

# Research Brief on the impact of the Community Based Monitoring and Planning process in the state of Maharashtra



## I. Introduction and background

The Community Based Monitoring and Planning (CBMP) initiative in India has been implemented since 2007 as a component of National Rural Health Mission (NRHM) and later through National Health Mission (NHM). Support for Advocacy and Training to Health Initiatives (SATHI) as the state nodal NGO presently coordinates CBMP activities across 13 districts (including 28 blocks, 189 PHCs and 886 villages) in Maharashtra in collaboration with 21 Civil Society Organizations (referred as partner CSOs), working with the State Health Department. The CBMP intervention, which is a significant process for social accountability of health services, has completed twelve years in Maharashtra state in 2019. Maharashtra's more than decade-long experience provides an important opportunity to assess the impact of CBMP, by analyzing various aspects of the CBMP process, and its influence on the interface between the community health system and communities which access healthcare through this system.

This policy brief is based on a research study undertaken by SATHI, Pune, Maharashtra, in collaboration with Accountability Research Centre (ARC) at American University in Washington D.C. **The study examines the extent to which CBMP processes have positively influenced community - health system interactions, and have contributed to improved functioning of health facilities in those areas of Maharashtra that have been exposed to the CBMP process. It focuses on assessing the impact of CBMP processes on improving availability, access and quality of facilities in health centers; awareness and participation of community-based actors; and responsiveness of the health system to community feedback.**

Using a mixed-methods approach, this research brief maps the impact of CBMP in comparison with areas without intervention of CBMP. **The study elucidates that despite ebbs and flow in the decade-long implementation of the process involving various hurdles, availability of facilities in health centers, awareness and participation of community-based actors, and responsiveness of the health system, is significantly better in CBMP areas compared to non-CBMP areas. Further, it illustrates the contribution and effectiveness of CBMP process in improving the interface between community health system and communities, and subsequently improving health service delivery.**

**Table 1 : Ebbs and flow in a decade of implementation of CBMP process in Maharashtra – some highlights**

Year 2007-09	<ul style="list-style-type: none"> <li>• CBMP initiated in 2007 in five districts (Amaravati, Nandurbar, Osmanabad, Pune and Thane).</li> <li>• CBMP process includes awareness-building, formation of monitoring and planning committees, community assessment of health services and its analysis, public hearings and periodic state-level dialogue.</li> <li>• First state level public hearing was organized in 2008.</li> </ul>
Year 2009-2011	<ul style="list-style-type: none"> <li>• In 2011, CBMP expanded to cover 13 districts and 860 villages, with addition of eight more districts.</li> <li>• Second state level public hearing was held in 2010 wherein various systemic issues, issues related to interdepartmental coordination were raised.</li> <li>• After persistent follow up with state officials, the decision was taken to include one CBMP nodal CSO representative, as a regular invitee in RKS.</li> </ul>

## Year 2012-2015

- Third state level public hearing, which happened to be the last such hearing was held in 2012. Later this activity was removed from the Program Implementation Plan (PIP) itself. Instead, an alternative of video conference was suggested, which was continued only for a year.
- State CBMP committee was formed in 2012. Only two meetings have been held in presence of the State health minister, the last being in Dec. 2013.
- Two external evaluations of CBMP process in 2013, both noted wide range of positive impacts of the process.
- From year 2014-15, besides regular CBMP the process was expanded to include lower intensity CBMP with 34 CSOs in 10 districts involved on voluntary basis. They were not given regular honorarium etc. but were provided trainings, resource material and funds to organize one public hearing annually.
- In 2015, state officials suggested an exit policy for NGOs and transition of the process. In 2015-16, the transition process was implemented by SHSRC in five blocks, which culminated in CBMP being completely stopped in these areas from 2019.
- In 2016, 'public hearing' was reconceptualized as 'public dialogue' (Jan Samvad), modifying its form to include felicitation of well performing health officials, presenting positive stories, along with presenting critical issues from community viewpoint. This change was made to ensure focus on problem solving, while ensuring that no particular official is targeted.
- Decentralized Health Planning (DHP) process (concerning PIP preparation) with participation of diverse stakeholders was effectively led by state and district nodal CSOs on pilot basis in Gadchiroli district in 2014-15. Recognizing its positive impact, process was included in PIP and generalized in CBMP areas in 2015-16.

## Year 2016- until present

- Leadership of DHP process was taken over by SHSRC in 2015-16, following which community and CSO participation in the process got tapered off, and role of non-officials significantly declined within a couple of years.
- Despite administrative and CSO experience in managing CBMP funds disbursement over previous several years, major delays in disbursement of CBMP related funds experienced from 2015-2016 onwards (see next section).
- In 2017-18 following the competitive process at state level, SATHI was reselected and reappointed as the state nodal agency for implementation of CBMP in the state. State also appointed STAPI as one more state nodal agency along with SATHI. STAPI was given charge of implementation of CBMP process in four districts.
- Recognizing the need for streamlining utilization of RKS funds, in 2017-18, Participatory Audit and Planning (PAP) was conceptualized and implemented officially in 189 PHCs from 13 districts under CBMP process.
- In last couple of years, State NHM is keen to show improvements in health indicators set by NHM. Accordingly, SATHI focused on set of specific indicators related to the maternal and child health and demonstrated certain improvements in these indicators in CBMP areas.

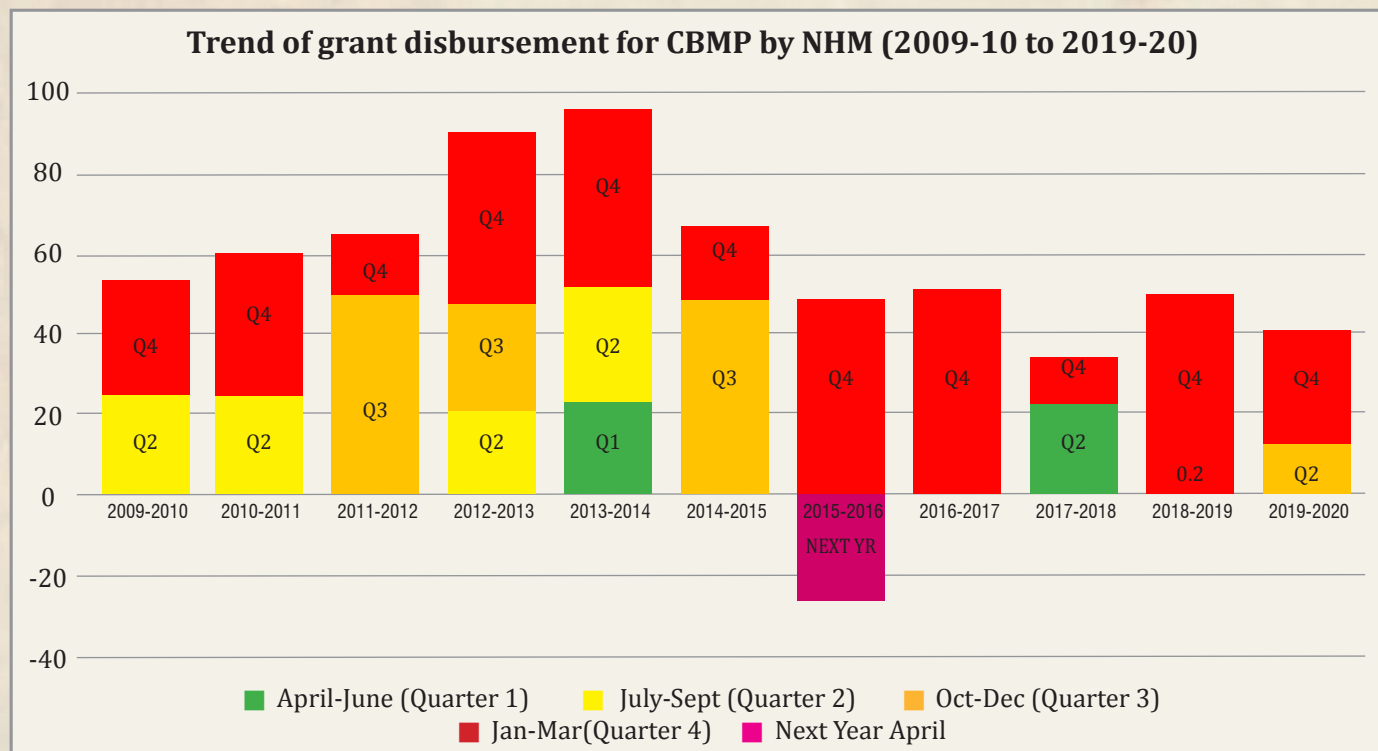
### Trend of fund disbursement for CBMP process (2009-10 to 2019-20)

Analysis of data for eleven years regarding fund disbursement for CBMP (Graph 1) depicts the overall trend of delayed disbursement of funds, affecting implementation of the process majorly especially in recent years. Out of eleven years, only in two years was the first installment of funds received in 1st quarter as required; in three years the funds were received in 2nd quarter; while in six years, the funds were much delayed and received in either 3rd or 4th quarter. From 2015-16 onwards, the total amount received in each financial year has been



only around half of the total expected amount. In 2015-16 there was exceptional delay, and part of the funds were received in April 2016 after the end of financial year. Such recurrent delays have majorly impacted cycle of conducting activities, as well as retention of experienced CSO karykartas. While financial systems are expected to become streamlined with experience over years, paradoxically timeliness of funds release by NHM has overall worsened in last five years (with exception of 2017-18). Such routine practice of majorly delayed contracts and fund disbursement has seriously impacted on completion of planned activities (especially resource intensive activities) leading to unspent budget and carrying forward those amounts to the next year.

**Graph 1**



## II. Key findings

### A. RKS committee members - awareness, functioning and participation

The survey with RKS members from both CBMP and non-CBMP are as focused on understanding awareness among members regarding key facilities in PHC, and roles and responsibilities of a member. They were also asked about their experiences and perceptions regarding capacity building, functioning of the RKS, participation of members in RKS meetings and related activities. Here we summarise comparative analysis of the survey findings from CBMP and non-CBMP areas.

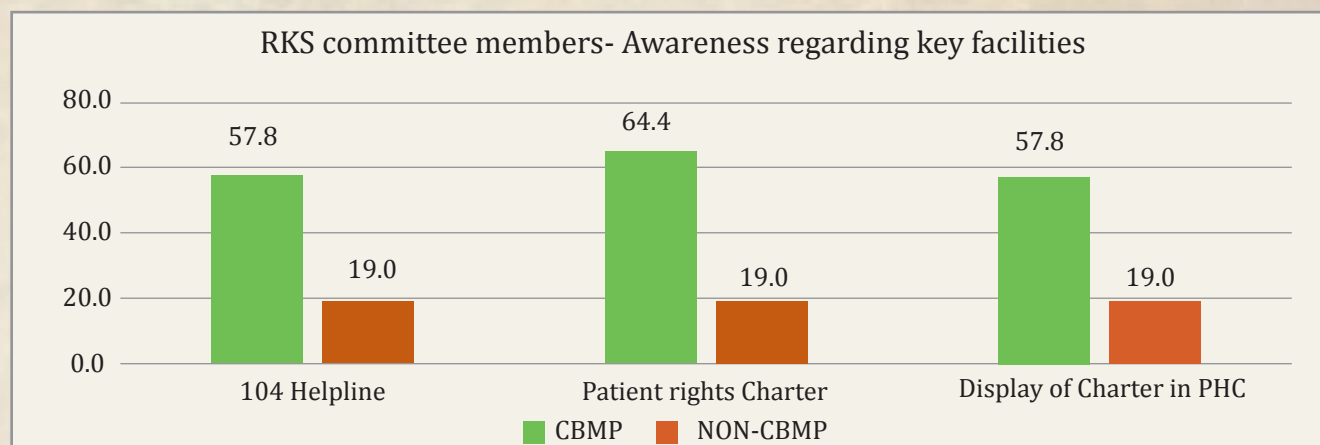
#### i. Awareness among RKS members regarding key facilities in PHC, modalities of RKS functioning, and their roles and responsibilities as a member

##### Awareness regarding 104<sup>1</sup> helpline and patients' rights charter

Respondents were queried on their knowledge concerning certain key facilities at the PHC level (Graph 2). **In CBMP areas, 58% respondents were aware about the 104 helpline, while in non-CBMP areas only 19% respondents were aware about it. Likewise, in CBMP areas, 64% respondents knew about patients' rights charter and 58% respondents could tell us that the charter has been displayed in the PHC. While this proportion is 19% in non-CBMP areas.** This difference is somewhat obvious as CSOs in CBMP areas do give emphasis on health rights, patients' rights and the health entitlements during awareness generation activities, which does not seem to be happening in non-CBMP areas, as reported by respondents.

1 104 is a toll-free number which to be used in critical situations like delivery complications, blood requirements, or in any medical grievances to seek help.

Graph 2



### Capacity building of RKS members

Building capacity of RKS members is an important step towards ensuring their involvement in functioning of this committee. Health department is expected to provide such training. However, the ground reality seems to be different from expectations. **We found 67% of the respondents reported receiving formal training in CBMP areas, while not a single respondent from non-CBMP areas mentioned receiving formal training regarding RKS. In CBMP areas, 71% respondents shared that capacity building workshops were conducted by local NGOs, and 10% respondents mentioned receiving information from health staff.** This indicates the significant involvement of CSOs in capacity building of RKS members in CBMP areas.

### Awareness regarding RKS sub-committees

RKS is comprised of two committees-Governing Body (GB) and Executive Committee (EC). The GB is responsible for policy formulation and oversight, while EC implements policy decisions towards patient centric services. **While 93% respondents from CBMP areas knew about their committee, 31% respondents from non-CBMP areas did not even know which committee they belonged to.**

### Knowledge regarding roles and responsibilities of RKS member

Respondents in CBMP areas were more aware about their roles and responsibilities as compared to those from non-CBMP areas. Nearly all members from CBMP areas described their various roles and responsibilities. **Only 4% respondents from CBMP areas could not tell about their roles and responsibilities, while in non-CBMP areas this proportion was nine times higher and quite significant i.e.36%.**

In a Beed non-CBMP PHC, **one non-official RKS member, a woman who is member of the committee for last six years** was interviewed. **However, she couldn't respond beyond saying that "my husband knows everything",** her husband being supposedly politically powerful person in the village.

It is clearly evident from the above data that awareness regarding roles among RKS members from CBMP areas is considerably higher compared to non-CBMP areas.

## ii. Functioning of RKS committees

### Frequency of RKS meetings

As per guidelines, Governing body is expected to meet at least twice a year while Executive committee should meet on quarterly basis(or as required). **In CBMP areas, 87% respondents reported that frequency of RKS meetings was monthly to quarterly, while in non-CBMP areas only 43% respondents reported meetings were conducted monthly to quarterly basis.**



### RKS fund flow

After completion of financial year, financial audit is conducted and accordingly funds are disbursed for the next year. RKS committee can function properly only if they receive regular supply of funds. **In CBMP areas, 71% respondents reported RKS received funds regularly.** In non-CBMP areas, 48% respondents mentioned receiving funds regularly. Delays in receiving fund is overall one of the consistently observed issues by RKS. Perhaps follow up by RKS members and CSO representatives in CBMP areas, seems to be effective in getting funds more regularly in many CBMP areas.

*“Expenditure copy is also given to each member and is presented and discussed in the meeting’  
(RKS-PRI member from Pune CBMP-PHC)*

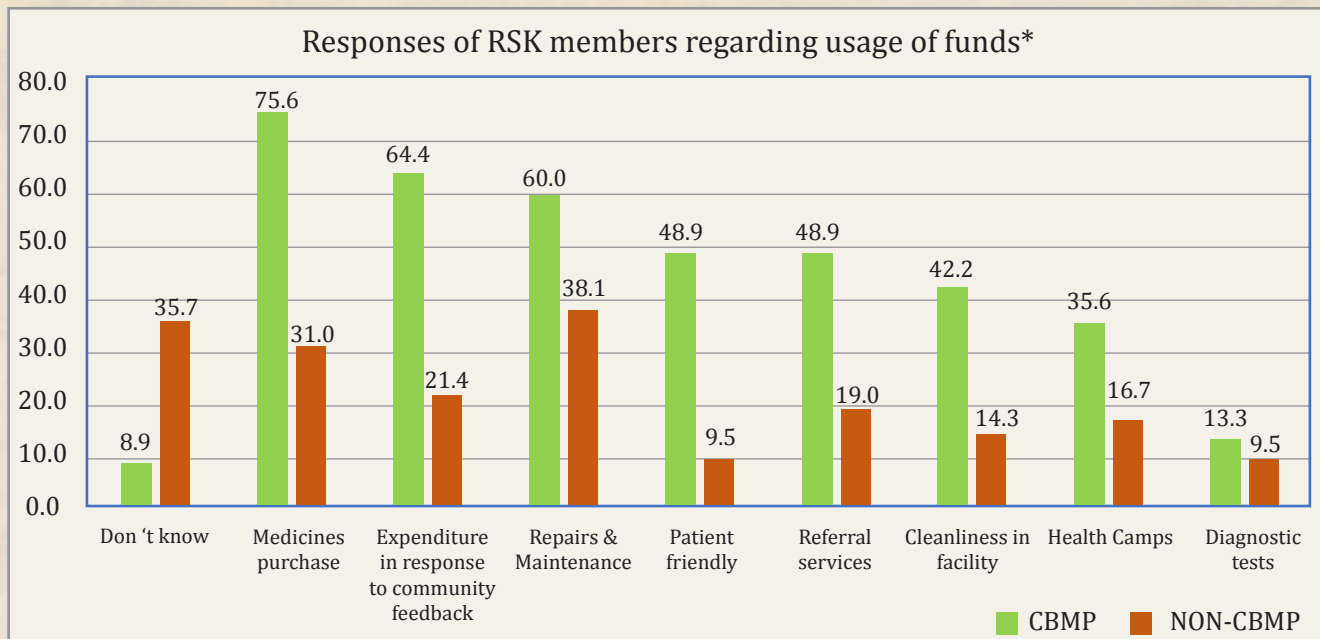
### Display board with RKS members name and contact number in the PHC

About 93% respondents from CBMP areas and 57% in non-CBMP areas reported that the board of RKS members and their mobile numbers is displayed at the entrance of PHC. 16% respondents from non-CBMP areas, didn’t know about such a board.

### Responses of respondents regarding expenditure of funds

**More than half the respondents from CBMP areas reported diversified pattern of RKS expenditure, while in non-CBMP areas, expenditure is mainly on two areas - purchase of medicines and repair and maintenance of PHC (Graph 3). Further, 64% respondents from CBMP areas shared that funds were spent on facilities for patients such as water facility, toilets, sitting arrangement, diet for patients etc. Such patient centric spending was reported by only 21% respondents from non-CBMP areas, indicating the RKS taking active cognizance of people’s needs much more in CBMP areas than non-CBMP areas. Also, more than one third (36%) respondents from non CBMP areas could not give any response about the RKS spending pattern reflecting their lack of involvement.**

Graph 3



\*Based on multiple responses by respondents

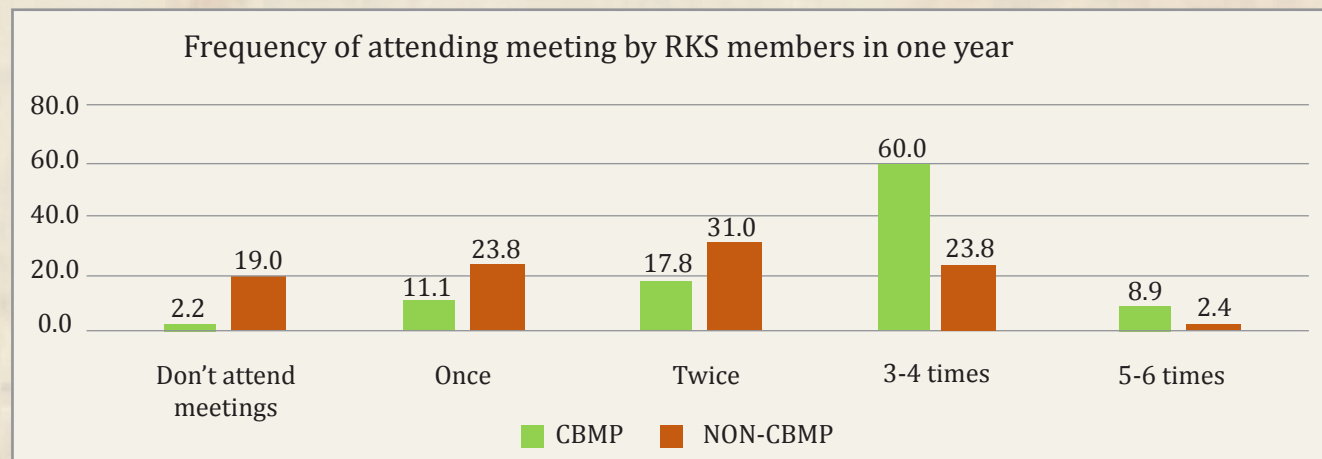
On the whole, RKS functioning seems to be significantly better in CBMP as compared to non-CBMP areas. Meetings seem to be taking place more regularly, and members were able to report in more detail about committees functioning, which reflect their involvement in RKS functioning.

### iii. Participation of members in RKS and related activities

#### Attending RKS meetings

69% respondents from CBMP areas mentioned that they have attended 3 or more meetings in year (Graph 4). In non-CBMP areas, only 26% respondents reported attending over 3 meetings in year. Notably, 19% respondents from non CBMP areas reported that they did not ever attend the RKS meeting.

Graph 4



#### Participation in decision making process in RKS

In CBMP areas, 89% of RKS respondents mentioned that they were involved in decision making process.

*"We collectively take decisions. If the chairperson takes any decisions and we members don't agree then we do object to it sometimes" (CSO representative-RKS member, CBMP-PHC, Gadchiroli).*

*"Water issue in PHC got resolved using 14th finance commission funds" (THO, CBMP-PHC, Gadchiroli).*

*"MO started staying in the PHC quarter" (RKS\_PRI member, CBMP-PHC, Pune, Gadchiroli).*

*Pharmacist's behaviour improved" (CSO representative-RKS member, CBMP-PHC, Gadchiroli),*

*"Sub Centre was made functional" (CSO representative-RKS member, CBMP-PHC, Pune).*

*"Members hardly speak in the meetings and decisions are taken by president of RKS", (PRI member-RKS, non-CBMP-PHC)*

#### Participation of RKS members in village level activities

Participation of RKS members in activities organized by RKS such as health camps, awareness rallies, poster exhibitions and wall paintings, is noted to be much more in CBMP areas as compared to non-CBMP areas. 44% respondents from CBMP and 15% respondents from non-CBMP areas mentioned about their participation in such programs. Raising health services related issues in Gram sabha and Gram panchayat also appears to be better in CBMP than in non-CBMP areas. 53% respondents from CBMP compared to 20% respondents from non-CBMP areas reported raising issues through these platforms.

*"People are disinterested to participate in any such activities" (RKS-PRI members, Beed, Nasik and Gadchiroli non-CBMP PHCs)*

Overall, in non-CBMP areas, it appears that non-official members do not contribute much in RKS. Their attendance in meetings was quite low. Also, RKS in non-CBMP areas seem to be dominated by officials and PRIs, however, in CBMP cases multi-stakeholder nature of committees with active contribution of members seem to be actualised. Active participation of members in CBMP areas seems to a large extent linked with the range of activities undertaken by CSOs implementing the CBMP process.



## B. VHSNC committee members - awareness, functioning and participation

The survey with VHSNC members from CBMP and non-CBMP areas focused on gathering experiences and perceptions of VHSNC members regarding three main themes- awareness regarding roles and responsibilities of a VHSNC member; functioning of the VHSNCs; and participation of members in VHSNC meetings and related activities. In non-CBMP areas, we were short of 33 respondents as we could not locate any committee members in several villages despite efforts. This indicates that in non-CBMP areas, many non-official VHSNC members might be enrolled only on paper. Here we comparatively analyse the survey findings from CBMP and non-CBMP areas, to shed light on the status of VHSNCs in both areas.

### i. Awareness among VHSNC members regarding their roles and responsibilities as a member

#### Knowledge regarding roles and responsibilities of a VHSNC member

**Most of the members (70%) from CBMP areas could talk about their roles and responsibilities** such as to attend VHSNC meetings, understand health problems in the village and discussing those in meetings, monitoring public services and providing information to villagers about health and other services. **In non-CBMP areas nearly half (44%) of the respondents couldn't tell about their own roles and responsibilities.** Further, as noted in an in-depth interview with ANM from Gadchiroli non-CBMP area, **she couldn't tell us anything about VHSNC meetings or about her role in it**, such lack of knowledge in an official functionary reflects low awareness of VHSNC members in non-CBMP areas.

#### Knowledge regarding funds to VHSNC

**Around 58% respondents from CBMP areas could inform the amount of VHSNC funds received by their village as per norm, while only 20% respondents from non-CBMP areas could tell about the amount of funds for their village.**

#### Knowledge regarding composition of VHSNC

**Nearly 90% respondents from CBMP areas correctly listed VHSNC members** as Sarpanch, ASHA, Anganwadi worker, ANM, non-official members, etc. However, **30% respondents from non-CBMP areas couldn't answer this question at all**, reflecting their poor knowledge and participation in VHSNCs.

#### Capacity building of VHSNC members

**50% of the respondents reported receiving formal training in CBMP areas, while only 8% respondents from non-CBMP areas received formal training regarding VHSNC.** On enquiring about source of formal or informal training, **in CBMP areas, 75% respondents shared that it was provided by local CSOs** while in non-CBMP areas 10% respondents reported that such trainings were held by health staff, indicating active facilitation of VHSNCs by CSOs in CBMP areas. Since capacity building activities for VHSNCs seem to have fallen short in non-CBMP areas, reflected in lower level of knowledge among such members.

### ii. Functioning of VHSNCs

#### Frequency of VHSNCs meetings

According to norms VHSNC members should ideally meet on a monthly basis. Data regarding this indicates that the norm is not being followed in both CBMP and non-CBMP areas, however the situation is better in CBMP areas. **In CBMP areas, 46% respondents reported that 6-12 meetings were conducted in a year. In non-CBMP areas, 28% respondents reported that VHSNC meetings were not conducted at all in the past one year, and 22% respondents had no knowledge if meetings were held or not.**



*“I belong to SC category and was quite apprehensive that how could I gather people for the meetings and who will come in the meeting which was Called by me. But with active support from CSO karykartas, I was able to facilitate those meetings well” (Anganwadi Worker-AWW, CBMP-PHC, Beed).*

*“Meetings are done only at the time when funds are received. The proper committee has not been formed. Only AWW and sarpanch are managing the funds.” (VHSNC member from non-CBMP PHC, Beed)*

### Responses regarding the expenditure of VHSNC funds

Respondents were asked if they discuss about how to spend funds during the VHSNC meetings. **64% respondents from CBMP and 21% respondents from non-CBMP areas said ‘yes’, while half of the respondents from non-CBMP areas could not answer this question.**

When respondents were asked about how has committee utilized the funds in last financial year, **in CBMP areas 67% respondents reported fund utilization details** such as spending on food for malnourished children, toys and weighing machines for Anganwadi, repairs and maintenance in Anganwadi, emergency medicines, referral services for poor patients, water purification, sanitation repairs, and health check-ups or camps in village. **However, 76% respondents from non-CBMP areas didn’t know about utilisation of VHSNC funds.** (Graph 5). This suggests that the functioning of VHSNC is more active and participatory with reasonable involvement of VHSNC members in CBMP areas compared to non-CBMP areas.

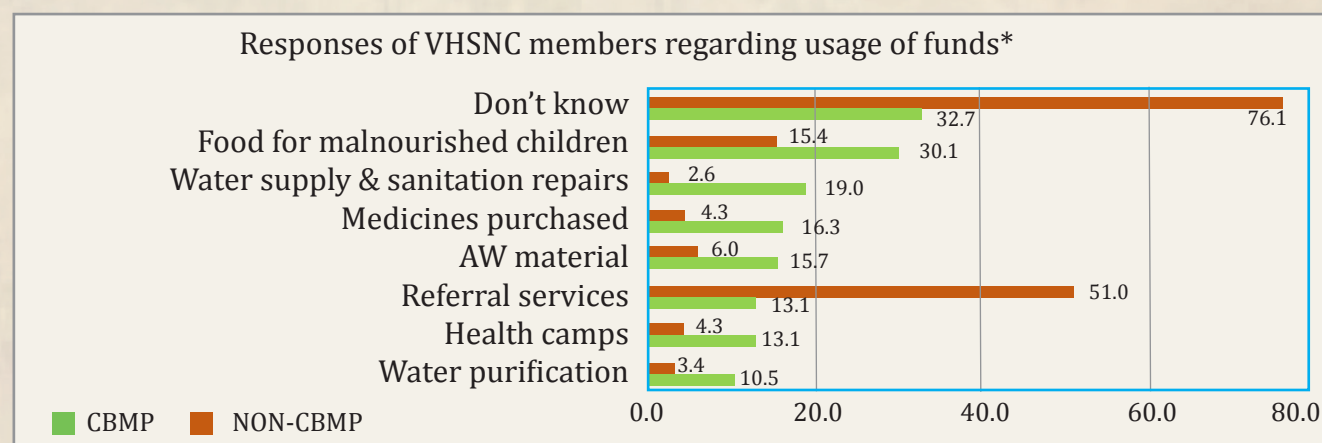
### Maintaining financial records of VHSNC funds

Until August 2018, AWW was the member secretary of the VHSNC. However, later ASHA was given charge of member secretary and hence responsibility of managing the funds. To understand the involvement of members in functioning of committees, respondents were asked about who maintains the financial records of VHSNC funds. **73% respondents from CBMP areas and 45% respondents from non-CBMP areas answered rightly that records were maintained by ASHA or Anganwadi worker.**

### Annual Planning by VHSNCs

69% respondents from CBMP areas said annual plans were prepared by their VHSNCs while only 15% respondents from non-CBMP areas said that VHSNC prepares annual plans.

**Graph 5**



\*Based on multiple responses from participants

### iii. Participation of members in VHSNC and related village level activities

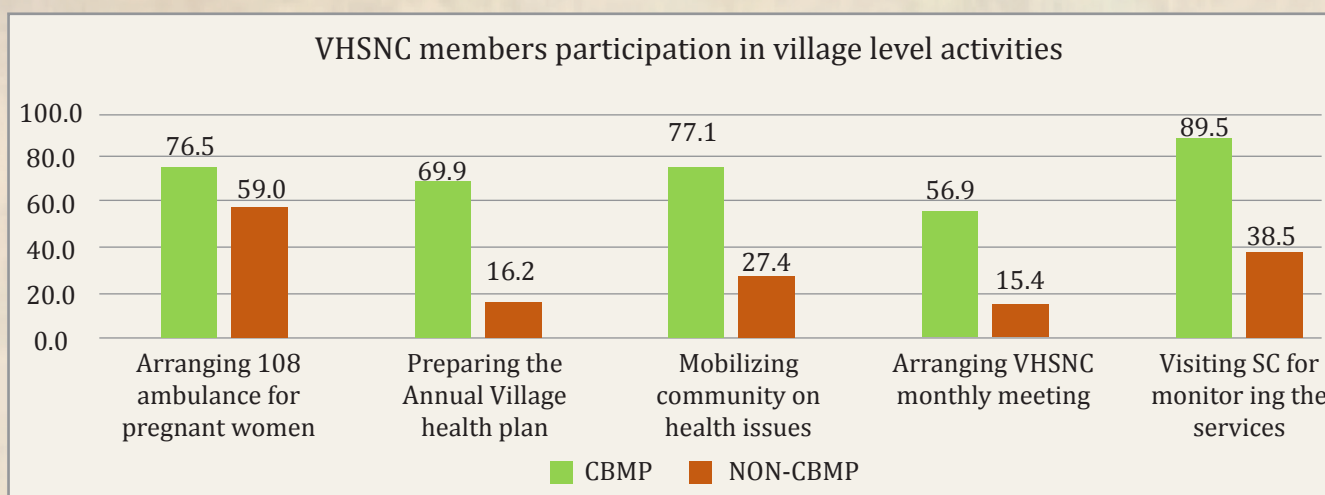
#### Attending VHSNC meetings

Nearly half of the respondents from CBMP areas mentioned that they have attended 3-6 meetings in a year. In non-CBMP areas more than half respondents did not attend even a single meeting in the last year.

*“There is no involvement of members in anything related to committees” (THO, Non-CBMP PHC, Kolhapur)*



**Graph 6**



\*Based on multiple responses

On the whole, participation of members in the VHSNCs appears to be more active in CBMP areas. However, even the minimum expectation of members attending meetings seems unmet in most non-CBMP areas. The state of all three aspects - awareness among members, the functioning of committees and participation of members in the committee are closely interlinked.

These findings in turn also underline the importance of the role played by CSOs implementing the CBMP process, which provide capacity building for members, and also help to activate committees, promote broader participation in their functioning, and raise issues in the meetings.

### **C. Mechanisms for feedback and responsiveness of public health system to community inputs**

During in-depth interviews, we specifically asked respondents from five PHCs each from both CBMP and non-CBMP areas across the five districts, regarding existing mechanisms for receiving community feedback and grievance redressal, as well as patterns of health system responsiveness to issues raised in such manner. Based on analysis of this qualitative data, this section is organized in two parts. The first part of this section describes to what extent existing mechanisms for community feedback are being used in CBMP areas compared with non-CBMP areas. The second part attempts to analyse the processes related to institutional responsiveness of the health system at different levels, including community-oriented problem-solving mechanisms.

#### **i. Status of mechanisms for providing community feedback to public health system**

Table 2 provides a snapshot of the use of various existing mechanisms for community feedback in CBMP and non-CBMP PHCs. Provision of complaint box, hotline, calling an official, Gram Sabha (village meeting), RKS and VHSNCs are generalised avenues which are potentially available for community members to participate and raise issues in both CBMP and non-CBMP areas. Further Public dialogue<sup>2</sup> (Jan Samvad) and CBMP committees are additional grievance redressal mechanisms which are unique to the CBMP areas, being core components of the process. The overall situation regarding level of use of mechanisms for providing feedback and raising issues seems to be high in all CBMP-PHCs from 5 districts.

Use of complaint box was high in all CBMP-PHCs except for Beed district, where it was moderate. According to staff and users interviewed from the concerned PHC, people were well aware of the hotline and use it frequently as required. This is why although complaint box is placed, people didn't use it much. However, in non-CBMP-PHCs from Nasik, Kolhapur and Pune, the hotline is not used. In Nasik and Kolhapur, even a complaint box or register is absent. While forums for community participation and feedback were available in non-CBMP PHCs, the actual use of most of these forums appears to be low.

<sup>2</sup> One of the core strategies of CBMP is the public dialogue or 'Jan Samvad', which is attended by large numbers of community members and diverse stakeholders such as health staff, officials, PRI members, CSO representatives. In these dialogues, people present their experiences and issues regarding health services in the presence of health officials and panelists from various fields and officials are expected to respond and resolve the issues raised.



Non-CBMP PHC from Kolhapur largely demonstrates the poor participation of committee members in the health system. According to the THO, *'complaint box is not placed, people don't even complain through other platforms, rather people just tolerate'*.

In contrast to this situation, **CBMP-PHCs from the same districts set an example of active participation of the community. The local level Grievance Redressal Cell (GRC) has been formed with the initiative of CSO representative, in collaboration with the THO, MO and active villagers.** According to the THO, CBMP-PHC, Kolhapur, *"people mostly call up CSO representatives, who then inform us about the complaint and necessary actions are taken to resolve those issues"*.

This underlines the critical role of 'facilitation' done by local CSOs, implementing the CBMP process as well as ensuring necessary coordination between officials, CSOs, and the community to improving the health system.

In summary, **we find much better use of existing forums for community feedback in CBMP PHCs** as compared to non-CBMP PHCs. Implementation of CBMP appears to have generated mass awareness regarding health rights and entitlements, encouraging community participation in health services, hence community members were actively providing feedback and raising issues to demand improvements.

**Table 2: Use of existing forums for community feedback**

Forums	Level of use of existing forums for community feedback/raising issues*					
		Beed PHC	Nasik PHC	Gadchiroli PHC	Kolhapur PHC	Pune PHC
Complaint box/register	CBMP	Moderate	High	High	High	High
	Non-CBMP	Low	No	Low	No	Low
Use of hotline 104	CBMP	High	High	High	High	High
	Non-CBMP	Low	No	Low	No	No
Direct contact with MO or THO	CBMP	High	High	High	High	High
	Non-CBMP	Low	Low	Moderate	Low	Low
Gram Sabha	CBMP	High	High	High	High	High
	Non-CBMP	Moderate	Low	Low	Low	Low
RKS	CBMP	High	High	High	High	High
	Non-CBMP	Moderate	Moderate	Low	Moderate	Low
VHNSC	CBMP	High	High	High	High	High
	Non-CBMP	Low	Low	Low	Low	Low
PHC level CBMP committee (only in CBMP areas)	CBMP	High	High	Moderate	High	High
	Non-CBMP	Not Applicable				
Public dialogue (only in CBMP areas)	CBMP	High	High	High	High	High
	Non-CBMP	Not Applicable				

## ii. Patterns of health system responsiveness and community-oriented problem solving

We further need to unpack the processes underlying institutional responsiveness towards the community feedback through existing forums in both CBMP and non-CBMP PHCs at different levels, ranging across local, block, district and state levels. In this study, we refer to responsiveness in two ways: firstly, one-off action in response to specific complaints, and secondly responses offering more in-depth problem solving leading to lasting resolution of the issues.

### Action at local-block level

Findings reveal that wide variety of issues do get resolved at the local level which include issues like rude behaviour of staff, ANM not making home visits, irregular attendance of MO at PHC, staff absenteeism, effectiveness of 108<sup>3</sup> helpline for getting ambulance, shortage of medicines, purchase of equipment such

3 108 is a toll free telephone number in many Indian states, to summon emergency ambulance service.



as blood pressure apparatus. Shortage of medicines is reported to be addressed at the local level in all five pairs of both CBMP and non-CBMP PHCs, by offering a temporary solution of local purchase of medicines, which is mostly done using RKS funds.

In CBMP-PHC from Gadchiroli, due to massive shortage of medicines, Sarpanch allotted Rs. 2 lakhs from Gram panchayat funds for medicines purchase for PHC. Although this depicts the severity of the problem, it also shows sarpanch's positive involvement to support PHC functioning, which is seldom seen in other areas.

**It has also emerged that staff-related issues were rarely raised in PHCs from non-CBMP areas. While, in CBMP-PHCs, staff-related issues were commonly raised in public hearings and addressed at the local level by THO. Action by the THO** generally includes, warning staff to improve behaviour or suggesting some adjustments in the timing in case of shortage of staff. In Beed PHC, a board with timings of MO was displayed in the PHC, after raising the issue of staff absenteeism in a public hearing.

### Action at block-district level

Issues such as illegal charging by MO or ANM, purchases or repairs involving major expenses, when raised in RKS meetings and public hearings were found to be resolved at the block-district level. For example, in CBMP PHC of Beed, the issue of illegal charges was identified in public hearing and in response to that warning was given to ANM by the panellists.

On the issue of medicine shortages, in CBMP PHC, in Beed district, the THO took the initiative of an inter-exchange of medicines between PHCs with excess stock and those experiencing a shortage of medicines.

#### **Action against illegal charging- "बदल पाहिजे, बदली नको"**

*'MO used to charge patients for Inj.Rabipur and Inj. Diclofenac. This was noted by CSO representative and active community members. The issue was raised in RKS and in the public hearing. After this THO gave a warning to the MO but his practice of illegal charging didn't stop. The issue was then escalated to the district level. DHO and Deputy Director took a decision and transferred MO to another PHC. As a repercussion of this action, no other MO was ready to join this PHC and then people started complaining about short of MO. Given this, we made a slogan that "बदल पाहिजे, बदली नको" 'we want change in the situation, we don't want just transfers', after which the same MO was re-posted to this PHC. But all these developments created a gap between the MO and people. We tried to improve the interface between MO and people. We also initiated awareness regarding the use and misuse of injection. Gradually it was noted MO stopped taking such charges from people'.(CSO representative, CBMP-PHC, Kolhapur)*

Overall, illegal charging by medical officers was a widespread challenge in the initial stages of the CBMP process. However, at the time of the study this problem was hardly observed in CBMP PHCs. Reduced reporting of this issue in CBMP-PHCs could be regarded as a reflection of the extensive work done in past on this issue by CSOs in CBMP areas.

In CBMP areas major repairs like improved staff quarters, electrical wiring, construction of kitchen, etc. and purchases like water storage tanks, operation table etc. were sanctioned at block and district levels, and were sometimes done using PESA <sup>4</sup>, or 14th finance commission funds. However, in case of PHCs from non-CBMP areas, it appears that responsiveness at block and district level was poor. PHCs where MO or THO were proactive, they followed up with district-level officials however, but most of the demands were reported to be unaddressed. For example, in non-CBMP PHC from Kolhapur, issues like repair of washrooms, labour room, water tanks were raised to district level but remain unresolved, also poor coordination of ambulance under 108 was never addressed and construction of waiting room in PHC was sanctioned after a lot of follow up with district by CSO representative.

Regarding escalation of issues to the district level, THO from CBMP PHC of Gadchiroli shared that, *"issues escalated to district level do get resolved but often requires consistent follow-up and hence causes delays in decision making. District officials often have waiting list of proposals for sanction. Hence follow up is must which is well done in CBMP area through an additional platform of CBMP committee as well"*.

<sup>4</sup> PESA funds- these are additional funds available for use by Panchayats in the Fifth Schedule Areas which have preponderance of tribal population. The Act is called "The Provisions of the Panchayats (Extension to the Scheduled Areas) Act, 1996".



It clearly appears that in CBMP PHCs, follow-ups were done quite well because RKS (and CBMP committees in CBMP PHCs) function effectively as local advocacy mechanisms in CBMP-PHCs as compared to non-CBMP PHCs. Having an additional platform of public dialogue in CBMP areas also seem to be instrumental in gearing up follow-ups and resolution of issues.

For example, according to a CSO representative, CBMP-PHC, Gadchiroli, *"we followed up with DHO and wrote nearly 130-140 letters to him, after which now two water tanks were given and one well is being constructed."*

### Action at the district or state level

Systemic issues like vacant posts of staff and shortage of medicines seem to be a deadlock in both CBMP and non-CBMP PHCs. **Nonetheless, as reported by respondents, in CBMP-PHCs follow-ups were done much better as compared to non-CBMP PHCs.** An example from Kolhapur district exhibits how persistent follow up done by CSO representative and active community can resolve certain issues.

CSO representative, CBMP-PHC, Kolhapur shared that, *"Kolhapur PHCs were facing a severe shortage of MOs, CSO representatives along with RKS, CBMP committee members followed up this issue up to the state level also and finally, Deputy Director was given special power to appoint MO as an exceptional case to resolve the issue effectively"*.

## D. Availability, access and quality of healthcare facilities in five pairs of PHCs

- i. **Availability of healthcare inputs and facilities in five pairs of PHCs** - The data from observation checklist (Table 4) used for checking availability of basic equipment, infrastructure and facilities in PHCs, **suggests no significant difference in physical inputs provided to CBMP and non-CBMP PHCs. However, IEC display was found to be better in all five CBMP PHCs compared to non-CBMP PHCs.**

Table 4

Observation checklist	Nashik		Gadchiroli		Kolhapur		Pune		Beed	
	CBMP	Non CBMP	CBMP	Non CBM	CBMP	Non CBMP	CBMP	Non CBMP	CBMP	Non CBMP
PHC building	Good	Bad	Good	Good	Partly Satisfactory	Good	Good	Good	Good	Good
Staff quarters	Good	Bad	Good	Good	Bad	Bad	Good	Good	Good	Bad
Electricity and Water supply	Good	Good	Good	Good	Good	Good	Good	Good	Good	Good
Availability of essential equipment	Good	Good	Good	Good	Good	Partly Satisfactory	Good	Good	Good	Good
IEC Display	Good	Good	Good	Partly Satisfactory	Good	Partly Satisfactory	Good	Good	Good	Partly Satisfactory

Bad Partly Satisfactory Satisfactory Good

\***PHC building:** functioning in Govt. building and in good condition, **Staff Quarters:** Habitable staff quarters for MO, ANM, other staff, **Electricity supply** with generator backup and **water supply** for whole year, **Availability of essential equipment:** stethoscope, radiant warmer, suction apparatus, Autoclave, Deep freezer, lab equipment, microscope, hemoglobinometer, Centrifuge, Autoanalyzer, testing kits. **IEC display:** Citizen charter, timings, essential medicine list, protocol posters, JSSK, JSY entitlements, immunization schedule.

Overall the physical inputs being provided by the public health system from state and district level to CBMP PHCs and non-CBMP PHCs were found to be largely the same, indicating that such inputs are being provided in uniform manner to PHCs across the state. However, IEC display was somewhat better in CBMP areas, reflecting that this local function is influenced by CBMP processes.

- ii. **Access and quality of healthcare services-** For the users' survey, our original sampling strategy was to select from each PHC area, ten women who had delivered in public health facilities in last six months. While we could locate and interview such women in all CBMP areas, despite significant efforts, in some non-CBMP PHCs we could not locate required number of women who had delivered in public health facilities in last six months. Hence, we modified the inclusion criteria to interview women who had delivered in public facilities in last one year, to ensure the adequate number of respondents per PHC.



However, despite expanding the inclusion criterion to include women with public system deliveries in last one year, **we remained short of 7 user-respondents each in non-CBMP PHCs from Pune and Beed district.** This brings out the worrisome picture of **low utilisation of public delivery care in non-CBMP PHCs; not even ten deliveries had taken place in last one year period in non-CBMP PHCs included in the study.** Despite the fact that CBMP and non-CBMP PHCs have similar state of physical facilities and infrastructure (table 4), **utilisation of delivery services in CBMP PHCs was found to be significantly higher compared to non-CBMP PHCs.**

This correlates with the findings from another analysis of data from NHM HMIS (2013-2017), carried out in 2017-18. According to this HMIS based analysis, the **aggregate scores for key delivery related indicators were 18% higher in CBMP PHCs as compared to non-CBMP PHCs in seven out of nine blocks. In Beed block this difference was noted to be highest, where key delivery related indicators, including utilisation of public facilities for delivery, were 50% higher in CBMP PHCs than in non-CBMP PHCs.**

Regarding quality of health services, we couldn't derive appropriate data from both CBMP and non-CBMP PHCs as respondents couldn't articulate much on quality of care, which could be due to their overall low expectations on quality of services, when services are accessed free of cost.

## E. Perceptions of key stakeholders regarding the CBMP process

In-depth interviews were conducted with 67 key stakeholders - frontline health staff, MO, THO and PRI members and non-official members of RKS and VHNSC, intending to understand their opinions and perceptions regarding implementation and usefulness of the CBMP process. Table 3 lists the respondents' perception of most useful aspects of CBMP process.

**Table 3: Aspects of CBMP process which have been found most useful - feedback from key respondents**

Increased community awareness regarding health services, schemes, entitlements
Enhanced participation of community in health system issues
Improving functioning and outputs from RKS meetings
Participatory monitoring of functioning of PHCs
Feedback provided from grassroots level to health officials regarding health service gaps
Improved dialogue between community and health officials through public dialogue
Following up action on issues and resolving issues at the local level
Improved performance of PHCs with improvement in healthcare services

CBMP process's major contribution in bridging the gap between health officials, staff and community is acknowledged unanimously by respondents. Public dialogue seems to be quite instrumental in increasing community participation in improving health services and changing power relations between people and officials where people raise issues, question officials and officials need to respond to issues presented.

According to THO of the CBMP-PHC from Pune said, *"Public hearing is certainly beneficial where people present issues quite frankly. It's a platform for people to speak out issues, through which communication takes place among users and officials"*.

Overall CBMP process has been found useful in increasing community participation towards improving health services in terms of providing a platform for raising issues, monitoring PHC services, ensuring public dialogue, filling the report card regarding the functioning of PHCs, and following up on issues raised. According to MOs and THOs, CBMP process is important to provide them feedback from grassroots level regarding health centres' functioning, making PHCs and RKS meetings more effective, and helping to resolve issues by follow up with respective officials at different levels.

As succinctly expressed by THO of CBMP PHC from Gadchiroli, *"CBMP is useful in getting people's feedback, to understand the peoples' needs, issues they face"*.

CBMP was also noted to be significant in generating awareness about community health rights and entitlements since awareness campaigns, rallies, and village level meetings are organized through the CBMP



intervention. Hence people are sensitized about health rights approach, and are provided with information about health services, health schemes, programs and related entitlements. Officials find this aspect of CBMP beneficial to fill the gap in awareness among community regarding health services.

Many respondents appreciated the CBMP process for raising and following up of health staff-related issues such as vacant posts and staff quarter facility which were followed by RKS member- CSO representatives and CBMP implementing local CSOs. Such incidences proved to be effective in converting health officials from 'adversaries' to supporters of the process, since they understand that CBMP plays role to support them too, with the broader objective of improving health services with community participation.

### Experiences of representatives of partner organizations regarding the CBMP process

We interviewed 11 senior CSO representatives from CBMP partner organizations to gather their perceptions on the CBMP process.

They highlighted these two issues as major implementation challenges to the CBMP process:

**Follow up:** Respondents reported follow up on policy level issues as a major implementation challenge. Issues escalated to higher levels such as district or state levels requires concerted follow up and despite consistent efforts, often remains unaddressed. According to respondents this leads to people thinking the process is "non-functional" and they may become "disinterested".

**Official delays:** Another implementation challenge highlighted by partner organizations is the major delay in contract renewals and release of funds. Many partner organizations connected other implementation problems such as disruption of core monitoring activities, "instability" within the organization as a result of interrupted work, and 'less motivated staff', to this challenge of regular delay in fund disbursement.

### Methodology of the study

This study adopts a mixed-methods approach, primarily utilizing a paired comparative case study (CCS) design. Paired CCS approach is considered useful to check variation in the outcome of program implementation, when context influences the success of the program, as in case of interventions like CBMP where the process is multidimensional, evolving and is implemented in diverse environments.

**We conducted 67 qualitative in-depth interviews with key stakeholders** such as members of Village Health Sanitation and Nutrition Committee (VHSNCs) and Rogi Kalyan Samiti (RKS), Panchayat Raj Institutions (PRI) and Civil Society Organization (CSO) representatives, Taluka Health Officers (THO) and Medical Officers (MO), to understand participation and responsiveness. **This component is further augmented with RKS and VHSNC survey data from RKS (n=86) and VHSNC (n=270) members across matched CBMP and non-CBMP blocks**, to understand the functioning of RKS and VHSNCs as well as levels of awareness among and participation of RKS and VHSNC members regarding these committees. In addition, **we conducted 11 in-depth interviews of representatives from partner organizations** covering CBMP districts, to understand their experiences regarding implementation of the process. We also draw on **direct observations at selected PHCs (n=10) and SCs (n=10), to understand availability of facilities and users' survey (n=100) for assessing accessibility and quality of health services.**

### Sampling

#### Selection of Cases for paired CCS

Five pairs of PHCs as cases were selected from CBMP and non-CBMP areas, using most similar type of case selection method, wherein only independent variables were used for the selection of cases. The sampling was done in a way to ensure representation across the various levels viz. the region (Vidarbha, Marathwada, North Maharashtra, South Maharashtra, and Konkan), district, blocks, and PHCs. Five districts (having at least one block covered by CBMP), viz; Beed, Pune, Gadchiroli, Nasik and Kolhapur; one from each region was randomly selected where CBMP interventions are being facilitated by SATHI as the state nodal NGO. Criteria for selection of CBMP blocks from five selected districts was: (a) facilitation of implementation of CBMP by SATHI in those blocks and (b) uninterrupted implementation of CBMP for the last five years (since year 2012-13). Blocks from non-CBMP areas which are adjacent or nearby to the blocks from CBMP areas were selected as matching blocks. Further, criteria for matching the CBMP and non-CBMP PHCs were- 1. Presence of at least one permanently posted MO, 2. Total population covered by the PHC, 3. Proportion of SC/ST population covered by the PHC, and 4. Distance from Block headquarter to PHC.

For the selection of Sub centers (SC) attached to the selected PHCs, any one SC with at least one regular ANM posted were selected randomly from both CBMP and non-CBMP areas. PHCs is considered as the primary unit of analysis.

Selection of respondents such as MO, THO, ANM and CSO representative for qualitative interviews was done purposively. Additionally, users' survey (n=100, 10 per PHC) consisted of women who have delivered in public health facilities in the last six months. This was conducted for assessing indicators related to accessibility and quality of health services.



### Selection of sample for quantitative survey

Quantitative surveys with RKS and VHSNC members were conducted in five CBMP and five matched non-CBMP blocks. For both surveys, non-official members were selected randomly from the list of those members who have completed minimum one-year tenure of membership.

For RKS members survey, total 15 PHCs from 5 blocks (3 PHCs from each block,  $5 \times 3 = 15$ ) were randomly selected from both CBMP and non-CBMP blocks. 3 non-official RKS members per PHC were selected, thus covering 45 ( $3 \times 15$ ) members from each arm, total 90 RKS members in the survey. Further for survey of VHSNC members, five members from each of 15 PHCs drawn from 5 blocks were selected, thus ( $5 \times 3 \times 5 = 75$ ) total 75 VHSNCs were randomly selected from CBMP blocks as well as non-CBMP blocks. Hence total 150 VHSNC members ( $75 \times 2$ ) were covered.

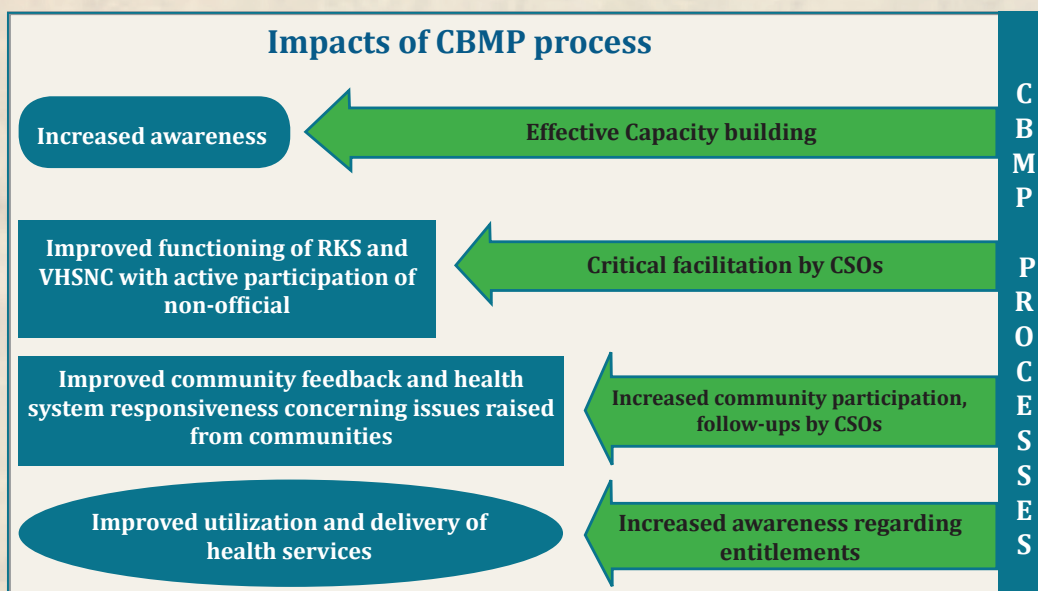
### Data collection and analysis

**The reference period for all type of primary data was previous one year (2017-18).** Instruments for data collection were pilot tested and finalized. Data collection was completed during February 2019 to May 2019. Ethics approval was obtained from Institutional Ethics Committee of Anusandhan Trust.

In-depth interviews were conducted in Marathi. Recordings of in-depth interviews were transcribed. All transcripts were anonymized and coded and categorized using both inductive and deductive codes with assistance from R software. Quantitative data was analyzed using MS excel, based on variables for respective themes. Findings are presented through synthesis of qualitative and quantitative data, using thematic analysis.

## III. Concluding Reflections

As evident from this study, in its eventful journey over the last twelve years the CBMP process has witnessed significant positive impacts, as well as ebbs and flows at various levels. Despite continued support from the State NHM leadership, the process has faced administrative hurdles such as major delays in release of funds, which have affected the implementation of the process. Despite these external constraints, the process has successfully maintained its effectiveness in improving the Health system – Community interface, and has proven to be effective in improving awareness and participation of community-based actors, responsiveness of the health system to community feedback, and availability of facilities in public health institutions. **The pathways of change which have been engendered at various levels through the CBMP process have been summarized in the diagram below**, mentioning the respective sections within this report which provide the evidence for each of these levels of change.



Here we may note that NHM has created potential spaces for community participation (VHSNC and RKS) in generalised manner, however these bodies do not automatically become participatory and active. **For the potential of social awareness and participation to be actualized, dedicated facilitation is required which has been achieved through the CBMP process.** Specifically, this has been achieved by nodal CSOs working to



involve, inform and activate non-official members in RKS and VHSNC. In non-CBMP areas multi-stakeholder bodies were found to be largely dominated by officials, however, in CBMP areas the multi-stakeholder nature of these committees is realised with active contribution of non-official members.

Similarly, operation of community feedback mechanisms and systematic Health system responsiveness to community concerns cannot be derived just by issuing of GRs and formation of related bodies. These **community feedback and responsiveness mechanisms need to be actively facilitated, which has also been done through the CBMP process.** One related unique feature of CBMP has been its **promotion of a 'community-oriented problem solving' ecosystem which may take place through diverse channels** – RKS, CBMP committees, Public dialogue (Jan Samvads), and less formalised but equally important mediation and follow up by local CSO activists. It is relevant to note that the degree of community responsiveness is higher from local to block levels, while this decreases at district and state levels. This is likely to be so because issues are raised more actively at local levels, and also get resolved better locally due to persistent follow up done through the CBMP process.

Further it is evident that **systemic issues remain a roadblock for the CBMP process.** The state level mechanism for dealing with these issues in form of the State Monitoring and Planning Committee (SMPC) has not met even once in last six years, and this key body may need to be re-formed and activated to ensure more effective action at higher levels. Improved community awareness of rights and entitlements in CBMP areas seems to be responsible for **higher degree of utilisation of delivery services in public health facilities** as evidenced through this study.

Overall, the persistence of multi-dimensional positive changes in CBMP areas – including raised awareness among community based actors, more participatory functioning of RKSs and VHSNCs, effectiveness of community feedback mechanisms, operation of responsiveness and problem solving platforms, and higher utilisation of public health services - despite serious constriction of flow of funds for CBMP in recent years, is testimony to the inherent robustness of the process. The next stage challenge is to widely generalise CBMP type processes in institutionalised mode, which will require strong and uninterrupted support from State NHM. Modified strategies are also necessary to carry forward the community mobilisation strengths provided by CSOs, while embedding these within appropriately generalised institutional structures. To address this challenge, all involved actors – government officials and staff, PRI members, CSOs and communities – need to combine their strengths and develop the next round of innovations based on synergising health systems efforts and people's initiative, which is essential to co-produce improved public health.

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