An Evaluation Report

Developing capacities for using community oriented evidence towards strengthening health planning in Maharashtra state, India

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SATHI
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Alliance for Health Policy and Systems Research

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GLOSSARY OF TERMS

AGCA	Advisory Group on Community Action for the National Rural Health Mission
AMG	Annual Maintenance Grant
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
CBM	Community Based Monitoring
CbMP	Community Based Monitoring and Planning
CBP	Community Based Planning
CSO	Civil Society Organisation
DHO	District Health Officer
DHP	The District Health Plan
DHS	Directorate of Health Services
DLHS	District Level Household Survey
DPC	District Planning Committees
DPDC	District Planning and Development Councils
HMIS	Health Management information System
HMS	Hospital Management Societies
ICDS	Integrated child development Scheme
IEC	Information Education & Communication
JSY	Janani Suraksha Yojana (cash transfer scheme for institutional deliveries)
MD NRHM	Mission Director National Rural Health Mission
MO	Medical Officer
MPC	Monitoring and Planning Committee
MPW	Male Multi Purpose Worker
NFHS	National Family Health Survey
NGO	Non Government Organisation
NRHM	National Rural Health Mission
PHC	Primary Health Centres
PIP	Program Implementation Plan
PRI	Panchayati Raj Institution (Local self government institutions)
RCH	Reproductive and Child Health
RH	Rural Hospital
RKS	Rogi/Rugna Kalyan Samiti (Patients Welfare Society)
SDH	Sub District Hospital
SHSRC	State Health System Resoruce Center
SMPC	State Monitoring and Planning Committee
THO	Taluka (Block) Health officer
VHSNC	Village Health Sanitation and Nutrition Committee
ZP	Zilla Parishad (District Elected Representatives Body)

EXECUTIVE SUMMARY

This is an Evaluation of a Project on Decentralised Planning within the National Rural Health Mission. The goal of the project was to build the capacity of members of Block and District Monitoring and Planning Committees (including health officials) towards facilitating their use of evidence for decentralized health planning. And the specific objectives were, to:

- train about 30 health officials, elected representatives and civil society representatives from three districts for using evidence, including community based evidence, for improved health planning
- develop and implement a generalisable course on 'Using evidence for Health Planning' which would impart the skills of using evidence for district health planning and policymaking
- demonstrate a process of decentralized evidence based district health plan preparation, in at least one district of Maharashtra state

The Project resulted in 25 people completing the Course on Decentralised Planning, but most of the participants were from civil society organisations. Systematic efforts to select more candidates, additional efforts to overcome lack of participation of some key-holders in the first round of contact training; the good quality of specially designed guide-books; systematically organised training sessions and the substantial progress made by participants as revealed by the systematic evaluation --- all these together indicate that the SATHI team did well on this specific objective.

The Course Curriculum developed by this Project is both unique and innovative, although there is scope for some improvements. The Evaluation also brings out that although the Course was originally designed for all three stakeholders - health systems representatives, PRI members and civil society organisations - there were considerable challenges to recruit health officers and PRI members, and that these groups do need systematic knowledge and skill building in Planning. The training and block level workshops made a difference to how these stakeholders perceived their role in Planning and the effectiveness with which they were able to influence the RKS and the Monitoring and Planning Committees to include community priorities in Planning.

The Evaluation points out that the Course should include some essential critiques of the current situation. Also, for subsequent courses, the reading material can be modified to include reflections on the reality of decentralised planning, the barriers that exist and based on the current project, what can be done to address them.

The Indepth interviews show that there is some increase in the knowledge levels of members of Monitoring and Planning Committees. Knowledge increase among the few Government Officers and the elected Representatives who took the training, was lower than the knowledge increase among NGO representatives. All those interviewed felt that after the intervention, there is greater participation in the PIP process. The results of the greater participation reported by respondents include: reduction of unnecessary expenditure and saving of resources, meeting local needs, improvements in health facilities, better utilisation, and improved communication.

The participants for the Course from the three intervention districts - Amravati, Nandurbar and Pune - used their newly gained knowledge to orient village communities, Monitoring and Planning Committees and the RKS members. Several positive changes resulted, including changes in decision making related to expenditures from the VHSC Untied Funds. In six health facilities studied in two blocks of Pune District, between 59% and 21% of the RKS funds were used for issues identified through the CBM process. There were increased expenditures from the RKS funds as a result of the project. The frequency of RKS meetings increased as well as the record keeping showed improvements in one of the two blocks. The findings indicate that spaces created through CBM for participatory planning were being effectively used to resolve the community oriented issues through the RKS in the two Blocks. In the comparison block facilities, the RKS fails to serve as a platform where community oriented issues, although raised, are not acted upon.

The Evaluation also finds that based on capacity building for decentralized health planning, several issues which were raised through participatory processes such as the Jan Sunwais, meetings of the Block Monitoring and Planning Committees, PIP preparation process under Decentralised Health Planning process, have been addressed and included in the Block as well as the District PIP, and significant amount of funds have been allocated in the district PIP for these. This is a significant step forward in the process of ensuring that community based priorities are addressed during District Health Planning.

Enlargement of spaces for community based inputs in planning process has resulted due to communication with state level authorities and raising the issue in various state level meetings. An official circular has been released, this specifies that CBMP civil society representatives should be permanent invitees in RKS at PHC and RH levels in CBMP areas across Maharashtra.

The Evaluation also brings out that there is a potential for sustainability through different strategies - making Decentralised Planning an integral part of the Panchayati Raj framework (as it is meant to be), involving youth and children in campaigns for health rights and in community monitoring, involving other sensitive and rights oriented activists (like media persons, Human Rights activists) and ensuring they become part of the Monitoring and Planning Committees and the RKS.

Based on the lessons learnt, the Recommendations are:

- Enabling conditions need to be created before Decentralised Planning can become a reality. All barriers to Decentralised Planning in specific contexts need to be identified and addressed as mentioned below.
- Changes need to be institutionalised in both Planning structures as well as processes. For example, issuing circulars to ensure participation of civil society organizations, modifying the PIP formats and process.

- Until such time as community members become informed and skilled to enter the Planning spaces, NGO/Civil Society Members need to be part of the Planning Committees. It may not be advisable to prematurely exit civil society organisations from CBMP - whatever has been achieved would be jeopardized.
- Sufficient time has to be allowed for the consultative bottom up process. Adequate time for community based meetings and consultative processes at various levels should be ensured.
- Formats and Account Heads need to be changed to incorporate community priorities. Current formats do not have sufficient space to encourage expression of local priorities which do not fit in the narrow official framework.
- Investment is required in training and capacity building of all stakeholders - this is urgent and critical. Training curricula in Decentralised Health Planning have to be created for Health Systems representatives as well as PRI members, to equip them with practical planning skills - this will help in avoiding unnecessary expenditures.
- There is need to institutionalize capacity building of RKS members to enable them to effectively carry out facility level planning based on local priorities and needs. Institutions like the SHSRC along with experienced NGOs could be given responsibility for designing short orientation courses for RKS members, drawing upon the experience of workshops carried out in this Project.
- There is need for systematic orientation of district and block level officials involved in PIP development, regarding decentralized health planning and using community based evidence during the local planning process. The structured learning course developed as part of this Project could be used as a base for developing a state level course, which could be administered by SHSRC.
- There is need for wide dissemination of good quality training / orientation material for RKS members and PHC, Block and District level stakeholders involved in the PIP process. Booklets and training material developed in this Project could be used as an input for such material.
- The District is too large with very different contexts - perhaps the unit of decentralized Health Planning needs to be a Block rather than a District.
- Health Planning at the village level should be made a part of the Village Planning exercise. All the village funds should be considered holistically and determinants of health as well as health services' needs should be planned for holistically. Thus, Health Planning should be an agenda in the November Gram Sabha which is meant for considering the annual village budget.
- A module on Village Health Planning should be developed for the VHSNC and training on this for all VHSNC members should become an institutional requirement. Civil society organisations should be involved in designing and administering such training.

To conclude, it is important to emphasise the relevance of this Project. Although NRHM mandates communitisation and decentralised planning, these are not happening to the extent desired. This Project demonstrates the kinds of inputs that are required to begin making a positive difference in Decentralised Health Planning. It is important that Health Systems and policy makers recognise that there is presently a major disjunct between the aspirations of Decentralised Health Planning and Communitisation desired by NRHM, and the Planning procedures currently being followed. There needs to be a radical overhaul of the PIP processes and the RKS functioning. And finally, we need to recognise that Planning entails decision making and control, related to financial resources. There is power vested in these functions. Decentralised Planning is all about sharing power. Tensions and conflicts are going to be part of the struggle and these need to be managed in the interests of the larger social good.

1. Background and Context

1.1 Information Systems for Health Planning

The Government of India recognises that the availability of Statistics is essential for planning and monitoring the impact of various health services. Thus a Bureau of Vital Statistics was set up in 1964 to ensure collection and compilation of civil registration data, as well as certain epidemiological data. In 1970, the responsibility to handle hospital statistics and related matters was also entrusted to the Bureau. From 1976, the Bureau of Vital Statistics was recognized as State Bureau of Health Intelligence & Vital Statistics (SBHI & VS). Its main function as it emerges today is registration of births and deaths and not much else.

In addition to the above, the Health Management information System (H.M.I.S) consist of compilation of Monthly Indicator wise performance of all Health Programmes reported upwards - from the Primary Health Centres (PHCs) to the Districts and then to the Regional level, and the consolidated report is received at the State Level. The information is analysed, and feed back is given to various levels for improving performance. (http://hetv.org/india/mh/healthstatus/2001-census.htm)

Another source of health information are periodic major surveys undertaken by the Government such as National Family Health Survey, District Level Household Survey and National Sample Survey Organisation surveys. These surveys provide information about important indicators pertaining to access to health care, condition of Public Health facilities and other indicators such as expenditure of health etc. These surveys are done once in about four-five years and except for the DLHS are not disaggregated at district level. While they may be useful for studying overall trends related to health care access and health expenditures, they may not be adequate for ongoing District Health planning.

1.2 Existing Structures for Policy Making and Health Planning

Five Year Plans[1] of the Planning Commission contain sections on the vision, policy and financial outlays for different sectors like Power, Infrastructure, Industry, Education, Health and so on. The Planning

1 http://planningcommission.gov.in/aboutus/history/about.htm

Commission is given the responsibility of making assessment of all resources of the country, augmenting deficient resources, formulating plans for the most effective and balanced utilisation of resources and determining priorities. These plans are prepared once in five years.

Annual budgets. The annual financial statement of the Union government presented to Parliament is popularly known as "the Budget". The process includes preparation of the Budget by the Executive; its consideration and adoption by the Legislature; its implementation by the administration and government agencies; and post-evaluation of achievement and performance by the Public Accounts Committee. A similar process takes place at the state level also.

Key policy documents also provide direction for the Health sector. For example the National Health Policy released in 2002, emphasised increase in access by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. With the recent launching of the National Rural Health Mission[2] (NRHM) in 2005 there is a major attempt towards further decentralization of the policy planning process towards district level as well as state level.

1.3 The National Rural Health Mission - Favourable Policy Environment

One of the core strategies of NRHM is to empower local governments to manage, control and be accountable for public health services. This decentralized approach is evident in the plans for State Health Missions led by the state Departments of Health and Family Welfare, the District Health Missions to be led by the Zilla Parishad (District elected body) and the District Health Plan to be finalised by the District Health Society and the Village Health Plan to be formulated by the Gram Panchayat (Village representative body). The NRHM has created structures at each of these levels for the planning and implementation of the initiatives to be under taken within the Mission.

At the core of decentralization is the idea of addressing the local needs by involving the community. However prerequisites for effective formulation of the district health plan, in the true spirit of decentralization as envisioned in the NRHM, requires: a. high degree of local capacities to use various forms of evidence for planning, b. scope to allow community participation, c. availability of the required resources and, d. transfer of power to the district level. Although formal directives for District Health Planning have been issued in the recent period, these four essential components have been neglected in the way the district health plans are being formulated.

Currently district health plans are created through fixed guidelines for activities, protocols, targets to be achieved, performance expectations, issued from the State level, leaving very little scope for district health authorities to add district specific health issues and proposals, let alone communities or civil society organisations being able to incorporate community priorities and suggestions. The present structure of the district health plan is largely confined to standardised strengthening of physical infrastructure, training and capacity building, improving availability of critical manpower and supplies

2 http://mohfw.nic.in/NRHM.htm

and provisioning for defined health programmes. The scope for district authorities to identify local priorities or use local evidence with involvement of community and ensure corresponding resource allocation is very little.

However, there is favorable policy environment created by NRHM, and there is some scope for changing the dominant mode of formulating the district health plan in an evidence based and pro-people direction. This requires significant capacity building of the district level decision makers to identify local health priorities emerging from community level processes, creating good data base on district health situation, while promoting community participation in the process of preparing the plan.

1.4 Community Based Monitoring and Planning

Before the launch of NRHM in 2005, the Public Health system was mainly dependent on two forms of information and evidence - Health Management Information System (HMIS) and periodic assessments or evaluations done by external agencies. HMIS provides data which can be disaggregated till the household level, however the main limitation of HMIS is that it is not completely reliable since it is entirely based on reporting of activities by public health functionaries. Similarly, the problem with the external surveys is that they are infrequently done, and may not address specific areas of health service delivery which would need improvement.

In order to introduce an improved, triangulated system of validation, Community based monitoring was introduced (from 2007 onwards) as the third leg of this system of information and evidence. This is a significant health policy initiative under NRHM and advocates the comprehensive framework for Community based Monitoring and Planning (CbMP) at various levels of the public health system. One of the key considerations while designing this framework was not just to ensure accountability but also promotion of decentralized inputs for better planning of health activities, based on the locally relevant priorities and issues identified by various community representatives. CBMP is a complex activity where a range of stakeholders ranging from community members, service beneficiaries, service providers, NGOs, elected representatives and Health officials are involved. Keeping this complexity in mind, the Union Ministry of Health and Family Welfare initiated a national pilot in nine states of the country in mid-2007. One of the states where this innovative activity was implemented, and is now being further generalized, is the State of Maharashtra. In Maharashtra community monitoring is ongoing in thirteen districts covering Primary Health Centres and villages. While during the first phase (mid-2007 to mid-2009) the emphasis has been on community based monitoring, from mid-2009 onwards the component of community based planning is also being given emphasis.

1.5 Situation in Maharashtra

Under NRHM[3], a study was conducted in the state of Maharashtra to examine how data are used for decision- making at different levels of the health sector and to highlight impediments to improved data utilization. The survey covered officials and health managers from the central, state, district and below

3 http://nrhm-mis.nic.in/UI/Reports/Data_Utilization.pdf

district levels. It was intended to explore both the supply and demand side issues of data use. On the supply side, issues including the accuracy, quality and timeliness of data were explored. On the demand side, incentive structures surrounding data use, accountability issues, analytical skills and perceived training needs were assessed. The results showed that analytical and interpretation skills are necessary to improve data use in the sector. But skills by themselves are not sufficient. Linking financing to results achieved would create strong incentives for data use. Incentives are perhaps the most effective intervention that improves data use. The study concluded that the data use for decision making in the health sector could be improved through:

1. In service training in health management;
2. Providing training and capacity building, especially at district and sub-district levels. Having an agreed set of indicators of success and making sure they are widely known;
3. Rewarding individual or group achievement;
4. Promoting accountability and regular performance assessments.

1.6 District Planning Processes in Maharashtra

After formation of the Maharashtra State in 1960, the State Government adopted a policy of balanced development on the basis of district as a unit for formulation of Five Year Plans and Annual Plans. For this purpose, District Planning and Development Councils (DPDCs) were constituted in every district. The Minister in-charge of the district was the Chairman of these committees. However, the DPDCs have now been replaced by District Planning Committees (DPC) with the following mandate: The District Planning Committee shall be constituted in each district to consolidate the plans prepared by the Panchayats (rural elected bodies) and the Municipalities in the district and to prepare a draft development plan for the district as a whole.

The District Health Plan (DHP) is supposed to set out the goals and strategies that will enable the district to best meet the health needs of its population. The framework of the DHP is to be based on the challenges identified in an annual report for the previous year, and is to include details of the funding allocated to implement the proposed strategies.

Currently the District Health Plans are prepared by the District Health Officer and other district level officials, based on guidelines given from the State government, and are supposed to be formally ratified by the District Health Society. However, with the development of Community Based Monitoring activity and recent formation of the District Monitoring and Planning Committees, which have a mandate of informing and feeding into the District Health Plan, now the stage is set for Community based evidence to be incorporated into the District Health Plan, based on active community and civil society participation in the planning process. This is the background of the work attempted through the project being evaluated.

2. The Project

2.1 Goal and Objectives

The project proposed to build the capacity of members of Block and District Monitoring and Planning Committees (including health officials) towards facilitating their use of evidence for decentralized health planning. The specific objectives were:

1. By 2012, train about 30 Health officials and civil society representatives from three districts for using evidence, including community based evidence, for improved health planning
2. By 2012, develop and implement a generalisable course on 'Using evidence for Health Planning' which would impart the skills of using evidence for district health planning and policymaking
3. By 2012, demonstrate a process of decentralized evidence based district health plan preparation, in at least one district of Maharashtra state

2.2 Planned strategies/interventions

The strategies proposed in three intervention districts were as follows

- Structured Learning Course on Health Planning', for District and block health officials and civil society representatives from the select districts
- At District and Block levels, practical capacity building of members of District and Block Monitoring and Planning Committees in the three intervention districts.
- Facilitation of processes for inclusion of community based evidence in the district health plan and activation of the District Health Monitoring and Planning Committee.

The expected outcome of the project was an increase in the capacity of the members of District and Block planning committees in using evidence while preparing plans.

2.3 The Conceptual Framework

Planning has to be seen as an issue of Power. It is associated with decision making of financial resources. The process of preparing PIPs has been mystified and made complicated. The essence of Decentralised Planning as conceptualised by this project is to create awareness among the community about the

availability of funds so that demand for decentralised planning is created from below. *Figure 1 is an attempt to illustrate the conceptual framework.*

Figure 1: Conceptual Framework

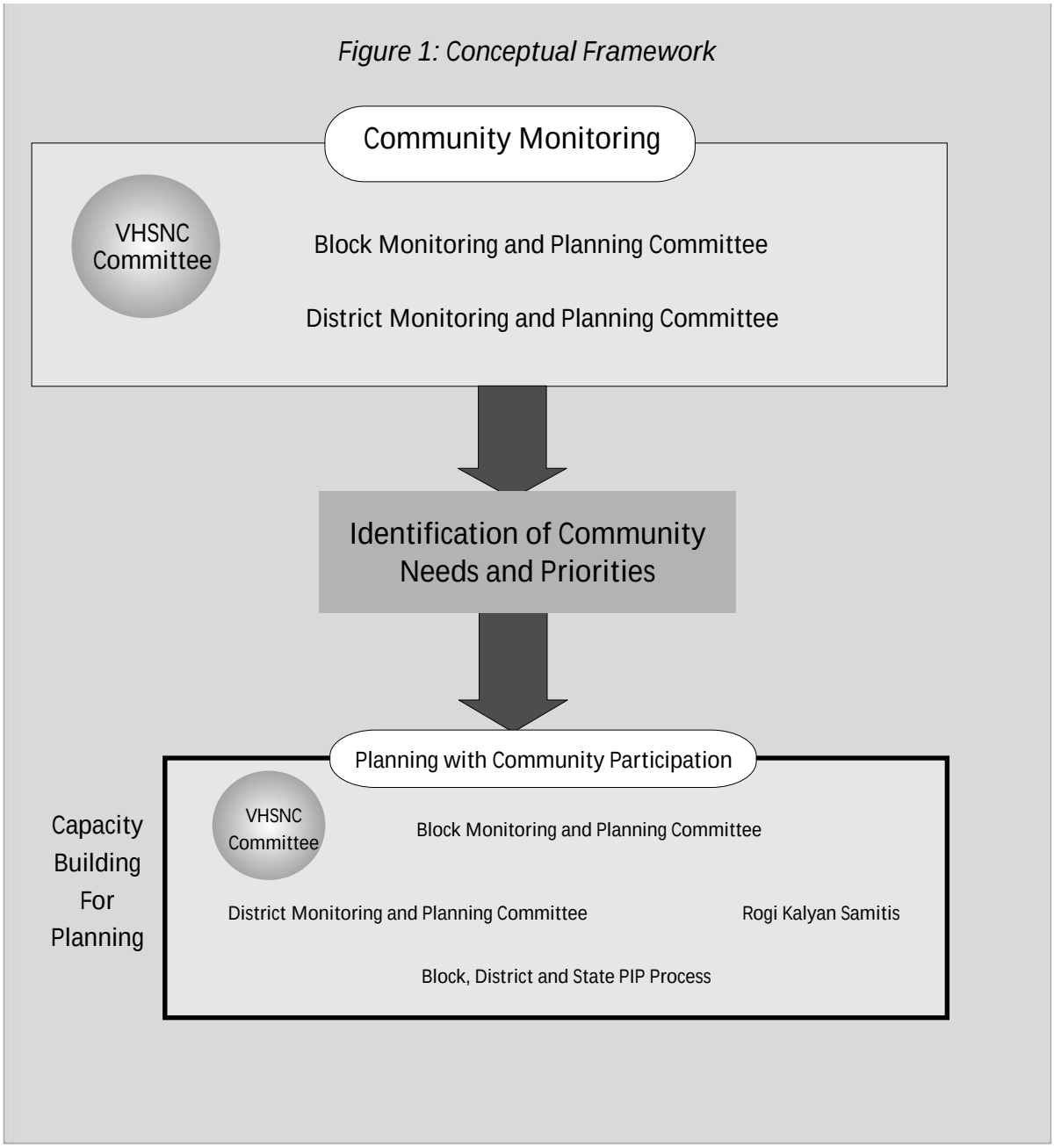


Figure 1 shows that the Community Monitoring process through the existing spaces - Village Health, Sanitation and Nutrition Committees, the Block and District Monitoring and Planning Committees - leads to identification of needs and priorities as experienced by the community. The existing spaces and processes - Village Health Plan, the PIP process - need to be utilised with informed community participation to bring the identified needs and priorities into the planning process. This is where capacity building for Decentralised Planning becomes very important.

Four key processes that are followed at the community level as part of community monitoring are:

A. Formation and capacity building, training of members of Village Health, Sanitation and Nutrition Committees

B. Periodic, systematic information collection about the performance, regularity and quality of the outreach and the PHC health services, based on tools which are used in community meetings and interviews of the beneficiaries at the village level.

C. Filling up of village and PHC report cards and analysis of this information.

D. Periodically sharing these findings in meetings and public hearings with relevant officials and ensuring corrective action.

The wide range of information collected at community and peripheral health facility level is an important independent source of evidence clearly delineating people's experience and actual functioning of public health services. Analysis of this collected information gives critical insights about community experiences about availability and quality of locally available health services.

Experience of collecting information in the process of community based monitoring shows that districts and blocks vary widely in needs, functioning of services and capacity of delivery systems thereby pointing to the need of decentralized, district specific planning. Valuable community based evidence which is being created through the process of monitoring can inform the process of planning on following parameters-

a. Functional status of infrastructure- e.g. electricity, water supply, labor room, laboratory and X-ray services

b. Actual state of Health services- e.g. outpatient services, delivery services, inpatient services, referral and ambulance services

c. Availability of essential medicines and supplies

d. Quality of services and behavior of providers

This rich community based evidence can be logically linked with the process of decentralized planning of health services. However such decentralized planning requires significant skills and expertise in identifying and prioritizing block and district specific health issues and suggesting strategies.

2.4 What was done in three years...

The geographical scope of the project as specified in the original proposal was three districts for capacity building of committee members and one of these three districts for promoting inclusion of evidence based proposals based on community priorities in the planning process. In actuality however, capacity building of representatives from thirteen districts was done, to attain a wider reach and impact; in this sense activities were carried out even beyond the formal project commitments.

I. Structured learning course on evidence base decentralized planning of health services

The Course was to be conducted in partnership with SHSRC, PRHN and SATHI. SHSRC had the responsibility of recruiting the health systems' participants. It was planned to include 30 participants in the Course from amongst health care providers, elected representatives and NGO/CSO representatives. Ultimately only three health systems' participants, two PRIs and the rest from amongst NGO/CSO partners could be recruited.

The following activities were conducted towards this Objective

- Development of a 6 Module Course in Marathi.
- Three contact sessions with 30 participants, for a total of 9 days.
- Dissemination of Modules and Teaching Material to participants as preparation for subsequent contact session.
- Ongoing development and production of Teaching Material.
- Concurrent evaluation of participants through Pre and Post Tests for the contact sessions.

For the last contact session, two groups of participants were included - 'old' participants and 'new' participants who were given a condensed course in Decentralised Health Planning. Parallel workshops were conducted for the two groups, with some overlapping sessions.

Thirteen of the thirty participants were from the three direct intervention districts - six from Amravati, four from Pune and three from Nandurbar. They applied what they learnt through this Course to facilitate the Planning process in the six intervention blocks in the three districts.

II. Capacity building activities for District and Block Monitoring and Planning Committee members for evidence based health planning

The following activities were done as a part of the capacity building.

- District level workshops were conducted in Amaravati, Nandurbar and Pune districts for members of respective Monitoring and Planning Committees. Thirty seven participants attended these workshops.
- Orientation programmes for Rugna Kalyan Samiti members and Monitoring and Planning Committee members about NRHM flexible funds.
- Block level workshops were conducted in Amaravati, Nandurbar and Pune Districts.
- Activities at grass root level like village level meetings with community and VHSNC members for creating awareness about the health planning process. Development of publications like poster and booklet on role and responsibilities of monitoring and planning committee member.
- An intermediate evaluation of the process of capacity building - assessment of knowledge and skills of Block and District monitoring and planning committee was done periodically.

III. Materials produced for orientation for evidence based health planning

A poster was published on appropriate utilization of NRHM funds as per the guidelines given by Government. Also one booklet was published giving detailed information about the constitution of Rugna Kalyan Samittee (RKS), role and responsibility of members of Rugna Kalyan Samittee vis a vis utilization of NRHM flexible funds. All these publications have been widely disseminated during community meetings, orientation workshops and convention for members of different committees in Amravati, Nandurbar, and Pune as well as other two districts (Osmanabad and Thane) where Community Based Monitoring and Planning process is being implemented.

IV. Collection and Analysis of Evidence for Planning

Evidence was collected in the 5 districts where Community based Monitoring was being implemented, in order to prepare health plans for the year. Services and facilities which were rated 'Serious' and 'Partially satisfactory' (i.e., 'Red' and 'Yellow' colored respectively) were used as the basis for decentralized planning inputs. Additional information required to prepare these plans was collected by visiting the health centre, interacting with health officials and community. Forums like the Jan Sunwai were specifically used to discuss people's alternative plans, besides raising consistently unresolved issues. Primary analysis of data was done at the local level by members and facilitators of the nodal NGOs. Identification and prioritization of health issues based on data analysis was a key input for decentralized planning.

V. Facilitation of processes for inclusion of community based evidence in District Health Plans

Various steps were taken in order to facilitate the community participation in the preparation of Program Implementation Plan (PIP) under NRHM in specific districts. These were:

1. Identification of issues emerging from Community Monitoring process as an input to preparation of proposals for PIP for coming year. Key issues were identified during implementation of different CbMP processes such as data collection, preparation of report cards, Jan Sunwais and CbMP committee meetings etc.

2. Orientation workshops/meetings with PRI members and key Health officials at different levels to discuss issues which need to be included in coming year's PIPs.

VI. State level advocacy workshops

In order to facilitate the community participation in decentralised planning of health services, SATHI organised a State level advocacy workshop in Mumbai on 3rd August 2011. In this workshop two members of the National Rural Health Mission's Advisory Group for Community Action (AGCA) were invited to review the Maharashtra CBMP process and also to interact with State level officials and emphasise the need for inclusion of community based evidence in the District Health Plans. District and block coordinators from five districts were also invited for this workshop. Various strategies for inclusion of the community level evidence in the preparation of the official health plans were discussed.

A State level consultation was organised on 19th January 2012 in Arogya Bhavan, Mumbai to discuss the

proposals submitted in respective districts with State level Health officials. In this consultation, representatives of civil society organizations implementing CbMP in 5 districts and State level NRHM officials as well as the Director of National Health System Resource Centre, participated.

VII. Exposure visits

The first such visit was to Tamil Nadu. In order to understand the process of decentralised planning in the state, two members of the SATHI team went to Tamil Nadu for a six days exposure visit. The objective of this visit was to explore the possibility of adapting some key strategies observed there in the State of Maharashtra.

The second exposure visit was to Kerala. A study tour was organized from April 8 to 18, 2012 to understand the Decentralised Planning process, health services and overall socio-political situation in Kerala. A total of 18 people went for this study tour, including activists from five districts- Amravati, Nandurbar, Pune, Thane and Osmanabad- and members of the SATHI team.

Box 1 : Lessons learnt from the Kerala study tour

1. We can conduct meetings and guide the Arogya Samiti in each village on how to undertake planning for health at the village level, and what processes should be used for the implementation of these plans.
2. Provide detailed information about the PIP process to the people's representatives and the VHSNC in the village, and involve ourselves in the process while preparing the PIP in the village. We can also attempt to solve problems which have remained unaddressed till now.
3. We can push for decentralized planning of funds by increasing people's participation in the planning workshops at the PHC and RH level.
4. If the health system in the village is not sufficient, then we can give suggestions to the Zilla Parishad at the District level, about a possible alternative system and its planning.
5. If health workers and doctors are not present at the health centre, then we can inform the higher officials at the earliest through a report with the help of panchayat representatives.
6. We can create awareness at the village level that the Government health service is meant for us, the people and hence we should make full use of this facility.
7. Health issues cannot be solved just by the health system, so we can meet the panchayat representatives and explain how they can help in solving the problems in their respective villages.

Source: Report of Study Tour, SATHI

VIII. Initiation of end project evaluation and conduction of various studies and analysis

According to the project proposal, four types of activities were to be monitored /evaluated:

1. Structured Learning Course on 'Evidence based Decentralized District Health Planning'

2. Capacity building workshops for DMPC and BMPC members

3. Collation and analysis of evidence for planning

4. Enrichment of District planning process based on inputs of evidence

The monitoring and evaluation plan is given in Annexure 1.

In accordance with the Monitoring and Evaluation plan the following were done:

- Analysis and evaluation of the Structured Learning Course was initiated.
- Indepth interviews with a cross section of participants of the capacity building workshops were done.
- A study on analysis of RKS Funds Utilisation in Pune district was done to assess effects of capacity building of RKS members.
- A comparative analysis of PIPs from two project blocks - Bhor and Velhe - and one non project block - Mulshi - was done.
- The planning outputs were compiled and assessed in one project district.

2.5 Methodology for the Evaluation

2.5.1 The various components of the project were evaluated separately.

2.5.1 The Structured Learning Course on 'Evidence based Decentralized District Health Planning' was evaluated by a public health specialist by assessing the course content and comparing the pre and post test scores of the participants.

2.5.2 The effects of the Capacity Building Workshops for members of the District and Block Monitoring and Planning Committees were assessed through indepth interviews with a cross section of participants. The rationale was to evaluate the impact of training inputs on the knowledge and skills of the participants, gauging whether these inputs have enabled them to play an enhanced role in the local health planning process and whether this process has become more participatory as a result of capacity building. In this study, semi structured interviews were used as the method of data collection.

This evaluation was conducted with key informants who are members of the Block and District Monitoring Committees, and who have been provided training and capacity building inputs by the SATHI team. The committees consist of various stakeholders and the selection ensured that a representative from each key category of stakeholders (Health officials, Panchayat representatives, Civil society representatives) was interviewed. A total number of 27 participants were selected. There were 3 persons from each committee, 3 committees from each district (two block level committees and one district level committee), taken from total of 3 districts (Pune, Amaravati, Nandurbar). Hence a total of 6 block level committees and 3 district level committees across 3 districts were covered for the study. The sampling was purposive. The selection of respondents was done on following basis-

- Representation of different stakeholder.

- Period of association and involvement of committee member in the decentralized planning process during project period.

There were chances of selection of more than one person. In that case, the person who was associated or involved for the longest period was selected.

Annexure 2 is the interview guide.

A senior consultant and a professional investigator were appointed. The investigator visited the participants at their respective workplaces, to conduct the interviews. Each interview took about 30-45 minutes. Informed consent was sought and based on consent, interviews were tape-recorded. The interviews were transcribed. The senior consultant analysed the interviews.

The evaluation was conducted during last quarter of year 2012.

2.5.3 A small study was undertaken to compare the effects of the planning workshops in on the utilisation of Untied Funds in two project blocks and one non project block.

The planning outputs were compiled and assessed in one project district.

2.5.4 In order to assess the impact of the intervention, proposed PIPs from two intervention blocks - Bhor and Velhe were collected and a comparative analysis done with proposed PIP from the control block - Mulshi in Pune district.

2.5.5 PIPs were collected for the six intervention blocks and three districts for 2011-12. They were analysed to assess the extent of inclusion of community evidence.

2.5.6 A half day workshop was conducted with CSO representatives from the three intervention districts to elicit their perspectives on achievements, challenges and lessons learnt through this Project.

3. Results of the Project

This section reports the Evaluation of different components of the Project - what it has been able to achieve against what it had set out to do and the quality of the various products. The first section is the Evaluation of the Structured Learning Course on 'Evidence Based Decentralized District Health Planning'. This evaluation was done by an experienced public health specialist. His report is reproduced below. This is followed by a section that contains perceptions of participants of the workshops on Decentralised Planning. The third section analyses the various ways in which the training inputs were actually translated into the Planning processes at the Block, District and to a lesser extent at the State levels. And the final section contains the perceptions of representatives of CSOs in the three intervention districts.

3.1 Evaluation of the Structured Learning Course on 'Evidence Based Decentralized District Health Planning' (Dr. Anant Phadke)

At the outset, a clarification is in order about the meaning of the term 'Health Planning' and the scope of this project. Health planning in the real sense of the word involves harnessing and use of resources to achieve socially defined objectives as regards health and health care. Out of this broad process, a project such as the current one can cover only a small area. This project was designed to develop capacity of some key-stakeholders' representatives in the planning and management of Public Health Services up to district level; concretely, based on the evidence generated during the Community Based Monitoring (CBM), in one district this project sought to influence things like the use of Untied Funds and proposed innovations in the Project Implementation Plan (PIP).

It may be noted that the other major components of health planning like planning to improve direct determinants of health, to improve private health services, to improve Public Health Services above district level upto highest level of decision-making --- all these major areas were outside the scope of this project. Even then the attempt to improve decentralized planning process as outlined in the orientation-training of this project, is an essential first step that needs to be taken from the village level upwards, to make improvements in the Project Implementation Plan for the district. In the current context of more or less exclusion of the community from the planning process, this first small step was also a big challenge.

3.1.1 The learning course and the participants

This learning course spanning a year seemed to be well thought out. It included both self-study and contact sessions. There were three contact sessions of 2-3 days each and at the end of each contact session the progress made in the understanding of the participants was objectively assessed with the help of a simple test. The curriculum was completed in three contact sessions.

Though the geographical scope of the project was three districts, representatives from five districts of Maharashtra (Pune, Thane, Amaravati, Nandurbar and Osmanabad) where Community Based Monitoring (CBM) of Public Health Services is presently underway, were included in this training process. The idea was to attain a much wider reach and impact. The course was conducted for a few selected health officials, civil society representatives and PRI members from these districts. The original proposal mentioned 30 participants but 25 completed the Course.

There were difficulties in carrying out the training as planned. Twenty four candidates from five districts had applied and were selected for the course. However, out of the 20 candidates selected for this training, 18 were from various NGOs involved in implementing Community Based Monitoring in three districts and two were District Programme Managers from two districts. One of them was unable to attend all the contact sessions. Due to the involvement of the State Health Systems Resource Centre, the District Health Officers in the concerned districts received official advice to send candidates for training. Yet the participation of Health Officials in this training was very limited. In spite of attempts to involve PRI members in the course only two PRI members applied and they were selected. However, both of them could not attend the contact sessions due to other commitments.

Box 2: Efforts made by SATHI, for ensuring participation of Government officials in structured learning course

For ensuring the participation of Government officials, permission was necessary. We wrote to MD-NRHM, Maharashtra and they issued a permission letter to all concerned Government officials. This letter facilitated participation of Government officials who were under NRHM. Three District Programme Managers were selected for the Course. But this order did not work for those Government officials who were permanent and regular in Public Health system.

In order to get permission for their leave, we discussed this issue with the Directorate of Health Services (DHS). After two rounds of meeting with DHS, we understood that DHS also does not have authority to sanction leave; all types of leave are sanctioned only by the Ministry through a lengthy and time consuming process. Keeping this scenario in mind, at last we decided to go ahead with limited participation of Government officials.

Source: Personal Communication with Project Coordinator, June 16, 2013

SATHI made some systematic efforts to overcome this deficiency in participation by key-stakeholder-representatives. Apart from efforts to increase the participation of those candidates who were invited in the first round of training, SATHI made efforts to involve District Programme Managers and selected Health officials at Block level in the three intervention districts by contacting them and by giving them course material and also by conducting orientation workshops within the districts. Secondly, in order to ensure that more optimum number of participants benefit from the course, at the time of the third contact session, 10-12 additional representatives of civil society organizations who were part of the decentralized planning process but had not participated in the course, were invited. A condensed two days' orientation course was conducted for them on the topics covered in the previous two contact sessions. These two additional efforts brought the total number of participants to 25.

For the third contact session, participants were divided into two groups. Group-A consisted of old participants who had attended the previous two contact sessions and Group-B were new participants who were attending contact session for the first time. While some key sessions were conducted as common sessions for all participants from both the Groups, some sessions were designed separately for the original and the new group so that both could be trained appropriately.

For these two different groups separate pre-test and post-test questionnaires were developed to assess the impact of the training on knowledge and understanding of the subjects covered in this third round of contact training.

The design of the training sessions and harnessing of various resource persons to conduct various sessions indicated that SATHI has made systematic efforts.

Box 3 : Innovative Training Methodologies

Third contact session -first session began with an innovative exercise in which the participants were asked to come together and create a model of their dream or ideal healthy village. The rule was that each one was required to participate in the process and the model village could be created with the help of available material within hall such as bags, water bottles, card sheet papers, markers etc. as well as from outside the hall such as flowers, leaves, stones etc.

Within half an hour, a beautiful model village had been created with available resources. Participants created roads, Health centers, Anganwadi, schools and public toilets and so on, facilities required for maintaining Health of each individual in the village. Once the model of the village was created, there was a discussion and the conclusion of the discussion was that there are lots of gaps between the present situation and their notion of the ideal village, such as, inadequate number of Health institutions, schools, human power and quality of services etc. In order to solve the problems, participants felt that they have to occupy every space which is available in Government systems in the context of decentralized planning. One participant expressed that these gaps can be solved through people's participation and for that we have to come together and work hard.

Source: Interim Technical Report, April 1 to December 31, 2012, SATHI

All these efforts and planning indicate the readiness of SATHI to overcome unforeseen problems in the planned training course and readiness to take extra, systematic efforts to achieve the project objectives and also to go beyond these .

3.1.2 The Guide-books for the trainees

The training/orientation material in Marathi was specially developed by SATHI for this course as no ready-made appropriate material was available. It consists of six small guide-books of 30 to 70 A-4 size pages each, a total of about 240 pages.

Training in the proper sense of the word is to be geared around learning objectives i.e. the specific tasks that the trainees would be able to do at the end of each training session. Given the nature and objective of this orientation course, except for a few sessions, this 'training' was naturally not geared around such learning objectives; it was more of an orientation course to develop an appropriate perspective, knowledge-base of the key-stakeholders in order to enhance their capacity to use evidence in decentralised district planning process.

These small guide-books have drawn liberally from the material already available in Marathi on the relevant subjects - various booklets, manuals, articles from SATHI itself, and from other NGOs like MASUM and TATHAPI. The manuals in English from Public Health Resource Network were also used as a resource. These guide-books are more of summarized, rendered collation of material from various sources and many SATHI staff members have played a role in compiling them, thus making it a collective effort.

Overall, as explained below, barring certain gaps and problems, especially in guide-book-III, the material in these guide-books is good. The welcome features of these guide-books are - simple lucid language, clarity of ideas, avoiding burdensome information-overload, appropriate diagrammatic illustrations and appropriate linkage to the issue of people's involvement in shaping of health services. These features make these guide-books a very useful reading material for the trainees of this course. Below, the overall content of each of these booklets is outlined, and some very brief comments have been made on each of the guide-books.

Guide-book I- This orientation-guide is devoted to perspective building about rights, development, and gender in relation to health. Part-I deals with rights based perspective and health rights. There is some detailed material available in Marathi on these issues. But this guide-book gives a good summary appropriate for the trainees of this course. The same can be said about Part-II and Part-III of this guide-book, which deal with equity and gender in health respectively. The short pieces on gender-sensitivity and the health care system would be quite enlightening for the trainees.

Guide-book II- This orientation-guide gives an introduction to the organogram of Public Health Services in Maharashtra and to some key National Health Programmes including the National Rural Health Mission (NRHM). The organogram of Public Health Services at district, regional and Mantralaya level is quite useful and is not available in any book in Marathi. There is a chapter each on main problems of the design and functioning of the Public Health Services, of the National Health Programmes and of NRHM.

This guide-book contains some specific suggestions for strengthening, reorienting the Public Health Services.

With this critical 'priming' about the Public Health Services, the last chapter introduces the issue of decentralized planning at district level and below, of the Public Health Services under NRHM. It points out some problems and limitations of the current mechanism of 'decentralised' planning and at the same time points out what role Community Based Monitoring (CBM) can play in this context. It gives a few illustrative examples of the improvements made due to the CBM process in the current planning from village level up to district level, mainly as regards use of Untied Funds.

Overall this 65 page guide-book combines a good critical introduction to the structure and functioning of Public Health Services in Maharashtra and links this understanding with the practical issue of what improvements CBM can do in the ongoing process of planning of Public Health Services at local level..

Guide-book III- This slender guide-book of 31 pages deals with people's participation in the decentralised planning. Conceptually this guide-book is weak and problematic. It does not distinguish between the official tall talk about decentralised planning and the harsh reality of actually increased centralized control over decision-making and resources in India. Since there is no mention of this reality in this or other guide-books, readers would not get any idea about the very great limitations of the kind of work/process of planning that has been outlined in this guide-book. There is no doubt that the decentralized planning process as outlined in this guide-book is an essential first step that needs to be taken from village level upwards to make certain improvements in the Project Implementation Plan for the district. However, the guide-book needs to also clarify that it is just one of the about dozen or so steps that need to be taken to make the planning really decentralized. For example, substantial increase in the budget for health services, and in the budget to improve direct determinants of health, substantial improvements in the supplementary nutritional programmes substantial increase in the range and quality of services available through Public Health Services, substantial improvement in the training, functioning, honorarium of ASHAs, a functional decentralised disease surveillance system to detect local epidemics at the earliest, etc. Secondly, it should also clarify that today, most of the decisions about planning , about harnessing and using resources, have already been taken at higher levels without involving the local community.

Guide-book IV- This 40-page booklet explains in a simple, clear language the various social determinants of health, some of the National Programmes of the government to improve some of these determinants and the measures and steps that social workers can take to improve planning at local levels to foster people's interests. Some of the social determinants of ill-health like environmental pollution, occupational environment, addictions, and migration have not been included and there are some minor technical inaccuracies at places. However, the booklet is lucid, is practically oriented and on the whole gives some insight into the issue of social determinants of health. The main problem is - there is no clarity in this guide-book about the very restrictive role left to local planning of social determinants of health in the current economics and politics of planning.

Guide-book V- This 30-page guide-booklet on use of evidence/information for policy planning is in the form of relevant, essential points to be considered in decentralised planning of Public Health Services. These points need to be elaborated and explained during contact-sessions. The guide-booklet begins by explaining the importance of accurate, relevant information in the planning process; by elucidating the importance of due care in collecting information and about the need to collect information about various aspects like status of health, of health care, of health infrastructure, about the felt needs of the people, about the current health policies/programmes etc. In the next sub-section/chapter of 5 pages it enlists about a dozen sources of health-information ranging from Census to hospitals records and enlists the key points/parameters about which information is available in these documents. It then turns to the nature of Project Implementation Plan (PIP) for the district and the kind of information that social workers need to have to participate in this process, by making suggestions for the implementation of health programmes and for some innovative programmes to be included in the PIP. The last subsection/chapter of this guide-booklet discusses how the information generated through Community Based Monitoring of Public Health Services can be used to foster pro-people planning. It gives six formats as tables which can be used to analyse/present information gathered during the CBM process in order to make specific suggestions in the planning process. It suggests that apart from intervention through the CBM process, this analysed information can be used to make suggestions in the use of Rugn Kalyan Nidhi and for making suggestions in the PIP.

All the above would be useful. But the guide-booklet should also have given a clear idea that in practice, currently this PIP exercise is only done perfunctorily and that most of the decision-making keeps happening at higher levels without involving the community.

Guide-book VI- This 30-page guide-booklet is the last in this series and explains the discourse of decentralised planning in India. After restating the basic concept of decentralised planning, it briefly describes the experience of Karanataka, West Bengal and Kerala who made use of the 73rd and 74th constitutional amendment to experiment with decentralised planning. It points out that decentralised planning is a socio-political process and Maharashtra has lagged behind in taking advantage of decentralised planning. It then turns towards the decentralised planning of Public Health Services through the district Project Implementation Plan as enunciated in the volume - 'Framework for Implementation for NRHM' by the Central Ministry of Health. It explains in some detail, how in order to prepare a PIP for the district, as per this manual various planning steps are to be taken at various levels (village, PHC, block, district level). It also briefly explains the committees at block and district level which are entrusted with the responsibility of carrying out this process of preparation of PIP. This is followed by specific information about the additional funds that have been allocated under NRHM to make improvements in Public Health Services and the guidelines for using these funds. The specific suggestions it gives at the end to ensure accountability of use of these small funds, would be useful to all the stake-holders. At the end, the guide-book explains the role and limitations of CBM in influencing the PIP process and shares some practical examples of what has been done by some organizations towards this end.

All the above would be useful for the trainees to undertake some initiative in the PIP process. However this guide-book does not give a clear idea that so far the way the district PIP is prepared is at complete variance with what has been outlined in the volume - 'Framework for Implementation' and the reason is

again the same - most of the decision-making keeps happening at higher levels without involving the community because of concentration and centralization of power and resources.

3.1.3 Outcome of the course

At the end of each contact session, the outcome of the training was assessed objectively by administering a questionnaire to participants to assess the impact of the training on their knowledge and understanding of the subjects covered. *Annexure 3 gives the details of the final assessment of knowledge of participants.* For group-A, analysis was done by comparing the answers to pre-test questionnaires at initiation of 1st and 2nd contact sessions, and answers to the post-test questionnaire filled at the end of the 3rd contact session. For group-B (new participants) pre-test and post-test questionnaires were developed, on the basis of topics which were discussed.

For analysis, the 23 questions were divided into 4 sections

A Perspective and conceptual understanding on Health and Health Rights

B. Decentralized planning process and NRHM related information

D. Preparation process of PIP and information related to it. RKS fund and information related to it.

A. Section on perspective and conceptual understanding on Health and Health Rights-

The changes in perspective and conceptual understanding of participants on Health and Health Rights ranged from 4.2% to 28.6 %. As many of the participants were already working on Health and Health Rights, the change observed in their perspective and conceptual level is moderate.

B. Section on Decentralized Planning Process and NRHM related information-

The changes in understanding and knowledge of participants about decentralized planning process and NRHM related information ranged from 29.2% to 80%. This means that participants generally understood about decentralized planning process and NRHM related information.

C. Section about preparation process of PIP and information related to it-

The changes in participants' understanding the PIP preparation process ranged from 37.5% to 65.8%. Participants understood about the framework of PIP, preparation process, role and responsibility of each stakeholder etc. The maximum change (65.8%) is observed in the participants' understanding about the concept of PIP and key component of PIP.

D. Section about RKS fund and information related to it.

The changes in participants' understanding of RKS related information ranged from -0.5 % to 67.6%. The maximum change was seen related to norms which need to be fulfilled by concerned Health institutions before providing IPHS funds - at 67.6%. The only question where there was no change was related to criteria on which health facilities are receiving the untied funds under NRHM. Probably the details of these criteria could not be adequately communicated, also these keep changing from time to time.

The average pre-test score for all participants at the beginning of training was 31.2% which increased to 66.3% in the post-test, an average increase of 35.1%. This indicates satisfactory

training outcome. However as stated earlier, the trainees need to be made clear that the work/process discussed in this training/orientation is only the first step towards de-centralised health-planning and that there are great obstacles in making substantial progress towards a genuine decentralised planning. The difficulty is primarily not on account of lack of evidence but due to various vested interests given the fact that planning is a socio-political process.

Box 4: Summary of Evaluation of the Course on Decentralised Planning

Systematic efforts to select more candidates, additional efforts to overcome lack of participation of some key-holders in the first round of contact training; the good quality of specially designed guide-books; systematically organised training sessions and lastly, the substantial progress made by participants as revealed by the systematic evaluation --- all this together indicate a good job done by the SATHI team on this aspect of the Project.

It is however necessary that this course also clarifies the following - In the current context of virtual exclusion of the community from the planning process, the attempt to involve people at village and block level, in improving the Project Implementation Plan for the district is an essential first step that needs to be taken. However, in order to do health planning in the full sense of the word, many more steps are needed. Currently there is no scope to take these steps and there are severe limitations to people's participation in planning of Public Health Services, because most of the decisions about harnessing and using resources, of setting planning objectives etc. have already been taken at higher levels without involving the local community.

For subsequent courses, the reading material can be improved by reflecting the reality of decentralised planning, the barriers that exist and based on the current project, what can be done to address them.

3.2 Perceptions of Members of Monitoring and Planning Committees.

In order to achieve the objectives of the project, following activities were conducted in the intervention areas (Amaravati, Nandurbar and Pune districts of Maharashtra)

"Block level conventions were organized for VHSNC members, especially for Sarpanches and Aganwadi workers to orient them about utilization of Untied Funds at the village level and their role as members of the VHSNC in appropriate decision making regarding these funds.

- Block level orientation workshops for non-official RKS members were organized in Pune, Nandurbar and Amaravati districts. In these workshops, the issues discussed were: different types of funds, guidelines for utilization, present gaps in utilization, what could be the role of committee members in strengthening decision making towards appropriate utilization of funds to ensure clear benefit to patients ('Rogi Kalyan').
- The Orientation Workshops were followed by visits to Health institutions for dialogue with local Health officials. Participant CBMP committee members identified issues which are directly relevant for patients' welfare such as unclean bed sheets, poor sitting arrangement for patients

and relatives, lack of cleanliness in the health institutions etc. and discussed these issues with relevant medical officers. Together they decided that these issues would be discussed and resolved in the next RKS meeting.

- As part of the capacity building process, publications like a poster and booklet on role and responsibilities of Monitoring and Planning Committee members were developed and disseminated.

It was expected that these workshops would help in developing capacities of the Monitoring and Planning Committee (MPC) members in terms of knowledge about various aspects of decentralised planning processes in NRHM, role and responsibilities as a MPC member as well as ability and confidence to intervene in the different planning processes such as preparation of a PIP, utilization of flexible funds of NRHM.

As committed in the project proposal, an evaluation of capacity building inputs provided to District and Block Monitoring and Planning Committee members was conducted; the main focus of this evaluation was to evaluate the impact of training inputs on the knowledge and skills of the participants, gauging whether these inputs have enabled them to play an enhanced role in the local health planning process and whether this process has become more participatory as a result of the capacity building.

3.2.1 Analysis of Interviews

Two types of questions were asked of the respondents. One set was knowledge related questions and the second one set of questions were related to the process. *Table 1 shows the correct responses of the three stakeholder groups on the Knowledge questions.*

Table 1: Correct responses to Knowledge Questions (consistent with training content)

Components on which information was collected	Government Officials N= 7	Elected Representatives N = 8	NGO representatives N=9	TOTAL N= 24
Knowledge related to Rugna Kalyan Samiti (RKS)				
Types of RKS funds, available at different levels	6	3	8	17
Office bearers of RKS (President and Secretary of RKS)	4	5	6	15
Types sub-committees of RKS	6	3	8	17
Types of non-Government Members in RKS	5	6	8	19
Knowledge related to Programme Implementation Plan (PIP)				
Meaning of Programme Implementation Plan (PIP)	6	4	7	17
Levels at which PIP is prepared.	7	2	6	15
Changes seen in the PIP preparation process	7	8	9	24

From above interviews, a variation is seen in the level of knowledge of different stakeholders although all the interviewed participants agreed that there are changes in the PIP process. In any learning process, time and application of knowledge are important factors. As time passes and if knowledge is not applied, there is a tendency to forget. This phenomenon is applicable here also. The orientation workshops were conducted during 2010-11 and for some questions, such as, structure of RKS committee, types of sub-committees, which do not have direct application to practice, the respondents were not able to give satisfactory answers.

Respondents were asked if they knew about different types of funds that were available to the PHC and RH, what for they are to be used and how much is the amount under each fund. Seventeen of 24 respondents (63%) had a clear idea about the Rugna Kalyan Samiti Fund, the Annual Maintenance Grant (AMG) and the Untied Fund. They mentioned that the amount under each fund is respectively Rs.1,00,000, Rs.50,000 and Rs.25,000 for PHC level. They also knew that the RKS fund is to be spent on equipments, lab material, medicines, for emergency expenses, etc. The AMG is to be spent largely on Repairs, Maintenance and painting etc. and the Untied Fund is to be spent for making payment for electricity and water charges, photocopying and other minor expenses like daily newspaper, etc.

3.2.2 Perceptions of the PIP Process

About the PIP Process there were some very interesting responses.

About what was meant by the word PIP, six out of seven Government Officials gave the aspirational answer, "Planning for next year through people's participation". One respondent who was perhaps more realistic, stated,

> "*We get a format from the civil surgeon's office which we have to fill and send. The process begins in December, we fill the formats that have a clear mention of our needs and demands".*

One of the Elected Representatives described it as follows:

> *'PIP can be very useful. People's participation hasn't increased. While preparing PIP, people have limited say. I am Aarogya Sabhapati but even then, I don't have much say. There has to be a need based programme in PIP. Last time we had given 2-3 suggestions in PIP but they weren't considered'.*

Two of the NGO representatives used the word 'decentralized planning' while describing PIP. One respondent mentioned,

> *"District gets a format from state level. Format has some information from village level. Out of 15 days available for total PIP process, ANM is given 4 days for collecting this data at village level. Village level and sub centre level information is collected and sent to PHC level. We just have to follow the formats. There is no scope for the points emerging from local level".*

3.2.3 Perceptions of Changes in PIP Process and Effects of those Changes

About the changes seen in the PIP process between 2009-10 and 2011-12, all three categories of respondents mentioned a large number of changes that are seen because of inclusion of people's representatives in the PIP process. As a result of people's involvement, better infrastructural facilities, human resources, and provision of equipment for health facilities have resulted - this is a major change seen by all the three stakeholders. Putting up demands from the local levels to higher authorities was also reported by many respondents. One respondent spoke very clearly about several changes in recent times. He said,

> *"Many things happened because of people's participation. E.g. repairs at the Sub Centre, staff at the PHC level, procurement of materials, were all added to the PIP. Contractually we filled up vacancies, one new Sub Centre is constructed, elected representatives were active at both village level and Taluka level while preparing PIP, now the meetings take place regularly. NGO representatives are invited. Funds are properly used for providing quality services. We have put up boards in facilities that have details of expenditure. This is for increasing transparency. We put labels on procured items that have details about funds, date of procurement etc. so people understand how funds are spent. It is better to let people know it before they question us.*
>
> *Nowadays, most members attend the RKS meetings and clearly voice their needs and expectations. Previously, there was unnecessary expenditure. During meetings, people talk about the problems faced and we make an effort to see that such mistakes or lacunae won't be there in future. Number of patients have increased and so has our credibility. There is now better communication with people. Schemes are reaching them. Even women from better off families come here for delivery. We conducted a multi-diagnostic camp in our area".*

All seven Government Officials mentioned many instances that indicate change seen as compared to earlier times.

The responses included: reducing unnecessary expenditure and saving resources, fulfilling local needs, checking registers regularly (under monitoring process) for bringing in transparency, trying to fill vacancies in health facilities, providing better infrastructural and manpower facilities, purchasing new equipment (x-ray machine, aquaguard etc.), improving performance of health facilities resulting in better utilisation, increase in participation by people, improved personal communication as well as communication in the form of IEC material, putting up demands at various fora such as meetings and jansunwai and demanding from higher authorities. A Medical Officer said,

> *"An NGO in our area keeps a close watch on the PHC. They know what patients want. Therefore they give very pertinent suggestions like providing drinking water, provide facilities for women. They also ask for expenditure accounts for inspection. They guide us to plan as per people's needs. NGO is a link between government officials and people's representatives. Previously patients were asked to buy syringes and injections from outside. But now these are procured through RKS. There is drinking water and food for patients, the bed-sheets are clean because of the NGO's close watch. They repeatedly give suggestions to people's elected representatives and others. RKS also demanded bigger place for PHC and now bigger place is available".*

The eight elected representatives mentioned that in the planning process, participation of other stakeholders has increased in the PIP process. Co-operation of NGO representatives towards solving local problems has increased and some problems are now resolved at local levels. One of the elected members said,

"Now RKS members can go through the accounts and ask questions. Unnecessary expenses are checked now".

Another respondent said,

"But now people know their rights. They now ask where and how the money is spent. Now days we announce a week in advance that a PIP is to be prepared. People attend the meeting and see that their needs are reflected in the PIP. We have now checked a lot of unnecessary expenditure. Now at the sub centre, if the patient is told that certain medicine is not available, they ask the ANM to show the stock register. Even if any boards for IEC have to be prepared a sanction from the committee is taken before the money is spent. Previously, members used to blindly sign the papers that were sent to them. That's when we did not know about the process. Now it doesn't happen".

There was a respondent who felt that not much has changed - he said,

"People here are illiterate. They say we are like this, let us be like this only. They don't demand anything. People's participation in PIP is nil. It is some NGO activists who say that certain things need to be done; people have nothing to do with this".

For the nine NGO representatives, regularity of meetings in recent times has emerged as a major change. One of the NGO representative said,

"Previously meetings weren't held regularly but after the inclusion of NGO representatives, there is a fear that these people will complain to the higher authority. Meetings are regularly held now".

In addition all the changes that have been reported by the other two stakeholders were also stated by these representatives.

"Because RKS and monitoring committee meetings are held frequently, problems become visible, get incorporated in PIP and this has resulted in some visible changes like cleanliness in health institutions, separate shade for vehicle, separate room for pharmacist, separate injection room, etc. because resolutions were made and actions were initiated. This gets reflected in increased number of patients in OPD and IPD. People have started demanding 24X7 services, availability of the staff at the centre/ hospital. Now there are banners about expenditure and utilization of funds. Stickers with cost and procurement date are put on items purchased. Now people know that it is their right to ask. When CBM process started and people got trained, they have started feeling that they must get quality services. Participation of elected representatives has also increased".

Contrary to the positive response of some respondents, one of the NGO representatives said,

"Earlier, many people used to attend RKS meetings but now the number has reduced because there are hardly any unresolved issues. There was greater enthusiasm earlier."

This response perhaps reflects that the challenge of making the system move has been overcome - because the RKS system is now working, members feel that now it is acceptable not to attend the meetings.

3.2.4 Case Studies reflecting Changes

From following case studies, it is seen that while there were some gaps at the knowledge level changes, at the application level some changes were observed.

Box 5: Initiating decentralised planning in Nasrapur PHC in Bhor block, District Pune

Issues identified and addressed during Dec. 2011 to March 2012 through decentralised health planning in RKS following capacity building and orientation:

- To provide drinking water to patients, a water storage tank with inbuilt water filter has been purchased. In the meeting it was decided that old leaking water tank would be used for storing scrap material of PHC.
- In order to make laboratory more functional, a tank for water storage has been purchased and new pipe line for laboratory has been constructed.
- There was no board showing the name of the PHC and it used to be difficult for any new patient to find it. Now an appropriate board has been arranged through RKS funds.
- Post of sanitation worker is vacant in Nasarapur PHC and hence it is very difficult to maintain cleanliness. So to tackle un-cleanliness RKS committee has decided to appoint a worker on contract basis.
- Workshops on 'Right to Health' and 'role of adolescents in the development of village' are being conducted for groups of adolescents through RKS fund.

Box 6 : Example of an issue identified at local level being addressed by District Planning - Pune

A workshop was conducted at Malshiras PHC as part of the decentralised health planning process. Among the participants were Radhabai and Sushilabai. With very low earnings and with no family support, they were not in position to afford cost of diabetic medicines, even the small cost of Rs. 20 for every 10 days. Neither could they afford to spend on travel to go to nearest government Cottage hospital for the same. Based on suggestions given by the CBMP committee members, the Medical Officer took the lead, investigated patients, and with the help of a specialist started a Medical Camp once a month in that PHC for Diabetes and Hypertension patients.

After positive responses from community and in order to sustain this activity, a proposal was prepared and submitted by MASUM- the District CBMP civil society organization and Medical officer, it was included in the district PIP. However this demand was not included in state PIP. In spite of this, the issue was again strongly raised in the District Monitoring and Planning meeting as well as in the meeting with Chief Executive Officer. After regular and continuous dialogue with the Chairperson of District Health Committee, he took initiative at district level and with the help of District Health Officer; he has allocated funds from the Zila Parishad (District elected council) to arrange these medicines. Now due to this initiative, medicines to treat Hypertension and Diabetes are being made available in all Primary Health Centres of Pune district.

Box 7: Activating the RKS and promoting appropriate planning in Rural Hospital, Velha

In the Rural Hospital, Velha it came to notice in Dec. 2011 that the RKS members, which included the BDO, Tehsildar and Private doctors, had never been called for planning meetings. The CBMP nodal civil society organisation called a meeting, inviting all RKS members as well as elected representatives like Chairperson and Deputy Chairperson of the Panchayat Samiti to discuss the need for effective facility level planning. It was reported that almost 60% funds for the financial year 2011-12 remained unutilized although nine months had already passed. After learning about this, based on capacity building processes the RKS members listed down key problem areas and needs in the RH.

After taking a round of the hospital they prioritized feasible action areas, such as arranging drinking water for patients, improving conditions in the ward for patients improving ambulance service etc. They also asked to include certain proposals in next year's PIP and asked the Block Medical Officer to do the follow up. Based on this process, now several water filters have been installed in the hospital to ensure drinking water, windows frames and mosquito netting has been fixed in the ward to ensure comfortable stay for patients and a shed has been constructed to park the ambulance and protect it from exposure during rain, hence ensuring its better functioning. Based on suggestions emerging from this process, now proper disposal of Bio-medical waste is being organised, and regular cleanliness of the Post-mortem examination room has been arranged by employing a person for this task.

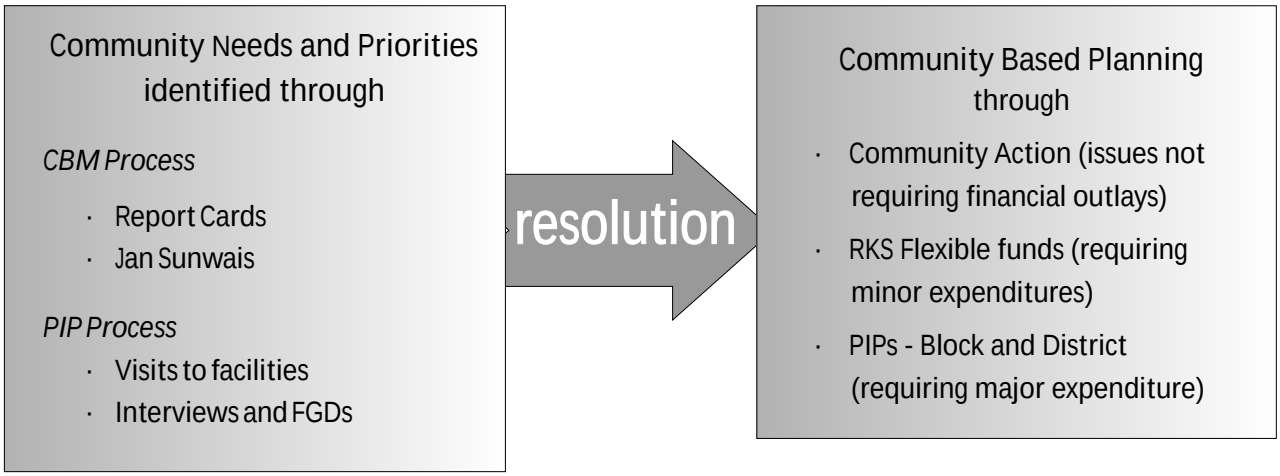
Box 8: Summary of Perceptions of Members of Monitoring Committees

The scores of the Pre and Post tests show that there is some increase in the knowledge levels of those interviewed about types of funds available with the RKS, the meaning of PIP and the levels at which PIPs are prepared. Knowledge increase among the Government Officers and the elected Representatives was lower than the knowledge increase among NGO representatives. All respondents felt that the PIP process has changed as a result of the project - there is greater participation in the process. The results of the changes reported by the respondents include: reduction of unnecessary expenditure and saving of resources, meeting local needs, improvements in health facilities, better utilisation, and improved communication.

3.3 From Community Based Monitoring to Community Based Planning

This section shows that community needs and priorities identified through the Community Based Monitoring process - the Jan Sunwais, the Monitoring Committee meetings at various levels, the Decentralised Planning Workshops organised under this project, special visits to health facilities by members of Monitoring Committees and their discussions with users and community members, as a part of the PIP process - are translated into Planning in various ways - through the Block and District PIP process and through facility based Rugna Kalyan Samities (Hospital Management Committees).

Figure 2 : Different pieces of 'CBM' evidence finding their way into 'CBP'



Different pieces of evidence of results of CBM finding their way into CBP are presented in subsequent sections.

3.3.1 Converting Community Based Evidence into Planning Proposals

Civil Society Organisations representatives who were trained through the structured course on Decentralised Planning went back to their Districts and Blocks and undertook several activities.

Village level meetings were conducted in dozens of communities of Pune, Amaravati and Nandurbar districts. The main objective of these meetings was to discuss what could be the role of community, especially the VHSNC members in the different planning processes such as preparation of PIP, utilization of flexible funds of NRHM etc. In these meetings it was decided that active community members and VHSNC members should be involved in the 2012-13 PIP preparation process. An attempt should be made to first resolve local level issues related to delivery of health services, while suggestions concerning some issues like vacant posts of doctors and staff, lack of adequate infrastructure in the Health institutions could be proposed for the coming year's PIP. In Pune district, it was decided that spaces like the Gram-Sabha would be used to resolve various local health service delivery issues identified during Community Based Monitoring.

Arogya Jatras were organized in each village in which skits were presented by groups of actors. The skits incorporated schemes declared under NRHM, information related to flexible funds under NRHM as well as the issues emerging from Community Based Monitoring such as vacant posts, infrastructure of Public Health institutions.

In addition to village level activities, Block level action was also done as a result of the training course. Box 9 below presents examples of these.

Box 9 : Example of Block level action - Shahada, District - Nandurbar

A workshop was conducted on 9th November 2012 and attended by 19 people, including Block Medical Officer (BMO), Medical Officers (MOs) and representatives of civil society organizations and RKS members of 3 PHCs in Shahada block of Nandurbar.

The issues which emerged through the CBM process were discussed with the Health officials, in the presence of members of the RKS. On the basis of discussion following decisions were taken and RKS members gave instructions to Health officials that these decision/issues should be incorporated in next year's PIP (2013-14). The decisions are as follows-

- Make provision for increased funding to strengthen the health centers in Shahada taluka, under the district PIP.
- The expense on electricity required in health centers, is very high, so a separate provision should be made for it from the district level itself.
- All health centers should be given funds to pay the honorarium of data entry operator, cleanliness workers and drivers. Or vacant post should be filled immediately and a separate provision should be made for this.
- RHs should be provided with sonography machines.

Source: Interim Technical report, April to December 2012

Annexure 4 shows the needs that were identified by the CBMP committees in six blocks of three districts after the block level workshops on Decentralised Planning. Members of CBMP Committees visited health institutions, interviewed users of the facilities, and conducted group discussions with community members. This was the first step towards proposing that these issues be included in the Block PIPs.

Most of the issues identified are around infrastructure development and construction - staff quarters for PHC staff, separate rooms for the laboratory, blood storage unit, post mortem room, repair of subcentres, provision of water supply, solar system, sitting space and kitchen for patients relatives, construction of a compound wall for the health facility, and so on. Another major category is purchase and/or repair of equipment- for example, labour room, lab, OT equipment, repair of sonography machine, repair and maintenance of generator, and so on. Other issues like fund for regular electricity, ambulance service, driver's salary and so on were also identified as needs to be addressed in the PIPs. District level contextual variations are interesting - in Nandurbar, district specific issues were- 'need to allocate village level untied fund for 73 forest villages', 'construction of a separate room for Panchkarma under AYUSH', 'construction of a waiting stop for patients availing the services of the floating clinic including beds and medicines'.

In several blocks, these proposals were presented in the Block PIP formulation meetings in December 2011.

3.3.2 Changes in Utilisation of VHSNC Funds

Members of Civil Society Organisations reported[4] that although there were several structural problems in the VHSNC - mainly that the bank account is in the name of the Sarpanch and the Anganwadi Worker and the expenditure of the Rs. 10,000 Untied Fund was controlled by the ICDS officers - gradually they have been able to bring about changes in the VHSNC Fund expenditures. Different strategies have been used - training of VHSNC members on the use of the Untied Fund, emphasising the fact that the fund needs to be spent on Health, Nutrition, Sanitation (all components of the VHSNC), ensuring display boards were put up with the items that the Untied Fund could be used for, and how the authorisation process would be done. CSOs also used the strategy of disarming the ICDS staff by suggesting that let the community representatives state what needs and priorities they saw in the area of Nutrition.

CSO representatives reported that in Pune District the VHSNC fund was used for organising women's health camps, for buying iron vessels to address iron deficiency anaemia. In Nandurbar District, VHNSC Funds were being used for transportation of women for deliveries.

Box 10 : Decentralised Health Planning creates space for innovative uses of the Village Untied Fund

Informed and inspired through the orientation they received, the activated members of the VHSNC in Degaon in Pune district expanded the Village Health and Sanitation Committee's mandate beyond the usual. They realised that anaemia is a serious problem among pregnant women in the village. This led them to use the annual Village Untied Fund to buy iron 'kadhais' for pregnant women, so that these expecting mothers could get a regular supply of iron in their diet. The VHSNC is also involved in inspecting quality of drinking water in the village water tank and well, and they have used the Untied Fund for disinfecting the water. They have further used this fund to organise house-to-house chlorination of drinking water. Part of the fund was also used to organise an educational visit of VHSNC members to Pirangut, to learn about use of organic fertilizers, vermiculture and kitchen gardens to improve nutrition in the village.

3.3.3 Changes in Utilisation of Funds - a comparative study in two intervention blocks and a control block

SATHI conducted a small study to analyse whether there was any change in the pattern of utilisation of facility based flexible funds due to community based planning. The study was conducted between August and October 2012[5]. Presented below is a summary of the study.

Under the National Rural Health Mission (NRHM), Hospital Management Societies (HMS) have been constituted - they are named Rogi Kalyan Samiti (RKS) or Rugna Kalyan Samiti (in Maharashtra). The RKS

4 Meeting with representatives of Civil Society Organisations from three intervention Districts. June 16, 2013, Pune.

5 Change in the Pattern and Decision Making in Utilisation of Facility Based NRHM Flexible Funds due to Community Based Planning – Organisation Report for Internship at SATHI. Dr. Surbhi Seth and Supriya Goswami. August 21 2012 -October 12 2012.

has a provision of certain flexible funds for the strengthening of the health institutions. The funds are provided to the RKS under the following three heads:

1) Untied Funds
2) Annual Maintenance Grants (AMG)
3) RKS funds

Every Primary Health Centre (PHC) has a provision of an Untied Fund of Rs. 25,000 per annum, an AMG of Rs. 50,000 per annum, and an RKS fund of Rs. 1,00,000 per annum. Similarly, each Rural Hospital (RH) or Sub-District Hospital (SDH) has a provision for an Untied Fund of Rs. 50,000 per annum, an AMG of Rs. 1,00,000 per annum, and an RKS fund of Rs. 1,00,000 per annum. In addition to these funds PHCs, RHs/ SDHs which are upgraded under the Indian Public Health Standards get funds of Rs 5,00,000 per annum and Rs. 12,00,000 per annum respectively.

According to the guidelines, the AMG funds must be used for the improvement and maintenance of physical infrastructure of the hospital. This includes funds for repairing work, purchase of essential medicines, referral transport, and quality assurance programme and security arrangements. The expenditure list is very broad and exhaustive. The RKS funds are also to be used in a similar manner. The Untied Funds must be used for any local health action, if needed. In addition Untied Funds may be spent to meet any shortage of funds required to complete an activity planned under the Annual Maintenance Grant or the RKS Fund. The guidelines also state that the Untied Funds must not be spent for procurement of stationary items, furniture, medicines, training related equipments and vehicles. Similarly these should not be used for engagement of full time or part time staff and payment of honorarium/incentives/wages of any kind.

In Pune district, where CbMP started since 2011-12, some positive changes were reported. This study was designed to gather concrete evidence about whether participatory planning was happening through the RKS and whether the participatory decision making process had led to any change in the utilisation of the RKS funds.

The Broad Objective of the study was

To examine the extent to which interventions for Decentralised Planning in Health services has influenced the utilization of health facility based flexible funds.

Specific Objectives

1. To study the pattern of expenditure of flexible funds before and after decentralised health planning intervention and analyse the linkage of expenditures to CbMP process.
2. To find out the common expenditure themes/ issues emerging from the CbMP process across intervention areas and to compare any change in expenditure made before and after decentralised.
3. To compare the process of decision making for expenditure of flexible funds in CBM block with that of Non-CBM block.
4. To compare and comment on the facility-wise record keeping and account maintenance in the CbMP and Non-CBM blocks

The study was done in two blocks- Bhor and Velhe of Pune District, where CbMP workshops were conducted. Two PHCs and one SDH/RH were selected by purposive sampling. One non-CbMP block Mulshi was chosen as comparison block for study. Two facilities (1 RH and 1 PHC) were undertaken for study in Mulshi block.

The Findings of the study were as follows.

- 59% of the expenditure done from flexible funds in Velhe RH, 26 % in Velhe PHC, 25% in Pasli PHC, 37% in Bhogowli PHC (Bhor Block), 35% in Nasrapur PHC, 21% in Bhor SDH, in year 2011-12 could be attributed to the CbMP process.
- Some of the cross cutting issues across the two blocks were
  - Cleanliness of facilities
  - Purchasing medicines
  - Water supply in the Velhe health facilities - in bathrooms and toilets as well as for drinking
  - Provision of clean bed sheets in Bhor block as well as in Velhe Rural Hospital.
  - Appointment of contractual staff

Issues like cleanliness which were raised through different processes under CBM at different levels, were resolved at the RKS level. Similarly, the issue of sustainable water supply which was common to all three facilities under study in Velhe block, was also solved at the RKS level. These cross-cutting issues are therefore generalisable and expenditures on these may be done through the RKS in other blocks without further study.

- Other expenditures sanctioned from the Flexible NRHM Funds in these facilities were on: ambulance repairs and maintenance, driver's salary, referral fuel, replacing broken window panes, contractual laundry services, purchase of cleaning material, sonography services, eye camps, wheel chair purchase, BP apparatus purchase, electrical repairs, child rights workshop, contractual OB-GYN, contractual Laboratory technician and so on.

Box 11: Some illustrations

- "In summers Gastro epidemics are high in this area. Patients have to use toilet water again and again. Many patients would complain about lack of water. In the RKS meeting we gave the idea of joining the Rural Hospital water tank with the tank in a nearby village which has a good supply of water. A network of pipelines was installed. Now there is 24 hours water supply in RH Velhe"- Civil Society Representative of RKS body, RH Velhe.
- According to Minutes of RKS meetings in 2009-10 in RH Velhe, two water filters were requested by the civil society representatives, for drinking water for patients. The issue was not solved for two years. In 2011-12, the same issue was raised again in the RKS meeting and CbMP workshops and expenditure on two water filters was finally sanctioned.
- Out of the total expenditure linked to CBMP process, 41% was spent on paying salary to a contractual pharmacist. Expenditure was sanctioned in December 2011 and five months' salary was paid till March 2012. The record indicate that the issue was raised by community in the Jan Sunwai and the

appointment might have been made right after that but since no meeting was scheduled near the time of appointment, the sanction for expenditure related to his salary was done in RKS Meeting in December.

"There was no pharmacist in PHC Pasli so we raised issue in tehsil level and district level Jan Sunwai."- Civil Society representative, Pasli.

- Solar water heater issue was raised by the social worker in the RKS meeting. The statement was- "The solar water heater was in non-operating condition. Even MO realised that warm water is needed in case of delivering and family planning operated women who had to sometimes stay for 3 days". The issue also came in CbMP Meeting of Bhongowli PHC dated 10.12.11.
- In the Jan Sunwai as on Feb. 1, 2011 in Nasrapur, Kaushalya, a resident of Nasrapur village spoke about how she was given a prescription from the PHC for Inj. Cefotaxime Sodium to be bought from outside. This injection was not available with the village chemists, so she had to travel very far to purchase it. On top of this, she was given the wrong injection. The issue also came in CBMP Meeting at Block level in Bhor on Dec. 8, 2011 as reflected in minutes of RKS Meeting dated 17.12.11.

The issue of people having to purchase medicines from outside was raised in Jan Sunwai (Bhor & Velhe blocks) in March 2011. The decision was taken to make provision for medicines from RKS fund.

Maximum share of amount was spent on medicines and rabies vaccine purchase. The issue of medicines was raised in Jan Sunwai according to the three civil society persons interviewed. A civil society person stated-

"Earlier people used to purchase IV injections, cough syrups etc. from outside. It is the effect of Jan Sunwai at District level that there is now more awareness for total provision of medicines among stakeholders".

The evidence of the issue being raised in "District Jan Sunwai of block Velhe and Bhor in March 2011" was found in the form of written report. The issue was taken in RKS meeting by the Medical Officer on 19.05.2011. The estimated expenditure was accepted by committee - Rs. 50,000 for essential medicines and of Rs. 40,000 for Anti-snake venom and Anti-rabies vaccine for the next one month.

- The findings also show that the total expenditure in all health facilities studied in Velhe Block and in two out of three facilities studied in Bhor Block increased in 2011-12 as compared to 2009-10 when there was no community involvement in Health Planning. (See Table 2)

Table 2: Comparison of Total Expenditure in Health Facilities Studied in Velhe and Bhor Blocks

Facility VELHE BLOCK	2011-12 expenditure in Rs.	2009-10 expenditure in Rs.
PHC Pasli	342697	213053
PHC Velhe	250294	61742
RH Velhe	371223	77523
BHOR BLOCK PHC Bhongowli	334585	298929
PHC Nasrapur	155031	160848
SDH Bhor	1041345	980226

- The records show that in Velhe health facilities the frequency of RKS meetings increased after the CbMP process started. The quality of the minutes improved and the minutes indicate that Planning decisions have been taken resulting in expenditures being sanctioned. In the Bhor health facilities marked improvements in the frequency of RKS meetings or record keeping and documentation, are not very evident.

Comparison of CBM and Non CBM Blocks shows that in CBMP Blocks, the presence of spaces for multi-stakeholder planning and civil society member participation can be attributed to CbMP process. The presence of civil society representatives in RKS can be seen in the documents and from the interviews done.

The findings indicate that spaces created through CBM for participatory planning are being used well to resolve the community oriented issues to a large extent through the RKS in Bhor and Velhe. The RKS is acting as a platform where community needs are being addressed and resolved through intervention in planning. Though SDH Bhor does not conduct too many RKS meetings, the impact of CBMP is perceived by the civil society member interviewed.

In Nasrapur PHC, civil society persons were invited to RKS meetings due to CBMP process. In RH Velhe, members, including tehsildar, were earlier not aware of RKS meetings and their membership in the committee. In 2011-12, however, the proceedings of RKS Meetings reflect participatory discussions and participatory decision making in RH Velhe.

In the Non-CBM Block of Mulshi, at PHC Mutha, no civil society representative is invited to RKS Meetings. During the study visit, the PHC staff failed to produce the meetings register when asked for. The cash books and vouchers were ill-maintained for both 2009-10 and 2011-12 - loose vouchers were produced and reason given was absence of clerk since a long time.

The Medical Officer interviewed at the PHC Mutha had the following to say about the planning process:

> *"First I call a staff meeting consisting of clerk, ANM and other staff of the PHC. They all give their requirements and the clerk notes it down. The RKS meeting is attended by 3-4 people and the list is presented to them. The Adhyaksh makes all decisions. "*

At the Mulshi Rural Hospital, the proceedings for the meeting for 2011-12 were well maintained. Proceedings clearly stated the estimated cost for commodity purchase but community oriented issues like new mattress for delivery room, benches for patients, solar light purchase, post mortem material kit purchase, incentives on institutional delivery especially for girl child while planned, were never implemented. The proceedings for RKS meetings in 2009-10 were absent.

The local media person interviewed at Mutha said:

> *"Many times I have raised the issue of drinking water at health facilities especially at RH in Paud. RH Paud has temporary drinking water facility. I have even written about this issue in my weekly local newspaper but there is no scope. There is nothing called Jan Sunwai in my taluka. But due to my political connections with ruling party, I cannot write much on issues against them. The Zilla Parishad person who heads the meetings at the PHC takes decisions which are politically motivated. No one is interested in details of any issue. A casual discussion takes place and the matter is finished. People are not aware of their membership in RKS. It is the Panchayat member who is the chairman who decides everything but the main unresolved issue is the irregular attendance of the Medical Officer at Mutha."*

Interview of member of RKS at RH Paud states:

> *"During the meetings, the Sabhapati is the ultimate decision maker. Nobody can cross his decision. Medical Superintendent (MS) prepares the list of issues to be discussed. We also raise issues. Issue on cleanliness was raised by me. I have also raised issues on drinking water supply in RH. Patients have to buy water bottles from outside. List for medicines is given to patients for purchase. There is shortage of anti snake venom. MS inspite of being a gynaecologist does not attend delivery cases and refers to private doctors. X-ray machine is not being used because the technician is almost always drunk. I have complained about this to the MS but he does not respond. RH needs a separate road and entrance - the ambulance cannot come in due to cars parked but the tehsildar and PWD persons are irregular in meetings. Benches for patients were demanded but no purchase was made"*

From the above interviews, it can be surmised that at PHC Mutha, there is no space for participatory decision making with respect to expenditure of flexible funds. Whatever discussion that takes place is between the staff of the PHC, the MO and the Chairman of the RKS.

At RH level, also though a social worker is appointed in the RKS, and issues are raised by multi stakeholders and planning is also done, the execution of the planned expenditure can be seen in only half the issues. This implies that RKS fails to serve as a platform in the non-CBM block where community oriented issues although raised are not acted upon.

Box 12 : Summary Findings of Changes in Utilisation of Funds

Participants of the Course on Decentralised Planning went back to the Districts and Blocks and facilitated different processes with members of the monitoring and Planning Committees to identify issues and present them in Block PIP meetings. They also undertook awareness programmes at the village level on RKS and PIP and managed to bring about changes in decision making of expenditures from the VHSC Untied Funds. In six health facilities studied in two blocks of Pune District, between 59% and 21% of the RKS funds were used for issues identified through the CBM process. Some common issues were: cleanliness of health facilities, improving water supply, improving distribution of medicines through the health facilities. There were increased expenditures from the RKS funds as a result of the project. The frequency of RKS meetings increased as well as the record keeping should improvements in one of the two blocks. The findings indicate that spaces created through CBM for participatory planning are being used well to resolve the community oriented issues to a large extent through the RKS in Bhor and Velhe. The RKS is acting as a platform where community needs are being addressed and resolved through intervention in planning. In the comparison block facilities, there is no space for participatory decision making with respect to expenditure of flexible funds. Whatever discussion that takes place is between the staff of the PHC, the MO and the Chairman of the RKS. The RKS fails to serve as a platform in the non-CBM block where community oriented issues although raised are not acted upon.

3.3.4 Comparative Analysis of PIPs of three Blocks in Pune District (2012-13)

In order to assess the effectiveness of facilitation of processes for inclusion of community based evidence in the district and block health plans, it was decided to do the following:

A. Comparative analysis of plans in two intervention blocks with control block plans in Pune district, to assess the impact of intervention to address issues identified through participatory processes.

B. Analysis of one district health plan proposed for the PIP 2012-13, to assess inclusion of decentralized community evidence.

Detailed analysis of component- A is given in this section and for component -B in section 3.3.5

In order to assess the degree of inclusion of priorities emerging from community based evidence in Program Implementation Plans (PIPs), SATHI compared two PIPs from intervention blocks and one PIP from a control block.

The proposed PIP 2012-13 for Bhor, Velha and Mulshi blocks were obtained and analyzed, focusing on those issues which were raised through various participatory forums in 2011-12 and were subsequently included in the final Pune District PIP for 2012-13.

Table 3: Identification of issues in Velhe and Bhor Blocks and included in District PIP

No.	Name of the institution Block -Bhor	Issues which were included in the PIP
1	Karandi Khurd- Sub Center	Issue of bad condition of building was raised in Jan Sunwai as well as in the RKS meeting. So this issue was included in the Block PIP 2012-13 and Rs. 100,000 was proposed for the same.
2	Harnas- Sub Center	Issue of bad condition of floor and roof of Sub center was raised by representative of civil society organization during the orientation workshop for members of RKS and Monitoring and Planning Committee. This issue was included in the proposed Block PIP 2012-13 and Rs. 100,000 was proposed for the same.
3	Nasarapur- Primary Health Center (PHC)	Following issues were raised in different forum such as RKS meeting and PHC and Block level Jan Sunwais- · Need to construct residential facilities for Medical officers and staff of PHC. · Need to repair Solar water heating system · Need to construct separate room for delivery In order to resolve these issues, proposal of new construction of PHC was developed and Rs. 22,000,000 were proposed in the Block PIP.
4	Jogwadi- Primary Health Center (PHC)	Need for repair of quarters for Medical officers and staff of PHC was discussed in the RKS meeting and budget of Rs. 400,000 was proposed and included in the Block PIP 2012-13
5	Bhongavali, Nasarapur, Jogwadi and Nere - Primary Health Centers (PHCs)	Issue of lack of water supply for these PHCs was raised in the block level Jan Sunwai, and as decided in the Jan Sunwai the proposal was developed and included in the Block PIP; Rs. 100,000 was proposed for each institution for ensuring water supply.
6	Ambavade - Primary Health Center (PHC)	Issues related to lack of facilities in the staff quarters were raised in the block level Jan Sunwai. As this issue was not included during the process of PIP (2012-13) preparation at Block level, this issue was included in the proposed PIP at District level directly. For this issue, Rs. 500,000 were allocated in Block PIP 2012-13.
No.	**Name of the institution Block -Bhor**	**Issues which were included in the PIP**
1	Karanjawane – Primary Health Center (PHC)	The new PHC construction was in progress but in that new construction, the quarters for PHC staff were not included. So issue of new construction of quarters for PHC staff was raised in the Pune district Jan Sunwai and this issue was included in PIP 2012-13 and Rs. 8,000,000 were proposed for the same in the Block PIP.
2	Margasani, Wangani, Kelad, Rule, Sub Center	Issues related to bad condition of infrastructure in these Sub centers were raised in Block level Jan Sunwai. As decided in the Jan Sunwai the proposals were developed and included in the Block PIP, wherein Rs. 500,000 were proposed for Kelad and Margasani Sub center while Rs. 1, 00,000 was proposed for Wangani and Rule.

(Note: The figures proposed for various facilities in Block level PIPs have been mentioned in this note. In some cases, these amounts have been modified during finalization of PIPs at District level)

Given the unique health care needs of remote and inaccessible hamlets which are located on the banks of backwaters of a major dam reservoir at Panshet, the issue of upgrading the Medical unit at Panshet (Velhe Block) to level of a PHC with full range of facilities had been raised repeatedly through various CbMP forums over the last two years. This issue was presented during the State review workshop in July 2012 by the Panchayat representatives before State level officials. As a consequence, this long standing issue was addressed and approval for upgradation to PHC was given by State level Health officials in Jan. 2013.

After discussion with the Block Medical Officer of Mulshi Block (comparison block where no specific capacity building for community planning has been carried out), it emerged there are no specific participatory spaces or forums for inclusion of community based suggestions in the Block PIP. Effectively no specific suggestions from civil society organisations or community members have been incorporated in the PIP 2012-13 in Mulshi. Planning for the Block PIP is done by filling of official formats in pre-decided manner by the health officials, without process to address broader inputs from civil society or community organizations.

Box 13: Summary of Findings of Issues proposed in Block PIPs

It is clear that in the intervention areas of Bhor and Velha blocks of Pune districts, inclusion of issues linked with community based priorities in Program Implementation Plans (PIPs) at various levels was possible due to participatory spaces which were promoted through capacity building for Decentralized Health Planning and Community based Monitoring and Planning processes. In the comparison block, there are no specific participatory spaces or forums for inclusion of community based suggestions in the Block PIP. Effectively no specific suggestions from civil society organisations or community members have been incorporated in the PIP 2012-13 in Mulshi. Planning for the Block PIP is done by filling of official formats in pre-decided manner by the health officials, without process to address broader inputs from civil society or community organizations.

3.3.5 Analysis of PIP of Pune district (2012-13) to assess inclusion of activities linked with decentralized community based evidence

For the analysis of the proposed PIP for 2012-13 for Pune district the team focused on issues which were raised through various participatory forums under CBM in the 2011-12 and were subsequently included in the PIP 2012-13, and for which funds were allocated. Table 4 shows the issues identified through CBM and subsequently proposed in the PIP and also what was finally allocated.

Table 4: Identification of Issues through CBM forums and proposed in PIP

Proposal for construction of new building for facility in following areas	
Name of the Facility	Details about forum / manner in which issues have been raised and funds allocated for the same
Nasrapur, Bhor Block (Proposed new PHC building)	Issue of new building for PHC has been raised by Block Monitoring and Planning Committee as well as RKS members,and was then included in proposed PIP. This Proposed PIP was submitted to Deputy Director, Health Services, Pune division on 7th January 2012. For this activity, Rs. 220 lacs were proposed from Block and in District PIP 2012-13, s. 120 lacs have been allocated.
Parinche, Purandar block (Proposed PHC)	Issue of new building for PHC was raised during 9 March 2012 Pune district Jan Sunwai, at Aundh Hospital. For this issue, Rs. 150 lacs were proposed from Block and in District PIP 2012-13, Rs. 100 lacs are allocated.
Sub Center- Ambale, Purandar Block	Issue of new building for Sub-centre was raised during 9 March 2012 Pune district Jan Sunwai, at Aundh Hospital. Rs. 25 lacs were proposed from block and in District PIP 2012-13, total proposed amount (Rs. 25 lacs) is allocated.
Issues related to repairing infrastructure of sub centers	
Name of the Sub-centre	Details about forum / manner in which issues have been raised and funds allocated for the same
Kelad , Block- Velha	Proposal for repairing of these sub-centres was submitted by nodal NGOs to Block Medical Officer, Velhe block, on 7th January 2012. These facilities were then included in PIP which has been proposed under Decentralized Health planning process. For this issue, Rs. 5 lacs/ institution were proposed from Block and in District PIP 2012-13, total proposed amount (Rs. 5 lacs/ institution) is allocated.
Margasani, Block- Velha	
Harnas, Block-Bhor	Proposal for repairing of these sub-centres was submitted by nodal NGOs as part of Decentralized Health planning process, to Block Medical Officer, Bhor block, on 7th January 2012. For this issue, Rs. 1 lac/ institution were proposed from Block and in District PIP 2012-13, total proposed amount (Rs. 1 lac/ institution) is allocated.
Rule, Block- Velha	
Wangani, Block- Velha	
Karandi Kh., Block-Bhor	

Issue related to proposal for new Rural Hospital at Khadakwasla	
Name of the Facility	Details about forum / manner in which issues have been raised and funds allocated for the same
Proposed Khadakwasla Rural Hospital, Velha block	Proposal in this regard was developed as part of Decentralized Health planning process. Suggestion for PIP was submitted to Deputy Director, Health Services, Pune division on 7th January 2012. This proposal had been sent at State level for the approval in 2012-13 and in January 2013-14, approval has been received from State Govt.

Issues related to lack of facilities in staff quarters of following PHCs	
Name of the Facility	Details about forum / manner in which issues have been raised and funds allocated for the same
Jogawadi- PHC, Block- Bhor	The issue related to lack of facilities in the staff quarters was raised in the Block level Jan Sunwai on 24th March 2012. As the process of PIP (2012-13) preparation was delayed, these issues were included in the proposed PIP at District level. For this issue, Rs. 4 lacs were proposed from Block and in District PIP 2012-13, total proposed amount (Rs. 4 lacs) is allocated.
Ambavade - PHC, Block- Bhor	Issues related to lack of facilities in the staff quarters were raised in the Block level Jan Sunwai on 24th March 2012. As the process of PIP (2012-13) preparation was delayed at Block level, this issue was included in the proposed PIP at District level directly. For this issue, Rs. 5 lacs were allocated in District PIP 2012-13.
Karanjawane - PHC, Block- Velha	This issue was raised during 9 March 2012 Pune district Jan Sunwai, at Aundh Hospital. Related to this issue, Rs. 80 lacs were proposed for construction of new staff quarters and in District PIP 2012-13, Rs. 50 lacs have been allocated.

Issues related to lack of water supply in specific PHCs	
Name of the Facility	Details about forum / manner in which issues have been raised and funds allocated for the same
Bhongavali - PHC, Block- Bhor	Issues related to lack of proper water supply in these PHCs was raised in the block level Jan Sunwai on 24th March 2012. As the process of PIP (2012-13) preparation was delayed, these issues were included in the proposed PIP at District level. For this issue, Rs. 1 lac/institution was proposed from Block and in District PIP 2012-13, total proposed amount (Rs. 1 lac) is allocated.
Nasarapur - PHC, Block- Bhor	
Nere - PHC, Block- Bhor	
Jogwadi - PHC, Block- Bhor	

(Note: regarding some of these issues, amounts had been proposed in the Block level PIPs however these amounts were modified during finalization of District level PIPs)

Table 4 shows that although 100% of what was asked for may not have been sanctioned, all the issues proposed have been accepted in the District - and in one case the State - PIP.

For period 2012-13, from Purandar block, an innovative scheme, 'Organization of block level health check up camp for patients having diabetes and high blood pressure with medication and follow up plan' was proposed. This scheme was included in District level PIP and sent for approval to the State level. But in 2012 -13, this innovative scheme was not approved by State NRHM. After continuous and rigorous follow up with Chairperson of District level Health Committee by civil society organizations from Pune district, Pune Zilla Parishad allocated funds for this innovative scheme.

Box 14: Summary Findings

Based on capacity building for decentralized health planning, several issues which were raised through participatory processes such as Jan Sunwais, meetings of the Block Monitoring and Planning Committees, PIP preparation process under Decentralised Health Planning process, have been addressed and included in the District PIP, and significant amount of funds have been allocated for these. This is a significant step forward in the process of ensuring that community based priorities are addressed during District Health Planning.

3.4 Perceptions of District Civil Society Representatives

As a part of this Evaluation a meeting was organised with persons directly involved in the Decentralised Planning Project from the three intervention districts, Pune, Amravati and Nandurbar. They spoke about their achievements, challenges faced, and lessons learnt.

For the Amravati team, information that Rs. 2.5 lakhs was available as the RKS Fund to be spent on people's priorities, was the biggest learning- something that was very empowering which strengthened their work. They told civil society friends in other districts about this fund and were invited by NGOs in Yavatmal - a non CBM district - to undertake sensitisation work in that district. The Amravati team shared the Course material and readings with the Medical Officers and the PRI Members.The Nandurbar team reported that the most important outcome of this Project is the fact that space has been created for an NGO member in the RKS. Their presence has been able to ensure that people's interests are represented in the meetings - as a result the pattern of expenditure has shifted from spending only on infrastructure needs to items that directly impact on patients' welfare. Their health system and government counterparts appreciate the fact that people's issues are being raised and are ready to address them.

The Pune team stated that before this Project community people were not at all aware of the available funds and how they could be utilised. The PRI members were not involved at all. What they have been

able to do is involve the some non CBM civil society organisations also in the planning process. Women and children have also been participating consistently. The Pune team has made special efforts to bring in PRI members, especially the newer and younger elected representatives who are more positive and constructive compared to older Sarpanches who have developed vested interests. RKS members have become very active now - they take responsibility for followup action after the RKS meetings, PRI members actually visit health facilities and followup on decisions. Political parties have been involved - both those in power and those in the opposition; they are present in Jan Sunwais although it is a matter of great tension for them as facilitators.

The Pune team also gave examples of how they are trying to create sustainability. The CSO has done capacity building of children in Health Rights. Children in Velhe Block have been raising issues in Jan Sunwais and in VHSNCs. They have also been involved in action - for example, purifying water in wells, adopting families for health promotion and so on. The Block Education Officer has recognised the capacity and contribution of these children and is now formally involving them in health monitoring. In Velhe, a media person who is a member of both the Rural Hospital RKS as well as a member of the Taluka Monitoring and Planning Committee, plays a critical role of raising important issues from the people's perspective. Similarly, a member of the Taluka level Human Rights Committee is in the Taluka Monitoring and Planning Committee in Bhor and has been now selected in the RKS. He has been trained by the CSO and now raises issues - thus even without the presence of the designated Civil Society Organisation, people's issues get raised in these two blocks.

Similar examples came forth from the Nandurbar team - youth groups have been oriented and trained. They are mobilised to visit public institutions like Ashramshalas, anagnwadi centres. They report and discuss their findings in the Gram Sabha thus making them public and of concern to the entire village.

3.4.1 Challenges Faced

It was difficult to change the mode of expenditure of the VHSNC. The formal responsibility as bank signatories is vested in the Sarpanch and the Aanganwadi Worker and it took a lot of effort to make the VHSNC functioning around the Rs. 10,000 Untied Fund truly people oriented.

In some places, Medical Officers are beginning to resent the frequent RKS meetings and people's pressure to reorient decision making around expenditures. Some Taluka Health Officers have developed the strategy of listening quietly without any reactions, in meetings and then not doing anything on the decisions made - a sort of a silent resistance!

Another challenge is the frequent elections of the various committees, change of members and transfers of doctors leading to the need of constant orientation (and convincing) of the new members.

While the Decentralised Planning process appears to have worked up to the District level, there are problems when it comes to the State level. Even though issues emerging from the CBM process are sent up to the District and State levels to be included in the State PIP, there is no acknowledgement of these

communications and no information on which issues have been incorporated into the State PIP. Feedback to the Districts and Blocks is missing.

Participants cited how last year the District PIP was made in a one day workshop with the participation of the Medical Officers and the Taluka Health Officers, but neither the MO or the THO received the copy of the finalised and accepted District PIP.

The State Nodal Organisation described how they were asked to submit a proposal for CBMP for 2013-14 within two days. They did a consultative process with all the partner CSOs and submitted a proposal for Rs. 3.37 crores. There was no feedback from the State for a long time. Finally, they were informed that the budget had been reduced to Rs. 2.72 crores! There was no discussion or consultation with the organisations involved in the CBMP process.

Apart from these challenges, CSO representatives mentioned all the barriers that they have been facing in Decentralised Planning, which in fact become the reason for this Project. Box 15 identifies the barriers as articulated by several stakeholders interviewed in this Evaluation.

Box 15: Barriers to Decentralised Planning incorporating Community Priorities

- Meaning of Planning: Health system recognises as Planning only aspects that have financial implications
- Fear amongst community people, of the word 'Planning' - it is associated with power because it involves decision making around financial resources, and also because it entails 'special expertise'
- PIP is difficult to understand - how to read a PIP has to be learnt
- ANM/MPWs fill up the formats following their own methods
- Not enough time available for the consultative process required for decentralized planning
- Irregular RKS meetings
- Lack of clarity among RKS members about role and responsibilities
- Inappropriate expenditures which are controlled by one person or are dictated from the 'top'.
- Non involvement of PRI members
- Above all, planning is a socio political process, ridden with issues of power - vested interests prevent power from being shared and planning to become truly participatory and decentralized.

3.4.2 Lessons Learnt

CSO representatives from the three intervention districts shared their insights and learnings as a result of this Project. These insights and lessons learnt can contribute to Recommendations for the future design of Decentralised Planning.

- PRI members involvement in the Planning process is very important. Not only does this uphold the constitutional mandate of elected representatives, it also facilitates the ear of the government - when the PIP process is done through the PRI members - and not merely through CSOs - there is greater acceptance by the Government. Participants described several examples of how the intervention of PRI members, especially on infrastructure related issues - resulted in these proposals being accepted into the Block and District PIPs.
- Health planning can be 'sold' to PRI members as an election issue - evoke their role as peoples' representatives to motivate them to represent people's health related needs and priorities, as was done with the younger PRI members in Pune District.The Gram Sabha should be used as forum for health planning. The Medical Officer should be directed by the Taluka Health Officer to attend the Gram Sabha.
- Instead of only giving lists of health related issues that need to be addressed through the Planning process, it is better to give concrete proposals on prioritized issues, with their budgets. Pune District's proposal for Hypertension and Diabetes medicines probably got sanctioned because the budget was clearly worked out.
- The District Niyojan Samiti is also an important body to be addressed. The priorities and proposals emerging from Community Based Planning should not only be submitted to the Taluka Health officer but also the Niyojan Samiti.
- Another important stakeholder who should be consciously involved in the preparation of PIPs, is the Deputy Director at the regional level. According to the experience of the Pune team, bringing him into the PIP process helped a lot.
- Issues emerging from Community Based Monitoring that are not addressed despite being presented repeatedly in Monitoring and Planning Committee meetings or Jan Sunwais, are the ones that should be prioritized in the Planning process. Followup of these issues is extremely important and it is best to involve PRI members in the followup - there is greater likelihood of success.
- Community processes for feeding into the PIP process should start at the beginning of the financial year and not in December as has been happening up till now. The process should be widely publicized - people should know about the PIP process and the RKS. There should be awareness of what issues can go into the PIP and what can be taken up by the RKS.
- The role of the media is very important - people's issues and priorities for health planning can be publicized through media.

- Stakeholders do not know how to make sense of PIPs or how to read budgets. Capacity building of all stakeholders is critical.
- It is not enough to give lectures or books on Planning - practical work has to be built into the training workshops. For example, in Bhor classroom sessions on the RKS budget were for half a day, followed by visits to the PHC to discuss those budgets and see their relevance in the actual situation. The Course on Decentralised Planning should not be centralized - it should also be conducted at the field level.
- There is a tremendous potential for the Course - even the Medical Officers do not know about the various categories of RKS funds and their uses and therefore need the Course.
- The Course may be modified according to specific needs of different stakeholders. Such a Course should be run by SHSRC and not a civil society organization - government officers and PRI members will then attend it. Government planning should be influenced by SHSRC inputs.
- PIP formats need to be changed to accommodate community needs and priorities - there should be space for Budgetted items as well as those that do not require budgets but are still very important from community perspectives - for example, action for regularity of ANM visits or behavior of health care providers.
- 5% of the budget is meant for Innovative proposals. The indicators for what will be accepted as 'Innovative', need to change - at this point in time, Innovative Proposals require to be almost research proposals!
- PIP preparation requires a particular type of a mindset - a bureaucratic mindset - which is trained to make budgets and think along linear, logical lines. Community representatives and CSOs methods and approaches should also be accommodated.
- Role of the CSOs is very important, at least in the short and medium term. An official mandate is required.

3.4.3 Community involvement in Planning links back to Community Based Monitoring....

Representatives from the three districts recounted several examples of how once they learnt to read the PIPs and budgets, they went back to the facilities and villages to monitor the effectiveness of the expenditures. In Nandurbar, the CSO representatives found that the fibreglass subcentres which were in past years' PIPs were actually in poor shape and did not serve the purpose - they were so hot that the intended deliveries could not be conducted in them. The Rs. 3.5 lakhs allocated for these could well be spent on a decent conventional building. They found several expenditures only on paper - floating ambulances, counsellors in hospitals in tribal districts, stationery purchased for subcentres which were actually closed. These issues were raised in Jan Sunwais.

In Amravati, similarly, CSO representatives found that there were no services being provided through the Ma Ghar Yojana. Or the School Health Programme was not being implemented even though it was budgeted for. Nor was the School Nutrition Fund of Rs. 10,000 being used. The School Health Programme was then activated through the intervention of the PRI member who wrote to the Taluka Health Officer. The schedule of School Health visits was sent to the Sabhapati who began personally visiting the schools and supervising the health visits. The School Nutrition Fund in 15 villages was similarly activated and eggs provided for malnourished children.

Box 16: Summary of feedback from Representatives of Civil Society Organisations

Persons involved in the Planning initiative from the three intervention districts reported that they found the Course on Decentralised Planning very useful - the material was simple to understand and they used it with many people in the health system and the elected representatives. The process of Planning and the PIP was demystified - they could make sense of the PIP and the budgets and use this knowledge to monitor the budgeted commitments in the field. They also spearheaded processes to bring in the issues from community monitoring into planning forums like the RKS and the PIP formulation. They reported that the involvement of the PRI members is critical in the planning process. While several challenges were faced - eg increasing resistance from the Medical Officers and Taluka Health Officers towards regular and participatory meetings - rich lessons were learnt which can be used in upscaling efforts towards Decentralised Planning.

4. Discussion and Recommendations

4.1 Summary of Findings of the Evaluation

The goal of the project was to build the capacity of members of Block and District Monitoring and Planning Committees (including health officials) towards facilitating their use of evidence for decentralized health planning. And the specific objectives were, to:

- train about 30 health officials, elected representatives and civil society representatives from three districts for using evidence, including community based evidence, for improved health planning
- develop and implement a generalisable course on 'Using evidence for Health Planning' which would impart the skills of using evidence for district health planning and policymaking
- demonstrate a process of decentralized evidence based district health plan preparation, in at least one district of Maharashtra state

The programme theory that this project was based on was that multi stakeholder training in Decentralised Planning would, with some facilitation, lead to community needs and priorities emerging from the Community Monitoring process, being incorporated in the District Planning. An assumption made was that if partnerships were forged with the SHSRC, it would be possible to recruit both health systems and PRI representatives for the training. The original understanding was that Decentralised Planning would happen through the PIP process, that this was the avenue / mechanism for Planning. The way the project unravelled, however, some of the initial assumptions were challenged - for example, the partnership with SHSRC did not fructify after the very early phase, and the PIP process proved to be very difficult to penetrate. On the other hand, there was a dawning realisation that the Untied Funds with the Rugna Kalyan Samities are a resource and an opportunity that can be harnessed for participatory planning. We discuss in the next section, some of the other challenges and the resultant modified strategies deployed during the project period.

Thus, the Project resulted in 25 people completing the Course on Decentralised Planning, but most of the participants were from civil society organisations. Systematic efforts to select more candidates, additional efforts to overcome lack of participation of some key-holders in the first round of contact training; the good quality of specially designed guide-books; systematically organised training sessions

and the substantial progress made by participants as revealed by the systematic evaluation --- all these together indicate that the SATHI team did well on this specific objective.

This Evaluation shows that the Course Curriculum developed by this Project is both unique and innovative, although there is scope for some improvements. The Evaluation also brings out that although the Course was originally designed for all three stakeholders - health systems representatives, PRI members and civil society organisations - there were considerable challenges to recruit health officers and PRI members, and that these groups do need systematic knowledge and skill building in Planning. The training and block level workshops made a difference to how these stakeholders perceived their role in Planning and the effectiveness with which they were able to influence the RKS and the Monitoring and Planning Committees to include community priorities in Planning.

The Evaluation points out that the Course should include some essential critiques of the current situation. For example, it needs to be mentioned that in the current context of virtual exclusion of the community from the planning process, the attempt to involve people at village and block level, in improving the Project Implementation Plan for the district, is an essential first step. However, in order to do health planning in the full sense of the word, many more steps are needed. Currently there is no scope to take these steps and there are severe limitations to people's participation in planning of Public Health Services, because most of the decisions about harnessing and using resources, of setting planning objectives etc. have already been taken at higher levels without involving the local community. Also, for subsequent courses, the reading material can be modified to include reflections on the reality of decentralised planning, the barriers that exist and based on the current project, what can be done to address them.

The in depth interviews show that there is some increase in the knowledge levels of members of Monitoring few Government Officers and the elected Representatives who took the training, was lower than the knowledge increase among NGO representatives. All those interviewed felt that after the intervention, there is greater participation in the PIP process. The results of the greater participation reported by respondents include: reduction of unnecessary expenditure and saving of resources, meeting local needs, improvements in health facilities, better utilisation, and improved communication.

The participants for the Course from the three intervention districts - Amravati, Nandurbar and Pune - used their newly gained knowledge on the PIP process and the types of funds available with the RKS, to orient village communities, Monitoring and Planning Committees and the RKS members. These inputs contributed to increased awareness that issues emerging from the CBM process can be channelled into the mandated Planning mechanisms. Members made systematic lists of issues that could be taken into the RKS Committees or the PIP process. Several positive changes resulted including changes in decision making related to expenditures from the VHSC Untied Funds. In six health facilities studied in two blocks of Pune District, between 59% and 21% of the RKS funds were used for issues identified through the CBM process. There were increased expenditures from the RKS funds as a result of the project. The frequency of RKS meetings increased as well as the record keeping showed improvements in one of the two blocks. The findings indicate that spaces created through CBM for participatory planning were

being effectively used to resolve the community oriented issues through the RKS in Bhor and Velhe - the RKS acts as a platform where community needs are addressed and resolved through intervention in planning. In the comparison block facilities, where there is no space for participatory decision making with respect to expenditure of flexible funds, the RKS fails to serve as a platform where community oriented issues, although raised, are not acted upon.

The Evaluation also finds that based on capacity building for decentralized health planning, several issues which were raised through participatory processes such as the Jan Sunwais, meetings of the Block Monitoring and Planning Committees, PIP preparation process under Decentralised Health Planning process, have been addressed and included in the Block as well as the District PIP, and significant amount of funds have been allocated in the district PIP for these. This is a significant step forward in the process of ensuring that community based priorities are addressed during District Health Planning.

Enlargement of spaces for community based inputs in planning process has resulted due to communication with state level authorities and raising the issue in various state level meetings. - An official circular has been released, this specifies that CBMP civil society representatives should be permanent invitees in RKS at PHC and RH levels in CBMP areas across Maharashtra.

The Evaluation also brings out that there is a potential for sustainability through different strategies - making Decentralised Planning an integral part of the Panchayati Raj framework (as it is meant to be), involving youth and children in campaigns for health rights and in community monitoring, involving other sensitive and rights oriented activists (like media persons, Human Rights activists) and ensuring they become part of the Monitoring and Planning Committees and the RKS.

4.2 Challenges and Lessons Learnt

What this project has illustrated very clearly is that Decentralised Planning is not something that can happen automatically. The barriers or obstacles that prevent people's participation in Planning first need to be recognised and then systematically addressed. As mentioned above, the biggest challenge that remains is how can all key stakeholders in the Planning process be made competent to handle the Decentralised and people oriented planning? How can this training be institutionalised? How can some of the other barriers to Decentralised Planning be addressed? For example, the constrictive formats for PIPs? Or the very limited time given for the PIP development process? These are policy decisions and need to be handled at that level. As is the fact, that right from the highest levels, there has to be a commitment to Decentralised Planning - willingness to demonstrate transparency about the financial resources available, commitment to giving information to the committees at lower levels, commitment to consult stakeholders if resources are less and budgetary adjustments need to be made and so on.

Some of the important lessons learnt from this process are:

- Planning needs to be done in differentiated manner for at least three types of issues - those that can be resolved without any financial outlays, for example, absent ANMs, or poor interpersonal behavior of health care providers. These kinds of issues may require monitoring and action by

appropriate health systems' officers or concerted community action. The second set of issues, may require small expenditures, for example, ensuring cleanliness in a health facility, or ensuring safe drinking water or functional toilets in health facilities. These issues can be addressed from the RKS funds. The third set of issues are those that require major financial outlays - like significant improvements to existing infrastructure or new infrastructure - these can be placed in the PIPs.

- This Project has demonstrated that there is relatively greater openness of RKS to local inputs for planning - this experience needs to be built upon and this space needs to be opened up and expanded in a major way.

- Related to the above point, it appears that there are relatively more serious constraints in democratising the PIP development process. There is an urgent need for a participatory review of the current PIP development process with involvement of experienced civil society representatives, leading to a re-design of this process keeping in mind the need to ensure much wider participation at various levels.

- To increase the chances of Innovative Proposals being accepted in the PIPs, it is advisable to do a detailed budgetary exercise and propose the approximate cost of the idea. This kind of concrete and systematic detailing will enhance the likelihood of convincing other stakeholders.

- Elected representatives have a pivotal role to play in decentralised planning - when PRI members have taken an interest, they have gone as far as sanctioning proposals from their own District budgets when even the State PIP process has sought it fit to reject them.

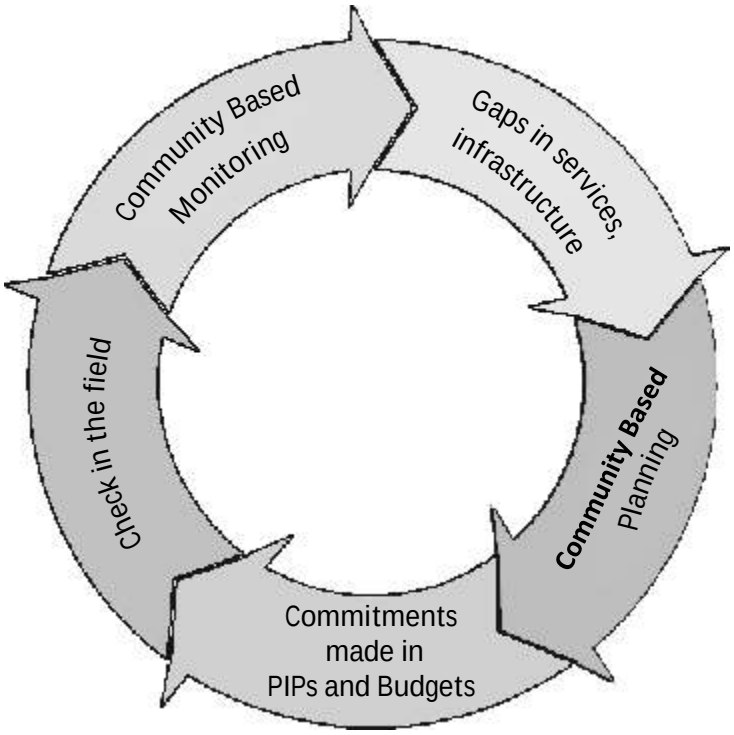
- Other important stakeholders who could be brought into the Decentralised Health Planning are the Regional Directors and the District Planning Committees - in this project the Regional Director has played an important role in bringing people's issues into the District PIP. The District Planning Committee is a mandated committee for the District and health planning should be made its concern.

- The structures for Participatory Planning have to be inclusive - they have to ensure spaces for informed and actual (and not notional) community representation. The processes also need to be participatory both in letter and the spirit - perhaps a checklist for ensuring that processes are indeed participatory needs to be developed and used for monitoring.

- Fiscal transparency is extremely important - RKS Funds and their expenditures need to be made public, guidelines for how these will be spent also need to made public.

- Conceptually, what this project has yielded is that Community Based Monitoring and Community Based Planning are part of a continuous cycle and have a two way connection. See Figure 3. While Community Based Monitoring provides the issues which should be included in Planning, Community Based Planning also provides the material in terms of the commitments made that should be monitored.

Figure 3 : Community Based Monitoring and Community Based Planning - a Cycle of change



4.3 Recommendations

- As mentioned above, enabling conditions need to be created before Decentralised Planning can become a reality. All barriers to Decentralised Palnning in specific contexts need to be identified and addressed as mentioned below.
- Changes need to be institutionalised in both Planning structures as well as processes. For example, issuing circulars to ensure participation of civil society organizations, modifying the PIP formats and process,
- Until such time as community members become informed and skilled to enter the Planning spaces, NGO/Civil Society Members need to be part of the Planning Committees. There needs to be plan for the evolution of civil society inputs over time with some clear indicators of expected corresponding changes in the community capacities. It may not be advisable to prematurely exit civil society organisations from CBMP - whatever has been achieved would be jeopardized.
- Sufficient time has to be allowed for the consultative bottom up process which would allow communities to identify and translate their needs into concrete proposals. Adequate time for community based meetings and consultative processes at various levels should be ensured.
- Formats and Account Heads need to be changed to incorporate community priorities. Current formats do not have sufficient space to encourage expression of local priorities which do not fit in the narrow official framework. - the requirements for Innovative Proposals, we were told, almost demand a research proposal, which is difficult for community representatives to produce.
- Investment is required in training and capacity building of all stakeholders - this is urgent and critical. Training curricula in Decentralised Health Planning have to be created for Health Systems

representatives as well as PRI members, to equip them with practical planning skills - this will help in avoiding unnecessary expenditures.

- There is need to institutionalize capacity building of RKS members to enable them to effectively carry out facility level planning based on local priorities and needs. For this institutions like SHSRC along with experienced NGOs could be given responsibility for designing short orientation courses for RKS members, drawing upon the experience of workshops carried out in this Project.
- There is need for systematic orientation of district and block level officials involved in PIP development, regarding decentralized health planning and using community based evidence during the local planning process. The structured learning course developed as part of this Project could be used as a base for developing a state level course, which could be administered by SHSRC.
- There is need for wide dissemination of good quality training / orientation material for RKS members and PHC, Block and District level stakeholders involved in the PIP process. Booklets and training material developed in this Project could be used as an input for such material.
- The District is too large with very different contexts - perhaps the unit of decentralized Health Planning needs to be a 'Block' rather than a 'District'.
- Health Planning at the village level should be made a part of the Village Planning exercise. The focus should not be on the Rs. 10,000 Untied Fund but all the village funds should be considered holistically and determinants of health as well as health services' needs should be planned for holistically. Thus, Health Planning should be an agenda in the November Gram Sabha which is meant for considering the annual village budget.
- A module on Village Health Planning should be developed for the VHSNC and training on this for all VHSNC members should become an institutional requirement. Civil society organisations should be involved in designing and administering such training.

4.3 Conclusion

We cannot emphasise enough the relevance of the project being implemented. Although NRHM mandates communitisation and decentralised planning, these are not happening - or at least not happening to the extent desired. This project demonstrates the kinds of inputs that are required to begin making a positive difference in Decentralised Health Planning. There are no short cuts to the process of intensive capacity building and handholding, which is required to enable community representatives to participate meaningfully in decisions that affect them. It is equally important that Health Systems and policy makers recognise that there is presently a major disjunct between the aspirations of Decentralised Health Planning and Communitisation desired by NRHM, and the Planning procedures currently being followed. There needs to be a radical overhaul of the PIP processes and the RKS functioning. And finally, we need to recognise that Planning is about decision making related to financial resources and control of these resources - there is tremendous power vested in these functions, power which is not easily shared by those who presently wield it. Decentralised Planning is all about sharing power. Tensions and conflicts are going to be part of the struggle and these need to be managed in the interests of the larger social good.

Monitoring and Evaluation Plan

Evaluation design: In this project, four types of activities will be monitored / evaluated. They are as follows:

1) Structured Learning Course on 'Evidence based Decentralized District Health Planning'
2) Capacity building workshops for DMPC and BMPC members
3) Collation and analysis of evidence for planning
4) Enrichment of District planning process based on inputs of evidence

1. Structured Learning Course on 'Evidence based Decentralized District Health planning

   Monitoring: The course faculty would scrutinize the successive assignments and practical exercises completed by course participants with a view to understanding their conceptual grasp of the key issues. This would be used to refine inputs during the course, both through distance and contact learning. Similarly, the response of participants during the three contact sessions would be taken into account to fine tune the course inputs. Short feedback forms would be given to participants during each of the contact sessions for this purpose.

   Evaluation: The participants of the course would be evaluated prior to the course to find out their conceptual understanding and skills regarding usage of evidence. Then there would be an assessment of knowledge and skills of course trainees at conclusion of the course at the end of one year.

2. Capacity building workshops

   To monitor the capacity building workshops, periodic assessment of knowledge and skills of Block monitoring and planning committee members would be done using a standard format. This assessment would be carried out twice in a year at conclusion of each orientation workshop. The analysis of these assessment exercises would be used for improving the workshops. Similarly periodic assessment of knowledge and skills of District monitoring and planning committee members would also be done twice in a year at conclusion of orientation workshops.

   After completing one round of capacity building of the members of District and Block monitoring and planning committees, an intermediate evaluation of the process of capacity building would be conducted. A small assessment would be undertaken to evaluate the process and the results would be used to modify the strategies and content of capacity building in year two. In addition, an end project assessment of knowledge and skills of District and Block monitoring and planning committee members would be conducted to assess the overall impact of the project.

3. Collation and analysis of evidence for planning

   To monitor the collation and analysis of evidence for planning, analysis of the forms of evidence

presented and used in BMPC, DMPC meetings would be done. In addition, an ongoing assessment of quality of planning proposals at block level would be done especially from the viewpoint of using relevant evidence.

A detailed assessment of the Block planning proposals presented at the end of second year as well the District planning proposals would be done to see how much evidence has been used in preparation of these plans. These plans can be compared with the plans in the districts where this capacity building intervention has not taken place.

4. Enrichment of planning process based on evidence inputs

Actual presentation of various Block planning proposals in DPMC meetings would be one of the indicators to evaluate the enrichment of planning process. Similarly other indicators such as number of meetings of DMPC held in the focus intervention district would be monitored.

How will findings of monitoring be used?

Ongoing monitoring activities during the course will help to develop and refine the conduction of the course, including addressing relevant feedback from the trainees.

Findings of monitoring of capacity building workshops will be regularly used to refine the practical orientation processes. Findings of monitoring related to analysis of evidence will be shared with the respective committee members to enable them to improve their analysis of information as inputs for planning.

Findings of monitoring of the Block and District planning process will be communicated to various stakeholders in a timely manner to improve the utilization of evidence towards preparation of the District health plan.

The findings of the evaluation will be shared with all relevant state, district and block level stakeholders during the final sharing workshop at the end of the project and may be published as part of the final report.

Who will carry out M&E?

The SATHI team and SHSRC will carry out the monitoring. The implementing team will involve an external expert to help carry out an end project evaluation.

Interview guide for Evaluation of capacity building for decentralized health planning

Appropriately framed questions in Marathi to each of the three categories of stakeholders (Medical officers, PRI members and civil society members) to be asked in the following areas:

1. Areas related to skills and knowledge of target stakeholders, concerning decentralised health planning

- *Knowledge about structure and functioning of Rogi Kalyan Samiti (RKS) including:*
  - Structure of RKS (office bearers, sub-committees)
  - Role of RKS members in facility based planning
  - Types and amounts of funds related to RKS
  - Guidelines regarding use of various RKS funds
  - How to prioritise utilisation of funds by RKS
- *Knowledge and skills concerning Project Implementation Plan (PIP) development process*
  - Need and importance of annual PIP development in context of decentralized health planning
  - Various levels of information collection and meetings required to prepare annual PIP
  - Understanding about role of PRI and civil society members in PIP preparation process
  - How to prioritise and select issues to be included in the block level PIP

2. Areas related to understanding changes in the local health planning process

- *Rogi Kalyan Samiti (RKS)*
  - Frequency of RKS meetings (compare situation during pre-intervention year 2010 and post-intervention year 2012, compare before and after the date of issuing state level guidelines in April 2012; ask this question from Medical officers and civil society members, who have been continuously involved across the relevant period)
  - Range of participation of diverse stakeholders including PRI and civil society members (compare situation during pre-intervention year 2010 and post-intervention year 2012; ask this question from Medical officers and civil society members, who have been continuously involved across the relevant period)

- Content of participation – any examples of interventions related to planning by non-official RKS members
- Any incorporation of suggestions by non-official members, related to decision making on expenditure by RKS
- Any follow up action related to issues raised by non-official members during previous meetings, or raised in various Community monitoring events / forums

· *Project Implementation Plan (PIP) development process*

- Any change in level of involvement of non-official stakeholders in the PIP preparation process, including non-officials being invited for official PIP meetings (compare situation during pre-intervention year 2009-10 with post-intervention year 2011-12) – any instances and examples
- Any change in process of formulation and presentation of proposals for PIP preparation (ask this question from Medical officers and civil society members, who have been continuously involved across the relevant period) – any examples
- Any change in terms of inclusion of suggestions / proposals given by non-official members in block level PIPs (ask this question from Medical officers and civil society members, who have been continuously involved across the relevant period)

Final assessment of knowledge of participants of Structured learning course

Background-

As part of the structured learning course, we have conducted three contact sessions within the project period. For this structured learning course applications were invited from Government health officials (Block health officials, district programme managers and medical officers), NGO representatives and elected members of Panchayati Raj Institutions (PRI) from the five districts. 24 candidates from five districts had applied and were selected for the course, however finally 20 selected candidates have actually attended the course, of whom 18 were from various NGOs involved in implementing community based monitoring in five districts and two candidates were DPMs from two districts. One of them had been unable to attend contact sessions on regular basis. In spite of attempt to involve PRI members in the course only two PRI members had applied and they were selected. However, both of them could not attend the contact sessions due to their other pressing commitments.

In order to ensure that adequate number of participants benefit from the course, at time of the third contact session, we have invited about 10-12 additional representatives of civil society organizations who are part of the decentralized planning process but had not yet participated in the course. A condensed orientation session was conducted for them on the topics covered in sessions 1 and 2.

So in the 3rd contact session, we divided the total participants in two groups (on the basis of old and new districts) and the session, in two parts. One group was for old participants who have attended last two contact sessions and another group was for new participants who have attended contact session first time.

Keeping this background in mind, the assessment about knowledge of participants from these two groups has been done separately. Following steps were taken for the assessment-

- We have developed separate pre test and post test questionnaires for these two groups. For the group A (old participants) the detailed questionnaire was formulated on the basis of questions which were asked in the 1st and 2nd contact sessions. We combined all the questions which were asked at the initiation of 1st and 2nd contact sessions and formulated a questionnaire, having a final total of 23 questions. One more question – "How much amount is available to purchase medicines in P.H.C. annually?" had been initially included but subsequently it was realised that due to frequent change in official norms for this during the training period itself, this question was not relevant and hence was not included in final post-test analysis.
- This questionnaire was filled by the participants during the 3rd contact session. The analysis was done by comparing the pre-test questionnaires filled by participants at initiation of 1st and 2nd contact sessions, and the post test questionnaire filled by participants at time of the 3rd contact session.
- For group B (new participants) pre test and post test questionnaires were developed, on the basis of topics which were discussed. The participants gave responses to the same set of questions in pre test and post test questionnaires.

The analysis of pre-test and post-test for group A is given below-

No.	Pre test post test comparison questions for participants from 5 districts (group A)	Pre test questionnaire filled during 1st and 2nd contact session	Post test questionnaire filled during 3rd contact session	Percent changes seen
A.	**Questions related to perspective and conceptual understanding on Health and Health Rights**			
1	As female are healthier than men, female access less Health care services. Is this statement true or false?	87.5	91.7	4.2
2	There are inequities related to infant mortality between rural and urban areas. What is the responsibility of Health care system to overcome this inequity?	37.5	58.3	20.8
3	There is higher death rate in old people as compared to young people. Would this be called a Health Inequity- justify your answer with reasons.	17.7	33.3	15.6
4	In present scenario, public health system is more focused on Maternal health care services. Is this statement true of false, please explain with reasons.	54.2	61.1	6.9
5	'To obtain Health Services is our Right'; 'Planning of health services should be decentralized' is there any correlation between above two statements. Give explanation.	29.7	58.3	28.6
B.	**Questions related to Decentralized planning process and NRHM related information**			
6	Who should be involved in decentralized planning process of health services?	38.8	78.3	39.6
7	State any two important provisions, related to decentralized planning process which is mentioned under N.R.H.M.	15.6	95.8	80.2
8	What is meant by R.C.H. Programme?	25.0	83.3	58.3
9	What are the 5 important steps necessary for planning?	45.7	78.3	32.6
10	Write down any five sources of data necessary for the decentralized planning of Health Services?	25.7	55.0	29.3

No.	Pre test post test comparison questions for participants from 5 districts (group A)	Pre test questionnaire filled during 1st and 2nd contact session	Post test questionnaire filled during 3rd contact session	Percent changes seen
11	Define Health inequity	31.3	75.0	43.8
12	According to you what are three key current limitations of the NRHM in the context of the decentralized planning of health services?	21.4	55.6	34.1
13	How much population is covered under P.H.C. in tribal area?	12.5	41.7	29.2
	C. Questions about process of PIP preparation and information related to it			
14	What do you understand by the term PIP? What are the five key components of the PIP?	8.0	73.8	65.8
15	What is the last step in sanctioning of P.I.P.?	12.5	50.0	37.5
16	Who is responsible Heath staff in the preparation process of village health plan?	57.1	100.0	42.9
17	In the NRHM implementation framework, who is authorized for sanctioning of the PIP at the State level?	7.1	58.3	51.2
18	What are the norms by government to include innovative activities under P.I.P.?	2.4	47.2	44.8
	d. Questions about RKS fund and information related to it.			
19	What is the amount of Untied fund for Rural Hospital?	18.8	83.3	64.6
20	What are criteria on which health facilities are receiving the untied funds under NRHM?	87.1	86.7	-0.5
21	How much IPHS grant under NRHM is disbursed to PHCs?	50.0	91.7	41.7
22	How much amount is supposed to be disbursed as a RKS funds at PHC level?	57.1	100.0	42.9
23	What are the norms which need to be fulfilled by concerned Health institutions before providing IPHS funds by Government?	17.9	85.4	67.6
	TOTAL of A, B, C, D sections	**31.2**	**66.3**	**35.1**

For analysis purpose, the entire set of 23 questions are divided into 4 sections and section wise conclusions related to change in knowledge of participants on the basis of above table are as follows-

A. **Section on perspective and conceptual understanding on Health and Health Rights**-

The changes at perspective and conceptual understanding of participants on Health and Health Rights vary from 4.2% to 28.6 %. As many of the participants have already been working on Health and Health Rights and have some experience in this area, change observed in their perspective and conceptual level is moderate.

B. Section on Decentralized planning process and NRHM related information-

The changes in understanding and knowledge of participants about decentralized planning process and NRHM related information vary from 29.2% to 80%. The ranges of minimum changes are from 29% to 45%. In two questions, maximum changes i.e. 58% and 80% are observed in the participants. It means that participants have generally understood about decentralized planning process and NRHM related information.

C. Section about preparation process of PIP and information related to it-

The changes in participants about understanding PIP preparation process and relevant information vary from 37.5% to 65.8%. Participants understood about the framework of PIP, preparation process, role and responsibility of each stakeholder etc. The maximum change (65.8%) is observed in the participants about understanding the concept of PIP and key component of PIP.

D. Section about RKS fund and information related to it.

The changes in participants about understanding RKS related information vary from -0.5 % to 67.6%. The maximum change was seen related to norms which need to be fulfilled by concerned Health institutions before providing IPHS funds – at 67.6%. The only question where there was no change was related to criteria on which health facilities are receiving the untied funds under NRHM. Probably the details of these criteria could not be adequately communicated, also these keep changing from time to time. On the whole we can say that participants understood most details about RKS framework, funds, role and responsibility about utilization of various funds.

Overall, the average pre-test score for all participants was 31.2% which increased to 66.3% in the post-test. This signifies an average increase of 35.1% between pre-test and post test. It is obvious that the starting level of knowledge of these civil society participants on these issues related to decentralised health planning was relatively low, but this has increased substantially through three rounds of training. Increase has often been higher on issues which are directly practically relevant to their work in Community based planning.

Analysis of PIP of Pune district (2012-13) to assess inclusion of activities linked with decentralized community based evidence

One of the essential features of decentralized district health planning is use of community based evidence. Under this project, 'facilitation of processes for inclusion of community based evidence in the district and block health plans' was one of the strategies. In order to implement this strategy, we had taken following steps at block and district levels in the intervention areas -

1. Identification of issues emerging from Community based monitoring processes as an input to preparation of proposals for PIP for 2012-13 –

   The basis were key issues which were identified during implementation of different CbMP (Community based Monitoring and Planning) processes such as data collection and preparation of report cards, Jan Sunwais, CbMP committee meetings etc. On the basis of this proposals were developed.

2. Orientation workshops/meetings with PRI members and key Health officials at different levels to discuss issues which need to be included in coming year's PIPs-

   One day capacity building workshops were conducted in each of the six intervention blocks from Nandurbar, Amaravati and Pune districts under the WHO supported project on capacity building for decentralised health planning. The main objective of these workshops/meetings has been to share information related to the process of preparation of PIPs under NRHM, and to discuss what could be the role of VHSC members in the different planning processes such as preparation of PIP.

3. Participation and interventions in the workshops organized by NRHM for preparation of PIPs at different levels-

   The Representatives of Civil Society organizations involved in implementing the CbMP process in Pune district have attempted to participate in the official workshops at district level which are being organized for preparation of PIPs.

In order to assess this intervention, following plan was finalized-

A. Analysis of one district health plan proposed for the PIP 2012-13, regarding inclusion of decentralized community evidence.

B. Comparative analysis of plans in two intervention blocks with control block plans in Pune district, to assess the impact of intervention to address issues identified through participatory processes.

Detailed analysis of component A is given below and for component B another report is prepared -

A. Analysis of one district health plan proposed for the PIP 2012-13, regarding inclusion of decentralized community evidence.

We obtained the proposed PIP 2012-13 for Pune district and analyzed it. We focused on those issues which were raised through various participatory forums under CBM in the year 2011-12 and were subsequently included in the PIP 2012-13, and for which funds were allocated.

Proposal for construction of new building for facility in following areas	
Name of the Facility	Details about forum / manner in which issues have been raised and funds allocated for the same
Nasrapur, Bhor Block (Proposed new PHC building)	Issue of new building for PHC has been raised by Block Monitoring and Planning Committee as well as RKS members,and was then included in proposed PIP. This Proposed PIP was submitted to Deputy Director, Health Services, Pune division on 7th January 2012. For this activity, Rs. 220 lacs were proposed from Block and in District PIP 2012-13, s. 120 lacs have been allocated.
Parinche, Purandar block (Proposed PHC)	Issue of new building for PHC was raised during 9 March 2012 Pune district Jan Sunwai, at Aundh Hospital. For this issue, Rs. 150 lacs were proposed from Block and in District PIP 2012-13, Rs. 100 lacs are allocated.
Sub Center- Ambale, Purandar Block	Issue of new building for Sub-centre was raised during 9 March 2012 Pune district Jan Sunwai, at Aundh Hospital. Rs. 25 lacs were proposed from block and in District PIP 2012-13, total proposed amount (Rs. 25 lacs) is allocated.
Issues related to repairing infrastructure of sub centers	
Name of the Sub-centre	Details about forum / manner in which issues have been raised and funds allocated for the same
Kelad , Block- Velha	Proposal for repairing of these sub-centres was submitted by nodal NGOs to Block Medical Officer, Velhe block, on 7th January 2012. These facilities were then included in PIP which has been proposed under Decentralized Health planning process. For this issue, Rs. 5 lacs/ institution were proposed from Block and in District PIP 2012-13, total proposed amount (Rs. 5 lacs/ institution) is allocated.
Margasani, Block- Velha	
Harnas, Block-Bhor	Proposal for repairing of these sub-centres was submitted by nodal NGOs as part of Decentralized Health planning process, to Block Medical Officer, Bhor block, on 7th January 2012. For this issue, Rs. 1 lac/ institution were proposed from Block and in District PIP 2012-13, total proposed amount (Rs. 1 lac/ institution) is allocated.
Rule, Block- Velha	
Wangani, Block- Velha	
Karandi Kh., Block-Bhor	

Issue related to proposal for new Rural Hospital at Khadakwasla	
Name of the Facility	Details about forum / manner in which issues have been raised
Proposed Khadakwasla Rural Hospital, Velha block	Proposal in this regard was developed as part of Decentralized Health planning process. Suggestion for PIP was submitted to Deputy Director, Health Services, Pune division on 7th January 2012. This proposal had been sent at State level for the approval in 2012-13 and in January 2013-14, approval has been received from State Govt.
Issues related to lack of facilities in staff quarters of following PHCs	
Name of the Facility	
Jogawadi- PHC, Block- Bhor	The issue related to lack of facilities in the staff quarters was raised in the Block level Jan Sunwai on 24th March 2012. As the process of PIP (2012-13) preparation was delayed, these issues were included in the proposed PIP at District level. For this issue, Rs. 4 lacs were proposed from Block and in District PIP 2012-13, total proposed amount (Rs. 4 lacs) is allocated.
Ambavade - PHC, Block- Bhor	Issues related to lack of facilities in the staff quarters were raised in the Block level Jan Sunwai on 24th March 2012. As the process of PIP (2012-13) preparation was delayed at Block level, this issue was included in the proposed PIP at District level directly. For this issue, Rs. 5 lacs were allocated in District PIP 2012-13.
Karanjawane - PHC, Block- Velha	This issue was raised during 9 March 2012 Pune district Jan Sunwai, at Aundh Hospital. Related to this issue, Rs. 80 lacs were proposed for construction of new staff quarters and in District PIP 2012-13, Rs. 50 lacs have been allocated.
Issues related to lack of water supply in specific PHCs	
Name of the Facility	Details about forum / manner in which issues have been raised and funds allocated for the same
Bhongavali - PHC, Block- Bhor	Issues related to lack of proper water supply in these PHCs was raised in the block level Jan Sunwai on 24th March 2012. As the process of PIP (2012-13) preparation was delayed, these issues were included in the proposed PIP at District level. For this issue, Rs. 1 lac/institution was proposed from Block and in District PIP 2012-13, total proposed amount (Rs. 1 lac) is allocated.
Nasarapur - PHC, Block- Bhor	
Nere - PHC, Block- Bhor	
Jogwadi - PHC, Block- Bhor	

(Note: regarding some of these issues, amounts had been proposed in the Block level PIPs however these amounts were modified during finalization of District level PIPs)

For period 2012-13, from Purandar block, 'Organization of block level health check up camp for patients having diabetes & high blood pressure with medication & follow up plan'- this innovative scheme has been proposed. This scheme has been included in District level PIP and sent for approval at State level. But in 2012 -13, this innovative scheme was not approved by State NRHM. After continuous and rigorous follow up with Chairperson of District level Health Committee by civil society organizations from Pune district, Pune Zila Parishad has allocated funds for this innovative scheme.

All the above facts show that based on capacity building for decentralized health planning, several issues which were raised through participatory processes such as Public hearings, PIP preparation process especially under Community based Monitoring and planning process have been addressed and included in the District PIP, and significant amount of funds have also been allocated for the same. This is a significant step forward in the process of ensuring that community based priorities are addressed during District health planning.