C B MP-Maharashtra

Community Based Monitoring and Planning of Health Services in Maharashtra

Supported by National Health Mission

UPDATE – JANUARY 2015

UPDATE

Community based monitoring and planning (CBMP) of health services is being implemented in Maharashtra with support from NRHM (now NHM) since 2007. Starting from 5 districts, it has been expanded to 13 districts, and since 2014 it is being expanded further across the state, with organisations in 9 more districts taking up CBMP activities on a voluntary basis, thus expanding the reach of this process to more than a thousand villages across the state. Along with this quantitative expansion, there has been qualitative deepening through processes for more intensive involvement of PRI members, launching of a transition process towards developing a more sustainable and generalized mode of CBMP, and taking the Community monitoring and action approach beyond health services, to cover ICDS services. This brief update outlines new developments related to CBMP in Maharashtra, from April to December 2014. We start with outlining the key results of a recent comparative study to understand the impact of CBMP processes on delivery of PHC level services.

Comparison of availability of key health services in PHCs covered by CBMP vs. PHCs not covered by CBMP processes

One of the expected impacts of CBMP is demonstrable improvement in services provided by Health facilities, related to increased community demand and systematic community pressure leading to improvements in service delivery. To understand whether any such impact of CBMP can be observed, we have compared the status of delivery of key health services in PHCs covered by CBMP and PHCs not covered by regular CBMP processes, which are otherwise comparable in terms of regional profile and major health system inputs being provided. For this purpose, a *set of 40 PHCs from 13 CBMP blocks from various regions of Maharashtra* was matched with another *set of 40 PHCs with similar regional profile, but from 13 other blocks where no CBMP processes have been underway prior to 2014*. Comparable type of Community monitoring data on status of delivery of key health services was available for both sets of PHCs. Routine CBMP data was available for the first set of PHCs from early 2014, while a first round of data collection using similar

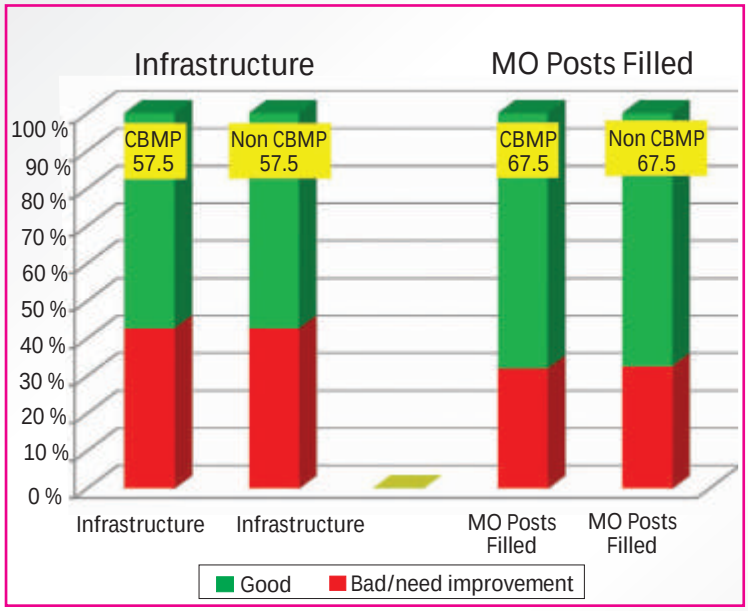
Two sets of PHCs where data has been collected during first quarter of 2014		
REGION	CBMP Blocks (13 blocks, 40 PHCs)	Non regular CBMP Blocks (13 blocks, 40 PHCs)
Konkan	Karjat, Sudhagad, Murbad, Shahapur (10 PHCs)	Chiplun, Sawantwadi, Vengurla (9 PHCs)
North Maharashtra	Igatpuri, Tryambak (6 PHCs)	Akole, Sangamner (6 PHCs)
Vidarbha	Chikhaldara, Dharni, Gadchiroli, Kurkheda (15 PHCs)	Ashti, Karanjya lad, Kalamb, Maregaon, Zari-jamani (13 PHCs)
Western Maharashtra	Ajara, Bhudargad, Akkalkot (9 PHCs)	Shirala, Mangalve, Sangola (12 PHCs)

CBMP tools had been carried out to create a base line in the latter blocks, where CBMP activities on voluntary basis were initiated in the first quarter of 2014. The details of regional distribution of these two sets of PHCs are given in the table.

To ensure that these PHCs have on the average a similar profile of health system inputs, the two sets have been matched for availability of infrastructure (building, quarters, electricity etc.) and presence of medical officers. As graph-1 indicates, the two sets of PHCs are in aggregate identical, in terms of the status of their infrastructure, and the availability of medical officers, two key input parameters.

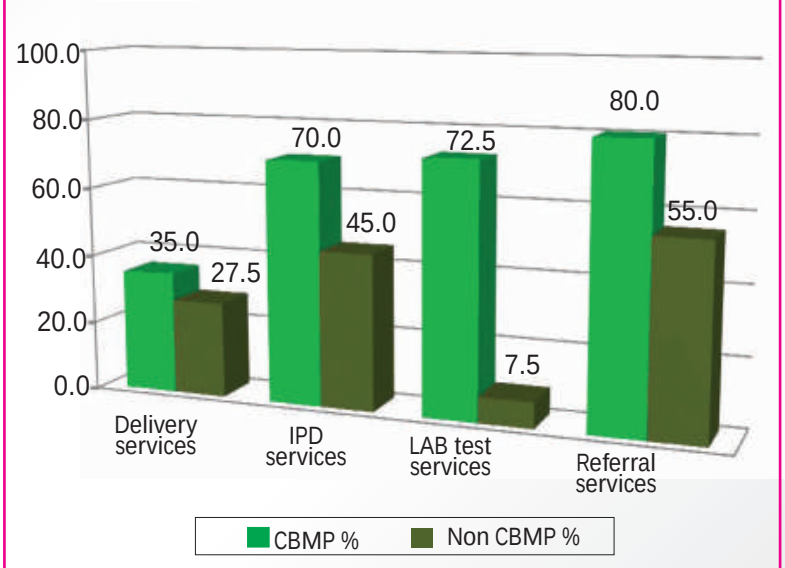
However, when the data from the same sets of PHCs is compared on four key parameters related to the delivery of services, major differences are seen. Overall with identical inputs, the outputs appear much better in CBMP areas as compared to non CBMP areas.

Graph1- Overall comparability of infrastructure and medical officers in the study PHCs in CBM areas (40 PHCs) and PHCs in non-CBM areas, where baseline data collection has been done in early 2014 (40 PHCs)



Graph2- Substantially better situation of 'Good' services,with improved Laboratory services, Referral services, Inpatient services and Delivery services in CBMP areas compared to non-CBMP areas.

Graph2 - Services in Good situation in CBMP and Non CBMP PHCs



The most substantial difference can be seen in PHC laboratory services, with 72.5% PHCs in CBMP areas receiving a “good” rating, as against only 7.5% PHCs in non CBMP areas. Improvement of diagnostic services has been one of the focus areas of CBMP in Maharashtra, for example as reported in a separate section of this update, a specific SMS survey of laboratory services had been conducted as part of CBMP. Overall significant follow-up has been undertaken by civil society organisations and PRI members to improve lab services, and a focussed attempt was made to improve these services during last few years (see story below). The much better delivery of lab services in CBMP areas compared to non-CBMP areas could be a result of this.

Story of change:

In Junnar block of Pune district, PHCs Aptale and Inglun are among the facilities covered by the CBMP process. The PHC monitoring and planning committees related to both these PHCs raised the complaint of inadequate availability of Lab services, and followed up this issue over a series of meetings, along with community discussions on the need for such services. Regular dialogue and community pressure has led to substantial improvement in Lab services since mid-2013, and now the entire range of lab tests are being performed in both these PHCs.

The demand for adequate referral services is another issue which has been consistently raised in all CBMP areas, especially during Jansunwais. There has been widespread community awareness building on entitlement to free ambulance services and continuous follow-up with the health system on this issue (see story below). The 80% good rating of referral services related to PHCs in CBMP areas (compared to 55% in non-CBMP PHCs) could be attributed to this.

Story of change:

The CBMP process is underway in Chandrapur block (district Chandrapur), where significant number of villages are covered by the Tadoba tiger conservation project. As a result, it used to be difficult for women in labour or serious patients to get routine transport in the evening and night time. As part of the CBMP process in 2013, awareness was generated on large scale in communities regarding the JSSK scheme and availability of free transport from the village to PHCs; boards were displayed regarding toll free lines 102 and 108. As a result, especially in the villages covered by Chichpalli PHC, now much larger number of women in labour are being able to avail of referral services, and they are able to reach the PHC in time to receive care.

Through the CBMP process, there has been an effort to advocate for full functionality of PHCs, including admission facilities and 24-hour delivery services. Demands for fully functional PHCs have been regularly raised in Jansunwais, as well as Monitoring and Planning committee meetings in all CBMP blocks, this may have contributed to better rating in IPD services and delivery services in CBMP PHCs, as compared to the non-CBMP PHCs. However, the fact that even in CBMP areas, delivery services are rated as 'Good' in only about one-third of the PHCs is a matter of concern which needs further definitive action. It may be noted that delivery services have been rated as 'Good' only if these are available around the clock, 24 hours in the day.

There is some regional variation related to improvement in specific services within the CBMP areas. For instance, delivery services and IPD services have shown maximum improvement in PHCs of Konkan region, referral services and lab services have shown the most improvement in PHCs in Vidarbha region, while lab services in PHCs covered by CBMPin North Maharashtra have received almost universal good ratings.

To conclude, it is obvious that community mobilisation, awareness and demand generation, regular multi-stakeholder dialogue and feedback, accompanied by mass accountability events – all these CBMP related processes can contribute to improvement in health services only if there is a reciprocal response from the public health system. Community and civil society initiatives need to be complemented by efforts of health care providers, in form of moving to correct the gaps that have been pointed out, and addressing the critical issues that are raised. While the process of improvement of health services due to CBMP processes is undoubtedly significant, it would be logical to attribute these improvements to community activists and elected representatives as well as concerned, related health officials and health care providers, who have all collaborated in this unique alliance for rejuvenating and upgrading public health services in rural areas of Maharashtra.

A. Innovations in CBM for transition to a sustainable and generalized model

Federations of monitoring committees, Community Action Resource Units (CARU), Grievance Redressal Cells – innovative mechanisms to ensure sustainable Community action for health

1. Federations of community monitoring committees at block level

Since community based monitoring in select districts of Maharashtra has shown significant positive results, the need now is social expansion and organizational sustainability of CBMP, moving beyond the project mode. The CBMP structure is comprised of committees at multiple levels, established from village to district level. Proactive committee members and consistent involvement of CSOs in the CBMP process, are important factors which have contributed to its positive impact until now.

However, for further strengthening and expansion of the CBMP process, and to explore the potential for implementing CBM related to other social services like ICDS, PDS, water supply - the need was felt to establish acomprehensive, participatory forum at the block level. This led to the idea of developing a "Federation of Monitoring Committees".

Key objectives identified for the federations –

- Obtain wider political and social backing for community monitoring, along with advocacy to tackle unresolved issues which require higher level decisions.
- Implement the proposed policy of transition- wherein the intensive inputs by CSOs, especially in the first phase pilot areas are gradually reduced, and oversight of the CBMP process, could be handed over to these federations.
- Putting CBMP of health and other social services on the agenda of political representatives.

Structure of the federations –

- 80% of the federation members will comprise of members of the existing monitoring committees. The other 20% will be local socially active people, popular and socially aware persons from the area, who can give the required time and attend the meetings of the federation.
- The PRI members will have an important role, but would not be the sole decision makers, there would be space for other members of the federations also.

Currently, such federations have been initiated in the five pilot phase districts. They have been formed at Pune (in Junnar, Purandar and Velhe blocks) and in Amaravati (Dharni block). The process for setting up federations has been set in motion in Shahada and Dhadgaon blocks of Nandurbar and preparatory processes have begun in Osmanabad district.

2. Grievance Redressal Facilitation cell at block level

The government has set up a Grievance Redressal system, which functions at the regional level, in various regions of the state. But this is an entirely departmental and formalistic mechanism which is

not sufficient to reach out to the people. If a grievance redressal cell is established at block level, the regional grievance redressal system can be strengthened.

Structure of Block level GRFC

- Panchayat Samiti member from the block monitoring and planning committee.
- Block Health Officer
- Representative of the block nodal civil society organization
- In event of any issues associated with the RH or SDH of the block, the Medical Superintendent of that hospital, will be a permanently invited member in the cell.

Responsibilities of GRFC

- Documentation of the complaints received.
- Detailed enquiry of complaint, visiting the place of incidence, interviewing the aggrieved person as well as health care provider etc. For this the committee will have the powers to summon information from any public hospital/health centre within the block, and interview the health workers/officials.
- They will have the powers for immediate resolution of complaints for which all contact details of the MOs, supervisors of all public health centres in that block, will be available with the GRFC members.
- Upon receiving a complaint, the GRFC will conduct an enquiry and send the report to the district cell within a span of one month. At the district level, within a time span of 15 days to 3 months, the issue will be discussed and related decisions will be taken.
- The mobile numbers of the GRFC members would be publicized among the people across the block, so that people can convey their complaints over phone. The members will take the responsibility to document the complaints, enquire into them, and find out any additional information as per the need. They will also classify the complaints into 3 categories – those which can be immediately resolved at the local level, those which need to be resolved at the block level, and the third category is those which need to be resolved at the district or state level.

Block GRFCs have been set up currently as per plan in Dharni block of Amravati, Velhe block of Pune and Murbad block of Thane.

Example of action taken due to GRFC

(Sub-centre – Dabiyakheda, PHC- Bijudhavadi, Block- Dharni, District- Amravati)

An ANM had retired from service but had not vacated and handed over the Government quarters since last 8 months. As per Government rules, the quarters have to be evacuated within 3 months. The matter came to the GRC in July 2014. It was reported that despite several reminders/memos to this effect from the Government, she had not vacated and handed over her quarters. This was a serious issue, as the new ANM could be present in the sub-centre only during the day. As she had no place to stay, she was not available in the night. This affected the services provided to people, especially women in labour and infants could not be catered to after evening. Within a couple of days of receiving the complaint, the chairperson of the block grievance redressal facilitation cell, noted in the sub-centre register that in the event of any untoward incident in the village, the retired ANM would be held responsible and that a legal complaint would be made; signatures of all concerned people were taken and she was also sent a letter to this effect. The next day she vacated and handed over the quarters. Thus the pressure and timely action of the GRC helped in solving a long pending problem.

3. CARU – Community Action Resource Unit

The evaluation process of CBMP indicated a need to move from the current relatively intensive model of CBMP towards a more generalized but less intensive one, with wider community outreach. Other similar efforts of community accountability, with wider generalisation were examined. It is known that as part of the process of social audit of NREGA undertaken in Andhra Pradesh, resource units have been established at state, district and block levels. Subsequently, the idea came up that a similar Block Resource unit might help to generalise CBMP also.

The overall functions identified for CARU:-

- CARU will facilitate selection of about a dozen young, educated volunteers in the block through appropriate local advertising, these volunteers will further play a role in the expansion of CBMP. They will receive appropriate training and certain specific village level activities will be assigned to them for a period of about two months.
- CARU will facilitate processes to involve large numbers of new villages in the CBMP process, and will communicate issues which come up in villages to the block monitoring committee.
- CARU will function as Secretariat for the Grievance Redressal Facilitation Cell as well as the Federation of monitoring committees at the block level.
- CARU will disseminate awareness material required for expansion of the CBMP process, which would be prepared in local language, adapted to local cultural beliefs and practices, and this should be printed and disseminated.
- CARU will make efforts towards establishing CBMP/ Social audit in other social sectors like ICDS, PDS, water supply etc.

CARUs have been initiated in Dhadgaon block of Nandurbar district, Murbad block of Thane district and Purandarblock of Pune district. In Nandurbar district 20 young volunteers have already been selected in co-ordination with the Narmada Bachao Andolan. A workshop orienting them about the CBM process was conducted during 24 - 26 of December 2014.

B. Expansion of lower intensity, voluntary CBMP processes to nine new districts

The experience of implementing CBMP in 13 districts in an intensive project mode so far has been very important to demonstrate the feasibility and effectiveness of this process. However, driven by the conviction that CBMP based on community accountability and participation is a principle which needs to expand far beyond selected areas in these 13 districts, SATHI has worked towards developing a somewhat less intensive model of CBMP, which could be spread to many other districts and blocks in Maharashtra. After an extensive process based on publishing a state level advertisement inviting all civil society organisations interested in implementing CBMP on voluntary basis, since February 2014, 33 new organizations have implemented community based monitoring in 25 blocks of 9 new districts. So far 16 of

them have also conducted Jansamvads in their blocks. Most of these are completely new districts in which CBMP had no earlier presence or precedence.

One of the key achievements of the CBMP process in these new areas, has been the remarkable Jan samvads. In all areas, there has been good mobilization of people by the newly involved local organizations (in the range of 100 to 500 people participating in each Jan samvad). Panchayat representatives have been proactively involved, and in some places, even MLAs were involved and they promised to take the process forward.

In many Jan samvads, the health officials who were present took on the spot decisions leading to improvements in health services.

Impact of Jan samvads and follow up actions – some recent stories of change

A Jan samvad was conducted in Wardha on 26th June 2014. The issue of referral was raised, people complained that they do not get vehicle/ambulance in case of emergency and for delivery. In a follow-up meeting held after the jan samvad, it was reported that the ambulance has now been made functional and vehicle is regularly available for referral and delivery.

During the Jan samwad held in Chamorshi block of Gadchiroli on 11 December 2014, one of the issues raised was about lack of knowledge about the 102 and 108 toll free numbers, which can be used to avail free vehicle and ambulance services in emergencies. People were spending money out of their pocket to hire vehicles to take patient in case of referral. It was decided that awareness about this needs to be created about this. There were meetings in several villages, and the women's self help group members demanded to the THO that boards highlighting this information should be set up in all villages.

In Umargaon village in Kalamb block of Yavatmal district, although an ASHA was appointed, she never had any stock of medicines with her. The ANM never visited the village besides immunization days. As a result the villagers had to visit a private doctor in the neighbouring Mohda village, even for minor illnesses. Connectivity from the village being a problem, the villagers often had to wait for treatment for a Tuesday, which was market day. All this was presented in the Jansamvad, held in February 2014, and there was a lot of discussion. The health officials that were present took cognizance of the issue, and they assured that health services would soon become available to the villagers. The promised change was visible soon, with the ASHA now working enthusiastically, equipped with a complete medicine kit. The ANM also now visits the village regularly, and provides required health services.

In Asoli village of Kalamb block in Yavatmal district, Seematai Pawar, an activist of Gramjyot, came across a group of people haggling with an auto-rickshaw driver. Upon enquiry she was told that a villager had been bitten by a snake and he was to be taken to the Metikheda PHC, 15 kms away, butthe driver was over-charging them. During the Jansamwad held earlier on 26th February 2014, in Kalamb, Seematai had learnt about the toll free number 108 to be dialed for free ambulance services. She informed the people about the same and immediately dialed 108. Within 15-20 minutes, the ambulance came. Due to the transportation issue, already there had been a considerable delay, hence the MPW on duty in the ambulance took the timely decision to admit the patient in the civil hospital in Yavatmal. Due to this incident, people were able to benefit from the effectiveness of the ambulance service, and a life was saved.

C. Participatory audit of utilization of Rogi Kalyan Samiti funds

One of the areas of intervention in the CBMP process, has been utilization of RKS funds. Consolidating the efforts taken on this front, and with an intention to strengthen the RKS, a series of participatory audits to ensure better planning and utilization of these funds has been recently undertaken. This process involves actually examining each of the expenses made through the RKS in the previous year and physical verification of the same (basically a proper audit process), and then using the findings to plan expenses under the RKS for the coming year.

This process has been undertaken in 3 districts – Thane, Nandurbar and Raigad, during November and December 2014. In each district, 2 PHCs and 1 RH/SDH were covered, thus a total of 9 institutions were covered in this process. The audit was conducted in the presence of RKS and Monitoring Committee members, local CSOs involved in the CBM process, state level officials and local PRI members. As a preparation for this, the details of expenses of the RKS funds in these institutions were sought from the MOs, and this information was analysed to figure out the heads which had incurred maximum spending. All this was displayed on a poster and presented to RKS and Monitoring committee members in a specially organized social audit meeting. As the state nodal agency, a representative of SATHI was present during each of these audits. Several interesting findings have come up in this process, of these one is given here as examples.

When the social audit at Sone PHC in Dhadgaon block, Nandurbar district was conducted on 17th December 2014, one of the issues that came up was purchase of equipment. Rs. 33,705 from last year's RKS funds was spent on purchase of equipment for the PHC. Actually for a purchase of this scale, quotations have to be sought first and then the purchase should be made. However, here the equipment was purchased in March 2013, while the quotations were invited only later in April 2014. Upon enquiry the explanation given was that the NHM funds come late and hence the purchase is made first and then the documents are prepared

later. It was further revealed that this expense and purchase was not done with the appropriate approval in the RKS Working committee. It seemed that the former MO had undertaken all these purchases at his own level. Ultimately the THO asked the current MO to submit a written explanation, regarding this matter.

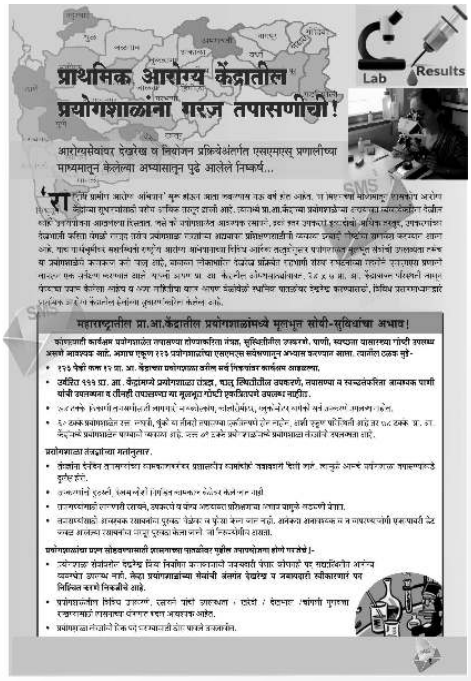
Follow- up

Post the audit process meetings are being held with members of the RKS to discuss issues which came up. All the lessons are being fed into into planning for the next years funds.

D. PHC laboratories in need of a 'microscopic examination'

Results from a State level SMS-based survey on laboratory services.

The CBMP process in Maharashtra has enabled raising of several crucial issues, pertaining to gaps in health services. One such issue is the availability of well equipped and functional labs in the PHCs. Laboratory services are crucial for timely and accurate diagnosis of the illness which can decide further course of treatment. A functional laboratory, should have a technician, working equipment, water facility and cleanliness. Information was collected from a total of 123 PHC laboratories across Maharashtra using the SMS technique. Similar SMS surveys have earlier been conducted on the issue of availability of medicines and 24 by 7 health services in PHCs.



The prominent findings of the survey are as follows:

- Only 12 of the surveyed laboratories were found to be 'fully functional' based on the abovementioned points.
- The remaining 111 PHC labs cannot claim to have all the basic facilities together - availability of all three tests and lab technician, working equipments, water for cleanliness
- In 74 % of the laboratories, all the equipment required for testing, like microscope, glucometer, colorimeter (essential for blood tests), are either not available, or are not functional. Of the 123 laboratories, only 28 have all three equipment available and functional. Further probing revealed that often, advanced equipment is purchased but their timely maintenance is ignored. In some places the arrangement for maintenance exists but that person or company is not paid in time and eventually the equipment becomes unusable due to lack of maintenance.
- In 60% of the labs, all three tests- urine, blood and sputum- are not available simultaneously. (73 out of the 123 studied). Of these 73, in 15 labs, all 3 tests are not available. Further analysis shows that the sputum test, essential for diagnosis of TB and other contagious diseases, is available only in 41% of the studied labs.
- Only 79% have a lab technician.

To understand the reason for non availability of tests, technicians themselves were asked the reasons. They quoted following major reasons:-

- Additional responsibility of administrative tasks and National programmes, due to which the technicians say they are not able to concentrate on the tests.
- Other main reason that has been quoted is shortage of the chemicals required for the tests. Despite demand, the essential chemicals are not supplied to the PHC or they are supplied in lesser quantity while other un-required chemicals are supplied in large quantities.

Other essential requirements for proper functioning of the lab services

Apart from equipment and lab technician, other crucial facilities are required for a functional laboratory.

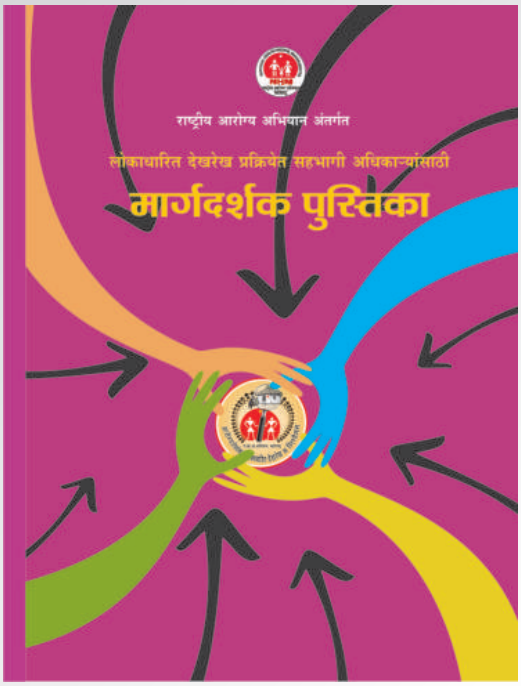
- Water- 22% of the surveyed PHCs did not have proper facility for water.
- Cleanliness – if there is no basic cleanliness, samples taken for tests can get contaminated leading to erroneous results. Of the surveyed PHCs, 13% were found lacking in cleanliness.

Some suggestions and possible solutions

- Regular monitoring of laboratory services is essential. As per Administrative rules, senior health officials are expected to keep a watch on the laboratories' functioning. But they do not do this regularly. It is only done in context of the National Programmes or specific camps.
- The Monitoring committees set up under the CBMP process should also study the situation and identify the problems. Some minor expenses can be managed through the RKS funds while for larger amounts, a provision can be made in the PIP.
- There should be a proper policy for filing vacant posts of lab technicians.
- The chemicals required for the testing need to be supplied regularly and in the requisite quantity.
- Mechanisms should be in place for proper and regular maintenance of the lab equipment.

E. Key recent publications associated with the CBMP process

The issues raised through community monitoring cannot be addressed without a responsive health system. In this context, the role of health officials is very important. In this context, the State Health Systems Research Centre (SHSRC), Pune, along with SATHI , Pune, came out with a guidebook for officials involved in the CBMP process. It was released at a state level PIP dissemination workshop organized in Nashik by the State Health Society, under leadership of the State MD NHM on 3rd December 2014. The workshop was attended by the State MD NHM, DHS, Deputy Directors, state level officials like Joint directors, programme officers and also Chief Executive Officers, ZP, Bureau Chiefs, Dy. Dir. Health Services I/c Circles, Dist. Health Officers, Civil Surgeons.



This guidebook on CBMP for Health officials explains the process of CBMP, structures established therein, with an emphasis on the crucial role of the officials. It highlights how the CBM process is important for health officials because it gives them qualitative feedback about the actual reach and condition of health services at the ground level. The information sought from people and their representatives (through CBM processes) is likely to be closer to the truth than that represented in routine annual reports and the MIS. Also positive changes, qualitative improvements are often missed out in routine processes. This process has enabled taking into account the perspective of the beneficiaries of health services.

The book, beginning with an overview of the CBM process, highlights the role of the health officials in various components of monitoring. It has a section where various health officials themselves vouch for how the CBM process has assisted in improving the health system.

The book provides details of the various activities implemented under CBM at different levels – state, district, block, PHC and village level, in an easy to refer tabular format. Several GRs and Government decisions regarding CBM have also been included. Overall the guidebook provides a useful tool for the health officials involved in the CBM process, with all the requisite information compiled in one place.

Latest issue of 'Davandi' – quarterly published forum linked with the CBMP process

With the CBMP process picking up in Maharashtra, a need was felt to systematically document the changes taking place, in a manner that would reach out to a wide audience. Thus came about "Davandi" - the quarterly newsletter of the CBMP process.

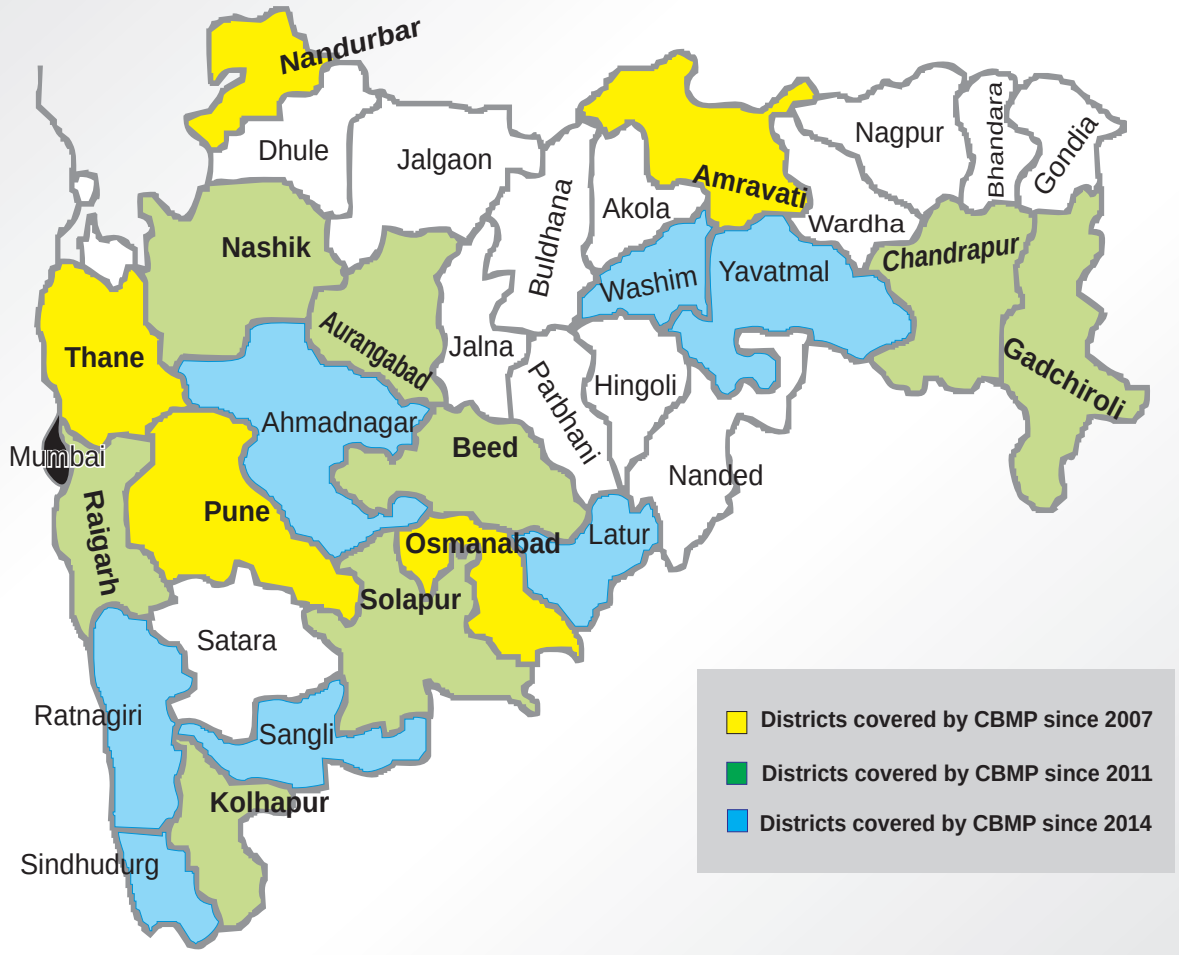
"Davandi" functions on the premise that the public health system is a key support to ordinary people, that there is a need to explore the various streams related to this perspective, along with appreciating positive aspects about the public health system. One of the aims of "Davandi" is also to increase the dialogue between the public health system and the common people (the beneficiaries of the system). The quarterly progress of the community monitoring process is reflected in "Davandi", so in a way the various stepping stones in the community monitoring process are being collated in "Davandi".

Maharashtra
Community Monitoring & Planning

UPDATE

Davandi has already completed 6 years and the current edition of Davandi is the 21st edition. The cover story speaks about the possibility of a system for Universal Health Care in Maharashtra. Davandi devotes its cover page space to make a case for UHC, detailing its logic and justification. It goes a step further and also presents a case from the perspective of doctors. Besides this cover story focus, a small write up gives analysis of the information collected regarding the spending of the untied funds which are provided at the village level. A description about the intervention on mental health undertaken by the Janarth Adivasi Vikas Sanstha in Nandurbar, is an eye-opener about the prevalence of mental health issues and the dearth of services available in the public sector. A news section takes a look at various crucial developments in the health field, especially in CBMP areas.

Districts covered by CBMP in Maharashtra in phases during 2007 to 2014



CBMP Update prepared by SATHI,
State nodal organisation for CBMP in Maharashtra supported by NHM

January.2015