Commentary

People Reclaiming the Public Health System: Community-based Monitoring and Planning in Maharashtra

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Abstract

Community-based monitoring and planning (CBMP) of health services is being implemented in selected areas of Maharashtra with support from National Rural Health Mission since 2007. CBMP processes are organised at village, Primary Health Centre, block, district and state levels by a network of nodal civil society organisations working with the State health department. Key components include multistakeholder monitoring committees at various levels; community-based data collection and filling of health report cards; organising public hearings and periodic state level dialogues, with community-based planning focused on appropriate utilisation of untied funds. Various indicators show positive impact of these processes in CBMP areas such as significant rise in positive ratings of public health services over time, increase in utilisation of PHC services in Thane district and numerous positive 'stories of change'. However, key policy decisions are now required to ensure optimal effectiveness, generalisation and sustainability of such community action processes.

Keywords

Community-based monitoring, accountability, monitoring committee, public hearing, health report card, community-based planning, community action

Background

The National Rural Health Mission (NRHM) was launched in India in April 2005 with a view to bring about architectural corrections and strengthening of the rural public health system, towards improving health services for the rural

population. The Mission has aimed at strengthening public health services by ensuring increased funds and a wide range of 'supply side' reforms. While strengthening the health care system has been essential, it has been recognised that this was not sufficient to attract people back to public health facilities which had, in many areas, largely given up on government health services. 'Supply side' improvements must be accompanied by enhanced 'demand side' processes. Hence, in order to increase the accountability of the health system by increasing people's participation in public health services and to convince people that they should avail of these services as a right, a novel process was introduced in the Mission—Community-based Monitoring and Planning (CBMP) of Health Services.

With facilitation by civil society organisations and support from the State NRHM, community members and grassroots activists have been involved in organising a range of processes for accountability of public health services.

Overview of CBMP Framework and Processes in Maharashtra

Community-based monitoring and planning (CBMP) of health services is being implemented in selected areas of Maharashtra, among certain other states in India, as a component of NRHM since mid-2007. CBMP processes are organised at the village, Primary Health Centre (PHC), block, district and state levels. A State nodal NGO (SATHI in the case of Maharashtra) coordinates the CBMP activities across districts, in collaboration with the district and block nodal NGOs, working with the State health department. A multi-stakeholder monitoring and planning committee at each level collates the findings from the level below, monitors the health system at its own level, and passes these results up to the next level one or two times a year. Such CBMP committees have been formed in implementation areas at PHC, block, district and state levels.

Scale of CBMP in Maharashtra

CBMP has been implemented in five pilot districts, (Amaravati, Nandurbar, Osmanabad, Pune and Thane) initially covering 15 blocks and 225 villages. Encouraged by the emerging model of CBM, in 2009 the State NRHM extended the process to additional blocks and villages, so that currently around 370 villages in 18 blocks are covered by the CBMP process in these districts. Since March 2011, the process has been further extended to eight new districts (Solapur, Gadchiroli, Kolhapur, Chandrapur, Nashik, Beed, Raigad and Aurangabad). So currently, the CBMP process covers over 600 villages across 13 districts. Within these 13 districts, a total of 30 civil society organisations are involved in collaboratively implementing the CBMP process.

Key Processes in Community-based Monitoring and Planning

Process 1—Expansion/Formation and Capacity Building of Community-based Committees

A key activity in the CBMP process is building awareness among communities regarding basic health entitlements related to NRHM. Following this, Village Health, Nutrition, Water supply and Sanitation Committees (VHNWSCs) have been significantly expanded with inclusion of active community members selected in village meetings. These village committees have been activated and members have been oriented to carry out CBMP activities. Similarly, multi-stakeholder community-based monitoring and planning committees have been formed from PHC level to State level in context of CBMP areas. Such CBMP committees include Panchayat members, Health officials, civil society representatives and certain delegates from lower level committees. Members of these committees have been given training related to health services in context of NRHM, health rights and entitlements, CBMP processes and promoting people's participation.

Process 2—Community Data Collection and Filling Health Report Cards

At the core of CBM is the act of recording and reporting the state of public health services in villages and facilities as experienced by the people. On the basis of the orientation, village committee members have been involved in the process of filling up village health report cards, with active guidance from facilitators and coordinators of the nodal NGO/Community-based organisation. Information is collected on indicators like village level disease surveillance services; maternal and child health services including immunisation, antenatal care and postnatal care; curative services at the village level; use of village untied funds etc. Once they are filled, the village report cards are displayed in a prominent place in the village, and a copy is sent to the PHC level monitoring committee for further dialogue and action. Similarly data is collected and report cards are prepared at the level of sub-centres, PHCs and CHCs.

Process 3—Jan Sunwai or Jan Samvad

These mass events are attended by large numbers of local community members, people's organisations, NGOs, government officials and prominent persons from the region. At Jan Sunwais or Jan Samvads, people are invited to report their experiences of health services and denial of care, as well as findings included in the health report cards. The authorities present then respond to these testimonies and findings, stating how the problems will be addressed. As part of CBMP in

Maharashtra, Public hearings have been organised at the PHC level, block level and district level; hence nearly 200 public hearings have been organised so far as part of the CBMP process.

Process 4—Periodic State Level Dialogues

Prior to development of CBMP there was no regular forum for community level groups to raise issues at the state level in ways that could elicit action. Now officially mandated dialogues between the state health officials, district and block health officials, and civil society representatives are organised on an annual basis. These dialogues help to address issues that have not been resolved at lower levels and reinforce the commitment of the entire health department. The participation of Health officials from various levels helps to assign responsibility to take corrective action, which is often declared during the meeting itself.

Process 5—Community-based Planning

In continuation of Community-based monitoring, to help tackle various local and facility level issues, promotion of decentralised community-based planning of health services has been initiated in five districts since 2011. It was observed that Rogi Kalyan Samitis (RKS) were not aware about their expected role in deciding about utilisation of flexible funds related to NRHM. In this context, workshops for Monitoring and Planning Committee members including Panchayat representatives as well as RKS members on community-based planning were organised at various levels regarding how flexible funds should be used for genuine patient welfare (Rogi Kalyan). This has led several RKSs to address key issues emerging from community monitoring in their facility-based plans.

Indicators of Positive Impact—People are Returning to the Public Health System

Significant Rise in Positive Ratings of Public Health Services in CBMP Areas

Village level health committees have used report cards to assess the state of health services. Four rounds of assessment were undertaken by the respective committees till 2010 by collecting information in 195 villages and 32 PHCs from four pilot districts. The committee members rated health services as either 'Good', 'Partly Satisfactory' or 'Bad'.

Analysis of information compiled through the village report cards shows an increase in 'Good' rating in successive rounds of community monitoring. In the first round (mid-2008), 50 per cent of the services were given 'Good' rating, this increased to 63 per cent by Phase 4 (end-2010). Thus there has

been a consistent overall improvement in village health services related to the CBMP process. There has been a major improvement in 'Good' ratings to certain services from first to fourth rounds, like Antenatal care (58 per cent increased to 72 per cent) and immunisation (65 per cent increased to 89 per cent).

Similarly, the data collected from PHCs can be divided in four categories: infrastructure, services, personnel and medicines. Analysis of information compiled from 32 PHCs in five districts reveals that in the first round, only 44 per cent of PHC services received a 'Good' rating. By the fourth round there was a significant improvement, with 75 per cent services being rated as 'Good'.

Significant Increase in Utilisation of PHC Services: Evidence from Thane District

Generally there has been an increase in utilisation of health facilities after implementation of NRHM. Moreover, there is a higher level of increase in CBMP areas. We studied three key utilisation indicators: outpatient attendance, inpatient admissions and institutional deliveries for three years—2007–08, 2008–09 and 2009–10 in Thane district. These trends related to utilisation of PHCs covered by CBMP were analysed in comparison with the average trends for PHC utilisation in the entire district, and it clearly shows greater increase in utilisation in PHCs in CBMP areas.

1. **Community monitoring process has promoted increase in OPD attendance**
   Between 2007–08 and 2009–10, the average increase in OPD attendance for PHCs in the entire Thane district was 17 per cent, whereas increase in OPD utilisation in CBMP covered PHCs was significantly higher at 34 per cent.
2. **Higher increase in utilisation of inpatient admissions**
   Similarly between 2007–08 and 2009–10, the average increase in inpatient admissions for PHCs in the entire district was 50 per cent, whereas the increase in CBM covered PHCs was significantly higher at 73 per cent.
3. **Greater increase in institutional deliveries**
   Between 2007–08 and 2009–10, the average increase in deliveries in PHCs in the entire Thane district was 48 per cent, whereas the increase in deliveries in CBMP covered PHCs in the district was significantly higher at 101 per cent.

It can be concluded that NRHM related improvements have led to some overall increase in utilisation of PHCs in recent years. Further, in PHCs covered under the CBMP process, increased community awareness along with additional improvements in services promoted by public dialogue and other accountability processes seem to have induced more people to access PHCs for various types of care, indicating a movement from private providers to the public health system.

Selected Stories of Change Related to Community-based Monitoring in Maharashtra

Thirty-five such stories of change in context of CBMP processes have been documented in Marathi in detail and the collection has been published in form of a book. Some are reproduced here as an illustration of the success of community monitoring in improving public health systems.

1. **Community Monitoring Helps to Complete the Half-built Sub-centre**
   People in Jamshet village in Dahanu block of Thane district required a Health sub-centre. The sub-centre was sanctioned but the 'politically connected' contractor who was supposed to build the sub-centre, delayed the construction which lingered on for over two years, resulting in a half-built, useless structure. Villagers visited block level authorities and complained, but no one responded. In such a scenario, the CBMP process made a difference. The village level members of CBMP discussed the issue in a series of Gram Sabhas, and then raised this in the block level monitoring committee meetings on repeated occasions. Further, given the inaction of the contractor, one day scores of mobilised community members took their implements and landed up at the sub-centre to 'complete' the construction on their own through 'Shramdaan'. This moved the local authorities and contractor into action. The sub-centre building got completed and it has become fully functional. Even an additional Auxiliary Nurse Midwife (ANM) got posted at this sub-centre and now this is a full-fledged sub-centre with active utilisation by the community. The ANM, Ms Vasawale reports that 'in the last six months, there have been 83 deliveries in this sub-centre'.
2. **Community-based Planning Leads to Major Improvements in Nasarapur PHC**
   On the basis of the issues identified during Community monitoring, capacity building of RKS members including PRI representatives and suggestions given by CBMP civil society organisations, several issues have been addressed in Nasarapur PHC in Bhor block of Pune district. The improvements mentioned below have taken place within a few months following initiation of community-based planning:
   a. Lack of drinking water was identified as a major problem. Now to provide drinking water to patients, a water storage tank with inbuilt water filter has been installed.
   b. In order to make laboratory properly functional, a tank for water storage has been purchased and new pipe line for the laboratory has been constructed.
   c. People complained that 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 displayed through RKS funds.

d. The post of sanitation worker is vacant in Nasarapur PHC which was leading to lack of cleanliness. So to maintain clean premises, the RKS committee has now decided to locally appoint a sanitation worker leading to a clean PHC.
e. Workshops on 'Right to Health' and 'role of adolescents in village development' are now being conducted for groups of adolescents in nearby villages, with support from the RKS fund.

3. **Kavita Chooses the PHC for Her Delivery and 'Trupti' is Born**

CBMP is gradually winning people back to the Public health system, helping them to escape impoverishment from health care expenditure.

The failure of the public health system in many areas to convince even poor people about its quality of services is an ongoing tragedy. No wonder Gopal Sonar, a poor landless labourer in Ajara *taluka* of Kolhapur District sold his only buffalo for ₹15,000, anticipating the expenses that would be required for his daughter's first delivery in a private hospital. His daughter, Kavita, during her pregnancy attended some meetings conducted in the village under CBMP. The local activist Shivaji briefed her about the improved functioning of the PHC due to CBMP, and entitlement to free delivery care. Kavita was convinced that her delivery should take place at the PHC and not in a private hospital, even though her father was reluctant. Repeatedly assured by Shivaji, the family took Kavita to the PHC when labour pains began, and she delivered normally at the PHC. Gopal was jubilant as he had to pay just ₹5 at the PHC for that delivery, as against the anticipated huge amount expected in a private hospital. The newborn girl has been named Trupti (meaning 'satisfaction')!

Some Further Steps and Decisions Required to Carry Forward Community Action Processes

Community-based monitoring and planning is a nascent and emerging process, which involves 'cooperation with assertive dialogue' to promote health system strengthening and reorientation. Despite positive impacts, since this process generates social momentum for positive change, some degree of resistance is encountered from certain health officials who are unable to respond to the need for change and accountability. Hence, a key challenge in this process is to ensure continued improvements in health services and enhanced responsiveness of the health system over time. This depends to a significant extent on health officials at various levels taking ownership and getting actively involved in the process, as well as adequate space being given to civil society organisations and community-based activists to effectively promote pro-people change.

Building on the positive processes so far, in order to carry forward the positive process of Community-based monitoring and planning in Maharashtra, further action on several fronts is required:

1. **Constraints being placed on representation of civil society organizations in the CBMP process need to be removed**. It has been observed during the last two years that the mandate/proportion of civil society organisations in key CBMP bodies (such as state and district mentoring committees) has been reduced. Such a reduction of the role of civil society in key communitisation bodies, which must be broad-based and participatory instead of 'official centred', tends to constrain important multi-stakeholder processes; instead adequate and effective civil society representation must be ensured.
2. **Need to widen spaces for decentralised health planning activities:** While CBMP committee members have taken initiative to give inputs to local health planning processes, medical officers often continue to dominate these, allowing only minimal inputs from PRI members and inadequate space for involvement of community representatives and civil society activists. Further, in states like Maharashtra, although several community-based planning suggestions for inclusion in the annual Programme Implementation Plan (PIP) have been endorsed by officials at lower levels, these seem to have been eliminated from the final state PIP, apparently due to decisions taken at higher levels—a situation that needs to change if community-based planning is to become a reality concerning the PIP development process. Much more receptivity, transparency and openness on behalf of most health officials is required to make health planning under NRHM genuinely decentralised and 'communitised'.
3. **Need to plan phased modification of civil society inputs instead of eliminating these inputs:** The CBMP process is based on people's participation, and Community-based organisations as well as grassroots NGOs are playing a crucial role in capacity building, facilitating various forms of collection and analysis of information, as well as ensuring dialogue with and response from health care providers at various levels. It also needs to be recognised that community action is primarily a collective process, where local organisations play a key role in mobilising people and articulating their issues. Given this situation, while civil society organisations need to modify their role to make it less intensive in first phase areas (where community level processes have been underway for over four years), if officials plan an 'exit' of these facilitating civil society organisations, this is likely to seriously damage the CBMP process.

   At the same time, provisions which can enable community members to directly demand accountability such as a wide display of guaranteed health services, publicising health entitlements through mass media, toll free help lines for persons seeking care in public health facilities, institutionalising participatory forums like Jan Samvads, and much more effective and

responsive grievance redressal systems need to be operationalised. Such measures would encourage ordinary people to ask for their health rights, requiring progressively less intensive inputs from civil society organisations.

4. **Addressing systemic and structural health system issues:** Community-based monitoring activities have so far been maximally effective regarding 'local health services' (for example, village, sub-centre, PHC levels) whereas 'actions and decisions at higher levels' (district, state) have so far been less amenable to community accountability. Similarly, community-based planning has also been allowed some space at local levels, such as incorporating suggestions related to spending of RKS funds. However, despite action on local implementation issues, 'key health system issues raised through the CBMP process need to be addressed much more effectively'. The recent formation of the State monitoring and planning committee is a positive step to address such issues. NRHM needs to develop a specific set of strategies to ensure that genuine systemic issues being raised though the CBMP process, such as medicine procurement or vacant posts, are effectively addressed in a timely manner.

On the basis of the process of community-based monitoring and planning, now people are getting involved in revitalising health services. All stakeholders involved in this process now need to ensure that this process of restoring people's confidence in the public health system, along with improving and reorienting public health services, is given maximum support and priority at all levels. Such a commitment backed by action can ensure that the 'public' comes to the centre of the public health system.

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