Community Monitoring of Rural Health Services in Maharashtra

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What happens when villagers are allowed to monitor their local public health facilities? India's National Rural Health Mission is making such accountability a reality through its community-based monitoring initiative. This article presents the first three rounds of data collected by village health committee members in Maharashtra's 225 pilot villages. The obstacles encountered by the process and its strengths and limitations are also discussed.

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This article is a contribution to the ongoing conversation about the merits, shortcomings and potential of India's National Rural Health Mission (NRHM). It specifically focuses on community-based monitoring (CBM) within NRHM. CBM is a form of public oversight where the rural communities that NRHM is intended to serve actively and regularly monitor the state of their local public health system as an input to improving the health services received by them.

The authors of this article are positioned to contribute insights into CBM because of their work at SATHI, a Pune-based non-governmental organisation (NGO). SATHI (which evolved from the Pune unit of CEHAT – Centre for Enquiry into Health and Allied Themes) has had a long-standing involvement with health rights activities in Maharashtra in partnership with people's organisations and grass-roots NGOs. SATHI is also presently the state nodal NGO responsible for facilitating the implementation of CBM in Maharashtra. Being one of the states included in the pilot phase of implementation of CBM, Maharashtra is the first in the country to include the CBM component of NRHM in its state Project Implementation Plan (PIP). This inclusion indicates the effectiveness with which this project has been implemented and the governmental support that CBM has found in Maharashtra.

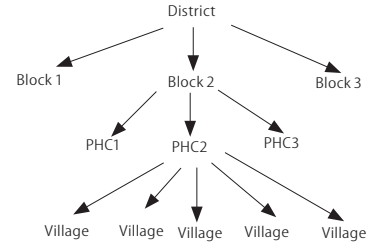
The first three rounds of community-generated data on village-level health services indicate that the CBM programme had an initial significant positive effect and is continuing on a positive trajectory into phase three, albeit more gradually. In this report we compare three sets of data from the initial 225 pilot villages: the first data gathered at the beginning of CBM in July-August 2008, the second round of data gathered in April 2009 and the third round gathered in October to December 2009. The quantitative data backs up qualitative reports gathered in public hearings called *jan sunwais*. Both kinds of data indicate that CBM in Maharashtra showed remarkable effectiveness between rounds one and two, but is perhaps approaching a plateau. CBM is credited with improving healthcare delivery and causing attitudinal shifts among government health workers, especially amongst the outreach functionaries, alongside raising awareness within communities regarding healthcare entitlements. Nonetheless, problems remain and there is evidence, discussed in this report, that the amount of improvement that CBM in its current form can bring about is perhaps reaching certain limits which need to be overcome through policy level actions.

While implementation over a three-year period is too short a time span to comment on the overall success or failure of CBM, in this article we discuss five key processes that have contributed to CBM's preliminary effectiveness in the pilot districts in Maharashtra. We highlight lessons from successes and challenges in the pilot phase that could provide useful insights for future CBM processes. We also point out and discuss several key tensions within the institutional form of CBM. In exploring these processes we seek to show the potential and limitations of this initiative as a credible model of public action in the health sector.

Background

NRHM was launched in 2005 by the union ministry of health and family welfare, under the United Progressive Alliance government. There are two key factors that facilitated the inclusion of CBM in NRHM. First, the architects of NRHM felt that introducing an officially sanctioned community monitoring programme would fill a critical gap in the Mission's validation system. CBM would act as the "third leg" in the monitoring system, joining the internal management information system (MIS) and the external evaluation surveys and audits. Second, the framework of CBM was significantly shaped by sustained people-oriented advocacy through networks such as Jan Swasthya

Figure 1: Structure of CBM within a District



Abhiyan (JSA), the Indian section of the People's Health Movement. JSA organised an effective right to healthcare campaign in 2003-04 and ensured that strengthening the public health system while making it accountable became a part of the political discourse in the 2004 general elections.

In 2006, the union health ministry constituted a panel of civil society experts called the Advisory Group on Community Action (AGCA) to support community-based action related to NRHM. The AGCA discussed the possible modalities for operationalising CBM and noted that CBM requires more complex and diverse partnerships compared to other elements of NRHM. They recommended that a pilot programme be implemented in selected districts in nine states of the country (Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu).

In accordance with the AGCA's advice, NRHM supported the CBM pilot project phase I in May 2007 in the nine pilot states, including Maharashtra. SATHI was selected as the state nodal NGO for coordinating implementation of this process. In Maharashtra, CBM was implemented in five pilot districts, covering 225 villages. Encouraged by the outcomes of the pilot phase of CBM, in March 2009 the Maharashtra government included CBM in the state's PIP for 2009-10. The plan mandated that CBM be extended to eight additional districts of Maharashtra, expanding the total statewide roll-out of CBM to 13 districts and 810 villages.

Basic Structure of CBM

CBM processes related to NRHM are organised at the village, primary health centre (PHC), block, district, and state levels. A state nodal NGO (SATHI in the case of Maharashtra) coordinates the CBM activities across districts in collaboration with the district and block nodal NGOs, working with the state health department. A monitoring committee at each level collates the findings from the level below, monitors the health system at its own level, and passes these results up to the next level two times a year (Figure 1). For example, the PHC monitoring committee collects results from the village report cards, monitors services in the PHC, and passes village and PHC information up to the block level monitoring committee.

Pre-existing 'Ingredients'

Maharashtra was characterised by certain pre-existing features, which were conducive to successful implementation of CBM.

First, there were already grass roots people's organisations (POs), community-based organisations (CBOs) and health advocacy NGOs with a strong community base operating in several districts. These organisations had been working with rural people to develop a basic awareness of health rights for several years. These existing relationships, nurtured through long-term association, made it easier for POs, CBOs, NGOs and communities to work together to implement CBM.

Second, Maharashtra has a history of action to demand community accountability of public health services, with strong support provided by CBOs across the state. For example, village health calendars were developed by the PO Kashtakari Sanghatana and used by communities for monitoring health services in Thane district in 1999-2000. In 2004, as a part of the JSA[1] right to healthcare campaign, health rights-focused CBOs played a key role in surveying public health facilities and documenting instances of denial of healthcare. Organisations in all the five current pilot CBM districts thus had experience of holding jan sunwais on health rights. When the district implementing organisations were selected for CBM in 2007, organisations already involved in such health rights activities were the natural choice for the state mentoring team.

Third, the Maharashtra government's health department displayed a basic willingness to support monitoring and engage in dialogue with communities and CBOs. From the introduction of CBM in mid-2007, state-level officials have been attending key meetings, attempting to address complaints and issues in a timely manner and overall displaying a level of genuine investment in the initiative. This is in contrast to the situation in some other states where health departments that are less open to community accountability processes have not provided continued support to the CBM process, either bringing it to a standstill or trying to dilute its independent, critical thrust.

We now move on to discussing five key processes that have made CBM in Maharashtra the positive force it currently is. We describe the various components that had to fall into place to make each of these processes possible, and highlight key tensions that continue to pose challenges. Following this, we move to an analysis of "outcomes", which provides an examination of preliminary data generated by CBM in the pilot villages showing the initial impact of this emerging initiative.

Process 1: Filling Health Report Cards

Building people's capacity to publicly rate health services

At the core of CBM is the act of tracking, recording and reporting the state of public health services in villages, as experienced by the people themselves. People need to know what they are entitled to in order to monitor whether it is delivered. They also need appropriate tools to record their observations.

These requirements have been met in two ways. First, village health, water supply, nutrition and sanitation committees (hereafter called VHCs) were formed, or, in many cases where they already formally existed, were significantly expanded. Second, village health report cards and related tools for community-based data collection were developed and, in some situations, adapted and simplified (see the box).

Box: Community Monitoring in Thane District

In Thane district, with its high proportion of adivasis in the population, several innovative modifications to these tools were suggested by implementing POs to increase accessibility for semi-literate community members. They helped develop a pictorial version of the questionnaire and village health report card where each question was written very simply and accompanied by a picture. Instead of using a numerical scale to rank services as 2 (good), 1 (partly satisfactory) or 0 (poor), images of a "full roti" for good, a "half roti" for partly satisfactory and no roti for poor service were used. This adaptation was an instance of an innovative practice, illustrating how local flexibility can lead to innovations that could be applicable in communities with similar special needs throughout India.

The VHC has 10 to 15 members, and is supposed to be selected during a gram sabha; more commonly in the CBM process the names of members emerged from smaller community-level meetings. In these meetings implementing organisations would introduce the idea of CBM and health rights to people in the villages. After the VHC was expanded, the members attended a one or two day training session on CBM, conducted by the block coordinator and facilitators from the block nodal NGO or CBO. In the training sessions, the VHC members were informed about how the public health system is structured, health rights entitlements in NRHM, and how to fill in the village health report card. The training aimed to motivate and build capacity of the VHC to play a proactive role in monitoring village health services.

Once the VHC was established and trained, they have been involved in the process of filling up the village health report card, with active guidance from the nodal NGO/CBO. Information is collected on the following indicators: village level disease surveillance services; maternal and child health services including immunisation, antenatal care and postnatal care; curative services at the village level; anganwadi services; availability of services and quality of care at PHC; utilisation of village untied fund; and adverse outcomes (denial of healthcare, maternal death, infant death). In the pilot phase, the block facilitator often played a key role in facilitating filling of report cards by the VHC members. Once they are filled, the village report cards are displayed in a prominent place in the village and a copy is sent to the PHC level monitoring committee for further dialogue and action.

Community members and block facilitators also fill out PHC and rural hospital report cards. A designated group of people visit their local PHC and/or rural hospital and mark the following indicators as poor, partly satisfactory or good: infrastructure (electricity, water, toilet, labour room, laboratory), services (infant delivery services, referral services, indoor services, laboratory services), human resources (MO, ANM, lab technician, driver, etc), and availability of essential drugs (stock of nine high priority essential drugs checked on the parameter of state guideline on minimum availability). They also conduct exit interviews with patients, asking them about indicators including the quality of service, behaviour of providers and whether they experienced any illegal charges or corruption.

Process 2: Jan Sunwais

Collectively raising voices for change

Jan sunwais are public hearings, attended by large numbers of local community members, POs, NGOs, government officials and prominent persons from the region. At jan sunwais, people are invited to report their experiences of poor health services and denial of care, as well as findings included in the village health report cards. The authorities present are then expected to respond to these testimonies, stating how the problems will be addressed. Under CBM in Maharashtra jan sunwais have been organised at the PHC level (42 hearings in the first phase and 45 in the second phase) and district level (hearings in each of the five districts in both the first and second phases) and in a few places at the rural hospital level. Thus, nearly a hundred jan sunwais have been organised in Maharashtra so far as part of the CBM process. It is important to note that though the jan sunwai strategy is not new, CBM is the first occasion that this strategy has been included as an integral activity for the public health system. This official mandate has helped implementing organisations ensure the presence of government officials in the hearing.

In these hearings, people have spoken passionately and movingly about problems with the availability of medicines, availability of medical personnel at the service point, inadequate ambulance services, irregularities in the provision of incentives, illegal charges, poor attitudes of service providers, instances of denial of health services and a number of issues with larger policy decisions. In many places, jan sunwais were often the first opportunity that communities had to publicly share their views about the local health services. Jan sunwais were also often the first time that health officials were held accountable and expected to respond to the health-related demands of villagers.

The health system's failure to provide basic care to meet even the low expectations of people was made apparent. A man said the following to the attending medical officer during the jan sunwai at his PHC:

> Please do not promise something which you know very well is impossible to provide. We don't want you to promise us guaranteed health services; just ensure that your doctors are present in PHC on the stipulated time and they behave properly with us (jan sunwai participant, Murbad).

Feedback from various implementing NGOs and CBOs indicates that jan sunwais have been an extremely effective tool of CBM in Maharashtra. They have brought many issues of denial of care to media and government attention. They have also brought about concrete outcomes where the PHC, block or district health officer issued orders for certain services to be improved or delivered. Some examples of such improvements are noted in the section on "outcomes".

Jan sunwais offered ordinary village people a direct face-to-face mechanism to communicate their personal experiences to medical officers and gave these officers a chance to respond. They also provided a mediation mechanism between programmatic design and systemic issues and local level implementation.

Our analysis of community participation in jan sunwais, and the impact of these hearings on local public health systems, revealed three key components which helped make Maharashtra's jan sunwais a success.

First were the report cards filled at the village and PHC levels. In filling the cards people became aware of what they have the right to expect from the health department in general and the local public health facility in particular. By making regular objective records of shortcomings, people's sense of being wronged was given legitimacy and made concrete. The report cards brought a renewed sense of hope to the people as well; no longer was denial of services expected and unremarkable. Recording problems, especially on government-supplied report cards, implies that something can and must be done about them. The report cards and the awareness that surrounded them helped generate the community level mobilisation required for the jan sunwais.

The second factor contributing to their success was the fact that jan sunwais and dialogue processes occurred at multiple levels. If they had only occurred at PHCs, the lower-level medical officers might have largely ignored them, not showed up, denied the testimonies or appeased the people with empty promises. However, since the PHC-level jan sunwais were followed up by district-level jan sunwais, lower government officials had to take them seriously, knowing their supervisors would hear of the problems reported. Moreover, after understanding that CBM is an officially mandated and ongoing process, the PHC staff was compelled to take the process seriously. The district-level jan sunwais provided a mechanism for rural people to report the actions of their local health officers directly to the district health officer and civil surgeon. The district medical officers were able to use jan sunwais to check up on their staff, seeing if they were actually doing what they were supposed to do. In cases where district level health officials were not enthusiastic about attending jan sunwais, state officials issued specific instructions that they must attend. The fact that periodic dialogue processes were being organised at the state level, with involvement of state health officials, also helped to add legitimacy to the district jan sunwais.

The form and location of the jan sunwais was the third factor enabling their success. They are direct communications between people and government, often held onsite at health centres. They constitute a unique form of mass mobilisation around health rights issues. They generate morally forceful and often moving stories that may inspire commitment to better performances and are certainly appealing to the media – another important factor in its own right.

Process 3: Networking

Linking up diverse civil society actors towards a common goal

CBM depends on the collective action of civil society organisations working at the state, district, block and village levels. The 2004 JSA Right to Health Care public hearings and the voluntary PHC survey discussed earlier were an early instance of such collaboration. In these instances, civil society organisations mobilised around short-term, clear goals. In contrast, CBM requires a long-term commitment to the multifaceted and evolving aims of NRHM. It also requires that the diverse organisations work not only with communities and each other but also with the government at all levels. The availability of hitherto unavailable funding from the government for CBM activities adds further complexity.

CBM in Maharashtra has been able to again harness the collaborative potential of the state's civil society organisations, but this time has done so in a more systematic, streamlined and sustainable way. The first phase required 15 diverse organisations to work with one another, with communities and with the government to make CBM work. POs and CBOs are generally membership driven organisations led by volunteers that are organisationally and financially supported primarily by their own membership. They publicly critique problematic policies or deficient programme implementation by the government. POs and CBOs are region specific and are concerned more with empowering processes rather than gathering data to measure specific outcomes. In contrast, NGOs are usually institutionally funded and may have no ideological opposition to government funding and partnership. Most POs and CBOs are grounded in various people's rights movements – some of which are not focused on health – while the NGOs are often more oriented towards the delivery of health services or fulfilling the health needs of specific social groups. There are also extensive ideological differences between different types of POs, CBOs and NGOs. How were these different groups able to cooperate?

First, these organisations found common ground in their commitment to a rights-based and community-centred approach to the health system. Second, each of the civil society organisations demonstrated an impressive willingness to adapt to the needs of CBM. Some of the NGOs have moved towards a more explicit focus on rights and raising awareness of entitlements. At the same time, the POs and CBOs have integrated systematic data gathering into their work. These adaptations can be thought of as "bringing rights to health organisations and bringing health to rights organisations". The third factor that facilitated collaboration was the early state level events that established common ground. The state level workshop and training of trainers (TOTS) events invited all concerned POs, CBOs and NGOs to the table with government representatives, and enabled participants to discuss their concerns and find common ground.

Process 4: State Level Dialogues

Enabling dialogue between civil society and the state health department

In the early stages it was largely considered an NGO initiative, despite CBM being an official component of NRHM. Although a few state government officials were sympathetic to CBM, it took extensive dialogue to bring the necessary critical mass of the state government on board. The state level dialogues, which took the form of state mentoring committee meetings and state workshops, were essential to the success of the pilot phase of CBM. They have generated the necessary state level government support for CBM and are an opportunity for civil society groups and government to develop a long term, mutually beneficial working dialogue.

Until the development of CBM there was no regular forum for community level groups to raise issues at the state level in ways that could elicit action. Under CBM, there are now officially mandated dialogues between the state and civil society every two to three months. These dialogues help to address issues that have not been resolved at lower levels and reinforce the commitment of the entire health department. They have proven instrumental to the development of CBM. One element that makes these meetings particularly fruitful is the simultaneous presence of state, district and block level health officials. The participation of these government representatives helps to assign responsibility to correct issues that are reported right away during the meeting itself. State officials benefit because they can use these meetings as a way to cross-verify reports from the district officers against community accounts. The meetings also provide an effective accountability mechanism since district officials know they will be held responsible at the state level meetings by civil society organisations.

Process 5: Media Involvement

Increasing public awareness and amplifying demands for accountability.

The media helped generate public awareness about the problematic condition of the public health system and the potential of CBM to improve it. When critical reports about the existing deficiencies in the public health services were published in local newspapers, district health officers and other functionaries took these issues seriously, often responded quickly and made efforts to address the issues at their level. Without media involvement the reports and jan sunwais would have been far less effective, would have received less attention from the government and would have led to fewer positive changes in the rural health system.

Several strategies increased the potency of media involvement in CBM. First, SATHI appointed and oriented media fellows to report on CBM-related activities. Second, SATHI convened a state media workshop. This workshop provided a forum to share preliminary data on healthcare deficiencies from 128 villages with the media, and helped reporters better understand issues associated with the quality of health services. The NRHM state director attended this workshop to give the official perspective. These strategies ensured that in the second half of 2008 over 120 news items concerning CBM in Maharashtra appeared in various newspapers, along with television coverage on several state level channels.

SATHI repeatedly encouraged media professionals to move away from focusing on sensational instances of denial of care and instead emphasise the unique process of community mobilisation, participation, and gathering data through the report cards. It was important that the empowering potential of CBM be emphasised, and that the agency of rural people in addressing their health issues be made central to the media image of CBM.

Outcomes

(a) Quantitative: Results of first, second and third round data comparison

This section presents the first, second and third rounds of CBM data from the initial 225 pilot villages. The CBM village health and sanitation committee members filled out their health report cards first in July-August 2008, then seven to eight months later in March-April 2009, then again seven to eight months later in October to December 2009.

The report cards marked health services using 11 indicators,[2] with each rated good, partly satisfactory, or poor. Each indicator received a rating based on the answers to three or four specific, predominantly quantitative, components. We emphasise that these measures are specific and largely quantitative to stress that the significant improvement in ratings between the first and second round is largely due to real improvements in service rather than changing opinions.

Graph 1 displays the average percentage of villages that scored each indicator "good" and "bad" in the first, second and third rounds. At the beginning of CBM, villages rated their health services "good" at an average rate of 48%. By round two, "good" ratings increased by 13 percentage points to 61% and by round three it increased by an additional 5 points to 66%. The average percentage of services rated "bad" by villages decreased from 25% to 16% to 14%.

Overall, we can see that a significantly greater percentage of villages ranked their health services "good" in the second and third rounds.

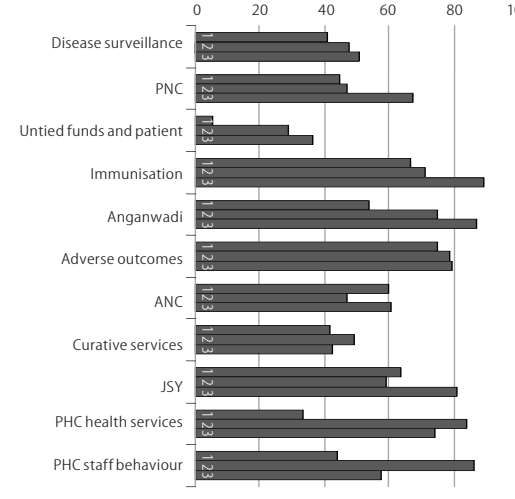
In Graph 2 we display changes in "good" ratings for each indicator. The first six indicators show a steady improvement across the three rounds while ANC and JSY exhibit a drop in "good" ratings for round two but a revival by round three. Curative services, PHC health services and PHC staff behaviour show an improvement between rounds one and two but a drop in quality by round three – although none drop to levels below those at round one.

Immunisation improved by 21 percentage points from 69% "good" in round one to 90% "good" in round three. Anganwadi services and use of untied funds improved by 33% and 31% points, respectively, between rounds one and three. PHC health services improved dramatically by 42% points from 32% in the first round to 74% in round three. ANC services showed the least improvement, with their 60% round three "good" rating only 1% point higher than round one.

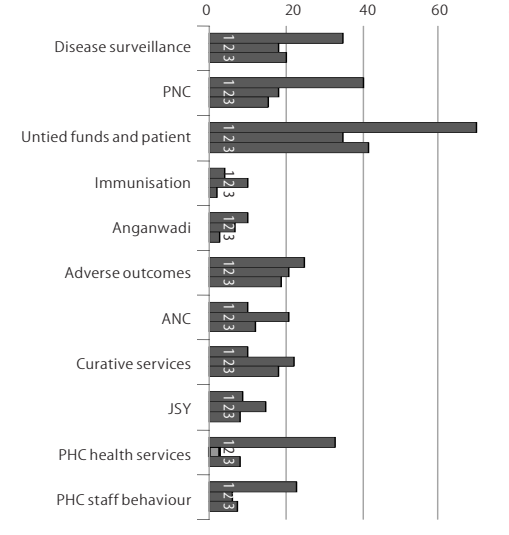
Graph 3 displays the changes in average "bad" ratings per indicator across the three rounds.

Graph 1: Average Per cent Indicators Rated 'Good' and 'Bad' during First, Second and Third Rounds CBM in 225 Pilot Villages in Maharashtra

Graph 2: Per cent of Villages That Rated Indicators 'Good' during First, Second and Third Rounds CBM in 225 Pilot Villages in Maharashtra



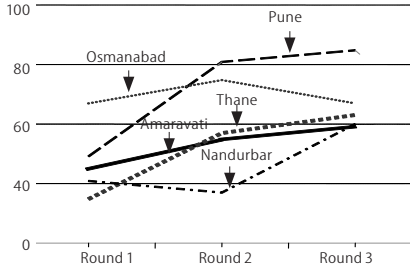
Graph 3: Per cent of Villages That Rated Indicators 'Bad' during First, Second and Third Rounds CBM in 225 Pilot Villages in Maharashtra



Almost every indicator was rated "bad" on average by less villages in round three than at the beginning, indicating overall positive outcomes. Three indicators showed a steady reduction of "bad" scores: adverse outcomes, PNC, and anganwadi services. Two indicators actually had a somewhat higher percentage of "bad" ratings by round three than they did at round one: curative services (8% higher) and ANC (2% higher). The use of untied funds and PHC services showed the most dramatic reduction of "bad" ratings, with 29 and 26 percentage point drops, respectively. Untied funds still remain the biggest problem though – and the slight increase in "bad" ratings between rounds two and three is cause for concern.

We now move on a disaggregation of village health service ratings by district. Graph 4 shows the average per cent of indicators rated "good" in each district across the three rounds.

Graph 4: Per cent of Indicators Rated 'Good' by District, First, Second and Third Round CBM in Maharashtra



Pune district showed the most striking improvement and, by rounds two and three, had the highest per cent of indicators rated "good". Osmanabad is the only district showing no improvement in percentage of indicators rated "good", although it remains the district with the second highest per cent "good" indicators, after Pune. Nandurbar's indicator ratings dipped slightly between rounds one and two but improved dramatically by round three. The remaining two districts, Amaravati and Thane, showed steady improvement across the three rounds, with about 60% of their services rated good by round three.

There are likely to be three components to the significant improvement of health services between the first and third rounds (except Osmanabad). First, and most obvious, is that health professionals are becoming increasingly aware that the community is regularly monitoring the services and community findings are being reported up the government hierarchy. This awareness surely motivates health workers to perform their duties more effectively. Second, there is feedback from implementing organisations that the community is learning to seek certain services that they were previously unaware of or uninterested in pursuing. As communities learn what they should be getting from the government and have a sense that the government has renewed its efforts to meet these commitments, perhaps more people are seeking these services. Third, and more difficult to observe (though expected as part of NRHM), is the possibility that those at higher levels in the public healthcare system are working harder at supporting village- and PHC-level healthcare providers through such actions as timely payments, filling empty staff positions and keeping medicine supplies stocked. Determining the amount that each of these factors contribute to the improvements will require further investigation.

(b) Qualitative: Additional outcomes reported by civil society organisations and at jan sunwais

At the PHC level, there are several anecdotal reports that patient attendance at a number of public health facilities has gone up (indicating increased confidence in the public system and a shift from the private sector), attendance of service providers has become more regular and illegal practices such as excess charging have reduced. In one case, a PHC doctor who used to have a "donations box" on his desk to collect illegal fees has, because of CBM, been forced to convert it into a "complaints box". All implementing civil society organisations have stated unequivocally that there has been some positive change in attitude among many of the health workers. In many blocks, discussions about health have become a village wide activity with women in particular using meetings to provide feedback to the auxiliary nurse midwives (ANMs).

In Amaravati, a village mobilised around the unjustified transfer of its PHC doctor, with around 325 people signing a petition that she be reinstated and presenting it at a district jan sunwai. One block coordinator stated that "people have a growing sense that their opinions about the public health department have some say in planning and functioning of the outreach and PHC services".

In a few instances, the empowering process of CBM appears to have spilled over into people's rights-based activity concerning implementation of other public services. For example, in one village, a

Table: Sample of Improvements Reported at Jan Sunwais

District	
Thane	• At the PHC level, laboratory services have improved, illegal charges have stopped and electric supply has improved by installing a generator.
	• In the outreach services, there is no longer a discrepancy between anganwadi records and independently taken weights of malnourished children.
	• Illegal charging by certain medical officers has stopped.
Pune	• Non-functioning subcentres are now functional.
	• The citizen's health charter has been displayed in every selected PHC.
	• As a result of repeated demands from the community as through CBM, new ANMs and MPWs have been recruited in some PHCs.
Nandurbar	• Some PHCs have now display boards stating the availability of various medicines in the PHC These displays are the result of state level discussions on the shortage of medicine in Nandurbar.
	• There is a documented improvement in the supply of essential medicines to PHCs.
	• Remuneration of beneficiaries under incentive based schemes such as Janani Suraksha Yojana (JSY) has improved in existing villages.
	• PHC staff attitudes towards patients have improved.
	• Immunisation coverage has improved in some villages.
Amaravati	• New ambulances have been provided to some PHCs.
	• JSY beneficiaries are being paid the rightful amount of Rs 700 rather than the Rs 500/- they were being paid before.
	• The number of out patients at PHCs has significantly increased in the CBM blocks
Osmanabad	• The Indian Public Health Charter has been displayed in every selected PHC.
	• The names of the PHC monitoring and planning committee members have been displayed in some of the PHCs.
	• The number of patients availing services from certain PHCs has roughly doubled since before CBM was launched.

group of people, many of whom were also closely associated with CBM, voluntarily organised a mass demonstration at the public distribution system (PDS), which is supposed to distribute subsidised food to poor people, and demanded a supply list from the owner.

Improvements that were reported across all the districts include an increase in the number of "out patients" and "in patients" in all blocks and the cessation of the practice of prescribing medicine from private external pharmacies. A sample of other specific improvements in each district is shown in the table (p 83).

At the state level, the government response to CBM has moved from being relatively passive to increasingly supportive. As mentioned earlier, Maharashtra was the first state in the country to include the CBM component of NRHM in its state PIP, a significant act of official recognition. SATHI, the state nodal NGO, has on several occasions requested assistance from the state government to facilitate CBM activities at the district level. The state government's response has generally been positive. For example, when some district health officers refused to attend jan sunwais, the state government, on request of the state nodal NGO, issued specific instructions for district health officers and other functionaries to attend these events and to be responsive.

Limits and Key Challenges

Systemic barriers to improvement

While not yet conclusive, it appears likely that improvements brought about by CBM will plateau off. Services or activities where the proportion of "good" ratings has generally not gone beyond the halfway mark through the three rounds are:

- Utilisation of untied funds
- Disease surveillance
- Curative services at village level

For each of these activities, there are basic constraints or entrenched problematic patterns of functioning that have prevented major improvements. The area with the poorest outcome is the use of untied funds. The sarpanch often has a vested interest in spending this money without consulting the Village Health and Sanitation Committee. In other cases, the local Integrated Child Development Services (ICDS) officials are known to direct the anganwadi worker to spend the funds as they see fit, rather than on areas that the village citizens consider a priority. Disease surveillance is another area rated "bad" or "satisfactory" more than half the time. This surveillance is to be carried out by MPWs though there are a large number of vacant MPW posts across Maharashtra. This high vacancy rate has led to continued suboptimal scores on this front. While ANMs are supposed to provide basic curative care for common ailments during their village visits, this duty continues to be considered a low priority by the health department and ANMs often do not receive the required medicine on a regular basis.

Hence while emphasising the positive value of CBM, we caution that it should not

be treated as a panacea for improving rural health services. The effectiveness of CBM is linked with the basic functionality and social responsiveness of the public health system. On its own CBM will not be able to effect drastic improvements in areas where deeper structural barriers or systemic constraints are operative. There will be a limit to how much services can improve through community monitoring alone, unless key governance issues afflicting the public health sector are not addressed effectively.

In addition, there is some tension surrounding conflicting goals within CBM. Particularly in the early days of CBM, the government saw community monitoring as a means of generating data. In contrast, health rights CBOs see CBM more broadly, as a key component of community led action. The official NRHM framework envisioned CBM as the third leg of the monitoring system. The first leg is the government's internal MIS and the second leg encompasses all the commissioned external surveys. In contrast to the government's goals, civil society organisations associated with this programme wanted to develop a shared model of CBM where there would be a synergy between the generation of data and community led action in the field of health.

There seems to be a growing acceptance among officials that community led action is integral to the CBM process. Yet some conflicts are bound to emerge since the traditional hierarchical relationship between functionaries and the community is challenged in a significant way. Media coverage related to CBM events, which may be critical and some times carries "sensationalised" reports regarding gaps in services, is generally not appreciated by public health officials. While there is evidence of an improvement in the health services across all pilot districts, further efficacy of CBM will also be dependent on the capacity for CBM to go beyond the peripheral staff in the public health system and to address key processes of governance and policy issues at the state level.

Future Directions

Despite its early success, great effort must be exerted to maintain momentum in Maharashtra and to ensure that CBM continues to move from the periphery of NRHM to its core. The fate of CBM is dependent on the success of two processes: first, continued effective community mobilisation around health rights and second, institutional acceptance by healthcare providers, from the state level down to the village level. Experience of the first phase of CBM in Maharashtra has shown that state officials are relatively cooperative and supportive of the initiative. However, the departmental formal decision-making process tends to be quite time-consuming. Key decisions must be made by top officials already occupied with many other issues, a situation that often leads to delays. In addition, district functionaries tended to perceive CBM as the imposition of a top-down government and NGO initiative with little linkage to the other elements of NRHM. This attitude has improved to some extent after the state level convention and culmination workshops, but additional efforts are required to ensure that district functionaries engage more fully with CBM processes. Another key challenge is to involve panchayati raj institution (PRI) representatives in the monitoring process. Earlier PRI members at block and district levels had shown little interest in the community monitoring activity, though there are some signs of involvement in the recent period.

CBM is in the process of expanding both within the original five districts and to eight additional districts in Maharashtra. Within the first five districts, CBM is expanding from 15 to 23 blocks from 225 to 510 villages. In the eight additional districts, CBM is to begin in 300 villages, bringing the total number of participating villages in Maharashtra to 810. However the selection of NGOs in the expansion phase has moved rather slowly due to delays at various government levels.

The facilitation of CBM is an inherently complex process. CBM seeks to significantly change the traditional vertical power relationship between educated, articulate healthcare providers and less educated, less influential village community members. The CBM model that has evolved in Maharashtra is a significant step for moving towards such equalisation of power. This model will go a long way towards making the health system accountable to ordinary people. Enabling citizens to monitor and hold accountable the government can become a vehicle for community empowerment and democratising social systems beyond the health sector. Food security and water supply systems are two areas where an appropriate model of community monitoring is urgently needed. Ultimately, CBM is about increasing government accountability to the needs of the people, and giving citizens a powerful voice in the issues that affect their lives.

NOTES

1 Jan Swasthya Abhiyan is the Indian chapter of the People's Health Movement, an international health rights network.

2 All indicators used a three-month recall period. The components of each indicator are listed below:

Disease surveillance: In fever cases, did MPW take a blood sample to check for malaria? Did he check water samples from wells? How many times did MPW or ANM visit the village in the last three months?

Curative services: If malaria was detected, did ANM provide chloroquine? Did ANM/MPW give tablets for fever, diarrhoea, cough and cold? In fever cases, when blood was taken for a malaria test, were malaria tablets immediately provided?

Adverse outcomes (infant mortality and maternal mortality): Did any mother die during delivery or within six weeks after? Did any babies die after birth within one year?

Untied funds and patient transport: The village gets Rs 10,000 in untied funds for health: Were you aware of this? Is a vehicle arranged, free of cost, in emergencies? Were there any health programmes in the village based on use of untied funds in past three months?

ANC (ante-natal care): How many check ups did each pregnant woman receive? Did each get iron pills? TT injection? Was each pregnant woman's weight checked? Did each get a pregnancy card in the first three months?

PNC (post-natal care): Did nurse visit within seven days of delivery? Are breastfeeding mothers getting food from the anganwadi? Are they getting the food regularly?

Immunisation: Has BCG been given to every child? When was last immunisation camp? How many times did ANM visit village in last month?

Anganwadi (child nutrition centre): Is the anganwadi giving the right amount of food to children? Did malnourished children get extra food? Compare government recorded weight of two malnourished and two regular children with actual weight at time of survey.

JSY (for SC/ST and BPL women): Did every SC/ST/BPL woman who delivered receive the requisite amount? Did the nurse take any bribe? Did anyone in the PHC demand money? Was there any trouble in getting this money?

PHC services: Was any additional amount taken beyond the cost of the case paper? Did the PHC tell you to get medicine from outside? Did the doctor check you properly? If a referral was made did they provide a vehicle?

PHC staff behaviour: Did staff in PHC behave well? Did the doctor speak courteously? Are you satisfied with overall PHC services?