C B M P-Maharashtra

Community Based Monitoring and Planning of Health Services in Maharashtra

Update - May 2016

UPDATE

Community based monitoring and planning of health services, a key component of the National Health Mission, has been effectively implemented in Maharashtra with progressive expansions over last eight years. During the financial year 2015-16, the flow of resources for activities approved in the CAH component of the State PIP was quite delayed, and were received only in early 2016. This proved to be a significant constraint in carrying out the range of planned activities and innovations, and maintaining continuity of community processes. Nevertheless a range of activities were carried out, many of which were conducted in the first few months of 2016, and are briefly reported upon in this update.

A. Selection of nodal organisations in 5 new districts, to further expand the CBMP process

Currently regular CBMP processes cover 14 districts of Maharashtra, based on which the process is now being expanded to cover 5 additional districts, thus bringing the coverage to 19 districts during 2016-17.

The process in such new areas for selecting nodal civil society organisations, which are genuinely interested in rights based, community oriented work, was viewed as a challenge. Hence in January 2014, an advertisement was issued for implementation of low-intensity voluntary CBMP, and after due process, 33 organisations from 17 districts were selected for this purpose. These organisations were provided with guidance, training, appropriate materials from time to time, and subsequently, information was collected at community and health facility level about the current status of health services, followed by Jan samvads in 32 blocks. Positive changes brought about by these Jansamvads were evident in many places – increase in OPD attendance, doctors began to reside on the premises of the health centre, cleaner health centres, availability of ambulances for the patients etc.

With the intention of taking this process further, moving from voluntary initiation to a more regular activity, a proposal for extension of CBMP to these new districts was discussed in the State Mentoring Committee. Based on involved districts and organisations active in implementing voluntary community accountability processes, it was decided to extend regular CBMP processes to the new districts Yavatmal, Bhandara, Sindhudurg, Ahmednagar and Sangli.

Another advertisement inviting applications for implementing regular CBMP activities was issued in newspapers in April 2015. Subsequently the selection process was delayed and finally, shortlisted organisations were interviewed in March 2016. Based on these interviews, two organisations each have been selected from Yavatmal, Sangli and Ahmednagar, and one organisation each was selected from Bhandara and Sindhudurg – a total of 8 organisations. The entire range of CBMP activities for these new blocks and districts have been proposed in Maharashtra state PIP for 2016-17, and it is expected that with selection of nodal organisations, now these processes would move forward.

B. Developing decentralised health planning as a component of CBMP

State level workshop on Decentralized Health Planning in Maharashtra supported by NHM

On 25th February 2016, a day-long state level workshop was held at Arogya Bhavan, Mumbai, on 'Decentralized Health Planning in Maharashtra related to National Health Mission' (NHM). Dr. Padam Khanna, Senior Consultant, National Health System Resource (NHSRC), GoI, New Delhi was invited as a technical expert and was the chief guest during the workshop. The workshop was attended by various senior level government officials and experts such as Ms. I. A. Kundan, Commissioner, F&W and Mission Director, National Health Mission, Maharashtra; State officials from NHM and the Public Health Department; and SHSRC representatives.

There were nearly 100 participants in the workshop, including District and regional level NHM officers concerning most districts of the state. In this workshop, the following points were discussed in detail -

- *Findings of the study regarding baseline status of PIP preparation process in pilot district –Gadchiroli*

The findings of a study on the status of PIP preparation processes in Gadchiroli district, prior to the intervention, were presented. Key findings that emerged from the study included poor co-ordination between Government officials and mandated committees, at various levels of PIP preparation. Recommendations for making the PIP preparation process more participatory and responsive to community needs were also presented, such as need to simplify PIP formats and ensure their availability in vernacular language, providing block budget envelope, preparing 'Annual Calendar for PIP preparation' etc. Dr. Padam Khanna said that NHSRC can technically facilitate and support promotion of participatory processes for PIP preparation in Maharashtra.

- *Experience of pilot implementation of decentralized health planning in Gadchiroli district during 2015-16*

Ms. Mukta Gadgil from SHSRC- Maharashtra and representatives from Gadchiroli who were actively involved in the process – a representative of the District nodal organisation for CBMP, Amhi Amchya Arogyasathi; PRI member, representative of District Monitoring and Planning Committee, Gadchiroli; and the ADHO, Gadchiroli- presented the experiences of developing decentralized and participatory health planning in Gadchiroli during 2015-16. They described various crucial steps, *starting from conduction of Gram sabhas to discuss community health needs, to block and district level multi-stakeholder meetings for prioritising issues and preparing* workable proposals. They briefly also touched upon the challenges faced during the process. As an impact of this participatory intervention, *ten concrete and relevant community based proposals had been developed with associated budget, and were submitted for support from specific budgetary sources,* including Tribal development department, District local body funds, and the District PIP related to NHM.

MD, NHM Maharashtra Ms. I. A. Kundan appreciated the process of participatory health planning and stated that Maharashtra is perhaps one of the few states in the country to take such initiative of decentralized, participatory health planning for PIP preparation, based on active community level processes. She opined that while we have started from Gadchiroli district, we should soon expand the process to other parts of the state in a phased manner, with emphasis on some priority themes such as maternal health services etc.

- *Plan for expansion of participatory, decentralized health planning and expected challenges, issues while implementing such participatory planning process in various districts*

A representative of SATHI (State nodal organisation for CBMP), made a presentation about various bottlenecks and issues related to the implementation of Decentralized Health Planning in context of PIP preparation processes, accompanied by suggestions regarding required modifications in the process from national to state and district levels.

Following this, there was a discussion on all the presentations. There were *certain key decisions like upscaling the process of Decentralised, participatory health planning for PIP development to 14 CBMP districts of the state, with an initial focus on certain themes like comprehensive maternal health services* etc. It was decided that State NHM with inputs from SHSRC and SATHI would develop a proposal for 26 blocks in 14 districts with components of community processes, capacity building and multi-stakeholder consultations, towards promoting decentralised and participatory health planning, which has been subsequently submitted for inclusion in the next year's (2016-17) State PIP.

Story of change from an activated and aware community: Borichak village in Gadchiroli district

Aamhi Aamchya Arogyasathi is the nodal civil society organisation in Kurkheda block, which is involved in promoting decentralised health planning processes. The youth in Borichak village in this block were activated due to the participatory processes related to involvement in the health planning processes during the last year, and their involvement continued throughout the year. They managed to develop a good understanding of health issues in the village, and tried to resolve them in various ways through meetings of the Village Health Committee. They especially focussed on cleanliness in the village, and tried to raise this issue in the Gram Panchayat, however the Gram panchayat paid no heed. Finally the activated Village health committee decided to take matters in their own hands, they conducted a meeting with villagers and it was decided to undertake a mass cleanliness drive on every Sunday in the village, with the involvement of men and women self-help group members, Village Health Committee members and active villagers. The situation of cleanliness showed remarkable improvement with this initiative, and the village youth have been actively working towards ensuring that the entire village remains clean on a regular basis.

The next issue which the Village health committee has decided to tackle is that of addictions in the village, they now intend to take steps towards a totally addiction-free village. Thus the processes of community action which have originated in context of community based monitoring and planning have enabled villagers to not only demand their health rights, but also to understand and tackle local problems through collective initiative.

C. Review of communitisation aspects of NHM in Maharashtra – facilitated by NHM-AGCA

The annual review of communitization aspects of NHM, particularly Community Based Monitoring and Planning processes in Maharashtra, was facilitated by the members of the NHM- Advisory Group on Community Action (AGCA) and was hosted by the Maharashtra State NHM office, on 1st March 2016 at Arogya Bhavan in Mumbai. The participants included Ms. I. A. Kundan, Commissioner F&W and Mission Director, National Health Mission, Maharashtra, members of the NHM- Advisory Group on Community Action (Dr. Abhijit Das, Dr. Mirai Chatterjee and Dr. Abhay Shukla), representatives of AGCA secretariat (Mr. Bijit Roy), officials from NHM Maharashtra and SHSRC, representatives from the state nodal NGO, SATHI as well as from selected Block and District nodal organisations.

During the review, there was a presentation and discussions on developments and innovations in CBMP process in Maharashtra during current year (2015-16). There was also a Discussion on the proposed transition process, including integration with existing structures such as VHSNC and RKS, followed by a discussion on perspective plan for CBMP process, and plan for next year's PIP- 2016-17. Next was a discussion on principles and broad considerations related to re-selection of State nodal organization for CBMP process in Maharashtra. Certain key decisions were taken in each of these areas after arriving at a broad consensus. This annual review was a significant contribution by AGCA, to facilitate the taking forward of CBMP / CAH processes in Maharashtra.

D. Proposed transition process and perspective plan for CBMP process

A transition process has been developed and is being proposed for CBMP Maharashtra, with an intention of moving towards a more sustainable, institutionalised and widely generalised model of Community Action for Health in Maharashtra. This would be implemented with modified, less central role of CSOs, based on main ownership being taken by PRI members and community based actors, with closer alignment with existing communitisation structures and less intensive use of resources.

The strategy for operationalising this transition over next two years (2016-2018) in all existing CBMP areas in 14 districts, along with expansion to new districts to cover most of the state, would also include the interfacing and articulation of CBMP structures with PRI institutions and NHM bodies like VHSNCs and RKS. A set of innovative strategies are being rolled out to facilitate this transition which include: Block level health

federations comprised of members of VHSNCs and community monitoring committees; engaging youth volunteers across large numbers of villages in blocks to widely propagate community awareness and accountability processes; Grievance redressal facilitation cells at Block level; and Arogya Gram Sabhas. As per the transition-cum-phased generalisation plan, the scope of Community based monitoring and planning would significantly expand, though with somewhat lower intensity of external resources, in the next two years as follows:

Present status of areas covered by CBMP in intensive mode (2015-15)	Total area that would be covered by CBMP in 2016-17	Total area that would be covered by CBMP in 2017-18
860 villages, 32 blocks, 14 districts	2153 Villages, 45 blocks, 19 districts	5126 Villages, 59 blocks, 26 districts

E. State level Melava (convention) of Panchayat Raj Institution members involved in Community Based Monitoring and Planning Process in Maharashtra

A state level Melava (convention) of PRI members who are actively participating in this process in various districts, was held on 3rd March 2016 at Pune which was attended by about 75 PRI representatives from village, block and district levels who are active in the CBMP process, drawn from 11 districts across the state. PRI members attending the convention included Gram panchayat members, Sarpanches, Block Panchayat samiti members, Block Panchayat samiti chairpersons and vice-chairpersons, Zilla parishad members, chairpersons of Zilla parishad health committees, and District monitoring and planning committee members.

PRI members have been active participants in the CBMP process in Maharashtra, and their participation remains crucial during the process of transition to a more sustainable model. This melava was organised with the intention of discussing how all PRI members can strengthen community accountability and participation for health while utilising the spaces and powers available to them, and while collectively working to resolve people's health issues by using the forums created by CBMP.

The PRI members were made aware about their crucial role in present and future communitisation processes. This was elucidated further through concrete examples of alert PRI members playing a proactive role in taking the CBMP process forward, and expanding the mandate of community monitoring to other social services beyond health care. There was reiteration of the role of PRI members, in long term political processes, not just for the next election, and not just power politics for self-advancement, but politics of people's development and welfare.

For generalisation of the CBMP process from few selected villages of a block, to across the block, initiative should be taken by the Sarpanch, Panchayat Samiti and Zilla parishad members. Along with their involvement in community based monitoring, the role of PRI members is also crucial in planning of funds being received by health institutions.

Some CBMP block co-ordinators gave their suggestions on how PRI members can actively engage with the existing processes, and there was also a sharing on part of many of the PRI members present, about their positive experiences in the CBMP process.

F. Participatory Audit and planning related to use of RKS funds – analysis of spending on routine medicines made through RKS funds.

'Social Audit' as a process is now well known in India, especially in context of the National Rural Employment Guarantee Act. Further during CBMP processes it was observed that the existing Rogi Kalyan Samiti (RKS) bodies were largely dominated by health officials, who were taking decisions related to spending various RKS funds in a limited manner without adequate wider participatory processes. Given this context, the

Participatory Audit and Planning (PAP) process for RKS funds has attempted to implement the process of social audit, using the spaces created through Community Based Monitoring and Planning.

The Participatory Audit and Planning process was initially conducted on a pilot basis in a total of nine health institutions of Nandurbar, Thane and Raigad districts of Maharashtra, during December 2014 to March 2015. This has then been further expanded to cover around 70 health institutions in 26 CBMP blocks, during 2015-16.

Objectives of the PAP process include promoting active participation of community based stakeholders in the decision making related to planning and utilization of RKS funds. This is combined with identifying gaps in the current expenditure of RKS funds, and building the capacity of RKS members on their roles and responsibilities.

Steps in the PAP process :-

1. Preparatory Phase- To understand the pattern of expenditure of RKS funds, a representative of Civil Society Organizations collected information for the financial year 2013-14, from the Health institution. The purpose was to assess the components that incurred the maximum financial spending, and based on the findings, a poster was developed and displayed in the premises of the Health Institution.

2. Participatory Audit and Planning (PAP) event-

- Joint meeting between RKS members and Community Monitoring and Planning Committee members in the premises of Health Institution, orientation followed by presentation of the poster summarising current breakup of expenditure.
- Verification of documents- Examination of financial documents and records related to RKS Committee expenditure such as vouchers, bills, tenders etc. as well as minutes of RKS Committee meetings.
- Tour of Health Institution by participants- cross checking of verified financial records versus physical availability of items purchased through RKS funds.

3. Dialogue among key stakeholders for discussing the issues and needs identified during examination of financial records, physical verification and issues arising through the community based monitoring process. Based on this, planning of next year's RKS Committee funds is done and decisions related to functioning of RKS Committee are taken in participatory manner.

The detailed report of each PAP event was also shared with district and state level health officials for taking further relevant actions.

Impacts: The process of participatory audit brought to the forefront various gaps in the manner of spending RKS funds, and also in utilisation of purchased items. Hence immediate decisions were taken, and concrete actions followed to rectify these gaps. Some examples of prompt actions :-

- A Community Health Center in Nandurbar had purchased a fridge and cooler from RKS funds last year, but this was placed in the staff quarters instead of the CHC at the time of the committee's visit. A district level official was of the opinion that the items should be immediately brought to the CHC, where they were meant to be. The fridge and the cooler were returned to the hospital for use by patients and staff in the facility.
- In a CHC in Dhadgaon block of Nandurbar district, curtains for doors and windows were bought from the RKS funds. However, the curtains had been put up only in the doctors' cabin, while the doors of other

wards like General Ward, Women's ward did not have any curtains. This issue was discussed during the participatory audit and curtains which were purchased through RKS funds, were promptly put up on the doors of all wards.

Based on the positive impact of PAP process leading to improvement in health services at local level, two important decisions were taken at the state level.

- It emerged from almost all participatory audit events that RKS coordinator and accountant, who are expected to facilitate the RKS functioning, do not have clarity regarding their responsibilities and overall use of the RKS funds. Hence a decision has been taken to conduct a state level workshop for orientation of these officials from all CBMP districts as a next step.
- NHM Maharashtra has decided to implement the PAP process for RKS from 2015-16 onwards, in 26 blocks from 14 districts of Maharashtra, where CBMP process of Health Services is being implemented.

Analysis of spending of RKS funds on purchases on medicines:-

As a part of the PAP process, information was collected from 65 PHCs regarding what proportion of RKS funds (Rs. 1 lakh annually) has been spent on purchase of medicines, in the previous year (2014-15). It was found that -

- Of the total RKS funds in the 65 PHCs, Rs. 14 lakhs has been spent on purchasing medicines at the local level, and if we look at percentages, this amounts to 22% of the RKS funds.
- A regional analysis reveals that in five districts, higher proportion of the RKS funds have been spent on medicines- Palghar, Amravati, Osmanabad, Thane, Nandurbar. This ranges from 43% in Palghar to 27.5% in Nandurbar district.
- In certain PHCs with high patient load, very high amounts have been spent from RKS funds to purchase routine medicines, such as Sakharshet PHC in Palghar (83%), Andur PHC in Osmanabad (71%) and Bijudhavadi PHC in Amaravati (69%), demonstrating the massive shortfall in routine supply of medicines to PHCs across districts of Maharashtra.

Concerned health workers and officials indicate that they routinely raise their demand for medicines, but these are not supplied to them on a regular basis in adequate quantities, hence they have no choice but to purchase medicines locally from the RKS funds. While RKS funds are supposed to be utilised for purchase of emergency medicines, this state level analysis of medicines purchased from RKS funds reveals that *most of the purchases are of medicines and supplies which are routinely required in the PHC, but are not being provided in adequate quantities.* Almost all these 65 PHCs have used RKS funds for purchase of large amounts of routine items such as paracetamol tablets, antibiotics, syrups for children, certain injections, needles and syringes, apart from gloves, betadine, spirit etc.

It is obvious that use of RKS funds on a large scale to purchase medicines that must be routinely supplied by the state is at best a stop-gap solution, and is not an answer to the persistent and serious problem of inadequate medicine supply to rural health facilities in Maharashtra. The most crucial factor which should govern supply of medicines-'facility specific demand'- is sidelined, paradoxically leading to shortages of some essential medicines and excess stock of certain other medicines, which then cross their expiry date and are thrown away as waste. *A definite solution to this issue could be adoption of the Tamil Nadu model of autonomous corporation for procurement of medicines, and managing distribution based on demand-driven supply through mechanisms like 'medicine pass book', which have been successfully adopted by other states also like Kerala and Rajasthan.* If RKS funds are to be used for meeting genuine community and patient needs in each facility in flexible and decentralised manner, then the current pattern of using large proportion of RKS funds for local purchase of routine medicines (often bought at much higher rates than centralised purchase) must be changed. And if the serious and persistent problem of medicine procurement and distribution of medicines in Maharashtra is to be resolved, then the Tamil Nadu model for medicine procurement and distribution needs to be adopted by the state without further delay.

G. 'Opinion Poll' on status of health services

As part of NHM, certain guaranteed health services have been assured at various levels. An attempt was made to understand the status of these services during the year 2015-16, in some of the areas where low-intensity CBMP has been recently initiated. This was done through a process of collecting people's feedback about the services that are supposed to be available at the village, sub-centre and PHC level. This was done through an 'opinion poll' process, whereby simple checklists were prepared with Yes/No type of questions. Partner organisations in these new areas were asked to cover a minimum of 50 participants in each 'opinion poll' which was carried out the level of either PHC, Sub-centre or village. The polling was often carried out at frequented public places like bus-stands or market places.

नागरिकांनो, आरोग्य जनमत चाचणीत सहभागी व्हा

अविल बोरकर : आरोग्य कर्मचारी प्रतिनिधींकरिता कार्यशाळा

Appeal published in newspaper, asking people to participate in opinion poll on health services - 28th February, 2016. Sakal, Bhandara.

Brief analysis of the data collected through opinion poll in two districts where the lower intensity process of CBMP is presently in its initial stage, is as follows:

In one block each of Ratnagiri and Sindhudurg districts, the opinion polls were conducted in 3 PHCs, 3 sub-centres and 3 villages, covering 50 respondents at each level. Thus in these two blocks combined, a total of 900 health system users provided their feedback about frontline health services.

Opinion poll covering 6 PHCs, involving 50 users for each PHC (total 300 respondents)		Yes	No
1.	Is extra money apart from the case paper fee charged from patients?	62	238
2.	Are medicines prescribed from outside?	90	210
3.	Are doctors and staff present at the PHC on time and attend punctually?	275	25
4.	Do doctors and staff stay in the PHC premiseswith proper residential quarters?	247	53
5.	Is there regular cleanliness in the PHC?	296	4
6.	Do normal deliveries take place round the clock in the PHC?	192	108
7.	Is there facility of water in the health centre?	300	0
8.	Are blood, urine and sputum tests being done in the health centre?	93	207

Some key issues which emerge from this opinion poll which covered 300 users of six PHCs:-

- 30% people experienced that medicines are prescribed from outside.
- Only 31% people said that blood urine and sputum tests are being done in the PHC lab.
- One-third of the participants (36%) reported that normal delivery does not take place round the clock.
- Around one-fifth users reported illegal charging in the PHC (20.6%)

Similar opinion polls were conducted at the level of sub-centre and village, concerning services expected at that level.

Some feedback that emerged at the sub-centre level (total 300 respondents) and village level (total 300 respondents):-

- Only half of the respondents reported that the sub-centre is opened/functional regularly, and that regular treatment is available at the sub-centre
- 66% people reported that even in Sub centres with residential quarter arrangements, health workers do not stay there.
- 96% of the people reported that normal deliveries are not being done at the sub-centre.
- Only 40% of the people stated that vehicle for referral is available to pregnant women or serious patient in the village.

The relevance of such 'Opinion polls' is that they provide a *simple and rapidly applicable tool for collecting feedback from users of health services*, regarding their experiences of health services at various levels.

H. Dialogue during Jan Sunwais/ Jan Samvads made more productive through adoption of 'Code of Conduct'

Jan Sunwais (public hearings) have functioned as one of the crucial tools in the entire Community based monitoring process in Maharashtra, especially at the level of the PHC, Block and District. Since they were initiated in 2008, until now a total of 550 Jan Sunwais have been conducted as part of the CBM Process in Maharashtra.

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Although initially considered rather contentious, health officials gradually began to accept the process, as it moved beyond being a forum for people to raise their demands, and also proved to be a platform for health workers and staff to share the obstacles they face while providing health services, such as lack of residential arrangements, water supply in quarters, safety for women workers etc.

During the last eight years, the Jan Sunwai has emerged as an effective medium for resolving most of the local level problems, and for taking the unresolved ones forward to the next level. In a few places however, where very serious issues related to denial of health services were raised and ordinary people were agitated, or authorities were denying the problems and behaved in very insensitive manner, sharp words were exchanged in the Jan Sunwai. In a few instances PRI representatives spoke rather arrogantly to the Health staff. Hence firstly it was decided in discussions among the State NHM officials and nodal organisations that henceforth these events will be termed 'Jan Samvads' in a spirit of promoting constructive dialogue. Further it was felt that a "Code of Conduct" was required for conducting Jan Samvads, which was evolved and widely publicised in 2015-16. During each of the Jan Samvads that have been conducted in 2016, the code of conduct is shared in advance with all the panelists, and it is also circulated at the time of the Jan Sunwai. Some of the key elements included in this code are as follows:-

आरोग्यसेवांवर लोकाधारित देखरेख प्रक्रियेअंतर्गत घेण्यात येणाऱ्या जनसंवादासाठी

आचारसंहिता

- The intention of the Jan Samvad is not to target any particular person, rather it is to improve the system; concerned authorities, civil society representatives and the panel members should adhere to this principle while conducting the event.
- Civil society representatives should ensure that information about issues and cases to be presented in the Jan Samvad would be sent to related officials at least 3 days before the event.
- No person will be insulted, talked down to, or threatened in any form during the Jan Samvad. The panel will be responsible to ensure that this norm is followed during the event.
- Officials with decision making powers must attend the Jan Samvad, and should respond appropriately to allegations. Where there has been a gross denial of health care leading to serious consequences, due cognisance of the issue should be taken by the health system followed by prompt related action.
- Some cases of denial of healthcare involve significant physical or financial loss for the patient. In such a situation, it is the responsibility of the health system to ensure that the complainant gets justice. Certain policy level decisions may need to be taken in the Jan Samvad to prevent recurrence of such instances. Concerned health officials will take such decisions if they are within their power, or will report the matter to their seniors as required.
- If any of the above rules are not followed during the Jan Samvad, then the panel will intervene.
- Officials and CSO members must ensure that decisions taken in the Jan Samvad are properly documented, and are implemented within one month of the event.

Policy brief prepared by SATHI, State nodal organisation for Community based monitoring and planning (CBMP) in Maharashtra supported by National Health Mission, responsible for state level facilitation of CBMP during 2007-16.

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