weekly/fortnightly meeting with ASHA & provide on-job training by discussing activities undertaken during the week/fortnight & provide guidance in case ASHA encounters any problem.
Guide ASHA in bringing beneficiary to outreach session.
Utilise ASHA in motivating pregnant women for coming to Sub-centre for initial check-ups and also take ASHA's help in bringing married couples to Sub centres and motivating pregnant women for taking full course of Iron and Folic Acid (IFA).

AWW

Will guide ASHA in performing activities such as organising Health Day once/twice a month at Anganwadi Centre & orientating women on health related issues such as importance of nutritious food, personal hygiene, care during pregnancy, importance of immunisation etc.
Depot holder for drug kits & will issue it to ASHA.
ASHA will support the AWW in mobilising pregnant and lactating women and infants for nutrition supplement. She would also take initiative for bringing the beneficiaries from the village on specific days of immunisation, health check-ups/Health Days etc. to Anganwadi Centres.

PANCHAYATI RAJ INSTITUTIONS

ASHA would be accountable to the community through the Gram Panchayat.
Village Health & Sanitation Committee (VHC), the standing committee of the Gram Panchayat (GP);
- Provide oversight of all NRHM activities at the village level.
- Develop the Village Health Plan.
- Support of the ANM, ASHA, AWW and Self Help Groups.

Block level Panchayat Samitis will coordinate the work of the GP in their jurisdiction & serve as link to the DHM.

DHM will be led by the Zila Parishad and will control, guide and manage all public health institutions in the district.

NON-GOVERNMENTAL ORGANISATIONS

In institutional arrangements at National, State and District Level.
Standing Mentoring Group for ASHA.
Member of Task Groups.
Provision of training, BCC and technical support for ASHAs/DHM.
Health resource organisations.
Service delivery for identified population groups on select themes.
For monitoring, evaluation and social audit.

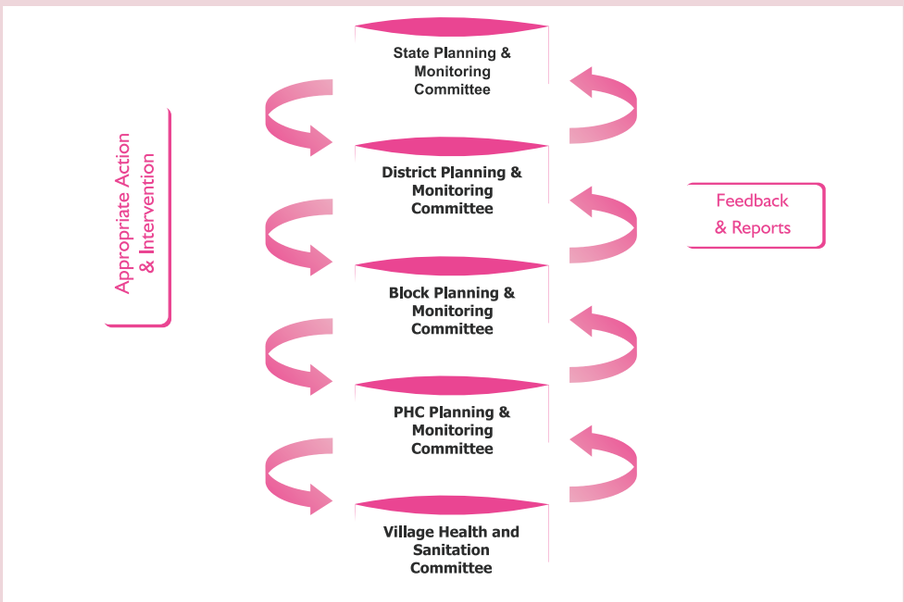
DISTRICT ADMINISTRATION

Constitution of District Health Mission.
Preparation of integrated District Action Plan.
Constitution of HMS for district hospital, CHCs & PHCs.
Opening Joint Account of ANM & Sarpanch to manage Untied Fund.
Facilitation of village health planning.

STATE GOVERNMENT

Establish State and District Health Missions.
Integrate the multiple Societies for Health and Family Welfare Programmes at State and District levels.
Formulate State Action Plan.
Commit to undertake systemic reform, including devolution of powers to Panchayati Raj Institutions and decentralisation of the programme to district levels.
Ensure smooth fund flow.
Technical and MIS support.

COMMITTEES AT DIFFERENT LEVELS



VHSC Issues & Process for Monitoring

COMMUNITY LEVEL ENQUIRY

Outcomes

Village Health Report Card
Subcentre Score Card

Frequency

Village & Sub-centre report card will be produced once in every three months.

Who will do it

CBO/NGO/SHG representative in the extended Village Health and Sanitation Committee and one Panchayat member should be nominated for preparing the village health report card.
Village Health Report card would be prepared in a span of two days.
It is strongly recommended that at least for the pilot phase, Block level coordinator should be present to demonstrate each monitoring activity.

Time

2 days

COMMUNITY MONITORING ISSUES FOR VILLAGE HEALTH REPORT CARD

THEMES	SOURCE OF INFORMATION
Disease Surveillance	Group Discussion with community members
Curative Services	do
Untied funds	do
Child Health	Discussion with Women
Quality of Care	do
ASHA community perceptions	do
Adverse Outcome or experience reports	Interview and Group discussions
Maternal Health Guarantees	Interview with JSY beneficiary
Janani Suraksha Yojna	do
Asha functioning	Interview with ASHA
Equity Index (to find out if there is a difference in perception and service delivery among the two groups)	Discussion with women from general & Marginalised communities

COMMUNITY MONITORING ISSUES FOR SUB-CENTRE REPORT CARD

THEMES	SOURCE OF INFORMATION
Infrastructure and Personnel	Facility Checklist
Equipment and Supplies	do
Service Availability	do

ACTIVITIES IN THE COMMUNITY MONITORING PROCESS

BENEFICIARY	COMMUNITY	FACILITY
Five Interviews with women who have delivered in the last three months	One Group discussion with community members	Observation of Sub centre using a checklist
	One Group discussion with women	
	One Group discussion with marginalised communities	
	One interview with the ASHA	

VILLAGE HEALTH REPORT CARD

S.No	Theme	Calculation	Score
1	Maternal Health Guarantee	Number of women * 10 = N	> 75 % of N 50 - 75% of N < 50 % of N
2	Janani Suraksha Yojana	Number of women * 8 = N	> 75 % of N 50 - 75% of N < 50 % of N
3	Child Health	Total Score - 20	16 - 20 10 - 15 0 - 9
4	Disease Surveillance	Total Score - 8	7 - 8 5 - 6 0 - 4

VILLAGE HEALTH REPORT CARD

S.No	Theme	Calculation	Score
5	Curative Services	Total Score - 8	7 - 8 5 - 6 0 - 4
6	United funds	Total Score - 8	7 - 8 5 - 6 0 - 4
7	Quality of Care	Total Score - 24	19 - 24 12 - 18 0 - 11
8	Community Perceptions of ASHA	Total Score - 16	13 - 16 8 - 12 0 - 7

VILLAGE HEALTH REPORT CARD

S.No	Theme	Calculation	Score
9	ASHA functioning	Total Score - 12	10 - 12 6 - 9 0 - 5
10	Equity Index	(Total score general community women)/ (Total score marginalized community women)	< 1 ⇒ Favorable to marginalised group 1 ⇒ No difference > 1 ⇒ Unfavorable to marginalised group
11	Adverse Outcome or experience reports	Total Score	

SUBCENTRE REPORT CARD

S.No	Theme	Calculation	Score
1	Infrastructure and Personnel	N=Maximum Score	75% of N 50-74% of N <50% of N
2	Equipment and Supplies	N=Maximum Score	75% of N 50-74% of N <50% of N
3	Service Availability	N=Maximum Score	75% of N 50-74% of N <50% of N

Community Mobilisation & VHSC Formation

MOBILISATION OF COMMUNITY

Need

Familiarisation of the village health services.
Compilation of baseline information to compare after community monitoring process.

Objective(s) of community mobilisation:

To make the communities aware of their health related entitlement within NRHM.
To have a shared understanding of the health issues of the community.
To facilitate the formation or expansion of the Village Health and Sanitation Committee.
To build ownership about public health service.

MOBILISATION OF COMMUNITY

Time: 3 days

Proposed Activities

(Assumption - the Block level organisation is familiar with the village).
Distributing pamphlets to literate people.
Putting up posters in the common meeting places of the people (e.g. near temples, wells, market place, etc.).

MOBILISATION OF COMMUNITY

Informal meetings with key people (leaders of CBOs, women leaders, Pradhan, in the village) to get an idea about;

- General layout of the village.
- Different social groups in the village and where they stay.
- Key health problems of the community.
- Key service providers of the area.
- Expense related to health problems.
- Communities opinion and use of government health facilities and service providers.

Village meeting to share findings, share NRHM information and facilitate formation of VHSC

- Share the Village health services profile in the village.
- Inform community of NRHM and community monitoring in NRHM (share pamphlets and posters and leave multiple sets behind in the community.
- Elicit interest from members of the community about formation of Village Health and Sanitation Committee.

MOBILISATION OF COMMUNITY

Village Health Services Profile

Outcome of the Mobilisation Process.
Should be used by the facilitators and the VHSC members to familiarise themselves before they start with the monitoring process.

Shall help in comparing the changes that will be brought about after the community monitoring process.
Expected changes are improvement in services, increased utilisation of government services and decrease in health related expenditure.

VHSC

Formed at the level of revenue village.
Composition:
- 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.

Chairperson would be Panchayat member (preferably woman or SC/ST member).
Convenor would be ASHA (if ASHA is not in position it could be Anganwadi Sevika of the village).

ROLES & RESPONSIBILITIES OF VHSC

Create Public Awareness about the essentials of health programmes.
Discuss and develop a Village Health Plan.
Analyse key issues and problems related to village level health and nutrition activities.
Present an annual health report of the village in the Gram Sabha.
Undertake Health Mapping exercise to understand the health profile of the village.
Maintain a village health register and health information board/calendar.
Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity.
Get 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.

FORMATION & STRENGTHENING OF VHSC/PHC/BLOCK/DISTRICT COMMITTEES

Formation of Committees

- VHC
- PHC M&PC
- Block M&PC
- District M&PC

Strengthening of Committees

- Orientation of VHC
- Orientation of PHC M&PC
- Orientation of Block M&PC
- Orientation of District M&PC

COMMUNITY LEVEL ENQUIRY- VILLAGE LEVEL

Outcomes

Village Health Report Card
Subcentre Report Card

Frequency

Village report card and facility score card will be produced once in every three months.

Who will do it

CBO/ NGO/ SHG representative in the extended Village Health and Sanitation Committee and one Panchayat member should be nominated for preparing the village health report card.
Village Health Report card would be prepared in a span of two days.
It is strongly recommended that at least for the pilot phase Block level coordinator should be present to demonstrate each monitoring activity.

Time

2 days

COMMUNITY MONITORING ISSUES FOR VILLAGE HEALTH REPORT CARD

THEMES	SOURCE OF INFORMATION
Disease Surveillance	Group Discussion with community members
Curative Services	do
Untied funds	do
Child Health	Discussion with Women
Quality of Care	do
ASHA community perceptions	do
Adverse Outcome or experience reports	Interview and Group discussions
Maternal Health Guarantees	Interview with JSY beneficiary
Janani Suraksha Yojna	do
Asha functioning	Interview with ASHA
Equity Index (to find out if there is a difference in perception and service delivery among the two groups)	Discussion with women from general & Marginalised communities

COMMUNITY MONITORING ISSUES FOR FACILITY SCORE CARD

THEMES	SOURCE OF INFORMATION
Infrastructure and Personnel	Facility Checklist
Equipment and Supplies	do
Service Availability	do
Unofficial charges	Exit Interview
Quality of Care	do
Functioning of Rogi Kalyan Samiti	Interview with MO

ACTIVITIES IN THE COMMUNITY MONITORING PROCESS

BENEFICIARY	COMMUNITY	PROVIDER	FACILITY
Five Interviews with women who have delivered in the last three months	One Group discussion with community members	One Interview with PHC Medical Officer	Observation of Sub centre using a checklist
	One Group discussion with women	One interview with CHC Medical Officer	Observation of PHC using a checklist
	One Group discussion with marginalised communities	Five Exit interviews of the PHC patients	Observation of CHC using a checklist
	One interview with the ASHA	Five Exit interviews of the CHC patients	

VILLAGE HEALTH REPORT CARD

S.No	Theme	Calculation	Score
1	Maternal Health Guarantee	Number of women * 10 = N	> 75 % of N 50 - 75% of N < 50 % of N
2	Janani Suraksha Yojana	Number of women * 8 = N	> 75 % of N 50 - 75% of N < 50 % of N
3	Child Health	Total Score - 20	16 - 20 10 - 15 0 - 9
4	Disease Surveillance	Total Score - 8	7 - 8 5 - 6 0 - 4

S.No	Theme	Calculation	Score
5	Curative Services	Total Score - 8	7 - 8 5 - 6 0 - 4
6	United funds	Total Score - 8	7 - 8 5 - 6 0 - 4
7	Quality of Care	Total Score - 24	19 - 24 12 - 18 0 - 11
8	Community Perceptions of ASHA	Total Score - 16	13 - 16 8 - 12 0 - 7

VILLAGE HEALTH REPORT CARD

S.No	Theme	Calculation	Score
9	ASHA functioning	Total Score - 12	10 - 12 6 - 9 0 - 5
10	Equity Index	(Total score general community women)/ (Total score marginalized community women)	< 1 ⇒ Favorable to marginalised group 1 ⇒ No difference > 1 ⇒ Unfavorable to marginalised group
11	Adverse Outcome or experience reports	Total Score	

Theme	Villages	Villages	Villages
Maternal Health Guarantee			
Janani Suraksha Yojana			
Child Health			
Disease Surveillance			
Curative Services			
United funds			
Quality of Care			
Community Perceptions of ASHA			
ASHA Functioning			
Equity Index			
Adverse Outcomes			

VILLAGE HEALTH REPORT CARD

S.No	Theme	Calculation	Score
1	Infrastructure and Personnel	N=Maximum Score	75% of N 50-74% of N <50% of N
2	Equipment and Supplies	N=Maximum Score	75% of N 50-74% of N <50% of N
3	Service Availability	N=Maximum Score	75% of N 50-74% of N <50% of N

CUMULATIVE VILLAGE REPORT CARD

S.No	Theme	Calculation	Score
4	Unofficial charges	Add points of all the persons interviewed (max 25)	≥ 19 13 - 18 ≤ 12
5	Quality of Care	Add points of all the persons Interview (max 35)	>28 18 - 28 < 18
6	Functioning of Rogi Kalyan Samiti	Total Points scored	> 7 5 - 7 < 5

Theme	Facility	Facility	Facility
Infrastructure and Personnel			
Equipment and Supplies			
Service Availability			
Unofficial charges			
Quality of Care			
Functioning of Rogi Kalyan Samiti			

REPORTS EMERGING FROM COMMUNITY MONITORING

Village Level

Village Report Card
Subcentre Report Card

PHC Level

Cumulative Village Report Card
Cumulative Subcentre Report Card
PHC Report Card

Block Level

Cumulative Village Report Card
Cumulative Subcentre Report Card
Cumulative PHC Report Card
CHC Report Card

Importance & Functions of Block Monitoring & Planning Committee

Roles & Responsibilities

Consolidation of the PHC level health plans & charting out of annual health action plan for the block.
Review of the progress made at PHC levels (difficulties faced, actions taken & 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.
Analysis of records on neonatal and maternal deaths; and the status of other indicators, such as coverage for immunisation and other national programmes.
Monitor of the 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 health services in the block.
Review the functioning of Sub-centres and PHCs operating under jurisdiction of the CHC and take 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.
Consolidate quarterly village, PHC and block report cards and organise Jan Samvad.

Importance & Functions of Village Health & Sanitation Committee

ROLES & RESPONSIBILITIES OF VHSC

- Create Public Awareness about the essentials of health programmes
- Discuss and develop a Village Health Plan
- Analyse key issues and problems related to village level health and nutrition activities
- Present an annual health report of the village in the Gram Sabha
- Undertake Health Mapping exercise to understand the health profile of the village
- Maintain a village health register and health information board/calendar
- Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity
- Get 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

Introduction to NRHM and Communitisation

THE VISION

Seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states (Arunachal Pradesh, Assam, Bihar, Chhattisgarh, HP, JH, J&K, Manipur, Mizoram, Meghalaya, MP, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand and UP), which have weak public health indicators and/or weak infrastructure.

Articulation of commitment of Govt. to raise public spending on Health from 0.9% of GDP to 2-3% of GDP.

Key components include

- Provision of a female health activist in each Village.
- Village health plan prepared through by the Health & Sanitation Committee of the Panchayat.
- Strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS).
- Integration of vertical Health & Family Welfare Programmes and Funds for optimal utilisation of funds and infrastructure and strengthening delivery of primary healthcare.

Revitalise local health traditions and mainstream AYUSH into the public health system.

Effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for health.

Seeks decentralisation of programmes for district management of health and to address the inter-state and inter-district disparities, esp. among 18 high focus states, including unmet needs for public health infrastructure.

Define time-bound goals and report publicly on their progress.

Seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

ENVISAGED OUTCOMES AT NATIONAL LEVEL

Infant Mortality Rate reduced to 30/1000 live births.

Maternal Mortality Ratio reduced to 100/100,000.

Total Fertility Rate reduced to 2.1.

Malaria mortality reduction rate by 50% upto 2010, additional 10% by 2012.

Kala Azar mortality reduction rate by 100% by 2010 and sustaining elimination until 2012.

Filaria/Microfilaria reduction rate by 70% by 2010, 80% by 2012 and elimination by 2015.

Dengue mortality reduction rate by 50% by 2010 and sustaining at that level until 2012.

Japanese Encephalitis mortality reduction rate 50% by 2010 and sustaining at that level until 2012.

Cataract Operation: Increase to 46 lakhs per year until 2012.

Leprosy prevalence rate: Reduce from 1.8/10,000 in 2005 to less than 1/10,000 thereafter.

Tuberculosis DOTS services: Maintain 85% cure rate through entire Mission period.

Upgrading Community Health Centers to Indian Public Health Standards.

Increase utilisation of First Referral Units from less than 20% to 75%.

Engaging 250,000 female Accredited Social Health Activists (ASHAs) in 10 States.

BROAD FRAMEWORK FOR IMPLEMENTATION

Among the other components

Institutionalising community led action for health.

- Involvement of PRIs in VHSCs, PHC monitoring & planning committees, etc.
- Amendments in Acts & Statutes to fully empower local bodies.

Provision of untied grant at various levels.

To empower local monitoring committees for planning & conduction of Jan Samvads.

Monitoring/Accountability Framework

An intensive accountability framework through a three-pronged process of community based monitoring, external surveys and stringent internal monitoring

Communitisation of the health institutions;

Compulsory for all the health institutions to prominently display information regarding grants received, medicines and vaccines in stock, services provided to the patients, user charges to be paid (if any) etc, as envisaged in the Right to Information Act.

Publication of Public Reports on Health at the State and the district levels to report to the community at large on progress made.

Block Level Jan Samvad

OBJECTIVES

To create a common understanding among residents of a Block on the state of implementation of NRHM in their area.
To highlight key issues emerging from the current implementation status.
To review and prepare action plans for improving NRHM Implementation.

PREPARATORY PROCESSES

The process of village, sub centre & PHC level community monitoring would have been complete and preparation of village, sub centre & PHC levels score cards also have been complete.
The village level sharing meetings of the area would have been complete.
Screening of cases of denial of care for presentation.

Organiser - Members of PHC/Block Community Monitoring and Planning Committee.
Participants

Chief Medical Officer of the District or her/his representative.
PHC/Block Medical Officer.
Member of District Community Monitoring and Planning Committee.
Members of PRIs in the block.
Members of VHSCs.
Member of CBOs in the block.

CONDUCTION OF JAN SAMVAD

Jan Samwad can take place in four parts

Introduction to the Jan Samvad - by Chair of the Organising Group.
Presentation of the Cumulative Village Report Card and discussion on implementation of outreach services in NRHM.
Presentation of Cumulative Sub centre Report Card and discussion on improving Sub centre level service utilisation.
Presentation of Cumulative PHC Report Cared and discussion on improving PHC level service utilisation.
Presentation of Block Report Card and discussion on improving Block level service utilisation.
Presentation of Denial of Care/Adverse Outcomes - discussion on improving quality of care and support to cases.
Preparation of List of Recommendations for Providers, Facilities and Community.

NRHM Service Guarantees, IPHS & Community Monitoring

NRHM: A BOLD VENTURE

Launched on 12th of April 2005.
Seeks to provide universal access to equitable, affordable and quality healthcare, esp. to rural poor, women & children.
Aims to promote healthcare which is accountable and at the same time responsive to the needs of the people.
Help achieve goals set under the National Health Policy and the Millennium Development Goals.
Proposes an intensive accountability framework that includes community-based monitoring as one of its key strategies.

THE VISION

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Publication of Public Reports on Health at the State and the district levels to report to the community at large on progress made.

SERVICE GUARANTEES UNDER NRHM AT SUB CENTRE LEVEL

Maternal Health
- Antenatal care
- Intranatal care
- Postnatal care

Child Health
Family planning and contraception
Adolescent health care
Assistance to school health services
Control of local endemic diseases
Disease surveillance
Curative services
Training, monitoring and supervision
Record of vital events

SERVICE GUARANTEES UNDER NRHM AT PHC LEVEL

Maternal health
Family planning
Treatment of RTI/ STIs
Basic laboratory services
Referral services

SERVICE GUARANTEES UNDER NRHM AT CHC LEVEL

Care of routine and emergency cases in surgery and medicine.
24-hour delivery services including normal and assisted deliveries.
Essential and Emergency Obstetric Care including surgical interventions .
Full range of family planning services.
Safe abortion services.
Newborn care and routine and emergency care of sick children.
Diagnostic services through the microscopy centers.
Blood storage facility.
Essential laboratory services.
Referral transport services.
All National Health Programmes should be delivered through the CHCs. E.g. HIV/AIDS Control Programme,National Leprosy Eradication Programme, National Programme for Control of Blindness.

INDIAN PUBLIC HEALTH STANDARDS (IPHS)

To provide optimal expert care to the community and to achieve and maintain an acceptable standard of quality of care.
Help in monitoring and improving the functioning of public health centers.

CHARTER OF CITIZEN'S HEALTH RIGHTS

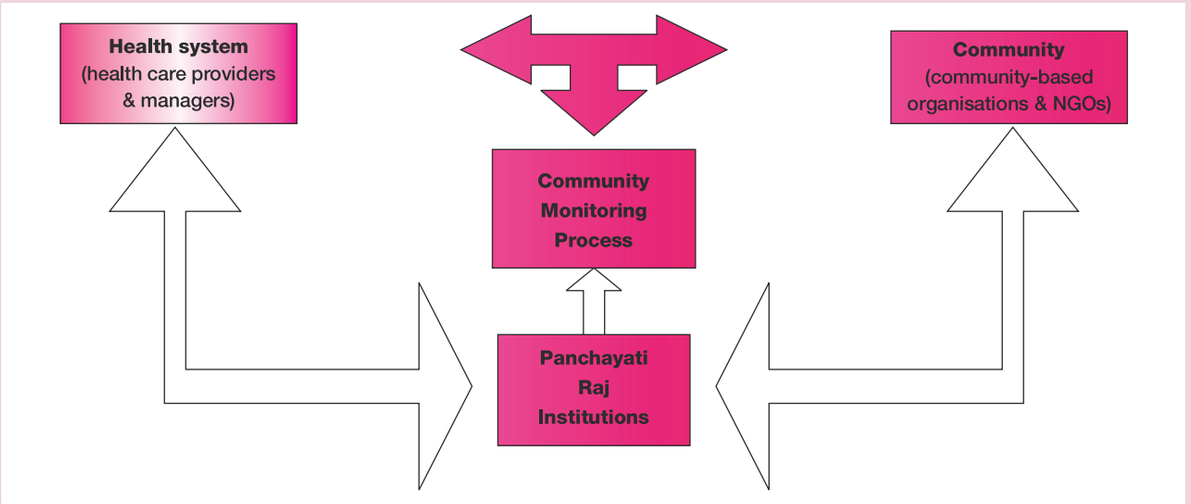
Seeks to provide a framework which enables citizens to know:

What services are available?
Quality of services they are entitled to.
Means through which complaints regarding denial or poor qualities of services will be addressed.

COMMUNITY MONITORING UNDER NRHM

Part of three-pronged process of accountability framework proposed in NRHM that includes internal monitoring & periodic surveys/studies.
Seen as an important aspect of promoting community led action in the field of health.
Places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.
Provision has been made through Monitoring and Planning Committees at PHC, Block, District and State levels.

COMMUNITY MONITORING: PARTNERSHIP



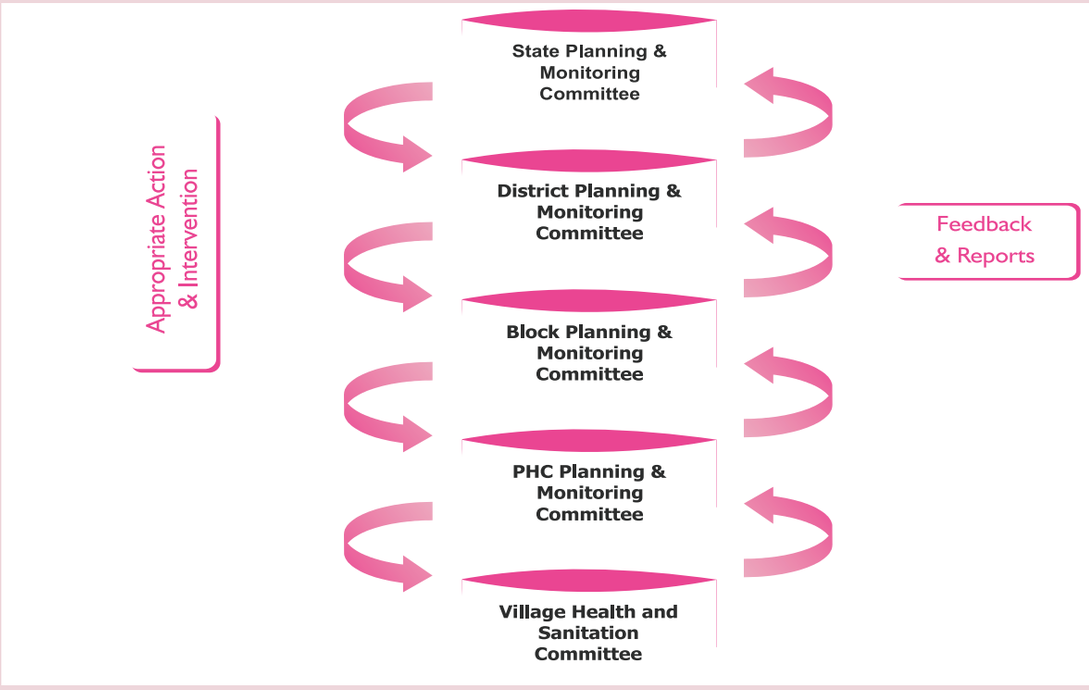
OBJECTIVES OF COMMUNITY MONITORING

Provide regular and systematic information about community needs.
Provide feedback according to the locally developed yardsticks, as well as on some key indicators.
Provide feedback on the status of fulfillment of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction.
Increase the community sense of involvement and participation to improve responsive functioning of the public health system.

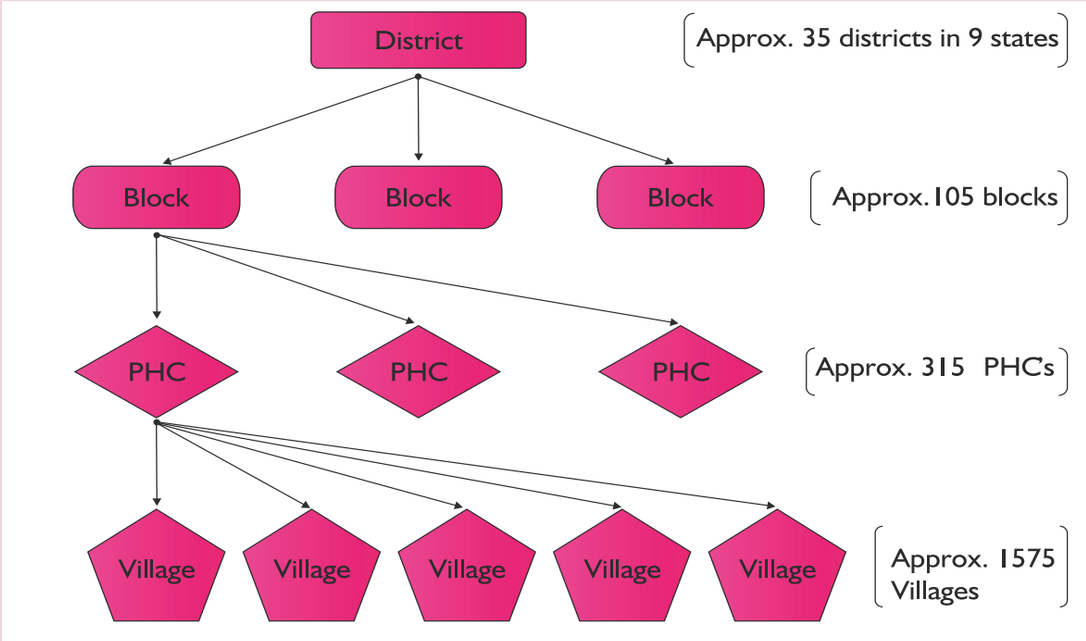
FIRST PHASE: INITIATION

Outlines of Community Monitoring process provided within the Framework of Implementation developed and elaborated upon by the Advisory Group on Community Action (AGCA).
Supervised at National level by a specially constituted Secretariat and Task Group constituted under the supervision of the Advisory Group.
States: 9 states (Assam, Chhatisgarh, Jharkhand, Karnataka, MP, Maharashtra, Orissa, Rajasthan, Tamil Nadu).

FLOW OF REPORT/ FEEDBACK & NECESSARY ACTION



PLAN OF IMPLEMENTATION



COMMUNITY MONITORING: DESIRED OUTCOMES

Change of perception about health.
Greater utilisation of public health service.
Increased availability of services.
Improved quality of services.
Reduced overall health expense.
Increased participation of excluded groups.

ADVANTAGES OF MONITORING AND PLANNING BY COMMUNITY

Advantage for health system

People's view point/feedback on services provided can be taken into account.
It helps in providing health services to a wider number of beneficiaries.
A relationship of mutual understanding and co-operation is built between people and public health employees.
Review can be taken on the extent to which the objectives of the health services are achieved.
Obstacles in achieving the objectives of health services can be identified well in time.
Transparency in functioning becomes possible while providing health services. Employees and officers at all levels become proactive.

Advantages for people

People get an opportunity and space to put forth their complaints regarding health services and to give their opinion about the health services they need.
Unnecessary expenses on private doctor are avoided as improved public services are utilised.
People learn in detail about the Government's health services and schemes. People do not remain mere beneficiaries of health services, rather they take on active role of participating in implementation of these services.
Certain health problems at the village level can be solved through everyone's cooperation.
The health system becomes accountable to the people.

Right's & Rights Based Approach

WHAT IS A RIGHT?

Minimum conditions/entitlements for the individual to live a life with dignity.
Underlying Assumptions;
- An authority which defines these minimum conditions.
- The recognition that every one does not enjoy these minimum conditions.
- A mechanism for identifying the gaps - violation and non-fulfillment of rights.
- A system that can fill the gaps, and provide JUSTICE.

AUTHORITIES & RESPONSIBILITY

Authorities

Must be articulated in Constitution, law or recognised custom.
Must emerge through international agreements and treaties.

Responsibility

Must be protected by the State.
Enabling conditions must be provided by the state.
Just as duty bearers require adequate capacity to perform duties, rights holders also require conditions necessary for claiming or demanding rights to hold duty bearers accountable.

CHARACTERISTICS OF RIGHTS

Rights are universal (for all; everywhere at all times).
Equality and Non-discrimination: All individuals are equal as human beings and by virtue of the inherent dignity of each human person.
Rights are inalienable (can't be taken away or given up).
Participation is a fundamental right (everyone is entitled to demand their rights…).
Rights are indivisible and inter-dependant (denying certain rights undermines respect for others).
Rights enable us to demand if necessary what is due, without having to beg for benevolence or compassion.
Rights are associated with Human Dignity and Respect for each and every person … a system and acceptance of rights contributes to personal self esteem.

SOURCES OF HEALTH RELATED RIGHTS IN INDIA

Indian Constitution - Article 14, 15,16, 21, 39, 42, 47.
Indian Laws - Sections of the IPC, Child Marriage Restraint Act, MTP Act, PCPNDT Act etc.
Policies - National Population Policy, National Policy on the Empowerment of Women, National Health Policy, National Youth Policy etc..
Programs - RCH program, Other national programs.
International Law and Agreements - Right to Health (ICESCR), CEDAW, ICPD PoA.

RIGHT'S BASED APPROACH

Aims to increase impact of programmes and strengthen sustainability by:

Addressing root causes.

Changing policies and practices.
Working together towards common goals.
Changing power relations.

RIGHTS PROMOTING ACTIVITIES

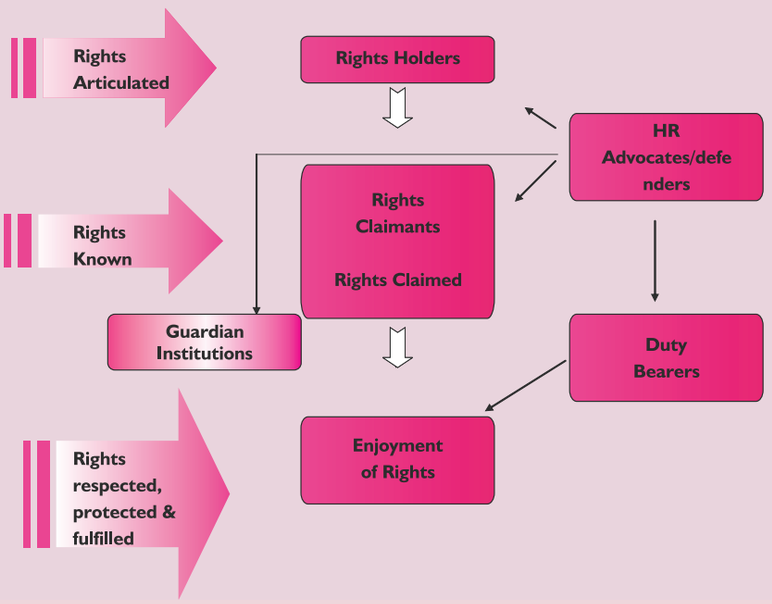
Rights/Entitlement Awareness.
Rights education - community and providers.
Community mobilisation/organisation.
Leadership development.
Building evidence - Case-studies, primary research, secondary data etc.
Sharing information - briefing kits, fact sheets, pamphlets, plays.
Media Advocacy - press conference, stories, opinion, editorial.

CLAIMING HEALTH RIGHTS

Asking for services, respecting the rules.
Filing complaints/making suggestions.
Dialogue with providers/managers/legislators, Representation, delegation.
Asking for grievance redressal/compensation.
Public hearing, social audit, legal action.
Direct action - dharna, protest, strike...

ACTORS IN RIGHTS BASED APPROACH

Rights holders - community (rights claimants).
Duty bearers - service providers, managers, bureaucrats, other government functionaries, guardianship institutions - courts, commissions etc.
Human rights advocates - us!



Role of Stakeholders & Organogram of Community Monitoring Programme

MAJOR STAKEHOLDERS

Accredited Social Health Activist (ASHA).
Auxillary Nurse Midwife (ANM).
Anganwadi Workers (AWW).
Panchayati Raj Institutions (PRI).
Non-governmental Organisations (NGO's).
District Administration.
State Governments.

ASHA

Health activist in community.
Counsel women on birth preparedness.
Mobilise community & facilitate them in accessing health & health related services available at Anganwadi/sub-centre/primary health centers.
Depot holder for essential provisions like ORS, IFA, chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.
Receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes & construction of household toilets.

ANM

Act as resource persons for initial & periodic training & also ensure that during training, ASHA gets compensation for performance & also TA/DA for attending training schedule.
Hold weekly/fortnightly meeting with ASHA & provide on-job training by discussing activities undertaken during the week/fortnight & provide guidance in case ASHA encounters any problem.
Guide ASHA in bringing beneficiary to outreach session.
Utilise ASHA in motivating pregnant women for coming to Sub-centre for initial check-ups and also take ASHA's help in bringing married couples to Sub-centres and motivating pregnant women for taking full course of Iron and Folic Acid (IFA).

AWW

Guide ASHA in performing activities such as organising Health Day once/twice a month at Anganwadi Centre & orientating women on health related issues such as importance of nutritious food, personal hygiene, care during pregnancy, importance of immunisation etc.
Depot holder for drug kits & will issue it to ASHA.
ASHA will support the AWW in mobilising pregnant and lactating women and infants for nutrition supplement. She would also take initiative for bringing the beneficiaries from the village on specific days of immunisation, health check-ups/Health Days etc. to Anganwadi Centres.

PANCHAYATI RAJ INSTITUTIONS

ASHA would be accountable to the community through the Gram Panchayat.
Village Health & Sanitation Committee (VHC), the standing committee of the Gram Panchayat (GP); Provide oversight of all NRHM activities at the village level.

Develop the Village Health Plan.
Support the ANM, ASHA, AWW and Self Help Groups.

Block level Panchayat Samitis will co-ordinate the work of the GP in their jurisdiction & serve as link to the DHM.

DHM will be led by the Zilla Parishad and will control, guide and manage all public health institutions in the district.

NON-GOVERNMENTAL ORGANISATIONS

In institutional arrangements at National, State and District Level.
Standing Mentoring Group for ASHA.
Member of Task Groups.
Provision of training, BCC and technical support for ASHAs/DHM.
Health resource organisations.
Service delivery for identified population groups on select themes.
For monitoring, evaluation and social audit.

DISTRICT ADMINISTRATION

Constitution of District Health Mission.
Preparation of integrated District Action Plan.
Constitution of HMS for district hospital, CHCs & PHCs.
Opening Joint Account of ANM & Sarpanch to manage Untied Fund.
Facilitation of village health planning.

STATE GOVERNMENT

Establish State and District Health Missions.
Integrate the multiple Societies for Health and Family Welfare Programmes at State and District levels.
Formulate State Action Plan .
Commit to undertake systemic reform, including devolution of powers to Panchayati Raj Institutions and decentralisation of the programme to district levels.
Ensure smooth fund flow.
Technical and MIS support.

ORGANOGRAM OF THE COMMUNITY MONITORING PROGRAM

AGCA - TAG

Conceiving and Planning the entire intervention.
Periodic review.
Support the relationship building with the state government.
Support the formation of State CM Mentoring Group.
Identify state level Nodal Organisation.
Technical inputs eg. Training designs, Community Monitoring Protocol, Jan Samwad protocols etc.
Distill lessons learnt.

National Secretariat

Assist in the implementation of the decisions taken by AGCA and support provided by AGCA-TAG.
Facilitate :
- Preparation of protocols and manuals.
- Preparation of IEC materials.

Coordinate between AGCA - TAG and State processes.
Document - Progress and Process.
Support state nodal organisation in implementing the CM project through.
Arrange for and if possible provide resource support.
Support problem solving.
Provide administrative and financial guidelines.
Facilitate financial disbursement and accountability.
Maintain overall accounts.

State Mentoring Group

Coordinate with State Government.
Prepare state level plan/design & budgets.
Identify districts & blocks.
Identify NGOs for district & block level.
Review progress at state level.
Distill lessons learnt from 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 decisions taken by CM Mentoring team.
Arrange for technical & resource support to district/block level NGOs.
Support process of adaptation, translation & 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 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.

District Nodal Agency

Coordinate with State Nodal Agency.
Coordinate with district officials - CMO; ZP, district mentoring team.
Coordinate with block agency and BMO.
Mobilisation and capacity building at district level.
Collation of records and reports.
Financial management.
Support for Organisation of Jan Samvad.

Block Level Agency

Mobilisation and capacity building at district and block level.
Organisation of Jan Samwad.
Encouraging participation of all stakeholders in CM process.
Facilitating balance of power between stakeholders - liaison with different stakeholders.
Declaring, Disseminating - health entitlements within rights based approach.
Reflect community/spokespersons of community concerns, experiences.
Collect and process information at the local level.
Orientation of community leaders.
Form committees at the village, PHC and block if such committees have not been formed.
Organise training at block and village level.

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