THE COMMUNITY MONITORING AND PLANNING PILOT PROJECT IN TAMIL NADU

a joint learning process

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METHODOLOGY

This paper is an exercise in evolving a joint learning from the recently concluded Community Monitoring and Planning Pilot Project in the State of Tamil Nadu. An initial draft was prepared by the Community Health Cell team. This was circulated among representatives of various civil society organisations as well as the Mission Director as well as the Director of Public Health. Comments of all were then put together to evolve this final version.

BACKGROUND

The Community Monitoring and Planning Pilot Project (CMP) was conceived off by members of the Advisory Group on Community Action (AGCA). This was in an effort to try out the ambitious and progressive plan on communitization of health services propounded in the National Rural Health Mission (NRHM) framework for implementation. It was felt that an initial pilot phase followed by learning from that phase and then expanding would be the most advisable in the case of complex interventions like this. Consequently the Population Foundation of India (PFI) and the Center for Health and Social Justice (CHSJ) were appointed as the secretariat for this pilot project which was implemented over 9 states. To assist the secretariat a Technical Advisory Group (TAG) was also constituted.

THE PROJECT AT THE STATE LEVEL

In each state a state nodal NGO was selected from among the civil society groups using transparent criteria laid down by the secretariat. The project was implemented as per GO.(D) No.1393 ..... The state nodal NGO led the implementation of the project in the state. In Tamil Nadu the state nodal NGO Tamil Nadu Science Forum (TNSF) was supported in all activities by the Community Health Cell Extension, Tamil Nadu Team, Society for Community Health Awareness Research and Action (CHC-SOCHARA). Members of the CHC-SOCHARA team were part of the AGCA, Technical Advisory Group (TAG) of the project as well as the Tamil Nadu State Mentoring Committee. Members of the CHC-SOCHARA team were also members of the State Resource Team along with others, this Resource team provided training and implementation support throughout the project at all levels.

The project essentially consisted of the formation of teams at various levels. These teams were oriented

and trained in the monitoring process and proceeded to actually monitor the health services available at that level. The monitoring was done with the help of a monitoring tool developed in Tamil Nadu, which was based on a template provided by the secretariat. Committees at the higher level were to aggregated data from the individual committees at the lower levels. Once the data was collected and aggregated a series of public hearings were facilitated where the district level health officials were invited to have a face to face dialogue with the people.

OUTPUTS OF THE PROJECT IN TAMIL NADU STATE

- State Level:
    - State mentoring committee -
    - State Resource group formed and in place – 6 (members)
    - Links with academic institutions / networks.
    - State Level NGOs identified – TamilNadu Science Forum (TNSF) & Community Helath Cell – SOCHARA (CHC-SOCHARA) &

- District level:
    - District nodal NGO identified – 5
    - District mentoring committee in place – 5
    - District resource groups oriented and trained – 5

- Block level:
    - Block level NGOs identified – 34
    - Block level mentoring committee – 14
    - Block level resource groups - 14

- Village level:
    - Village Health and Sanitation Committees – 210

In the next section individual components of the project will be presented and discussed and lessons from the pilot phase drawn out.

S. No.	***Activity***	***Description of Activity in Pilot Phase***	***Remarks***	***Proposed activity in next phase***
1.	Area covered	A total of 210 villages (at level of Panchayats / Panchayat villages) were covered.	This needs to be expanded to cover complete adminstrative sub-units to get a comprehensive idea of implementation.	All the villages within blocks covered in the pilot phase will be taken up in the next phase.
2.	Level of formation of Village Health and Sanitation	In the pilot phase the project followed the GoTN order with formation at the Gram	The national guidelines are for a committee at the level of hamlet village (roughly a	Decision needs to be taken by the Government.

	Committees (VHSC)	Panchayat level (though coverage was limited to the Panchayat village in most cases)	population of 1500). Thus each village should have a VHSC and receive Rs.10,000 as untied funds.	In the next phase it is proposed to cover only Panchayats (roughly 450)
3.	Composition of the VHSC	As per the GO issued the composition of the VHSC consists of: 1) The Panchayat President. 2) The VHN 3) The Anganwadi worker 4) The Health inspector. 5) One SHG member nominated by the Panchayat president. In the pilot project it was decided to expand these committees as per the guidelines of the National government in the pilot villages.	The VHSC as per the GO consists of a majority of public sector personnel and thus cannot be truly considered a community level committee for accountability, for infact the people to be held accountable are members of the committee. This contradiction was discussed in detail at a meeting with the Mission Director NRHM and it was decided to include at least 10 members extra during the training phase of each VHSC, with more members from SHGs other than the nominated member as per GO.	Final decision and amendment of GO needs to be done in this regard. This may be done after the feedback of initial rounds of training for the expanded VHSCs.
4.	Formation of VHSC	This was done through multiple community contacts (a minimum of three public meetings before the formation of the committee were mandated). The NGO facilitator welcomed volunteers, those suggested by the VHN and the Panchayat President. The final composition was ratified in a gram sabha / public meeting.	While the intensity of community contact during the formation of the VHSC varied from Block to block, the essential steps of having all sections of the community represented, and obtaining ratification at a public forum were maintained in all case	This can be continued in the next phase.

5.	Orientation of the VHSC	Material and Handbills were developed by the implementing team.	These have been submitted to the Government. Some of the civil society groups involved in the project were also invited to comment on and develop parts of the VHSC training module developed by the government. A finalized version of the VHSC module has been evolved.	Modular sessions based on the government modules can be developed so that it can be implemented at a large scale.
6.	Monitoring Tool	A monitoring tool which included the quesitons / dimensions to be monitored and essential background information was developed and used.	The monitoring tool was very detailed and bulky. Some of the dimensions measured may not have too much relevance. Need for validation of many aspects. While the color coding was greatly appreciated, the consolidation process was extremely complicated. It was suggested that the VHSCs should only collect user perspectives about the services, while the monitoring with regards to other more technical issues be done by other groups including NGOs etc. Audio/Visual aids suggested.	These various issues need to be worked out in detail. It is proposed that as part of the preparatory phase of the project a workshop to discuss and develop this was planned. The final tools can be evolved in this workshop.
7.	Data Collection	The members of the VHSC along with the	Both the MOs and VHNs were vital informants in	These issues will be discussed at the

		NGO facilitator collected the data in the pilot phase.	many of the blocks, however some of them felt threatened by the data collection. The capacity of the VHSC members need to be developed as an NGO facilitator cannot be present all the time.	workshop on developing the tools. Sensitization of the Public health staff on community monitoring and planning needs to be done pro-actively and is proposed in the next phase.
8.	Data consolidation	Due to the complicated nature it was done by the Block or in many cases the district level NGO.	The tool needs simplification and rationalization – this will be done at the workshop. The principle will be that the consolidation of at least some of the more relevant aspects of the data should be done at the village level.	Can be finalized at the tool development workshop.
9.	Data Feedback	The data was fed back to the community in a series of village level meetings. The information was fed back to the department through public hearings.	Given the sometimes threatening / confrontational nature of public hearings a regular system of feedback to the department in addition to public hearings is required. Making discussion / presentation of Village health report card a core activity of the Panchayat is important. However this needs to come with a commitment from the government for definite redressal of the issues brought to their notice.	Evolve regular protocols for feedback such as : 1) regular presentation at the PHC review meetings, District level review meetings etc. 2) Making it mandatory for the VHreport card to be presented and discussed in the Gram Sabha. 3) Developing clear mechanisms of redressal.

10.	Other uses of information generated.	While examples of the potential types of data that can come out of such an exercise was presented a systematic quantitative exercise was not undertaken due to the small number of villages covered.	This needs to be studied in detail and concepts like triangulation need to be explored. This information needs to form the basis of health planning. Different levels of aggregation of this data can feed into monitoring and evaluation activities within the system.	Workshop of evolution of Health Planning models is proposed.
11.	Transfer of information from Village level upward to state level	It was proposed that this will be done by a consolidation of information from the lower level committees to the higher level.	However this did not happen very actively.	Some specific guidelines for the functioning of the committees at various levels needs to be evolved.
12.	Monitoring / governance	In the pilot phase it was the State mentoring committee that oversaw the implementation as well as the monitoring of the implementation.	This was an inadequate model as pointed out by the external review. It has been suggested to have a separate oversight body completely dissociated from implementation.	Government & civil society organisations to decide on constituting this committee and its composition.

The above tabular columns set out the broad contours of the next phase of the program. Of course this document is also not written in stone and will need to be revisited every year to incorporate the learnings of that period and the insights from accumulated experience.