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Reclaiming public health through community-based monitoring

The case of Maharashtra, India

Abhay Shukla and Shelley Saha Sinha
Support for Advocacy and Training to Health Initiatives (SATHI)

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ABOUT THE PROJECT

The Municipal Services Project (MSP) is a research project that explores alternatives to the privatization and commercialization of service provision in electricity, health, water and sanitation in Africa, Asia and Latin America. It is composed of academics, labour unions, non-governmental organizations, social movements and activists from around the globe who are committed to analyzing successful alternative service delivery models to understand the conditions required for their sustainability and reproducibility.

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EXECUTIVE SUMMARY

Community-based monitoring and planning (CBMP) of health services in Maharashtra state, India represents an innovative participatory approach to improving accountability and healthcare delivery. This paper examines the successes and challenges of this process, discussing lessons learned and the potential for generalizing such initiatives to other sectors and regions. Maharashtra's experiment could inform 'communitization' of health services in diverse contexts, as an alternative to privatization and as a means to enhancing the 'publicness' of health services.

The global discourse on community participation and accountability in health has been dominated by the perspective of the World Bank, which instrumentalizes it in the pursuit of narrow efficiency goals. In contrast, approaches based on rights that seek to reconfigure power relationships and strengthen public systems carry the potential to effect genuine change. Internationally, there have been some successful experiences of democratization of public health services, which are reviewed in this paper: health centre committees in Zimbabwe, national health assemblies in Thailand and health councils in Brazil.

CBMP in India is another such example. It has been developed on the basis of broad-based mobilization for health rights by *Jan Swasthya Abhiyan* (JSA or People's Health Movement – India) and the subsequent implementation of the National Rural Health Mission (NRHM). JSA was initiated at the turn of the millennium as a nationwide coalition of health groups and social organizations committed to achieving the goal of "Health for All". In 2003-2004, JSA launched a "Right to Health Care" campaign in collaboration with the National Human Rights Commission, which included regional and national public hearings on health rights. Thereafter, the NRHM was launched by the Government of India in 2005 to address important health system gaps identified in rural areas. As part of the NRHM framework, community-based monitoring and planning was put in place to ensure regular feedback and accountability in the process of strengthening health services. Nine states of the country, including Maharashtra, were selected to implement CBMP on a pilot basis between 2007 and 2009. In subsequent years CBMP processes have continued to expand in Maharashtra, covering 860 villages in 13 districts at present.

CBMP in Maharashtra is organized at multiple levels, from village to state. Health officials, elected local *Panchayat* representatives, civil society organizations and active community members form multi-stakeholder monitoring and planning committees at each level. The implementation of CBMP includes awareness-raising and preparatory activities, capacity-building and training of participants, formation and functioning of monitoring and planning committees, community-based assessment of health services, organization of public hearings and state-level dialogue events. One of the core strategies of CBMP is the *Jan sunwai* or public hearing, which is attended by large numbers of community members and diverse stakeholders. In these hearings, people are invited to report their experiences of health services in the presence of health officials and panelists from various fields. Since 2008, as part of CBMP, over 450 public hearings have been organized in Maharashtra.

Community-based planning has been developed to complement monitoring activities, focusing on widening participation in the planning process of local health facilities, based on the use of flexible public funds. Major successes and challenges of CBMP have been identified through two recent external evaluations.

Supported by diverse stories of change, the paper describes how increased accountability is an important area of CBMP impact, how the process has created various forums and spaces for dialogue among stakeholders, and how it has led to systematic data collection on health indicators. Analysis of data regarding accessibility and quality of services generated through successive rounds of community-based monitoring demonstrates substantial improvements in services being delivered at village as well as primary health centre levels. Some examples are major improvements in immunization and antenatal care at village level, availability of ambulance services and medical officers staying on the premises of primary health centres. Despite positive impacts, there are several challenges in the implementation of CBMP, including the need to address systemic and structural issues, the importance of greater political commitment, and the need to make CBMP a core element of public health policy.

Notwithstanding these challenges, CBMP has contributed to deepening democracy by:

- Creating forums for direct democracy
- Expanding representative democracy and ensuring participation of community-based actors in local health planning
- Reclaiming representative democracy
- Promoting external accountability processes, which have triggered internal accountability mechanisms

From the Maharashtra CBMP experience, we can identify critical ingredients for the effectiveness of accountability processes. Its socio-political significance is clear: it presents a functional framework for converting social aspirations and policy commitments into actual vehicles for change. CBMP may be viewed from various angles as: a concrete mechanism for realizing health rights; an intervention 'from below' to monitor and influence health sector reform; a people-based, practical alternative to privatization; a multi-pronged process for expanding democracy in the social sector; and a process for enhancing the 'publicness' of health services.

Finally, it would appear possible to generalize the CBMP approach to other social services, as illustrated by the recent initiation of "community-based monitoring and action" related to child care and nutrition services on a pilot basis in certain areas of Maharashtra. As for reproducing the model in other countries, it is argued that in each context an appropriate framework for community accountability and participation would need to be elaborated, keeping in mind the community, social, political and health system contexts, along with securing adequate resources to support its implementation.

Introduction

The right to health is enshrined in the International Covenant on Economic, Social and Cultural Rights and in over 130 national constitutions worldwide, yet the majority of the world's population continue to be denied their health rights, or they are inadequately protected. During the last few decades, there has emerged a "rights-based" discourse to development, which aims to ensure sustainable development outcomes by analyzing and addressing the inequalities, discriminatory practices and unjust power relations at the heart of development problems (Flores 2011). The human rights paradigm provides a compelling framework for mobilizing around health care and the social determinants of heath, and accountability is a powerful concept to involve people in demanding their rights to services necessary for their health and well-being.

In this context, many countries have created spaces for citizen participation in the delivery of health services (McCoy et al 2012). However, there are relatively few effective and widely applicable approaches to guaranteeing accountability of health services in a participatory manner that have been implemented on a large scale with clearly demonstrated impacts. It is important therefore to study examples that have been found to make public services more democratic, accountable and participatory. Community-based monitoring and planning (CBMP) of health services in Maharashtra, India is one such example. The paper draws key lessons from Maharashtra CBMP processes to inform the development of similar initiatives in other regions and sectors. The data for this paper are generated from various reports on CBMP activities, two recent external evaluation reports, individual interviews, and a workshop organized with practitioners of CBMP in Maharashtra.

This paper analyzes the CBMP process as a framework to build accountability, improve access and enhance responsiveness of public health services. After briefly tracing the historical backdrop and some relevant international experiences, we describe the development of this innovative participatory approach in India, based on activities of the People's Health Movement related to the right to health and in the context of the National Rural Health Mission. Further, we describe the framework and scope of CBMP in Maharashtra, we identify key ingredients that have made its successful implementation possible in Maharashtra, and outline key challenges. Finally, the paper draws out lessons learned from this experience, which might be relevant for generalizing such initiatives to other sectors and regions.

Community members participate in a public hearing organized at a Primary Health Center in Amaravati district. Photo: KHOJ, Amaravati

Perspectives on community accountability in health

The idea of community participation in health has been discussed since the early 1970s, based on the notion that basic health needs can only be organized with greater involvement of local people themselves (Rifkin 2012). The concept was formally articulated during the World Health Assembly at Alma-Ata in 1978, and was henceforth considered a cornerstone of the strategy to achieve "Health for All" by the year 2000. The Alma-Ata Declaration argued that a focus on hospital-based programs was inadequate for achieving public health, and that there was a need to promote concepts such as empowerment, health promotion, collective action and community participation.

Over time, community accountability of health systems has emerged as an important focus area within the broad theme of community participation. In neoliberal discourse, the concept of accountability is at the basis of options such as increasing competition and the introduction of community financing schemes intended to make health providers more accountable to their paying clients. However, defenders of citizenship rights have challenged the assumption that increasing competition would strengthen accountability of the public health sector. They have pointed out that the concept of accountability includes two elements: "answerability" to citizens by those in power and "enforceability" of penalties in the event of abuses. It has been noted that the strategies promoted by the World Bank for participation and accountability within health system reforms, have often failed to increase participation of marginalized groups when health personnel had the political upper hand (Murthy and Klugman 2004).

Other authors also criticize the World Bank's limited accountability framework, which has appealed to a large section of policy-makers, international agencies and practitioners (Joshi 2007). This may be so because they promote formal accountability mechanisms and present simplistic thinking when it comes to addressing issues of a socio-political nature; they are blind to the fact that accountability unfolds in complex political and social environments in developing countries.

If mainstream accountability mechanisms are mostly anchored to the concept of 'efficiency', among social movements and activist groups accountability usually invokes the concept of 'rights' and seeks to transform structures of power. Innovative experiments in governance have been initiated across the world, opening up spaces for active public involvement in deliberation over policies and a greater degree of popular control over resources (Cornwall 2002).

International experience

Since the 1990s there have been numerous experiments to promote health system accountability and greater popular participation in health planning processes. Many countries have pursued innovative mechanisms to promote more direct citizen engagement in the processes of governance,

ranging from the creation of new decentralized institutions, to a wide variety of participatory and consultative processes. A few such significant experiments of democratizing public health services in selected countries are discussed below, by way of example.

Health centre committees, Zimbabwe

Zimbabwe's national health policy states that the government's role is "to ensure that communities are empowered to take responsibility for their own health and well-being, and to participate actively in the management of their local health services" (Rusike 2013). Although the policy has strongly endorsed community participation since the 1980s, it was implemented within a system where decision-making was generally centralized and dominated by administrative inputs (Loewenson et al 2004). In the absence of wider, more coherent powers and responsibilities given to local structures, some of their rather ad hoc roles became a source of tension. In 1998, a network of membership-based civic organizations called the Community Working Group on Health (CWGH) was formed in Zimbabwe to focus on advocacy, action and networking around health issues. The civic groups expressed public discontent with the manner in which community participation was being implemented in the country, and in 2001 the CWGH initiated a process of revitalizing health centre committees (HCCs) to strengthen their capacity to obtain resources from the health system. HCCs are a mechanism for community participation at the primary care level. These are meant to complement vital initiatives such as the deployment of community health workers and mechanisms for public participation.

HCCs subsequently got formal recognition when the National Health Strategy 2009-2013 made specific note of their importance, explaining that "during the next three years, communities, through health centre committees or community health councils will be actively involved in the identification of health needs, setting priorities and managing and mobilizing local resources for health" (Rusike 2013). Now the HCCs identify priority health problems with communities, they plan how to raise their own resources, organize and manage community contributions, and advocate for resources for community health activities. The committees discuss key issues with health workers, report on community grievances about quality of health services, and raise community health problems with healthcare providers. Thus HCCs have become critical to achieving a sustainable people-centred health system in Zimbabwe (McCoy et al 2012).

National health assemblies, Thailand

In 2008, Thailand launched participatory processes on national health policies in the form of an annual national health assembly (NHA), as mandated by the Thai National Health Act of 2007. The assembly comprises three main groups: representatives from government; representatives from academia and expert groups; and representatives from civil society. According to the chairperson of the organizing committee for the first NHA, it is "a forum for the public to pool views and initiate health agendas that truly address people's needs" (Treerutkuarkul 2009). More than 1,500 people

participated in the event in 2008, including 178 delegations from government agencies and provincial authorities, the private sector and civil society. Marginalized groups such as stateless people living near the Myanmar border gave presentations at technical briefings for participants. Since then the NHA has been convened every year, engaging all constituencies – government sector, academia and civil society – in the entire policy process, from agenda-setting to implementation (National Health Commission Office of Thailand 2014).

These participatory processes have helped increase awareness of health issues among the general public, and have fostered local commitment to solving problems at this level. As part of discussions on a proposed agenda, local constituents have analyzed the health problems they faced, and some interventions have been implemented without waiting for the government to change policy. It has also built capacities to analyze and collect data to understand the situation in each area. However, many challenges remain, especially on ensuring equitable representation and getting NHA resolutions implemented.

Health councils, Brazil

The 1988 Brazilian Constitution sanctioned the decentralization of policy-making and established mechanisms for citizen participation in the formulation, management and monitoring of policies. These mechanisms have included health councils (HCs) prominently at the federal, state and municipal levels, with the principle of parity between representatives of civil society (50% of seats) on the one hand, and government representatives (25% of seats) and public and private service providers (25% of seats) on the other. The number of members in each council ranges from 12 to 48, and presently there are over 5,500 municipal councils, 26 state councils and one national council. The HCs participate in the planning of health strategies, decide on the distribution of financial resources and monitor implementation of policies. In addition, health conferences are held at each of the levels of administration every four years to evaluate the health situation and set priorities for the formulation of health policies (Cornwall et al 2008).

Health councils make decisions, act as consultative bodies and approve annual plans and health budgets. They also assist health departments with establishing priorities and auditing accounts. These councils engage citizens not as 'choosers', but as those who should be actively engaged in shaping policies and holding the state to account for delivering on them. It has been observed that Brazil's participatory institutions "were given extensive powers of spending oversight, and federal transfers of funding made conditional on their approval of budgets and health plans"(Cornwall and Shankland 2008, 2176). The system of periodic health conferences at municipal, state and national levels complements the participation in the health councils, and the "extraordinary capillary reach of these institutions engages literally hundreds of thousands of citizens in deliberation over health policy" (Cornwall and Shankland 2008, 2176).

Analysis of these new democratic spaces in the context of health services shows that the NHAs in

Thailand provide an innovative model for increasing public participation and inter-sectoral collaboration that could be adapted to other contexts. However the challenge remains to translate NHA resolutions into policy. The Brazil health councils have succeeded in improving accountability, but are limited in their autonomy as they function within a bureaucratic setup with which HC members often have multiple linkages. The Zimbabwe model shows that without adequate resources and mandate, citizens may face constraints in effectively shaping local health services.

Based on this brief background of representative processes for promoting accountability and participation in the health sector in selected countries, we now discuss CBMP as it is practised in India, focusing on the example of Maharashtra.

Community-based monitoring and planning in India

As democracy evolves in India, there is a growing role for citizens in monitoring the bureaucracy and state functionaries. Several pieces of legislation over the last decade, including the Right to Information Act, have empowered the public to demand accountability from civil servants. Recognizing the importance of health in the broader process of economic and social development and its key role in improving the quality of life of citizens, the Government of India launched the National Rural Health Mission (NRHM) in 2005 to carry out architectural corrections in the rural health care delivery system, providing the basis for the emergence of the CBMP framework. The conceptual basis for CBMP in India can be condensed into three key inter-related ideas: ensuring people's rights; reclaiming public services by intervening 'from below' in health sector reform processes; and deepening democracy.

There have been efforts to decentralize the health system in India for decades. The 73rd amendment to the Indian constitution in 1992 sought to decentralize power to the elected local bodies (*Panchayats*) at district, block and village levels. But, for all practical purposes, national ministries and departments have remained the main policy and decision-making units. A few states in India have been exceptions such as Kerala and Nagaland, where the state governments have taken initiative to involve the local governments or village councils in the management of the health system.

In Kerala state, the local planning process has been conceptualized as an instrument of social mobilization, and health issues, along with related subjects such as drinking water, nutrition and sanitation, are discussed in *Gram sabhas* (village assemblies). The process of decentralized planning has consisted of *Gram sabha* discussions, secondary data collection, preparation of development reports, incorporation of suggestions made by people into projects, and formulation of local health plans (Elamon and Ekbal 2000), which implementation is supported by devolution of substantial funds to the local elected bodies.

Likewise, Nagaland has adopted a democratized local planning process inspired by the Naga traditional village administration. Each recognized village has a council that looks after law and order matters and a village development board that undertakes development activities. The Nagaland government enacted the Communitisation of Public Institutions and Services Act 2002, which provides for the transfer of ownership of public resources and assets and transfer of control over service delivery to the community. 'Communitization' has been introduced in three government sectors, namely, elementary education, grassroots health services and power utilities (Government of India 2006).

Besides the above mentioned government initiatives, diverse civil society organizations have also worked to ensure accountability and participatory planning for various public services, including health services (Shukla and Phadke 1999). These initiatives have contributed to building the health movement in India, and have enabled communities to build pressure for the fulfillment of health rights. There are notable instances of people's organizations mobilizing large numbers to take up health rights issues. In Maharashtra, two such organizations, *Kashtakari Sanghatana* and *Shramik Mukti Dal*, have collaborated with the health professionals and social workers at the NGO Support for Advocacy and Training to Health Initiatives (SATHI), contributing directly to the launch of health programs from 1998. Women volunteers in these people's organizations were trained by the SATHI team to work as community health workers, to challenge medical exploitation and overcome medical deprivation in remote rural areas. This was combined with mass mobilization to pressurize the local primary healthcare system, to improve its functioning and to make it more responsive to people's needs.

Nationally, an important step forward was taken in 2000, when a large number of health groups, people's science and women's organizations came together to form the national coalition *Jan Swasthya Abhiyan* (JSA, People's Health Movement – India). In the preceding year-long campaign the goal of "Health for All" had been popularized, and people in various states were mobilizing around the lack of adequate health services in the public system. This process culminated with the National People's Health Assembly 2000 in Kolkata, where activists deliberated on various health policy issues and adopted the People's Health Charter. Soon after, an Indian delegation participated in the International People's Health Assembly in Dhaka, Bangladesh.

In September 2003, JSA decided to commemorate the 25th anniversary of the Health for All Declaration by launching a national "Right to Health Care" campaign. It called for a significantly stronger and people-centred public health system, a demand based on documented cases of denial of health care in public health facilities and other findings from participatory surveys on public health services. The National Human Rights Commission (NHRC) was approached in 2004 regarding the widespread denial of health rights, and during that year JSA and NHRC collaboratively organized a series of five regional public hearings (*Jan sunwais*) in the public health system during which selected cases of denial of health care were presented to the NHRC officials.

These hearings mobilized public opinion for improvement of public health services. This was

followed by a national public hearing, when the NHRC came up with a National Action Plan for the realization of the right to health care. Influenced by such developments and following a change in national government after the 2004 general elections, the NRHM was launched in 2005 to provide accessible, affordable, equitable and quality health services to the poorest households in the rural areas of the country.

National Rural Health Mission: space for community action

The most extensive community accountability initiatives in the health sector in India today are being developed within the framework of the NRHM. The Ministry of Health introduced the first phase of the mission from 2005 to 2012 and the current phase until 2017 is now combined with an Urban Health Mission to constitute a National Health Mission. The program was launched to provide equitable, affordable, accountable and effective primary health care to the poor and marginalized population. The mission's uniqueness lies primarily in the institutional instruments used to pursue these goals, foremost the attempts at structurally reconfiguring the public health system to facilitate decentralization and communitization, widely accepted as beneficial development trends. Key elements of this 'architectural correction' include the provision of flexible and need-based financial allocations for innovative utilization at various levels. Further, following advocacy by activists associated with JSA, a system of community-based monitoring was included in the framework of NRHM.

The Government of India constituted the NRHM Advisory Group on Community Action (AGCA) in 2006, consisting of civil society representatives expected to provide guidance for community action. The pilot phase of community-based monitoring was implemented with facilitation by AGCA in nine states (including Maharashtra), covering more than 1,600 villages and 300 public health facilities (Centre for Health and Social Justice and Population Foundation of India, 2010). During this phase, model community monitoring tools, formats and manuals were prepared and state preparatory meetings and workshops were held. In each state, a state mentoring committee and district mentoring committees were set up involving health officials as well as civil society organizations and experts; in addition, multi-stakeholder district, block and PHC planning and monitoring committees were constituted; finally, village health and sanitation committees were formed and oriented. Based on community experiences, data was collected and public report cards on services were prepared; public hearings were conducted at PHC, block and district levels. It is within this complex and carefully orchestrated context that CBMP was implemented in Maharashtra.

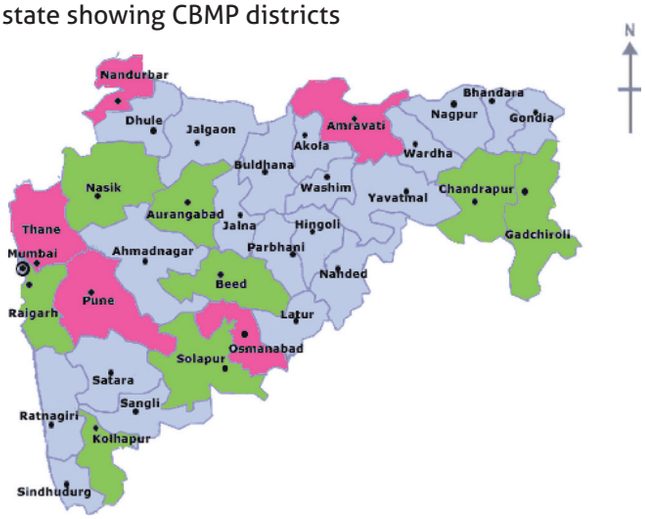
CBMP implementation in Maharashtra

Maharashtra is, population wise, the second largest state of India (more than 115 million people), and is located in the western part of the country. Maharashtra has a long tradition of social reform movements and voluntary initiatives in the health sector, which have formed the backdrop for development of community-based monitoring and planning.

Maharashtra was one of the nine states selected for the CBMP pilot phase in 2007, when five districts were chosen for implementation. In the second phase (2011 onward), this activity was expanded to eight additional districts. Over time, the process has expanded to include additional blocks and villages in each district. By mid-2014, the process was being implemented in 13 districts (out of 36), 36 blocks and 125 primary health centres covering 860 villages. Twenty-six civil society organizations have been collaboratively involved in facilitating CBMP processes across these districts.

Prior to the 2005 launch of NRHM, the public health system was mainly dependent on two forms of information and evidence – the internal Health Management Information System and periodic assessments done by external professional agencies. In response to inputs from civil society activists, officials agreed to introduce a third source in the form of community-based monitoring and planning reports, leading to a more robust, triangulated system of validation. One of the key considerations while designing this framework was not only ensuring accountability, but also promoting decentralized inputs for better planning of health services, based on priorities and issues identified by the communities (Shukla et al 2011).

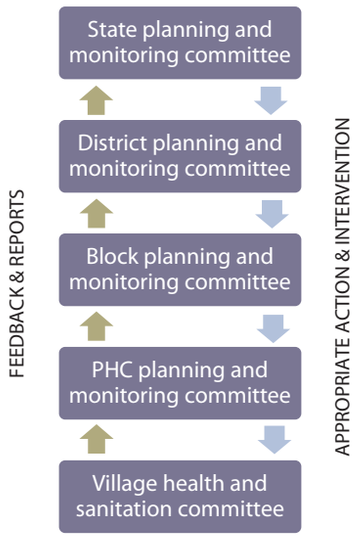
FIGURE 1:
Map of Maharashtra state showing CBMP districts



At the core of CBMP processes are multi-stakeholder bodies. The base is formed by the village health, water supply, sanitation and nutrition committee, which includes local elected representatives, health functionaries and community members. Monitoring and planning committees at PHC, block, district and state levels include health officials, elected Panchayat representatives, NGO and community members. A state nodal organization coordinates the CBMP activities across districts (SATHI in the case of Maharashtra), in collaboration with the district and block nodal organizations working in their respective areas as well as the state's health department. The committee at each level collates the findings from the level below, monitors the health system at its own level, and passes the results and unresolved issues up to the next level one or two times a year (see Figure 2).

FIGURE 2:

Structure and composition of monitoring bodies



Proportion of representation in the committees from PHC level and above:

- Representation of elected members of local government bodies: 30%
- Representation of health officials: 20-30%
- Representation of civil society bodies: 15-20%
- Non-official representatives from lower level committees: 15-20%
- Representation of *Rogi KalyanSamiti* (health facility development committee) members: 10%

Source: Shukla et al 2013.

TABLE 1:

Broad responsibilities of the monitoring and planning committees

Level	Responsibility
Village	a. Reviews village health services, village health calendar b. Reviews performance of local health and nutrition related functionaries c. Sends periodic reports to the PHC committee
PHC	a. Reviews and collates reports from all village committees b. Members visit the Primary Health Centre, review records, discuss with health functionaries and patients, discuss the PHC report card c. Sends periodic reports to the block committee d. Facilitates the organization of a PHC-level *Jan sunwai* (public hearing)
Block	a. Reviews and collates reports from all PHCs b. Members visit the Community Health Centre and review records, discuss the report card c. Sends periodic reports to the district committee d. Facilitates the organization of a block-level *Jan sunwai*
District	a. Reviews and collates reports from all blocks b. Members visit district hospital and review records, discuss key community monitoring findings in the district c. Sends periodic reports to the state committee d. Facilitates the organization of a district-level *Jan sunwai*

Development of the CBMP process includes preparatory activities, capacity-building, training of trainers, community assessment, public dialogue and state-level facilitation. Brief details about these activities are given below:

Awareness-building and organizational frameworks

- Meetings and workshops with key stakeholders are held at different levels to orient them about the CBMP process, to share the concept and ensure broad-based participation and cooperation from all involved.
- Community monitoring teams are constituted by nodal civil society organizations at different levels to lead the development of activities.
- Community awareness-building and mobilization regarding health rights is carried out in all involved communities, through various interactive processes such as health awareness campaigns, cultural programs and village meetings.

Cultural programme for awareness regarding CBMP organized in a village in Pune District. Photo: MASUM, Pune

Formation of monitoring and planning committees

- Multi-stakeholder monitoring and planning committees are formed at various levels as described above. This is facilitated by three-member teams at each level, which include a civil society activist, an elected representative and health official.
- Capacity-building of all committee members is ensured through orientation workshops and meetings.

Community assessment of health services

- The experiences and feedback of community members are collected using specific tools, through in-depth interviews, focus group discussions, case studies and review of records.
- Data are collated and analyzed in a standardized manner at different levels so as to present an aggregated public document called a "citizens report card" (prepared at village, sub-centre, PHC and rural hospital levels).
- Monitoring and planning committees send periodic reports to the committee above their level to ensure action on issues they cannot resolve.

Jan sunwais (public hearings)

- These are mass events where people are invited to present their experiences of health services and denial of care, which are followed by response from authorities (see Box 1).
- *Jan sunwais* are facilitated by the district and block nodal organizations, in collaboration with elected representatives and civil society organizations working on health rights.
- Relevant health authorities (including an official from the higher level) are present; they respond to the testimonies and findings, stating how the problems will be addressed.

Periodic state-level dialogue

- Through state-level dialogues, generally involving state health officials and nodal civil society organizations, the entire process is monitored and active cooperation of health officials at all levels is ensured.
- Issues left unresolved at the district level are discussed with state officials, who provide relevant directives. Simultaneous participation of health officials from various levels helps to clearly assign responsibility (overcoming tendencies to 'pass the buck'), which facilitates corrective action.

The above steps have been followed in all the CBMP areas, and have led to widespread and significant qualitative and quantitative improvements in health services across all the districts (see section on successes, below). Maharashtra was the first state in the country to include the CBMP component in its state Project Implementation Plan in 2008-2009. This is a reflection of the effectiveness with which this pilot process has been implemented, and the governmental support that CBMP has found in Maharashtra, unlike several other states where CBMP processes have been stalled or significantly diluted following the pilot phase.

Promotion of community-based planning

During the first phase of CBMP in the state of Maharashtra (2007-2009), the emphasis was on community-based monitoring (CBM); from 2010 onward, the component of community-based planning (CBP) started being developed. While community monitoring has been effective in highlighting the deficiencies in health service delivery, it is now being complemented by a CBP process that proposes appropriate solutions to these problems.

Health planning in India, especially at the district and sub-district levels, has traditionally been monopolized by the bureaucracy, with nominal roles for political representatives and practically no space for intervention by community groups or civil society organizations. CBMP in the context of NRHM seeks to reverse this trend by promoting CBP as a continuation of CBM activities. From 2010 to 2013, SATHI, in collaboration with various nodal civil society organizations, has focused on

BOX 1 JAN SUNWAI: A PEOPLE-CENTRED MASS EVENT FOR ACCOUNTABILITY

Jan sunwais are public hearings where local community members recount their experiences of poor health services or denial of care and present findings from village health report cards, while health officials are expected to respond. They do so before prominent citizens from various fields (lawyers, private medical professionals, academics, etc.) who form a panel that hears both sides and provides expert comments, raising people's awareness of their rights as well as putting pressure on health officials to implement the recommendations. Further, media is actively involved in public hearings, adding to the social pressure necessary to impulse positive changes in the rural health system. For instance, after a public hearing at Saswad Rural Hospital in Pune, action was taken on the following issues (Khanna and Pradhan 2013):

- A medical officer working in the hospital who was practising illegally and denying proper treatment to patients was transferred.
- The physical condition of the hospital was improved.
- Staff behaviour significantly changed.
- Representatives from the Public Works Department (responsible for construction and maintenance of hospital buildings) were included in the monitoring committee to ensure their accountability.

Between 2008 and 2014, over 450 public hearings have been held in various districts of Maharashtra, at PHC, block and district levels. It is widely acknowledged that such hearings are a crucial 'engine of change' for the community-based monitoring process.

Source: Shukla et al 2013.

capacity-building of community-based actors in selected CBM areas to promote additional participatory health planning roles. The use of information collected locally through the CBM processes to effect change via CBP actions has led to stronger and wider community engagement (see Box 2).

CBP so far has been centred on certain key processes to ensure that community-based evidence is fed into the local health system's planning process. Interventions have included: community discussions to identify major health-related areas of concern for community members; active intervention by civil society activists and elected representatives in planning *Rogi Kalyan Samiti* (RKS or health facility management committee) expenditures; formulation of proposals for inclusion in block- and district-level plans based on community evidence; active efforts to ensure spaces for participation by community-based organizations and grassroots NGOs, including advocacy for issuance of relevant state-level orders. To enable such activities, capacity-building activities for district and block monitoring committee members for evidence-based planning was undertaken by SATHI, along with a structured learning course on decentralized planning (Shukla et al 2012).

BOX 2 NASARAPUR PHC: FROM OFFICIAL TO COMMUNITY-BASED PLANNING

In Nasarapur PHC in Pune district, NRHM flexible funds were being spent by medical officers who were taking all the decisions regarding their utilization, without informing or getting sanction from the *Rogi Kalyan Samiti* (RKS or health centre management committee). Following a special orientation program, the civil society-based CBMP block coordinator, the president of the committee and an elected representative spoke to the doctors and insisted on regular RKS planning meetings, and circulation of decisions to all members. Civil society representatives of the block monitoring and planning committee were invited for the first time to an RKS meeting, where they actively participated and made several proposals, which led to the RKS committee taking a number of positive decisions, whose impact could be seen within a few months:

- The serious problem of water supply was solved by installing four water tanks, resulting in direct benefits to patients, cleaner premises and a fully functional laboratory.
- A display board was installed for easy location of the health facility.
- A sanitation worker was appointed using RKS funds, to ensure regular cleaning of premises.
- A workshop on the role of adolescents in the development of village health was conducted for school youth using the RKS fund.

These improvements have been very important from the community's point of view, whereas they were not considered relevant by officials during earlier planning. This experience shows that involving diverse stakeholders including elected representatives can create social momentum for more responsive planning. Formal democratic spaces have been expanded and occupied by community-based actors who focus on people's priorities.

Source: SATHI 2012a.

This process highlights the fact that while knowledge and skills are necessary, they are not sufficient to open and democratize a closed power structure, especially decision-making related to financial resources. There is a need for parallel social processes and advocacy to ensure that relevant stakeholders are effectively (not just formally) included in the planning process.

Positive impacts of CBMP

Two recent, independent external evaluations (Khanna and Pradhan 2013; State Health System Resource Centre 2013) of CBMP were undertaken to study its effects on public healthcare delivery and the interaction between communities and the public health system. Both evaluations noted that the CBMP interventions significantly contributed to strengthening health services and improving quality of care; they also recognized their potential to mobilize communities to demand services, and to create positive pressure on the system to become more responsive and accountable. Both external evaluation reports have strongly validated the benefits of the CBMP process in pilot phase districts, where the process is now well-rooted. Key areas of positive impact of CBMP are described in the sections that follow.

BOX 3 POSITIVE EFFECTS OF COMMUNITY-BASED MONITORING AND PLANNING AT A GLANCE

- Several closed sub-health centres have been reopened and have started functioning.
- Some medical officers and staff who were not staying in the PHC/CHC campus despite availability of quarters have come back to stay on the premises.
- Prescription of medicines to be purchased from the private sector has been practically eliminated in PHCs.
- Doctors and health centre staff have stopped charging illegally for services.
- Beneficiaries are now receiving their full pregnancy and delivery related allocation in a more timely manner under the *Janani SurakshaYojana* program.
- Behaviour of staff toward patients in PHCs has substantially improved and complaints of once common abusive behaviour have practically ended.
- Frequency of visits by Auxiliary Nurse Midwives (ANMs) to villages, including remote hamlets, has improved.
- Health facility management committee (RKS) funds are being utilized more appropriately.
- Disparity between the actual and recorded weights of the children in *Anganwadis* (community-based child care and nutrition centres) has been reduced to a great extent.
- The untied funds assigned to the village health and sanitation committees, which were being spent mostly for the *Anganwadis* in the past, are now being used in part for broader activities related to community health.
- In response to people's expressed need, ambulance services have become regularly available in the great majority of PHCs.
- The number of outpatients, inpatients and deliveries in PHCs in CBMP areas has significantly increased, with people shifting away from private providers to public facilities.

Source: SATHI 2012a.

Greater accountability and responsiveness

Implementation of CBMP has enabled community participation to increase accountability and responsiveness of the public health system. The role of civil society organizations in this context has included building mass awareness and community mobilization, documenting gaps, assertively dialoguing with healthcare providers and officials to demand improvements, and providing ongoing guidance to the village health, water supply, sanitation and nutrition committees and community members in general.

Increased participation was observed among village committee members and civil society activists as a result of heightened awareness about their role in monitoring of health services. Once these stakeholders were empowered, they were found to be actively taking up issues and contributing to improving health services, and in some cases even taking action beyond the formal CBMP framework (see the case of Moroshi village in Box 4).

BOX 4 TRIBAL PEOPLE GET THEIR PHC BACK

In 2008, due to political pressure, a PHC covered by CBMP in a tribal area in Thane district was closed down and merged with another PHC, despite the objections of the people of Moroshi village. As a result, villagers had to travel a distance of over 30 kilometers to visit their newly assigned PHC. The people's organization implementing CBMP in the district took the lead in orchestrating several protests, collective letters to elected representatives, and filing a case on behalf of the village. Bureaucrats had to respond to people's demands, and in January 2014 the government sanctioned a new PHC for Moroshi village, which is now functioning.

Source: SATHI 2014a.

Furthermore, participation of various stakeholders in publicly raising issues related to health services has increased due to CBMP. Periodic reviews in monitoring committees at PHC, block and district levels and public events such as *Jan sunwais* are important spaces where community members can actively get involved.

As community members have started to raise issues publicly, involvement of local elected representatives has also increased because they are now required to respond to public demands. Some representatives reported being significantly more aware about health rights and being actively involved in the monitoring process.

Forums and spaces for dialogue among key stakeholders

One of the most important enabling factors to increase accountability is the creation of multi-level dialogue mechanisms, from village to state. Periodic meetings of monitoring committees at all levels have been appreciated by all stakeholders as much-needed forums for discussing gaps in health service delivery, and also for proposing possible solutions. There have also been several examples of people in CBMP areas now contacting PHC staff in case of emergencies and facilitating prompt care. Involvement of government officials such as block health officers and local elected representatives at block and district levels in the CBMP process has resulted in people gaining direct access to these officials, helping to ensure access to quality health care at the grassroots level.

Annual *Jan sunwais* ensure that issues get reported and discussed publicly in a broad forum, promoting direct democracy. Community members and CSO representatives can demand justice for denial of services, seek explanation for gaps in healthcare delivery and present their needs to concerned officials.

While *Jan sunwais* were not welcomed by health officials initially, over the years they too have realized the potential of such forums for improving health service delivery. Regularly held sessions have

convinced most officials to embrace this process and health workers have started using these platforms to voice and resolve their own concerns (see for example how women health workers have protested against harassment in Box 5). The very nature of such hearings has also evolved over time; they are considered more collaborative now and in many places have become *Jan sanwads* (public dialogues).

The experience of *Jan sunwais* has provided several important lessons. First, that without a mandate requiring officials to attend, *Jan sunwais* are less effective: if health system representatives do not come then the gathering becomes a space of protest rather than a hearing. Second, *Jan sunwais* are an effective tool for promoting accountability of the system: they are great power equalizers where users of the health system can, in an organized fashion, present their grievances and complaints; for their part, health officials become answerable to the rights claimants and must find solutions. Third, since *Jan sunwais* can be such a powerful democratic tool, they should be used strategically and not ritualistically.

BOX 5 CBMP COMMITTEE MOVES TO PROTECT WOMEN HEALTH WORKERS FROM HARASSMENT

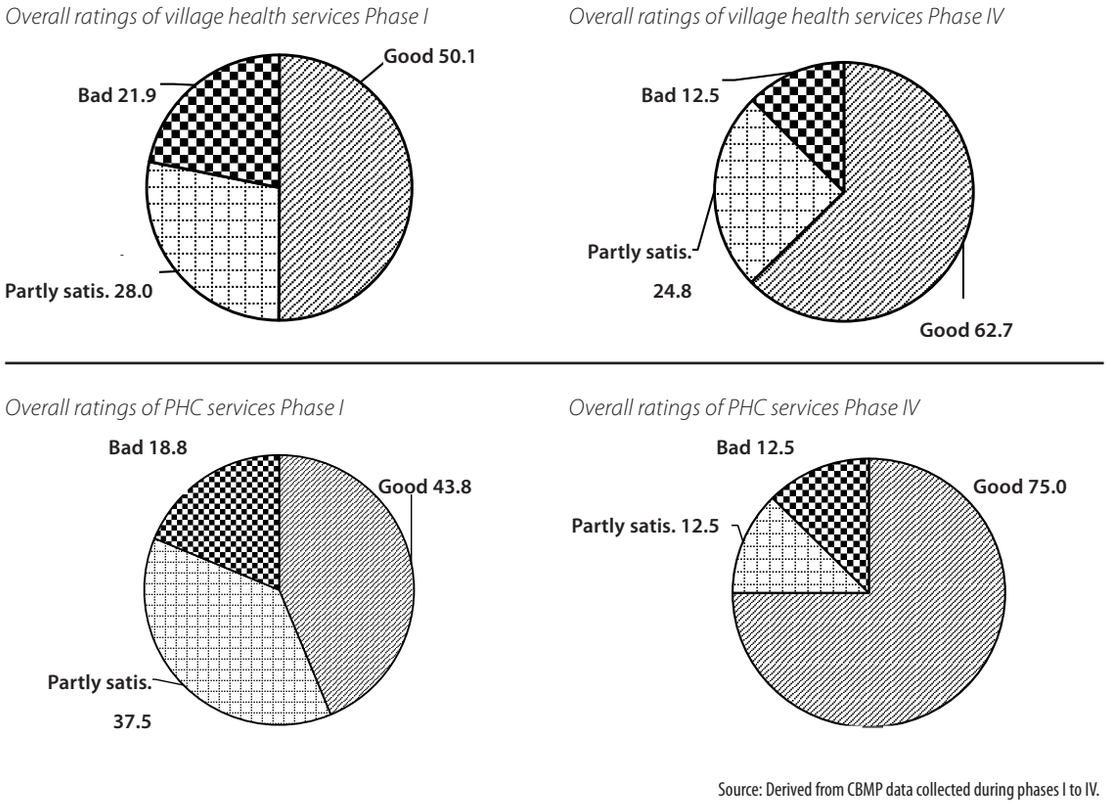
At a district level Jan sunwai in Nasik, a woman community health worker (Accredited Social Health Activist, ASHA) made a complaint of harassment against a male health worker from the PHC. Based on ongoing CBMP processes, a committee was appointed to enquire into the case, comprising of a medical officer, a representative of the ASHA union, and a woman member of the monitoring and planning committee. Committee members then made visits to the village and received many other complaints regarding the health worker harassing adolescent girls too. On confirming the allegation, a decision was made to suspend him immediately. The aggrieved ASHA and many other women were relieved, and frontline health workers realized the power of *Jan sunwais* for resolving their own issues as well.

Source: SATHI 2014b.

Information on health indicators and community health needs

A key factor responsible for increased accountability is regular and systematic information gathering on the status of health service provision and community health needs. Along with the village-level committee, the respective monitoring and planning committees collect data regarding service delivery aspects such as provision of entitlements, medicine stock updates, human resource deployment, quality of care and attitudinal issues. Their periodic reviews not only create empirical evidence but also induce healthcare providers to perform their duties appropriately and create channels for communication. An example of change related to community-based identification of health needs is provided in Box 6.

FIGURE 3:
Change in ratings of village and PHC health services in CBMP areas (Phases I to IV)



Source: Derived from CBMP data collected during phases I to IV.

Accessibility and quality of health services

While certain infrastructural improvements in public health facilities have been made possible due to resources provided by the NRHM, the greater responsiveness of healthcare providers involved in the community-based monitoring process has contributed to eliminating illegal charges for health services, has reduced absenteeism and has improved attitudes and behaviour of health staff. To track actual changes in health services over time, we can examine successive report cards filed by committee members annually. Figure 3 reflects the substantial improvement in health services delivery in CBMP pilot areas between Phase I of data collection in mid-2008 and Phase IV in late 2010. The data comes from 185 villages and 33 PHCs.

Implementation challenges

Despite the undeniably positive impacts of CBMP, this process of promoting 'creative conflict' is still in its initial stage. Resistance by many officials to accountability processes, attitudinal as well as

structural barriers to improving services, and deeply ingrained undemocratic modes of functioning contribute to the following major challenges:

- *Defending the democratic spaces that have been created as part of the CBMP process is a continuous struggle* because they are not yet fully integrated in the system. There are persistent pressures from some health system officials to constrict or dilute certain accountability processes, a situation that has to be resisted by nodal civil society organizations in an ongoing manner.

- There is a need for overall *higher priority and political commitment to the CBMP process, which should be regarded as a core public health strategy.* Experience with CBMP in Maharashtra has shown that although state-level officials are supportive of the process, this activity is treated as a lower priority, delaying crucial decisions. This is linked with a degree of uncertainty about continuation of the CBMP process, due to the fact that political commitment is still tentative and fragile. CBMP is a contested space that reflects the shifting power balance between people and the public health system; the process needs to be maintained and expanded by ensuring wide social support and political endorsement.

- A key challenge is to *continually ensure positive health system responses to the issues that are raised by community members.* CBMP is based on developing a 'new compact' between people and the public health system, where restoring confidence in the functionality and responsiveness of the public system is central. The aspects of health service delivery that CBMP has significantly improved may be termed 'CBM sensitive'. However, major unresolved systemic deficiencies remain, such as the shortage of specialists and general doctors, insufficient essential medicines in public health institutions and poorly built health facilities linked with entrenched corruption at various levels. Such issues have been raised repeatedly without much effective change, and have been termed 'CBM resistant'.

- *CBMP is but one component of a larger public health system strengthening process, and can effectively develop only in tandem with various supply side improvements*. Major policy changes at the state level are required to address these issues, or communities and local health activists risk becoming de-motivated, and may lose interest in the CBMP process.

- In the context of widespread privatization of health care and growing general demand for newer technologies and procedures, the e*xpectations that ordinary*

people have of public health services frequently go unfulfilled. On the one hand, emerging health needs that have been neglected in the public system so far (such as diabetes and hypertension, see Box 6) must be addressed. On the other hand, 'false health needs' created by the private sector (e.g. unnecessary injections and saline infusions) must be challenged through popular campaigns to promote rational health care.

BOX 6 TREATMENT FOR DIABETES AND HYPERTENSION AT PHC: EXPANDING THE SCOPE OF SERVICES

As part of the CBMP process, a workshop was conducted at Malshiras PHC in Pune district. During the workshop, the medical officer from the PHC checked the blood glucose of the persons who participated. Two village committee members were found to have high blood glucose levels and were prescribed medicines; however, with very low earnings and no family support, they were not in a position to afford the drugs for diabetes, nor could they afford to travel regularly to the nearest government hospital to obtain these. Based on suggestions given by the CBMP committee members, the medical officer declared that, with the help of a specialist doctor, monthly medical camps would be conducted for diabetes and hypertension patients, and medicines would be given to them in the PHC itself. After trying out this intervention in one PHC, based on interventions through the CBMP process additional financial allocations were made by the elected district council, and now this service has been expanded to 22 PHCs in the district. Thus CBMP has successfully expanded available services at PHCs, even beyond their conventional mandate.

Source: SATHI 2013.

Deepening democracy

A core challenge in 'limited democracies' such as India is the need for radical expansion of social and economic democracy, including democratization of public systems. In the context of public health services, CBMP has helped with 'deepening democracy' in four strategic ways.

The first involves the *creation of forums for direct democracy*. In the current public health system in India, there are no institutionalized spaces where ordinary people can collectively voice their issues and concerns. The organization of each *Jan sunwai* is a critical moment, which draws upon other CBMP processes, and empowers ordinary citizens to engage in democratic dialogue in an accountability framework that challenges traditional power hierarchies.

Jan sunwai: a forum for direct democracy. Photo: Rachana Samajik Punarbandhani Sanstha, Pune

The second concerns the *expansion of representative democracy* through multi-stakeholder forums. Under the current 'monopoly of representation', in which formally elected representatives (usually from mainstream political parties) are considered the only 'authorized' representatives of the people, the local elite has continued to rule the game and marginalized groups have been left out. Multi-stakeholder monitoring and planning committees have enlarged the range of representation to include civil society organizations, community groups and active community members, enabling a range of community-based actors to intervene in local public decision-making processes.

What is more, CBMP is encouraging people to *reclaim representative democracy.* As both evaluation studies have observed, once the process raises and begins to resolve specific issues, elected representatives become motivated and participate because they need to respond to popular expectations. Such 'reclaiming' of elected representatives has proved instrumental in exerting pressure for improved services and has enabled the formation of alliances even beyond health care.

Finally, *external accountability processes have activated internal ones*. In India, the few hierarchical accountability mechanisms in place within public systems are usually ineffective; instead, public services are often dominated by corrupt patron-client relationships. CBMP committees at each level have created accountability imperatives that move upward, holding higher level officials accountable for the poor performance of lower levels of the system falling under their jurisdiction. Inadequate performance of lower level functionaries and officials is reviewed in the presence of their superiors, activating the mandated but hitherto inactive internal accountability processes and strengthening an important link in the chain of democratic control.

Lessons learned

Although certain pre-existing factors facilitated the implementation of CBMP in Maharashtra, they do not necessarily constitute conditions for implementing CBMP processes in general. Nonetheless, our analysis highlights critical ingredients that would be important for effective implementation of CBMP in other states of India, and perhaps relevant for other countries in the South, as outlined below.

Ensuring significant levels of community participation and activism

Although easier said than done, community participation and activism can be energized through: the systematic orientation of active community members and health activists; prioritizing issues through community-based processes rather than technical or external criteria; encouraging activists to raise issues and follow up until they are resolved to promote a positive 'cycle of change'; keeping the monitoring tools and reports simple, using pictorials and local terminology; fostering collaboration among community members, civil society activists, elected local representatives and sympathetic public service providers to develop a 'coalition for change'. Community-based monitoring should not be reduced to 'committee-based monitoring', and direct involvement of people from communities in dialogue processes must be actively ensured.

Facilitating regular multi-stakeholder dialogue and periodic mass accountability events

A major observation emerging from repeated experiences on the ground is that CBMP has been effective because it has ensured periodic dialogue between health system officials and ordinary people. Opening up such a space for dialogue is a critical component of the CBMP process, enabling people and community-based activists to communicate their needs and concerns to providers, and eliciting action for improvement. The organization of public hearings as direct democracy events is critical for ordinary people to express their grievances and experiences, which exerts pressure on healthcare providers and officials to deliver services in an accountable manner.

Ensuring a chain of reinforcing actions across various levels

Another key lesson is the importance of following up on issues across multiple levels. For example, because each public hearing was followed by a presentation of unresolved problems to the next level of government, lower level officials began to take those issues seriously, realizing that their superiors would eventually come to hear about them. Also, structural and systemic issues being raised at progressively higher levels when they are not addressed at lower ones allows effectively cutting across the hierarchy of the public health system by ensuring problem-solving instead of problem-shifting.

Developing and sustaining a coalition of rights-oriented civil society organizations

Grassroots NGOs, community-based organizations and people's organizations working with a rights-based approach have played a central role in the CBMP process – ranging from building mass awareness and community mobilization, to objectively documenting and voicing health gaps, to assertively dialoguing with healthcare providers and officials. It has been observed in Maharashtra

that many NGOs that had not previously done 'rights-based' work have, through practice, developed the capacities and attitudes to champion people's health rights. At the same time, people's organizations have started reporting on issues in a more systematic manner since the CBMP process started. Nodal organizations working at block, district and state levels have clearly defined, mutually supportive roles; they complement each other while dealing with the health system as a coalition working for people's health rights.

Popularizing health entitlements and sanctions

Healthcare entitlements under NRHM are not usually presented using 'rights' discourse, but in the CBMP process in Maharashtra they have been presented and popularized using that framework. This has enabled ordinary people as well as activists to express the need for services, and to track their delivery. CBMP activity has moved ahead because the system has tried to meet such entitlements, at least to some extent. However, much stronger official endorsement of 'guaranteed health services' in the form of widely publicized people's health rights is required to further strengthen the accountability process. It is important to secure government sanction for CBMP, which makes it mandatory for public officials and staff to participate in the process and to address issues that are raised. Enabling official orders and directions are also quite useful, especially to establish the mandate of civil society organizations in the overall process and to ensure their involvement in decision-making, access to relevant information, and so on. Financial support for various CBMP activities from public funds allows for systematic activities at all levels, contributing significantly to the effectiveness of the process.

Engaging with healthcare providers

The purpose of CBMP is to improve the performance of the public health system, rather than simply blaming frontline providers. Here, proper orientation of healthcare providers and officials at various levels at the initiation of CBMP processes helps reshape their attitudes and primes them to respond to accountability mechanisms in a positive manner. Proactive and responsive healthcare providers have been publicly appreciated, and genuine constraints they face have been raised during multi-stakeholder dialogues involving officials with a view to addressing them.

Community members gather in large numbers for a district-level public hearing organized in Nandurbar district. Photo: Janarth Adivasi Vikas Sanstha, Nandurbar

A people-based, practical alternative to privatization

A phrase that has been used in the context of CBMP is: "the alternative to privatization is communitization." Given the frequently dysfunctional, bureaucratic and unresponsive nature of many public health facilities, along with their larger financial constraints and political neglect, large numbers of people in most states of India have moved away from the public health system to the private medical sector (see Sengupta 2013). As a result, it is also important to rebuild people's confidence in public health services; this is being actively sought through CBMP. Such processes, if expanded and generalized, could start a movement in the opposite direction, with people returning to public health facilities (see Box 7).

CBMP also offers the possibility of *enhancing the 'publicness' of health services*. McDonald and Ruiters (2012) have identified criteria to assess the degree of 'publicness' of essential services. The CBMP approach fulfills many of these criteria:

- accountability by mobilizing people to make the system more responsive
- equity by promoting improved access to health services for marginalized groups
- participation by providing structures for community involvement in monitoring as well as planning
- efficiency by improving various aspects of quality in health services
- transparency by making information public and promoting open discussion on health facility accounts
- quality of the workplace by creating spaces for frontline health staff to raise issues concerning their working environment
- solidarity by creating a platform for diverse local stakeholders to work for a common goal
- public ethos by promoting shared involvement of community members, elected representatives and health staff in improving public health services

Generalizing the CBMP approach

As a result of the CBMP process, people in rural communities in several parts of Maharashtra have been empowered to collectively raise questions, and now they can demand their rights even from other departments about various public services. For example, on several occasions public hearings have elicited responses from officials related to the Integrated Child Development Scheme or from the Public Works Department concerning the construction of health facilities. This is important since community monitoring as an approach should encompass various social services including nutrition, water supply and food security.

BOX 7 TRANSFORMATION OF MALIGRE PHC, END OF PRIVATE CLINICS

Maligre PHC in the Ajara block of Kolhapur district was very poorly utilized until 2011 and most people in the covered villages were unaware of its services. After the first *Jan sunwai* organized as part of CBMP, a new doctor was appointed and meetings were organized by CBMP activists in various villages to inform people about services at the PHC. Thanks to this initiative, the number of outpatients, inpatients and deliveries performed at the PHC have drastically increased (e.g. from eight deliveries per month in 2010-2011 to 125 deliveries in 2013-2014). Quite significantly, three private clinics in the village have closed down, as patients now prefer the rejuvenated PHC.

Source: SATHI 2012b, p. 29.

The community monitoring approach is now being extended to cover child care and nutrition services on a pilot basis in Maharashtra. Since mid-2013, a process of community-based monitoring and action related to the Integrated Child Development Scheme (a program for pre-school child care and nutrition) has been initiated on a pilot basis in six areas of Maharashtra. The CBMP approach, which is tried and tested for health services, was adapted for the specific framework and features of child care and nutrition services delivered as part of this scheme. In this sector, community-based monitoring is being combined with community action for improved child nutrition, especially for children under three years of age who are most vulnerable. A year into implementation, there are positive results in terms of increased community awareness regarding entitlements and active monitoring of the *Anganwadis* (community-based child care and nutrition centres) by women's groups, ensuring regular and adequate food grains to these centres, improved water supply and improved regularity in provision of supplementary food across various areas.

This serves to show that the CBMP approach has applicability for various social services that are delivered at community level, and for which popular feedback can play a meaningful role in ensuring quality. Basic training can ensure that entitlements are understood by ordinary community members and local activists who can then monitor services.

Having said this, CBMP is a complex, multi-dimensional and context-dependent process, and it would be neither possible nor desirable to blindly generalize such an approach to other locations or sectors. However, since similar factors may be at play to varying degrees and forms in different places, some general points can be made with regard to the possibility of developing community accountability and participatory planning processes in other countries, as follows:

- **Community context:** While initiating community accountability processes, there would be a need for identifying and mapping actors in the community, especially organizations defending rights (though they may not be working specifically on health), women's groups, local elected representatives, traditional community leaders and community health workers or similar grassroots workers linked with public services. Existing forms of community solidarity and mutual support – whether traditional or modern – and modes of action to claim rights, if existing, would be important reference points to keep in mind while developing a framework for community accountability and participation.

- **Presence of social organizations:** The CBMP process in Maharashtra has been significantly based on civil society organizations working at various levels. Their presence, forms and modes of activity vary tremendously across contexts, and hence their role would need to be carefully considered. In general, in any setting there is likely to be a spectrum, with largely state/funder-controlled NGOs at one end, rights-oriented people's movements at the other end, and member-based community groups somewhere in between. It is obvious that the ability of various kinds of CSOs to effectively build community awareness for rights, to help represent community issues with the state, and to develop larger alliances to ensure accountability of public services would shape their role in CBMP-type processes.

- **Political context:** The degree to which governments would be willing to either encourage or constrain participatory accountability processes also varies greatly. While the Indian government, and specifically the state of Maharashtra, has provided significant scope for accountability processes (with certain definite boundaries), the same may not be true of other settings, and the form in which accountability can be claimed might be different. CBMP-type processes would require a minimum level of acceptance by the state of accountability-oriented shared spaces that are not completely controlled by officials, where autonomous actors such as civil society organizations and community groups are allowed to frankly raise issues. The presence or possibility of state-society interaction forums such as monitoring committees and public hearings, where citizens can raise issues and elicit responses from the state, would appear quite important for ensuring accountability.

- **Health system context:** Any mapping exercise should also identify the health policy and decision-making processes in the country or region, since this is necessary to formulate an effective accountability framework. Preferably, multi-stakeholder, participatory processes and structures should be operationalized at

each of the levels where health system decisions are taken or implementation is managed. It may also be noted that the overall level of functionality of public health services is generally closely linked with the depth of people's confidence in these services, and their willingness to engage with them. Broader policies for public health system strengthening or reform, including provision of additional resources and decentralization of decision-making, may provide appropriate spaces within which CBMP-type processes could be developed.

- **Financial and human resources:** Financial and human resources have been instrumental to the effectiveness of CBMP processes in Maharashtra. The fact that the entire activity has been supported by public funds has simultaneously been one of its strengths (ensuring ownership by the public system) and a source of vulnerability, because the process can be stalled or constrained by the government at any stage. Voluntary initiatives and contributions from the community are another source of support for accountability activities, but if these are insufficient, appropriate, complementary and sustainable forms of resource support would need to be identified based on the context.

Understanding and appropriately dealing with each of these dimensions is obviously a complex exercise. However, in each social context there would be specific enabling conditions, which could be drawn upon as a basis for building accountability and participation mechanisms. It is more likely that effective social accountability of public services can be achieved when the interventions are participatory, evidence-based and sustained, involving multiple actors and able to build broad stakeholder coalitions. There is probably no social context today where democracy is not a significant aspiration of ordinary people; yet how to radically expand democracy and make it real in the context of public services and other spheres of life is a key challenge. The emerging initiative outlined in this paper is one of many such efforts that seek to pave the way forward.

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ABOUT THE AUTHORS

Abhay Shukla is coordinator of SATHI, he is a member of the National Rural Health Mission's Advisory Group for Community Action (AGCA), and a national co-convenor of *Jan Swasthya Abhiyan* (People's Health Movement – India). He has been centrally involved in organizing the national 'Right to Health Care' campaign in India (2003-2004), and works on promotion of health rights in the public and private healthcare sectors. He has been involved in developing the framework for community-based monitoring and planning of health services at the national level, and is coordinating its implementation in Maharashtra along with SATHI team members.

Shelley Saha Sinha is a post-graduate in social work who conducts independent research on public health. She is a consultant with SATHI.

SATHI is the state nodal organization responsible for facilitating the implementation of CBMP in Maharashtra. SATHI is the action centre of Anusandhan Trust based in Pune, Maharashtra, which works through various kinds of collaborations to advocate for health rights and universal access to appropriate health care. For more information visit: www.sathicehat.org and www.cbmpmaharashtra.org.

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www.municipal**services**project.org

Canadian office

Queen's University
Global Development Studies
100 University Ave.
Kingston, Ontario, K7L 3N6
CANADA

South African office

University of the Western Cape
School of Government
Private Bag X17
Bellville 7535
SOUTH AFRICA