



**Community Based
Monitoring and Planning
in Maharashtra
A Case Study**



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- Theories of change in community monitoring
- Tracking and assessing progress and evaluating impacts
- Social accountability of private sector services
- Role and ethics of facilitating organizations: putting people center-stage

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Abbreviations

ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
ADHO	Additional District Health Officer
CBMP	Community used Monitoring and Planning
CBM	Community Based Monitoring
CBP	Community Based Planning
CHC	Community Health Centre
CS	Civil Surgeon
CSO	Civil Society Organisation
DH	District Hospital
GP	Gram Panchayat
JAA	Jan Arogya Abhiyan
JSA	Jan Swasthya Abhiyan
JS	Jan Sunwai
MLA	Member of Legislative Assembly
MP	Member of Parliament
PHC	Primary Health Centre
PIP	Program Implementation Plan
PS	Panchaya Samiti
PRI	Panchayati Raj Institution
RH	Rural hospital
RKS	Rogi Kalyan Society
SC	Sub-centre
VHSC	Village Health and Sanitation Committee
ZP	Zilla Parishad

Community Based Monitoring and Planning in Maharashtra: A Case Study

I. Background

The most extensive community accountability initiative currently underway in the health sector in India is taking place within the framework of India's National Rural Health Mission (NRHM). NRHM was launched in 2005 and while the first phase is due to end in 2012, the Health Ministry has decided to launch a second phase from 2012-2017. The Mission aims to improve the quality of health care through implementation of a health systems strengthening approach, hence the NRHM framework represents a conscious decision to strengthen public health systems and the role of the State as health care provider. The NRHM recognized the need to give special attention to the following issues, each of which is made up of a number of overlapping core strategies:

- Sufficient budgetary allocation for public health.
- Providing quality and effective health services to the rural population, with a special focus on women, children and poor people.
- Improved access to health services.
- Strengthening and decentralization of health services.
- Increasing people's participation in health services.

The Mission lists a set of core strategies to meet its goals like decentralized village and district level health planning and management and appointment of female Accredited Social Health Activists (ASHAs) to facilitate access to health services. The Mission attempts a major shift in the governance of public health by assigning prominence to Panchayati Raj Institutions in matters related to health at district and sub-district levels coupled with the other key strategy of the Mission, namely decentralization of programmes for district level management of health. Hence under the scheme, all existing societies for Health and Family Welfare Programmes, Reproductive and Child Health and National Programmes for TB, Malaria, Blindness, Filariasis, Kala Azar, Iodine Deficiency and Integrated Disease Surveillance, are integrated into a unified District Health Mission and funding for all these programmes is funnelled into the District Health Mission, which is empowered to formulate an integrated health plan of the district. Yet another core strategy of the Mission is to empower local governments to manage, control and be accountable for public health services at various levels. The Village Health and Sanitation Committee (VHSC), the Standing Committee of the Gram Panchayat (GP), provides oversight of Mission's all activities at the village level and is responsible for developing the Village Health Plan with the support of the ANM (Auxiliary Nurse Midwife), ASHA, Anganwadi Worker (volunteer child health and nutrition worker) and Self-Help Groups. Block level Panchayat Samitis co-ordinate the work of the Gram Panchayats in their jurisdiction and serve as a link to the District Health Mission, led by Zilla Parishad (ZP) which controls, guides and manages all public health institutions in the district. Hence states are being encouraged to devolve greater powers and funds to Panchayati Raj Institutions (PRIs).

The general neglect of preventive health care in India and the increasing push towards the involvement of the private sector in the delivery of health services highlights a dramatic weakening of public

commitment to health. The public sector in health exists without a minimum legislative framework. 'In the absence of law making it mandatory to provide the stipulated minimum health care, citizens are not able to exercise any right over the quantity and the quality of health care provided'.¹ Moreover, declining public investment and expenditure in health is compounded by the fact that the system is not only heavily bureaucratized, but also marked by erosion, corruption, inadequate infrastructure, and non-availability of medicines. In this context, community based monitoring was seen as an important step in promoting accountability and community led action in the field of health.

Community Based Monitoring and Planning (CBMP)

India has a long history of civil society activism on health issues. The national campaign platform for health rights – *Jan Swasthya Abhiyan* (JSA), the Indian section of the People's Health Movement – has frequently raised the above mentioned concerns at the state and national levels. Upholding the right to health care, JSA strongly advocated for improvement in and strengthening of public health system. In 2006, a Task Group on District Health Planning was constituted by the Health Ministry. JSA activists who were part of the task force, strongly urged adoption of community based monitoring, which was finally incorporated in the NRHM framework. The National Advisory Group for Community Action (AGCA) that was formed as part of NRHM further explored ways to ensure community participation which led to the formulation of CBMP framework under NRHM.² The Advisory Group recommended that the approach be piloted in nine states³ before being rolled out at national level. The pilot phase began in 2007 and ended in 2009. By 2010 nearly all NRHM states had incorporated community mobilization into their Program Implementation Plans (PIP).⁴

Community monitoring, internal monitoring and periodic surveys together comprise the overall accountability framework of NRHM. However, community monitoring is conceptualized as being more than a data gathering exercise; it is also a key strategy for ensuring that health services reach the people who need them (through community inputs to local level planning), and for extracting public accountability for service delivery failures (see Box 1). In other words, through NRHM the supply side of Health services has been ensured by Government and the demand of Health services from community has been ensured by community based monitoring and planning process.

The theoretical underpinnings of CBMP can be condensed into three key inter-related concepts, citizenship, democratization and rights. CBMP is closely related with the exercise of citizenship. A maturing democracy envisages a growing role for citizens in the monitoring of bureaucracy and functionaries. Hence several legislations of the last decade beginning with the right to information have increasingly empowered the public to call for accountability of public servants. Restoring to the citizen, acting through the agency of the gram sabha, centrality in the governance of welfare is yet another feature of governance in a maturing polity. CBMP as democratization, recognizing and restoring power to the citizen, is reflected in the exercise of peoples power (demos + kratia) to affirm the centrality of the citizen in the in the governance of welfare. Democratization also envisages horizontalization of relations between the citizen (public) and the bureaucracy (public servant) with a recognition that the public servant as duty bearer is accountable to the citizen as rights holder. CBMP in the discourse of rights envisages the assertion and enforcement of right to health as an act (kratia) of the citizen. Hence CBMP

¹ Jesani, A. (2002): "Social Objectives of Health Care Services: Regulating the Private Sector". In K. Seeta Prabhu and R. Sudarshan eds, *Reforming India's Social Sector: Poverty, Nutrition, Health and Education*. Social Science Press, pg 112, New Delhi .

² SATHI (2012): *People are Reclaiming the Public Health System - Qualitative Report of CBMP of Health services in Maharashtra*, pg 6, Pune.

³ The nine states are – Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu.

⁴ http://mohfw.nic.in/NRHM/Documents/Mission_Document.pdf. Accessed on 24th Sep 12.

as a step in the direction of democratization seeks to bridge the distance between the hapless citizen, rights holder and the unaccountable official, duty bearer and by mediating an accountability matrix gives the citizen both voice and agency.

Box 1: Objectives of Community Monitoring within NRHM

The *Manual on Community Based Monitoring of Health Services under National Rural Health Mission*, prepared by the Advisory Group for Community Action envisages that community monitoring will do the following:

- It will provide regular and systematic information about community needs, which will be used to guide the planning process appropriately;
- It will provide feedback according to the locally developed yardsticks, as well as on some key indicators;
- It will provide feedback on the status of fulfillment of entitlements, functioning of various levels of the public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability;
- It will enable the community and community-based organizations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system. The community should emerge as active subjects rather than passive objects in the context of the public health system;
- It can also be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

http://mohfw.nic.in/NRHM/Community_monitoring/Implementers_Manual.pdf

Community based planning under NRHM

CBMP is a form of social audit of public health services, which facilitates active participation of people who are otherwise indifferent towards the state of affairs in the health system. There are two key factors that facilitated the inclusion of CBMP in NRHM. First, the architects of NRHM felt that introducing an officially sanctioned community monitoring programme would fill a critical gap in the Mission's validation system. CBMP would act as the "third leg" in the monitoring system, joining the internal management information system (MIS) and the external evaluation surveys and audits. Second, the framework of CBMP was significantly shaped by sustained people-oriented advocacy through networks such as Jan Swasthya Abhiyan (JSA).⁵

National Rural Health Mission envisages the planning process to be participatory and decentralized starting with the village community. It seeks to empower the community by placing the health of the people in their own hands and determine the ways they would like to improve their health as it was felt that it is the only way to ensure that health plans are local specific and need based. The District Action Plan was the most important aspect of the NRHM and to make District Plan more meaningful and address local health problems, preparation of Block Health Plans was considered essential. The decentralized planning process involved village consultations and preparation of Village Health Plans by the Village

⁵ Shukla, A., Scott, K. and Kakde, D. (2011): 'Community Monitoring of Rural Health Services in Maharashtra', Economic and Political Weekly, Vol XLVI, No 30, pg 78-85.

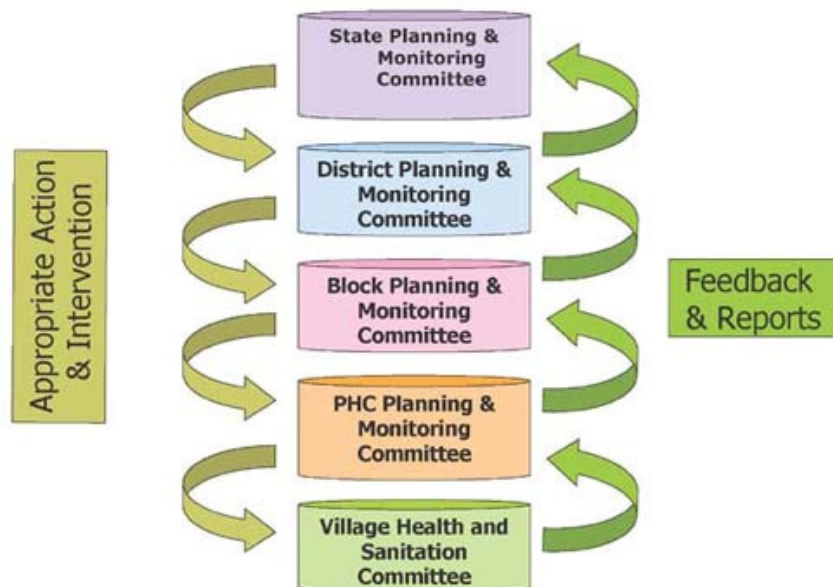
Health Water and Sanitation Committees (VHSC); followed by preparation of health plan at Primary Health Centre (PHC) level by PHC Monitoring and Planning Committee. Based on the PHC level plans a Block Action Plans were prepared through integration of all plans at the block level by the Block Monitoring and Planning Committee. The Block Action Plans including health facility surveys were then integrated to form District Action Plan by the District Monitoring and Planning Committees (For details of Committee see Fig 1 and 2).

Apart from the above mentioned monitoring and planning committees, for efficient management of public health institutions, NRHM proposed Patient Welfare Committee known as Rogi Kalyan Samiti (RKS) to bring in community ownership in running the PHC, Rural hospitals and District Hospitals.

Scope and structure of CBMP

Community Based Monitoring and Planning process has been implemented as a pilot in selected nine states of India of which Maharashtra is one state. In the first phase (2007-09) districts namely Amaravati, Nandurbar, Osmanabad, Pune and Thane were selected. In the second phase (2010 onwards) of CBMP, this activity was expanded to Aurangabad, Beed, Chandrapur, Gadchiroli, Nashik, Kolhapur, Raigad and Solapur districts. At present Community based Monitoring and Planning process is being implemented in 13 districts, 37 blocks and 150 PHCs and 680 villages across 13 districts. About 30 civil society organizations (CSOs) are involved collaboratively in implementing CBMP in these 13 districts.

The representatives of Health Officials, Panchayat Raj, Community Based Organizations/ NGOs/ Peoples Movements and villagers are part of Monitoring and Planning Committees at Village, PHC, Block, District, and State levels. 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 the 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 the results and unresolved issues up to the next level two times a year (Figure 1⁶)



⁶ <http://www.nrhmcommunityaction.org/pages/organogram/monitoring-and-planning-committee.php>

Stages of CBMP

Community-based monitoring process includes preparatory activities, capacity building and training of trainers, community assessment, interface meeting and finally the evaluation. Key details about this five stages process are given below:

Stage I: Preparatory activities

Creating environment to smoothen the monitoring process as well as to get mandate and co-operation from different stakeholders at different level

- Meetings and discussion with key stakeholders at different levels to orient about concept and processes which are going to implement through CBMP process as well as to ensure participation and cooperation from them.
- Constitution of a task force group by inclusion of representatives from the coordinating agency, state policy makers and civil society members for planning, designing, advising and overall monitoring of the community process.
- Community monitoring teams are constituted according to the programs at the different levels of healthcare services in a sequential manner. These have predefined criteria for eligibility for inclusion as team members so as to have an equal representation of all users.

Proportion of representation in the Committees from PHC level and above-

- Representation of elected members of local government bodies – 30%
 - Representation of medical officers – 20-30%
 - Representation of NGOs/ civil society bodies – 15-20%
 - Representation of RKS members – 10%
- In addition, members include heads of health committees of local government bodies, District Medical officer and Nodal NGO representative.

Stage II: Formation of Monitoring and Planning Committees followed by capacity building through workshops, training and orientation meetings

- In order to monitor the health services, the monitoring and planning committees were formed at various levels as described earlier. These committees consist of representatives of different stakeholders like Panchayat representatives, health providers, community-based organizations (CBOs) and community members (Fig 2).
- For better functioning of these committees, capacity building of the committee members is done through training, orientation workshops and meetings.
- State and district level workshops are held to share the concept, identify blocks and PHCs, involving key district health officials, PRI members and civil society organizations.

Stage III: Community feedback/Assessment about health services through data collection and preparation of Report card.

- The experiences and feedback of local community was collected by developing tools and techniques like in-depth interviews, focus group discussions, case studies, record review and citizen's report card.

- The report card has three colour codes on the basis of the progress of the various activities. (Green = 75-100% activities completed or on track; Yellow = 50-74% activities completed or on track; Red = 1-49% activities completed or on track.)
- Data collected are compiled, collated and analyzed in a standardized manner at different levels depending upon the availability of services so as to present an aggregate data and also have specific information about the individual service.
- Members of the task force monitor the implementation in the field through regular and planned visits.
- The committees send a periodic report (Quarterly at the village, PHC, block or district level and six monthly for state level) to the next higher level committee.

Stage IV: Public hearing 'Jan Sunwai'

- Here people are invited to report/present their experiences of Health services and denial of care; followed by respond from authorities.
- These are facilitated by the district and block facilitation groups in collaboration with panchayat representatives and CBOs/NGOs working on the issue of health rights.
- The authorities present then respond to these testimonies and findings, stating how the problems will be addressed.

Stage V: Periodic state level dialogue-

- In the state level dialogues issues which are not resolved at district level are being discussed with state level officials.
- The participation of health officials from various levels help to assign responsibility to take corrective action, which is often declared during the meeting itself.

Being one of the states included in the pilot phase of implementation of CBM, Maharashtra is the first state in the country to be able to include the CBMP component in its state Project Implementation Plan (PIP) in the year 2009-10. This inclusion indicates the effectiveness with which this component of NRHM was implemented and the government support that CBM has found in the state.

So in order to get a greater insights on CBMP as a key strategy for ensuring health care entitlements, this paper undertakes an indepth analysis of selected Jan Sunwais conducted in the last 1 year in Maharashtra and 'Stories of Change' within CBMP framework. It tries to identify the causal factors that led to positive change (or otherwise) in health service delivery. At the end it highlights the challenges ahead for health advocacy in the state with respect to CBMP.

II. Methodology

Under CBMP in Maharashtra Jan Sunwais have been organised at the PHC level, at block level and at district level. Thus around 200 JSs have been organized so far. From 2011 March to 2012 April, 12 Jan Sunwais were held in 5 districts of Maharashtra. From them, 3 JS organized at different levels are selected – Daund PHC JS, Pune RH JS and Nandurbar DH JS - for the present analysis. The selection is purposive though while selection it is kept in mind that different stakeholders are involved with the JS so as to allow better analysis of the causal factors. 3 positive stories of change were also selected by keeping the above criteria in mind.

Box 2: The origins of ‘Audit’

The term ‘audit’ owes its origins to the Latin word *audire*, which means ‘to hear’. In modern times, people associate the task of auditing with financial accountants who use technical standards to examine the propriety of organizational finances. Social auditing, on the other hand, stays much truer to the original Latin interpretation of *audire* by requiring public officials to *hear* the findings of citizens regarding government programs.

Information for analysis is collected from reports/ minutes of JS, *Dawandi* newsletter, interviews with selected stakeholders, existing publications and discussions with the community monitoring team of SATHI.

The JSs thus chosen for the analysis are from Pune and Nandurbar district of Maharashtra. In Pune district, CBMP is being implemented in 75 villages of 5 blocks – Velhe, Purandar, Daund, Bhore and Junnar - from 15 PHC areas. Four NGOs, MASUM, Rachana Trust, Chaitanya and FRCH are engaged in the implementation of CBMP process. In Nandurbar, CBMP is being implemented in 4 blocks – Akkalkuwa, Taloda, Shahada and Dhadgaon, comprising 90 villages from 18 PHC areas. Three CSOs, Janarth Adivasi Vikas Sanstha, Loksagarsh Morcha and Narmada Bachao Andolan are associated with the CBMP process in Nandurbar district.

III. Jan Sunwai (JS) and NRHM

The MKSS (Mazdoor Kisan Shakti Sangathan) pioneered the use of Public hearing or Jan Sunwais⁷ as a technique to empower villagers to ‘speak truth to power’, enabling them to challenge an opaque and oppressive State in rural Central Rajasthan in the 90s. MKSS employed a range of strategies to obtain the wages owed to workers in public projects. When neither the executive nor the judicial institutions were providing redress, sympathetic officials made critical project documents available. To leverage the information for effective advocacy and public mobilization, MKSS conceived of a forum in which village communities (many of whom were public wagedworkers) could discuss public expenditures incurred in their areas. This led to the birth of *Jan Sunwais* (public hearings), also called social audits.⁸ The first *Jan Sunwai* was held in December 1994 in *Kot Kirana Panchayat*. In this hearing “*outraged people came and testified that they had never gone to those work sites, that false signatures had been used and that there were names on the muster rolls of people dead and gone, and others unheard of*”.⁹

Since then, MKSS has used JS for both social audits of work done and a kind of forum for ascertaining the (truth) about the nature of democratic functioning at the most tangible and immediate level: the village panchayat. It has allowed for the expression of genuine people’s opinions and has empowered them, leading to an understanding of both the machinations of corruption and the way it can be fought.¹⁰

Ever since, campaigns in the country have effectively used JS as a tool for public accountability. Schedler¹¹ defines public accountability as “the relationships between the power holder (account - provider) and delegator (account - demander).” There are four key elements of an accountability relationship which include setting standards, acquiring information about actions, making decisions about appropriateness and identifying and censoring unsatisfactory performance.¹²

Right to health care campaign and Jan Sunwai:

Since its formation following the ‘National Health Assembly’ in 2000, opposing weakening of public health systems by making health systems accountable and effective, countering commercialization of health care and ensuring access to health care for all within a broader ‘Right to Health’ framework remained a strong focus of Jan Swasthya Abhiyan (JSA -PHM-India). JSA organized a national ‘Right to Health Care Campaign’ in 2003-04 which included organization of a national public consultation, documentation of cases of denial of health care, surveys of rural public health facilities, local Jan Sunwais in some states, regional JS in all regions of the country followed by a national Jan Sunwai on Health rights, the last two in collaboration with the National Human Rights Commission (NHRC).¹³ The national Jan Sunwai was held in

⁷ Hereforth, Jan Sunwai and public hearing is used synonymously.

⁸ <http://www.justassociates.org/MKSS%20Case%20Study%20Section%20II.pdf>. Accessed on 5th Sep 2012.

⁹ Mishra, N. (2003). “People’s Right to Information Movement: Lessons from Rajasthan”. Human Development Resource Center, Discussion Paper Series 4.

¹⁰ <http://www.mkssindia.org/about-us/story-of-mkss/>. Accessed on 4th Sep 2012.

¹¹ Schedler, A (1999). “Conceptualizing Accountability” *The Self-Restraining State: Power and Accountability in New Democracies*. Ed. Andreas Schedler, Larry Diamond, and Marc F. Plattner. Boulder and London: Lynne Rienner Publishers, pg 13-28.

¹² <http://www.scribd.com/doc/75642405/Technologies-for-Transparency-and-Accountability-Implications-for-ICT-Policy-and-Recommendations>. Accessed on 4th Sep 2012.

¹³ <http://www.phmovement.org/es/node/3051>. Accessed on 10th Sep 2012.

Dec. 2004 in Delhi where senior health officials from 22 states were present with Union Health Minister and Central senior health officials.

In these public hearings, case studies of denial of health care were presented before the panel comprising of NHRC members, officials and JSA members. Senior health officials, of the states from which the cases arose, were made respondents in the public hearing. It was an opportunity for people who were denied health care to ask for effective action by state health authorities and investigation by the NHRC. At the national hearing, issues arising from the regional hearings were discussed, and recommendations were released by the NHRC.¹⁴ The pressure created by the health advocacy groups following these JSs and a change in government in the Centre lead to the launch of NRHM to address the health system crisis. CBMP introduced in 2007 as a part of NRHM gave space to people to seek accountability from the government.

Jan Sunwai: The process involved

a) *All Jan Sunwai dates being usually decided well in advance, so that enough time is available to collect necessary evidence and testimonies. Event is usually held in the public health facility itself or at a common place easily accessed by people. For the actual event, the following preparations are done:*¹⁵

- ***Mobilization of people from communities:*** Local organizations mobilize people and active groups from the area, so that they come for the Jan Sunwai. Their presence ensures their participation (assertion) in raising issues, and is required so that they can act as a pressure group for fulfilling the demands made in the Jan Sunwai.
- ***Involving and inviting Panchayat representatives:*** Panchayati Raj is a system of governance in which gram panchayats are the basic units of administration. It has 3 levels: village, block and district. At the village level, it is called a Gram Panchayat. The block-level institution is called the Panchayat Samiti. The district level institution is called the Zilla Parishad (see box 3 for details). As per the Constitution, Panchayats in their respective areas would prepare plans for economic development and social justice and also execute them. Presence of PRI members ensures the much needed interdepartmental coordination for solving the issues raised in the Jan Sunwais.
- ***Inviting elected members:*** Elected members to the state legislature or Parliament from the area are invited. This is a crucial and the most challenging thing to involve elected members.
- ***Inviting government health officials:*** The presence of health officials is essential for the public hearing. The Medical Officers of different PHCs in the region, Civil Surgeon (CS), District Health Officer (DHO), Additional Director of Health Services (ADHO) etc., are invited and it should be ensured that they are present at the time of JS. The class of officers to be invited would depend on the level at which JS is being organized. For e.g. for regional JS, state level officials should be invited whereas for district level JS the officers up to the level of DHO should be invited. In this hearing along with health officials, officials of administrative departments (e.g. Collector, S.D.M.) can also be invited.
- ***Constituting a panel of judges:*** a neutral body: Prominent experts from various fields like teachers, lawyers, professionals etc. are invited for the Jan Sunwai to participate as panelists who mediate the dialogue and give an autonomous opinion or 'judgement', thus contributing to taking of key decisions

¹⁴ http://www.sochara.org/new/index.php?option=com_content&task=view&id=72&Itemid=66. Accessed on 4th Sep 2012.

¹⁵ JSA (2004): Handbook One for Documentation and Presentation of Evidence Concerning Denial of the Right to Health Care; CEHAT, Mumbai.

during the event. The panel has a very vital role to play in the JS in terms of listening to the complaints of the people and the responses to them by the government officials. The panel is briefed about the purpose of JS, the survey findings beforehand. After listening to both the sides' views, the panel gives their expert comments. The opinion of the panel members' is crucial for creating awareness amongst the people and also to pressurize the government to implement the recommendations.

- **Seeking media attention for the event:** Media play a vital role in disseminating the findings. That is why it is important to contact media and sensitize them in the whole process.

As a follow-up of the JS, a meeting is usually planned with the Government officials after the Sunwai. A small group of activists discuss the details of plan of action to improve the health services based on the recommendations. If needed regular meetings are held to ensure the implementation of the JS recommendations.

Jan Sunwai in Maharashtra under CBMP

So far from 2007 to 2012, over 200 Jan Sunwais have been held in 13 districts of Maharashtra. Details are given in Table 1 (to be added).

Details of Jansunwai in Maharashtra					
Jansunwai	2008-2009	2009-2010	2010-2011	2011-12	TOTAL
PHC Level Jansunwai	42	45	70	56	213
Block Level Jansunwai	Jansunwai was not conducted in pilot phase at block level		16	12	28
District Level Jansunwai	5	5	4	2	16
State review and culmination workshop	1	-	1	1	3

IV. Jan Sunwais: Selected cases

We start this section by giving a brief description of the 3 Jan Sunwais followed by key insights from the Jan Sunwais.

■ *Daund Primary Health Centre (PHC) Jan Sunwai*

Daund is a block of Pune district. CBMP is being implemented in 3 PHC areas since 2009 by MASUM, an organisation working on the issues of health, domestic violence, women's resource development and self-employment of rural and tribal people since 1987. A Jan Sunwai was held in Barkhand PHC on 26th March 2012. This was a PHC level JS of Barkhand, Nangaon and Kedgaon PHCs. This JS also took into account the issues of the 8 health sub-centres, which falls under the jurisdiction of the above mentioned 3 PHCs.

Before the JS, the following strategies were used which was crucial for the success of the JS:

- Preparation and planning meeting with karyakartas (activists) in terms of taking stock of the present situation of health care services as they do regular monitoring of it, discussion of denial cases and remaining information need to be collected, logistic arrangements, village and block level mobilization.
- Documentation of denial cases and analysis of data collected from PHCs.
- Preparing report in a simple language to disseminate it among panel members, media person, committee members, ZP/ panchayat samittee members and health officials during Jan Sunwai.
- Planning and orientation meeting with PHC and VHSC committee members before Jan Sunwai.
- Orientation and involvement of PRI , Zila Parishad members and Chairperson of Health and construction, ZP about CBM process and their role and responsibilities in it. Ensuring their participation in Jan Sunwaies and giving responsibility to do follow up about unresolved PHC and RH level issues.
- Preparing an invitation letter and fixing date with health official, panel members to insure their presence in Jan Sunwai.
- Inviting panel members, health officials, PHC/VHSC committee members, Sarpanch by giving hand to hand invitation letter or through email.
- Preparation with people to present their denial cases with concrete evidence for the Jan Sunwai.

The event: The JS was attended by Chairperson of the PS (Block level elected local body), 4 members from ZP (District level elected local body), a senior journalist from a reputed Marathi daily (Lokmat) and

health activists from SATHI¹⁶. From government health functionaries, the Taluka health officer(THO) and medical officers from Nangaon, Kedgaon and Parband PHC were present to respond to the issues raised in JS. Thus one can see presence of people from diverse background from elected representatives to government health officials. The event was organized by MASUM.

Some of the key issues presented in the JS are as follows:

- Incomplete construction of Kedgaon PHC even after 3 years of its beginning was presented in the JS. It was then decided that a letter to the Zilla Parishad (ZP) *Mukha adhikari* will be written. After the JS, a follow up meeting of block health committee in presence of Panchayat committee members on unresolved issues were held. Chairperson and members of PS visited Kedgaon PHC and took stock of incomplete work and then they wrote the letter to ZP and also raised the issue in district monitoring committee meeting in front of Chairperson of Health and Construction department, ZP and District Health Officer (DHO). Following their involvement, the construction work got completed within months and is now delivering services.
- Inadequate outreach services by ANM were another issue being raised at the JS. Medical Officer of Nangaon PHC promised to look into the matter and the services have improved since then.
- Death during tubectomy camp: Ratanbai Subhash Lahire went for her tubectomy operation in a camp organized by Parband PHC. She died 2 days after the operation. The doctor who operated on her did not disclose any thing to her relatives except telling them to take her to a higher level facility. Her family was asking for compensation (Ministry for Health and Family Welfare provides insurance to people opting for family planning operation - compensation of Rs 2 lakh in the most unlikely event of loss of life during operation at hospital or within 7 days from date of discharge from the hospital. Rs 50,000/- for loss of life within 8 to 30 days from the date of discharge from the hospital.) and has raised the issue at Block level and District level monitoring committee, following this JS. But nothing happened for more that 8 months. So the issue was again raised in the Stale level dialogue. The district health officer (DHO) who was recently appointed, opened the case again, looked into all the aspects and as a kind of intermediate relief ensured that the family got Rs 50000 from the ZP welfare fund.

■ ***Pune Rural Hospital Jan Sunwai***

As part of CBMP process on 9th March 2012, a JS was held at Pune District Hospital. Services of 5 Rural Hospitals (RH) of the 5 blocks were reviewed. It was a common JS for all the RH of the CBMP areas of the district instead of separate JS for each RH.

The following strategies were used for making the JS successful:

- JS of 5 RHs were combined together instead of doing it separately as it was felt that as the higher officials remains the same for each RH and so if it is done separately they will not come again and again for each JS. This change in strategy was possible because of the flexibility that is allowed as per the need under the CBMP process.
- JS was held at Pune District Hospitals as this will ensure that the Civil Surgeon (CS) (District level head of Medical Superintendents (MS)) will be present for the JS.

¹⁶ SATHI is the state nodal NGO responsible for facilitating the implementation of CBM in Maharashtra.

- As the CS was newly appointed, representatives of all the Block Level monitoring committees conducting meeting with him prior to 3 months of the JS so as to update him about the issues as well as getting acquainted with the members of the monitoring committees.
- These interactions resulted in the CS ensuring the presence of all MSs of all blocks (including non-CBM blocks) in the JS.
- Intensive mobilization ensured that around 100 people comprising of block and PHC level monitoring committees, Chairpersons of many villages, media, lower level health functionaries and people associated with the cases being present during the JS.
- Prior to JS, block coordinators and activists meet discusses the issues to be presented. This helps in developing analytical observation skills, prioritization of issues. They also make the presentations in the JS and in turn build their confidence.

The event: The panel consisted of Co-convenor of JAA , a senior gynecologist and a senior journalist. From government functionaries, the Civil Surgeon) and the Resident Medical Officer of District Hospital were present as respondents. Medical Superintendent of all Rural Hospitals including non CBM areas was also present.

Some of the key issues presented in the JS are as follows:

- In Saswad PHC in spite of the presence of a gynaecologist, necessary cesarean deliveries were not taking place resulting in increased cost and difficulty to the patients. This was inspite of the fact that this issue was presented in PHC level JS. It was assumed that this is because he had a political connection and thus refraining higher officials to take action against him. As this issue did not get solved even after raising at the block level, activists then raised the issue in the State level dialogue. Then eventually he was transferred and proper services are now delivered by the PHC.
- Lack of proper infrastructure like waiting facilities were absent in most of the RHs was presented in the JS. The government officials solved this problem by sanctioning buying of benches from RKS funds. Other problems like lacks of clean bed sheets, toilets were also solved during the JS.

■ ***Nandurbar District Hospital Jan Sunwai***

On 28th March, 2012, a special JS was organized at District hospital level. This was done as it was felt that lot of issues regarding this health facility needs to be addressed and the flexibility in the CBMP process allows for a change in the stated strategy as per the need of the area as also seen earlier in the Pune RH JS.

The following strategies were used for making the JS successful:

- Karyakartas ensured that PRI members are involved in the CBM process leading to their active participation during JS.
- Meetings of activists with monitoring committee members.
- Careful selection of denial cases for presentation.
- SMSs were send by 200 people to the government officials ensuring their participation.

The event: Jan Sunwai was held at Indira Gandhi *Karyalaya*. It was attended by around 500 people. The panel consisted of the Nandurbar ZP Vice president, Pune District Coordinator of CBMP, health activist from SATHI and President of District Anti-corruption Samiti). District Health Officer (DHO) and Block Medical officers from the 4 CBMP blocks were present as government respondents.

Some of the key issues presented and actions taken related to these, in context of the JS are as follows:

- A mother presented the case how his sick son (affected with eye cancer) has been denied treatment in the public facilities. This moved the panel so much that people donated money there itself for the treatment of the child. The DHO responded that he would ensure whatever possible at the district facilities.
- Another key aspect of the JS was that though all the problematic issues were presented and discussed with the DHO prior to 1 week of the JS, yet DHO had not done anything about any issues and could not respond during the JS. This agitated the people present during the JS. Regarding this Munnadada Patil (ZP-VP) said that he would take all the responsibility and review all the issues and take meeting with the concerned officials.

The above 3 JS cases highlights how the CBMP process has successfully leveraged the findings of its public hearings to build momentum around the right to health care campaign. The tremendous response and participation that public hearings have engendered among residents of villages shows that there has been a huge support for the *Jan Sunwai* method. To summarize one can say, the supply of rights which can help citizens hold the state accountable is most effective only when it meets a strong civil society demand.

V. Jan Sunwai: Key insights

The concept: Deepening of democracy

In the contemporary political scenario across the world, representative democracy is put forward to be the political system shaped by the aspirations of citizens. The representative democracies rely heavily on elections as a mode of accountability. As a result performance of the representative in protecting or promoting the interests of the voter is rarely a factor of ensuring compliance of responsibilities undertaken by the candidate. The management of voters and votes therefore remains the priority of poll managers to the detriment of the priorities of the people. A large number of electoral candidates erodes any obligation of responsibility to the electorate. Further in the absence of the 'right to recall' at any level of representation, leaves the voter powerless even when casting his vote to seek accountability. A strange metamorphosis overtakes the successful candidate who identifies himself/ herself a part of the ruling regime rather than as a representative. As a result the electoral system in place, necessarily deprives the citizen voter both agency and voice.

This sort of accountability has been criticized on four grounds as stated by Walker: firstly, there is information asymmetry both between elected officials and the electorate and between bureaucrats and elected officials; secondly, elections only operate ex-post; thirdly, elections only allow citizens to exercise accountability 'externally,' from 'outside' of government and lastly, citizens send representatives in government through their vote, but do not participate themselves in the tasks of government. Too much dependency on electoral accountability has made the accountability mechanisms distorted and the citizen's voice has got lost in its long and complex process.¹⁷ Indirect nature of representative democracy necessarily needs to be complemented with direct and participatory horizontalization of accountability.

Accountability can be seen in the binary framework of vertical accountability and horizontal accountability. Conventional conceptualizations of accountability distinguish between horizontal and vertical forms of accountability (there are alternatively referred to as supply and demand side of accountability). Horizontal accountability refers to the host of mechanisms checks and balances internal to the state (judicial oversight, auditing and accounting, performance incentives) through which state agencies are held to account. Vertical accountability refers to the mechanisms through which citizens hold the state to account. Elections are the classic form of vertical accountability. State society relations are mediated by the range of rights that the state extends to its citizens. This determines the nature and form of citizen participation in state affairs and the ways in which citizens may mobilize to exercise their rights. The relationship has always been a linear one- the state extends rights to its citizens which it is obliged to fulfill and citizens draw on different forms of participation to exercise these rights. When the state does not fulfill its obligations vis-a-vis rights to citizens, citizens use various mechanisms to enforce these rights.¹⁸ However the current construction of 'rights' is recognized as an adversarial position wherein citizens have to enforce their rights against the executive, by accessing the power of the other arms of the state, namely the legislature and the judiciary to ensure compliance and very rarely

¹⁷ PRIA Global Partnerships (2011): Democratic Accountability in Local Governance Institutions: Experiences from South Asia', New Delhi. Pg 3.

¹⁸ Goetz, A.M and Jenkins, R (2001), 'Hybrid Forms of Accountability: Citizen engagement in Institutions of publicoversight in India', Public Management Review, Vol. 3, No. 3 (2001).

exercising their collective power. Dissatisfaction with existing horizontal and vertical accountability mechanisms, leading to the virtual dis-enfranchisement and dis-empowerment of the citizen, has triggered increased involvement of civil society in articulating demands for accountability on the state.

It is in this context that Public hearing or Jan Sunwai functions as a mechanism to seek accountability of the state to the citizen and can function as a bridge bringing in the citizen space both axis horizontal and vertical, to establish an effective accountability system. The hybrid form of accountability which cuts across the traditional distinction between horizontal and vertical accountability, requires institutional support in the form of a legal mandate for the non-government actors to act as agents of public sector oversight, easier access to information, right of observers to issue dissenting reports and the existence of clear procedures for conduct between citizen and public sector actors. The Jan Sunwai as a mechanism, in some measure, acts as a process that merges both planes of accountability. It aims to achieve vertical accountability and energizes intra-State horizontal mechanisms leading to greater accountability in the political systems. It provides a forum for justice that is more direct and accessible than the current formal justice systems which is prolonged, technical and uncertain and mostly remains inaccessible for the rural and the marginalized sections of the society.

The JS experience transcends the linear relationship by demonstrating the role, that the State if willing, can play (in the form of CBM), in creating spaces which can be used by CSOs for mobilizing, conscientizing and organizing citizens to operationalize their rights. After all, CBM is about citizens exercising their right to know and participate in government affairs. JS as tool for demanding accountability is not new, but in CBM as part of NRHM, is being used for the first time to demand accountability from the state with regard to health services, through a mandate given by the state to the citizen. Civil society has an important role to play in facilitating this process. It can, as the above JSs demonstrated, enter into strategic partnerships with the state and help facilitate societal participation in the core activities of government. This has important ramifications on current conceptualizations of state-civil society relationships and their individual roles in addressing accountability deficits.

CBM has emerged as an effective approach, as visible in repeated JSs, to foster accountability through meaningful engagement of citizen communities in implementation and monitoring of community projects. An effective implementation of CBM process at community level can significantly contribute to the transparent and accountable local governance system. Besides CBM can function as a critical mechanism which empowers citizens and strengthens democratic action. For instance, the preparation of Health Report cards enables people to recognize their rights and entitlements and offers a space and mechanism through which these rights can be enforced. Neera Chandoke, in her analysis of the public hearing argues that the public hearing performs three functions intrinsic to democracy. First, it produces informed citizens, second, it encourages citizens to participate in local affairs through the provision of information and social auditing and third, it helps create a sense of civic responsibility by bringing people together to address issues of collective concern.¹⁹ The Jan Sunwai ensures diverse stakeholders with different interests; community, civil society, government officials, local governance systems (PRI members), media, to come together and form a temporary alliance for a common goal, the improvement of health services.

¹⁹ Chandoke, N (2007), 'Engaging with Civil Society: The democratic Perspective', Non-governmental Public Action Program, Center for Civil Society, London School of Economics and Political Science. Accessed from http://webfirstlive.lse.ac.uk/internationalDevelopment/research/NGPA/publications/WP_Engaging_Civil_Society_Web.pdf

Accountability requires functional interface between the one accountable for (duty bearer) and the one who the duty bearer is accountable to (claim holder) and the JS provides a efficacious multi tiered platform for both to dialogue. The district level JS provides a mechanism for rural people to report the actions of their local health officers directly to the district health officer (DHO) and civil surgeon. On the other hand, dt medical officers were able to use JS to understand the performance of staff and delivery of health services at block and PHC level. Moreover periodic state-level JSs were held where the findings of the district JSs were presented, which puts pressure on lower level officials to implement the JS decisions before the state JS.

The state level dialogues, which took the form of state mentoring committee meetings, were essential as they helped to generate state level government support for CBM and became an opportunity for the civil society groups and government to develop a long term, mutually beneficial working dialogue. The participation of the state level government representatives helps to assign responsibility to rectify issues that are reported right at the JS itself. State officials also benefit from state level dialogues as a way to cross verify reports from the districts officers against community accounts and thus acts as an effective internal as well as external accountability mechanism.²⁰

Jan Sunwai not only generates egalitarian aspirations among the marginalized but it also enhances the confidence of the victim (in this case people who are denied proper health care). It makes the victim occupy the public space not for achieving personal gain or performance but to achieve an egalitarian impact over the citizens. Thus, the JS entails a democracy with moral dimensions. Albeit, it reverses the legal relationship, wherein the marginalized and the poor do not continue to be the guilty, while those in the power like doctors, bureaucrats and other state health officials, who in the formal legal system hardly appear in the witness box, are required to respond and held accountable and on occasions reprimanded by their own department officials. JS thereby triggers the democratic resurgence of the marginalized and the poor through expansion of spaces for democratic engagement.

Box 4: Platform for change

Prior to one JS, the MPW (male village level health worker) feared that people would speak against him, so he tried to lure people by offering them alcohol. But many more people gathered for the JS, and those who had not taken his 'favor' spoke frankly about their genuine problems. Gradually mutual trust was developed with the service providers and the MPW was reprimanded.

PHC Jan Sunwai, Amaravati.

The Jan Sunwai as an event does not recognize any hierarchy and thereby challenges the remote culture of the bureaucracy. The very act of placing health system deficiencies by the people in front of higher health officials serves to remove the shroud of apathy that surrounds government operations, which allows the bureaucracy to distance itself from its citizenry (Box 4). It acts as a relatively equitable platform for dialogue for users and providers leading to problem solving, has bridged the gap between administration and local people and lead to redressal of their genuine grievances and problems. For the rural poor, who are most often locked in exploitative patron-client relationships, standing up in front of

²⁰ Shukla, A., Scott, K. and Kakde, D. (2011): 'Community Monitoring of Rural Health Services in Maharashtra', Economic and Political Weekly, Vol XLVI, No 30, pg 78-85.

local officials and expressing their grievances is no ordinary feat. Recording of health system problems in government-supplied report cards have restored hope in people and no longer is denial of health services accepted.²¹

The impact:

The impact of Jan Sunwai activities could be seen in two spheres: first the people are more aware now of their rights and, secondly, government officials are progressively answerable to them and admit their own responsibility. In so doing, rgw Js has unveiled a culture of participation and openness. By mandating the presence of officials and instituting mechanisms for regular follow up on Jan Sunwai findings, the JS process is an illustration of how efficacious accountability can be reinforced and strengthened from within the administrative system. It also provides a mediation mechanism between programmatic designs and systemic issues and local level implementations. For example, in a Jan Sunwai it was asked that if posts of village-level health workers are vacant in many villages, the existing worker would have extra workload. In that case, how would they be able to provide all the services? Moreover, subsequent to the JS people realized the importance of health services like ANC check-up and its importance. Once people realized this, they began to access services more often and demand for services increased.²²

The JS cases mentioned earlier highlighted the fact that the Jan Sunwai is a powerful instrument to look into and provide instant relief to the people by initiating prompt action in a time bound manner. CBM in particular and NRHM in general, has helped in creating widespread awareness of the issues involved and their significance. The power to affect decisions, in turn has contributed to wider community engagement, which in turn generates one of the most valuable products of CBM: social capital. Social capital is value created by the combination of people and their skill sets, bond to each other in trust and respect for the other, stimulating widening circles of internal consensus, commitment and solidarity to work together for the betterment of their lives a part of which is the public health system. Increased social capital improves the community capacity to deal with complex issues and choices associated with internal sustainability and external efficacy. This became a major factor in the popularity of the Jan Sunwai and with the success of each Jan Sunwai, the attendance, the participation, the involvement and the mobilization kept increasing as seen in the Nandurbar Jan Sunwai mentioned in the earlier section.

Another encouraging impact of JS is the increasing coordination between local governance institutions like Panchayat samiti (PS) and Zila Parishad (ZP) with District Health departments. For instance, in cases of under-construction health centres, ZP health committee members ensure that the decisions taken in JS regarding these issues are completed in a time bound manner (box 5).

Box 5: Involvement of PRI members

Kedgaon PHC construction was incomplete even after 3 years. When this issue was presented in the JS, it was decided that a letter would be written to the ZP president. By his initiative within 4 months the PHC building was completed and now has been open for public.

Saswad PHC Jan Sunwai

²¹ Shukla, A., Scott, K. and Kakde, D. (2011): 'Community Monitoring of Rural Health Services in Maharashtra', Economic and Political Weekly, Vol XLVI, No 30, pg 78-85.

²² SATHI (2012): *People are reclaiming the Public Health System - Qualitative Report of CBMP of Health services in Maharashtra*, pg 27, Pune.

Another positive impact of JS is that it can be an effective tool for building community capacity and local networks as well as stewardship and public education. The enhanced capacity of the community enables more effective public participation in local governance. In turn, leading to a more inclusive decision-making process. JS has been able to focus on deficiencies related to behavior of staff towards patients in PHCs, functioning of health centers, irregularity in drug supply, lack of infrastructure of health facilities and utilization of untied funds, to name a few.

However JS is not limited to highlighting deficiencies, though that has generally been the case in the first phase JSs. The increased public focus on functioning of the system occasionally resulted in the withdrawal of health officials from the process, though in fact on many occasions the source of the deficiency lies in policy level issues and lower level medical functionaries are unable to do anything about it. Recognizing the constraints of the system, the Jan Sunwai (public hearing) evolved into Jan Sanvad (public dialogue) in the second phase in Maharashtra. The change in terminology also helped for better cooperation of health officials and has progressed to a mature discourse as the locus for affirmative action and not fault finding. In fact medical officers from non-CBMP areas recognizing the positive outcomes of the process have started demanding CBMP in their areas (Box 6).

Box 6: Demand for CBM by officials

The local association of doctors took this initiative to find fault with them. Basically they did not like the idea of people questioning them and making them answerable. However, our aim to improve health services was clear and we persisted. Gradually the misunderstanding among the doctors also got cleared. So much so, Dr. Dani, MO in Shahana PHC, strongly urged us to initiate CBM process in his area.

District Coordinator. Nandurbar

Jan Sunwai: Strategies and factors contributing to success

In this section we try to analyze the factors that lead to the success of Jan Sunwai as a tool of CBMP in Maharashtra. Conscious strategies adopted to make CBMP a success are mentioned below.

The presence of a large number of community members is an important factor enabling the success of any JS. It creates moral pressure on the health officials and compels them to respond positively and not make false promises. The nodal agencies associated with CBM ensure that monitoring committee members, PRI members are present in the Jan Sunwai. They are given invitation letter along with the program schedules. Vehicles are arranged to bring people to the place of JS. Specific cases of denial of health care is selected and presented with feeling by the affected person themselves with concrete information and evidence, who have been prepared how to present the cases. Speakers are not allowed to make wild allegations, derogatory and abusive language is prohibited, and traditionally disempowered groups, including women, lower caste members and the poor, are actively encouraged to contribute their points of view. All these help to build momentum before JS and ensure active participation.

Another strategy adopted for the success of the JS successful is its locus at multiple levels. As mentioned earlier, though JS were organised before CBM was recognized as a part of JSA, they did not enjoy a high

level of success in addressing the problems, though these Js were able to highlight the health system deficiencies as denial of health care. Post CBM, however, as each JS is followed by a presentation of the cases at a higher level JS, lower government officials began to take them seriously, knowing well that their supervisors would hear of the problems subsequently. Moreover after recognizing that CBM is an officially mandated ongoing process, the PHC staff was compelled to attend and take decisions seriously. For instance, Shirdhon PHC ambulance was not being used for more than a year for lack of funds to buy new tyres. Once this issue was presented in the District JS, the DHO immediately sanctioned necessary funds, knowing that otherwise it would get presented in the state JS.

In fact, most of the times the approach of the nodal NGO has been to strategically involve the higher officials prior to the JS. As seen in the case of Pune RH Jan Sunwai, where the Civil Surgeon, the highest health official at the district level, was met prior to the JS and he subsequently send a memo instructing all Medical Superintendents of all blocks including non-CBM blocks to attend the JS.

Another strategy employed is to public facilitate the medical officers at State JS who took extra effort to ensure that JS decisions are followed up and worked to improve quality of health care services.

Box 7: Innovation emerges from Jan Sunwai

Subhash, a TB patient was admitted to Ganjad PHC for treatment. He was given saline but when the bottle emptied no one was around to replace it. He was very frail and weak and was unable to get up and call the nurses. Blood in his vein climbed up slowly through the IV set. But before anything fatal could happen, a nurse fortunately notices that and removed the bottle.

Subsequent to his testimony, participants in the Jan Sunwai forum discussed this and came up with the innovative idea of installing a mechanically operated table bell beside every bed. This technique was not costly and also does not need electricity.

Ganjad PHC Jan Sunwai.

Involvement of the media is yet another part of the strategy employed for the success of JS in Maharashtra. In fact as part of CBM, media fellows were oriented on CBM-related activities, followed by a state level workshop which gave the reporters better a understanding of issues related to quality of health care. During JS, health services data is distributed to journalists and in some cases journalists are invited as panelists, as was the case of Saswad JS. Following the JS, briefings were given to media personnel. Due to continuous engagement with NHRM issues, media has responded by giving prominent coverage and in the process created pressure which helped in implementation of JS decisions (box 7).

A responsive administration is thus critical to success of any Jan Sunwai. The willingness of people to participate in the JSs, in some over 500 people have gathered to participate and to express their grievances, is to a large extent, a result of the fact that corrective action is taken immediately (box 8). As Dr Satish Pawar, Joint Director, NRHM Maharashtra says, "Let us use the CBM process to help solve problems through mutual understanding. This process helps articulation of people's expectations from the health system to fulfill its expected tasks, hence medical officers should avoid getting into unnecessary disputes".²³

²³ SATHI (2012): *People are reclaiming the Public Health System - Qualitative Report of CBMP of Health services in Maharashtra*, pg 47, Pune.

VI. Stories of change related to the CBMP process

It is a well known fact that, the most important feedback on what, where and how health services are needed and should be provided or improved can be given most efficiently by the users / beneficiaries of the services themselves. Community based monitoring under NRHM places people at the centre of the process and enables them to give such feedback in a regular, organised and systematic manner. Thus this process has been able to bring about many positive changes in the realm of health service delivery. In this section, we describe 3 cases of positive change brought about by the CBMP process, with a view to draw lessons about how accountability processes can induce change in health systems.

Nasarapur PHC: From 'official based planning' to 'community based planning'.

In Nasarapur PHC in Bhor block of Pune district, NRHM flexible funds were being used even without getting sanction by the RKS committee. RKS members revealed that no committee meeting has been called so far, and doctors themselves were taking all the decisions regarding utilization of funds. Shivaji Konde, President RKS, following CBMP orientation program, spoke to doctors and insisted for regular convening of planning meetings by the RKS and circulation of decisions of each meeting to all members. Civil society representatives of the Block Monitoring and Planning Committee were invited for the first time to the RKS meeting on 12th December 2011, where they actively participated and made several proposals, which led to the RKS committee taking a number of positive decisions. The result of this could be seen within few months as the following changes have taken place.

- There was no display board displaying the name of the PHC and it was difficult for any new patient to find the facility as it is located in an old building. Now through RKS fund a board has been prepared and put up in a prominent location.
- There was a serious problem of water which was pointed out. Now 4 water tanks have been installed in the PHC.
- The toilets were non-functional and cluttered with materials, due to lack of water. Now these have been cleaned up and have become functional.
- In order to make the laboratory more functional, a tank for water storage was purchased, a cupboard and a new pipeline for laboratory was installed, making the lab fully functional.
- The post of sanitation worker which was vacant in the PHC for quite sometime was addressed by appointing a worker on contract basis using RKS fund..
- A workshop on role of adolescents in the development of village health was conducted for school children from two villages using the fund

Key insights:

- ✓ Certain issues like cleanliness, availability of water and board are very important from the community point of view, but were not recognized or considered relevant by officials during planning. It showed that if the space for community based planning is provided local organizations, PRI members, and

community members can suggest genuine priorities and ensure improved planning for health facilities within the specified framework.

- ✓ Bringing together key stakeholders including elected representatives in the process created social momentum for more responsive planning, besides suggesting actionable issues.
- ✓ CBMP which relies on the concept of co-management, incorporates community participation at a higher level and gives the community greater control over its own destiny.
- ✓ CBMP process in health service delivery is more effective because it incorporates the relevant knowledge and experience of those affected by lack of proper health care. In this way, participation can help to mitigate potential and existing conflicts and empower the community to take a more active role in exploring management issues and initiating possible responses.
- ✓ RKS funds are being utilized more appropriately based on community priorities being communicated through the CBMP process. This serves as an example where formal democratic spaces are used to make real spaces for citizens.

Similar experiences of community based planning are being reported from other CBMP areas, making it evident that through CBMP process, information generated through community monitoring is now being contributed to enhance popular participation in the local health planning process. Through this process, the health system is also realizing that ordinary people do come up with appropriate innovative ideas to improve health system and many such proposals are being formulated for inclusion in district level PIPs.

From a half-built to completed sub-centre

A sub-centre (SC) was sanctioned for Jamshet village of Dahanu Taluka in Thane district but the 'politically connected' contractor, who was supposed to build the SC, stopped construction after building the SC half way. It had remained incomplete for more than 2 years. This issue was raised in 4 consecutive village meetings, as also at the block level committee meeting, but nothing changed. At last, villagers decided that they would build it through voluntary labour or *shramdan*²⁴. Around hundred people gathered in front of the SC with construction tools. Once the Vice-Chairperson of GP (village level elected body) and Gramsevak²⁵ came to know about this, they came to the sub-centre along with the contractor. They apologized to the villagers and the work started on that very day. Now the SC is complete and services are being rendered and accessed by the villagers. An additional ANM was posted and significant numbers of deliveries are being performed in this sub-centre now.

Key insights:

- ✓ Shift in balance of power: with the system failing to complete construction of the sub-centre, people took the issue into their hands and this signifies a major shift regarding 'who is in-charge'. The threat of people taking things into their own hands provoked a prompt response from the system.
- ✓ The CBMP process created a valuable space for the community to pursue issues, follow them up and make public health facilities functional.
- ✓ Reclaiming elected representatives: Elected members, on the other hand, have recognized that they cannot get away with incomplete work and hope to get re-elected. This has been one of the main

²⁴ *Shramdan* means putting in own labor voluntarily to achieve some public good.

²⁵ They are nominated members for the GP and can be said that he performs the work of the secretary to the Chairperson of GP.

reasons for greater involvement of members of local governance structures like Gram Panchayat, Panchayat Samiti and Zila Parishad, with the CBMP process. CBMP can be seen as a form of direct democracy which can make representative democracy work better.

- ✓ The above case shows that the whole CBMP processes has been able to instill confidence among the community, who are now not afraid to confront the system. The process has created a valuable space for community to pursue issues, follow them up, and make improvement in public health service delivery.

In fact going beyond health, the concept of CBMP is now getting internalized in the minds of people, and is being used to monitor other social services like education, water supply and sanitation to name a few.

Treatment for diabetes and hypertension at the PHC

A workshop was conducted at Malshiras PHC as part of the CBMP process. Among the participants were Radhabai and Sushilabai. With very low earnings and no family support, they were not able to afford cost of diabetic medicines, even the small cost of Rs 20 every 10 days, nor could they afford to spend on travel to the nearest government rural hospital for the same. Based on suggestion given by the CBMP committee members, the Medical officer of the PHC took the lead, investigated patients and with the help of a specialist doctor started a medical camp every 2nd Thursday of the month in the PHC for diabetes and hypertension patients.

After positive responses from the community to these camps and in order to sustain this activity, a proposal was prepared and submitted by MASUM - the District CBMP civil society organization and the PHC Medical officer, and this was included in the district PIP. However this genuine demand did not get included in state PIP. In spite of this, the issue was again strongly raised in the District Monitoring and Planning meeting. After regular and continuous dialogue with the Chairperson of the Zilla Parishad Health Committee, he took interest and with the help of District Health Officer, funds have been allocated from the Zila Parishad to supply these medicines. Now due to this initiative, medicines to treat hypertension and diabetes are being made available across all PHC in Pune district.

Key insights:

- ✓ An important health priority, which was not picked up through routine health planning, was identified through CBMP process.
- ✓ CBMP process expanded the scope of available services at the PHC beyond its traditional mandate.
- ✓ Community and civil society, elected reps and local medical officers all came together to respond to a genuine health need.
- ✓ The PIP preparation process, which is supposed to allow space for decentralised planning also failed to respond to this genuine need; then due to push from elected representatives this was met from district level elected body funds.

The above case shows that CBMP has successfully expanded the perimeter of available health services at the health facilities beyond its traditional mandate. It is also gradually winning people back to the public health system, helping them to escape impoverishment from health care expenditure.

Linkage between CBM and CBP – synergy between these two approaches

While community based monitoring (CBM) in Maharashtra has been successful in highlighting the deficiencies in functioning of health service delivery, change/ improvements in different facets of health delivery, it is also important that these findings are discussed at the local level planning bodies and suitable solutions to the problems are conceived through the community based planning process (CBP). There is a close and mutually reinforcing (supportive) relationship between monitoring and planning. Neither of the two can be done in isolation from the other. While monitoring provides information for project planning and implementation, planning describes ways in which implementation and monitoring should be done. For instance, while CBM has highlighted how untied funds are not being used for the said purpose, CBP has been able to find effective solution for the use of the funds to achieve the desired goals as seen in the Nasarapur PHC story earlier.

Success of CBM and CBP process with regard to the health service delivery, fosters a sense of ownership, and generates commitment within the community and is self-reinforcing. The effective use of locally collected information generated through CBM and the power to change decisions through CBP, leads to stronger and wider community engagement. This positive change builds social capital, which is one of the most valuable benefits of CBMP. Social capital, as created through CBMP, can fuel sustainable community development.

VII. Conclusions: Lessons learnt and further steps

The above sections highlight how JS has become a key tool for ensuring CBMP of health services in Maharashtra, leading to positive changes in health service delivery in the state as is evident from the stories of change. This approach is consistent with the 'Right to Health Care' since it places health rights of the community at the center of the process. It seeks to enforce the right to health by addressing gaps in the implementation of various programs, while enhancing transparency down to the grassroots. It is also being seen as an important aspect for promoting community-led action and can act as a powerful mechanism to promote accountability and stimulate responsive, accountable and transparent local governance. Moreover, it demonstrates that it has an impact on implementation processes, while at the same time it significantly enhances community confidence and self respect. This case study of JS in particular and CBMP process in Maharashtra in general, provides key lessons which can be relevant for groups working on accountability of health services in other contexts as well. Based on the Maharashtra experience, key lessons learnt are presented below.

- **Ensuring high quality community participation and ownership in the CBMP process**

- ✚ Build ownership of the community monitoring approach through careful preparation of communities.
- ✚ Planning meeting with health activists at regular intervals.
- ✚ Use facilitators/CSOs with prior experience of participatory approaches, health rights and social accountability.
- ✚ Keep the monitoring tools simple – use pictorials/adopt local terminology to describe different measures of performance.
- ✚ Enhanced mutual cooperation among the villagers, local elected members (PRI members) and public services providers.

- **Promote accountability and responsiveness**

- ✚ Build in mechanism(s) that promote ongoing dialogue about quality and performance between users, communities, providers and local government eg. meetings of monitoring committees.
- ✚ Incorporate mechanism(s) that provide opportunities for regular interaction between community representatives and health officials with space for concrete decision making eg Jan Sunwais.
- ✚ Joint planning, implementation, monitoring and review help overcome communication barriers between providers and users.
- ✚ Combining community monitoring with community based planning results in better designs through local knowledge.
- ✚ Constructive involvement of the media.

- **Build provider support for performance monitoring**
 - ✚ Create a problem-solving culture and address performance gaps from the perspective of lesson learning and how to move forward
 - ✚ Public felicitation of providers for good performance.
 - ✚ It was important to keep a strong focus on action and results – ensuring that communities and providers looked beyond the actual scoring process.

- **Formal sanction for CBMP process by the government**
 - ✚ CBMP process has the government sanction and therefore mandatory for the government officials to participate in the process.
 - ✚ Dialogue process at multiple levels eg JSs at multiple levels which add legitimacy to the process.

Further steps to carry the CBMP process forward

Despite the undeniable positive impacts of CBMPs as mentioned earlier, it is still in a nascent stage. As stated in the 5th section earlier, JS/ CBMP leads to development of social capital, empowering the marginalized, it is bound to generate social change. Our own understanding of such changes is that there are some phases in the change process where first change happens in the desired direction probably due to ‘novelty’ of the intervention and the energy generated in the community from the initial interventions. However in interventions like CBMP impacting social hierarchical relations – there will be resistance and the speed of change may/will reduce and the direction of change may/will reverse. CBMP contains the seeds for growth of a highly significant new dimension to empowerment of the marginalized, and the momentous enlargement of their space and strength in relation to structures of the State. And if this process does not contribute to incremental improvements, then people’s enthusiasm for participation will decrease.

Hence a key challenge in this process is to continually ensure positive responses to issues raised by community members, with increasing responsiveness of the health system over time. This depends on health officials at various levels taking ownership of the process and getting actively involved in them, with adequate space given to the CSOs and activists to effectively promote pro-people change. The State Health Department of Maharashtra has internalized a level ownership of the CBMP process, which in combination of civil society efforts has made many changes possible. Building on the positive processes so far, in order to carry forward the positive process of CBMP in Maharashtra, further action on several fronts are required which are listed below:²⁶

- ***Regular, periodic multi-stakeholder reviews-*** there is a need to conduct CBMP review process at state and national levels to take key process related decisions and tackle issues that need to be resolved for ensuring that community action continues to be developed effectively.

- ***Removal of constraints on civil society representation on CBMP bodies-*** in the last few years the mandate / proportion of CSOs in key CBMP bodies (such as state and district mentoring committees) has been reduced. For instance, while constituting the State mentoring and planning committee, civil

²⁶ SATHI – Booklet on CBMP in Maharashtra

society representation has been truncated compared to national guidelines. Such reduction of civil society role will lead to reduction of participatory approach of CBMP process.

- ***Phased modification of role of CSOs instead of their 'exiting'***- as seen in the earlier sections, CSOs play a crucial role all phases of CBMP process. Now in CBMP areas people are gradually coming forward to claim their health rights. Given this situation, CSOs need to modify from intensive role to less intensive role especially in areas where the process is underway for more than 4 years. Hence guidelines need to be developed how after a defined period, CSOs should move to giving lower intensive inputs in a 'consolidation and maintenance' phase.
- ***Need to further enlarge spaces for decentralized planning-*** CBMP committee members have taken initiative to give inputs to RKS and local PIP processes, however medical officers often continue to dominate the planning process. In Maharashtra there has been instances where suggestions from the committees formulated through CBP process have been endorsed for the annual PIP at lower levels like districts, only to be eliminated from the finalized State PIP. This situation needs to change if CBP is to become a reality in context of state PIP development.
- ***Need for more effective grievance redressal system-*** provisions which can enable community members to directly demand accountability like institutionalizing participatory forums for accountability like Jan Samvads (public dialogues) need to be operationalized.
- ***Addressing systemic and structural health system issues-*** CBM should not be viewed as the sole strategy for improving rural health services. The effectiveness of CBM is linked with the basic functionality and social responsiveness of the public health system. On its own CBM will not be able to effect drastic improvements in areas where deeper structural barriers or systemic constraints are operative for instance deployment of doctors at rural public health centres. There is an urgent need for key public issues afflicting the public health sector to be addressed effectively.
- ***Need for CBMP to move from its present relative peripheral position to being a core strategy -*** Experience of CBMP in Maharashtra has shown that though state level officials are supportive of CBMP, but as they already preoccupied with various issues and decision making process of the key issues being dependent on them, often leads to delays. However, this cannot be done unless there is a commitment and deeper understanding among the service providers/ government officials of the benefits that CBMP would have on the overall process.

This paper has sought to present key issues and experiences related to CBMP in Maharashtra and showed that in spite of the hindrances and challenges, the rural people, who had no voice, and no participation in local planning earlier, and who were caught in the vicious cycle of poverty and misery are now coming up. The voice of the voiceless is now breaking the cycle of misery, traditional bureaucracy, widening vertical accountability channels and deepening local democracy.



