

**Manual on
Community based Monitoring of Health
services
under
National Rural Health Mission**

Drawing from
NRHM Framework of Implementation

**Prepared by
Task force on Community Monitoring
Of
Advisory Group on Community Action**

Based on the Proposal Sanctioned by Mission Directorate of NRHM,
MoHFW, Government of India

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Preface

The National Rural Health Mission (NRHM) was launched on the 12th of April 2005 with the goal of improving the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. . In order to ensure that the services reach those for whom they are meant the NRHM proposes an intensive accountability framework that includes Community-based Monitoring as one of its key strategies.

The NRHM Framework for Implementation outlines the composition and broad roles of monitoring and planning committees at various levels. These outlines were to be subsequently elaborated for developing the process of community monitoring. The Advisory Group for Community Action (AGCA) is a standing committee within the NRHM, constituted to support and advise the MoHFW in the implementation and review of the NRHM across the country. The AGCA took a lead in initiating discussions with the MoHFW to develop a detailed proposal on how “Community Monitoring” could be rolled out in a phased manner across the country. Through a process of discussions and deliberations the AGCA developed a comprehensive proposal for decentralized ‘Community Monitoring’ with the active partnership of the Department and Civil Society institutions. The proposal was then forwarded Union Ministry of Health and Family Welfare (MoHFW) for implementation on a national scale. The MoHFW has approved this first phase of the “ Community Monitoring” proposal and has suggested that the AGCA for a special Task Group for overseeing the implementation.

The AGCA has established a Task Group for the technical support and oversight in implementing the project and it is being Chaired by Mr A R Nanda of PFI. the convener of AGCA. A Secretariat has also been established jointly by Population Foundation of India and Centre for Health and Social Justice at New Delhi

This Manual is based project proposal that has been approved being presented through this manual for different stakeholders in the community.

Introduction to NRHM

There is an increasing recognition that despite significant improvements in health parameters like life expectancy at birth of and the reduction of infant mortality there are large parts of the country where people continue to have very poor access to health care services and their health status continues to be abysmal. A high proportion of the population continues to suffer from and die of preventable conditions like maternal deaths, malaria and tuberculosis. Persistent malnutrition and high levels of anemia

amongst children and women is widespread. Due to the poor status of public health systems people are also facing poverty and indebtedness from the costs incurred in seeking health care. Public spending on health in India, especially on preventive and promotive health is also very low in India. On the other hand the private, out of pocket, expenditure on health is very high, about three times higher than the public expenditure. Thus there is an urgency to deal with the multiple health related crisis that the rural poor in the country are faced with. There is also the need to transform the health system into an efficient, transparent and accountable system delivering affordable and quality services.

The National Rural Health Mission has been conceptualized and is being implemented to bring about these fundamental changes in the way health care services are being

GOALS
<ul style="list-style-type: none">• Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)• Universal access to public health services such as Women’s health, child health, water, sanitation & hygiene, immunization, and Nutrition.• Prevention and control of communicable and non-communicable diseases, including locally endemic diseases• Access to integrated comprehensive primary healthcare• Population stabilization, gender and demographic balance.• Revitalize local health traditions and mainstream AYUSH• Promotion of healthy life styles

delivered to the rural poor. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

The Mission seeks to provide universal access to equitable,

affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance. In this process, the Mission would help achieve goals set under the National Health Policy and the Millennium Development Goals.

In order to achieve its goals and objectives the Mission seeks to forge effective partnerships between the Central State and Local governments. There are flexible mechanisms built into the Mission so that local needs and priorities can be identified and addressed and local initiatives promoted. Intersectoral convergence is also seen as a key strategy of the mission for improving interventions in preventive and promotive health. The Panchayati Raj

The Vision of the Mission

- To provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- 18 special focus states are Arunachal Pradesh, Assam, Bihar, Chattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.
- To raise public spending on health from 0.9% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling.
- To undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.
- To revitalize local health traditions and mainstream AYUSH into the public health system.
- Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.
- Address inter State and inter district disparities.
- Time bound goals and report publicly on progress.

institutions and the community have been given key roles in the management of primary health care programmes as well as infrastructure.

Some of the key areas that have been identified for concerted action within the NRHM framework of action are the following :

- Well functioning health facilities;
- Quality and accountability in the delivery of health services;
- Taking care of the needs of the poor and vulnerable sections of the society and their empowerment;
- Prepare for health transition with appropriate health financing;
- Pro-people public private partnership;
- Convergence for effectiveness and efficiency.
- Responsive health system meeting people's health needs.

The expected outcomes from the Mission are:

1. Reduction of Infant Mortality rate to 30/1000 live births by 2012.
2. Reduction of Maternal Mortality to 100/100,000 live births by 2012.
3. Reduction of Total Fertility Rate to 2.1 by 2012.
4. Reduction of Malaria Mortality Rate by 50% up to 2010 and an additional 10% by 2012.
5. Reduction of Kala Azar Mortality Rate by 100% by 2010 and sustaining elimination until 2012.
6. Reduction of Filariasis/Microfilaria Rate by 70% by 2010 by 80% by 2012 and elimination by 2015.
7. Reduction of Dengue Mortality Rate by 50% by 2010 and sustaining at that level until 2012.
8. Increasing Cataract operations to 46 lakhs until 2012.
9. Reducing Leprosy Prevalence Rate from 1.8 per 10,000 in 2005 to less than 1 per 10,000 thereafter.
10. Maintain 85% cure rate in the Tuberculosis DOTS series through the entire Mission Period and also sustain planned case detection rate.
11. Upgrading all Community Health Centers to Indian Public Health Standards.
12. Increase utilization of First Referral units through increased bed occupancy by referred cases from less than 20% to over 75%.
13. Engaging 4,00,000 female Accredited Social Health Activists

At the community level it is expected

- that there will be increased awareness about preventive health including nutrition
- that there will be a trained worker available at the community level with a drug kit for common ailments
- a monthly health day will be organised where services related to maternal and child health eg. immunization, ante-natal checkups and nutritional services will be available

How to trigger Community action?

- Through household and health facility survey that involve Village Health Teams and discuss findings locally.
 - Through Health Camps that bring a range of health services to the community and makes them aware of their entitlements.
 - Through “Public Hearings” or Jan Sunawai organized periodically where people share their experience of seeking health care. Such Jan Sunwais may be organized twice a year, or at least once a year at PHC, block and district levels.
 - Through training and orientation of village Health Teams for community action.
 - By building team of Community Workers like Aangan Wadi Sevika , ASHA, School Teacher, Mahila Samakhya worker, PTA/MTA’ members, etc.
 - By involving group like SHGs, Community based organizations, MTAs, PTAs, literacy volunteers, Containing Education Centre volunteers, etc. who have motivation for Community action.
 - By making local level health functionaries visit households frequently.
 - By making Block and District level Health Mission teams, including NGOs, organize a series of activities like health camps, public hearings, etc.
- generic drugs for common ailments will be available at the Sub-centre and good hospital care will be assured through availability of doctors, drugs and quality services at PHC/CHC level
 - there will be improved facilities available for institutional deliveries and the Janani Suraksha Yojna will also provide opportunities for subsidized hospital care for those below the poverty line
 - Mobile medical units will ensure availability of services to remote underserved areas
 - There will be provision of safe drinking water and household toilets

In order to ensure that these outcomes are achieved and quality and accountable health services which are responsive and are taking care of the needs of the poor and vulnerable sections of the society, community ownership and participation in management has been seen as an important pre-requisite within NRHM. Community monitoring is an important component for achieving these results.

Community Monitoring in NRHM

Introduction to Community Monitoring - The accountability framework proposed in the NRHM is a three pronged process that includes internal monitoring, periodic surveys and studies and community based monitoring. Community Monitoring is also seen as an important aspect of promoting community led action in the field of health. The provision for Monitoring and Planning Committees has been made at PHC, Block, District and State levels. The adoption of a comprehensive framework for community-based monitoring and planning at various levels under NRHM, places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.

The community monitoring process involves a three way partnership between health care providers and managers (health system); the community, community based organizations and NGOs and the Panchayati Raj Institutions. The success of the community monitoring process will depend upon the ownership of the process by all three parties and a developmental spirit of ‘fact-finding’ and ‘learning lessons for improvement’ rather than ‘fault finding’.

The objectives Community Based Monitoring can be seen as follows:

- 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 organisations 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.

Process of Community Monitoring - The exercise of “Community monitoring” involves drawing in, activating, motivating, capacity building and allowing the community and its representatives e.g. community based organizations (CBOs), people’s movements,

voluntary organizations and Panchayat representatives , to directly give feedback about the functioning of public health services, including giving inputs for improved planning of the same. The community and community-based organisations will monitor demand / need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. The monitoring process will include outreach services, public health facilities and the referral system.

The key institutions for community monitoring as laid out in the Framework of Implementation are the

- Village Health and Sanitation Committee
- The PHC Planning and Monitoring Committee
- The Block Planning and Monitoring Committee
- The District Planning and Monitoring Committee and
- The State Planning and Monitoring Committee

Guidelines regarding the composition, roles and powers of these committees have been laid out in detail in the Framework of Implementation and are reproduced in Annexure XX.

The monitoring process will begin with a village report being prepared by the Village Health and Sanitation Committee after consulting village records (eg. ASHA records or ANM records or the Village Health Register) and also conducting interviews and meetings with potential beneficiaries (like women who are pregnant or have undergone childbirth in the recent past, or those with small children) to understand the community members experiences and problems faced as well as assess the extent to which key services are being delivered effectively. The Monitoring committee at each subsequent level would review and collate the reports coming from the committees dealing with units immediately below it. For example, Block Committee will receive and review the VHSC reports while the District committee would receive and review the reports from all Block committees. However the Monitoring committees would not only rely on reports, but would also make its own independent observations on selected key parameters. Each committee would appoint a small team drawn from among its civil society and PRI representatives who would visit on a quarterly / six monthly basis a small sample of units (say one facility or two villages) under their purview and directly review the conditions there. This will enable the committee to not just rely on reports but to also have a first-hand assessment of conditions in their area. For example, the PHC committee representatives would visit two villages and conduct Group discussions there, in each trimester selecting different villages by rotation. Similarly the Block committee representatives would visit one PHC by rotation in each trimester. The monitoring committees at PHC / Block / District levels will be responsible for making an assessment

of the functioning of the major Health care facility at their respective level (PHC / CHC / District Hospital).

Sharing of the findings of monitoring committees will not only take place through the periodic report submitted to the next level of monitoring committee but also through periodic public sharing . Monitoring committees at PHC, Block and District level will be involved in six-monthly or annual Jan Samvads or Public hearings at their respective levels, where committee members would get share the results of their findings and also get direct feedback of the situation including possible presentation of cases of denial of health care. Similarly, it is State Planning and Monitoring Committee will conduct an annual public meeting open to all civil society representatives where the State Mission report and independent reports will be presented and various aspects of design and implementation of NRHM in the state, including State specific health schemes, would be reviewed and discussed enabling corrective action to be taken.

A broad outline of the ambit and scope of community monitoring at different levels is given below in the Table below.

Community Monitoring Committee	Periodicity of Monitoring	Activities to be undertaken
Village Health and Sanitation Committee	Quarterly	<ul style="list-style-type: none"> a. Reviews Village Health register, Village health calendar b. Reviews performance of ANM, MPW, ASHA c. Reviews communities own experiences as beneficiaries of services d. Sends brief three monthly report to PHC committee
PHC Monitoring and Planning Committee	Quarterly	<ul style="list-style-type: none"> a. Reviews and collates reports from all VHSCs b. An NGO / PRI sub team conducts FGDs in three sample villages under PHC c. Visit PHC, review records, discuss with RKS members d. Send brief three monthly report to Block committee

Block Monitoring and Planning Committee	Quarterly	<ul style="list-style-type: none"> a.Reviews and collates reports from all PHCs b.NGO / PRI sub team visits at least one PHC of the block, conduct interviews with MO and make observations c.Visit CHC and review records, discuss with RKS members d. Send brief three monthly report to District committee
District Monitoring and Planning Committee	Quarterly	<ul style="list-style-type: none"> a. Reviews and collates reports from all Blocks b. An NGO / PRI sub team visits at least one CHC of the District, conducts interviews with Incharge, meets Block committee members and RKS members, makes observations c. Visits District hospital and reviews records, discuss with RKS members c. Send brief three monthly report to State committee
State Monitoring and Planning Committee	Six Monthly	<ul style="list-style-type: none"> a. Reviews and collates reports from all Districts b. An NGO / PRI sub team visits 3 to 5 Districts, conducts interviews with DHO and District Committee members, makes observations on DH c. Sends six monthly report to NRHM / Union Health Ministry

First Phase of Community Monitoring

The outlines of Community Monitoring process provided within the Framework of Implementation have been developed and elaborated upon by the Advisory Group on Community Action. The first phase is being seen as a learning phase because no similar community monitoring activity, either in the health sector or in other social sectors has been implemented on a country wide scale before. Thus in the first phase the implementation will be supervised at a national level by a specially constituted Secretariat and Task Group constituted under the supervision of the Advisory Group. It has been decided that the first phase will be of eleven months (March 07- Jan 08) and cover eight states.

Some reasons because of which it would be desirable to start with a learning phase are as follows:

Learning from experiences and mistakes on a smaller scale, then moving to a larger scale: This is probably the first time in the country that the official health system is institutionalizing community monitoring of health services on a major scale. There is scope for many kinds of experiences and even deviation from objectives, so it is thought

to be desirable to try out the process on a smaller scale and make corrections before moving to a state-wide scale

The need to pool expertise and build an initial critical mass: The number of organizations with experience in rights-based and accountability oriented work related to the Health sector may not be very large in many states. Similarly, expertise and commitment related to this activity within Health departments may also be limited to begin with. It would be desirable for facilitating agencies both within and outside the Health department to come together, share expertise, help launch pilots in a few areas, and analyse experiences, before going to scale at the state level. This would also strengthen ownership of the process within the Department. Starting directly with a widely generalized model would demand very extensive involvement of comparatively few facilitators from day one, they would have to immediately spread themselves thin – not allowing much space for initial development of methodologies and building a critical mass.

The process of developing community monitoring is a delicate process that needs to be handled carefully. Community mobilization experiences in the Health sector show that the initial response of community representatives is often to assertively point out a whole range of problems, deficiencies, gaps and even alleged cases of denial of health care which may be quite difficult for the Health officials to digest and take in the right spirit – which could even at times, lead to a virtual breakdown of dialogue. Maintaining the vitality and authenticity of the process, but not allowing complete polarization which would disrupt the dialogue and convergence process itself is a delicate task. Starting by launching the community monitoring process all over the state on a large scale may conceivably lead to potentially disruptive situations and even demotivation of Health functionaries – which could be avoided by first working out the process in pilot areas and building appropriate checks and balances in the methodology before moving to generalization.

Scale of Implementation of the First Phase - The first phase of the Community Monitoring component of NRHM will be implemented in 30 selected districts of 8 states of the country. These are

Assam

Jharkhand

Maharashtra

Rajasthan

Chhattisgarh

Madhya Pradesh

Orissa

Tamil Nadu

In each of these states a number of districts will be selected (between three and five depending upon the number of districts in the state) on the basis of regional diversity as well as the presence of a credible district level NGO/ Civil Society Organisation which can facilitate the implementation. In each of these districts 3 blocks will be chosen for the first phase, and from among these three blocks the operational area of 3 PHCs will be

selected. Five villages will be selected for initiating Community Monitoring in each of the 3 PHC areas. The total numbers of districts, blocks, PHCs and villages is summarised below

- For States with 15 to 29 districts: 3 pilot districts to be selected
- For States with 30 to 39 districts: 4 pilot districts to be selected
- For States with 40 and above districts: 5 pilot districts to be selected
- This will lead to a total of 30 districts spread across these eight states.
- In each district, three blocks shall be identified giving a total 90 blocks
- In each of these blocks, three PHCs shall be identified giving a total 270 PHCs
- In each PHC area, five revenue villages shall be identified giving total 1350 villages

Need for involving Civil Society Organisations/ NGOs in the first phase – NGOs or Civil Society Organisations have been given crucial roles in the NRHM. It is envisaged that besides providing services in selected areas, they will not be members in institutional arrangement at all levels, but will also act as resource organizations and provide support for evaluation, monitoring and social audit. These organizations will have a crucial role to play in the first phase of Community Monitoring to ensure its success. Although State health departments would play an extremely important role in developing community-monitoring activities, however the facilitation of Community based monitoring has not been left to State health departments. Some of the reasons for this are as follows:

It is largely the Health department functionaries themselves who would be monitored; hence for the monitoring to be robustly independent, it is not sufficient to leave the entire task of developing the monitoring framework to the Health department alone.

For effective Community monitoring, *capacity building of a whole set of actors like beneficiary representatives, community based organizations (CBOs), people's movements, voluntary organizations and Panchayat representatives, who will eventually do the monitoring*, is imperative. Hence involvement of networks, organizations and individuals with experience of community mobilization and community based monitoring to facilitate involvement in the health system of this whole new set of actors is needed.

To facilitate change in the balance of power in the Health sector, in favour of people. The exercise of community monitoring carries meaning only if ordinary people and their spokespersons in form of both Panchayat representatives and Community based organizations, gain a degree of authority to identify gaps and correspondingly propose priorities and influence decision making regarding the Health system.

The kind of capacity required to develop a participatory community monitoring system is quite different from programme implementation and training usually conducted by the Health department; hence involving voluntary sector agencies with some experience of accountability building and health rights work would be desirable to help facilitate this process.

Role of Civil Society Organizations in the First Phase - Civil society organizations i.e. Community based organizations (CBOs) and Non Governmental Organizations (NGOs) would have three kinds of roles in the process of Community based monitoring

- As members of monitoring committees e.g.
- As resource groups for capacity building and facilitation
- As agencies helping to carry out independent collection of information.

As members of monitoring committees, social organizations working in close, regular contact with communities on health related issues, especially from a rights-based perspective, would be able to present in various monitoring committees the community concerns, experiences and suggestions regarding improving public health system functioning.

As resource groups for capacity building and facilitation, NGOs and CBOs will have the responsibility for overall facilitation of the initial process of committee formation and capacity building of Community Monitoring committee members about the process of Community based monitoring including the roles of members, at different levels, including peripheral committees at PHC and village levels. Based on national model material, training modules and materials for orientation of Community Monitoring committee members would be adapted and published at state level and used for this capacity building process. All three types of members – Panchayat representatives, civil society organisations and health system functionaries would benefit from such capacity building.

As agencies helping to carry out collection of information, NGOs and CBOs would contribute to the collection of information relevant to the monitoring process at all levels – from the village to state level. In these processes, an element of community mobilisation may be involved. Specific teams would dialogue with communities and would collect and process community-based information. These teams could be sub-groups drawn from the larger Monitoring committee at specific levels, but could also include some persons from beyond the Monitoring committee. Formation of such teams should be encouraged especially at the PHC and Block levels. Each team should include members from one or more facilitating NGOs and PRI members, and could also include representatives from among the Health care providers. Such teams should undergo a short orientation exercise before they undertake the community monitoring exercise.

Implementing the first phase of Community Monitoring

The first phase of the Community Monitoring process is being implemented under the overall supervision of the specially constituted Task Group of the Advisory Group on Community Action. A National Secretariat has been set up in Delhi through the collaboration of Population Foundation of India and Centre for Health and Social Justice.

Preparatory Phase - The activities that are to be undertaken during the first phase and the persons responsible at each level are given in the table below. The preparatory phase will last from March 07 to June 07.

Activity	Responsibility	Support from
Setting up Task Group	AGCA	MoHFW. GOI
Setting up National Secretariat	AGCA- Task Group	
Contacting State Secretaries in the 8 states	MoHFW	
Contacting Civil Society Organisations in the 8 states	Task Group	
Preparation of necessary Materials, Curricula and Modules	National Secretariat	Task Group
Meeting with state CSOs and identifying State Nodal organization	AGCA- Task Group	National Secretariat
Meeting with State Health Secretary and NRHM Directorate and setting up State Community Monitoring Mentoring Group	AGCA- Task Group	National Secretariat

State Mentoring Group – The State Mentoring group would be formed involving representatives of the State Health department and state level Health sector voluntary networks. Based on experience and demonstrated interest, the State Mission Director and the state designated AGCA members would suggest the names for this mentoring team. This team would have definite responsibilities to develop community monitoring in the state during the first phase and beyond, which would be clearly spelt out. This team would have seven to eleven members, of which at least four to seven would be civil society representatives. In addition, the designated national AGCA members would be permanent invitees to the State mentoring team.

State Nodal Organisation - One of the State level NGOs with membership in the State mentoring team would be selected to work as the state nodal NGO during the pilot phase. This state nodal NGO would work under the direction of the State mentoring team.

Other state level activities to be carried out in the preparatory phase are as follows:

Activity	Responsibility	Support from
Selection of districts and blocks for implementing the project	State C M Mentoring Group	Task Group – National Secretariat
Selecting organizations which will be implementing activities at the district and block level	State C M Mentoring Group	Task Group – National Secretariat
State level workshop to finalise the districts and modalities of district and block level activities	State C M Mentoring Group	Task Group – National Secretariat
State level TOT	State C M Mentoring Group	Task Group – National Secretariat
Adapting and translating materials, curricula and modules for the state	State C M Mentoring Group	Task Group – National Secretariat

A **State level workshop** will be organised by the State mentoring team and State Health Mission involving all stakeholders (State Mission officials, District health officials and PRI representatives from selected districts, NGO networks and civil society organizations from these districts) along with NRHM GoI representatives. The activities of the first phase will be shared and the process would be finalised. Detailed timetable for District level meetings, formation and orientation of committees could be worked out in this two-day State level workshop.

State level Training of Trainers for the facilitating teams from all pilot districts would need to be conducted primarily by voluntary sector facilitators in the pilot phase, since Government officials may not have adequate experience in community monitoring activities. However State Health department officials would be present and would be involved in these workshops, enabling them to actively participate in further such trainings.

Outcomes of the Preparatory Phase:

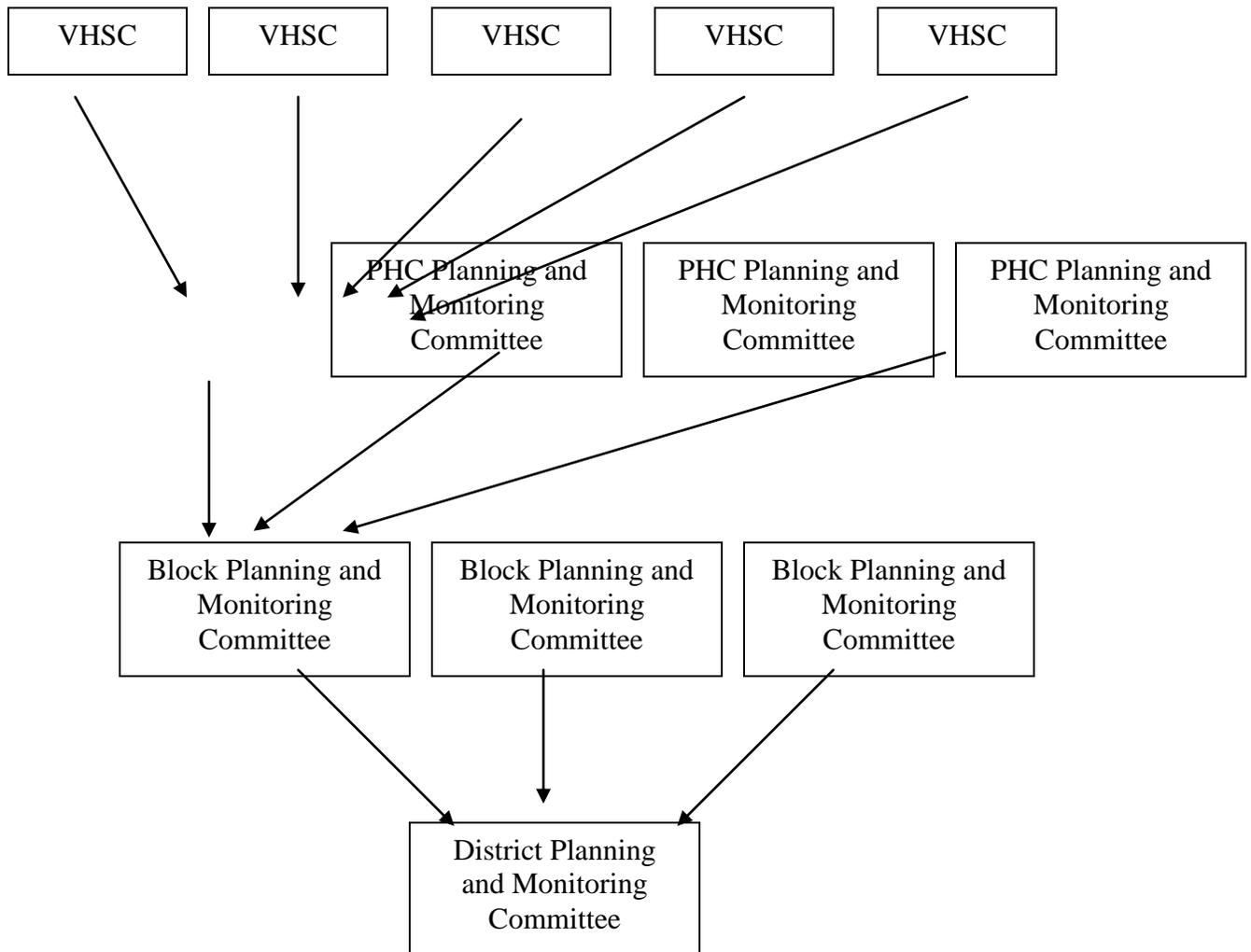
- National Secretariat has been established
- State Community monitoring mentoring groups have been established in all eight states
- State Nodal Organisation has been established in all eight states
- State level workshops have been organised in all states
- State level TOT has been organised in all states
- Draft of materials, curriculum and modules have been prepared
- State level adaptation has begun

District level implementation phase - Once the District and block level facilitating organizations have been trained and selected the key activities will shift to the district and block levels. The time allocated for these activities is July 07 to December 07 in the first phase.

The activities at the district and block level will proceed in the following manner:

Getting Ready for Community Monitoring - District processes would be facilitated by NGOs taking responsibility in the first phase districts along with the District health officials and PRI representatives. A *District mentoring team* (including representatives of each of the three groups) to facilitate the Community monitoring process will be put in place, which would facilitate the orientation activities in this and subsequent stages. In each district one NGO would need to take responsibility as the District nodal NGO. This NGO would be assisted by other civil society organisations that would take specific responsibility in various blocks. The process could start with a *District level workshop* to share the concept, identify Blocks and PHCs, involving key district health officials, PRI members and civil society organisations. Three blocks within the district could be selected for pilot implementation. Block nodal civil society organisations would take up responsibility for specific blocks in coordination with the District nodal NGO.

There would be a need to conduct a *Block level training* for at least a four member Block Community Monitoring facilitation team, including at least two NGO/CBO members. Preferably half of the Block team should be women. These Block facilitation team members would be responsible for the subsequent committee formation and orientation processes. It is anticipated that these activities could be completed in the month of July 07.



Formation of Committees -

During the next four months (Aug. – Nov. 07), there would be formation of committees at Village, PHC, and Block levels in the selected blocks (in that order), along with organising primary orientation of their members. Formation of Community Monitoring committees would start from village committees, then PHC, then Block, and then District committees. A few members from VHCs would be included in the PHC committee; similarly a few PHC committee members would be included in the Block committee. Therefore it would be important to constitute the committees from village level upwards in such a sequential order. CBOs / NGOs and Panchayat representatives who have shown leading initiative in organising community monitoring activities at any level should find representation in the next higher level committees. Adequate representation of women, Dalits and Adivasis should be ensured in various committees.

Following committee formation at the peripheral levels, the District level committee could also be finalised and would become functional by Nov. 07. In the pilot phase, at the state level a provisional committee could be formed by Dec. 07. This would be given final shape only after the next phase of 'Extended implementation' is completed and at least half of the Districts of the state have in place Community monitoring committees, which could send representatives to the State committee.

Community Monitoring - The community and community-based organisations will monitor demand / need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. The monitoring process will include outreach services, public health facilities and the referral system. The Community Monitoring exercises and collation of information should be organised village wise, PHC wise, Block-wise, District wise. In this way these exercises should aggregate information upwards. The monitoring results should also be shared at the Village level, Block and District level in the appropriate PRI fora. Some of the frameworks on which Community Monitoring may be done, and which are included within the NRHM are as follows:

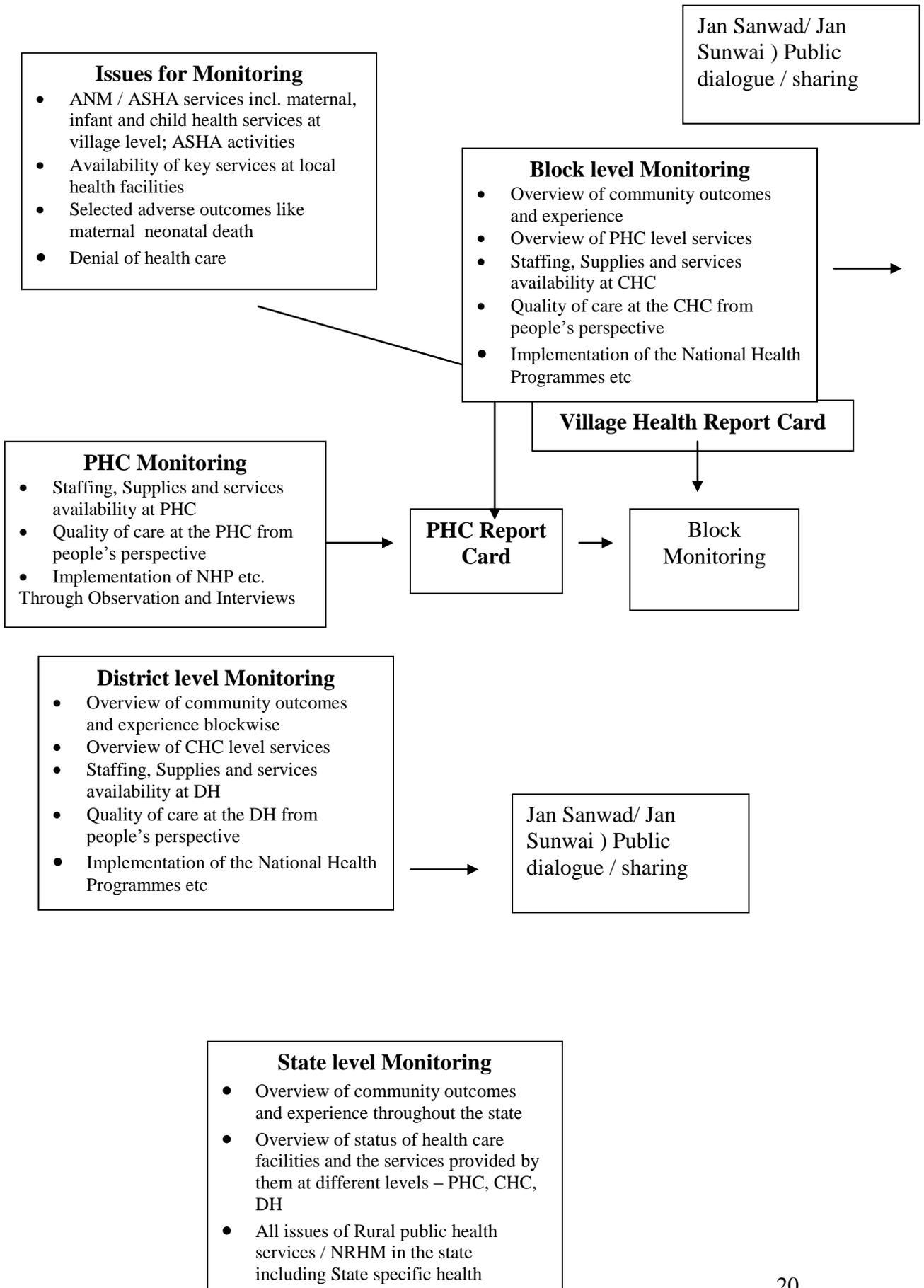
1. Village Health Plan, District Health Plan
2. Entitlements under the Janani Suraksha Yojna
3. Roles and responsibilities of the ASHA
4. Indian Public Health Standards for different facilities like SubCentre, PHC, CHC
5. Concrete Service Guarantees
6. Citizen's Charter and so on.

Activities that have to be undertaken at the village level for community monitoring have already been Table x Section y Page z.

PHC and Block level community monitoring exercises would include a *public dialogue* ('Jan Samvad') or *public hearing* ('Jan Sunwai') process by Dec. 07. Here individual testimonies and assessments by local CBOs / NGOs would be presented. Individual testimonies could be identified through the adverse outcome recording process. These Public dialogues should be moderated / facilitated by the District and Block facilitation groups in collaboration with Panchayat representatives and CBOs / NGOs working on the issue of Health rights.

Mechanism for Monitoring

- Review of documents like - Village Health register, Village Health calendar, ANM / MPW records
 - Group discussion with women
 - Interviews of ANC/ PNC/ Immunisation beneficiaries
 - Interview with ASHA and ANM
 - Interview with those with adverse outcomes and denial of care
- 



The Monitoring committee at each level would review and collate the summary reports coming from the committees dealing with units immediately below it. This enables it to make an assessment of the situation prevailing in all the units under its purview, and to make a report at its level. For example, the District committee would receive and review the reports from all Block committees.

However ***Monitoring committees would not only rely on reports, but would also directly interact in the field situation and get feedback.*** Firstly, each committee would appoint a small sub-team drawn from its NGO and PRI representatives who would *visit on a quarterly / six monthly basis a small sample of units* (say one facility or two villages) under their purview and directly review the conditions there. This enables the committee to not just rely on reports but to also have a first-hand assessment of conditions in their area. For example, the PHC committee representatives would visit two villages and conduct Group discussions there, in each trimester selecting different villages by rotation. Similarly the Block committee representatives would visit one PHC by rotation in each trimester.

Secondly, monitoring committees at PHC, Block and District level would be involved in six-monthly or annual *Jan Samvads or Public hearings* at their respective levels, where committee members would get direct feedback of the situation including possible presentation of cases of denial of health care. Similarly, it is suggested that the State health mission could conduct an annual public meeting open to all civil society representatives where the State mission report and independent reports would be presented and various aspects of design and implementation of NRHM in the state, including State specific health schemes, would be reviewed and discussed enabling corrective action to be taken.

Screening Civil Society Organizations for involvement in Community Monitoring

In order to screen civil society organizations for their capacity to partner in community monitoring activities, and to participate in monitoring committees at various levels, a simple questionnaire will be used. Such organisations may include Community Based Organisations (including self-help groups and people's organisations) as well as NGOs working at the respective level, with documented activity in the area since at least three years. In addition to other questions about the organization, the following issues will be included in the questionnaire.

Activity Profile	Community Mobilisation	Women's Empowerment Activities	Rights based Activities
A1- Income Generation A2 - Environment / Natural Resource Mgmt A3 - Education A4- Health	C1- Self Help Groups C2- Village Level Committees C3- Federations C4- Community Leadership training C5- Work with PRIs C6 – Village based organisation and mobilisation on specific issues	W1- Village level women's groups W2 – Women's leadership development and training W3 – Women and PRI	R1- Right to Healthcare R2- Right to Food R3- Right to Information R4- Right to Employment R5- Livelihood rights e.g. rights related to Forest, Land, Wages, Displacement etc. (specify)

On the basis of their responses to their questionnaire the following screening table will be used and any organization that has at least one entry in all the four aspects (with brief report of the activity carried out in that aspect) may be considered as having qualified. Any organisation with demonstrated experience of monitoring Public services, organising public dialogues or public hearings should be given priority to participate in the Community Monitoring committees.

Name of CSO	Activity Profile				Community Mobilisation Activities					Women's Empowerment Activities			Rights based Activities		
	A1	A2	A3	A4	C1	C2	C3	C4	C5	W1	W2	W3	R1	R2	R3

Key considerations while making a selection- To ensure wide participation diverse group of civil society networks and organizations involved in promotion of Health rights and monitoring shall be involved at various levels

The process of selecting civil society organisations to be involved in monitoring committees at all levels could be facilitated by the mentoring team of the respective level, with guidance from the mentoring team of the higher level. For example, the district mentoring team could suggest the names of civil society organisations to be involved in the District monitoring committee, with inputs from the state mentoring team as relevant. This should be a participatory process including various civil society networks and organisations. It should not be limited to NGOs, and should also definitely involve Community based organisations and people's organizations

Civil society involvement in monitoring should not be focussed only on ‘mother NGOs’ which are often deeply involved in implementation and who may not always be the most objective monitors of work which they themselves are involved in implementing. Particularly for the Community monitoring process in NRHM, it is imperative that the idea is not confined to just ‘leave it to mother NGOs’ but rather that organizations with experience of rights based activities and accountability enforcing activities be given adequate space and responsibility at all levels.

Process documentation and review

Since the first phase of the Community Monitoring process is a learning phase it will include process documentation and review as an important component. This will include the following three distinct stages:

Process Documentation: To ensure uniformity of recording the activity, each activity of the project that has been mentioned above will include a documentation procedure. These documents will be filled in by the responsible agency at different levels and collated at the state level. The state mentoring team will be responsible for analyzing these documents and will prepare a review report on the state implementation, reporting what interventions worked and why and suggesting changes.

Evaluation of the state level intervention: There will be an independent evaluation of the different interventions and their impact on different stakeholders by a team of two experts. The evaluation will include review of the documentation process, interviews with different stakeholders, including members of the community in a limited number of locations across each of the 8 states.

State level review workshops: The third component of the review process will comprise of an endline workshop with those involved in implementing the pilot phase to review the process of the pilot in each state.

Organisational responsibilities

The entire range activities during the first phase would need to be supported by NRHM Mission Directorate from the Union Health Ministry level for rapidity of execution, given the compressed timeframe available. Responsibilities for handling funds and ensuring activities at various levels may be allocated as follows:

Level	Responsibility
National	Overall facilitation by AGCA (in consultation with NRHM officials). Financial responsibilities and coordination handled by AGCA secretariat along with sub-group of AGCA
State	State Nodal NGO under guidance of State Mentoring team (which would include State Mission Director)
District	District nodal NGO under guidance of District mentoring team (which would include District Health Officer)
Block and below	Block nodal civil society organisation (in coordination with District nodal NGO)

National Secretariat on Community Action – NRHM

At the national level, the Task Group of the Advisory Group on Community Action (AGCA) will be facilitating the entire process of community action in consultation with the Ministry of Health and Family Welfare. The Population Foundation of India is the Secretariat for the AGCA. A National Secretariat will be set up under the leadership of PFI along with Centre for Health and Social Justice at New Delhi. The Secretariat will be undertaking special facilitation of the community monitoring process at the national level in consultation with the MOHFW and NRHM Mission. The National Secretariat would function within the framework formulated by the AGCA for community based monitoring of programmes under NRHM.

The National Secretariat would have the following role and responsibilities:

- Coordinating activities of the national preparatory phase, which includes developing tools, model curriculum, workshops, awareness materials and documentation formats for the programme.
- Assist the AGCA members and the state NRHM Directorates and NGO networks for the state preparatory stage.

- Facilitate process documentation and review of the pilot implementation phase in consultation with AGCA members.
- Develop a website on community based monitoring of processes and access to services under NRHM
- Manage the financial responsibility of the pilot programme
- Prepare progress reports, field visits and the national dissemination workshops of the programme at the national level
- Conduct quarterly review of AGCA for review of the pilot programme.

Staffing - The National Secretariat would be managed by two officers responsible for the overall programmatic and financial coordination of the programme. The coordinators would report to the Task Group of AGCA.

Organogram

<p>Ministry of Health and Family Welfare (GoI)- NRHM (The pilot project on community based monitoring of health services under NRHM is a GOI initiative. The fund for the pilot phase facilitation and implementation would be given by the NRHM. Supported by the MoHFW, the State health departments have a central role in developing the Community monitoring framework)</p>
<p>Advisory Group on Community Action (AGCA)</p>
<p>National Secretariat on Community Action- NRHM</p>
<p>State Monitoring and Planning Committee</p>
<p>State Mentoring Team (At the State level, the State Mentoring team would be formed involving representatives of the state health department and state level health sector voluntary networks. This team would have definite responsibilities to develop community monitoring in the state. It will organize State level workshop with State Health Mission)</p>
<p>State Nodal NGO (Out of the state mentoring team, one NGO Member will designated as State NodalNGO)</p>
<p>District mentoring Team (This team will include PRI representatives, district Health Officials and NGO representatives)</p>
<p>District Nodal NGO The District level and Block level funds in the pilot phase in each state would be given to designated District nodal NGO to enable a fast start-up and adequate flexibility in the process)</p>
<p>District Monitoring and Planning Committee</p>
<p>Block nodal civil society organizations (The District nodal NGO would collaborate with Block nodal civil society organisations for execution of activities in specific blocks)</p>
<p>Block Community Monitoring Facilitation Team (Responsible for subsequent committee formation and orientation processes)</p>
<p>Block Monitoring and Planning Committee</p>
<p>PHC Monitoring and Planning Committee</p>
<p>Village Health and Sanitation Committee</p>

Budget Break Up for Community Monitoring

Activity Budgets

Block Level

	Level	Number of unit activity	Participants in each unit activity	Cost activity per	Budget
1	Orientation of members of community monitoring team				
	Block	1	20 members per block committee	15000	15000
	PHC	3	15 members per PHC committee.	16500	49500
	Villages	5	10 VHC members per village	16750	83750
	Total				148250
2	Formation of community monitoring Committees				
	Block	1	30 participants (panchayat members, NGO/ CBO members and PHC committee members)	3000 per block meeting	3000
	PHC	3	30 people	1000 per PHC meeting	3000
	Village	5	2 facilitators	1000 per village for 2 preparatory visits and 1 meeting	5000
	Total				11000
3	Conduction of Jan Samvad / Jan Sunwai in each of the pilot PHCs and blocks				
	Block Jan Samvad	1	5 panelists / experts, 200 participants	18000 per block Jan Samvad	18000
	PHC Jan Samvad	3	5 panelists / experts, 100 participants	10000 per PHC Jan Samvad	30000
	Total				48000
	Block budget total				207250

District Level

Budget- Of one District				
	Type of Activity	Number of Participants unit in activity	Cost in each unit activity	per Budget
1	District facilitation, training of trainers			
	District workshop – one in each district, one day	1	25 participants	22,000
				22,000
2	Formation of Community Monitoring committees			
	District	1	20 participants	7000 per district meeting
3	Orientation of members of Community Monitoring committees			
	District	1	20 members per district committee @ Rs. 6000/- for 2 meetings	23,000
				23,000
4	Training of Block level Trainers			
		3		42,000
5	Facilitation costs for dist. NGO			
			One middle level staff member full time for 7 months.	226000
			3 Field staff full time for six months (one in each block.	226000
6	Budget for each district			404,000
7	Budget for each block		3 Blocks	207250
	Total Budget Allotted for one district (including the Block budget)			1025,750

State Level Budget

Activity	Budget	Total Budget With 3 districts	Total Budget With 4 districts	Total Budget With 5 districts
State level workshop(2 days) – leads to selection of districts	110000	110000	110000	110000
State Training of trainers (5 days)	187500	187500	187500	187500
State level facilitation by State nodal NGO	250000	250000	250000	250000
District level budget Including Block Budget	1025,750	3077,250	4103,000	5128,750
Total Budget		36,24,750	46,50,500	56,76,250

Annexure 1 : NRHM STRATEGIES

(a) Core Strategies:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).
- Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.
- Technical Support to National, State and District Health Missions, for Public Health Management.
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of Human Resources for health.
- Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.
- Promoting non-profit sector particularly in under served areas.

(b) Supplementary Strategies:

- Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.
- Promotion of Public Private Partnerships for achieving public health goals.
- Mainstreaming AYUSH – revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.
- Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

Annexure 2 : MONITORING AND EVALUATION

- Health MIS to be developed upto CHC level, and web-enabled for citizen scrutiny
- Sub-centres to report on performance to Panchayats, Hospitals to Rogi Kalyan Samitis and District Health Mission to Zila Parishad
- The District Health Mission to monitor compliance to Citizen's Charter at CHC level
- Annual District Reports on People's Health (to be prepared by Govt/NGO collaboration)
- State and National Reports on People's Health to be tabled in Assemblies, Parliament
- External evaluation/social audit through professional bodies/NGOs
- Mid Course reviews and appropriate correction

(NRHM – Mission Document)

Monitoring outcomes of the Mission

Right to health is recognized as inalienable right of all citizens as brought out by the relevant rulings of the Supreme Court as well as the International Conventions to which India is a signatory. As rights convey entitlement to the citizens, these rights are to be incorporated in the monitoring framework of the Mission. Therefore, providing basic Health services to all the citizens as guaranteed entitlements will be attempted under the NRHHM.

Preparation of Household specific Health Cards that record information on the following - record of births and deaths, record of illnesses and disease, record any expenditure on health care, food availability and water source, means of livelihood, age profile of family, record of age at marriage, sex ratio of children, available health facility and providers, food habits, alcohol and tobacco consumption, gender relations within family, etc, (by ASHA/AWW/Village Health Team).

Preparation of Habitation/Village Health Register on the basis of the household Health Cards. (By the Village Health Team)

Periodic Health Facility Survey at SHC, PHC, CHC, District level to see if service guarantees are being honoured.[By district /Block level Mission Teams/ research and resource institutions].

Formation of Health Monitoring and Planning Committees at PHC, Block, District and State levels to ensure regular monitoring of activities at respective levels, along with facilitating relevant inputs for planning.

Sharing of all data and discussion at habitation/ village level to ensure full transparency.

Display of agreed service guarantees at health facilities, details of human and financial resources available to the facility.

Sample household and facility surveys by external research organizations/NGOs.

Public reporting of household and health facility findings and its wider dissemination through public hearings and formal reporting.

(From : NRHM Framework for Implementation)

Annexure 3 : COMMUNITY MONITORING FRAMEWORK

124. We have discussed the overall monitoring framework in an earlier section (IV L). The basic change that NRHM wishes to bring about in the monitoring framework is to involve local communities in planning and implementing programmes with a framework that allows them to assess progress against agreed benchmarks. While external institutions will also assess progress, they will do so on benchmarks that have been agreed with local communities and health institutions. The intention is to move towards a community based monitoring framework that allows continuous assessment of planning and implementation of NRHM. Besides the issues already mentioned earlier on the monitoring framework, the broad principles for community based monitoring are listed below.

125. Given the overall objective that people should have complete access to rational, appropriate and effective health care, community based monitoring should preferably fulfill following objectives:

- It should provide regular and systematic information about community needs, which would guide related planning
- It should provide feedback according to the locally developed yardsticks for monitoring as well as key indicators. This would essentially cover the status of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.
- It should enable the community and community-based organisations 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 could be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

(i) Ownership of Community monitoring process

- The health department functionaries need to be involved in the preparation and mobilization phase of the initiative so as to enable ‘ownership’ of the process and outcomes among the providers and users.
- PRIs, community based organizations and NGOs, along with health department functionaries should be involved in the preparation and mobilization phase of the initiative so as to enable ownership of the process and outcomes among the providers and users.
- The government can enable such interactive processes through issuing relevant Government Orders, and by ensuring effective communication to all levels of public health functionaries
- All the members of any committee that is formed (for example the Village Health Committee) must have their roles and responsibilities clearly defined and articulated.

(ii) Powers and capacity building

126. The committees that are formed at various levels **must have concomitant authority i.e. they must have the power to initiate action.** The capacities of the members of a village level committee have to be built continuously for them to be able to function effectively. This would require allocation of resources and capacity building inputs. This process must begin with full and ready access to information.

127. The intent of the newly launched NRHM as mentioned in the core strategy is that it will promote community ownership and decentralised planning from village to district level. This is supposed to be through participatory processes, by strengthening evidence based effective monitoring and evaluation. In order to actually do so it will be imperative that:

- The government should enable such interactive processes by issuing relevant Government Orders. One example of such orders is the one passed by the Government of Rajasthan for the formation of Convergence Committees at the district and PHC level. A similar example is the response of the Gujarat Government to the National Human Rights Commission, wherein coordination bodies at various levels of the Public Health System are proposed for operationalising a State level health services monitoring mechanism.
- All the members of any committee that is formed must have their roles and responsibilities clearly defined and articulated.
- Effective and quality monitoring requires institutional mechanisms at various levels beginning at the community and going upwards. Adequate investment (time and resources) must be made in capacity development at various levels.
- Analysis of the collected information must be undertaken at various levels so as to enable prompt action and corrections. The committees that are formed at various levels must have concomitant authority i.e. they must have the power to take action.
- The monitoring system must be directly linked to corrective decision making bodies at various levels. The information and issues emerging from monitoring must be communicated to the relevant official bodies responsible for taking action (from PHC to state level) so that monitoring results in *prompt, effective and accountable remedial action.*

(iv) *Further, some overall points to be kept in mind are:*

- Effective Community Monitoring would change the status of community members from passive beneficiaries to active rights holders, enabling them to more effectively access health services.
- We must be realistic in setting indicators and planning activities. Communities need few and simple indicators for monitoring, and the time devoted by members, especially community representatives involved in various committees must be utilized optimally.
- Community Monitoring must be seen as an integral part of the Public Health System at all levels and for all activities, and not as a stand-alone process.
- Panchayati Raj Institutions are not synonymous with the community. For community ownership and effective monitoring, even if PRI representatives are involved, one still needs to involve user groups and beneficiaries, and to include Community Based Organisations.

(v) *Involvement of the general public by means of regular 'Public dialogue' or Public hearing (Jan Samvad / Jan Sunwai)*

128. Most of the public participation in the monitoring process would be mediated by representatives of the community or community-linked organisations. However, to enable *interested community members to be directly involved* in exchange of information, and to improve transparency and accountability of the health care system, ‘Public dialogues’ (Jan Samvad) or Public hearings (‘Jan Sunwai’) would be need to organised at regular intervals (once or twice in a year, depending on the initiative of the local organisations) at PHC, block and district levels (see section V-I).

What should the community monitor?

129. The community and community-based organisations should monitor demand / need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. This should be monitored related to outreach services, public health facilities and the referral system.

Annexure 4 : COMPOSITION, ROLES AND RESPONSIBILITIES OF MONITORING COMMITTEES

Composition of the Village Health committee

This committee would be formed at the level of the revenue village (more than one such villages may come under a single Gram Panchayat).

Composition: The Village Health Committee would consist of:

- Gram Panchayat members from the village
- ASHA, Anganwadi Sevika, ANM
- SHG leader, the PTA/MTA Secretary, village representative of any Community based organisation working in the village, user group representative

The chairperson would be the Panchayat member (preferably woman or SC/ST member) and the convenor would be ASHA; where ASHA not in position it could be the Anganwadi Sevika of the village.

Some yardsticks for monitoring at the village level

- Village Health Plan
- NRHM indicators translated into Village health indicators

Some roles of the Village Health Committee

Activities

- Create Public Awareness about the essentials of health programmes, with focus on People’s knowledge of entitlements to enable their involvement in the monitoring.
- Discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community
- Analyse key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present an annual health report of the village in the Gram Sabha

- *Participatory Rapid Assessment*: to ascertain the major health problems and health related issues in the village. Estimation of the annual expenditure incurred for management of all the morbidities may also be done. The mapping will also take into account the health resources and the unhealthy influences within village boundaries. Mapping will be done through participatory methods with involvement of all strata of people. The health mapping exercise shall provide quantitative and qualitative data to understand the health profile of the village. These would be Village information (number of households – caste, religion and income ranking, geographical distribution, access to drinking water sources, status of household and village sanitation, physical approach to village, nearest health facility for primary care, emergency obstetric care, transport system) and the morbidity pattern
- Maintenance of a *village health register and health information board/calendar*: The health register and board put up at the most frequented section of the village will have information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc. Similarly dates of visit and activities expected to be performed during each visits by health functionaries may be displayed and monitored by means of a Village health calendar. These will be the most important document maintained by the village community about the exhibition of health status and health care services availability. This will also serve as the instrument for cross verification and validation of data
- Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW
- Get a bi-monthly health delivery report from health service providers during their visit to the village. Discuss the report submitted by ANM and MPW and take appropriate action
- Take into consideration of the problems of the community and the health and nutrition care providers and suggest mechanisms to solve it.
- Discuss every maternal death or neonatal death that occurs in their village, analyze it and suggest necessary action to prevent such deaths. Get these deaths registered in the Panchayat.
- Managing the village health fund.

Some tools for monitoring at the village level

- Village Health Register
- Records of the ANM
- Village Health Calendar
- Infant and maternal death audit
- Public dialogue (Jan Samvad)

Powers of the committee

- The convener will sign the attendance registers of the AWWs, Mid-Day meal Sanchalak, MPWs, and ANMs.
- MPWs and ANMs will submit a bi-monthly village report to the committee along with the plan for next two months. Format and contents of the bi-monthly reports would be decided village health committee.
- The committee will receive funds of Rs.10,000 per year. This fund may be used as per the discretion of the VHC.

2. PHC Health Monitoring and Planning Committee

Role and Responsibilities of the Committee

- Consolidation of the village health plans and charting out the annual health action plan in order of priority. The plan should clearly lay down the goals for improvement in health services and key determinants.
- Presentation of the progress made at the village level, achievements, actions taken and difficulties faced followed by discussion on the progress of the achievements of the PHC, concerns and difficulties faced and support received to improve the access to health facilities in the area of that particular PHC. The discussion could include:
 - Sharing of reports of Village Health Committees
 - Reports from ANM, MPW about the coverage of health facilities
 - Any efforts done at the village level to improve the access to health care services
 - Record and analysis of neonatal and maternal deaths.
 - Any epidemic occurring in the area and preventive actions taken.
- Ensure that the **Charter of citizen's health rights** is disseminated widely and displayed outside the PHC informing the people about the medicine facilities available at the PHC, timings of PHC and the facilities available free of cost. A suggestion box can be kept for the health care facility users to express their views about the facilities. These comments will be read at the coordination committee meeting to take necessary action.
- Monitoring of the physical resources like, infrastructure, equipments, medicines, water connection etc at the PHC and inform the concerned government officials to improve it.
- Discuss and develop a PHC Health Plan based on an assessment of the situation and priorities identified by representatives of village health committees and community based organisations
- Share the information about any health awareness programme organized in the PHC's jurisdiction, its achievements, follow up actions, difficulties faced etc.
- Coordinate with local CBOs and NGOs to improve the health scenario of the PHC area.
- Review the functioning of Sub-centres operating under jurisdiction of the PHC and taking appropriate decisions to improve their functioning
- At the end of the meeting brief minutes of the meeting will be developed along with the action plan emphasizing the actions to be taken by different committee members, which will be shared at the District level committee. The minutes will also serve as a reference point, while sharing the progress done between two committee meetings.
- Initiate appropriate action on *instances of denial of right to health care* reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The report may become a part of the performance appraisal of the concerned staff member. The committee may recommend corrective measures to the next level (block/ district). The decisions taken in the committee need to be forwarded to higher concerned officials and a copy to the corresponding health committee of that level who will be responsible to take necessary decision for action to be taken on the inquiry within a period of three months.

Constitution of the PHC Health committee

The PHC Health committee would function as the health monitoring and planning arm of the Panchayats coming under the PHC area. It is recommended that the PHC Committee have the following broad pattern of representation, including members from Panchayats, health care service providers and civil society:

- 30% members should be representatives of Panchayat Institutions (Panchayat samiti member from the PHC coverage area; two or more sarpanchs of which at least one is a woman)
- 20% members should be non-official representatives from the village health committees, coming from villages under the jurisdiction of the PHC, with annual rotation to enable representation from all the villages
- 20% members should be representatives from NGOs / CBOs and People's organizations working on Community health and health rights in the area covered by the PHC
- 30% members should be representatives of the Health and Nutrition Care providers, including the Medical Officer – Primary Health Centre and at least one ANM working in the PHC area

The chairperson of the PHC committee would be one of the Panchayat representatives, preferably a Panchayat Samiti member belonging to the PHC coverage area. The executive chairperson would be the Medical officer of the PHC. The secretary of the PHC committee would be one of the NGO / CBO representatives.

Power of the committee

- Contribute to annual performance appraisal of Medical officer / other functionaries at the PHC.
- Take collective decision about the utilization of the special funds given to PHC (say Rs.25,000) for the repairs, maintenance of equipments, health education etc and any other aspects, which will facilitate the improvement of access to health care services. The MO can utilize this fund after the discussion and approval from the committee.

Some yardsticks for monitoring at the PHC level

- Charter of Citizens Health Rights
- IPHS or similar standards for PHC (this would include continuous availability of basic outpatient services, indoor facility, delivery care, drugs, laboratory investigations and ambulance facilities)
- PHC Health Plan

Some tools for monitoring at the PHC level

- Village health registers / calendars
- PHC records
- Discussions with and interviews of the PHC committee members
- Public dialogue (Jan Samvad) or Public hearing (Jan Sunwai)
- Quarterly feedback from village Health Committees
- Periodic assessment of the existing structural deficiencies

Block Health Monitoring and Planning Committee

Role and Responsibilities:

- Consolidation of the PHC level health plans and charting out of the annual health action plan for the block. The plan should clearly lay down the goals for improvement in health services.
- Review of the progress made at the PHC levels, difficulties faced, actions taken and achievements made, followed by discussion on any further steps required to be taken for further improvement of health facilities in the block, including the CHC.
- Analysis of records on neonatal and maternal deaths; and the status of other indicators, such as coverage for immunization and other national programmes.
- Monitoring of the physical resources like, infrastructure, equipments, medicine, water connection etc at the CHC; similar exercise for the manpower issues of the health facilities that come under the jurisdiction of the CHC.
- Coordinate with local CBOs and NGOs to improve the health services in the block.
- Review the functioning of Sub-centres and PHCs operating under jurisdiction of the CHC and taking appropriate decisions to improve their functioning
- Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The committee may also recommend corrective measures to the district level.

Constitution of the Block committee

It is recommended that the Block Committee have the following broad pattern of representation, including members from Panchayats, health care service providers and civil society:

- 30% members should be representatives of the Block Panchayat Samiti (Adhyaksha / Adhyakshika of the Block Panchayat Samiti or members of the Block Panchayat samiti, with at least one woman)
- 20% members should be non-official representatives from the PHC health committees in the block, with annual rotation to enable representation from all PHCs over time
- 20% members should be representatives from NGOs / CBOs and People's organizations working on Community health and health rights in the block, and involved in facilitating monitoring of health services
- 20% members should be officials such as the Block Medical Officer, the Block Development Officer, selected Medical Officers from PHCs of the block
- 10% members should be representatives of the CHC level Rogi Kalyan Samiti

The chairperson of the Block committee would be one of the Block Panchayat Samiti representatives. The executive chairperson would be the Block medical officer. The secretary would be one of the NGO / CBO representatives.

Yardsticks for monitoring at the Block level

- ⌚ IPHS or similar standards for CHC (this would include continuous availability of basic outpatient services, indoor facility, community outreach services, referral services, delivery and antenatal care, drugs, laboratory investigations and ambulance facilities)
- ⌚ Charter of Citizens Health Rights for CHC
- ⌚ Block Health Plan

Some tools for monitoring at the Block level

- ⌚ PHC and CHC records
- ⌚ Discussions with and interviews of the CHC RKS members
- ⌚ Report of Public dialogue (Jan Samvad)
- ⌚ Quarterly feedback from village and PHC Health Committees
- ⌚ Periodic assessment of the existing structural and functional deficiencies

District Health Monitoring and Planning Committee

Role and Responsibility

- Discussion on the reports of the PHC health committees
- Financial reporting and solving blockages in flow of resources if any
- Infrastructure, medicine and health personnel related information and necessary steps required to correct the discrepancies.
- Progress report of the PHCs emphasising the information on referrals utilisation of the services, quality of care etc.
- Contribute to development of the District Health Plan, based on an assessment of the situation and priorities for the district. This would be based on inputs from representatives of PHC health committees, community based organisations and NGOs.
- Ensuring proper functioning of the Hospital Management Committees.
- Discussion on circulars, decisions or policy level changes done at the state level; deciding about their relevance for the district situation
- Taking cognizance of the reported cases of the denial of health care and ensuring proper redressal.

Constitution of the District committee

It is recommended that the District Committee have the following broad pattern of representation, including members from Panchayati Raj Institutions, health care service providers and civil society:

- 30% members should be representatives of the Zilla Parishad (esp. convenor and members of its Health committee)
- 25% members should be district health officials, including the District Health Officer / Chief Medical Officer and Civil Surgeon or officials of parallel designation, along with representatives of the District Health planning team including management professionals
- 15% members should be non-official representatives of block committees, with annual rotation to enable successive representation from all blocks

- 20% members should be representatives from NGOs / CBOs and People's organizations working on Health rights and regularly involved in facilitating Community based monitoring at other levels (PHC/block) in the district
- 10% members should be representatives of Hospital Management Committees in the district

The chairperson of the District committee would be one of the Zilla Parishad representatives, preferably convenor or member of the Zilla Parishad Health committee. The executive chairperson would be the CMO / CMHO / DHO or officer of equivalent designation. The secretary of the PHC committee would be one of the NGO / CBO representatives.

Some yardsticks for monitoring at the District level

- Charters of Citizens Health Rights
- District Action Plan
- NRHM guidelines
- Indian Public Health Standards

Some tools for Monitoring at the District level

- ⌚ Report from the PHC Health committees
- ⌚ Report of the District Mission committee
- ⌚ Public Dialogue (Jan Samvad)

State Health Monitoring and Planning Committee

Role and Responsibilities

- ⌚ The main role of the committee is to discuss the programmatic and policy issues related to access to health care and to suggest necessary changes.
- ⌚ This committee will review and contribute to the development of the State health plan, including the plan for implementation of NRHM at the state level; the committee will suggest and review priorities and overall programmatic design of the State health plan.
- ⌚ Key issues arising from various District health committees, which cannot be resolved at that level (especially relating to budgetary allocations, recruitment policy, programmatic design etc) would be discussed an appropriate action initiated by the committee. Any administrative and financial level queries, which need urgent attention, will be discussed.
- ⌚ Institute a health rights redressal mechanism at all levels of the health system, which will take action within a time bound manner. Review summary report of the actions taken in response to the enquiry reports
- ⌚ Operationalising and assessing the progress made in implementing the recommendations of the NHRC, to actualize the Right to health care at the state level.
- ⌚ The committee will take proactive role to share any related information received from GOI and will also will share achievements at different levels. The copies of relevant documents will be shared.

Composition of State Health Monitoring and Planning committee

- ⌚ 30% of total members should be elected representatives, belonging to the State legislative body (MLAs/MLCs) or Convenors of Health committees of Zilla Parishads of selected districts (from different regions of the state) by rotation
- ⌚ 15% would be non-official members of district committees, by rotation from various districts belonging to different regions of the state
- ⌚ 20% members would be representatives from State health NGO coalitions working on Health rights, involved in facilitating Community based monitoring
- ⌚ 25% members would belong to State Health Department:
 - ⌚ Secretary Health and Family Welfare, Commissioner Health, relevant officials from Directorate of Health Services (incl. NRHM Mission Director) along with Technical experts from the State Health System Resource Centre / Planning cell
- ⌚ 10% members would be officials belonging to other related departments and programmes such as Women and Child Development, Water and Sanitation, Rural development.
- ⌚ The Chairperson would be one of the elected members (MLAs).
- ⌚ The executive chairperson would be the Secretary Health and Family Welfare.
- ⌚ The secretary would be one of the NGO coalition representatives.

Some yardsticks for monitoring at the State level

- NHRC recommendations and National Action Plan on Right to Health Care; responses of state health departments and actions to which the State Government has committed itself
- NRHM state level plan and the State Health Mission guidelines
- IPHS

Tools for monitoring at the State level

- ⌚ Reports of the District Health committees
- ⌚ Periodic assessment reports by various taskforces / State level committees about the progress made in formulating policies according to IPH Standards, NHRC recommendations and its implementation status etc.

Annexure 5 : CONCRETE SERVICE GUARANTEES

Concrete Service Guarantees that NRHM will provide:

- Skilled attendance at all Births
- Emergency Obstetric care
- Basic neonatal care for new born
- Full coverage of services related to childhood diseases / health conditions
- Full coverage of services related to maternal diseases / health conditions
- Full coverage of services related to low vision and blindness due to refractive errors and cataract.
- Full coverage for curative and restorative services related to leprosy
- Full coverage of diagnostic and treatment services for tuberculosis
- Full coverage of preventive, diagnostic and treatment services for vector borne diseases
- Full coverage for minor injuries / illness (all problems manageable as part of standard outpatient care upto CHC level)
- Full coverage of services inpatient treatment of childhood diseases / health conditions
- Full coverage of services inpatient treatment of maternal diseases / health conditions including safe abortion care (free for 50% user charges from APL)
- Full coverage of services for Blindness, life style diseases, hypertension etc.
- Full coverage for providing secondary care services at Sub-district and District Hospital.
- Full coverage for meeting unmet needs and spacing and permanent family planning services.
- Full coverage of diagnostic and treatment services for RI/STI and counseling for HIV – AIDS services for adolescents.
- Health education and preventive health measures.