Community based monitoring of health services in Maharashtra, India

Use of community based evidence, accountability processes, trends of improvement in Health Services

Background

The National Rural Health Mission (NRHM) was launched in India in April 2005 with a view to bring about architectural corrections and strengthening of the rural public health system, expected to improve health services for the rural population. One significant policy initiative under NRHM has been in the form of a comprehensive framework for *Community based monitoring and planning* at various levels of the Public Health System.

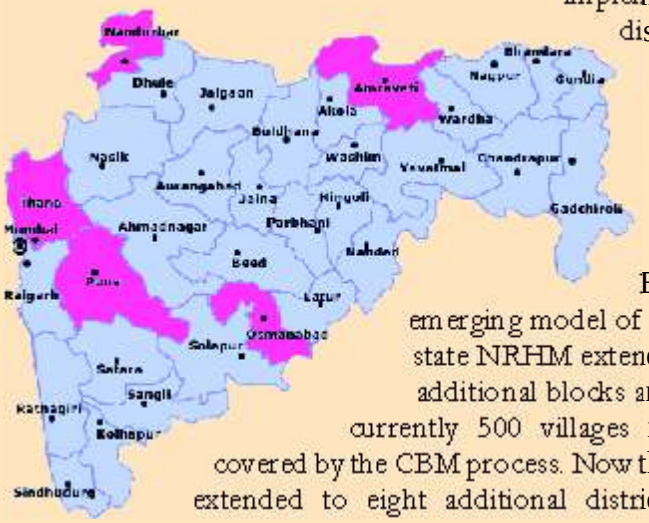
Community based monitoring (CBM) of health services is being implemented in Maharashtra as well as certain other states in India, as a component of NRHM since mid-2007. With facilitation by civil society organisations, community members have been involved in periodically collecting information about local health services, preparing and displaying 'report cards' on health services, dialoguing with health service providers and officials in various committees, organising Public hearings on health services, and raising issues at State level programmes.

Basic structure of CBM

CBM processes related to NRHM are organised at the village, Primary Health Centre (PHC), block, district and state levels. A state nodal NGO (SATHI in case of Maharashtra) coordinates the CBM activities across districts in collaboration with the district and block nodal NGOs, working with the State health department. A monitoring committee at each level collates the findings from the level below, monitors the health system at its own level, and passes these results up to the next level one or two times a year. For example, the PHC monitoring committee collects results from the village report cards, monitors services in the PHC, and passes village and PHC information up to the block level monitoring committee.

Scale of CBM

CBM Districts in Maharashtra



In Maharashtra, CBM has been implemented in five pilot districts, (Amaravati, Nandurbar, Osmanabad, Pune and Thane) initially covering 15 blocks and 225 villages. Encouraged by the emerging model of CBM, in 2009 the state NRHM extended the process to additional blocks and villages, so that currently 500 villages in 23 blocks are covered by the CBM process. Now the process is being extended to eight additional districts, which would expand the coverage to 13 districts and about 800 villages of the state.

Key processes in Community based monitoring

Process 1- Filling health report cards

At the core of CBM is the act of *tracking, recording and reporting the state of public health services in villages and facilities, as experienced by the people themselves*. These requirements have been met in two ways. First, Village Health, Water supply, Nutrition and Sanitation Committees (hereafter called VHCs in short) were formed, or, in many cases where they already formally existed, were significantly expanded and

activated. Second, village health report cards and related tools for community based data collection were developed. Once the VHC members were trained, they have been involved in the process of filling up Village health report cards, with active guidance from the nodal NGO/Community based organisation. Information is collected on indicators like village level disease surveillance services; maternal and child health services including immunisation, antenatal care and postnatal care; curative services at the village level; use of village untied funds etc. Once they are filled, the village report cards are displayed in a prominent place in the village, and a copy is sent to the PHC level monitoring committee for further dialogue and action. Similarly data is collected and report cards are prepared at the level of PHCs and Rural Hospitals (equivalent to CHCs). From 2010 onwards, separate report cards are also being prepared for Anganwadis and Sub-centres.

Process 2- Public Hearings

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

Under CBM in Maharashtra, Public hearings have been organised at the PHC level (42 hearings in first phase and 45 in the second phase) and district level (hearings in each of the five districts in both the first and second phase) and in a few places at the rural hospital level; hence over one hundred public hearings have been organised so far as part of the CBM process.

Process 3- Networking of civil society organizations at multiple levels

CBM depends on the collective action of civil society organizations working at the state, district, block and village levels. The first phase required 15 diverse organizations to work with one another, with communities and with the government to make CBM work. These organizations have mostly been involved in the People's health movement (Jan Arogya Abhiyan), and have found common ground in their commitment to a rights-based and community-centred approach to the health system.

Process 4- Periodic state level dialogues

Until the development of CBM there was no regular forum for community level groups to raise issues at the state level in ways that could elicit action. Under CBM, there are now officially mandated dialogues between the state officials and civil society representatives on an annual basis. These dialogues help to address issues that have not been resolved at lower levels and reinforce the commitment of the entire health department. They have proven instrumental to the development of CBM. One element that makes these meetings particularly fruitful is the simultaneous presence of state, district and block level health officials. The participation of these government representatives helps to assign responsibility to take corrective action which is reported right away during the meeting itself.

Process 5- Media Coverage

The media has helped generate public awareness about the problematic condition of the public health system and the potential of CBM to improve it. When critical reports about the existing deficiencies


Improvement in rural health of 5 districts: Survey

They ensure rural health is in good shape

Community monitoring of health services takes off

People's participation improves district healthcare

in the public health services were published in local newspapers, district health officers and other functionaries took these issues seriously, often responded promptly and made efforts to address the issues at their level. Without media involvement the reports and Jan Sunwais (public hearings) would have been far less effective, would have received less attention from the government and would have led to fewer positive changes in the rural health system.

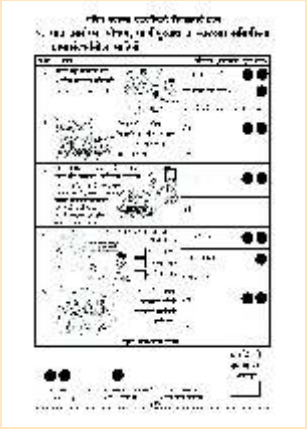
Indicators on which information is collected

Almost all indicators for collection of information are based on the service guarantees stated in the NRHM implementation framework. Presently information is collected on basis of specific tools, and report cards are prepared at village, Anganwadi, sub-centre, PHC and Rural hospital levels. Key types of information collected at village and PHC levels are given in the table below.

Information is collected for the village level report cards on the following parameters	Information is collected for the PHC level report cards on the following parameters
a) Disease surveillance services b) Maternal and child health services (ANC, PNC and immunisation) c) Curative services at village level d) Anganwadi services e) Availability of services and quality of care available at PHC	a) Infrastructure- Electricity, water supply, toilet facility, labour room, indoor facility, laboratory facility b) Services- Delivery services, referral services, indoor services, laboratory services c) Availability of Human resources- MO, ANM, lab technician, driver etc.

Information is collected for the village level report cards on the following parameters	Information is collected for the PHC level report cards on the following parameters
f) Utilisation of village untied fund g) Adverse outcomes (Denial of health care, maternal death,	d) Availability of essential drugs- Stock of nine high priority essential drugs checked based on the state guidelines on minimum availability. e) Exit interview of patients - Quality of service, behaviour of providers, illegal charges etc.

Development of pictorial monitoring tools



It was realised that in the areas where literacy level is low, especially in tribal areas, VHC members may not be able to understand the questionnaire and report card tools properly. To make it easier for VHC members to understand and use the questionnaire and report card tool, a pictorial tool was developed and phrasing of questions in the tools was modified.

Group discussions, facility survey, exit interviews and interviews of Medical Officers

In each monitoring cycle at the village level, two group discussions were planned. One of these group discussions was with the general community including men, and one was exclusively with women. Similarly, at the PHC level, exit interviews of the OPD patients were to be conducted in each cycle. These group discussions and exit interviews

were accompanied by a facility survey at the PHC and interview of the PHC MO. Facility surveys were mainly conducted by the block coordinators. It should be noted that some of these surveys were also conducted by the VHC members.

Similarly exit interviews and interview of MOs in the pilot phase were also conducted by the block facilitators or coordinators. It seems that significantly more capacity building of the VHC members will be required before they can perform somewhat complex tasks like the exit interviews and the MO interview.

Rounds of data collection and trends of improvements

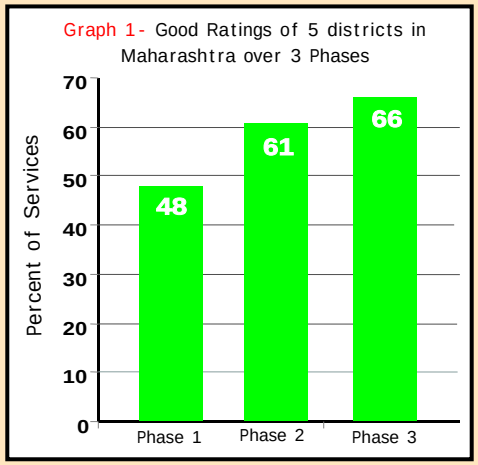
So far, four rounds of data have been collected at level of villages, PHCs and Rural Hospitals. The first round of data was collected in July-Aug. 2008, the second round in Mar.-Apr. 2009, the third round in Oct.-Dec. 2009 and the fourth round in Nov.-Dec.2010. Data from the first three rounds has been analyzed so far. This data has been collected from about 220 villages and about 40 PHCs covered under CBM across fifteen selected blocks in five districts of Maharashtra.

Here we are briefly analyzing the changes seen, based on analysis of three rounds of village and PHC level data over this period of about one and half year, (mid 2008 to end 2009) by comparing the data for each round. While significant improvements in certain services have taken place in the mentioned period, these are due to a combination of NRHM 'supply side' inputs and 'demand side' push by CBM. *Combined with NRHM related increased funds, administrative drive and reorganization 'from above', the CBM process under NRHM has provided a matching yet critical 'push from below' to help ensure that desired changes are actually implemented.* Availability of finances, supportive directions and untied funds give the basic inputs for improvement to the local health facilities, and do result in certain changes. But when combined with this, people collectively monitor the activities of ANMs and MPWs, periodically visit the PHCs and audit the availability of medicines and services, document the regularity of services and behavior of providers, point out irregular practices, and repeatedly raise these issues with officials at various levels, then the enabling climate created by NRHM is more likely to result in real improvements at the ground level.

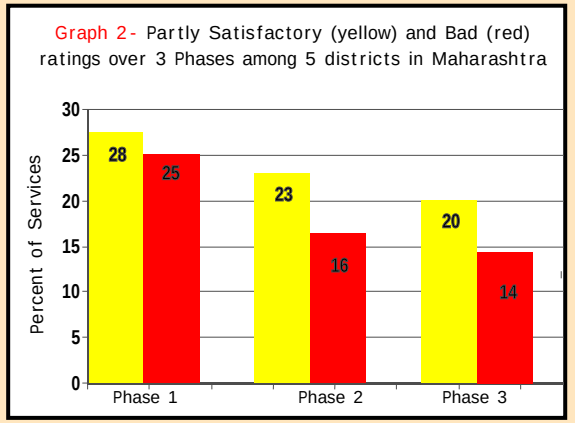
At the same time, not all aspects of the health system are amenable to improvement by Community based monitoring, and larger constraints like non-availability of skilled staff or medicines may limit the overall possibility of improvements. Such largely systemic problems highlight the need to sustain change and to ensure positive changes at policy levels. Below we have briefly analyzed the data gathered over a period of one and half year in first three phases of Community based monitoring.

1. Improvements in Village level health services

Regarding Village level report cards, nine key health services were rated by Village Health committee members as either 'Good', 'Partly satisfactory' or 'Bad'. This information was collected from the approximately 220 villages where report cards were prepared. Graph 1 shows the trend of good ratings for these services across 5 districts in Maharashtra over the 3 phases of CBM. 48% of the services were given 'Good' ratings in Phase 1, this increased to 61% in Phase 2 and further to 66% in Phase 3. Thus *there has been a consistent overall improvement in Village health services in the CBM covered villages.*

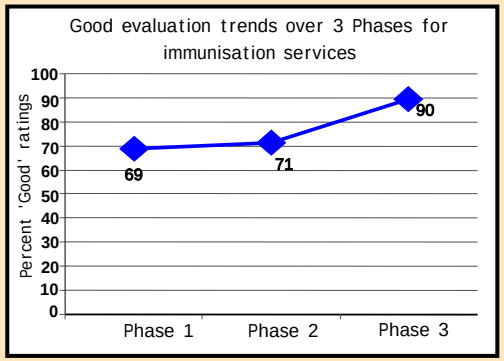


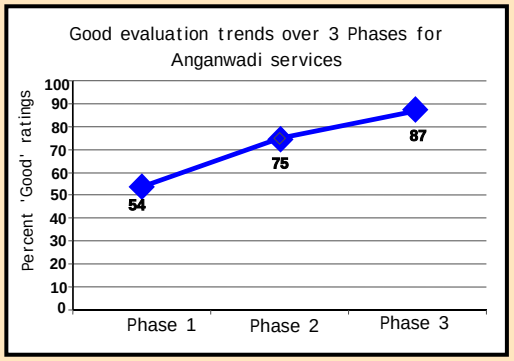
Similarly Graph 2 shows the concurrent reduction in 'Partly satisfactory' (yellow) and 'Bad' (red) ratings of services in these 5 districts over the 3



phases of CBM. Services rated as 'Bad' have reduced from 25% in the first phase to 14% in the third phase.

Certain health services have shown high and consistently improving 'Good' ratings across the five CBM districts over the 3 phases. At the end of Phase 3, 90% of districts



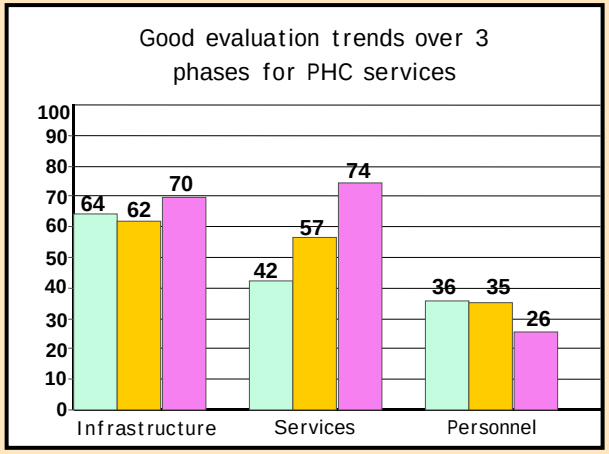


received a rating of 'Good' for immunization services and 87% of districts received a rating of 'Good' for Anganwadi services. The following graphs display trends for these services.

2. Changes in health services from Primary Health Centres (PHCs)

The data collected from PHCs in the CBM process can be divided into four broad categories: infrastructure, services, personnel and medicines. The following graph displays the aggregate PHC trends of 'Good' ratings across the 5 CBM districts in Maharashtra over 3 phases.

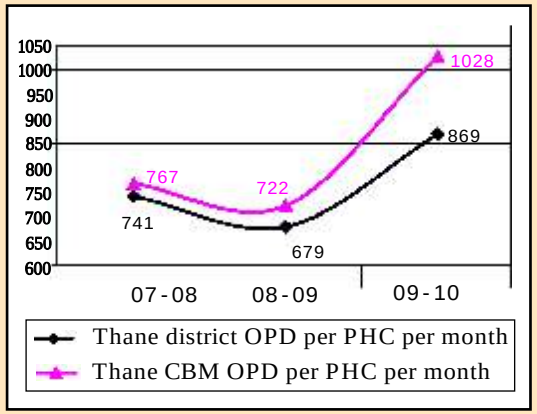
Parameters such as availability of electricity, water, cleanliness of toilets and the access to lab tests were evaluated under 'Infrastructure'. The graph depicts that the 'Good' ratings went up from 64% to 70% between phases 1 and 3. 'Services' refer to 24 hour delivery care, indoor patient services, lab service availability and ambulance for referrals. A steady increase in the 'Good' ratings for 'services' was observed. Only



42% of the ratings were 'Good' at phase 1, they increased to 57% and were calculated to be 74% at the end of phase 3. Lastly the category of Personnel included filled Medical officer positions, present paramedical workers, lab technicians, ambulance drivers. Although the proportion of 'Good' ratings for Personnel stayed the same from phase 1 to phase 2, they have decreased in phase 3 indicating some decline in availability of staff.

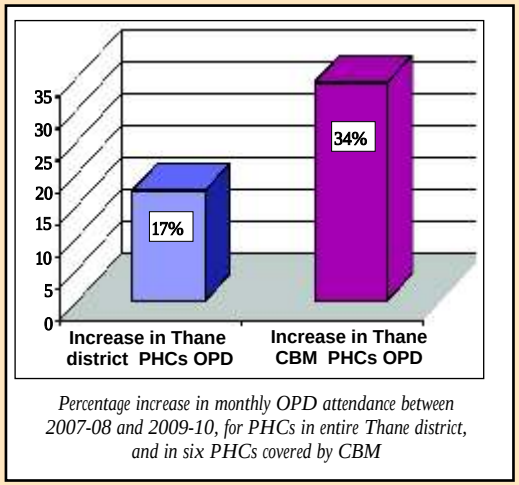
3. Significant increase in utilisation of PHC services – evidence from Thane district

Anecdotally, there have been several reports about increased numbers of people accessing local public health services, associated with the Community based monitoring (CBM) process in Maharashtra; of course such increases need to be located within the larger context of general improvements



in health facilities due to NRHM. Time trends related to utilization of PHCs covered by CBM were analysed in comparison with the average trends for PHC utilisation in the entire district.

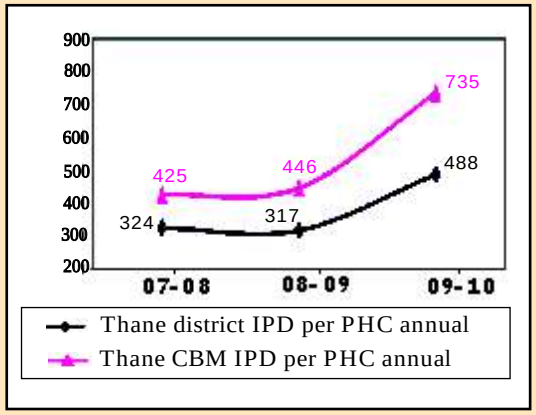
Three key utilization indicators: outpatient attendance, inpatient admissions and in-facility deliveries were analysed for three years – 2007-08, 2008-09 and 2009-10. This exercise was done for two districts - Thane and Pune, to start with.

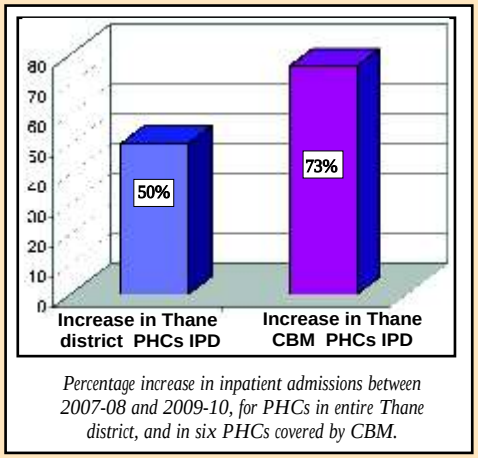


Percentage increase in monthly OPD attendance between 2007-08 and 2009-10, for PHCs in entire Thane district, and in six PHCs covered by CBM

The PHC utilization data for Thane district shows that baseline for OPD attendance in 2007-08 was similar for CBM PHCs and PHCs from the entire district. However between 2007-08 to 2009-10, the average increase in OPD attendance for PHCs in the entire district was 17% whereas the *increase in OPD utilisation in CBM covered PHCs was significantly higher at 34%.*

Simlarly, between 2007-08 to 2009-10, the average increase in inpatient admissions for PHCs in the entire district was 50%, whereas the *increase in CBM covered PHCs was significantly higher at 73%.* Further, between 2007-08 to 2009-10, the average increase in deliveries in PHCs in the entire district was 48% whereas the *increase in deliveries in CBM covered PHCs was significantly higher at*

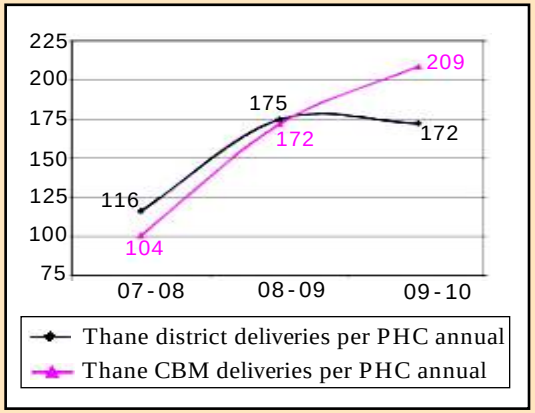


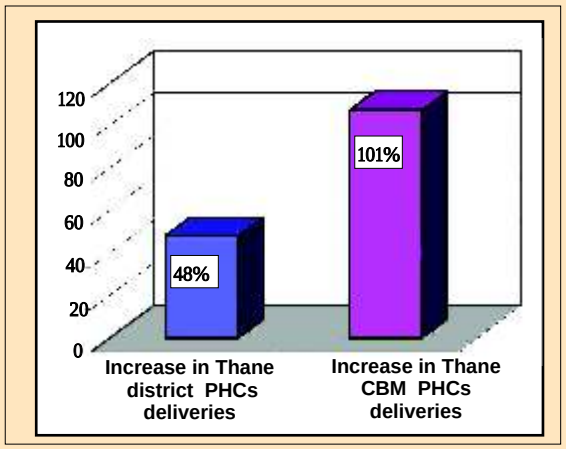


Percentage increase in inpatient admissions between 2007-08 and 2009-10, for PHCs in entire Thane district, and in six PHCs covered by CBM.

101%. Data from Pune district shows similar trends, of significantly higher increases in utilisation of CBM PHCs compared to average increases for PHCs in the entire district.

It seems that NRHM related improvements have led to some overall increase in utilisation of PHCs in recent years. Further, in PHCs covered by the CBM process, increased community level awareness along with additional improvements in services promoted by accountability processes seem to have induced more people to access PHCs for various types of care,





and this has reduced the 'public facility utilisation gap'. This has led to a *significantly higher increase in utilisation of PHC services in CBM covered PHCs over the period 2007-08 to 2009-10, in Thane and Pune districts.*

4. Qualitative improvements due to CBM in five districts

As mentioned above, regular discussions and dialogue between health service providers and villagers, civil society representatives have resulted in a range of improvements and changes in health services. *The qualitative improvements listed below concern specific issues which were raised through the CBM process*; of course most of these improvements were actually made possible because of the larger framework and funds available under NRHM.

District	Sample of improvements reported at Public Hearings
Thane	•At the PHC level, laboratory services have improved, illegal charges have stopped and electric supply has improved by installing a generator. •In the outreach services, there is no longer a discrepancy between anganwadi records and independently taken weights of malnourished children. •Illegal charging by certain medical officers has stopped.
Pune	•Non-functioning subcenters are now functional. •The citizen's health charter has been displayed in every selected PHC. •As a result of repeated demands from the community through CBM, new ANMs and MPWs have been recruited in some PHCs.
Nandurbar	•Some PHCs have now display boards stating the availability of various medicines in the PHC. These displays are the result of state level discussions on the shortage of medicine in Nandurbar. •There is a documented improvement in the supply of essential medicines to PHCs. •Remuneration of beneficiaries under incentive based schemes such as Janani Suraksha Yojana (JSY) has improved in existing villages. •PHC staff attitudes toward patients have improved. •Immunisation coverage has improved in several villages.

District	Sample of improvements reported at Public Hearings
Amaravati	• New ambulances have been provided to some PHCs. • JSY beneficiaries are being paid the rightful amount of Rs. 700/- rather than the Rs. 500/- they were being paid before. •The number of out patients at PHCs has significantly increased in the CBM blocks .
Osmanabad	•The number of patients availing services from certain PHCs has roughly doubled since before CBM was launched. •The Health Rights Charter has been displayed in every selected PHC. •The names of the PHC monitoring and planning committee members have been displayed in some of the PHCs.

From Community based monitoring to planning of health services-

The existing health planning process is mostly top-down with very little input from communities or grassroots organisations. To change this situation qualitatively, one of the key future strategies for planning of health services would be to use information about local issues/priorities and resources identified during the community monitoring process. To achieve this objective process of enabling and empowering communities has been initiated recently.

Conclusions

At the time when the community monitoring process started (first round of data collection, mid-2008), it was found that there were significant gaps in services provided at the PHC and village levels across all districts. When the third round of data was collected (end 2009) *considerable improvement in various health services across all 5 districts was observed*. However improvements regarding certain health services were not as expected, here systemic changes such as recruitment of staff and improving medicine procurement system are required.

NRHM's goal has been to make quality health services accessible at the village level. Given the above experiences, in order to meet these goals, along with improving provision of health services, it is necessary

to deepen and widen the Community Based Monitoring process which can greatly strengthen demand and utilisation, and can enable corrective feedback from the community to providers. Through the CBM process, communication between health system officials and providers and the rural public has improved significantly. Several positive outcomes associated with such improved communication are evident. However not withstanding these positive outcomes there is a need to address lacunae in the programme design and policy, and corruption at various levels. Hence there is a need to extend the concept of community based monitoring to a number of key processes of governance at higher levels, with monitoring ranging from block, district to the state level. It is also imperative that along with CBM activities at local level, there is civil society involvement to help resolve key systemic issues at the state level and to propose people-centred solutions and policies, which would help in assuring "quality health services for all".

District & Block Nodal NGOs implementing CBM -

District nodal NGOs - Amaravati- KHOJ; Osmanabad- Lok Pratishthan & Halo Medical Foundation, Nandurbar- Janarth Adivasi Vikas Sanstha; Thane- Van Niketan; Pune- MASUM.

Block Nodal NGOs-

1) Pune- Purandar block- MASUM; Velha block- Rachana- Society for Social Reconstruction; Khed block- Chaitanya

2) Nandurbar- Shahada block- Janarth Adivasi Vikas Sanstha; Dhadgaon block- Narmada Bachao Andolan; Akkalkuwa block- Lok Sangharsh Morcha

3) Amaravati- Paratwada block- Khoj Melghat; Dharni block Apeksha Homeo Society; Achalpur block- Mamta Bahudeshiya Society

4) Osmanabad- Tuljapur block -Halo Medical Foundation; Osmanabad & Kalam blocks- Lokpratishthan

5) Thane -Murbad block- Van Niketan; Jawhar block- Dr. Manibhai Desai Adivasi Mahila Sangh; Dahanu block- Kashtkari Sanghatana

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(Part of this short report is adapted from an article written by Abhay Shukla, Kerry Scott and Dhananjay Kakade; Deepali Yekkundi carried out analysis of data)

More information available at www.sathicehat.org

A detailed report of Community Based Monitoring of Health Services in Maharashtra may be accessed at:

www.sathicehat.org/uploads/CurrentProjects/CBM_Report_June10_ Final.pdf

For any further information SATHI team members may be contacted at

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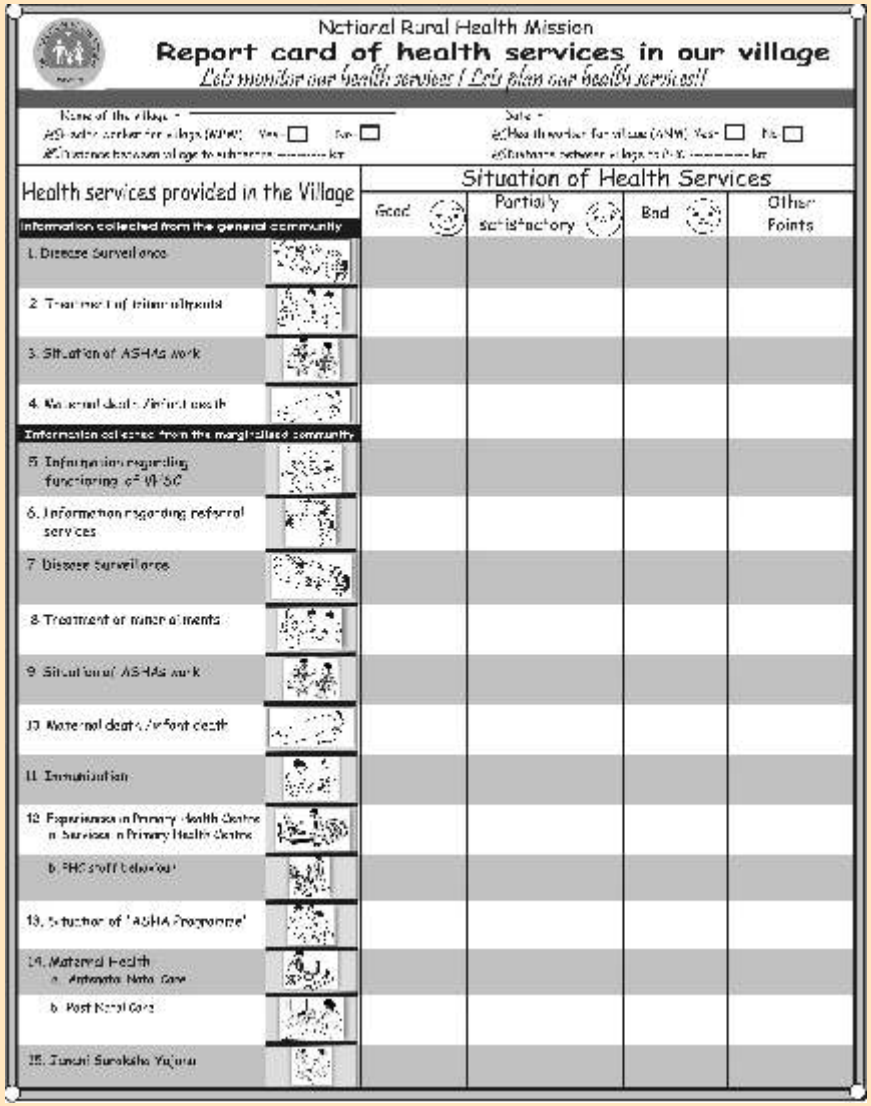
Village Health report card used for Community monitoring



National Rural Health Mission

Report card of health services in our village

Let's monitor our health services ! Let's plan our health services!!

Name of the village -

ASHA worker for village (ASHW) Yes ☐ No ☐

Distance between village to sub-centre ---- km

Date -

Health worker for village (AWW) Yes ☐ No ☐

Distance between village to P.H.C. ---- km

Health services provided in the Village	Situation of Health Services			
	Good	Partially satisfactory	Bad	Other Points
Information collected from the general community				
1. Disease Surveillance				
2. Treatment of minor ailments				
3. Situation of ASHAs work				
4. Maternal death / Infant death				
Information collected from the marginalized community				
5. Information regarding functioning of V.H.S.C.				
6. Information regarding referral services				
7. Disease Surveillance				
8. Treatment of minor ailments				
9. Situation of ASHAs work				
10. Maternal death / Infant death				
11. Immunisation				
12. Experiences in Primary Health Centre a. Services in Primary Health Centre				
b. PHC staff behaviour				
13. Evaluation of 'ASHA Programme'				
14. Maternal Health a. Antenatal Care				
b. Post Natal Care				
15. Janani Suraksha Yojana				