



People's Health in People's Hand : Community Monitoring of Health Services

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Empowerment is a key concept at the heart of radical community development. It is a process whereby we develop the theory and practice of equality in order to get to grips with this critical insight into the way that power in society favours the already privileged and the way that forces of disempowerment perpetuate these inequalities is essential. Communities are context for liberation as well as domination and there is a fine line between the two. Our fundamental purpose is not simply to understand our environment but to use that understanding to bring about change. New paradigms offer new possibilities for a participatory paradigm, a participatory consciousness that contributes what is seen as resacrilisation of the community. In order to do this we need to analyse knowledge and power as they act as one of the greatest obstacles to overcome. Radical practice i.e. community monitoring provides a starting point for linking knowledge to power and a commitment to develop forms of community life that takes seriously the struggle for democracy and social justice.

One of such paradigms of practice is community monitoring of various policies, strategies and programmes in the social sector including health. The community (primary stakeholder) should monitor health and health care status to be healthy. Often there is a mismatch between its expectations and its entitlements or rights and the actual service delivery. Internal management information systems of the government provide information with various limitations and are often not reliable. There is an inherent trend by government to hide data that are poor than average performance. It is also difficult in analyzing these information with relation to equity and other social and even programmatic determinants.

Community monitoring has the potential to make services more equitable to the poor and marginalised sections that are denied service and can improve the quality of health services. It creates a mechanism that enables a partnership between the users and the providers of the health care services. Community monitoring seeks to lead towards greater accountability of public health system to the people. Such monitoring works more effectively if the government takes the initiative to devolve authority and power to the community.

The community should monitor public services that have been provided by the government to all sections of the society, its quality and its effectiveness. The community also needs to monitor key health practices that are essential to protect the health of the society. Such monitoring should ensure that there is no social exclusion due to social, physical or economic causes and that such sections get excluded from access to services.

Post independence, India launched several national health programmes for the control, eradication of communicable diseases, improvement of environmental sanitation, raising the standards of nutrition, stabilization of population and improving rural health. Various international agencies like

World Health organization (WHO), UNICEF, UNFPA, World Bank and number of bilateral agencies like SIDA, DANIDA and USAID provided technical and material assistance in the implementation of these programmes. These were mostly vertical programmes with a top down approach. These programmes were based on the Internal Management Information Systems (MIS) which were patchy and under reliable. It was in the 1990s that the MIS was supported by independent external surveys, assessments and reviews which were highly reliable and had least biases and gave a different view point on performance against which the internal data could be reassessed. However though it is useful to assess the validity of the system as a whole it does not help in providing specific information on performance at the village and community level. In search of a model to validate information from the internal MIS and the external surveys a workable system was suggested by the National Rural Health Mission (NRHM 2005-2012)) to use community monitoring as the third leg of the system. This emerging concept (triangulation) would use monitoring/performance data of the internal MIS system, external survey data and the community monitoring data to analyse the programme processes and results, which will be used to plan and implement corrective measures.

In India there are many models of community monitoring ranging from those done by students, by self help groups, by volunteers, by NGOs, by activists. Monitoring is undertaken at the ward or hamlet level and most importantly the data generated by the monitoring is analysed and discussed at the community level. Some of the successful community monitoring have been the Red Alert Project in Raichur and Gulbarga in Karnataka on access to health services and change of negative health practices, Low Birth Weight Project in Ranchi, Hazaribagh and Gumla Block of Jharkhand, Reduction in Malaria Prevalence in Kalahandi, Orissa, Arogya Ekayam Project on Reduction of Child Malnutrition in Tamilnadu. Apart from these efforts there are alliances and networks like Health Watch, Jan Swasthya Abhiyan, Federation of Obstetrics and Gynaecology in India (FOGSI) who monitor policies and programmes in health. The processes used are events reporting, public hearing (Jan Sunwai), use of participatory rapid appraisal (PRA) and other community diagnostic tools.

The National Rural Health Mission (NRHM) with special focus on 18 states in India, seeks to provide accessible, affordable and quality health care to the rural population, specially the vulnerable sections. It seeks to reduce maternal mortality, infant mortality and fertility in span of seven years. The key features to achieve the goals of the mission include making the public health delivery system functional and accountable to the community, human resource management, community involvement, decentralisation, rigorous monitoring and evaluation against standards, convergence of health and related programmes from village level upwards, innovations and flexible financing and for first time communitisation for improving the health indicators.

The implementation framework of NRHM proposes an intensive accountability through a three-pronged process of community based monitoring, external service and stringent internal monitoring. Facility and household survey, NFHS-2 and RCH-DLHS 2002 would act as a base for the Mission against which progress would be measured. While the process of communitisation of the health institutions itself would bring in accountability, the NRHM would help this process by dissemination of results which could be understood by the community. The government hopes that the outcome of these processes would hopefully lead to ensure entitlement of the citizens thereby providing basic health services to all citizens as guaranteed entitlements and right to health.

The adoption of comprehensive framework for community based monitoring and planning at various levels under NHRM was a bold decision to place people's health in people's hand by involving community members, beneficiaries, community based organisations and NGOs working with communities along with Panchayat representatives. The Implementation Framework besides ensuring accountability and promote decentralization in planning, prioritising and identifying issues is consistent

with the right to health care approach as mentioned in the NRHM document. It is a key step towards bringing the public back to public health by allowing community members to directly give feedback about the functioning of public health services including giving inputs for improving planning of the same. The implementation framework rightly does not provide any detailed guideline for community communitisation but provides the flexibility to civil society groups and state governments to develop processes of communisation, which includes community monitoring, planning and action. An important step in this effort of communitisation is the programme on community monitoring of health services under NRHM implemented in nine state of the country namely Rajasthan, Chhattisgarh, Madhya Pradesh, Jharkhand, Orissa, Assam, Maharashtra, Karnataka and Tamilnadu with support from the Union Ministry of Health and Family Welfare. In each of the states the number of districts has been selected between 3-5 depending upon the total number of districts in the state. In each of these districts three blocks have been chosen with three operational Primary Health Centres (PHC). In each PHC area, 5 villages have been selected for initiating community monitoring. Across these states the programme is being implemented in 35 districts, 105 blocks, 315 PHCs and 1575 villages.

The pilot programme will monitor demand, need, coverage, access, quality, effectiveness, health care personnel availability and behaviour, denial of services and negligence. The entire exercise entails a collaborative process with the government at each stage where the community based organisations, people's organisations, and panchayat representatives directly give feedback about the functioning of the public health services. The entire programme is implemented by civil society groups guided by their respective state mentoring groups which consists of representation from civil society groups and the government. The monitoring process includes outreach services, public health facilities and the referral system through a process of setting up the following:

Village Health and Sanitation Committee (VHSC)

PHC Planning and Monitoring Committee

Block Planning and Monitoring Committee

District Planning and Monitoring Committee

State Planning and Monitoring Committee

The process seeks to empower the committees at each level with roles and powers as the NRHM implementation framework to help the community monitor the health services through intensive cascading capacity building efforts. Facilitated and supervised by civil society groups, the outcome envisaged is the development of village and facility level report cards on key NRHM indicators which will be monitored by the above mentioned committees to influence better health outcomes at the local level. It is hoped that the process will not only lead to regular monitoring of health services by the community but also lead to community level planning and action to improve services and address denial of health care.

This innovative programme for the first time provides an opportunity to institutionalize the process of community monitoring, planning and action of and within the public health system. A key feature of this programme is that it is a collaborative effort between the government and civil society organisations. The civil society organisations act as the catalyst to develop processes of community monitoring in collaboration with the government. It has a major role to play in the programme as members of monitoring committees, as resources groups for capacity building and facilitation and as agencies helping to carry out independent collection of information. There is no formula for community monitoring prescribed in the process. The programme provides broad guidelines, flexibility

and innovation to determine the type and process of community monitoring at the state level based on the local needs. The entire process is consultative and based on evidence building at village and facility level, dialogue between civil society groups and the government.

The above programme and many other independent community based efforts in empowering the community to monitor health outcomes has provided opportunities to create models of community based interventions in public health. The intense community mobilization efforts have helped form and in most places activate the VHSCs. Significant in this process of formation has been ensuring that the VHSCs are formed in their true spirit of composition as envisaged in the NRHM i.e. comprising of the community level health workers (ASHA, ANM, AWW), members of self health groups and panchayat representatives. For the first time the VHSC has provided a common platform for direct interaction and interface between the community and the health system. The involvement of community based groups have also ensured that women particularly women from dalit and other marginalised communities have been represented and have found a voice in the process. From the village onwards the various planning and monitoring committees are also being set up to initiate community level enquiry and action on the implementation of NRHM. Such processes have also created a window of opportunity to shape a more consistent path of collective advocacy for NGOs and community based groups both at the national, state and local level. Organisations and individuals as trainers, advisory/mentoring group members through this effort are continuously advocating with their respective governments not only to maintain a steady pace of implementation of the programme but also to create joint platforms of discussion and negotiation. One of the significant aspects of the programme is the space it has provided for innovations in its design and implementation. As mentioned earlier, the national guidelines provide only a broad guideline of what and whom to monitor. Through this process in the nine states, civil society groups have adopted innovative approaches in designing a local need based, easy process of monitoring of health indicators by the community. Materials relevant for low literacy population in local dialect has been developed along with a more participatory approach in the community data gathering exercises. It is here that the diversity nature of NGOs has come to play. Different types of NGOs and a vast gamut of people's organisation that are involved in the process are helping implement this process in an innovative, people oriented way.

Such a community level process oriented programme of evidence building and action is not without its challenges. Lessons from the field reflect challenges related to implementation, insitutionalisation and scaling up of the process. In the process of implementation one of the major challenge is establishing linkages with the panchayat system. The NHRM provides for the public health system to be monitored and supervised by the panchayats along with the people. However lack of understanding of roles and responsibilities among panchayat members across all three tiers, mutual mistrust between the public health system and the panchayat bodies especially at the block and district level threatens to derail the process of employment and effective functioning of the planning and monitoring committees at various levels. Delay in government orders at state, district and block level also leads to delay in implementation of such programmes. The second major challenge is creation of a pool of human resources who will train, facilitate and supervise the process of community monitoring, planning and action. Currently through the pilot programme, civil society groups are investing in identifying and training this resource pool from among its representatives who along with the VHSCs are in the process of data gathering for developing the village and facility level report cards. However concerns remain that in many places especially in the EAG states there is need for greater number of trainers, agencies for capacity building to handhold this process. Not all VHSCs formed and part of the programme are confident and empowered to undertake community monitoring on a regular basis on its own. Therefore concerns remain on the type of continued facilitation that may be required from

civil society groups in future for this transfer of knowledge and skill without completely representing the voice of the community. At the block level the various meetings and orientation programmes undertaken as part of the interface with the services provided reveal the lack of comprehensive knowledge about what NRHM has to offer. For example, most service providers and health officials has focusing on Janani Suraksha Yojana.

The entire pilot process of community monitoring is currently being implemented by NGOs and civil society groups in consultation with the government. Questions remain regarding the viability of replication and scaling up of such a process across the country. Efficacy of such an intensive process driven programme in data collection by the community and will it reflect the reality. The larger question remains about the redressal mechanism. Will the government take complete ownership of the programme at the state, district, block and village level without diluting the supervision and facilitation required for such a process, will it allow for a dialogue between the two without being confrontational on issues of denial and neglect in health service delivery or will it allow for VHSCs to function with active support of the gram sabha without continuous political interference.

The past one year has shown that in many places the word monitoring itself has been has been uncomfortable for the representatives of the health department. The community has raised questions on the issue of community health workers participating in the process but also trying to influence the findings of the monitoring process especially poor performing districts and blocks in the country. Overall the programme outcomes are largely dependent on the pace and performance of NRHM across the states as seen in the case of numerous delays in issuing government orders and taking decisions. It is here that the challenge of ensuring such a process of continued monitoring and action lies.

Dr Lynn Friedman in one of her lectures mentioned the 'broken zipper' problem that exists in public health programme across many countries. It is a situation where there are progressive government programme and policies in health at the central level as those that exist in India at one end, diverse innovative civil society approaches and model in public health interventions at community level on the other hand and the non responsive, poor performing 'broken zipper' middle order public health implementing system. Community based monitoring processes such as the one described above seek to correct the faulty and often failing system by greater community power to take action. It remains to be seen to what extent such processes can develop a functioning redressal mechanism and planning process at the community level and become a model for change.

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