Book 07

PUBLIC HEALTH RESOURCE NETWORK

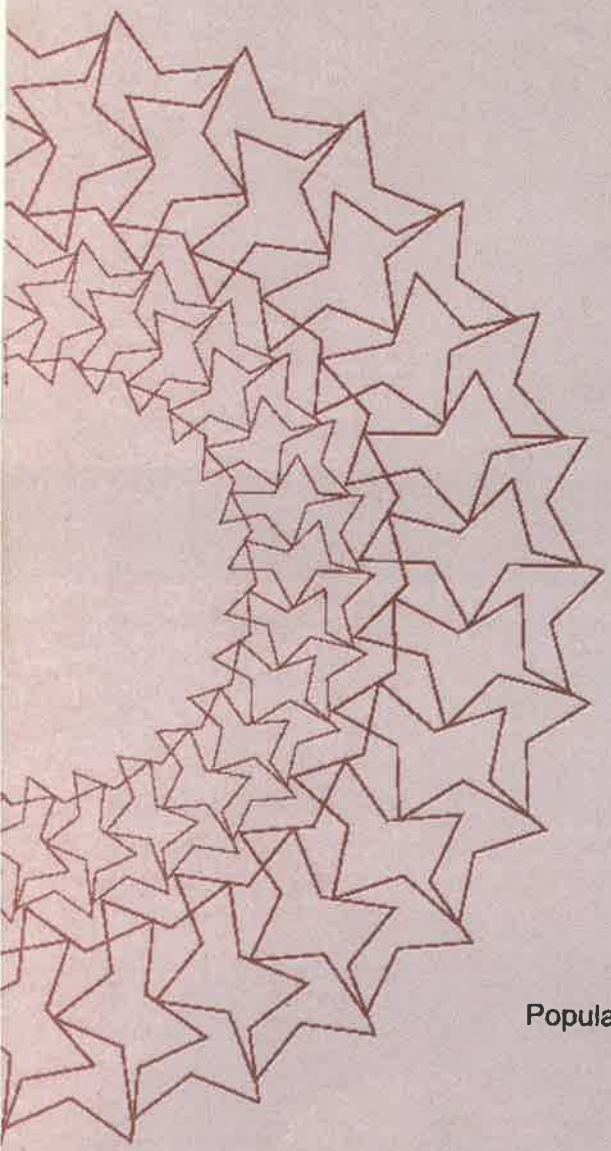
Community Participation

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
(2005-2012)

Book 7

Public Health Resource Network

Community Participation



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Public Health Resource Centre

Partners

National Rural Health Mission

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National Institute of Health and Family Welfare

Department of Health and Family Welfare, Chattisgarh

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Preface

The National Rural Health Mission's vision of a national programme planned at the district level, and if possible at the village level, needs an exponential increase in capacities across the board. The NRHM has initiated many steps in this direction. However the nation is vast and diverse. And there are many constraints in existing planning and implementing structures that would need to be overcome. This calls for the official national mission-led process to be supplemented with many varied, creative and massive endeavors at capacity building. State governments, health resource centers, different professional sections and different sections of civil society all need to contribute to meeting these enormous needs of capacity building.

This initiative, called the Public Health Resource Network (PHRN), aims to provide support to public health practitioners working in the districts in all aspects of district health planning and public health management. The central element of this initiative is a capacity building effort structured as a distance learning programme. This distance learning programme is not a substitute to formal professional public health training and it does not carry with it any guarantees of increased employment or career options. It is meant to support individuals and organisations both within and outside the health department who are committed to working for a more equitable and effective public health system. This programme complements official training and education programmes through an open-ended, more informal and immediate reaching out with information, tools and a diversity of programme options and perspectives.

A Mission needs Missionaries, and it needs them where the challenges are greatest - in the remote and most underdeveloped areas of the northern and eastern states, and indeed in all the under-served areas

of all the states. A Health Mission needs these Missionaries to also be professionals, where being a professional is not one more form of privilege, but a competence that anyone willing to put in the time and effort – and a little expense – can acquire!! Thus the contact programmes at district, regional and state level would evolve into mechanisms of sharing of resources, and building mutual solidarity amongst those who work for change, and of those who work in the health sector because they seek to work for the poor. The true test of the programme is thus not the number of certificates that we issue but the better quality of district plans, a higher motivation of district teams and eventually better health outcomes in the district. The immediate context is the National Rural Health Mission. But hopefully the voluntary network that emerges will contribute over the years to the evolution of a network of district and block level resource groups who provide technical support to all efforts at decentralised planning and decentralised governance and to all societal efforts towards an equitable and just society.

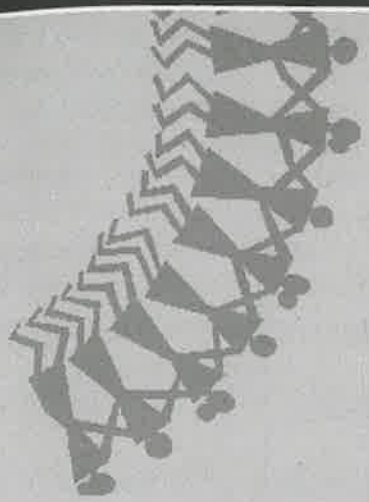
In this book, the seventh volume of the PHRN series, we explore the different meanings of community participation. We discuss firstly the issues of effective local governance as the cornerstone of community's primacy in health plan. Then we discuss village health committees as structures of mediating such local governance and village health plans, and community diagnosis as tools of enabling it. We then consider the role of non governmental organisations and people's movements in facilitating participation of weaker sections in local governance followed by the role of all of these structures together in community monitoring. Public participation in public health management and hospital management is discussed next and we close with a brief consideration of the many possible meanings of 'public' with reference to public ownership of health facilities.

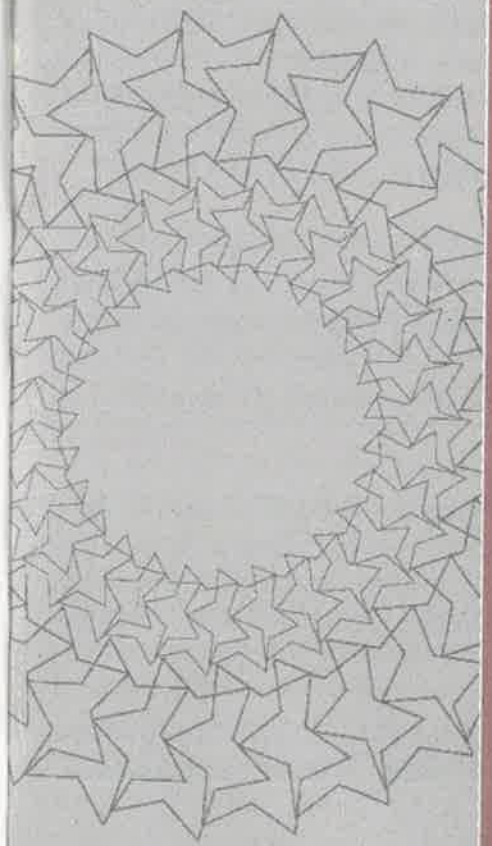
These books are written based on a synthesis of theory from academic public health with experience from district level public health practitioners. Many of the latter have no formal training on public health, but nevertheless are repositories of much public health knowledge. We need to continue this process inspired by a much more democratic vision of how knowledge is created. This book in particular needs much more inputs from many states and districts as the variety of examples alluded to in this book are only a small fraction of the enormous experience that exists in this area. The PHRN looks forward therefore to an active process of feedback and interactions that leads to future editions that are even more enriched by district level experience.

Dr. T. Sundararaman
PHRN Programme Coordinator

Lesson ONE

Panchayati Raj Institutions and Health Programmes





In this lesson we shall discuss:

- Constitutional role and structure of Panchayats.
- Panchayats as structures of governance in health.
- Panchayats as merely a form of community participation in health.
- NRHM and Panchayati Raj Institutions.
- Panchayats in the district health plan.

CONSTITUTIONAL ROLE OF PANCHAYATS

"Panchayats are institutions of governance". What does that mean? Who makes the policies that decide our social life? Who controls the institutions that make policies, that collect taxes, and that decide how to spend the money collected? The government? But who is the government? Who appoints all the government officers? Who do they serve? Who makes the laws? Who has given us our fundamental rights? The Supreme Court interprets and upholds the constitution. But who made the constitution?

We, the people decide, for we the people have given ourselves fundamental rights.

"We, the people of India.....do hereby adopt, enact and give to ourselves this constitution" is what the preamble of the Indian Constitution states. That is why we say "India is a Republic". Which means that the people are sovereign. Which simply means people are meant to rule and to remember this and remind ourselves of this we observe Republic day every year on the 26th of January.

In earlier times it was the king who was sovereign. And the king drew his power from the perception that he represented the divine. Then the country came under the control of the British and they decided the policies, made the laws, collected the taxes and appointed the officers. Such rule was oppressive and people yearned to be free. This gave rise to the Indian freedom movement which ultimately led to Indian independence. People from all sections had united for this freedom movement because the nation was to become a republic, where people themselves ruled. The way in which such rule would be organised is enshrined in the document called the Constitution of India that was drafted and adopted soon after Independence. This Constitution proudly begins with the declaration quoted above.

But how can 'we' decide what 'we the people' want? Especially if there are so many people, and it is a large country. Also, there are so many wants – sometimes different people want opposite things. So what people want is decided by electing representatives – for the parliament and for the state legislatures. It is these elected representatives, who on behalf of the people, control and conduct the government. These are elected representatives of the people who speak and act on behalf of the people. *(The fact that in practice this is not so, is an issue which we will discuss further.)*

However the country is a very large place. Even a single state is very large and the legislature can only decide on a few broad policies. Within this policy framework it becomes the job of the institutions of the state government and central government to deliver the various services and programmes. But since each of the state governments is controlled from the state capital it is difficult to influence them or for them to even know what the *local* need is.

Therefore there is a principle in all democracies that people are best governed from institutions that are as close to them as possible and that such institutions should also be controlled by elected representatives.

As much as can be pragmatically managed by these institutions should be left to them to manage. This principle is known as decentralisation. The term decentralisation is best used only for decentralised governance. If only some administrative powers are transferred to lower authorities without political decentralisation, it can be better called de-concentration or devolution of powers. When decentralisation is without devolution of powers, financial or administrative, it defeats the purpose of decentralised governance.

In India, the institutions of such decentralisation are known as the Panchayati Raj institutions. This refers to an Indian tradition which goes a long way back where there were some broadly equivalent forms of such rule called Panchayats – though there is considerable difference between the modern Panchayats and the traditional Panchayats. Panchayati Raj institutions are really institutions of governance and as central to Indian democracy as the state government or the central government.

STRUCTURE OF INDIAN PANCHAYATI RAJ INSTITUTIONS

Rural India has what we call a three-tier Panchayati Raj system.

Nearest to the people is what are called Gram Panchayats. In some parts of the country a Gram Panchayat has about 10,000 to 30,000 people. In others it has 3000 to 5000 people. Usually it has one or more villages in it. A village is a social unit, but the Gram Panchayat is a unit of governance. The administrative unit called the revenue village may be same as the social village or similar to the Gram Panchayat or may overlap both the above. (All this causes considerable confusion but trying to resolve it and reach common boundaries may cause even more confusion.)

There are many experts who believe that the larger Panchayat is more viable, for one can build up capacities and organise administration more effectively than if the Panchayats are very small. If they are very small, then the Block Panchayat – the second level – may be more viable as a unit of planning and governance. We need to keep this in mind when comparing the experience of different states.

The general body of the members of the Panchayat is called a gram sabha. The gram sabha is an attempt to reach the ideal of direct democracy in contrast to representative based democracy. However, the body is so huge that it is difficult to hold its meetings and these become more an avenue for announcements and a display of some sort of transparency rather than real in-depth decision making. Ideally the gram sabha should be the general body of all members of the village or even the hamlet, in which case every Gram Panchayat would have more than one gram sabha. However in most states, the gram sabha is a general body of the Panchayat. The convening and the functioning of the gram sabha are of much interest and worth understanding further.

The Gram Panchayat usually has 15 members each representing a constituency. One-third of the members

have to be women. The elected head is directly elected and one-third of all Panchayat heads have to be women. Similarly there is reservation for scheduled castes. The constituency which is reserved for women and for SCs is to rotate.

The Panchayat usually has a Panchayat office and one staff member – a paid Panchayat secretary who forms its modest executive arm!

The Gram Panchayat has a number of sub-committees which varies between the states. Most have limited it to three or four committees.

The Block Panchayat is known as the Panchayat Samiti or the Janpad Panchayat. This is contiguous with the administrative community development block (*prakhand* or *vikas khand*). The members are elected directly by the voters and the head of the Panchayat is voted by the members. One-third of its members are women. There is reservation for Scheduled castes and one-third of all heads of Block Panchayats are also women. The Block Panchayat has an executive headed by the Chief Executive Officer or Block Development Officer and a number of officials and employees working under him. Block Panchayats have the manpower, infrastructure and resources to potentially be viable and effective bodies of governance.

The District Panchayat, better known as the Zilla Parishad, is the local governance body at the district level. The District Panchayat has an empowered executive in many states and considerable powers too. The reservations in it are the same as at other levels.

The Nagar Panchayat, the Municipal Council and the Municipal Corporation are the three forms of urban local bodies. The Nagar Panchayat is for small towns, the municipal council for larger towns and the corporation is only for major cities.

The unit of representation for each of these bodies is the ward. In many of the larger cities and towns, municipal councils have considerable powers and resources. Many of them, like the municipalities of Kolkata, Mumbai and Chennai are managing a large number of hospitals and nursing homes and this forms a large and poorly recognised part of the public health system. (We discuss the urban local bodies further in the Book on Urban Health.)

There are, and may be, many problems with Panchayats. They may be inefficient, in capable or corrupt but like any institutions of government that is only a reflection of the problems of inequality and injustice in society. This should be a reason for improving them not for doing away with them or avoiding them. After all, state governments and central governments are also known to have these problems but we persist with them to uphold a democratic system. Thirty years back there were still many people who would say that given the problems of democracy a military dictatorship is better. But over fifty years and

A Historical Perspective to Panchayati Raj

The notion of local self governance is by no means unique to India. But it is interesting to note that the desire to create these with much more powers – almost as self sufficient republics – was a major ideal that animated the Indian Independence Movement. This central importance that the notion of Panchayati Raj had in mobilisation for independence was largely due to the Gandhi's personal conviction with this concept as an ideal. But to Gandhi this was more than a mere institution of local self governance – it was part of his vision for the way the economy and the politics of the nation were to be organised.

Despite this, or perhaps because of this, the promise of local self governance took a long time in the coming. Even today, even the limited modern ideal of self governance (as different from the more romantic village republic) is far from achieved.

In the early phase of Indian democracy, Panchayats were only mentioned in concept in the Directive Principles of State Policy. It is only the 73rd Constitutional Amendment of 1992 that ensured:

- the existence of Panchayats was guaranteed by making it mandatory for state governments to hold local government elections every five years, and within six months if it is dissolved.
- that such Panchayats would exist as three tiers – village level, sub district level, district level, with the gram sabha recognised as part of Panchyati Raj.
- all seats to be filled up by direct election. Chairpersons can be directly or indirectly elected at the gram level and always indirectly at the block and district level.
- seats reserved for SC/ST representatives at all levels and also one thirds of seats at all level for women.

This amendment also specified in what is known as the Eleventh schedule of the Constitution the areas of jurisdiction that come under the Panchayats.

The amendment also mandated that the Finance Commission of each state would state the areas where the Panchayat could raise resources and the amount of funds from various sources that the state would make available to the Panchayats. By law this has to be done every five years to ensure that the Panchayats have adequate resources to be effective. The 74th Amendment made similar provisions for urban local bodies.

numerous examples of failed dictatorships – all more corrupt and inefficient and tyrannical than the worst democracies – we know that for all its failings there is no alternative to democracy. We only need a more genuine and a more participatory democracy and Panchayats are one of the most important ways of achieving this.

UNDERSTANDING THE DEBATE ON PANCHAYATI RAJ INSTITUTIONS IN HEALTH POLICY

The scope and extent of involvement of the Panchayati Raj Institutions in public health provisioning and public health policy is one of the more controversial and unsettled areas of health policy. To understand

this let us look at the dialogue as taking place between two different and opposing positions and then try to reconcile the concerns from which these positions emerge. One position is to discuss Panchayats as a part of the community participation efforts. Another is to discuss Panchayats as part of governance.

Panchayats for Governance of the Health Sector

The position on governance requires Panchayats to have planning, and monitoring and some management functions in the health sector.

One should then not talk of the health department getting Panchayats to do BCC or fulfill family planning goals or reduce epidemics. Rather the Panchayats should talk of getting BCC done by various employees and by other voluntary resources it commands. They should talk of ensuring that people have access to family planning services. They should mobilise the concerned employees and create local participatory structures to ensure that people can take preventive measures against epidemics.

The elected Panchayat member is not a paid member. He or she has to earn their livelihood too. They can only contribute to planning, supervision and decision making that enables the goals to be achieved. Often 'line' department employees talk of Panchayats not doing anything as if they are expected to spend time in helping in service delivery – which is really a failure of understanding. The limited employees of the Panchayat have their own functions to fulfill and they cannot take over other departmental functions.

In a state like Kerala, village level facilities like the primary school, the Anganwadi, the ration shop, the health Sub-center are all placed under the administrative and financial control of the Panchayats. All the employees are Panchayat employees. Block level facilities (and sub-block facilities) like the CHC and the PHC, the middle school etc. are under the charge of the Block Panchayat and the district hospital and the high and higher secondary schools come under the District Panchayat. An IAS officer acts as the executive officer to the chairperson of the Panchayat.

In a few other states, the employees are government employees but placed on deputation to the Panchayats. Otherwise the Panchayats are in control. This is much more the rule in urban local bodies.

If we look at it from the view point of community participation, complete decentralisation is the acme of community participation. People through their elected representatives at the local level actually own, plan, administer and monitor the performance of health services. Of course there is still the need for technical resources. In such complete decentralisation, the center still has an important role to perform. The role of the state-center in a decentralised health sector is to ensure that:

- uneven growth is identified and corrected. Thus some areas cannot be allowed *not* to plan, in the name of decentralisation.

- that equity concerns are taken care of: A minority section may be too weak to secure its rights in a local governance structure while together at the state or national level they are able to secure safeguards for basic rights. This refers to gender equity, equity between different community and ethnic groups and all other marginalised groups whether they are the aged or the handicapped.

- that quality concerns are attended to. The center lays down certain norms and quality standards which are national and state level norms. These define a policy framework within which Panchayats must operate. Freedom and powers do not imply the freedom to do anything – but anything within an agreed upon framework and quality norms.

- provision of an enabling policy framework that ensures that the human resources needed and the technical resources and the financial resources needed for such local planning are available.

Panchayats for mere Community Participation

In contrast to the earlier position, many health planners would attribute only a supplementary role for the Panchayats. Thus the issue is posed as one of 'involving' the Panchayats.

Typically in such a state policy framework, the Panchayat would be represented on a health committee – like the District Health Society or the Rogi Kalyan Samiti. Even then this representation would be not in the position of the chairperson, but as one of the office bearers or as an ordinary member.

In such a framework, the Panchayat is only one other organisation like women's self-help groups or NGOs or youth forums and one has to inform and involve them. Unofficially many employees of the Department may say that whereas the other organisations would actually help in the work, the Panchayat has to be informed and involved because other wise they could create trouble. In a more positive light, they are seen as persons of influence who can be used to make the programme more effective.

In such a framework, the bureaucracy would assign work and even targets for Panchayats to achieve, and look at a system of incentives and disincentives by which they can be persuaded to achieve the same. In the allocation of work, none of the facilities and very little of the resources are transferred to the control of the Panchayats.

Therefore the main concern becomes how the Health Department can involve the Panchayats and tap their concern and their accountability to their electorate to improve the performance of various centrally decided health programmes. This concern is usually expressed as "involving Panchayats to ensure community participation."

The reasons attributed for rejecting the position that increasing Panchayats role in governance is the

only form of community participation are as follows:

a) That Panchayats have poor capabilities. (which is often true, for they never got a chance to develop their capabilities)

b) That Panchayats have poor motivation. They are more concerned about their own welfare than people's welfare (which could often be true as people of influence who are used to having their own way in the village get elected.)

c) That Panchayats are not equity sensitive and may discriminate against women and weaker sections. This is unfortunately true for many Panchayats. In its worst forms it leads to harassment of women employees and those they consider inferior or have power over.

In addition we need to consider the following reasons.

Employees in the Department come from and enjoy a certain social status. Access to government jobs is not easy and social status helps get the job and it enhances status. Subjecting themselves to being governed by elected members, who had until that point not had the privilege of governing, is resented and rejected.

Also, the authorities at the state and district level have got used to a certain set of powers today. Parting with it is difficult.

Reconciling the Two Positions: A Way Forward

In practice, most districts and states have a position that strikes at various mid points between the two polar positions described above. The exact position arrived at is a function of the relative strengths of the two groups of stakeholders and the awareness of the Panchayats of their role and their rights.

Thus in a politically conscious state where many of the elected leaders are highly educated, belonging to political formations who have to be seen as having contributed to improving the status of people's lives, there is a much larger chance of such decentralisation being put in place. It is not surprising that the maximal decentralisation, the largest public health system and the best health status are all three present in the same state – Kerala. In such states the problems of inequity are less because the poor are organised and redressal mechanisms are effective.

In other states where there is a high degree of inequity in the village and Panchayats contribute to change much more slowly if at all, it is the latter approach that predominates and PRIs become merely one other

Case Study: What did Kerala really do?

Decentralisation and Health: Six key issues addressed in Kerala

- Functional clarity – all development functions transferred from district level to local government.
- Transfer of human resources – balance between disturbing staff cadres, dual control, authority to penalise for non performance, fair and open transfer policy, and protection of professional interest through Code of Conduct.
- Transfer of funds – One third of Plan funds devolved to PRIs, 90% in untied form within a broad policy framework, with 30% in productive sectors, not more than 30% in roads, and at least 10% in gender sensitive schemes, flow of funds procedure designed, traditionally non-plan funds are also given.
- Decentralised Participatory Planning – needs identification, situation assessment, plan development and approval.
- Good Governance – transparency, Right to Information, De-bureaucratisation, especially in technical matters, Code of Conduct, Citizen's Charters, simple Office Management Systems.
- Capacity Building – general and theme based training.

The Kerala experience in strengthening PRIs, while not immediately and completely replicable, offers useful insights and lessons. Several factors influence the progress of decentralised planning and implementation, not the least being political will, and people's readiness to engage with decentralisation.

organisation involved in implementing national health programmes. If we study it most closely, most states are not in one position or the other but moving towards the first position with different rates from the latter position, at which all of them were. This gradient, along which change is occurring, is present within states and districts also – as it is between states. As the weaker sections of society become organised and politically conscious, they demand more accountability from elected representatives. Representatives of local governments are far easier to hold accountable and even to replace than members of parliament or legislatures. As local governments improve their functioning, public services improve and people get empowered setting up a positive feedback cycle of change.

The question then is, how to construct programmes at the district level so as to accelerate this change? It is true that Panchayats in poor performing states have low capacities, poor governance and high inequity. But this is true of their higher levels of governance also (after all why are they poor performing states)? The approach therefore is to look for encouraging such community participation processes as would lead to increased capacity of the Panchayats. Community participation programmes should also be designed to strengthen equity concerns and empower weaker sections within the Panchayat so that they get their due place not only in access to basic services but also in decision making.

This is the task that this Book undertakes. An earlier module (Book 4) had discussed community participation in the context of community health workers. But community health workers are only the starting point to get a process going. Beyond the community health worker is the process of building the community's capacity to understand the health situation in the village (Lesson 3), to arm the community to plan for it (Lesson 4), to enable the community to seek out technical resources from pro people NGOs and peoples movements (Lesson 5 and 6), to monitor the health services (Lesson 7) and to participate in the management and ownership of public health facilities and programmes (Lesson 8).

We could have addressed the issue as one of community participation in TB control programmes, community participation in vector control programmes, community participation in RCH, community participation in HIV control, community participation in RCH programmes, community participation in blindness control etc., but we have not done so for that is a different approach to community participation. Of course each of these aspects is essential and funds may also be available along these heads, but these need to be brought into the larger understanding of community participation.

Community Participation and Decentralisation in the NRHM

When the NRHM talks of community participation, it talks of this primarily in the context of decentralisation. We quote from the NRHM below:

In the vision statement itself, the NRHM states its goals to include:

- *To set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure.*
- *To provide an opportunity for promoting equity and social justice.*
- *To establish a mechanism to provide flexibility to the states and the community to promote local initiatives.*
- *To develop a framework for promoting inter-sectoral convergence for promotive and preventive health care.*

In the section on the core strategies of the Mission the NRHM states:

- *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.*

In the section on "Institutionalising community led action for health", the NRHM states:

Nearly three fourth of the population of the country lives in villages. This rural population is spread over more than 10 lakh habitations of which 60% have a population of less than 1000. If the Mission of Health for All is to succeed, the reform process would have to touch every village and every health facility. Clearly it would be possible only when the community is sufficiently empowered to take leadership in health matters. The Panchayati Raj institutions, right from the village to district level, would have to be given ownership of the public health delivery system in their respective jurisdiction. Some States like Kerala, West Bengal, Maharashtra and Gujarat have already taken initiatives in this regard and their experiments have shown the positive gains of institutionalising involvement of Panchayati Raj institutions in the management of the health system. Other vibrant community organisations and women's groups will also be associated in communitisation of health care.

The NRHM would seek to empower the PRIs at each level i.e. Gram Panchayat, Panchayat Samiti (Block) and Zilla Parishad (District) to take leadership to control and manage the public health infrastructure at district and sub district levels.

- *The Village Health and Sanitation Committee (VHSC) will be formed in each village (if not already there) within the over all framework of Gram Sabha in which proportionate representation from all the hamlets would be ensured. Adequate representation to the disadvantaged categories like women, SC / ST / OBC / Minority communities would also be given.*

- *The Sub Health Centre will be accountable to the Gram Panchayat and shall have a local Committee for its management, with adequate representation of VHSCs.*

- *The Primary Health Centre (not at the block level) will be responsible to the elected representative of the Gram Panchayat where it is located. All other Gram Panchayats covered by the PHCs would be suitably represented in its management.*

- *The block level PHC and CHC will have involvement of Panchayti Raj elected leaders in its management even though Rogi Kalyan Samiti would also be formed for day-to-day management of the affairs of the hospital.*

- *The Zilla Parishad at the district level will be directly responsible for the budgets of the health sector and for planning for people's health needs.*

To institutionalise community led action for health, NRHM will seek amendments to acts and statutes in

States to fully empower local bodies in effective management of the health system. NRHM would attempt to transfer funds, functionaries and functions to PRIs. Concerted efforts with the involvement of NGOs and other resource institutions will be made to build capacities of elected representatives and user group members for improved and effective management of the health system. To facilitate local action, the NRHM will provide untied grants at all levels [Village, Gram Panchayat, Block, District, VHSC, SHC, PHC & CHC].

Key issues in PRIs making a difference

- **Empowerment of Panchayat and the assured availability of adequate funds, clear articulation of functions, & transfer of requisite functionaries to carry out such functions.**
- **Enlisting NGO support in building capacity among PRI members to efficiently handle development related functions.**
- **Repealing penalties and disincentives such as the two child norm, which violate individual rights.**
- **Critical role of Panchayati Raj Institutions in the success of the NRHM – planning, implementing, monitoring, inter sectoral convergence, community ownership.**

FROM COMMUNITY PARTICIPATION TO DECENTRALISATION

Panchayats in the District Plan

The main steps needed for decentralisation are to be taken at the state level. It may be argued that there is little scope for the district plan to contribute unless such action at the level of state policy precedes it. However to facilitate this process and to make it more useful when it happens, there is need for the district health plan to engage with Panchayats in a number of ways.

Even within the logic of PRIs as merely another opportunity for community participation, they are the most important organisational form in which the community must be involved since they are elected representatives. However, when involving PRIs, the goal is not only to implement a national programme, it is also to ensure that in the process there is capacity built up in these institutions and that there is greater role in planning and monitoring and management and ownership of the public health system. It is not just that the involvement of the PRIs is an instrument of achieving health goals. Equally the achieving of health goals is also an instrument of strengthening PRIs.

In this spirit, there are many processes in which Panchayats can play a central role. These would include:

a) **Initiating organisations and institutions of people's participation.** This enables weaker sections to participate and also facilitates people's participation. Many health programmes require such organised people's participation. Village sanitation, vector control, addressing social exclusion from services, health campaigns for behaviour change where the behaviour is one that the majority

of people have to change, are all examples of such programmes. The next lesson – Lesson 2 discusses this.

b) **Village Health Planning** is another major area of community participation. This requires tools of assessing the health status and eliciting people's views and needs. This is discussed in Lesson 3 and Lesson 4. It also requires skills to identify goals and build indicators and monitor the programmes. It also needs to create an enabling environment where village health planning is encouraged, and used to decide on allocation of resources. One example of doing this is also described in Lesson 4.

c) To **plan and effectively manage health programmes**, one needs technical resources. Empowering Panchayats with financial and administrative powers without building technical and management capacities is a prescription for disaster. Therefore when Panchayats are ineffective, despite the transfer of financial and administrative powers, it would discredit the whole hard won battle for decentralisation of powers to Panchayats. Lesson 5 discusses the role of NGOs and how they could help with the process of making community and PRI participation more effective. Non governmental organisations and Panchayats are often seen as vying for the same space in a village context. There is also concern that Community Based Organisations, such as Self-help Groups and Users' Associations are getting direct funds, thus bypassing Panchayats. NGOs are often equipped with professional staff and financial resources to undertake developmental work, while PRIs are not. Thus Panchayats are often sidelined. However where the NGO's mandate is community participation and strengthening participatory processes, PRIs are central to their work. NGOs could be involved in PRI strengthening in a variety of ways, including

It is not that the involvement of the PRIs is just an instrument of achieving health goals. The achieving of health goals is an instrument of strengthening PRIs.

consciousness raising, provision of technical advice, support in participatory planning, capacity building and facilitating monitoring processes. They could also play a critical role in community and social audits to improve accountability. NGOs that have sectoral competency could serve to support PRI in village and block level planning based on local needs and resources.

d) **Addressing equity issues** within Panchayats remains a central problem of decentralisation. One important way forward is to help the marginalised sections organise and assert their rights and ensure their participation through the village planning process and through other processes.

For this, people's movements which are organisations of weaker sections and committed to change and equity are important allies. Though many of these may be hostile to the idea of working with governments their cooperation needs to be secured. Lesson 6 gives us an understanding of some important people's movements and campaigns. Addressing equity issues also involves monitoring for ensuring equity.

e) **Monitoring of health programmes and facilities** is also another major role that Panchayats and communities must play. Important reasons for this are to ensure accountability, to facilitate services, and to identify areas where community response is needed. Community monitoring is discussed in some detail in Lesson 7.

Repealing penalties and disincentives such as the two child norm, which violate individual rights and discriminate against women's participation in Panchayats

Several states include disincentives in their population policies. The *most draconian is that which bars people who have more than two children from holding office.* Such policies are anti-women, anti-poor, anti-dalit, and threaten to undo the good of a decade's work in enabling poorer and marginalised sections and women in particular to participate in political processes. They feed son-preference actions such as sex selective abortions, pushing down an already unfavorable sex ratio. There are cases of women being abandoned, the third child given away or disowned, and consequent denial of the child's rights. Policies and laws such as this need to be repealed or they might have serious negative consequences for women and society at large. Population stabilisation is a function of women's empowerment, access to high quality RH services and equal participation of men. PRIs should be encouraged to support these interventions to further promote improved health.

f) The role of PRIs in **hospital management and district health administration** varies from a formal token involvement to active participation to actually being in control and the owners of the hospital. The issues involved in this and the way forward is one of the most important areas in decentralisation. Even where powers have been decentralised the technical dimensions of the task can make such decentralisation ineffective. Lesson 8 looks at the various dimensions of this area.

g) There are a number of **other health related functions** that in most states the PRI already perform and even in other states the PRI ought to perform. The most important of this is the registration of births, marriages, and deaths. The goal of 100% registration of births, deaths and marriages is a social priority and something that we should try to achieve within 5 years. Other related functions are enabling death audits, ensuring transport for emergencies, ensuring legal provisions regarding age at marriage.

Capacity building of Panchayats

Capacity building of PRI is required in thematic areas, leadership skills, negotiating, monitoring, and in ability to withstand patronage and political interference- at least where there is the desire to do so. Capacity building processes and content need to be tailored to literacy levels, sex and circumstances of PRI members. Experience has shown that internalisation of new knowledge and skills is much more effective through peer learning processes and exposure visits in similar contexts. Where women PRI are to be trained, female trainers are much more acceptable. Capacity building of PRI members should also include information on legal provisions and government schemes within the purview of PRI. The role of NGOs in effective capacity building has been appreciated in many programmes. State level institutions are also active.

I. Review Questions

1. What are the three tiers of the Panchayat structure?
2. Why is there a commitment to Panchayati Raj institutions?
3. What are the reasons given for failure to decentralise and what are the constraints in decentralisation of power to PRI?
4. How does the NRHM relate the concepts of community participation and decentralisation?
5. How does health sector involvement strengthen Panchayati Raj institutions?

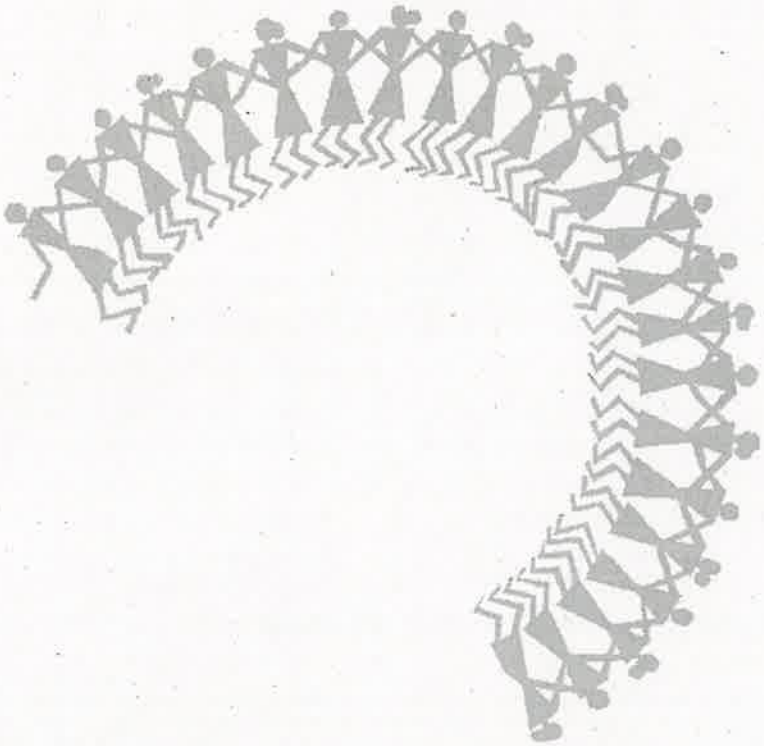
II. Application Questions

1. In many areas the district hospital is in an urban area but it serves a rural population. So who should have control - the municipal corporation or the zilla parishad ? How does one resolve this problem?
2. What is the involvement that MLAs and ministers have in the district health society and hospital development committees? Does this cut into the role of elected Panchayat representatives or enhance it? Would it be better to have only the Panchayats involved or should we have both?

III. Project work

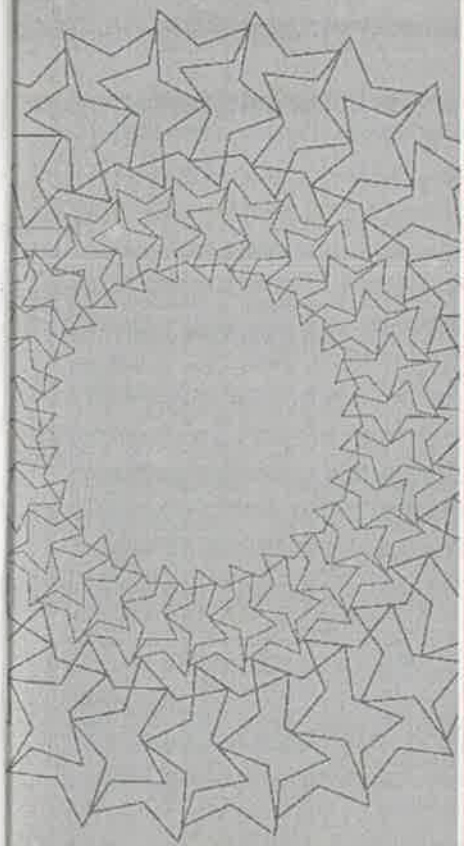
1. What roles are Gram Panchayats playing in the health sector in the district? Discuss with a few Panchayats to find out their views.
2. What is the role the zilla parishad and Block Panchayat has in the health sector (on paper and in practice)?

NOTES



Lesson TWO

Institutionalisation of Community Participation: Village Health Committees and Community Based Organisations



In this lesson we shall discuss:

- Types of community based organisations including village health committees.
- Relationships of different community based organisations to Panchayati Raj Institutions.
- Suggested processes of forming village health committees and other organisational forms of community participation.
- Common roles for the village health committees.
- Guidelines in the NRHM.

WHY DO WE NEED TO INSTITUTIONALISE COMMUNITY PARTICIPATION IN HEALTH?

Informed and involved communities can have a major impact on health practices and outcomes. The behaviour and practices that people follow are much influenced by the values and practices of the group or community they identify with. It is known that addressing people as individuals and families has little impact unless there is also an effort to influence them as a community.

But community participation is much more than merely securing people's participation in making some health programmes successful. It is a process that enables citizens to become an essential part of decision making and actions that affect their lives.

Such community participation works at various levels. Community participation could be a part of combating exclusion, empowering people, mobilising resources and energy, developing integrated locally appropriate approaches to improving health care of for ensuring ownership and sustainability of programmes. Community participation draws on the energy and enthusiasm that exists within communities to be healthy and active and in control over their own lives. The various ways by which or levels at which community participation may be enhanced are discussed below.

Constant consultation by the decision makers

We saw in the earlier lesson that the elected Panchayat is the representative and official expression of the will of the community. However for any elected body to remain in touch with all sections of the community it needs institutional mechanisms of consultation. The further removed the body from the people, the more the need for such mechanisms.

Thus the Gram Panchayat has the gram sabha. Even then we shall see that it needs other organisational forms of community participation. But the Janpad Panchayat has no equivalent direct contact with all people, and the District Panchayat is even further removed. By constructing a number of sub-committees it is able to discuss various aspects in detail. Also by listening to various bodies representing different sections of the people it can understand their views and this would guide its decision making. Sometimes elected representatives think that because they are elected, their views always reflect people's views. However more capable representatives know that this is not the case and they consult with different bodies that represent people. Often elected bodies have to create organisations or institutional forms in which the community can put forth its views and discuss alternatives.

Technical consultation

Another reason for having organisational/institutional forms through which community can participate is because there is a need to understand choices of technology and take in technical inputs. No one lifts

themselves up by their own boot laces. Taking technical information from outside is essential and such information is also community knowledge accumulated from a wider part of society. Even the community's own experience has to be analysed and understood and remembered for guiding action in subsequent years. This is called 'institutional memory.' All of this needs institutional/organisational forms within which community participation occurs.

Promoting Collective Action

Another major reason for building up organised forms of people's involvement is because many changes require collective action by people. Some of the more common examples are cleaning the village of rubbish and stagnant dirty water, or reducing vector breeding sites. However even in aspects like promotion of breastfeeding or timely and adequate introduction of complementary feeding, which are normally seen as family or individual actions, a collective decision to promote these concepts and many persons taking up local advocacy for such issues makes a huge difference. They also require the building of community level systems for support, such as crèches. Indeed on many issues of changes in health care and health related practices, unless it is taken up at this collective level, change does not occur. Individuals and families respond only in an enabling environment created by collective action.

Ensuring Representation/Empowerment for weaker sections

Very often the will of the community becomes in practice the will of the dominant or privileged people within the community. Usually the privileges of these few come from either being the owners of the means of production (land, factories, workshops, money lenders etc.) where others are dependent of them for their livelihood, from their caste or gender status or from their connections to powerful people outside the village or combinations of these factors. Whenever a call for community involvement is given and the actual process is left to spontaneity, what happens is that the powerful people within the community would decide and the weaker sections are often not consulted and they may have to remain silent. This is particularly true of the poorest or the most marginalised 10 to 20% of the population who would be in a minority and therefore even the will of the majority may not favour them. And of course seldom will the majority be ready for affirmative action that treats these poorest 20% preferentially. Unless there is a conscious effort to create organisational or institutional forms where they are represented or where they can be organised and empowered to participate, they would remain excluded. Sometimes when the programme is aimed to meet only the weakest sections without an external force like a pro-poor NGO or a sensitised officer meditating, the weaker sections cannot find their due place even by organising themselves.

Building Sustainability and Institutional Memory

Community participation needs to be sustained. Individuals may move on, may lose interest, may have different personal reasons for withdrawing, or there may be changes taking place due to electoral

processes and rotation of responsibilities. Yet, the experience and learnings from past community participation needs to be recorded in collective memory, so that those entering decision making do not start fresh, but build on the past. This is the notion of institutional memory – of building an organisation where within the system, past knowledge is retained and transmitted. The functionaries who do this work and the sources of funding for the programme itself also need to continue so that the benefits continue. This along with institutional memory is the notion of sustainability. This too requires organisational and institutional forms.

VILLAGE HEALTH AND SANITATION COMMITTEE IN THE NRHM

In the National Rural Health Mission's Framework for Implementation there is a section on "Strategies for institutionalising community level action for health". This section clearly states :

The Village Health and Sanitation Committee (VHSC) will be formed in each village (if not already there) within the overall framework of Gram Sabha in which proportionate representation from all the hamlets would be ensured. Adequate representation to the disadvantaged categories like women, SC / ST / OBC / Minority communities would also be given. The Sub Health Centre will be accountable to the Gram Panchayat and shall have a local Committee for its management; with adequate representation of VHSCs.

The Framework for Implementation also states that:

Village level Health and Sanitation Committee (VHSC) will be responsible for the Village Health Plans. The ASHA, the Anganwadi Sevika, the Panchayat representative, the SHG leader, the PTA/MTA Secretary will be key persons responsible for the household survey, the Village Health Register and the Village Health Plan.

In paragraph 52, the Framework of Implementation further states that:

A revolving fund would be set up at the village level for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalisation. The fund would be operated by the VHSC. Untied fund would also be made available to VHSC for various health activities including IEC, household survey, preparation of health register, organisation of meetings at the village level etc. Since VHSC would be asked to play a leading role in the health matters of the village, its members would be given orientation training to equip them to provide leadership as well as plan and monitor the health activities as the village level.

Thus we can see that the notion of the Village Health and Sanitation Committee forms one of the core strategies of the NRHM. Its key function is the village health plan – not only making the plan, but implementing it as well – for which an untied fund per village committee is sanctioned.

Indeed it promises that '*every village with a population of up to 1500 will get an annual untied grant of up to Rs. 10,000, after constitution and orientation of Village Health and Sanitation Committees*'. The untied grant is to be used for household surveys, health camps, sanitation drives, revolving fund etc. The national budgetary allocation for this item alone would exceed Rs. 400 crores annually. Obviously there is a serious intent at some level to go down the road of village committees which is very different from past expressions of intent (because the village health committee is by no means a new idea). However it is also worth noting that after one and half years of NRHM's initiation – no funds have been released against this head. Obviously there are serious constraints in getting this programme going.

POSSIBLE FORMS OF VILLAGE HEALTH AND SANITATION COMMITTEES

There are many possible interpretations of the mandate to form village health and sanitation committees. But first we need to examine what exists on the ground in different states.

The Statutory Panchayat sub-committee Model (Model 1)

One form of village health committee is as a statutory sub-committee of the Panchayat. For example, one state defines the composition of the VHSC as made up of:

- the sarpanch as chairperson
- four of the elected panches as members
- nominated two persons as non-voting members
- a further optional two persons related to a health or ICDS or education department as special invitees.

This committee looks after school education, health care, ICDS, sanitation and welfare and sports. In this structure the Panchayat has two other sub-committees - a statutory development committee and a general administration committee.

The strengths of this committee structure are that it has adequate Panchayat involvement and there is also enough space for peripheral department staff to interact with it. The committee is small and its topics are integrated and it would have a high chance of being functional. The main weakness of such a structure is that it would be dominated by a few and it cannot even provide a wide ranging consultation with different sections. Weaker sections would almost get excluded. One problem in some states is that too many sub-committees are formed and all of them just cannot meet.

We note that if a Panchayat has many villages such a structure may go along with the village health and sanitation committee by merely specifying that the six Panchayat members should be representative of the different villages. Indeed in the Mitanin programme, the attempt was made to form hamlet level women's

committees or give self-help groups this status. This was then to be linked as an advisory structure to the statutory Panchayat's health sub-committee. This did not happen because despite its theoretical strength, these sub committees seldom if ever meet.

The Statutory Representative Committee (Model 2)

In some other states, it is a village health committee and is representative. Let us look at a model from Madhya Pradesh. The Gram Swasthya Samiti has the following features:

- It would have 12 members.
- All the 12 members are elected by the gram sabha.
- There is a president elected by the 12 members.
- 50% of the members are reserved for SC, for ST and for OBC with OBC not being more than one thirds of the reserved seats.
- 33% of the members is reserved for women.
- The post of president shall rotate between women, SC, ST, OBC, Others- 5 categories.
- The term of the president is one year.
- A secretary will be elected by two thirds majority. Any of the gram sabha members can be the secretary.

The roles and responsibilities are laid down pertaining to only health sector and sanitation.

The strengths of this committee are that it is representative and has really addressed equity concerns. However there are two problems with this. The role of the elected Panchayat is not defined, and it may get composed without any of them given due place. If the funds are to be routed through the Panchayats as for reasons of governance they must, this would create problems. It would also be a problem for convergence and integrated planning. The other problem is in initiating the committee. The gram sabha is too big a forum of discussion that everyone attends, and too often the problems is that it is rather poorly attended. If it is left to the Panchayat the equity aspect would be diluted, and more important it may never be started up nor function adequately. There would be the worry that they are creating a parallel forum. If it is done by facilitators then finding and creating a cadre of facilitators would be a problem. (Either way without the Panchayat involved, where would they keep the funds and how would they work it?). Net result, these health committees were very poorly formed and are poorly functional. This is not only related to the structure as we shall see, but also to its work definition and facilitation.

The Mobilisational Committee Structure (Model 3)

A third form of village committee is an informal structure, more in the character of a people's organisation. This for example is the situation in Jharkhand. The rules in Jharkhand are, unlike Madhya Pradesh, not rules but guidelines and they state the following:

- VHC members will be above 18 years of age.
- Majority of the members should be women.
- The VHC would have socially active and involved members of the community, including those who are engaged in other development initiatives/committees, such as self-help groups and Joint Forest Management Committees, to ensure that health issues are not addressed in isolation.
- The composition of the VHC and its position must be designed to allow its integration into the Panchayati Raj system in the future.
- The AWW and the ANM should be permanent invitees
- Representation from all *tollas* and all ethnic groups should be there.
- Office bearers should be preferably functionally literate.
- The President, Secretary and Treasurer should be women for at least the first year.
- There would be orientation of all members on health issues and training for VHC leaders
- The committee would select the Sahiyya (ASHA) and she would be a member of the committee.

The strengths of this structure are a much greater equity concern and a much greater representation for women and weaker sections. Its weakness is a lack of linkage with the Panchayat (which in the Jharkhand context is justified as there are no elected Panchayats). Jharkhand has been clear that formation of this is based around the work of trained facilitators. The committee is empowered to decide on rules for proper functioning, making village health plans, networking with ANM, AWW, TBA, arranging transport (vehicle and cash management) for referral, building up and operating a village health fund and other activities.

There is an effort involved in keeping these committees active but this happens with assistance from facilitators. And in this arrangement, it is well functional too.

Structure and its relationship to function

It is difficult to comment on which structure is the most functional. This is because we have no adequate model of large-scale, functioning, village health committees. There have been few powers given to them and almost no resources. There have also been minimal capacity building inputs. So irrespective of the structure the outcomes in terms of functionality have been very poor. Despite this, there are a number of compulsions (discussed earlier in Lesson 1) to find an intermediate structure between the Panchayat and the community. Though the gram sabha exists as a possible source of direct democracy, for a number of reasons this is not sufficient.

To move forward we need to draw some very tentative conclusions from the various experiences on record.

The first of the models is very useful for governance roles. It can handle money. There is little controversy

over who was chosen to be on the committee and how. It however does not perform many of the functions for which a village health committee is mooted.

The third model is much more useful for empowerment and equity, for mobilisational purposes and for holding the system accountable. However it is not properly anchored in the Panchayat and threatens to become a parallel, and therefore less official, structure, which would still deny the weaker sections a role in decision making

An ideal would be to create a Jharkhand-like structure at the village level and link this through a mandatory advisory function to the Panchayat sub committee of the first type. This would combine the advantages of each model and cover up the weakness of each. Instead of village level informal committees we could have hamlet level committees if the boundaries of the village are diffused and the hamlets are dispersed and function as the social units that people identify with. This situation happens in many tribal and hilly areas.

Or one could alter the second model of the statutory village level representative committee to include the Panchayat representative as chairperson and two or three other elected members and insist that there is also hamlet wise representation in the choice of these members. This would have statutory status for some functions and advisory status for functions of governance where the Panchayat sub committee and the Panchayats executive committee would have to decide.

Whether or not the second model is applicable to the village, this approach of a representative health sub committee, with some Panchayat representatives certainly has advantages for the Panchayat health committees of the block and district level.

The NRHM guidelines envisage a health and sanitation committee at the village level in linkage with the Panchayat – but the exact guidelines are not specified in view of wide variation between the states. However it states that the committee would be made of Panchayat representatives, ANM/MPW, AWW, teacher, ASHA and other community health volunteers.

The question of the ideal village health committee structure is far from settled. Districts must know and must be told that there is no tested model, and that there is a need to be conscious of this gap and that they need to lay down guidelines for forming village committees. Often this is not done, perhaps because the health administrators do not believe it would succeed anyway, given their poor faith in communities. But it is usually a design problem and its failure is an administrative failure being generously attributed to the community.

The other problem in defining the structure of the village health committee is the multiplicity of such committees.

The Health Department is not the only one around with this idea. The Total Sanitation Campaign has put a major emphasis on this too, and where they are active have created village level water and sanitation committees – some of them quite functional. The ICDS programme has also mooted women's committees or village committees around Anganwadi centers. The school education system has mandated village education committees. All these committees overlap. There may be other committees related to irrigation and agriculture – but those are distinct and do not overlap. It is these social sector committees that overlap. For many reasons it would be difficult to resolve this at the state level. Each Department swears by the existence of its committees and is unwilling to concede its space to others. On the other hand at the district level, there is a greater awareness of the sub-optimal or non-functioning of all these village level structures, and in the office of the district administration, a greater readiness and possibility of merging these structures meaningfully..

MINIMUM CONDITIONALITIES FOR A FUNCTIONING VILLAGE COMMITTEE

Irrespective of the model chosen, there is one lesson from all the experiences to date that we need to heed. It is not the structure alone that is the key. It is solving the problems of support to the committee and the problems of scaling up from the successful models of village committee functioning in small scale programmes that holds the key to effective well-functioning village committees.

For the village health and sanitation committee to succeed as a state wide or even district wide institution, we need:

a) A cadre of facilitators or mechanism of facilitation who act / which acts as agents of change, providing an external, small but critical energy input needed for ensuring
   i. that the committee starts up, and overcomes the traditional inertia of the village and the reluctance to try for a change, especially given the past experience with many such committees.
   ii. that the committee continues to meet regularly, being reminded and urged to do so if there is any reduction of enthusiasm.
   iii. that the committee has the necessary capacities and understand the programme.
   iv. that the committee receives support whenever it encounters problems.

b) Such a mechanism of facilitation may be made of hand-picked block level employees, or one may assign the task to a suitable NGO for each block or one may recruit community volunteers or paid full timers and train them to play this role. Either way there is an investment of time and effort and money in a support structure. 'The village health committee does not come for free.'

c) A clear programme of capacity building through training camps, supplemented with on-the-job training by the facilitators and good reference and reading material that the committees can use.

d) A regular coordinated programme of village health planning so that the planning is completed *with quality* in a time bound manner. The village health plans need to be appraised and if they are missing out on some key dimensions – like failure to make a budget, or failing to define objectives clearly – need to be corrected by the village committee with the facilitators' help. One must also not underestimate the degree of support that village health planning needs. The simple act of writing down the plan they have made in a cogent manner, is quite a challenge, as those who have done it would know. There is a danger of course that the facilitator would impose his or her views on the plan forcing it into a centrally decided mind-set. But the bigger problem would be the village health committee, intimidated by the task of writing their own plan, copying down mechanically, from other village plans. Facilitators are more often needed to prevent the latter. Anyway, for avoiding both deviations, the facilitator would themselves need to be trained and supported.

e) A clear plan to follow up with each Panchayat and village to ensure that they implement the plan. The facilitators would guide this process helping them with flow of funds, providing training or technical assistance or motivation where needed, ensuring that weaker sections are able to participate and ensuring a minimum quality in the process. Even making copies of the finalised plan, sharing it back with the village and ensuring that all those allotted roles actually know their roles, requires facilitation and money!! Also remember that if the village health committee has more equity than the general social structure of the village (which it must have, for that is its purpose) then those in power in the general social structure do not have enough interest in the village health committee continuing, much less succeeding. An external hand of support is a must to balance the equations of power.

f) A clear definition of roles that the village health and sanitation committee needs to play in addition to the village planning and plan implementation need to be defined. The process of village health planning is discussed in the next lesson.

It is clearly a lot of work. One can now begin to understand why, though there is a compulsion to have institutional forms of community participation for the health sector, it has been so difficult to achieve anywhere. We have never gone beyond a token gesture to this cause. Till now...

Some Roles of the Village Health Committee
(as defined in the NRHM Framework for Implementation)

- 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.* 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. This 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.
- *MPWs (M) 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 by the village health committee. Get this report 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, analyse it and suggest necessary action to prevent such deaths. Get these deaths registered in the Panchayat.
- *Managing the village health fund.* The committee will receive funds of Rs.10,000 per year. This fund may be used as per the discretion of the VHC.

Some yardsticks suggested for monitoring at the village level
- Village Health Plan
- NRHM indicators translated into Village health indicators

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)

Roles of the VHC in the Jharkhand context: An Alternative

In contrast to the NRHM list, the Jharkhand health system had issued the following lost of roles.
Read through it and discuss it in comparison to the shorter list given in the NRHM Framework for Implementation.

The essential roles of the VHC will be:

- The VHC will be responsible for the overall health of the community.
- It will undertake a participatory assessment of the health situation and needs of the community. The VHC should assist the ANM and AWW in conducting their respective health surveys.
- On the basis of the assessment, the VHC should plan for and prioritise services. This information should be shared with the ANM and AWW and could take the form of a dynamic village health plan.
- The VHC will be engaged in increasing health awareness, disseminating information and initiating demand generation. It should also mobilise the community to ensure access to services.
- The VHC should be informed and able to seek attention for major public health concerns, such as malaria and waterborne diseases.
- In especially inaccessible areas, the VHC will have to develop innovative means of service delivery through mobile vans, health outposts, and perhaps even skills training for selected members of the community.
- The VHC will be responsible for selecting and supporting the ASHA.

They may also take up any or all the following recommendations based upon local conditions and capabilities:

- The VHC should spread positive messages about family welfare, immunisation, and pregnancy. For the increased effectiveness, it is important that most of the members of VHC are women, so that they can talk on these issues among women.
- To assume the responsibility of construction, repairs and maintenance of public wells, hand pumps and ponds.
- To select a suitable place for dumping garbage outside the village, and oversee that the community follows the process.
- To help in the prevention in the spread of communicable diseases.
- To inform the community about the national and State Health programs like RCH, TB, Malaria, Leprosy, AIDS, Blindness etc. and help in the successful implementation of these in the village.
- To work towards social and gender equity, and women empowerment.
- To arrange for the distribution of nutritious food among the malnourished children of the village.
- To promote proper ANC and arrange for safe delivery.
- To take care of the Government Sub-centre and the dispensary in the village.
- To keep contacts with the health functionaries, community members, voluntary organisations/individuals and the ASHA for the prompt and quality service delivery to the community.
- To ensure that the ANM comes to each *tola* at least once a month and gives her services.
- To make sure that the information about the availability of health services is made available to the community in easy and accessible format.
- To promote the innovative methods that matches the culture and mentality of the community.
- To make continuous attempts to eradicate the social evils like liquor consumption, etc by promoting the use of folk media, theatre, and street plays.
- To promote the best health practices at the household level.
- To promote the concept of kitchen garden at Household, *Tola*, and village level.
- Awareness about all government schemes such as PDS, EGS, etc

Looking at the case study on the role of the VHCs in Jharkhand given above, it is obvious that the lists are indicative of much more service delivery oriented role. Since this is built around the Sahiyya programme 0(the ASHA programme in Jharkhand), many of the functions would actually be either done by her or she would define her task as conveying the messages to the village health committee. In practice most would consider an adequate sensitisation of the committee members itself as the main activity. From there diffusion of knowledge would take over. Still the list is too large and overlaps some functions that are primarily employee functions and some that are better assigned to the Sahiyya. When there are functions that appears on the job chart of both, it helps to define whose work it is primarily. It also helps to define the roles in such a way that we can later monitor to see whether the VHSC was functional of not.

FORMING VILLAGE HEALTH & SANITATION COMMITTEES: A DISCUSSION ON DIFFERENT APPROACHES

Whether we define the VHSC as a combination of the first and the third model or a modified form of the second model, there is clearly a process of setting up VHSCs. Merely giving an order to the second and third level government officers or a peripheral employee or informing the Panchayat heads to do this, does not give the desired results. Let us study three different cases for formation and functioning of VHCs in Jharkhand.

Case Study 1

The formation of VHCs in Palamu district offers a good study of the impact of the two different approaches. In Palamu district there were many VHCs formed by the BDO who considered it unnecessary to involve NGOs. He was confident of his abilities in this regard, and of the power of his office and also that this approach was faster and less troublesome (*jhanjhat*). In some other blocks the VHCs were formed by the supervisors of an NGO. Most of the NGO supervisors had been trained in community facilitation and mobilisation. The BDO on the other hand had approached the issue like any other government order. Both received some basic orientation on community mobilisation and VHC formation. The BDO's method was to make a personal visit, pick up some names form a village as suggested by one or two elders whom he considered influential and took their names down as VHC members. The supervisors on the other hand went on the first day and spoke to some village members. Sensing the caste and political dynamics of the village, they spent more time meeting people. After a week they visited again and this time walked about in the village talking to women and other groups that do not naturally come forward. By continuing to sharing names suggested by some women with other groups the supervisors found a few names that most people were happy about and some whom sections wanted strongly. They then suggested these to be proposed in a village and there in the meeting they got approved. After a year when the officer in charge (MO-IC) visited these districts, he saw that the villages covered by the NGO supervisors had very active VHCs, while he could not even find the people whose names had been given in by the BDO as VHC members and the VHC had never met in these other villages.

Case Study 2

In Ranchi district many NGOs got training for how to facilitate VHCs. This training was focused on issues of community mobilisation, with attention to involving all sections and ensuring equity. They were also explained the need and

process of creation of VHCs. However after six months during evaluation it was observed that most of the VHC members that were selected were from the dominant caste of the area, and the Sahiyya selection had the same bias. The Sahiyyas selected were from the dominant caste, and majority tribal, and weaker caste groups had little representation in the selected group. Studying the situation further, it was observed that the facilitators were also from the same area. They had worked with the NGO's in that area for a long time and had become entrenched in local politics. So the supervisors or facilitators of these areas had started functioning as small units of power and influence and this programme became another opportunity to do so – eventually defeating the purposes of their training and orientation. One lesson was that even a good training and guidelines on community processes may eventually not get the desired results if one is not watchful of what is happening at the ground level.

Case study 3

In Hazaribagh district, only the BDOs received a Government Order to create VHCs. They were all given a basic orientation on the issue of community mobilisation and equity and health. They went to the villages and spoke to many people in the first instance, checked their past records of the existing caste and tribal demographics of these villages and very consciously worked to get the marginalised section's representation in the VHC. The VHCs then selected the women from various groups to become Sahiyyas. Here the Sahiyyas worked for all and the VHCs looked at many local issues from many perspectives.

From the above three case studies one can understand the following:

- The critical difference is not whether it is NGO or government implementing the programme. The difference lies in what process they follow and whether the facilitator is conscious of their own bias, and whether they want to overcome it by following processes that will help them overcome it.
- Forming VHCs can be a complicated task, and requires monitoring for equity and quality. It is not a spontaneous response to a call, but needs careful planning and work.
- The process of VHCs requires a facilitator who needs to undertake this task in competent and conscientious manner.
- The goal of equity is the single most difficult aspect of the village health committee and the measure of its functioning.

Process Guidelines for VHC formation [1]

VHC formation is a well-planned, intensive and continuous process of social mobilisation and negotiation. What are the processes involved in the formation of VHCs?

Essentials Steps of VHC formation

1. A VHC should represent the population of a 'natural village' rather than a 'revenue village' and is likely to be most effective at the tola level. If a natural village covers more than one tola, each tola should be represented in the VHC.

1. This section draws from the Operational Guidelines of VHC and Sahiyya , Ministry of Health and Family Welfare, Government of Jharkhand, 2005.

2. Women should form a majority of the VHC.
3. Facilitators, who may be from the government health department or local NGOs, should have prior field experience and should undergo a short training course before initiating the process.
4. The process should be initiated by a general announcement to the department staff and the Panchayats and the media. This is part of creating an enabling environment.
5. This should be followed up by the facilitator making 3-4 general visits to the village. During these visits she will initiate a relationship with community members, especially women and also opinion leaders, about the movement. She will need to emphasise and rationalise with them the need, the processes, the profile and the roles of the VHC and the ASHA. Though men can be facilitators, women facilitators have the advantage of being able to secure women's participation better.
6. Social mapping of the community is essential. It is essential that the facilitator is aware of village dynamics and of the formation of the VHC as a process of negotiation.
7. The community should be oriented towards the need to prioritise health and equity. This is done through small focus group meetings of weaker sections as well as in village level meetings, the most important being gram sabha meetings.
8. After a process of meetings and orientation, members of the VHC will be elected by the community through a gram sabha meeting. The profile, roles and responsibilities of the VHC will be discussed in the sabha, and the appropriate candidates will be selected in a democratic manner.
9. VHC formation cannot and should not be achieved through a target-oriented process.
10. There is a need for sensitisation and awareness of officials at district and block levels.
11. There is a need for activities to create an enabling environment for the formation and functioning of these committees.

The Enabling Environment

1. The process of VHC formation requires an enabling environment which evokes interest and overcomes reluctance to change.
2. Awareness and credibility of the programme needs to be established through use of mass media activities that can be felt at the village level.
3. Social mobilisation activities around general health issues and health as a right of the people need to take place for the positioning of the ASHA and the VHC. The repeated meetings on this issue and cultural programmes and the use of *kalajathas* built around this theme also cause social mobilisation and help this purpose.
4. Credibility is also to be established by choosing and deploying facilitators who are local persons either already known to the community or good at establishing a rapport within the community. Adequate time should be given for establishing community rapport and trust.
5. The programme leaders and facilitators should establish contact with the opinion leaders and the influential people of the community. The influential persons might be the elderly of the community, religious leaders the, Panchayat members, the Anganwadi Worker or influential women from the

local SHG. Contact with such persons also enables the facilitators to cross check and verify the information gathered from the community. The initial contact with such persons enables the facilitators to make them feel involved and consulted and assess whether they would be a resource to help with this task. This activity should take place over 3-4 visits to the village over a period of 10 days to a month. There are many ways of a facilitator gaining access to the community – friends, relatives, formal introductions from persons in authority to opinion leaders, through other networks of people's organisations or NGOs etc. There should be some care taken to see that the facilitator does not get too identified with this entry contact person – for that may cut him or her off from some sections.

6. If possible, position some major publicity events where everyone gets to hear of the programme – like the Chief Minister inaugurating a campaign etc. This helps win local social sanction for the work and helps over come the usual initial resistance to change.

Possible Challenges in VHC Formation in the Mobilisation Approach

1. One challenge is in getting the facilitator strategy right. There are many problems possible. Facilitators all have their own perceptions and biases and they need to be recognised and corrected for. Scepticism of the VHC facilitators themselves can be a major hurdle. To convince the community, the facilitator has to be convinced. From some experiences from the field in which VHCs were formed it was found that many of the facilitators were themselves in doubt over the process. A few early gains made in some villages would provide a positive feedback. This is the task of the programme leadership.

2. The village level contacts should be established with somebody who is widely respected and positive. The facilitators should be cautious about certain people who are generally pessimistic and will discourage all efforts. If the programme has such friends then it will not need enemies.

3. The presence of other committees within the village might be presented as a reason to avoid forming another committee for health. The decision has to be tailored to the situation. Can the work of the existing committee be expanded to include the health agenda? Or do we need a separate committee? The village has to realise the generally secondary position that is given to health and has to thereby recognise the need to have a body that looks adequately into health related concerns of the community.

EXPECTATIONS OF THE VHSC

For being functional, a minimum criteria is usually a monthly meeting. Preferably this should be with the ANM, AWW or ASHA facilitator in attendance. They will together discuss the progress on implementing the health plan and review the health data received, especially on vital events (births, deaths, marriages)

Case Study

In VHCs formed in 2 blocks of Ranchi district, an innovative approach was undertaken where the VHCs collected a minimal amount of funds from the community. This was termed as the Village Health Kosh (VHK) and was a voluntary contribution raised within the community with the purpose of undertaking collective health initiatives (like cleaning the wells, repairing hand pumps, organising health camps, etc.) and meeting health emergencies (such as meeting immediate costs of transport for EmoC referrals etc.). The VHK was mobilised and managed by the Village Health Committee. The treasurer was responsible for the effective utilisation and management of the fund in consensus with the other members of the VHC. Here the VHC regularly put up the report on the utilisation of the funds for the viewing of the community and they were also responsible to the gram sabha, and appraising the gram sabha at regular intervals on the status of the fund.

and on malnutrition and illness. The VHC will also be able to send official petitions to the Block Medical Officer for any special action at the village through the ANM.

Beyond this it is difficult to expect too much of the village health committee. If the committee is active, only would the meetings happen. If it is meeting regularly then it is doing something even if it is not apparent what precisely it is doing. Each committee does a little bit, and that too at different times in different areas. There is no predicting quite what it would do and it is rather difficult to measure too. Usually evaluators used to working with 30 village programmes, or academics wandering around with structured questionnaires miss the functioning of village health committees altogether. One needs good qualitative work and one needs to be able to listen to and document the little things that such committees do to understand the working of village health committees. Sometimes even where village health committees are non-functional, the very effort to create and maintain them has itself becomes an enabling environment for the ASHA programme or other community participation efforts.

ROLE OF OTHER COMMUNITY BASED ORGANISATIONS

There are a large number of other community based organisations present in the village. These are women's self-help groups, youth forums, irrigation groups, milk cooperatives and other cooperatives, village units of political parties or of NGO organisations, faith based organisations and so on. The potential of these organisations for being involved in health activities have been discussed in some detail in Book 4, Lesson 7.

The question here is to try to understand how these relate to the institutional forms of community participation and to situate them in relation to the Panchayat and to the village health and sanitation committee.

For however effective these forums are, they cannot replace Panchayats or even village health and sanitation committees. There is an effort to make self help groups take up this task. But we have to

Case Study

In Ambajharia village of Jharkhand the Medical Officer was visiting the villages as the VHCs of that region had invited him there to facilitate their ASHAs. Many VHC members took this opportunity to air their grievances. They spoke about problems that they were having with their ANMs (such as extra charges, or absenteeism of ANM even after the VHCs had cleaned up and painted the dilapidated Sub-centres of their villages). They spoke about problems of execution of many government programmes. One of the interesting exchanges that took place was around the distribution of bleaching powder, where one of the ASHAs and the VHC leader complained that they were aware that though the village in the next block had been supplied with bleaching powder by the government, their village had not been provided with the same. The Medical Officer explained that the Sub-centre which provided services for three villages had got just 3 bags of bleaching powder and they had chosen to supply it to only one of these villages, because they had information from the VHC about a possible outbreak of diarrhea. Since no such complaint had been received from this cluster of villages and their VHC had only invited him to facilitate ASHAs, he had not brought or arranged for bleaching powder supply. Many Medical Officers resent such questioning and complaints from the public. But fortunately this Medical Officer was quite excited about this. For the first time he was seeing a community actively interested in its health care and taking so many initiatives to achieve it. Instead of preventive measures being like an imposition, thrust down people's throats, this work too was getting social recognition. Quite correctly he saw it as a harbinger of change.

remember that there are parallel efforts to make self help groups, run ration shops, mid day school meal programmes, Anganwadi centers and so on.

One solution is to require them to play the role of the voluntary mobilisation committee of the hamlet level and then give them representation in the formal statutory health committee. At the hamlet level there is little point in forming a separate women's health committee and a separate self help group. If the latter is present and can be sensitised they are quite willing to play the roles expected at the hamlet level. And then it can be decreed that the self help group will nominate one of its members, to represent the hamlet in the village health and sanitation committee.

There are many advantages in doing this. One can then use a parallel chain of command and communication to reach the weaker sections in the village and empower them to participate in the village health and sanitation committee. Pro-poor information and impulses for change that maybe filtered out by the dominant Panchayat leadership can now enter into the village through this chain. Of course this is best achieved if the self help groups can be federated into a network in the block or district level. The representatives of such groups will then be able to raise their issues in the village committee with more confidence knowing that there is some backing from this network.

This is true not only of self help groups but of any community based organisation which is networked to a leadership at the block or district level. Indeed one of the most useful roles that NGOs play is to reach out to organisations of weaker sections in the villages and empower them to be able to voice their concerns and needs in the VHSC and to ensure that the village health plan attends to these concerns.

I. Review Questions

1. There are five reasons stated for Panchayats to construct institutional structures through which community can participate in health planning. Which are these?
2. What is the NRHMs approach to institutionalisation of community action? What activities does NRHM envisage for the VHSC?
3. What are the three main types of structures discussed for the village health and sanitation committee? What is suggested as a solution?
4. What are the minimum conditions for successfully establishing a district wide functional village health and sanitation committees?
5. What processes did Jharkhand health society aim for to establish its village health committees?

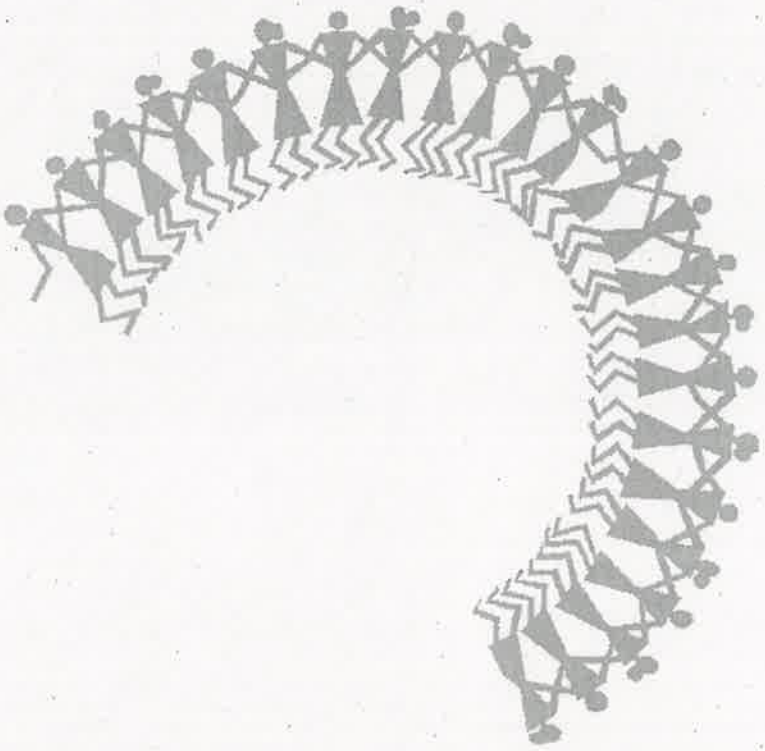
II. Application Questions

1. How do we perceive and deal with pressures from political parties in the formation and functioning of village health and sanitation committees?
2. Is it more useful to have them as all women's committees? Especially if they are two tier structures, is it not better to have the hamlet level tier as self-help groups or as all women's committees?

III. Project Work

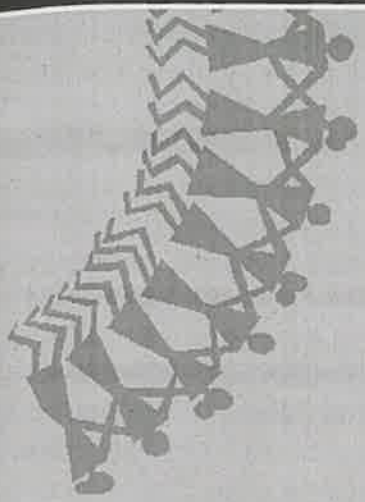
1. If village health committees have been formed in your district, visit a few, attend one of their meetings and write up a report using this lesson to analyse them.
2. If village health committees are not formed or even if they are formed draw up a plan to facilitate the formation and functioning of these committees? Budget for this plan too.

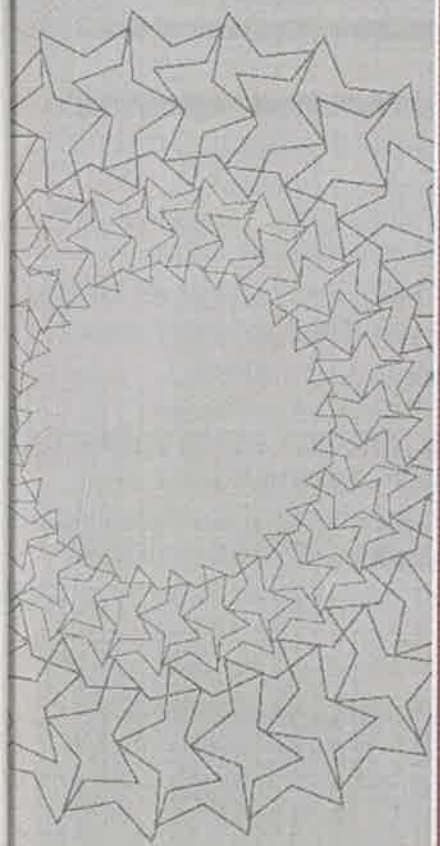
NOTES



Lesson THREE

Village Health Planning





In this lesson we shall discuss:

- Compulsions for promoting village health planning.
- Constraints: why it has been rather ineffective so far.
- Different approaches to village health planning.
- Developing indicators for village health planning.
- Indicator based actionable village health planning.

INTRODUCTION: THE COMPULSIONS OF VILLAGE HEALTH PLANNING

The notion of village health planning has been around for a long time; unfortunately not very successfully. Nevertheless this is an idea that keeps coming back. The question we need to ask is not whether it would succeed, but why it keeps coming back. Village Health Planning is now back again as one of the key components of the National Rural Health Mission (NRHM).

WHAT ARE THE EXPECTATIONS OF THE VILLAGE HEALTH PLAN?

a. ***Improved Community Awareness:*** That in the process of making the health plan, the community learns about their health status, the main health issues, and what needs do be done at the household level and the community level to address these problems.
b. ***Improved Performance of Programmes:*** There is concern that many government schemes and programmes are not having desired outcomes due to village level failures in programme implementation and utilisation. The village health plan could identify these gaps and help close them.
c. ***Horizontal Integration:*** There is recognition that there are many health related inputs going to the village in the form of various government schemes in the social sector. However due to lack of coordination these inputs are fragmented and dissociated from one other. Yet many of these programmes need to synergise for a desired outcome.
d. ***People's Health in People's Hands:*** There is a commitment that people must have control over decisions that, quite literally, affect their lives. Village level planning is a tool of local autonomy and decision making.
e. ***Promoting Decentralisation in Governance:*** There is a commitment that institutions of governance should be brought as close to the people as possible. The Panchayati Raj Act is in place to guarantee this. Village health planning helps these bodies understand health issues and exercise leadership in planning and administration of local health management. Thereby it readies them for an even more comprehensive role in governance.

The Alma Ata Declaration states that *"the people have the right and duty to participate individually and collectively in the planning and implementation of their health care".* In the Indian context this would mean the implementation of local planning – district, block and village. Of these, village health planning is the form where this vision can be realised most directly. In block and district planning people can participate only through representative mechanisms, and any system of finding the correct representatives has many limitations.

One of the basic tenets of the NRHM is that people are actively involved in planning, implementing, and monitoring programmes to improve their health status. The NRHM understands that village health planning is a complex process and that it would take considerable capacity building to achieve these goals. Also

the process of participatory planning raises several expectations and the state must be serious in its commitment to meet such expectations and fulfill people's demands. Village health planning is perhaps the only effective way of catalysing improvements in primary health care, enabling the goals of the NRHM and ensuring sustained gains.

PROBLEMS OF VILLAGE HEALTH PLANNING

1. Problems Related to Participatory Approach

a. **Gap between People's Stated Needs and People's Health Needs :** In any participatory exercise, people would express their most immediate needs (like a public bus-service connectivity, or electricity, or livelihoods, or irrigation etc.) and yet most local health planning processes cannot cater to them. A good facilitator is needed to direct them to health and related sectors – but this not easy as there is no demarcation between health related sectors and others.

b. **Gap Between People's Perceived Health Needs and People's 'Real' Health Needs :** Problems like anemia, malnutrition, hypertension, mental health are for different reasons either not perceived or not expressed as health problems. Again, facilitation helps.

c. **Raising Expectations :** Participatory planning raised people's hopes that soon action will follow. Yet the system is not in such a state that the widespread expectations it raises can be met. This could cause considerable frustration.

2. Technical Constraints

a. **Absence of Indicators and Outcomes :** Very often the locally made plans are good on identification of problems and descriptions, but short on measurements. There is no sense on what the quantity of the problem is now and how much change can be reasonably expected.

b. **Non-applicability of Usual Indicators :** The indicators usually used for health status assessment are often not valid for local planning as the events the indicator measures has too low a frequency for us to draw any general lessons from it. Thus the maternal mortality rate and even the infant mortality rate are misleading indices of child health - whereas child malnutrition rates could be a good indicator. Finding specific and reliable indicators is a problem.

c. **Lack of Skills in Analysis and Writing it up :** After the data is collected, it needs to be studied and understood. Then it needs to be written up, and writing a plan document is an achievement in itself.

d. **Lack of Untied Resources:** A plan needs funds to implement. Few funds come to the village. And what comes is tied to very specific instructions, leaving few untied funds for local priorities.

3. Power Relationships

a. **Impact of Unequal Distribution of Power and Resources:** The village is not homogeneous in distribution of power and influence, or in the distribution of knowledge and skills or in terms of control of natural resources or access to government programmes. The health problems are

usually maximal in sections which are marginalised or excluded from decision making and positions of power, influence and control. Local planning would also get affected by this asymmetry and would largely fall into the control of the powerful. Since the locally powerful in a rural area are still much deprived as compared to the rich or even the middle class in urban areas they tend to be worried about their own necessities and have little sympathy to spare for those poorer than them. Thus local planning can often be inequitable. Also, the poor who are supposed to benefit from local planning, may look at the process suspiciously and stay away from it.

b. **Lack of Negotiators and of Negotiation :** The poor and the marginalised may have different needs and perceptions from other better-off sections, but because of lower social status and assertiveness skills they cannot articulate them. There is a need for persons who have the skills and have a pro-poor understanding and some standing of their own to be able to negotiate on behalf of the poor – at least until a more genuinely-local democracy can be established.

The presence of so many constraints could be seen as a reason to declare the village health plan as an inoperable idea. However despite these constraints, if there is a recognition of the compulsions of village level planning and a perspective on democracy and development which sees such planning as a goal in itself, then one does find the necessary will to go ahead. In such a context, village level planning becomes a tool of addressing these constraints as part of a vision of building a better society. There may be other ways of achieving the health goals without village planning- but village planning is a process that needs to be put in place for its own sake. The question is therefore not of whether village health planning is needed but how to make village planning effective so that it contributes to a positive impact on health status and health equity.

NRHM FACILITATION OF VILLAGE HEALTH PLANNING

The NRHM has several features that would contribute substantially to enabling village health planning and local action:

- Decentralisation of the NRHM to the Gram Panchayat.
- Activation of the Village Health Committee and involvement of a greater number of stakeholders particularly women and those from marginalised communities.
- Appointing and training a woman from the community (ASHA) to play a key role in mobilising people and supporting village health planning and action.
- Enabling support to ASHA from the ANM, AWW, and village based functionaries of other departments.
- Involvement of the ANM in village planning process made possible by provision of an additional worker at the Sub-center (depending on the states' need).
- Ensuring inter-sectoral convergence, particularly with programmes for women's empowerment, nutrition, water, household and environmental sanitation.
- Establishment of an untied fund at the Sub-centre level to meet unmet health related needs of the

Sub-centre facility and the population in its area of coverage.

- Establishment of an untied fund only to support the activities of the local health and sanitation committee.

> *The question is not of whether village health planning is needed, but how to make village planning effective so that it contributes to a positive impact on health status and health equity.*

SOME IMPORTANT PAST EFFORTS

Community Needs Assessment Approach (CNAA) : CNAA is a village based planning tool currently being used by the ANM to assess key reproductive and child health (RCH) needs in her Sub-centre area. CNAA is described as a combination of a household survey and qualitative methodologies, primarily interviews with the AWW, TBA, representatives of the Panchayati Raj Institutions, and members of the women's groups. CNAA serves as a basis to estimate service requirements of a Sub-centre. Thus the information collected is collated into a Sub-centre action plan to assist the ANM to ensure that all women and children in her area are covered by the service delivery package of RCH. In practice CNAA often becomes an exercise for ANMs to estimate the number of eligible couples who need contraceptive services, the likely number of children who would require immunisation and pregnant women who would require antenatal care. This has been an advance over centrally fixed targets which used to be wide off the mark. There is a clear sense of outcomes and what is needed to be done. But as village level planning, it is completely inadequate. Its processes are seldom participatory and it scope is very limited. The NRHM intends to go beyond a very limited understanding of RCH to cover a wider range of public health needs, such as communicable diseases, nutritional issues, water and sanitation, other medical and health issues, and life style related conditions.

Village Health planning under bilateral programmes : This has been tried, based on participatory rural/health appraisals and based on formats prepared centrally to guide the process of local planning. One effort, important for its sheer scale, was the People's Report Campaign in Madhya Pradesh. There are no reports of significant improvements or evaluation of scaled up efforts at planning. All the problems of planning are inherent in these efforts. Often the effort becomes one of mechanically copying a model plan, or the plan is made – but the exercise ends there. The plan *as a document* is now available. But it is quickly forgotten and it does not inform any action. The NRHM on the other hand aims to draw upon the strength of the processes and participatory nature of planning efforts but importantly, link it with a sharp focus on outcomes which characterised the CNAA effort.

Given this understanding of the compulsions, constraints and experience of village level planning and the context of the National Rural Health Mission, how should we define the objectives and processes for village level planning under the NRHM?

OBJECTIVES OF VILLAGE HEALTH PLANNING

The objectives of village health planning can be seen as:

In terms of **awareness**:

- Heightened community awareness regarding community health status and the multiple determinants that affect health.
- Better understanding of the roles and responsibilities of various providers in the health care system, organisation of health care services and of collective action required from the community
- Information with the community on their entitlements of various health and nutrition related schemes of the government.

In terms of **capacities**:

- Improved skills in conducting community surveys, prioritising problems based on local evidence and data, and demanding services as appropriate;
- Skills needed for the development of a Village Health Plan – including the skills of understanding how to draw up goals, outcomes and indicators, how to budget, and the skills involved in writing it.
- Skills needed for participating in and monitoring its implementation.

In terms of **processes**:

- Development of a Village Health Charter that lists the key goals of the village health plan and a commitment from people and the system that together they will work towards achieving the goals of the charter.
- Building up a more effective and capable local government with a greater participation of women and other sections in its functioning.

In terms of **outcomes**:

- Better health status.
- Better health equity - lesser differentials of health status between different sections.

WHO TAKES THE LEAD?

The Village Health Committee (which needs to be defined as a standing committee of the Gram Panchayat) is expected to own the process of developing the Village Health Plan. The VHC requires training in

participatory appraisal methods as well as basic orientation to key health issues to conduct this process. The Sarpanch, ANM, ASHA, AWW and school teacher are some of the necessary participants. Others are community based organisations like self-help groups. Wherever possible, local NGOs with expertise in participatory appraisal should be included in the planning process.

The Gram Panchayat should formally endorse and approve the plan. The village health committee cannot replace the elected Panchayat.

Village Health Plan or Panchayat Health Plan

In some states there are two or three villages in a Gram Panchayat. Then the question arises – should we make a village health plan or a Panchayat health plan? Where the two are synonymous there is of course no problem. There are many reasons why a village health plan is preferred. People identify with the village. The Panchayat may be in the control of vested interests etc. However even if each village draws up a separate health plan, these would still have to be aggregated at the Gram Panchayat level and the funds would have to come through these institutions.

Within the village health committee structure and the Panchayat, there would be required some individuals in whom sufficient capacity and motivation has been built up to undertake this task. These could be ASHAs/community health workers, whose work definition includes this and who are selected by the community. This helps the ASHA emerge in a leadership role within the community.

Process of developing a Village Health Plan

The Gram Panchayat would have to be sensitised and oriented to this task. This is easiest done in a meeting of Panchayat leaders with senior officials attending.

Then the Village Health Committees will require orientation to the planning process. To undertake this, one or more facilitators would have to be assigned to the task in addition to training the conveners of the Village Health Committees who are preferably the community health workers or ASHA.

The VHC will need to organise meetings with stakeholders in the village in different groups at periodic intervals to discuss the process, and finally present the plan to the Gram Sabha.

Then the team would draw up a situational analysis based on:

a) data available in ANM and AWW and ASHA registers.
b) household surveys whereever required
c) participatory appraisals

This has also been called **community diagnosis**. Community diagnosis identifies the main problems affecting the village/community, largely based on information collected from the community.

The process of planning would include a process of understanding the situation and then of drawing up plans. Both these processes overlap. The various component steps would be:

- Community survey, listing of all households and identification of vulnerable – poor, landless, marginalised. Leads to an accurate estimate of population and its categorisation by different degree and types of vulnerability. Ideally needs a household survey.
- Status of environment – safe drinking water, proper sewage disposal, improved sanitation, housing and settlements, attention to pollution- soil, water and air (pesticides, groundwater contamination), specific to local areas. This would often emerge from participatory appraisals.
- Mapping of health care facilities that offer quality primary, secondary, and tertiary services. This could come from a combination of focus group discussions and by observation and interviews during visits to the facilities.
- Defining what are the various services that are reaching people and to what extent they are doing so. This could come from participatory appraisals, from ANM and AWW registers and from household surveys. If possible, do all three, but at least one approach other than the registers is a must.
- Understanding the health status and the base line of the plan from a number of indicators. This too would emerge from the same data sources as above.
- Conducting audits of maternal and under-5 deaths. This can be done only if there is already such a protocol established or there is a trained person in that area.
- Understanding the situation with regard to discrimination on grounds of gender, caste and religion – including neglect of girl children, dowry, domestic violence – and specific action to reach the most vulnerable. This requires careful stakeholder dialogues.
- Plans for community health education.
- Action for improved nutrition, universal coverage of maternal and child health services, identification and management of blindness, TB, malaria, filaria, and other communicable diseases, improved environmental sanitation, universal coverage for water and sanitation facilities, and promotion of rational drug use, including preservation and use of proven indigenous health practices.
- Enumeration of births, deaths and marriages and supporting village level surveillance systems.
- Understanding and using the indicators that are most appropriate for monitoring and evaluating the implementation of the plan. (Indicators help to assess and make visible to the public the major public health issues and the state of access of services by different sections.)

While planning is ideally an annual process, periodic updates (maybe biannual) are required to include emerging issues and review progress towards meeting the goals of the plan.

Consolidating the Plans

After the finalisation of the Village Health Plan, the Gram Panchayat presents/submits the plans to the Panchayat Samiti or Janpad Panchayat (Intermediary/block level Panchayat) where a consolidated block health plan is developed, with flexibility to address common health problems across the block, and plans for village haat/cluster level interventions that would cater to a cluster of villages.

The final decision done at the level of the block is a budget release done against a set of activities and outcomes expected. To make such an individualised release for over 60 Panchayats could be quite a task – and careful planning and *in-sourcing* of human resource for this work would be required.

Case Study: Swasthya Panchayat Yojana

In 2005, the Department of Health and Family Welfare, Chhattisgarh decided to build on the Mitanin programme to make for a programme of village health planning. This was called the Swasthya Panchayat Yojana. This effort at village health planning had the following components:

1. **Mobilisation:** A massive mobilisation of PRIs was done in the form of 'Sarpanch/panch Sammelans' (events in the honour of PRI heads) and then village level orientation programmes were organised for active women's groups, youth groups and other individuals within the GPs other than the Mitanins in all these Blocks/Panchayats.
2. **Developing Indicators:** The State Health Resource Center developed a set of 26 indicators for measuring the health status and the delivery of health and health related services at the village level. Twelve indicators reflect functioning of the health sector, (including the active role of GP bodies, Mitanins, local community,etc. in health), four indicators measure steps related to food security, three are on water and sanitation, and one indicator measures performance of school education. Thus twenty indicators relate to performance of health services or services of closely related social sector. Health outcomes are measured by six indicators- child malnutrition, low birth weight babies, age of marriages, spacing between children, infant deaths, and outbreak of waterborne disease. The indicators could be altered to suit the plan priorities. The indicators were properly framed so that they were specific and measurable (see box on pages 46-47). The programme understood that these indicators could be modified each year and were needed for different districts. These were only the choice for the current level of health development.
3. **Collection of Data**: One round of Mitanin training was specifically devoted to village health planning. The Mitanins learnt the importance of village health planning and then the ways of assessing health status. The status on each indicator was then collected as part of the training programme itself, at the hamlet level, by Mitanins together with ANMs, Anganwadi workers, women's groups, self-help groups, and Panchayat representatives of the locality. The Mitanin programme had been operational for the last three years in the state with more than 60,000 Mitanins working for the cause. It was thus possible to complete the data collection over six months.
4. **Scoring of Data**: Based on this data each block team calculated the level of achievement on each parameter and for all 26 parameters taken together for each hamlet and Panchayat. The Panchayats were then ranked. This helped each hamlet, village and Panchayat know its relative performance. This process has been completed for 8600 out of the states 9800 Panchayats (128 out of 146 blocks). A simple software which was used for feeding in the raw data and getting an immediate print out of the results helped. It took about 10 hours to feed in the data of one block – about 60 Gram Panchayats.

5. **Awarding the Achievers and identifying the weak**. Based on these ranks the top two Panchayats were given an award in each block on Republic Day. This brought considerable recognition to this process. Panchayat leaders took notice of the entire process and so did the media. This process of scoring and ranking also helped to identify the weak Panchayats and push resources to the poorly performing ones.
6. **Village Level Planning**: This was followed by getting every Panchayat to make plans so that they improve their scores in each parameter. The planning is done in the form of a focal group discussion and many issues beyond these parameters can be brought in. But the parameters must be covered. Parameters where the Panchayat lags behind are given more focus. Further hamlets which are doing poorly get more attention. This hamlet level disaggregation and analysis is often the main element of the planning. This brings in a considerable amount of emphasis on equity concerns. The process of planning requires active support by facilitators. There are a large number of model plans made for varying situations which are made available. A set of guidelines is also made available. The untied fund with the Sub-center and the Panchayat and with the health and sanitation committee and resources from all available schemes would be utilised effectively to implement the plan.
7. **Plan Implementation**: The final plan drawn up is made available to all key stakeholders. The plan specifies the role of various stakeholders. Periodic reviews are to be organised. Some Panchayats receive a lot more focus so as to demonstrate some early gains that would encourage other Panchayats to do well also. Major implementation in the form of Panchayat sammelans is also undertaken.
8. **Evaluation and Redoing the Cycle**: At the end of the year the situation would be reassessed and the plan could be reviewed and updated. By supporting the Panchayat to do this through an entire year sufficient capacities are built up in the Panchayat. However to provide such support, a strategy of technical assistance to the Panchayats has to be put in place.
9. **Certification**: Any Panchayat which feels it has reached a desired level of performance can apply and be awarded a certificate of achievement at any time in the year.

THE SWASTHYA PANCHAYAT SCHEME : HEALTH & HUMAN DEVELOPMENT INDEX

	BASIC HEALTH SERVICES
Sr. No.	**Indicators**
1	% of completely immunised children – in age group of 12 months to 36 months
2	% of women who got full antenatal care as defined
3	% of women who had institutional delivery
4	% of women who had skilled assistance at birth (ANM, nurse or doctor)
5	% of newborn weighed within three days (after birth)
6	% of newborns who were breastfed in the first hour
7	% of blood smears in fever cases where reports received within 48 hours.
8	% of hamlets with shop/person having unbroken supply of chloroquine last year.
9	% of hamlets with shop/person having unbroken supply of OCP+condoms last year.
10	% of target couples who had unmet needs which were met during the year.
11	% of hamlets where Mitanin make first day visits/or are consulted at least 50% of the time
12	% Panchayat level health committee meetings held in the last year.
13	% of hamlets with active women's committee

	HEALTH RELATED SERVICES
Sr. No.	**Indicators**
	WATER & SANITATION
14	% of hand pumps without stagnant water in and around the water pump (index of both vector control and focus of environmental sanitation currently)
15	% of families using safe drinking water as defined
16	% of families where all members are using domestic/community toilet
	FOOD SECURITY RELATED
17	% of children, who are eligible for Anganwadi (6 months to 60 months) getting diet regularly
18	% of schools giving cooked midday meals
19	% families getting grains from PDS shop
20	% of families getting low cost grains from PDS shop
	EDUCATION
21	% of children (6-14 year) in age group going to school

	HEALTH STATUS
Sr. No.	**Indicator**
1	% of children equal or below 3 years age with malnutrition (weight for age – any grade)
2	% of newborn babies born Low Birth Weight in last year.
3	% of girls married below 19 years of age.
4	% of those who were born with less than 36 months difference.
5	% of any deaths of any child equal to or below one year in the last year.
6	% of Sum of water borne disease outbreaks as defined. (More than three cases of a disease in the same week)

Hamlet score card	
Health services/ practices Score	Max score 12 Min score 0
Water and Sanitation Score	Max score 3 Min score 0
Food Security Score	Max score 4 Min score 0
Schooling score	Max score 1 Min score 0
TOTAL HEALTH AND RELATED SERVICES SCORE	Max score 20 Min score 0
CHILD MALNUTRITION SCORE	Max score 1 Min score 0
HEALTH OUTCOME SCORE	Maximum 0 Minimum 6

To calculate scores:

$$\frac{\text{Actual \% - Minimum\%}}{\text{Maximum\% - Minimum\%}}$$

The maximum and minimum are set for each block separately. Thus the Panchayat scores cannot be compared between blocks only within a block.

DISCUSSION

Issue 1 : Is this not a huge effort? Do the results merit it?

This needs to be seen. But otherwise the Mitanin programme gets so focused on only some elements of child health. This makes its approach more comprehensive. Also if we see the process itself as useful than it becomes well worth the effort.

Issue 2 : Is not the data reported often inaccurate or false? Will planning under such circumstance be useful?

The involvement of ASHAs and Panchayat members and facilitators makes it much more reliable. At any rate the main use of the data is to guide local planning and not for central monitoring. Data errors get contested and corrected during the planning step. The process of voluntarily declaring that they are ready and then asking for certification also helps.

Issue 3 : By introducing so many indicators and measures are we not again straight-jacketing planning into a few compartments?

To some extent, yes. This is being done to ensure that these parameters get attended to – with equity of access as the focus. But there is space left for wider expression of felt needs to come into the plan. Also the parameters are so chosen that on discussion they lead onto a wide range of health issues and processes. Each year some indicators should be dropped and new ones added in. Qualitative planning without any indicators and guidelines can theoretically be done but requires such good facilitators that to scale up seems near impossible at present. And even then whether it would lead to better outcomes is not certain.

Issue 4 : Is the process costly?

The main costs are in the making of copies of the scores and the instruction sheets etc and some travel. The rest of it is taken into the costs of one round of Mitanin training of three days. Many NGOs contribute actively for planning in the blocks where they are managing the Mitanin programme. There is no outsourcing. This also helps contain costs. The lead role of an organisation like the SHRC is however mandatory.

Issue 5 : What is the choice between awards and certification?

Giving awards to the top two Panchayats draws public attention to it. Not all this attention is healthy and may lead to different pressures. Also those who are known to be weak are not incentivised by this process. Thus it is better to have a process where each Panchayat can submit itself for review when it is

ready and then an inspection team can be sent to visit and certify it as achieving a Swasthya Panchayat status for which it would receive the prize anyway. But the suggestion is despite all its problems to also retain the prizes for the best two – for that it was what brings political and media attention to it – which too is needed for the programme.

Issue 6 : Can we call the Swasthya Panchayat Yojana a success story or a best practice?

This programme is still ongoing and one cycle has not been completed. Though the baseline measurements and awards have been done, the process of indicator based planning and monitoring implementation of the plans are ongoing. It would take another year before one could declare the level of outcome an 'achievement' and therefore it would be premature to call it a success story. However for what it has achieved in processes and on scale – it is certainly a "best practice".

I. Review Questions:

1. Why is village health planning needed?
2. What are the constraints on village health planning?
3. What is the Community Needs Assessment Programme?
4. Who or who all should make the village health plan?
5. What are the forms of data collection and what type of data is each form of data collection best suited for?

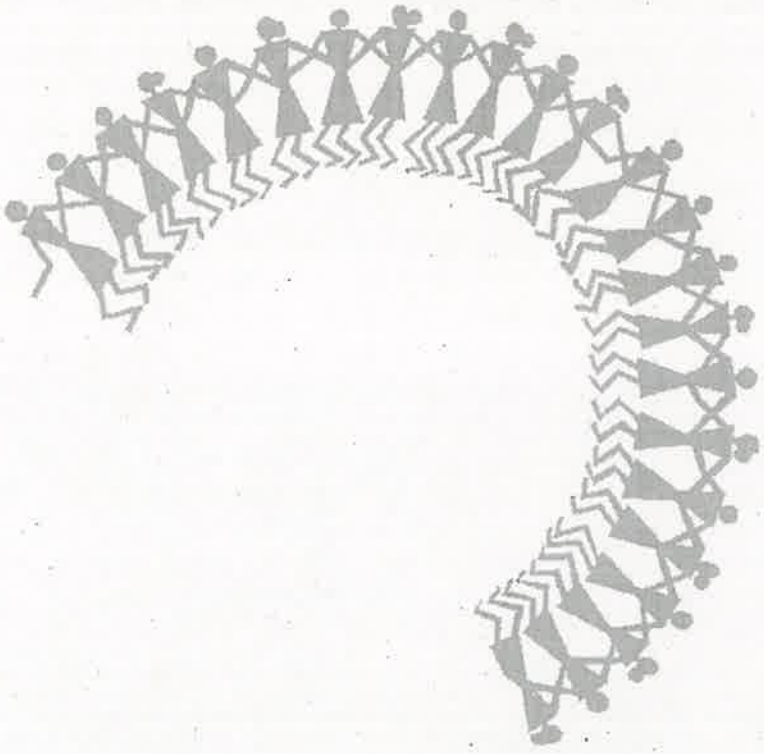
II. Application Questions:

1. Is the poor record of village health planning a result of poor technique or a result of lack of seriousness in trying it out?
2. Is there any point in village health planning if control over health facilities and budgets are not also decentralised?

III. Project Work:

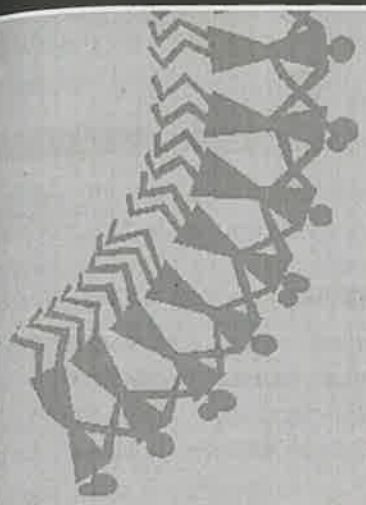
1. Undertake to make at least one village health plan. You could use participatory appraisals alone, or in combination with household surveys to calculate some of the indicators given above.
2. A case study, a specific experience from Chhattisgarh, has been presented in detail. Are there any specific experiences from your state which can be written up? Send in a village plan already made from your state with your critical appraisal comments.

NOTES



Lesson FOUR

Community Diagnosis



In this lesson we shall discuss:

- Significance of community diagnosis for community participation.
- Tools of community diagnosis and planning.
- Participatory Rural/Health Appraisal
  - Village Profile Maps.
  - Seasonality Analysis.
  - Timeline Analysis.
- Transect Walk.
- Venn Diagrams.
- (Focus) Group Discussions.

COMMUNITY DIAGNOSIS

A community is made up of a large number of people. There can be people or groups belonging to different castes, classes, religions and sometimes even languages in the same community with different and sometimes conflicting interests. The community may also be divided on political lines, that often cuts across caste and class.

These heterogeneous sections command influence and power in varying degrees within the community. Thus it is not an easy job to bring these often mutually opposing factions of the community together for a common purpose like mobilisation around a health issue or decentralised health planning. The problem is less if, as a community organiser, one has to organise only those who are directly concerned, such as mothers for immunisation programmes. However, experience suggests that when mobilisation is restricted to only selected groups, in this case perhaps the most vulnerable with often limited decision making powers, the cause often loses ownership of the other sections and may exclude some groups from the benefits. Also when only select groups are involved, mobilisation is difficult to sustain, and divisive forces may get strengthened. Due to these dangers, community organisation or mobilisation must elicit participation from all the sections of the community, even those that are not directly affected or benefited by the interventions and who may not have equal interest in the outcomes.

Processes like household surveys and collection of data from service registers are done by a limited number of volunteers/employees. Such data is analysed and translated into plans of action by even fewer number of people. However since such plans will empower weaker sections there could be a refusal of ownership of such plans by more influential sections of the village. There is a need therefore, for the process of planning to be a public and highly visible process with considerable dialogue between sections where the influential sections are publicly committed into the planning process and the weaker sections also get to have their say.

Organising persons in the village for securing their entitlements, through such processes of planning and through constructive action has been repeatedly shown to be useful and effective by non-governmental organisations working at the size of 30 to 60 villages. In such small projects a highly motivated and capable leadership, usually well supported financially and with a fair degree of access to decision makers at the district level, lead the planning process. The challenge is to scale up such experiences to a district level.

To organise and plan for such a complex entity as a community, one has to understand far more than the health status and health indicators that we learnt about in the last lesson. We also need to understand the interrelationships between various groups in the community, who dominates whom, and which are the power groups in the village. One has to understand why certain people may oppose the interventions, why certain people are respected or feared, and who the opinion leaders in the village are. One also needs to identify

potential leaders of the weaker sections who can withstand the high social pressure from vested interests. Unless one understands the heterogeneity of the community with all its various sub groups and their interests, it is not possible to even begin to expect active participation or mobilisation on common issues.

Community diagnosis is a process that helps understand all these interrelationships, dynamics and heterogeneities that exist within the community.

Community diagnosis is diagnosis of the health situation in the community, but it is also diagnosis of the health situation *by* the community. Community diagnosis is a process of integration of data collection with health planning. It is an integration of the process of health planning with the process of organisation and empowerment of weaker sections to participate better in the planning process. Since pro-equity change in the village requires an external intervention and support, community diagnosis also provides a context within which such support can enter into the community and become acceptable.

The significance of community diagnosis in facilitating community participation can be illustrated with the following case studies.

Case Study 1: Selection of a Community Health Worker in Dhangaon village of Bihar

The CHW Programme in Dhangaon village in Bihar required the CHW to be selected by the community so that she is a true representative of the village, and is accountable and supported by the people in her work. To facilitate this process, the community organiser visited the village and attended a Gram Sabha meeting to meet all the community representatives. He met a large number of people, as they had gathered that day to discuss preparations for Shivratri that is celebrated in the village. The community organiser introduced the CHW programme to the people, who showed a lot of interest and enthusiasm, and extended their support for the programme. The organiser fixed up another meeting the following week and called all those present to attend. The subsequent meetings were attended by significant number of people from the village. On the day of selection, these people recommended the name of a woman – Savitri Devi – who was present in the meeting. She agreed, and was formally selected as the CHW for Dhangaon village.

However, as the programme progressed, Savitri Devi faced a lot of problems in her work. There were a significant number of households, belonging to the Muslim community, who were not receptive to her health education and never approached her in case of illnesses, immunisation or antenatal care. This affected the outcomes of the programme negatively, as the vulnerable minority groups were excluded from the benefits of the programme.

In analysing the reasons behind these problems, it was found that the Muslim households perceived the CHW Programme as something meant only for the Hindus. This was because in all the formative

meetings, the community organiser interacted only with the Hindu community. Although this was not intentional, it was by default – as the organiser happened to interact with the people (Hindus) who had gathered to plan Shivratri celebrations. He also announced the subsequent meetings in the same forum, therefore, limiting participation to only this particular community, and excluding the Muslim households from the entire process. Seeing the large turnout in the meetings (since majority of the population in Dhangaon was Hindu), the organiser overlooked the need to understand if there were other communities in the village, if they would feel excluded by this process, and the programme ehich would result in the CHW not being a representative of all sections.

The lack of community diagnosis and genuine participation by all sections of the population, not only led to the failure of the programme in the village, but also introduced divisive forces between the two communities.

Case Study 2: Formation of a Village Health Committee in Sonapada village of Orissa

In forming village health committees (VHCs) towards community mobilisation around health, a community organiser was appointed by the programme to facilitate the process in Sonapada village of Orissa. In order to understand the community, the facilitator visited households in different parts of the village to interact with the people informally. Through these visits, the facilitator built a rapport with the people, assessed the areas where there was concentration of vulnerable or excluded households/groups (based on caste, class, tribes) in the village, and identified common problems in health and related areas that families face. In the subsequent week the facilitator attended the Gram Sabha meeting where he met the powerful people of the village – the Sarpanch and the Panches, community leaders, and socio-economically better off people. In these interactions, he introduced the idea of the VHC and how it could benefit the whole community. The facilitator also interacted with other community based organisations – the self help groups in the village and the farmers club. After these meetings in the first two weeks, he organised a community meeting which saw the participation of all sections of the village. The people discussed the programme in detail, planned the process of VHC formation, the constraints that they may face in implementation, and the role that they envisage the VHC to play. After iterations and debates, the process was finalised, and fifteen members were nominated by the community to form the VHC.

Going forward, it was seen that the VHC had representation from different sections of the community, and had the support of the village in their work.

Discussion

The above case studies show the dangers of not understanding the community in detail and the benefits of undertaking community diagnosis for mobilising active community participation. Community

diagnosis can not only facilitate participation of all sections of the community, but can also help predict potential barriers to the interventions or the programme, plan strategies to overcome them, and most importantly contextualise the programme to meet the needs of the community - especially the most vulnerable groups.

If one thinks about it one can come up with many such instances where failures or barriers to programmes could be prevented through community diagnosis and participation. Most persons working with NGOs in community development activities can list a community diagnosis activity that may have been undertaken. This is now a basic skill for community work in the non governmental sector. It is a useful skill for anyone working with village level planning to have.

TOOLS FOR COMMUNITY DIAGNOSIS AND PLANNING

How does one undertake the process of community diagnosis? Can the community organiser go to the village and directly ask questions like the ones given below

- Who is the most powerful person who may try to stop the project?
- Who is ready to resist the vested interests in the village to take up the project ahead?
- Who has shown interest in working for a common cause?
- Who are the persons likely to get left out if we entrust the programme to the existing institutional set up (Anganwadi, sub-center, primary school etc.)?

Clearly not! One will not get truthful or complete answers to these questions if they were posed directly. Also, one may end up alienating the people in the community and losing their cooperation. But then, without the above information, one cannot undertake the project.

Then how do we gather such meaningful information regarding the community and its history so that a well-balanced, democratic organisation of the community can emerge to initiate, implement and sustain meaningful health interventions? There are many tools available to analyse and study a community, to understand the various resources and resource gaps and the various relationships and conflicts between different sections in a community.

Three such tools are described below – Participatory Rural Appraisal (PRA), Transect walk and Venn Diagram. The Participatory Rural Appraisal is itself made up of a number of techniques and if a term best used to describe an overall approach to data collection and analysis- almost synonymous with the term Community Diagnosis. We have described all these techniques – the village profile map, the timeline trend analysis and the seasonality diagram, the Venn diagram and the transect walk – as being part of the PRA, though some sources may prefer to limit the term to some of these components.

Participatory Rural Appraisal (PRA)

Participatory rural appraisal or PRA is an approach, which combines a number of participation- enhancing methods in order to initiate and support a process of self-analysis, planning and implementation by the community. The techniques are helpful for capturing and analysing information of relevance to local action in a participatory process. It is a relatively short exercise consisting of a few meeting that helps to understand the village systems, its social dynamics, and politics by using various techniques and helps people to make technical choices keeping such dynamics in mind.

With good facilitation, PRA has also been excellent in helping politically marginalised communities develop a sense of dignity through a more holistic understanding of their strengths, cultural assets and overall "social capital".

(As expectations and standards for participation have evolved, however, emerging program models are attempting to establish much more comprehensive and long-lasting community engagement. This raises expectations of the community, of the process of facilitation and of the external support required.)

The objectives of conducting the PRA may be stated thus :

1. To help the community to understand their village, its problems and resources
2. To know the geographical layout and infrastructure and socio-economic context of the village.
3. To understand the situation of health, the prevalence pattern of common illnesses and common health related practices,
4. To know the public health system personnel who work in the facilities in that area, to understand issues of availability and access to health services, and to other related systems such as the food and nutrition schemes (ICDS and PDS), and water and sanitation facilities.
5. To understand the socio-political context, cohesion, heterogeneity, segregation of groups before starting the door-to-door survey and to understand the results of a door-to-door survey in its social context. One uses the PRA map along with inputs from the household survey to locate the stakeholders, caste/class groups political factions, and later relate it to the residences of the health workers or personnel involved in the project.
6. To provide quick and reliable insights to complex multidimensional problems existing between different groups/hamlets/sections of the community.
7. To establish rapport with the people (for the external facilitator) while collecting data on the village profile.
8. To assess the feasibility and desirability of different possibilities for action and different technical choices from the viewpoint of different sections of the community and their inter-relationships.

However, before going forward, some points of caution need to be considered.

- Most participatory approaches based on PRA do not substantially enhance weak community capacity to assess or validate the accuracy and implications of information that local people help to provide. They are more often destined for use 'by experts' from outside the communities where it is gathered. In the NRHM district planning approach, this weakness of the conventional PRA is sought to be overcome by its integration with data from registers, with household survey data and with the use of indicators, all of which has been outlined in the earlier lesson.
- PRA approaches are rather limited in terms of establishing long-lasting participatory community information gathering, planning, decision-making and implementation processes. The use of indicators, the allocation of work responsibility for monitoring different aspects of the programme and the repeat of the PRA at least annually once if not six monthly would help overcome this.
- The PRA model is generally oriented toward helping communities to assess and respond to external development interventions, or to a limited level of perceived local priorities and needs. Systematic support to communities in assessing the technical, financial and environmental feasibility of development options is not often a part of 'participatory' program designs. If they were, it would call for a considerable technical support to the village plan effort. In the context of scaling up to reach the entire district, it implies a general strategy of providing technical assistance to all villages.
- The PRA is not as simple as it appears at first glance. Household surveys are indeed simpler. In reality to make PRA really effective, one requires a very good facilitator who himself/herself is well sensitised to the power dynamics of the village and to some extent a least makes himself / herself available as a negotiator on behalf of the weaker sections, without becoming partisan. This is easy in small projects, but while scaling up becomes the central challenge. Along with the other cautions outlined above, it is clear that the PRA itself changes character as it becomes large scale. This is one reason why we have preferred to use the less commonly used term of community diagnosis to depict this.

PRA Techniques

- Village Profile Map: Resource and Social mapping
- Timeline/Trend analysis
- Seasonality Studies
- Matrix Ranking

Village Profile Map

This is a constant feature of most PRA approaches. There are numerous ways of mapping the village. One way is to mobilise a sizeable portion of the village to a common place and ask them to draw the map of their village. This can be done using the locally available materials like chalk powder, broken bricks,

stones, twigs, leaves, grasses, clay, sand, soil and anything the community can make use of depending on their own imagination and creativity. Often it is done on a chart paper. Even if done on the ground, it is a good idea to have one volunteer simultaneously copy it on the chart paper so that there is a hard copy that one can take back to write the plan and report.

Sometimes gathering the people from different sections together may be difficult to achieve since there are local conflicts between communities, or since there is limited interaction between different castes or simply because the village is too big. In such instances, it is better to hold separate stakeholder group meetings where the overall village map is reconstructed from small maps of streets/lanes etc. drawn in a number of small group meetings. Also people speak more freely in sub group meetings rather than in bigger gatherings. After this, one has to combine all the maps and reconstruct the whole village map with all the features, reconciling different perceptions.

Ideally, the village profile map should indicate:

- Different roads / streets / hamlets in the village
- Houses with concrete, tiled, thatched roofing details
- Residences: Classification of houses by socio-economic characteristics (income, landholding, caste)
- Commercial establishments: Shops / ration shops / industries
- Public Services: Post office / schools / Anganwadi / bank / Sub-centre / PHC / other health facilities or health providers.
- Public places such as community hall / meeting places / weekly markets / graveyards / maidans
- Religious centers: Temple / Churches / Mosques/ others.
- Water and Sanitation: Drinking water facility, overhead tanks, taps, hand-pumps
- Problem areas like water stagnated area, sewerage, wastes dumping, stretches of roads with no street lights etc.
- Any other features that may be required for specific objective

When done before the household survey, the village profile map enables one to decide on households to be approached for collecting data to stratify samples. It also helps frame the questionnaire. When done after the household survey it helps correlate findings with pattems related to geographic distribution. It also helps us to understand stakeholder distribution, and their access to public health facilities or other provisions within the village, which may be useful to mobilise various stakeholder groups according to their location.

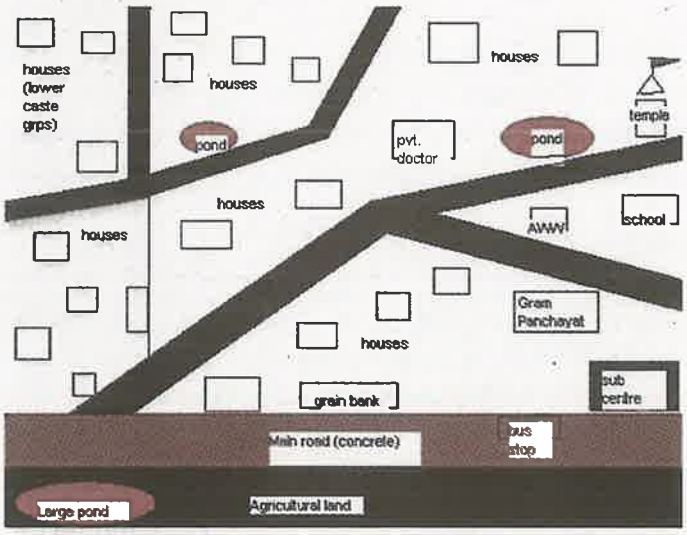
The following guidelines need to be kept in mind when forming the village profile map:

- Decide on the type and purpose of the map to be drawn.
- Select a suitable site where all people can assemble.

- Explain and discuss the purpose of the village map to the community in a facilitative manner.
- Involve both women and men, belonging to different age, socio-economic, caste and religious groups.
- Arrange for appropriate drawing materials like colour powder, sheets of paper for recording and for transfer of map to paper, colour pens etc.
- Encourage the stakeholders to draw the map in their own style and in a reasonable time.
- Facilitate lively interactions among the participants while drawing the map.
- After the completion of the exercise, volunteers can be requested to explain the salient features of the village map.
- Question and answer sessions in a constructive way should be encouraged.
- After making necessary corrections on the ground, the final map should be transferred on chart papers by the participants.
- Inventory of problems and solutions may be recorded for future references.
- Facilitators must make a report of the exercise on the same day.

Example: A Village Profile Map of Doona village, Madhya Pradesh

A community organiser undertook a village profile mapping exercise as a part of community diagnosis in Doona village of Madhya Pradesh to understand the geography and the location of health facilities, Panchayat offices, schools, Anganwadi (AWC), water sources, agricultural farms, roads and houses. After following the above steps, this village profile map emerged.



This map clearly shows community assets like ponds and the location of various services. Note the physical location of public services and their relationship to the lower caste area.

Timeline / Trend Analysis

Timeline or trend analysis provides a chronological picture of various resources of the particular village in a sequential order and their impact on the socio-economic issues. A timeline refers to a calendar of historical events from as far back as one can remember up to the present – in the life of a person, community, village, area or institution, depending on the purpose of the exercise. Timeline analysis is a tool as well as an opportunity to find out the nature of key opinion leaders in the village and their contribution towards the village's development. While the events are noted down in the timeline sheet, the references regarding persons behind these events are to be kept in mind by the facilitator/community organiser. These references shall be helpful while the community organiser starts the process of identifying key activist for implementing the action plan. Also those people who had helped the community organiser with relevant information are in general, found to be supportive to the project implementation, although this may not be true in all cases.

The following are some guidelines for timeline analysis:

- Encourage participatory discussions in the community.
- Encourage elderly and knowledgeable community members to join in the discussion.
- Initiate disclosure of major events with relative memory of world/national events. If group discussion is not possible then individual discussions can be conducted and then all available information can be merged in a community meeting.
- Record all the inputs in detail on paper.
- Compare the changes, identify the trends and patterns, and clarify and correct any information.

Once the merging of all available information is done, a lot of mismatches may be observed. These need to be corrected with crosschecking of data. It needs to be remembered that the elderly may not have an accurate sense of the years passed. But they can relate to major happenings in the village which can be crosschecked with other people. In brief, a timeline analysis is a reconstruction of history.

How does timeline analysis help community organisation?

It is important to know what happened in the past in the village – such as major conflicts between different groups, who did what in as far as health programmes or projects are concerned etc. – as this would indicate individuals who would potentially contribute to the proposed health interventions and who are respected by the majority of the village as far development work and voluntary spirit is concerned. The timeline analysis would also throw some light on who would be potential problem makers for the project. Various group dynamics would also be discovered by a properly conducted timeline study.

As an example, the timeline study of Bahoor village in Orissa is given below to get an idea of what had happened in the village over a long period of time. This was collected from different sources, mainly from

old and experienced people and later cross checked again with other sources of information from Panchayat documents and other individuals.

REPORT ON BAHOOR VILLAGE TIMELINE ANALYSIS

HISTORY OF BAHOOR VILLAGE

The village was believed to be constructed during 800-900 AD by the Pallavas. The age of the village is more than 1200 years. During the Pallavas period, the village came under Thondai Mankalam and during the Chola period, it came under Jayankonda Chola Mandalam.

This village was ruled by various kings before India became independent in 1947.

1950-52	Severe drought occurred in this village.
1955	Street light facility by using electricity is introduced.
1955	Bus facility started to connect the village to the nearest district. The bus stop is on the main road.
1956	Veterinary dispensary is started.
1960	Sub-centre is started in Kora street, and PHC is started 3 kms from the bus stop.
1960-62	Fair price shop started.
1963-65	First MBBS doctor came to the village PHC.
1965	Metal road is introduced. (Before this, gravel road was there.)
1967	Water supply is started.
1968-70	PHC is shifted to Kannaikoli street, 2 kms from the village.
1971-72	Severe flood occurred.
1971	Post office is shifted to Kanniakoli street.
1976	Anganwadi centre is started.
1975-78	ANM is changed and new ANM comes to the Sub-centre.
1975-78	Four 'Bengali doctors' start their practice in the village.
1975	Rural family planning centre is started.
1979	The Gram Panchayat was formed and the first Sarpanch elected.
1980	The Panchayat office was set up in Kannaikoli street.
1983	Two Medical Officers (male and female) are deputed to the VHC.
1985	Female MO leaves the PHC and gets transferred.
1986	Immunisation camp was held for the first time for children.
1988	Immunisation camp started getting organised at the Anganwadi centre.
1990	The first school in Bahoor village was constructed in this year. Now a government middle school exists in the same location.
1997	Rural family welfare planning centre is changed to Bahoor primary health centre.
1998	NGO called Vidya starts project in the village on adult literacy.
2000	NGO called KM Foundation starts project on health and organises health camps every month with their own doctor.
2001	The current programme of community mobilisation for the community health worker programme starts.

The above timeline study throws light on the history of the village, how the village evolved into its present condition, when major events had happened and who were the key people who were instrumental in the major changes that had occurred.

Seasonality Mapping

Seasonality mapping is done to assess the seasonal changes in the health status of the community. Various features of the local economy like labour migration, when people have adequate work, the features of cropping patterns and related income levels, rainfall pattern and its relationship to agriculture and communicable diseases, all show considerable seasonal variation and it is important to know these.

Seasonality mapping is useful for the planning phase and for implementation of health interventions since the diagram depict when certain seasonal diseases such as malaria during the monsoons and summer months, diarrhoea during monsoons, influenza and ARIs during the winters, increase in undernutrition during the slack period in agriculture. Besides these, diseases such as HIV/AIDS or STIs may have higher incidence after the period of migration of community members for work to nearby towns.

A seasonality diagram can be drawn by the community members themselves as part of the PRA subgroup meetings. The main climatic changes with seasons must of course be known- usually the timing of rainfall, and the dry months, the hot months The key variations with seasonality that we usually wish to assess are (i) common diseases- diarrhea, fever, acute respiratory infections, others, (ii) time when adequate food is not available, what food consumption pattern change with various seasons, (iii) social changes – times when labour migrate to other places; times of festivals, times of sowing, harvesting, times whene there is some seasonal manufacture or produce, (iv) access to essential services – drinking water, sanitation, food supplies, Anganwadi, schools.

Seasonality maps help in understanding disease patterns, food and nutritional availability, in planning the best time for undertaking a particular programme to facilitate maximum participation, to address the problems faced in a particular season, such as malaria treatment during monsoons, or because the problem is more amenable to management at the time, HIV/AIDS awareness campaigns prior to the migration season. Seasonality maps are even more relevant in a community with low literacy levels.

Example: Making a Thali Map to understand food patterns in Sonhat village, Chhattisgarh

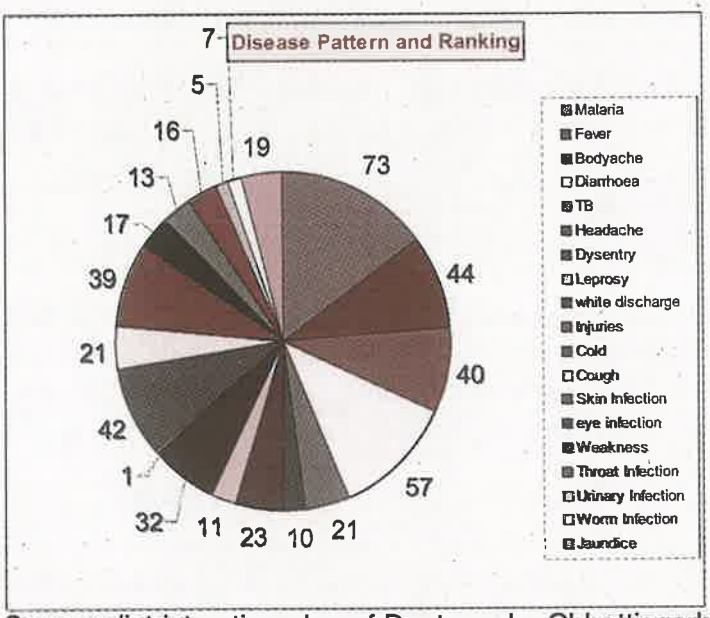
To understand the community's food patterns and nutritional intake, a thali map (a type of seasonality mapping) was undertaken in Sonhat village in Chhattisgarh. A thali (a plate from which people eat) was placed for each season and the people were asked to fill the thalis up with the different food stuff they eat in that season. Where the food item is not immediately available, the people could draw it on a piece of paper and put it in. The information was then put in tabular form (shown below).

Month	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct.	Nov.	Dec.
Thali Contains	Chawal Dal (Mung, Masur, Rahar, Urat)Sabji (Bhaji) Fish, Meat (Occasionally)			Chawal Dal (Mung, Rahart) Sabji (Lal Bhaji) Potato Fish, Meat (Occasionally)			Roti (wheat), Chawal Dal (Mung, Rahar, Usar)Sabji (Lal Bhaji, palak Bhaji) Mushroom (Footo) Fish, Meat (Occasionally)			Roti, Chawal Dal (Mung, Rahar, Urat) Sabji (Lal Bhaji, palak Bhaji), Pumpkin, Rakri Kumra, Karela Fish, Meat (Occasionally)		

Matrix Ranking

Here the process is to understand the importance of different problems, or the priority people accord to different issues. The group is asked to first list the problems. With everyone contributing, such a list is compiled. Then one asks, who are the different sections affected? Then they are asked to list in order of priority which they think is more important – from the most important to the least. Each is assigned a rank. One or two rounds of discussions are needed before they come to a commonly agreed upon ranks. The ranks could be displayed as a bar chart or pie chart – but this is not essential.

Example: Disease ranking as per priority of community:



Source: district action plan of Dantewada, Chhattisgarh

Transect Walk

A transect is a cross section of major land use zones. A transect shows different land use areas, water bodies, channels etc. and compares the main properties/features, resources and resource use, problems in each land use zone. It gives detailed idea of a village community and how the community makes use of the resources, problems related to each type of zone and related to usage of each resource.

The following guidelines can be observed for a transect walk:

- A transect walk needs people from the community who are experienced and knowledgeable. Preferably both men and woman should be involved.

- The transect route has to be decided and this can be done by prior visits to the area and noting key land-use zones, resources, problem areas, landmarks etc. The transect route should cover all the health facilities and providers in the village – public and private, any common places such as the Panchayat office, community hall or maidan, offices of NGOs, the water sources for drinking and agriculture, sanitation facilities, Anganwadi centres, PDS shops, schools.
- After deciding the transect route, a good map of the area is required. This can be an already available map or one which is prepared with help from the community (through a village mapping exercise) if a ready made is not available.
- Once the preparation is done, start walking along your transect route with representatives/ volunteers from the community and one or two friends of yours to assist you to note down the details. (In large villages with hamlets spread across a few kilometers it may be a pragmatic idea "to walk" using a jeep!!)
- While walking, discuss with the community members different factors to be drawn on the transect – problems related to each sector of transect and opportunities, technical improvements required etc.
- Take detailed notes related to each resource like residential area, health facility, health providers' residences, water sources, Anganwadi centres, etc.
- Draw the transect and cross check the transect map with the people who had assisted you.

A transect walk is an excellent tool to extract useful information of natural resources, other community resources, health facilities, and other important structures in the area. It also gives a good idea about the condition of health facilities (physical infrastructure), and whether people are seeking care from that particular facility. It can also show different social groups and their differing perceptions.

Thus a good transect walk can be used to record the requirements of the community as well, and helps start the planning process especially when you are under pressure to speed up the process of community organisation. The exercise of conducting a transect walk need not be a one time event, but several walks with different stakeholders groups. The walk itself serves as a mobilisation and opportunity for people to interact, and can become the beginnings of more organised collective action.

Transect walks before a PRA exercise or combined with a PRA exercise gets a much better village profile map done. In public health, transect walks are particularly useful to discuss vector control, safe water and sanitations issues, and social exclusions.

Venn Diagrams

Constructing Venn diagrams (or *Chapati* diagrams as they are often called), can be another tool used in community diagnosis. This method uses circles of various sizes to represent institutions or individuals. The bigger the circle, the more important is the institution or individual. The distance between circles represents the degree of influence or contact between institutions or individuals. Overlapping circles

indicate interactions, and the extent of overlap can indicate the level of interaction. Normally in a Venn diagram, one dimension, the size of the circle, represents the importance of the institution, influence, perceived danger of disease etc. The second dimension, distance from the village or individual, represents proximity, psychological distance, prevalence of disease, etc. Paper circles are the most frequently used material in Venn diagrams. Drawings on the paper and ground are also used, although this does not allow the size or location of circles to be changed. Sometimes, after the circles are drawn, participants discuss the diagrams and want to change the size or location. They hesitate to do so where the Venn diagram is drawn, but if the circles are cut from paper, they are encouraged to make corrections.

The process of drawing a Venn diagram involves the following steps:

- Carry some colour circular paper in the village to make the Venn diagrams.
- Ask for the names of persons/institutions involved in local power structure - local elite, political leader, religious leader, influential persons, local NGOs, CBOs etc.
- Ask them to make the size of the Venn according to strengths (in terms of resources, manpower/ supporter, control/ working area) of each persons/ institutions.
- Write the name of the village in the middle of a big sheet and ask the participants to put the Venn nearer or furthest to the village according to their linkages/contact with the persons/institutions. After having consent by all, fix the Venn on the sheet.
- Draw lines between each Venn to show their linkages/relationship with each other.

The Venn diagram method in PRA is very useful to study and understand local people's perceptions about institutions, individuals and programmes. The method provides valuable insights into power structures and decision making processes. The extent to which community institutions need to be strengthened can be ascertained. The relative importance of services and programmes can also be studied.

Example: Venn diagram in Tigeri village, Bihar

A Venn diagram was used by an organisation called MAMTA in Tigeri village of Bihar to study the local perception of diseases and their prevalence. The steps used in the Venn diagram process, included:

- listing of diseases by the locals,
- writing the names of diseases/or symbols for different diseases on small cards,
- putting the cards in descending order of perceived danger of diseases,
- asking people to allot different sizes of cut paper circles to the diseases, such that the greater the perceived danger, the bigger the circle and,
- drawing a circle representing Tigeri and asking people to place the circles, such that the closer the circle to Tigeri, the more prevalent is the disease.

The following Venn diagram emerged out of this exercise:

Group Discussion

A group discussion about a specific thematic issue can be organised to understand the community better. The emphasis in GDs is not just to choose the right theme, but also the right people to form the group. The group must represent all the different sections of the community in order that one gets a comprehensive understanding of the issue at hand. Also the group should not be too big, as people may not talk freely in bigger gatherings. However, in ensuring heterogeneities among the group members, it must be remembered that the people from the marginalised sections would require to be constantly encouraged to share their opinions in front of the other, more stronger members. The onus of this lies with the facilitator of the GD.

The following steps can be observed in the process of conducting a Group Discussion:

- It needs a group of people to discuss on a range of issues necessary in the project.
- The group, usually consists of 8-12 members, must be represent cross-sectional people.
- It needs to consider age, sex, occupation, religion and other social groupings in forming the group.
- Ask the possible people/participants to be available in a particular place in a particular time; also inform them about the total time might be consuming for the discussion.
- Let them be well informed about the objectives of such discussion, and try to select appropriate persons/participants for achieving the target of the discussion.
- They will be the key players of the discussion; your role is to facilitate the discussion on issues;

you should not state your own views too strongly. However, the discussion should not be out of track/objective.

- Make a tentative plan about what issues need to be discussed, and how. Try to follow the plan according to the time as well as objectives.
- Make everybody participate well and actively in the discussion. Take care that nobody is trying to influence the discussion or leading it off track.
- Take note of what the people say, which you can record with their permission. Share the responsibilities of who will do what throughout the programme. A team of 2-3 members is better to conduct a group discussion.

Example: Group Discussion on child feeding practices in Gumla district, Jharkhand

Before formulating the intervention plan for behaviour change communication, the community organiser with her colleague facilitated a group discussion among 10 women (from different sections of the community, in the age group of 20-50 years). The theme for discussion was child feeding practices prevalent in the community. The women gathered in the Anganwadi Centre, which was a common venue and easily accessible for all. The women were informed earlier about the topic of the discussion and the participants were selected so that different knowledge and practices prevalent among different generations – new mothers, middle aged mothers, and grandmothers – and among different caste and religious groups. The facilitator, at the outset, made the group feel comfortable about the discussion and with each other, laid out the objectives of the discussion, and how it will inform the programme interventions.

The discussion went on for more than two hours, and the community organiser and her colleague facilitated it to achieve the set objectives, while eliciting active participation from all members. After this process, the following findings emerged out of the group discussion:

- Newborns were not fed colostrum. This was either discarded or offered to the ancestral gods (by the tribal community). The general belief was that colostrum is not good for the newborn.
- The baby is fed goat milk and water immediately after birth.
- Breastfeeding was initiated only after the first three days, after the baby was given a name.
- Exclusive breastfeeding was not practiced, as they continued to feed the baby water and goat milk, even with breast milk.
- Breastfeeding usually continues for 2 years, even after the introduction of solid foods.
- Semi solid foods, cereals, and other foods are initiated when the child reaches 6-7 months of age, and a ceremony is organised to celebrate this.
- Vegetables that are orange or red in colour (such as pumpkin, papaya, mangoes, tomatoes, etc.) were considered 'hot' and not given to children.
- When the child is ill, with fever and cold or diarrhoea, he/she is not given any juicy food items, and the intake of liquids is also controlled, as the belief is that these ailments are caused by excess water in the body.

Community Diagnosis in making village plans for the District Plan

In this lesson we use the term community diagnosis as indicating a process where the commnity is involved using more than one tool (PRA, household surveys, data from records, and other sources) to come to an understanding of the health situation in the village and its determinants and what needs to be done for changing it. This process looks at a combination of subjective perception and objective evidence. It is therefore important to understand the ways in which data from qualitative methods, as outlined in this lesson can be combined with more quantitiative methods as outlined in the earlier lesson.

Relating the PRA/Community Diagnosis Exercise to Village Household Surveys

a) *Before the Village Level household survey*: A PRA can be conducted to help design the questionnaire
- where needless questions need not be asked (for example, if the only source of water that everyone in a village uses is the well or the handpump then one need not have a question in the sheet on the different sources of water and waste time asking this from everyone)
- where essential areas and concerns are not missed (for example, typhoid may be a problem in that village – but a question that would probe this may not be there at all)
- where the choices given to a possible answer cover all the possibilities (for example, many persons may be going to a RMP for curative care in this village – and they call him the doctor without differentiating him from the MBBS doctor. If we knew this confusion we would give the choices such that we can differentiate whom they are talking about)
- that uses the right words and phrases which are locally understood.

b) *After the household survey had been analysed* the PRA helps to:
- seek explanations for different findings (for example, we find in the survey that only one-third of pregnant women are going to the PHC for delivery but two-thirds are going to the RMP or a dai, and then in a PRA we can ask and see patterns and find out which one third it is is and what reasons the others give for not going to a PHC).
- seek determinants for different findings (for example, if there are a number of neonatal deaths we want to know whether the deaths are evenly distributed or more in some communities/hamlets).
- compares situation as assessed from survey with perceptions as assessed from PRA (for example, the PRA may declare that there is no diarrhoea but the household survey may reveal considerable incidence. Or the household survey may have failed to find many RTIs though in group discussions, women declare that it is a common problem. (Note that it is not that one information is correct and the other is wrong but that both methods bring out different perceptions of this issue and their accuracy will vary depending on what is being queried and how.)
- relates the survey data – which is necessarily cross-sectional- with respect to timeline and to seasonlity. (Thus for example we find a lot of diarrhoea in the household survey and the seasonality

study will tell us whether this is an year round phenomena or reflective of the peak occurence because that is the diarrhoea season. In a survey one does not ask about diarrhoea in the past year , one always asks only for incidence of diarrhoea in the past one or two weeks, because recall is poor)

c) *Independent of the household survey:* The PRA helps to get a quick appraisal of the situation and more important it helps to assess the possibilities for action and the perceptions and responses to different proposed action components. This is essential for certain dimensions where household surveys would not have given information and where doing a PRA in all villages is too time consuming. For certain dimensions of programme planning, a limited but very detailed or a theme focussed PRA done in a few villages – just two or three would be very useful. For example just on nutrition issues in one tribal village, or just on the problems of migrant labour and their issues in another village etc.

A RELATIVE ASSESSMENT OF STRENGTHS AND WEAKNESSES

Done by a sensitive facilitator, the PRA could help ensure that people's needs and felt needs are not being forced into the framework set by the programme planners, and there is enough space left for spontaneity and their own perceptions. Household surveys and the very act of making a questionnaire are embedded with a certain desired outcome and therefore the survey makes the whole process more planner-driven. This bias can be overcome by the PRA. But on the other hand the PRA itself can have its own bias and more often than not, the PRA is used to gain acceptance for an externally designed programme also. Only a very conscious facilitator can come outside this mould, and in large scale replication one would never be able to get such sensitive facitilators. The converse of this is that in a poorly done PRA, very little useful action would emerge. On the other hand a survey would always have a minimum level of information output which would be adequate to make a basic plan. It would tend to go a lot less wrong.

For these reasons, it is better to have a mix of both in large scale programmes. On one hand to have an indicator-based numercial assessement that flows out of household surveys, from detailed group discussions and gathered from information available in ANM and AWW records. On the other hand to have a PRA to bring in unstructured concerns, to explore determinants, to make the process of planning public and create community ownership about it. Before the survey, only a few villages need to have PRA done. This is adequate for designing the questionnaire. After the survey/measurement of indicators, there should be a PRA ideally in every village to confirm and share survey findings and to evolve a plan of action.

Faciliators can be trained for this purpose. These would probably be the same faciliators that were required to form the village health and sanitation committees (as has been discussed in Lesson 2). It may also be the same as the facilitators for the ASHA programme.

If the facilitators after training, use their skills to make a few village plans , under guidance then they become fully equipped to train the village health committees, and ASHAs and others for this purpose. But they must make a few plans themselves and these plans must be appraised and improved upon by their guides before they are allowed to train others.

I. Review Questions:

1. Why is it needed to involve the community in a community diagnosis process as part of village health planning?
2. What are the objective of the PRA?
3. What are the various techniques of PRA?
4. What is a transect walk- which components of health planning is it most useful for?
5. How can PRA be used in conjuction with a household survey?

II. Application Questions:

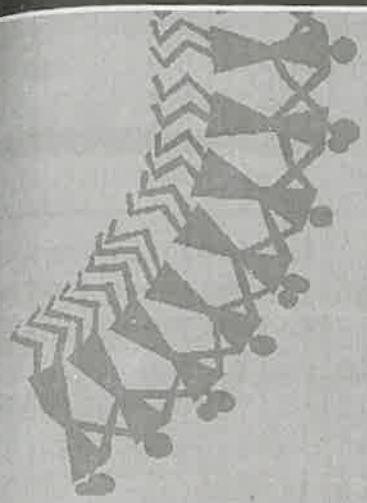
1. Which do you think is more reliable – data from a PRA or data from the household survey?

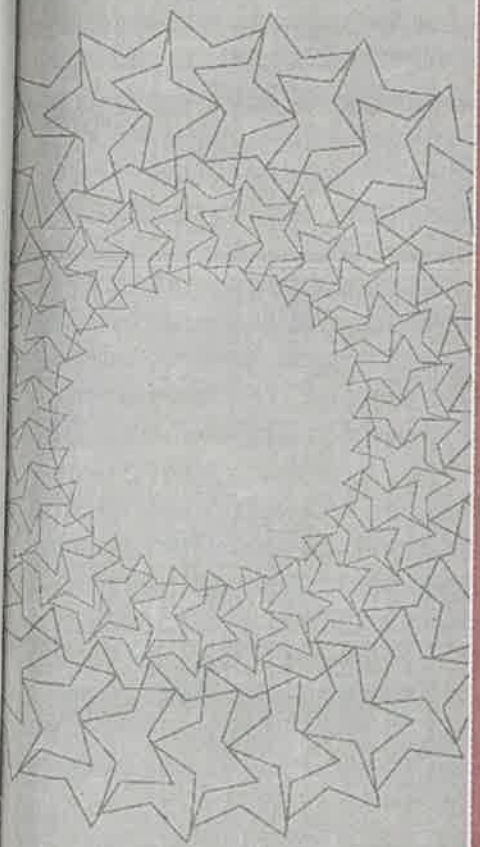
III. Project Work:

1. Do a village PRA to understand the extend and determinants of one major health programme in a village?

Lesson FIVE

Involving Non Governmental Organisations for Community Participation





In this lesson we shall discuss:

- Meaning of the terms organisation, civil society, non governmental organisation (NGO) and people's movements.
- Different types of NGOs.
- Various ways in which NGOs work.
- Advantages and concerns about NGO involvement in the health sector.
- Construction of a policy framework for NGOs within the district plan.

UNDERSTANDING THE TERMS

The term 'NGO' has become commonplace for people working in the areas of development. However, it first came into existence only some decades ago with the establishment of the United Nations in 1945 with provisions in the United Nations Charter for a 'consultative role for organisations that are neither governments nor member states'. Since then, with the evolution of the roles of the NGO, it has come to mean a large variety of organisations which may be very different from one another in many significant ways.

To say that an organisation is an NGO, is therefore no longer sufficient to really understand it at all. In this lesson we shall try to examine the ways in which NGOs differ and their role in development and health in India.

We shall also try to understand another set of processes, largely termed 'movements' and their roles and impact on health and development.

THE MEANINGS OF VARIOUS TERMS

An **organisation** has been defined as a social arrangement which pursues collective goals, which controls its own performance, and which has a boundary separating it from its social environment.

Civil society is composed of the totality of voluntary, civic and social organisations and institutions that form the basis of a functioning society as opposed to the structures of a state (regardless of that state's political system) and of commercial institutions. Civil society refers to the arena of un-coerced collective action by people and their organisations and institutions, around shared interests, purposes and values. In theory, its institutional forms are distinct from those of the state, family and market, though in practice, the boundaries between state, civil society, family and market are often complex and blurred. Often it is not easy to categorise and different authors would use it differently. For example, Panchayati Raj institutions could be considered part of civil society by some or as the state by most, though there are features of both state and civil society that it shares! To the extent that the powers of governance are not transferred to it, its functioning is more akin to civil society.

The term 'civil society', in contrast to the term non governmental organisations, commonly embraces a diversity of spaces, actors and institutional forms, varying in their degree of formality, autonomy and power. Civil societies organisations can be registered charities, development non-governmental organisations, community groups, women's organisations, faith-based organisations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions and advocacy groups.

A **non-profit organisation** "NPO", or "not-for-profit" organisation is one whose primary objective is to support an issue or matter of private interest or public concern for non-commercial purposes. Non-profits may be involved in an innumerable range of areas relating to the arts, charities, education, politics, religion, research, sports or some other endeavor. In the health sector the term is used mostly in reference to the description of the ownership of private hospitals or health facilities where the ownership defines itself so.

The term **non-governmental organisation (NGO)** is used in a variety of ways all over the world and, depending on the context in which it is used, can refer to many different types of organisations. In its broadest sense, a non-governmental organisation is one that is not directly part of the structure of government. It is autonomous of the government for its decision making and ownership. It has its own aims and objectives that it pursues irrespective of the government's aims and objectives. To understand an NGO, one needs to look at different types of NGOs.

Government Led /Sponsored NGOs

A contradiction in terms: The term NGO and the term civil society is often counterposed visavis the government and visavis corporate bodies and commercial bodies. It is generally expected that the non-governmental organisation is independent of both the government and the corporate sector, or at least of the government, as the name implies *that it is not government*. However, this is hardly true today and an increasing numbers of NGOs are not only dependent on one or the other, but are even part of one or the other.

Why do governments sponsor non governmental bodies? The promotion of NGOs by governments is because they realise that to achieve certain goals, it is useful to partner with institutions that have been founded to achieve certain well-defined social objectives but which also enjoy the flexibility of being outside many restrictive government rules. The rules by which people enter into governance roles (their recruitment), their terms of service, their freedom to take initiative are all well regulated if the institution is governmental. This is necessary because the government by definition has power and authority. Many persons would want to enter or command such power, and precautions need to be taken so that access to this power is fair and as per rules. A governmental body is also directly accountable to the minister or council of ministers and its actions thus always reflect government policies. For many roles that are needed to make a public health system functional, such power is unnecessary and such regulations are restrictive. For example, the government's leadership may want to allow space for advocacy which is critical of the government, or for independent evaluation of its programmes, so as to identify its weaknesses and promote change in its own functioning. But this would bring it into conflict with government personnel at lower levels of functioning, and therefore it would create a body that is autonomous of the government for its day-to-day functioning even though this body is fully dependent on grants from it. These are the r easons that governments themselves sponsor non governmental organisations.

Specific Purpose Vehicles: Certain types of service delivery require high degrees of dedication and motivation and specialisation where a person who has made such service delivery his/her life's mission would do much better than someone who is transferred into the job transiently as part of his/her government service. Or as often happens they want an NGO or individual to replicate their work on a larger scale. For such reasons, government encourage interested groups to form organisations and institutions and provide support to them, or they choose an existing group doing good work and equip and support them to provide some of the functions needed on a regular basis.

Para-statal Bodies : Another type of NGO that is increasingly founded by governments is what is called a para-statal body. Here there is a need to fulfil certain roles with a high degree of managerial autonomy and the need to put together a team to do certain tasks. For example, manage a state training center or share management powers of the directorate of health services with others sectors or members of the public. For this purpose a society is formed and registered under the same Societies Registration Act that gives legal status to non governmental organisations. Most or sometimes even all the members are government officers in ex-officio capacity, and therefore they tend to function much like the government except for some flexibilities in human resource management and finance. Not all such flexibilities are put to good use. In our discussion in this chapter such organisations are not considered as NGOs. They will be referred to as para-statal bodies and discussed in Book 11 along with district health management.

NGOs In India: Some Interesting Facts

- It is estimated that there are between 1 and 2 million NGOs in India!
  About 55,000 NGOs exist in Mumbai alone
- About 19.4 million people work in the NGO sector
  Of these about 60 Lakhs are full timers
- During 2000-2001, Rs. 4535.23 crores was recieved as foreign contributions by NGOs
  This was15.56% more than the amount received in the previous year
  Top three recipients were Delhi, Tamil Nadu, Andhra Pradesh
  Largest amount received for Rural Development, Health Care & Family Welfare and Relief for natural calamities :
- Some of the states with high number of NGOs:
  - Gujarat
  - Maharashtra
  - Tamil Nadu
  - West Bengal

Sources: www.indianngo.com, PRIA study

CATEGORISING NON GOVERNMENTAL ORGANISATIONS

What we call NGOs today have evolved from many roots and even now there is such a bewildering variety of NGOs of different purpose and perspective and activities and influence that it is impossible to categorise them in any way without admitting considerable overlaps between different categories.

Over time the main self-image of NGOs in the development sector has developed along two or three distinct lines. One line of development is the change in image from one of doing charity to one of provision of welfare to being rights based organisations. Another path of development of NGOs has been from

doing charity to managing welfare to being social sector entrepreneurs. A third stream of development has been from that of being political organisations of protest to being people's movements and then to NGOs who do both constructive work and advocacy.

Similarly, there has been a transition of the civil society organisations from charity-giving organisations that subsisted on voluntary work and personal donations, to the current trend of large and powerful organisations with formal structures and large funding support from bilateral agencies, international donor agencies or corporate houses. Of course, this entire range of organisations continue to be found in India.

1. Charity Based Organisations : These are no longer as common as earlier. But we do find community groups doing philanthropy or faith based groups dispensing charity. Like we have many organisations who feed the poor on specific days or even daily, or collect and distribute clothes to the poor. The NGO may notice any immediate need and respond to them. They are particularly active in disasters. Indeed all NGOs tend to undertake such work in disaster situations. Even many typical rights based organisation may raise funds from specific charity images of themselves – like helping poor children through education and life. Organisations who do **only** charity work typically have not questioned the structure of society and the causes for poverty and ill health. **They accept the present structure as given and their motives vary.** Some see their charity work as a form of responding to a humanitarian instinct. Some do it for a good name and some for religious motives or for easing their conscience when they are so wealthy amidst so much poverty.

2. Welfare Organisations : The typical welfare organisation is reaching out to vulnerable sections to ensure that they receive some basic provisions of life like food, shelter or health services. Unlike charity they see this service as a necessary social function that society must deliver. However they too do not question the causes of such ill health and inequality and poverty. Rather they may see inequality as essential to encourage growth and ethically acceptable as long as society takes care of welfare functions. Often they have simply not thought about it. Many of them believe that NGOs are inherently better endowed to take on welfare functions than the government. They are characterised by being limited to service delivery with almost no role in advocacy and almost no interventions into the making of health policy or health strategy. Many of the mother NGOs at work are of such a persuasion. Indeed most of the NGOs usually associated in implementing health programmes have such a perspective and limitation.

3. Rights Based Organisations : Here the NGO has a perspective that every citizen has a right to all of the basic provisions of life – food, clothing, shelter, education, health, employment and for freedom from discrimination. Therefore their work is neither charity nor welfare but assisting people to get their rights. To such organisations the current denial of rights is not acceptable and society has to be organised such that everyone will get these rights as part of the normal working of society. It therefore follows that even while they work for immediate provisioning of these basics of life they also work for the reorganisation of society so that inequality and poverty can be put to an end.

4. Developmental NGOs Type 1 : Some of the rights based organisations would focus on developing models of Small Scale self reliant local development. These models they hope can provide models for alternative development policies. Or even if they are not clear about alternatives it provides for the rights of those citizens in that limited number of villages, which to them is better than talking about larger social change. These NGOs put emphasis on building the capacities of local communities to meet their needs through 'self reliant local action'. Many of these organisations would be quite happy not to be known as a rights based NGO and may prefer being known as a developmental NGO. Others would be happy to be known as such (this depends on what is their keenness for change in the system.)

5. Developmental NGOs Type 2 : Other rights based organisations engages in a search for 'sustainable equitable systems development'. This kind of NGO tries to advance changes in policies and institutions at a local, national and international level. They move away from their service delivery role or limited local action role towards actively engaging in policy change- towards a catalytic role. These NGOs would like to be known as rights based NGOs and as development NGOs. Many of the community health worker programmes run by NGOs in India – Jamkhed, Ghadchiroli, Mandwa, Ganiyari Bilaspur, would belong to this stream though a few would belong to the earlier stream. Also many mission and faith based groups have moved through this path of evolution – from charity, to welfare to rights based work.

6. Advocacy Organisations : There are a number of rights based organisations who work only on advocacy issues, building up debate on public policy, and advocating change and articulating the demand of weaker sections. They are not involved in any development action . One major trend amongst the development NGOs and their rights based action is a disbelief in the ability of political processes to effect change. But increasingly this too is giving way to a better understanding of the leading role that political processes have to play for social change to take place.

7. Social Sector Entrepreneurs : Not all welfare organisations moved to becoming rights based organisations. The major trend was for many welfare organisations and groups involved in service delivery to articulate the position that inherently there are many areas where service delivery by NGOs would be more cost efficient and more economic option for the government to exercise – rather than for it to run the programmes itself. With the rise of the ideologies of neo-liberalism and globalisation it has become fashionable to characterise the government as the source of all problems and private sector options as the solution to all problems. In this framework NGOs became a part of the private sector – a form of entrepreneurship for the social sectors that could deliver such services more efficiently than the government could. Now tasks are to be contracted out to NGOs selected through tenders and public bidding much like any other commercial commodity- and NGOs are to prove themselves by bidding to provide the same services at lowest costs. Typically all these NGOs would look at effective service delivery 'as per contract terms' as the goal and most would not be even willing to question these terms let alone subscribe to equity as an essential value.

Earlier only some services like IEC work or services to marginalised sections were seen as NGO strengths in service delivery. But now even mainstream health facilities like primary health centers and district hospitals are planned to be "contracted out" to NGOs. This is discussed further in Book12 along with public private partnerships- and not dealt with further in this section which relates only to NGOs as a form of community participation. Often the donor agencies or government agencies impose pre-selection qualifications like having over 5 lakhs in assets or having done similar contracts before to ensure that only well established NGOs of this type survive.

Such NGOs too like to use the term developmental NGOs to describe themselves. Many of these NGOs are not related to government funds but to one or more corporate sponsors and are forms of corporates exercising their sense of charity, or social responsibility, in a meaningful form. They try to be organised along corporate lines of efficient management. Some of these NGOs themselves raise the funds that they then proceed to spend – thus defining a livelihood closely linked to the corporate structure and its values and standards.

8. NGOs as People's Movements or People's NGOs : There is also increasingly a phenomenon of many organisations which are also registered under the Societies Registration Act which are indistinguishable from other rights based non governmental organisations but which prefer to be known as people's movements.

The central characteristic of these organisations is the importance they place to the understanding that change comes only if people who are most affected themselves take up action for change. They have an understanding that current political forces represent privileged sections and would not be willing to change towards a pro-poor direction unless urged to do so by popular protest or popular pressure. The most important of these is electoral pressure reflected through political parties, but even agitations and mass mobilisation contributes and makes the issues a matter of public debate. This eventually helps building a public consensus around the issue.

Many of these movements arise from explicit political ideological roots – the three most important being the Gandhian movements, the movements of the Left and to a much lessor degree in India, the Green movements.

These organisations are however better understood as NGOs and not as people's movements for they are neither representative of these sections nor constituted by members of the working or marginalised sections themselves. In contrast a trade union is an organisation of workers, a women's movement of women, a youth movement is made of youth, a dalit movement or an adivasi movement or a movement of displaced people is made up of people from these very sections – all fighting for their own sectional rights and for larger political change. All these movements are also largely based on funds raised from amongst the members themselves and dispersed sources of donations. In contrast NGOs that prefer to

be called people's movements see themselves as working *for* these sections or working amongst them but are not constituted by them. Their funds are also external to the people they work.

Some of these people's movement NGOs would emphasise mass membership to differentiate themselves from NGOs. Other would not, being content to see their role as supportive to people's movements. Some of the people's movements would emphasis a democratic decision making and elected office bearers as defining their people's movement status- but in practice key positions are decided by a process of consensus building where the negotiations are not unlike the process of selection seen in all NGOs which have a governing body and executive committee structure. Thus the difference may be more apparent than real. Some of these organisations describe their people's movement character by their oppositional nature to the government and their readiness to, if the need arises, go onto agitation and similar direct forms of protest. To some of these oppositional groups it is a principle not to take funds from the government though they may or may not be open to funds from international funding agencies. Other such NGOs would take funds from the government and even work with it while retaining an independent position on policies and advocacy and even agitation. They see this combination of working with governments and advocacy as the most effective way of influencing government policy and of building public opinion in favour of more pro-poor policies.

The Ideal People's NGO

Ideally we feel that for an organisation to qualify for being called a People's (movement) NGO it should share the following characteristics:

a) It should be committed to a growing mass membership, not an exclusive limited body.
b) It should have a democratic system of governance.
c) It should have an understanding of itself as supportive and catalyst to people's movements and political processes – not replacing them but supplementing them.
d) It should seek to influence government policy in favour of ensuring that people access their basic entitlements and in favour of equity and sustainability as values that govern development.
e) It should be a voluntary association of individuals (members) and with a leadership who see this organisation and its functions as an opportunity to contribute in the spirit of community service to building a better society. This does not preclude being able to make an adequate livelihood and have a sense of personal achievement and social recognition from this engagement, but without detriment to the organisations goals.
f) It may work with the government or outside it, but at all times retaining the institutional mechanisms by which its autonomy in its own governance and in the formation and expression of its views and the priorities it takes up is safeguarded.

Obviously this is an ideal list and we would find very few NGOs that would qualify if all criteria are applied strictly. However it is worth noting that NGOs who call themselves people's movements or see themselves

as supportive to people's movements would agree that these are the ideals that define them. In contrast there are many NGOs, especially most entrepreneur or commercial NGOs which would clearly be excluded by such criteria.

The discussion is not about which is the ideal or even which is the desirable NGO model. The experience with the NGO movement is that for the promotion of health equity, the availability of such a people's NGO is an invaluable asset. And even where no such NGO is available the extent to which the available NGO approximates these features it could help weaker and marginalised sections in accessing health services. Participation of such NGOs at the village level, in the block and district level committees, in community monitoring programmes and in all policy making bodies helps in pushing forward to health equity. Not all governments or administrative leaderships are keen to involve such NGOs. The commitment to involve such NGOs (and the commitment to involve people's movements) is directly proportional to the commitment to achieving health equity.

POLICY CONSTRAINTS AND SELECTION PRESSURES

We are often told that most NGOs have no voluntary spirit and that many are even fraudulent. There is increasing cynicism about this sector. But as we shall see below much of this is also due to problems of governance. Many NGOs are founded with a high degree of motivation and sincerity. However they are acted upon by external forces that mould them and create an atmosphere where the survival of some of them is favoured. Let us look at these pressures:

a. Funding is available only for certain activities. What these activities are, changes abruptly and randomly and sometimes on a continuous basis. Thus an organisation formed from a certain perspective but which is dependent on funding agencies may not survive. Either the organisation should have the flexibility to source funds from many donors or have its own internal funds. Few NGOs manage this and thus most NGOs who survive are service delivery NGOs who will do anything that keeps them employed. These are useful for service delivery but not for advocacy nor for promoting equity or even change.
b. No overheads funding is available. Thus there are no funds to develop internal processes or capacity or survive between projects. This leads to high turnover of staff and poor capacities and poor internal functioning. Indeed only those who manage to save some funds by showing false accounts may survive. In the long term this favours unethical NGOs surviving.
c. There are no fair systems of appraisal and transparent basis of giving NGOs projects. There is not even any effort to ensure that good performances are rewarded by continued programmes and bad performances leads to exclusion from the list. This opens the door to misgovernance and NGOs are given projects based on kick-back payments. This eliminates almost all ethical players and only non-ethical players survive. Thus if authorities complain that 90% of NGOs are bad, there is truth in this, but invariably in such places it is the authorities themselves who made it so.

d. When NGOs are given large projects their internal procedures of functioning are weak. They seldom have democratic systems of governance in place. They can become even more bureaucratised and arbitrary than the government. Thus they may do well in small scale programmes, but seldom deliver on very large programmes which they are doing alone. The ability of corporate NGOs and of large social sector entrepreneur NGOs to manage such projects gives them an ability to survive in such a system. Also systems of selection are designed so that only such NGOs qualify. These have advantages in managing large projects but as forms of community participation they tend to do very poorly.
e. People's NGOs and people's movements which are membership based have high degrees of motivation and voluntarism. Their orientation makes them ideal organisations to provide support to local self governance bodies or to community based programmes. But because of their low budgets and because of the problems of retaining and sustaining high paid technical professionals in a membership based democratic set-up, their capacities for providing technical support tend to be weak. In contrast social entrepreneur NGOs and established service delivery NGOs retain professional capacities much better. If needed they can hire it at short notice. However they are oriented towards centralisation and weak on both participatory processes and empowerment dimensions. If the work is mobilisation, like the ASHA programme, the social entrepreneur has few skills and people's NGOs are needed. But their lack of institutionalisation, a result of current policy frameworks, limit their outreach.

Because of all these pressures and problems, most surviving NGOs do not live up to the expectations that as a sector they have given rise to. This must be seen as a governance problem. A policy framework that brings out the best in NGOs and favours the best NGOs, needs to be put in place. As we show in the section below, this can be done even at the district level.

NGOs can also be classified on the basis of the work they take up, their area of operation or on the nature of their funding.

NGOS AND THE HEALTH SECTOR

NGOs have had a critical role to play in the health sector in India as:

Health care providers: Specially to remote areas and populations. This can happen through NGO community health workers, running clinics and / or running full fledged hospitals
Examples:

- Mission hospitals and faith based organisations: Ramakrishna Mission runs a large network of hospitals and dispensaries. Ramakrishna Mission runs a major hospital and education complex in the Bastar district. The hospital has 30 beds and surgical facilities. This hospital

has considerable government support as well. The Catholic Hospitals Association, the Christian Medical Associations have a network of over 100 hospitals each.

- Worker-run Hospitals: Shaheed Hospital is run by workers associated with the Chhattisgarh Mukti Morcha. This is completely independent of the government, or of any corporate funding. It works by a very efficient management, a very modest remuneration for its dedicated work team, supplemented by voluntary contribution of work time by workers who help with the management.
- Mother NGOs: A large number of NGOs have been chosen for a government funded scheme called the mother NGO scheme. This scheme envisages that a mother NGO would train a number of field NGOs to deliver primary health care services in well defined medically underserved areas. These NGOs are selected through a well laid out process where both state and central government have ownership over this. At the state level another set of Resource NGOs provide support to the mother NGOs through regional resource centers that they run.
- Contracted out Public Services: There is an increasing trend to contract out certain public health facilities- primary health centers, CHCs etc. to NGOs to provide the services in a specified area. An MOU is signed with these NGOs which spells out what services have to be delivered and what payment the government would make. We would discuss this in greater detail in the book on public private partnerships. Here we only note that this could become a major form of NGO contribution in health.

Disseminators of health education: Raising and addressing sensitive issues like sexuality and violence.
Examples:

- CHETNA, Gujarat
- Voluntary Health Association of India

Organisers of people for health rights: There are many NGOs who have sponsored organisations of people for their rights. Some of these could be called people's movements, but most of them are providing support to movements and not movements themselves.
Example:

- People's Science Movements: This has more than 20 organisations which are part of the network.
- NGOs working for womens rights : Centre for Women's Development Studies (CWDS), Joint Women's Programme (JWP), YWCA of India, NAWO
- NGOs working in right to food campaigns and Jan Swasthya Abhiyan.
- NGOs working in areas like tribal rights, rights of dalits, rights of fisher folk etc.

People's Movements who work in this area are discussed in the next section.

Innovators of new programme ideas and methods

Examples

- Jamkhed Programme was a pioneer of community health worker programmes in the country. This success has inspired many community health worker programmes by governments and other NGOs in India and all over the world. .
- SEARCH, Ghadchiroli pioneered the development of Home Based Neonatal Care. They demonstrated that by developing a programme focus on neonates by which community health workers can bring about a measurable change in infant mortality rates. This idea has now been taken up for replication in all the rural districts of five poor performing states of India.
- Jan Swasthya Sahyog, Bilapur has developed low cost diagnostics for a wide range of rural laboratory support.

Advocates for policy reform: These conduct studies and evaluation of health programmes, undertake policy analysis and consultations and at the policy level act as watchdogs on health policy.

Examples:

- Many of the organisations who constitute the Jan Swasthya Abhiyan (see next lesson)
- Population Foundation of India (on population)
- Community Health Cell (on tobacco control)
- Center for Enquiry into Health and Allied Themes (CEHAT)

TECHNICAL SUPPORT NGOS/RESOURCE GROUP NGOS

There is an increasing number of NGOs which are active in the provision of technical support to state governments and to district health societies and to bodies of local governance. Here the major overlap is with consultancy firms and individual consultants, but there are many tasks which NGOs are better suited for. Thus where the technical support is for community based programmes – like the ASHA programme, or building up village level health plans, or working with people living with HIV, or working for street children etc. – NGOs, especially the category described as pro-people NGOs, have distinct advantages. Again where extended support is needed to a programme, not merely a one time consultancy, NGOs may have advantages. This is especially true if the organisation that needs technical support is an elected body of local governance or if it is forum of public participation and the specific need being addressed is to ensure that equity concerns are adhered to. There is a difference in the content of technical assistance given by an NGO concerned in equity and by a commercial consultancy firm .

In the event of decentralisation being taken up seriously, a general strategy of providing technical assistance would be needed. This would require the emergence of a large number of district level resource groups and even block level resource groups who can provide such assistance. While some of the members of the resource groups may be in jobs in various institutions a large number of them would be

part of NGOs. A public health system requires a policy framework that would build such effective district and state health resource centers.

Decentralisation in Kerala

The best example of decentralisation in health care is that of Kerala (described in Lesson 1). Kerala has also some of the most outstanding results on health status. One little appreciated dimension of the Kerala model, is the active role of the NGO in providing technical support to this process. Kerala has a state level NGO called the Kerala Shastra Sahitya Parishad (KSSP). In such an environment other health NGOs have also established themselves. These NGOs especially the KSSP, which is the pioneer of the people's science movement concept see their central role as providing technical assistance to the local self governance bodies. Even where the KSSP as an organisation is not invited, its network penetrate. Its members get included in decision making capacities for a variety of reasons and identities. They are well versed on the critiques of existing health systems and on alternatives. They act as carriers of information on technical choices, and perspectives that relate to such choices and are able to influence decisions so that they are equity sensitive and technically more sound.

CIVIL SOCIETY BEYOND NGOs

Civil society, as we had defined earlier, is composed of the totality of voluntary, civic and social organisations and institutions that form the basis of a functioning society as opposed to the structures of a state (regardless of that state's political system) and of commercial institutions. Civil society refers to the arena of uncoerced collective action by people and their organisations and institutions, around shared interests, purposes and values.

NGOs are one constituent of civil society. But they are not by any means the only or even the most important constituent. We find that the following associations of people also fit into the definition of civil society.

a. Organisations of workingpeople – trade unions, farmers associations, fishermens associations,
b. Associations of different communities – dalits, tribals, caste based organisations
c. Production cooperatives
d. Cultural organisations
e. Organisations of women
f. Students and youth organisations
g. Religious and faith based organisations
h. Educational societies and associations
i. Professional associations
j. Community Based organisations including self help groups

It is worth noting that many of these associations are also very active contributors to the health sector and involved in its decision making and in service provision. Whereas even amongst NGOs there is a majority section that is not committed to equity, most of the above organisations, unless they are organisations of the elite, would have such a commitment and would be able to contribute in a number of ways. They are also more representative of the public as compared to many NGOs and could serve in decision making bodies where civil society representation is called for, especially in pro-equity watchdog bodies.

Even in public provisioning of health services there is scope to expand the use of the term 'public' to go beyond government and include many of these bodies. Some of them like cooperatives and trade unions are already running medical facilities and even hospitals. Though admittedly there are few such examples, these are so inspiring that it is worth emulating. Take for example the Shaheed Hospital in Dalli Rajhara, Chhattisgarh which workers have built and run to take care of a wide variety of medical and surgical illness at amazingly low costs. Or the faith based/mission hospitals many of which have a good track record though equitable access to them could be a problem.

Professional organisations, especially of doctors, are very active in the area of health policy, largely, but not only, to safe guard their interests. Some like the Indian Academy of Pediatricians have been proactive in taking up programmes of social importance or in advocacy campaigns for specific issues.

Advantages and Concerns

The main advantages of civil society participation are :

a. They are needed to play a *watch dog role*. When the government or corporate agencies are playing a major role as providers of health care and funding of health care these agencies have such power vested in them that abuse of such power is frequent especially with respect to weaker sections and more marginalised groups. As individuals these sections cannot ensure a fair deal from the power of the state. Civil society organisations as associations of or for the weaker sections act as checks and balances to government and corporate authority. They also ensure the accountability of systems meant to provide health care.

b. Civil society especially NGOs are needed to *bring in innovation and creativity into health planning*, to experiment with new approaches and designs, to plan new studies and gain new insights into ways of public health.

c. NGOs are needed *to keep equity issues in focus and to reach out to marginalised sections*. This they do by advocacy for health care for these sections and by organising service delivery to reach the unreached.

Concerns

There are three major concerns regarding a policy of funding NGOs in service delivery:

a. *That NGOs are used as cost savings* : One major concern is that the provision of health care through NGOs is being used as a way of reducing public expenditure on health care. This is unacceptable for two reasons. One is that public expenditure in India is already one of the lowest. The second is that such cost savings is usually by lowering wages, that too for women, in positions like nurses and paramedicals, or by reducing quality of care. Of course it need not be so if an NGO with a high motivation is chosen. However, when contracting out to NGOs becomes a system, entrepreneur NGOs would dominate and then in that logic such cost cutting is not bad ethics, it is sound business practice and efficient management.

b. *That NGOs are being used as a cover for the retreat of the state and avoiding accountability:* The concern is that eventually NGOs would be encouraged to charge user fees and recover costs in part or on fully. Gradually the government would retreat, and reduce its share till it builds a system where most payments are made by the people. The NGOs would be accountable to deliver what is in its contract to deliver and not what people need or want. Indeed the fear is that accountability to the community would decrease.

c. *That NGOs are being used to reduce public participation:* This is a paradox and should be explained as such. A concern is that with contracts between the state and the NGO taking center stage, the role of community participation and local accountability would paradoxically decrease. Though NGOs are involved in the name of increasing community participation, we have discussed above how it is not necessarily the outcome. This is specially likely to be the case as the system is auctioned out to lowest bidders and NGOs are selected on grounds of ability to provide the cheapest service.

In summary: the eventual outcome of how we use NGOs or civil society depends on what planners expect from it and what we use them for. They could be used for increasing accountability, and creativity and sensitivity to equity concerns within the health system – or they could be used to reduce costs of care and accountability. They could be used to supplement and strengthen a robust public health system, or they could be used to begin a retreat from the promise to provide such a system.

INVOLVING NGOs IN THE DISTRICT PLAN

1. **Listing all NGOs and getting to know them and their strengths and limitations.**
   One important step is to list all NGOs, and build a small profile of them. The profile should include in the least an assessment of their past work, their management structure, their capacities, and their perspectives

2. **Involving all NGOs in various activities at village, block and district level.**
There is enough work to go around. Though it is impossible to provide funds to all NGOs one can find work that they can do – often with no funds, so that they are recognised and may be available for future roles. The activities that they could be entrusted with include:

   a. Assistance in making village plans in a few villages.
   b. Assistance in the block or district health planning team.
   c. IEC work in some villages.
   d. Participation in hospital management committees.
   e. Organising community monitoring.
   f. Conducting capacity building programmes especially in the community.
   g. Managing special facilities or mobile units.
   h. Participation in major campaigns like pulse polio or rapid fever survey when much voluntary manpower is needed.
   i. Providing regular support and encouragement to ASHAs.

3. **Policy framework for encouraging NGOs.**
Some of the NGOs could be chosen for a more central supportive role or their capacities developed for providing services on the long term. To do this the district would need to develop a policy framework for involving NGOs. The district health society should decide and adopt such a framework. Such a framework would specify:

   a. The formation of a grants in aid or NGO committee that would choose and allot projects to NGOs on a fair and transparent basis. Also where appropriate NGOs are chosen for different tasks based on their capacities and their perspectives.
   b. The provision of adequate overheads (normally 10%) in the budget given to the organisation which the NGO could use towards its own corpus and for internal processes – so that it is not forced to use wrong accounting and has a reserve to survive between projects.
   c. Capacity building of the organisation or provision for them to acquire capacity where required.
   d. A clear MOU which lays down the responsibility of both the NGO and the government and defines what outcomes are expected and what budget has been committed. This MOU would also be the basis for accountability, deciding whether they have delivered on their commitments or not.
   e. Being able to define clearly how credit for the NGO contribution would be acknowledged and how they would acknowledge government role – so that there is no misunderstanding on this score.
   f. Clear respect for the autonomy of the NGO. Beyond the area of accountability as specified by the MOU, the NGO requires such autonomy in its own internal processes and in what other activities it takes up.

g. Assistance to the good NGOs who are able to provide technical assistance and support to community mobilisation to institutionalise and continue to provide support within the district. One approach to institutionalising an NGOs support is to give it a core support for it to sustain itself and then in addition give it projects from time to ensure full utilisation. Where extensive use of NGOs to provide technical assistance to different levels of decentralisaed planning is intended and one needs to ensure that the NGO can build and retain professionals, such an approach would be essential.

I. Review Questions:

1. what are the different roles played by NGOs in the social sector?
2. what are the different perspectives that define NGOs?
3. what are civil society organisations other than NGOs?
4. what are the concerns regarding the increasing involvement of NGOs
5. How does one build a district policy to encourage good NGOs.

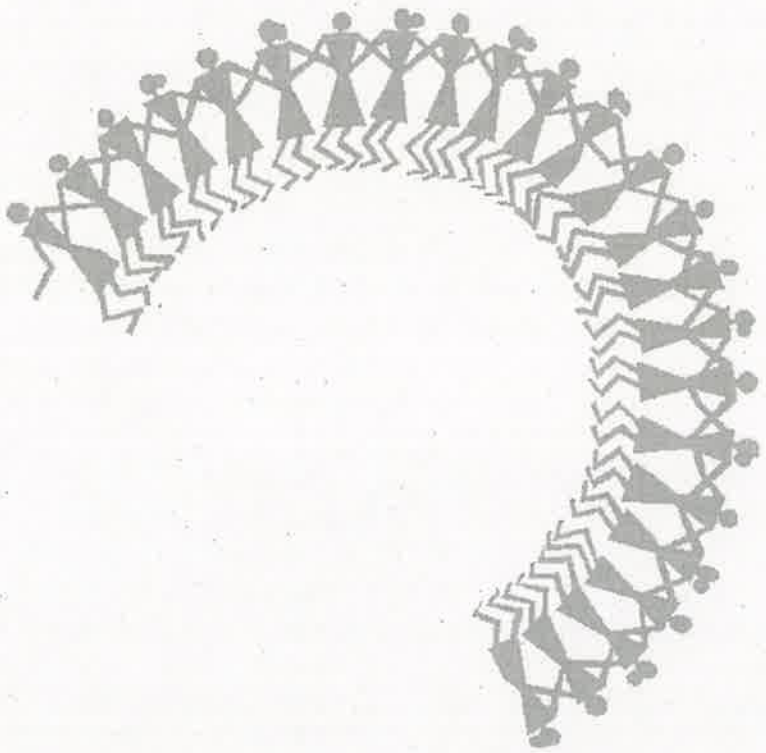
II. Application questions:

1. how can NGOs participate in the NRHM? At what levels and for what functions? Describe the role of NGOs in the District Health Plan in some detail. Give examples for your suggestions.
2. Do you think the nature of funding influences the policies and practices of recipients? If so, how? Give examples
3. in your opinion, do NGOs help or harm? Discuss in detail with reasons and evidence.

III. Project Application:

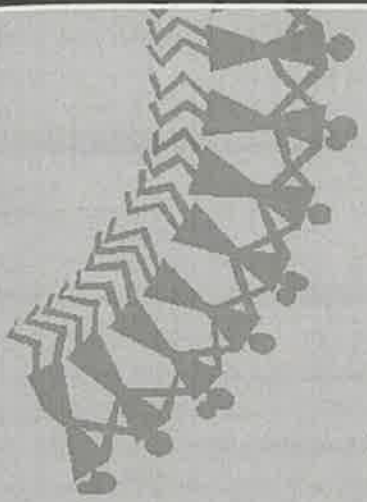
1. Study, analyse and describe the history and work of one prominent health- NGO working in your area.

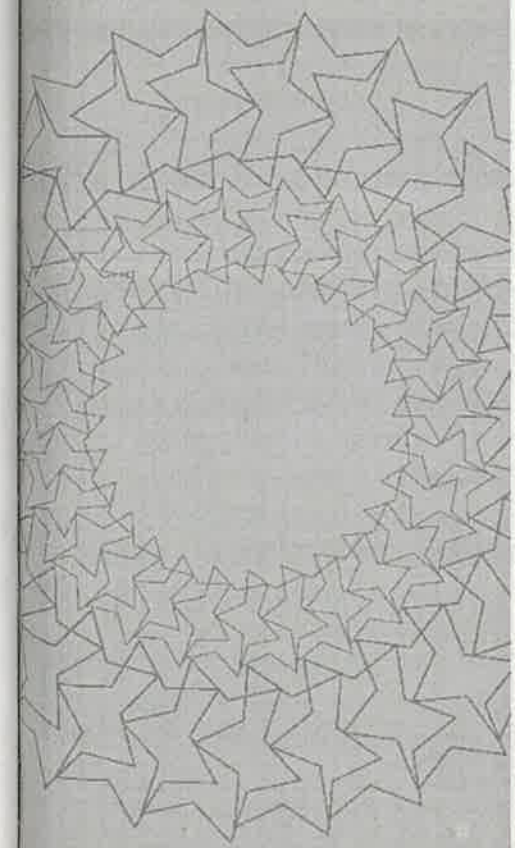
NOTES



Lesson SIX

People's Movements and Campaigns for Health





In this lesson we shall discuss:

- The way the terms people's movements and campaigns are used.
- Growth and experience of the People's Health Movement.
- Growth and experience of the Right to Food Campaign.
- An assessment of the potentials and limitations of movements.

UNDERSTANDING THE TERMS

A people's movement can be defined as 'a collective acting with some degree of organisation and continuity outside of institutional channels for the purpose of promoting or resisting change in the group, society, or world order of which it is a part'.[1] Or to put it more simply, it is a group of individuals and/or organisations that have come together to gain strength for a common cause. Usually in this context "people" gain power by acting together and they use this power to question or change decisions made by individuals who command privilege and power.

A campaign is defined a series of operations/activities undertaken to achieve a set goal. A campaign can be launched by an organisation (for example, an advertising campaign, or a political pre-election campaign) or by people's movement.

In the context of this lesson, the campaigns being referred to are of two types. The first type is campaigns launched by people's movements in order to realise specific rights, such as the right to health or the right to food or the right to free education, or the right to shelter/housing etc. In India, significant people's movements of our time also cover areas such as civil liberties, women's rights, ending discrimination on caste and ethnic grounds, peace and de-militarisation or nuclear disarmament. Such campaigns may or may not be linked to political parties, but since they are seeking change in power relationships they are in the larger sense of the term, always 'political'.

The second type of campaigns is those also launched by governments and non governmental organisations. In this context they usually imply an active process of social mobilisation – for instance, a family planning campaign or a pulse polio campaign or a campaign for promoting breast-feeding etc.We have discussed the concept of social mobilisation in Lesson 4. In this context, campaign is the coordinated activity of a large number and variety of forces to act together for a common cause where usually some change in behaviour/practice is sought. These campaigns do not seek to alter current relationships of power and are therefore usually non political. However this does not exclude political parties – usually ruling parties who have reasons for preferring the status quo in power relationships – from being associated with such mobilisation.

In some issues such a differentiation is difficult. Thus a campaign against sex selective abortion is a mobilisation for a change of behaviour but it is also a struggle against relationships of power. Whether it would have the latter characteristic, depends on who takes up this campaign and their own perspectives.

1. McAdam, Doug and David Snow (1997) (Eds.): *Social Movements: Readings on their Emergence, Mobilization and Dynamics*, Oxford University Press, New Delhi.

ONGOING PEOPLE'S HEALTH CAMPAIGNS

With this background, we shall look at two campaigns that are active in India and have significantly influenced public heath. These also serve as case studies of how people's movements and campaigns can influence policy and health practices.

These are the People's Health Movement – India i.e. the Jan Swasthya Abhiyan and the Right to Food Campaign. Both are specifically related to the right to health, and thus very relevant to public health goals, though they do not participate directly in the implementation of health programmes.

The processes involved in such people's campaigns are many. They include:

- Meetings of concerned citizens and organisations.
- Organisations of seminars and conferences for public education on the concerned issues.
- Adoption of resolutions expressing joint views and submission of these to authorities.
- Press releases and promotion of media stories in support of the cause.
- Public education through a variety of means – use of folk art, use of mass media, distribution of pamphlets and sale of books on the topic.
- Rallies, jathas and events organised to draw media and public attention to the cause.
- Protests, demonstrations and agitations organised to show anger and to bring public pressure to bear on the topic.
- Innovative direct action organised as events. (For example, in the Right to Food Campaign, protesters demanding universal school mid-day meals raised funds and cooked food and served mid-day meals to children in all schools in their area as part of drawing attention to the issue). These forms of direct action are often called Gandhian forms of protest - inspired as they are by the famous Dandi yatra to make salt, which caught the imagination of the nation then - once again and increasingly catching the attention of people all over the world.
- Influencing electorates or specific electoral constituencies to bring pressure to bear on the candidates and those elected so as to induce change. Raising the issue in legislatures and parliaments and in local bodies of governance are important processes for securing change.
- Using the power of the judiciary to seek certain changes as part of the rights to equality and right to life and social justice. Judicial pronouncements force policy changes in themselves and, in an era of public litigation, also serve to highlight issues and strengthen people's campaigns, rather than themselves being able to force change.

The processes described in the examples below illustrate the various actors and players involved in processes of building such campaigns, other than organisations of working people, such as the judiciary, the media, the academic community, NGOs and concerned intellectuals.

Such people's campaigns can either involve only one or two organisations, or can be a form of joint action by a number of organisations. Since the latter brings far more pressure to bear on the issue, the more successful campaigns are usually of this type.

Joint campaigns require processes for maintaining unity, coordination and coherence. These could take highly organised forms when they become a virtual mega-organisation or it could take the form of networks or a joint platform, where the organisations maintain their distinct identity and goals and activities – coming together only for the specific cause. The process of maintaining such a joint platform or coordination is now known by the term 'networking' – where there is a constant effort to build up synergies between the participating organisations and arrive at consensus positions with those working for change.

JAN SWASTHYA ABHIYAN [2]

Jan Swasthya Abhiyan (JSA),literally means People's Health Campaign. This is a national level rights-based campaign having as its guiding vision statement the simple but powerful phrase, 'Health for all – Now!' coined in the year 2000. This symbolically represented a reaffirmation from people's movements, that governments be held to the commitment of "Health for all by the year 2000" that they had signed in Alma Ata in the year 1978. This campaign is organised by a coalition of networks of non governmental organisations and people's movements involved in health care delivery and health policy, who made themselves a part of the People's Health Assembly campaign in India in 2000, and have continued to participate in this process.

PEOPLES HEALTH ASSEMBLY (PHA) IN DHAKA IN 2000

The Alma Ata Declaration of 1978, to which all governments of the world were signatories, promised "Health for All by 2000". However as the year 2000 approached it was clear that this promise had been largely forgotten by governments and international institutions around the world. To remind people of this forgotten commitment, the First People's Health Assembly was organised in Savar, Bangladesh in December 2000. The People's Health Assembly was a coming together of people's movements and other non government civil society organisations all over the world to reiterate the pledge for Health for All and to make governments take this promise seriously. The assembly also aimed to build global solidarity, and to bring together people's movements and organisations working to advance the people's health in the context of policies of globalisation.

NATIONAL HEALTH ASSEMBLY - THE YEAR 2000 MEGA EVENT

Prior to the International People's Health Assembly, India witnessed the largest mobilisation, spread across almost 30,000 villages. More than 2000 organisations participated in a country-wide mobilisation in about 300 districts in 20 states. The campaign was jointly led by 18 National Networks. This was the first time the

2. This section is adapted from a number of JSA documents including the JSA brochure and JSA Charter, as well as the brochure for the National Health Assembly II, Bhopal, 2007. You could also refer to the JSA website (http://www.phmindia.org).

country witnessed the coming together of many diverse organisations and movements on the issue of health. Over the course of the years, new networks and organisations have added their strength to JSA.

The final culmination of this nationwide process was the National Health Assembly (NHA-I) held in Kolkata on December 1, 2000. More than 2300 delegates from all parts of the country traveled to Kolkata to participate in the National Health Assembly. Significantly the conference was inaugurated by none other than the great Hafden Mahler, former secretary of the World Health organisation and the key architect of the Health for All declaration. Hafden Mahler called the series of books on primary health care brought out by the People's Health Campaign India as the one of the best expositions of the concept of primary health care he had ever seen. Along with explaining and reaffirming the commitment to universal comprehensive primary health care, the basic papers of the conference, outlined a critical analysis of the Indian health scenario in the context of globalisation. One of the most important events of the National Health Assembly was the adoption of a 20-point charter known as the **Indian Peoples' Health Charter.**[3] This charter provided a statement of the shared understanding and goals that unite all the organisations working as part of this network of networks.

Following the conference, the organisations that had come together for the assembly, decided to take the movement forward as a more sustained campaign. More lasting organisational structures were developed to sustain this campaign and a decision was taken to call this network of organisations as the Jan Swasthya Abhiyan (JSA) which translates in English as the People's Health Campaign.

The Jan Swasthya Abhiyan is the most significant non governmental coalition existing today which is active for health rights and it is a source of considerable inspiration and motivation to those working for pro-poor changes in the health system.

Objectives

The main objectives of JSA are as follows:

1. Jan Swasthya Abhiyan aims to draw public attention to the adverse impact of the various economic policies on the health of Indian people, especially on the health of the poor.
2. Jan Swasthya Abhiyan aims to focus public attention on the passing of the year 2000 without the fulfillment of the 'Health for All by 2000 A.D.' pledge. The JSA seeks a renewal of this commitment, with the slogan 'Health for All - Now!' JSA considers the Rights to Health and Health Care as basic human rights and is committed to work towards it. It also believes that health and equitable development need to be re-established as priorities in local, national, international policy-making, with Primary Health Care as a major strategy for achieving these priorities.
3. The thrust for privatisation and retreat of the state with poor regulatory mechanisms has exacerbated the trends to commercialise medical care. Irrational, unethical and exploitative medical practices are

3. See the PHRN / SHRC website (http://www.shrc.org) for this charter.

flourishing and growing. JSA expresses the need to confront such commercialisation, while establishing minimum standards and rational treatment guidelines for health care.

4. Jan Swasthya Abhiyan feels that there is an urgent need to promote decentralisation of health care and build up integrated, comprehensive and participatory approaches to health care that places "People's Health in People's Hands".
5. Jan Swasthya Abhiyan seeks to network with all those interested in promoting people's health. It seeks to initiate and promote a wide variety of people's initiatives that would help the poor and the marginalised to organise and access better health care, while contributing to building long-term and sustainable solutions to health problems.

Ongoing JSA campaigns

The participating organisations and networks in the JSA have their own independent activities. In addition, the JSA co-ordinates national or regional campaigns/activities that involve all or a major section of its constituents. Some of the major campaigns initiated and co-ordinated by the JSA are given in the box below.

Ongoing JSA Campaigns

People's Rural Health Watch (PRHW): The PRHW is an initiative to collect information on, assess and analyse the activities under the National Rural Health Mission (NRHM), both at the state and national levels; communicate and disseminate all such documentation and information through reports and other means; and provide feedback for improvement.

Right to Health Care Campaign: A nationwide campaign by Jan Swasthya Abhiyan to establish the Right to Health Care as a basic human right for every citizen in India. As part of this campaign Public Hearings on Denial of Health Care have been organised all over India in collaboration with the National Human Rights Commission.

Campaign against Sex Selective Abortions: In response to the Public Interest Litigation regarding Pre Natal Diagnostic Tests and Sex Selective Abortions filed in Supreme Court, JSA initiated a campaign related to constitution of appropriate authorities, registration of ultrasound centers, ban on advertisements, displaying posters in clinics and the issue of son preference. This campaign was taken up intensively in a number of states especially in Tamil Nadu, Haryana and Himachal Pradesh in 2001.

Hunger Watch: Jan Swasthya Abhiyan has set up a 'Hunger Watch' group consisting of public health and nutrition experts to provide assistance to the Right to Food Campaign. A JSA 'Hunger Watch' group has prepared a protocol to investigate cases of hunger-related or starvation deaths.

Involvement in the Right to Food Campaign: In several states, surveys have been conducted by JSA constituents on the status of mid-day meal and other schemes. In several states, a convention on 'Right to Food - Right to health' has been organised. A resource material package in the form of a book "If even one person goes hungry...." was brought out by Tamil Nadu Science Forum and Bharat Gyan Vigyan Samiti for the Right to Food Campaign and it has served to inform the public and keep the issue alive. There is a growing focus on 'Children's Right to Food' and Jan Swasthya Abhiyan has played a key role in the development of this campaign and issue within the overall campaign for the Right to Food. Many policy interventions in schemes like National Maternity Benefits Scheme and the ICDS have been incorporated by the Supreme Court in its orders as well as by the government.

Civil Society Facilitation in the Asian Region for the Commission on Social Determinants of Health: JSA has been identified as one of the two organisations in the Asian regions to facilitate civil society participation in the Commission on Social Determinants of Health, constituted by the WHO. Towards this end JSA has helped convened meetings in 10 countries of the region. JSA is in the process of facilitating Civil Society inputs into the Commission's final report.

Interventions by the JSA in major issues related to Public Health

In addition to the major campaigns described above, JSA has intervened in several national policy issues and processes. Some of the key ones are given in the box below:

Interventions by the JSA in major issues related to Public Health

National Rural Health Mission : The recently launched National Rural Health Mission aims to fulfill the United Progressive Government's commitment to meet people's aspirations for better health and access to health care. The JSA has been engaged in impacting on the development of the Mission's perspective and plan of action through dialogues with policy makers, participation in the Mission's Task Forces, and mobilisation of its constituents.

The Eleventh Plan : Many JSA members have been participating in the various committees and sub groups set up by the government to assist the Plan process. The information received by these participants is shared within the campaign and consensus positions are developed and taken to the committees and sub committees.

TRIPS and the Indian Patent Amendment Act : The TRIPS agreement required India to change to a Product Patent regime in the area of pharmaceuticals and food, from the earlier system provided in the Amendment of the Indian Patents Act of 1970 which did not provide for Product Patents in these areas. Such a move has many negative implications on people's ability to access essential medicines. The JSA has been an active partner in the campaign to pressure the government to make full use of the safeguards available in the TRIPS agreement to safeguard Public Health.

Initiatives related to Drug Policy : The JSA has been active in pursuing the development of a National Pharmaceutical Policy that addresses the critical issue of universal access to essential medicines and of national self-reliance. The National Policy on Pharmaceuticals was discussed when it was in the draft stage and a JSA critique was evolved which was widely shared. JSA participated in a public campaign concerning the Pharmaceutical Policy, which was initiated by one of its constituent organisations – the Federation of Medical Representatives Association of India (FMRAI). Many states have held discussions regarding an essential drug policy and to build public awareness on the impact of globalisation on the pharmaceutical sector.

Tsunami Response : Many JSA constituents were involved in the relief and rehabilitation work after the December 2004 Tsunami. Those involved were often able to draw upon help where needed from other network constituents.

Initiatives related to Health Policy : The JSA has been involved in a number of critiques of government policies both at the state and at the national level. The JSA elaborated a detailed critique of the National Health Policy draft in 2001, which pointed out to the inadequacy of the Policy in many key elements. The critique served to educate all the JSA member organisations on this development, and has been published in booklet form. A series of seminars and press releases explained this position to the general public. This detailed critique with alternative proposals was submitted to Health Ministry but unfortunately could not influence the policy in a significant manner.

National Health Assembly II : Currently, the campaign is engaged in preparing for the National Health Assembly II, March 2007, Bhopal. The process is intended to rejuvenate the campaign and provide an opportunity to take stock of the current health scenario in the country, evaluate the campaign's own functioning and effectiveness over the last few years, regroup as well as plan for the next few years.

An Assessment of Jan Swasthya Abhiyan

Strengths

The campaign is able to respond with considerable intensity and depth to a wide number of public health issues. It is thus able to respond to and intervene in public health policy as it is being laid down by the government.

It searches for, offers and widely disseminates alternative perspectives on technology and public health policy, that can question dominant perspectives. The campaign, with its various processes and events, brings in many diverse players, with a very wide diversity of views and ideologies into the same platform. It also sensitises and inspires many young people especially young intellectuals to take to a path of service for the poor. It has played a critical role in creating a civil society mass movement, providing a base for alternative dialogue and enriching the democratic society of India.

Weaknesses

The JSA can speak with many voices. On many issues, important constituents of the network may take actions quite different from the common position or even from what they themselves are articulating separately. This is natural, for it is a network and not an organisation, and such diversity is its strength. But it can be very confusing for those dealing with it or for bringing effective pressure to shift policy making in a pro-poor direction. For example, on the ASHA programme, the JSA was able to secure many design changes – but on many crucial points, its opinion was divided. Another example is public private partnerships. There are at least three positions within the movement. On many issues like this, it takes time for consensus to evolve and indeed a consensus may never evolve. As a result there is an understanding that constituent members of the network can take up work or even take positions which at times are at variance with the JSA "consensus" position. On a number of issues the JSA articulates "consensus" positions, because of the pro-active role of some members who feel strongly about it. The process of a stand point becoming a JSA consensus position is not clear.

Despite these limitations, and perhaps because it allows such flexibility, the network survives and continues to serve. However its impact on various issues varies from having had no impact to having been able to set the pace on change.

Such networking is an organisational challenge. The challenge is a painstaking process of maintaining communication amongst a variety of groups that are spread all over the country. Internet access has made this possible. But where participants may not have Internet access, communication tends to break down. Most persons earn their salary from different jobs and therefore spend only a part of their time on this network's coordinated actions. Only a handful of persons work full time. As a result planning work is

difficult and much flexibility and uncertainty surrounds its functioning. However many activists are leading members of different NGOs and to some extent can command their own time.

Of course, this form of organisation is a conscious choice and offset by the understanding that decentralised, voluntary functioning is the core principle of the campaign. Currently, a group of 12 persons constitute a working group that is assisted by two Secretariats (with 1-2 full time employees each). The decision making body is the National Coordination Committee that comprises of representatives of each of the member networks. The charter is used as the broad consensus statement to which all members conform and to which they refer in case of confusion or conflict. This is periodically updated as is to happen in the NHA-II by democratic processes and wide consultation.

A BRIEF NOTE ON SOME OF THE CONSTITUENT ORGANISATIONS/NETWORKS

JSA is a mix of other people's movements and NGOs and resource groups for research and advocacy on health issues. We give below a brief profile of each of these organisations and their strengths and contact addresses.

All India People's Science Network (AIPSN)

This is a network made up of over 20 state level registered NGOs known collectively as people's science movements. More well known of these are the Kerala Shastra Sahitya Parishad, the Tamil Nadu Science Forum, the Delhi Science Forum and the Pashim Bangla Vigyana Manch. There are similar state level organisations in over 21states and union territories. These organisations have a focus on science popularisation and on issues of science and technology policy including health policy. They are strongly pro-equity and ideologically very much of a leftist persuasion. Their capacities vary widely from state to state. In the Hindi speaking states their state organisations are usually known as Gyan Vigyan Samitis and also part of the Bharat Gyan Vigyan Samiti.

Strengths: Good for advocacy roles. Willing to work with governments if the policy framework is acceptable. Capacities vary from state to state, but have some of the best networks extending to wide number of districts.

Contact
c/o Delhi Science Forum, D 158, Lower Ground Floor, Saket, New Delhi, India 110 017
Phone: 011-2652-4323, 2652-4324; Fax: 011-2686-2716
Website: http://www.delhiscienceforum.org

All India Drug Action Network (AIDAN)

For the past 20 years, a group of activists-doctors and non-doctors-under the banner of the All India Drug Action Network (AIDAN) have been in the forefront of advocacy for a rational drug policy. AIDAN was founded in 1981-82. Before this, members of the Medico Friends Circle had been expressing concern about the political economy of the drug industry. AIDAN was the first nationwide network on the drugs (medicines) issue, seeking to bring together a diverse range of activists, academicians and even trade unionists.

Contact
A-60 Hauz Khas, New Delhi 110 016
E-mail: drdabade@gmail.com / mirashiva@yahoo.com

Asian Community health Action Network (ACHAN)

ACHAN was started in 1980 to specifically address the health needs of the poor in Asia. It was started by a group of practitioners of community health, academicians and philosophers from Asia. It is an international NGO with limited national presence.

Strengths: International Policy articulation.

Contact
Post Bag 1404, Chennai 600 105
Phone: 044-2823-1554; Fax: 044-2827-0424
E-mail: prem@md2.vsnl.net.in / achan@aworld.net.in

All India Democratic Women's Association (AIDWA)

AIDWA is an independent left-oriented women's organisation committed to achieving democracy, equality and women's emancipation. AIDWA members are from all strata in society, regardless of class, caste and community. It has an organisational presence in 22 states in India, with a current membership of more than 1 crore. About two-thirds of the organisation's strength is derived from poor rural and urban women. AIDWA was founded in 1981 as a national level mass organisation of women. Most of the membership is from the CPM ruled states of Kerala, West Bengal and Tripura, but it has an impressive presence in over 14 states. Funded purely from its own membership subscription. Very close to ideal of people's movement.

Strengths: Advocacy, protest in favour of pro- poor policies. Considerable political presence. Limited strengths in working with governments or in interventions to improve quality of programme implementations.

Contact
121, Vithal Bhai Patel House, Rafi Marg, New Delhi – 110 001
Phone: 011-2371-0476 / 2331-9566; Fax: 011-2371-0476
E-mail: info@aidwa.org / aidwa@ndb.vsnl.net.in / aidwa@rediffmail.com
Website: http://www.aidwa.org

Association for India's Development (AID – India)

Association for India's Development (AID) is a volunteer movement committed to promoting sustainable development of India. It was started in Maryland, USA in 1991 by a group of Indian students. Its volunteer base grew rapidly and there are 40 chapters currently in the USA. Today AID-India (an associated but independent organisation) has ten chapters across the country and 1,000 direct volunteers who participate in the NGO's education, women and children's health, rural development programmes, and technology and agriculture initiatives in 300 villages. It also works with partner NGOs in around 1,000 villages providing training, materials and field level support to improve the quality of education in government schools and *balwadis*. The organisation is led by a number of foreign-returned technocrats and is funded by progressive

NRI individuals in the US and by Indian students studying abroad. AID works closely with people's science movements and with national alliance of people's movements. It has a good presence in about four states.

Strengths: Can deliver partnership programmes in states and districts where they have strength and agree to take it up. Excellent support NGO for small local NGOs. Since their funds are raised by themselves from small dispersed contributions largely from Indian students themselves, they do not have many of the problems associated with other foreign funding agencies.

Contact
P.O Box "F", College Park, MD 20741-3005, USA Website: http://www.aidindia.org

Bharat Gyan Vigyan Samiti (BGVS)

Sponsored jointly by the government and a number of people's science movement in 1990, for providing "people's support" to the total literacy campaigns. It is an off shoot of the All India People's Science Network and subsequently became a full fledged national NGO, with state branches in 15 states, but retaining its links with the AIPSN. From 1993 to about 2003, it led community health programmes in a number of states pioneering the concept of CHW as a village health activist working to secure health care entitlements.

Strengths: Good district level contacts in a large number of districts. Skilled in the use of the *kalajatha* for mass communication. Good in mobilisation and can ensure a large turn out in national and state level events. Capacities in health currently restricted to a few districts across the country.

Contact
Basement of Y.W.A. Hostel No. II, Avenue - 21, G-Block, Saket, New Delhi 110 017
Phone: 011- 2656-9943; Fax: 011- 2656-9773
E-mail: bgvs_delhi@yahoo.co.in / bgvsdelhi@gmail.com

Breastfeeding Promotion Network of India (BPNI)

BPNI, founded in 1991, is a registered national organisation that works towards protecting, promoting and supporting breastfeeding and appropriate complementary feeding of infants & young children. It serves as the Regional Coordinating Office of International Baby Food Action Network (IBFAN) for Asia Pacific, which is a network of groups working to promote optimal infant and young child nutrition in over 43 countries. BPNI is also the Regional Focal Point, South Asia for World Alliance for Breastfeeding Action (WABA) for the celebration of the first week of August as the World Breastfeeding Week. It is also a member of the UNICEF NGO Committee

This is a membership of health professionals including a number of pediatricians along with a few professionals from other areas. They have been very focused and quite effective in pushing through major changes in favour of promoting breastfeeding. They have done important work in enforcing and protecting the IMS Act.

Contact
BP-33 Pitampura, Delhi 110 088
Phone: 011-2734-3608; Fax: 011-2734-3606
E-mail: bpni@bpni.org / bpni.india@gmail.com / Website: http://www.bpni.org

Catholic Health Association of India (CHAI)

A faith based organisation, its members run a very large network of mission hospitals and other health facilities. CHAI is one of the world's largest non-governmental organisation in the health sector with nearly 3,226 member institutions, which include big, medium and small hospitals, health centres and diocesan social service societies. it was established in 1943. The members of the association are located in various parts of the country – urban, semi-urban, rural and tribal settlements and are predominantly engaged in providing curative care extending health care facilitates to the poor and marginalised. The health centres, which form majority of CHAI membership, deliver mainly curative and promotive health services. It also comprises of organisations of sisters who are qualified doctors, of hospital managements etc. The organisation has moved from charity to welfare and now agrees with rights perspectives too in most areas of work.

Contact
157/6, Gunrock Enclave, Secuderabad 500 009
Phone: 040-2784-8293, 2784-8457, 2784-1610; Fax: 040-2781-1982
E-mail: info@chai-india.org / Website: http://www.chai-india.org

Centre for Community Health and Social Medicine, JNU

This is a Department of the Jawaharlal University which has a strong programme on the sociology of health and has played a key role in advocacy that highlights the links between macroeconomic and political policy and health policies. Under the overall objective of creating academic programmes for making health services meaningful to the people of the country, the CSMCH sets out its objective to understand the health problems and health needs of the Indian people with a view to find workable solutions for them in the existing social structure and to examine the social structure itself to delineate the structural constraints which limit the scope of health interventions

Strengths are in being able to articulate radical ideological perspectives on health issues and their published studies on health policy.

Contact
Jawaharlal Nehru University. New Mehrauli Road, New Delhi 110 067
Phone: 011-2671-7676, 2671-7557; Fax: 011-2671-7601

Centre for Health Enquiry into health and Allied Themes (CEHAT)

CEHAT is the research centre of Anusandhan Trust. It is involved in research, action, service and advocacy on health and allied themes. Socially relevant and rigorous academic health research and health action at CEHAT is for the well being of the disadvantaged masses, for strengthening people's health movements and for realising right to health care. It acts as an interface between progressive people's movements and academia. Its Mumbai wing focuses on regulation of private sector and issues of medical profession and medical science. Its Pune wing Saathi is focused on community health work and advocacy for stronger public health systems. They act as a effective NGO resource group for many issues.

Contact
Mumbai Office:
CEHAT, Survey No. 2804 & 2805, Aaram Society Road, Vakola, Mumbai 400 055

Phone: 022-2667-3571, 2667-3154; Fax: -022-2667-3156; Email: cehat@vsnl.com

Pune Office:
CEHAT, Flat No. 3&4, Aman-E Terrace, Plot No. 140, Dahanukar Colony, Kothrud, Pune 411 029
Phone: 020-2545-2325; Telefax 020-2545-1413; E-mail: cehatpun@vsnl.com

Christian Medical Association of India (CMAI)

CMAI is a fellowship of doctors, nurses, administrators, chaplains and allied health professionals. It works on various fronts, in diverse sectors, to bring relief and health among India's poorest and most deprived sections of society. It also assists and supports the Church and its healthcare institutions to rededicate themselves to this mission. It is similar to the CHAI and has an equally wide network of hospitals and health facilities. It is also very active in medical and allied education.

Contact
A-3, Local Shopping Centre, Janakpuri, New Delhi 110 058
Phone: 011-2559-9991, 2559-9992, 2559-9993; Fax: 011-2559-8150
E-mail: cmai@cmai.org / cmaidel@vsnl.com / Website: http://www.cmai.org

Society for Community Health Awareness, Research and Action (SOCHARA)

Society for Community Health Awareness, Research and Action (SOCHARA) is a multidisciplinary professional association with a functional unit called Community Health Cell which supports community health action, training strategies and health policy advocacy and action. It promotes the social paradigm in community health with a focus on the social, economic, political and cultural determinants of health. It partners with NGO networks, campaign groups, people's organisations, universities, state and national governments and international bodies in its initiatives.

Contact
Community Health Cell, 367 Srinivasa Nilaya,
Jakkasandra 1st. Main, 1st. Block, Koramangala, Bangalore 560 034
Phone: 080-2553-1518 / 2552-5372; Fax: 080-2552-5372
Website: http://www.sochara.org

Forum for Crèche and Child Care Services (FORCES)

Forum for Child Care and Crèche Services (FORCES) is a network of over 100 organisations involved in the provision of child-care services. Many of these groups provide daycare services for marginalised sections like construction workers, whereas others are trade unions and workers associations involved in policy issues concerning the child. One of its important constituents is Mobile Creches.

Contact
c/o YWCA of India, 10, Sansad Marg (Parliament Street), New Delhi 110 001
Phone: 011-2334-0294 / 2334-5235; Fax: 011- 2334-1763
E-mail: forces@vsnl.com

Federation of Medical Representative Associations of India (FMRAI)

A trade union of medical representatives and pharmaceutical salespersons. Curiously they collectively champion issues of rational drug policy while individually as their company representatives they are usually required to do the opposite.. The Federation Of Medical and Sales Representatives Associations of India (FMRAI) is a network that has played a significant role in creating an awareness of drug policy issues and in drawing attention to the adverse impact of globalisation pressures on the pharmaceutical sector.

Contact
372/21 Russa Road Est, Kolkata700 033
Phone: 033-2424-2862, E-mail: fmrai@vsnl.net

Medico Friends Circle (MFC)

This is a nation-wide group of socially conscious individuals interested in the health problems of people of India. Since its inception in 1974, MFC has critically analyzed the existing health care system and has tried to evolve an appropriate approach towards health care which is humane and which can meet the needs of the vast majority of the people in our country. A network of intellectuals who are committed to a radical discourse on the politics of medical science and technology. Though it is limited in its action to being a discussion forum, it is still the boldest and often the only one to enter into debates on technology. Some of its notable contributions have been promotion of rational drug use, promotion of community health worker programmes, questioning the rationality of the pulse polio campaign and so on. Regular interaction is through in web based egroup. It meets twice a year.

Contact
11, Archana, Kanchanjunga Arcade, 163, Solapur Road, Hadapsar, Pune 411 028
Phone: 020-2687-5058; E-mail: masum@vsnl.corn

National People's Movements (NPM)

This was previously known as National Alliance of People's Movements or NAPM. National Alliance of People's Movement (NAPM) is a network of over two hundred people's movements in India with a clear ideology against corporate globalisation, religious fundamentalism, discrimination of any kind and struggling for people's right over natural resources, for true internationalism and for a just and egalitarian society.

The core of this network is the Narmada Bachao Andolan, the National Fish Workers Forum and many other local people's movements such as Samajwadi Jan Parishad, Ganga Mukti Andolan, Shoshit Jan Andolan, Sarva Seva Sangh as well as many NGOs. An important people's movement, not linked to any major political party, it however is willing to intervene in political issues. Its interventions in health are more limited.

Potential Strengths: Strong mobilisers for the concept of health rights. Good for community monitoring roles and in stakeholder consultations where interests of marginalised sections need to be articulated.

Contact
NAPM Website: http://www.narmada.org/NAPM/napm.html

Contact Person: Sandeep Pandey
Address: A-893, Indira Nagar, Lucknow-226016, U.P.
Phone: 0522-2347365; Email: ashaashram@yahoo.com
or
Sanjay M.G. C/O Chemical Mazdoor Sabha, Room No. A/29-30, Haji Habib Bldg.,First Floor,
182, Naigoan Cross Road, Dadar (E), Mumbai 400 014; Phone: 022-2415-0429

National Federation of Indian Women (NFIW)

A large membership based organisation of women, who mobilise for womens rights. **National Federation of Indian Women** is the women's wing of Communist Party of India. It was established in 1954 by several leaders including Aruna Asaf Ali. The organisation has members among all sections of women belonging to different tribes, castes, religions and other social groupings and also among women of all economic strata, the agricultural labourers, factory and office workers, those in the field of academics, and all service sectors, women working in the home-based sector and housewives etc.

Contact
1002, Ansal Bhavan, Kasturba Gandhi Marg, New Delhi 110 001

Ramakrishna Mission (RKM)

This Mission has a very large network of hospitals and health facilities some of them working in remote areas. They largely remain confined to service delivery and do not enter much into advocacy areas. In that sense their willingness to be included in the JSA was unusual within their terms. Some of their branch organisations have done excellent pioneering work in areas like sanitation – where the national model draws from their experience. Strengths: Good for partnership in remote areas where they are established.

Contact
Secretary, Ramakrishna Mission Ashram, Loke Shiksha Parishat,Post Office: Narendrapur, Calcutta 700 103
Phone: 033-2477-2204 / 2477-2070; E-mail : ramcnpur@cd.vsnl.net.in

Voluntary Health Association of India (VHAI)

VHAI is an institution for both interventions in health policy and for organising health programmes with a community orientation. It is linked to state level voluntary health associations. which are however independent organisations. Their main office is in Delhi and is known for its excellent publications on a wide variety of health issues Strengths in different states varies widely. They are keen on advocacy as well as on service delivery roles. Their section on advocacy has worked on a number of issues related to drug policy and community health.

Strengths: Institutionalised organisation, good credibility with government offices.

Contact
B-40, Qutab Institutional Area South of I.I.T., New Delhi - 110 016
Phone: 011-26518071-72, 5168-8152-53
E-mail: vhai@vsnl.com / vha@sify.com; Website: http;//www.vhai.org

RIGHT TO FOOD CAMPAIGN [4]

The "Right to Food Campaign" is an informal network of organisations and individuals committed to the realisation of the Right to Food in India. It considers that everyone has a fundamental right to be free from hunger.

Article 21 of the Constitution is a guarantee of the "right to life", and imposes upon the state the duty to protect it. The Supreme Court has held in previous cases that the right to life includes the Right to Food. However, under-nutrition is widespread and even starvation deaths occur periodically in the country.

In April 2001, the People's Union for Civil Liberties filed a writ petition in the Supreme Court of India demanding that the country's mounting food stocks be used to prevent hunger and starvation in the country. In subsequent hearings the Supreme Court issued interim orders with directions for the government. The task of implementing these orders highlighted the need to move beyond the Court to ensure that the Right to Food is upheld. This was the genesis of the Right to Food Campaign. The campaign's activities now include research, dissemination, media advocacy, mobilisation of public opinion and action on the ground.

The campaign works on food-related issues, with a special focus on children and the destitute. The introduction of cooked mid-day meals in all primary schools and expanded coverage of destitute households in food-security schemes are some specific achievements of the campaign. Some progress has also been made towards providing nutrition and health services to all children below the age of six, under the Integrated Child Development Services (ICDS) as also the development of an Employment Guarantee Scheme. In general, the campaign has been successful in drawing greater attention to food-related issues through its participants and through concerted efforts to engage with policy makers and the media on these issues.

Its processes are best exemplified through the year-long efforts to promote the ICDS Scheme as described in the accompanying box. It illustrates the role of research, media advocacy, engagement with policy makers and grassroots action in any campaign.

As with JSA, the campaign's advisory committee comprises of other people's movements such as the National Alliance of People's Movements (NAPM) and Majdoor Kisaan Shakti Sangathan (MKSS), networks of grassroots organisations such as Bharat Gyan Vigyan Samiti (BGVS), women's organisations such as the National Federation of Indian Women (NFIW), Jan Swasthya Abhiyan, dalit organisations such as National Conference of Dalit Organisations (NACDOR) etc.

Many organisations are common to both Jan Swasthya Abhiyan and the Right to Food Campaign and the two campaigns are often able to coordinate their activities and plans.

4. See http://www.righttofoodindia.org

Action on ICDS 2006

The Hyderabad Convention: A Convention on Children's Right to Food was held in Hyderabad on April 7-9, 2006. The main purpose of this convention was to bring together individuals and organisations with a special commitment to children's Right to Food, to share experiences and plan future action. About 400 participants from 15 different states, who are working on this issue in various ways, took part in the Convention. This led to plans for a year long 'Bal Adhikar Yatra'.

The Bal Adhikar Yatra and Anganwadi Diwas: A week long process was carried out by different organisations and networks in many states such as Delhi, Andhra Pradesh, Tamil Nadu, Orissa, Chhattisgarh, Jharkhand, Karnataka, Gujarat, Rajasthan, Kerala and Assam during November 14-21, 2006. Activities included surveys and fact-findings of ICDS (Anganwadi) centres, public meeting to explain provisions of ICDS, cultural programmes at Anganwadis, special meals for children on that day, district level meetings with district collector, CDPOs, health officer and other officials. Apart from activities spread over the week, in some places special activities were planned for November 21, 2006 (Child Rights Day).

Bal Adhikar Sammelan: These activities culminated in a national 'Bal Adhikar Sammelan' on the December 19, 2006, which was also used as a major press event around the release of the FOCUS report, a report of a survey done by the campaign participants to study the status of the ICDS in the country. It was also used to highlight the highly significant orders of the Supreme Court on the ICDS (Refer to Lesson 4, Book 9).

The Bal Adhikar Sammelan has been followed by a spate of press and media articles on the situation of children under six as well as the ICDS. Simultaneous meetings with the Prime Minister and the members of the Planning Commission have also brought about some action like the Prime Minister's letter to all Chief Secretaries asking them to report to him on the ICDS periodically, and assurances of greater stress within the Eleventh Five Year Plan.

Strengths

- Very focused on achieving well defined goals related to food security.
- Very inclusive. Almost anyone who subscribes to or could contribute to the goal is included.
- High impact. Has been able to make a difference on many issues. Has played a major role in getting these issues into debate and then lobbying for them. Though political pressure from the left has contributed more to securing the policy changes, the movements own understanding of the importance of political processes and their stimulating effect on left involvement has contributed to making these changes occur.
- Very effective use of judicial interventions for advancing their cause.
- Able to attract, sensitise and retain many young intellectuals for a social purpose.

Weaknesses

- Amorphous organisational structure.
- Ability to sustain their work once the immediate goals are secured remains a challenge.
- In contrast to the JSA where the presence and identity of the organisations dominates over that of the individuals working with it, in this campaign the presence of the organisations is much more

limited and the individuals have a more prominent space. To take it forward new organisational structures may become required.

- The Right to Food Campaign despite its limitations remains one of the most important examples of how civil society action, is able to initiate, advance and win dramatic changes in policy in the interests of the poor. Such civil society action is not a substitute to political action and the Right to Food and the Right to Health campaigns have been characterised by a mature understanding of the centrality of political processes, without diminishing any of their own initiative or awareness of the critical difference made by their own role.

Some key constituents of the Right to Food Campaign are:

People's Union for Civil Liberties (PUCL)

Veteran leader Jaya Prakash Narayan (JP) founded the People's Union for Civil Liberties and Democratic Rights (PUCLDR), in 1976. The idea was to make an organisation that is free from political ideologies, so that people belonging to various political parties may come together on one platform for the defence of Civil Liberties and Human Rights. PUCL was an offshoot of this organisation, Founded in November 1980, it became a membership organisation. Its constitution declared that the members of a political party will not have the right to hold any office if they joined the organisation; the number of members, belonging to political parties, in the national or state executive committees shall not be more than 50% of the members of the National Council and the National Executive Committee respectively and not more than 10% shall be members of any single political party. The PUCL publishes a monthly journal, the PUCL Bulletin, in English. It is the only journal of its kind in the country and is read all over the world in the human rights circles. It also organises a JP Memorial Lecture on March 23rd every year, the date on which the Emergency was lifted. As a matter of policy, the PUCL does not accept money from any funding agency, Indian or foreign. All the expenses are met by the members, the office bearers, and the activists.

Contact
81 Sahayoga apartments, Mayur Vihar – I, Delhi 110 091
Phone: 011-2275-0014; Fax: 011-4215-1459 (pp)
Website: http://www.pucl.org

BGVS (as described above)

JSA (as described above)

NPM (as described above)

Mazdoor Kisan Shakti Sangathan (MKSS)

Mazdoor Kisan Shakti Sangathan (MKSS) is a large grassroots organisation working in rural Rajasthan that was formed in 1990,. Its objective was to use modes of struggle and constructive action for changing the lives of its primary constituents — the rural poor. it has taken up issues of re-distribution of land and minimum wages and has also

spearheaded the right to information movement in Rajasthan - and subsequently, throughout India. MKSS famously used the right to information as tool to draw attention to the underpayment of daily wage earners and farmers on government projects, and more generally, to expose corruption in government expenditure. It has been an active partner in the campaign for promoting and monitoring the NREGA and scheme.

Contact
Village Devdungari, Post Barar, Dist. Rajsamand 313 341
E-mail: mkssrajasthan@yahoo.com

National Conference of Dalit Organisations (NACDOR) is a growing movement/ network of grass-root Dalits organisations. Strongly committed to Dalits and their cause, it collaborates with broader 'secular, democratic, progressive, egalitarian' movements without loosing its 'Dalit perspective'. It was initiated by Centre for Alternative Dalit Media (CADAM) in December 2001 in New Delhi and is presently comprised of more than 300 organisations all over the country. NACDOR is the founder of World Dignity Forum and an active promoter and supporter of World Social Forum in India. As a core member of Wada Na Todo Campaign (Indian version of Keep Your Promise Campaign), it lead 'Dalit Voice' of Wada Na Todo Campaign

Contact
M-3/22, Model Town-III, Delhi 110 009
Phone: 011-3290-3429; Fax: 011-2744-2744
E-mail: nacdor@gmail.com; Website: http://www.nacdor.org

NFIW (as described above)

Paschim Banga Khet Mazdoor Samiti

This is a Kolkata-based rights group that works on issues of land and livelihoods.

Contact
Paschim Banga Khet Mazdoor Samiti, 324, Basunagar, Madhya Nagaram, Kolkata 737 101
Phone: 033 - 2538-4779; E-mail: jsk@cal2.vsnl.net.in

Citizens' Initiative for Rights of Children Under Six (CIRCUS)

This is not an organisation, but a loose group of individuals associates with the Right to Food campaign and the Commissioner's Office (Commissioner appointed by the Supreme Court for the PUCL case on the Right to Food). The group has a special interest in the ICDS and other issues related to the very young child and takes various research and campaign initiatives to further this. One of its recent publications has been the Focus on children under Six (FOCUS) report on the status of children under six, and related schemes such as the ICDS.

Contact
Right to Food Campaign Secretariat, Q - 21-B, Top Floor, Jungpura Extension, New Delhi 110 014
Phone:011-4350-1335/ 093505-30150
E-mail: righttofood@gmail.com; Website: http://www.righttofoodindia.org

Office of the Commissioners to the Supreme Court

In interim orders dated May 8, 2002 and May 2, 2003, respectively, the Supreme Court appointed Dr. N.C. Saxena and Mr. S.R. Sankaran as "Commissioners" for the purpose of monitoring the implementation of all orders relating to the Right to Food (PUCL vs Union of India and others, Writ Petition 196 of 2001). The Commissioners are empowered to enquire about any violations of these orders and to demand redressal, with the full authority of the Supreme Court. They are also expected to report to the court from time to time.

Technically, the commissioner's office is not a part of the Right to Food campaign. However, there are many links. Many key individuals associated with the Commissioner's Office are also active members of the campaign.

Also, it is proposed that in each major state, members of the Right to Food campaign will help the Commissioners to identify an "adviser" to assist them. The adviser will be assisted by a secretariat including at least one full-timer in every state. The state governments have also been requested to appoint a "nodal officer" to enable periodic interface with the Commissioners and the secretariat. The main role of the adviser will be: (a) to send the Commissioners regular updates about the situation in the state, (b) to convey to the Commissioners any appeal for intervention that may be made in the state, (c) to work towards a more effective monitoring and redressal system within the state. In addition, the adviser and the secretariat may assist in other functions of the Commissioners listed above. This has only been partially possible in most states.

Other important examples of such campaigns that have had an impact on health are:

a. Campaigns against sex selective abortions.
b. Campaigns against domestic violence.
c. Campaigns against child labour.
d. Campaigns for the promotion of rational drug use.

HEALTH CAMPAIGNS THAT ARE GOVERNMENT SPONSORED

It is interesting to study the general structure of campaigns that are sponsored by the Health Department. Most such campaigns aim to achieve a change in one or more set of health seeking behaviours or health care practices so as to impact on one or other of the health goals.

Examples are:

a. Family Planning Campaigns (a major feature of the past – not so much now)
b. Measles Immunisation Catch up Round Campaigns.

c. Pulse Polio Campaign.
d. Total Sanitation campaign.
e. Campaigns for promotion of breast feeding.
f. Campaigns for promotion of hand washing.
g. Campaigns for use of ORS.

In all these, what is common is that a process of social mobilisation is set in motion that goes beyond mere health communication. Let us look closely at the processes of such mobilisation. By comparing and contrasting it with the processes used for people's movement campaigns we can understand both of them better.

- Meetings of all the workers of the Department.
- Organisations of conferences or sammelans for public education on the concerned issues. Leading members of the government speak on such occasions.
- Press releases and promotion of media stories in support of the cause.
- Multi media publicity campaign – the extensive use of folk art and *kalajathas*, the extensive use of mass media, the use of touring mobile publicity vans.
- Rallies and events organised to draw media and public attention to the cause.
- Celebrity endorsements of the specific purpose being promoted.e.g. film stars, sports stars. At the local level political leaders, district collectors and other senior administrators.
- Observing a certain day – as an 'event day' – Pulse polio day, catch-up 'week', iodised salt campaign day etc.

We note that a government campaign is a strategy of mobilisation that aggregates and intensifies the activities in time and enhances their visibility through a multi media package that includes celebrity endorsements. It is not surprising that this does not question power relationships. But curiously, and perhaps quite unintentionally, it does the reverse – the health campaign becomes an endorsement of power and authority as it is currently organised – the elected office, the power of the government and its authorities, the role of celebrities. Thus we have the Chief Minister administering polio drops, or a ruling party being highly visible at a health mela, or a ministry advertisement asking everyone to wash hands (with the ministry source prominently displayed) and so on. Such political endorsement is very useful to build an enabling environment for the work of health workers and health facilities.

I. Review Questions

1. How do we understand the term people's movement?
2. What are the similarities and differences between campaigns conducted by people's movements and by NGOs and by government?
3. How has JSA contributed to the NRHM process?
4. What are the major gains that the Right to Food campaign has helped to secure?
5. Which are the national networks which have been identified as having strengths in advocacy?

II. Application Questions

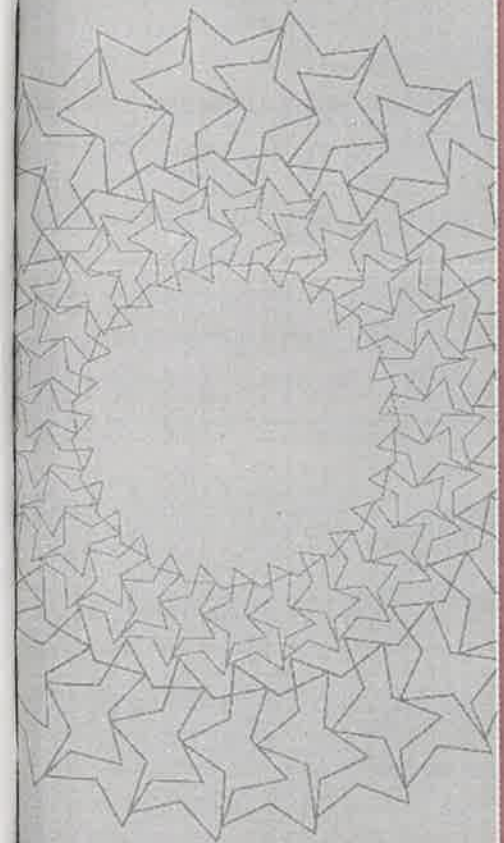
1. Why are many people's movements unwilling to work with the government? What are the ways that the pro-poor energy of people's movements could be used to improve on going health programmes by a district health officer- even where they are not readily willing to work with the government? On what health issues could they contribute?
2. Which government campaigns of the recent past have been successful and which have not been so? Discuss with reasons.

III. Project Work

1. Which of the organisations described above are working in your district?
2. Discuss the work of any one of the above organisations as applicable to your district?

Lesson SEVEN

Community Monitoring



In this lesson we shall discuss:

- Importance of Community Monitoring in Health.
- Relationship of Community monitoring to other forms of Monitoring.
- Different ways Community can monitor health programmes
- How to organise a quality community watch in the district.

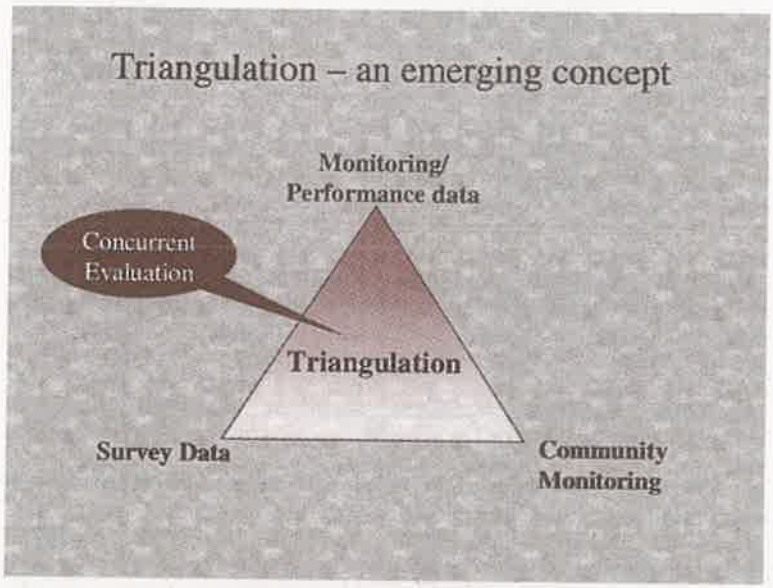
INTRODUCTION

Health care services by the government are meant for all, but invariably we see that the poor and vulnerable do not get to use these services for a variety of reasons. Now the common person, armed by developments like the recent Right to Information Act can find out what services he/she can receive and also find out who receives which service.

One important opportunity for ensuring that the poor get their rights to health care is the inclusion of Community Monitoring in the NRHM agenda.

Monitoring is an ongoing process and a continuous management function. It primarily aims at providing programme managers and key stakeholders with regular feedback. It shows early indications of progress or lack thereof in the achievement of intended results. It tracks the actual performance against what was planned/expected according to pre-determined standards. Community Monitoring data forms a component of Monitoring data which is more reflective of the user's perspective.

Monitoring involves collecting and analysing data on programme processes and results which leads to information that is used to plan and implement corrective measures.



Note:
Monitoring/Performance Data: This refers to review of performance data based on reported figures of the department's routine monitoring information system and includes validation of reported MIS data by comparisons to other indicators (like comparing reported cases of immunisation with consumption of vaccines).

Survey data: This refers to data from field monitoring visits and from commissioned external sample surveys

DIFFERENT WAYS OF MONITORING PROGRAMMES

In the government health system there are different ways to monitor the programme activity.

One major system is the ***Internal Monitoring System***. It is also known as a Health Management Information System (often referred to as HMIS or MIS). Every department has such a system in place. It may not be computerised. It may not be very functional. It may not even have been thought out well- but still there is always some system in place and we need to start by recognising its existence and understanding it.

The most important forms of monitoring in place currently are:

1. Maintenance of registers by each functionary where they note down an allotted activity eg: counterfoils of immunisation card, other beneficiary register, Labour Room register, Out-patient Register, case sheets of inpatients etc. Then at a pre-fixed interval, on a standardised format they submit this information to supervisor.

2. Monthly/Bi-annual Annual flow of reporting data, which the supervising officer may use to review the programme.

3. The review meeting may be used to collect the information and the minutes/decisions are recorded. The supervisor then passes this information on to the district office and from this it moves to the state. The entire information is self reported. Supervisors are also expected to crosscheck the reports at each level to ensure truthfulness in reporting.

Another important form of assessment or evaluation is ***Periodic Surveys*** done by external agencies or internally by the supervisors and middle level managers. Internal surveys can are organised by making Field Monitoring more systematic and using it to validate the genuineness of the MIS data. Simple 30-cluster sample surveys are expected to be carried out by supervisors routinely.

External Surveys are part of a built-in component of a project or programme to know the usefulness of the interventions. Evaluation surveys can be done as periodical-annual, mid term of a project cycle or end stage evaluation. These typically look at larger aggregations. Most look only at state level data. A few look at district level data. The National Family Health Surveys (NFHS), the district level household surveys (DLHS) – both organised by the International Institute for Population Sciences (IIPS) and the Sample Registration System (SRS) from the Office of the Registrar General and UNICEF coverage evaluation surveys are the three main surveys in use. Some states have commissioned state level surveys that yield district level data. These data are generally used for national and state planning.

Strengths and Limitations of MIS

The Internal Management Information System provides data which can be disaggregated literally till the household level. It is a different matter that one can do this sitting at the state capital or even district capital, as so many HMIS designers hopefully aim to achieve. But potentially the information is there, and if it is able to reach the next level one can find the disaggregation for that level. So if the programme is not doing well on a certain parameter one can go down the data collection tree and find out which root is the source of the problem. This is not possible in external surveys as they are based on a representative sample and can never be large enough to do this.

The main limitation of the internal information system is that it is seldom reliable since the information is completely self reported. Since one can trace the problem to its roots there is an inherent trend for the employee to be defensive and hide data that would be poorer than the average performance. This would be expected to attract the unwelcome attention of the supervisor's gaze and the follow up action taken is most often disciplinary

The other less recognised difficulty is in analysis with relation to equity and other social and even programmatic determinants. This is partly because of the patchy way in which data will be unreliable. (Patchy because different persons will report to varying degrees and some will not over report at all.) It is also inherently more difficult to aggregate at different levels without losing some of the dimensions of the data.

Strengths and Limitations of External Surveys

In contrast to this, external data has a high reliability or at least a different set of biases and helps to give a different view point on performance against which the internal data can be re-assessed. However, though it is useful to assess the validity of the system as a whole, it does not help know what specific areas have poor performance. This is explained better by the example below:

In one state we know that if we compare the MIS data on institutional delivery with that of NFHS we have closely corresponding figures. On the other hand on immunisation for the last 20 years internal data reports about 105% achievement and external surveys reports about 55% achievement. We can therefore proceed to use the internal data for identifying poor performers in institutional delivery but we know it is not reliable for immunisation. But knowing this much is not enough to correct it.

COMMUNITY MONITORING

In search of a workable system of validation the suggestion being worked on by the NRHM is to use community monitoring as the third leg of the system. We need to examine whether it is possible for the community to monitor the activities of the health system, why it would choose to do so, and what benefits community monitoring would provide other than helping the state and the national health authorities in planning.

Why would the community want to monitor?

There are many reasons why community monitoring is needed. Validation of monitoring data is only one of these, and not even the main reason for such monitoring.

- The main reason that a community wants to monitor health and health care status is because they want to be healthy. They are the primary stakeholders in the health service delivery process.

- Often at the community level there is mismatch between its expectations and its entitlements (or rights) and the actual service delivery. Therefore the community would wish to monitor the health care process. Community monitoring would empower the community and give them some control over its outcomes. Initially the health system may find it difficult to accommodate all expectations of the community. However, even a small move in this direction would improve confidence of the community in the system, and once the inertia is broken, the rate of change for the better could be very fast indeed!

- Community monitoring also has the potential to make for more equitable allocation and use of services. Eligible beneficiaries of poorer and marginalised section who are denied services are more easily identified by neighbourhood leaders than the service provider.

- Community Monitoring also can improve the quality of health services. It would promote better communication with the health care personnel and create mechanisms that enable a partnership between the users and providers of health care services. For example, in Raichur, the neighbourhood leaders of various Gram Panchayats are allowed a one hour interface with Medical Officer / ANM / Health Supervisors at the monthly staff meeting of the PHC. It will also enable them to take local action if the services that are provided do not fulfill their health needs.

- Community monitoring will lead to the accountability of public health system to the people. These services are set up to serve the people and paid for by the people. Public money, especially in India is largely people's money. Public service providers, and in the health sector even private service providers have a trend to command the public or be rude to them – as if they are higher up on a hierarchical relationship. There is a need to lower the gap and to build an equal mutually respectful relationship.

However such monitoring works more effectively if the government takes the initiative to devolve authority and decision making to lower levels. Government orders would have to be issued mandating such authority to the village and block level committees and progressing upwards to the committees at other levels. If the officers that the community can access are equally powerless to effect changes that are needed, then the impact that community monitoring could make are limited.

What should the community monitor?

What the community monitors is defined by the objectives of monitoring. The main dimensions of what is to be monitored are as follows:

- *Access to and functioning of Public Services*: The community should monitor public services that have been provided for by the government to ensure that all sections are able to access it, that it has sufficient quality, and that it is effective. This includes presence of health care personnel and other service providers at service points and the quality of their interaction with the public they serve.

- *Health Related Practices*: The community also needs to monitor key health practices. Some of it is essential to protect the health of the rest of the population. For example, the letting out of waste water into pools in the roads so that they form mosquito breeding sites endangers somebody else's health. Or untreated tuberculosis and malaria spreads to others. On the other hand, some health related practices require monitoring because the community wants to ensure a certain minimum quality norm or sense of values in the community as related to healthy living. These could be practices relating to, early age of marriages, alcoholism, violence against women, timely initiation of breast-feeding, universal registration of births, deaths and marriages etc.

- *Community Health Status*: The community should also monitor its own health status. It needs to know what common health problems are and what are the trends in the measure of health of the community as compared to not only neighbouring communities but also in relation to the ideal – which is what people want for themselves and their families.

- *Social Exclusion*: The community should also monitor to ensure that there is no social exclusion. In particular it should recognise that there are sections that are marginalised due to social, physical or economic causes and that such sections get excluded from access to services. Community monitoring must be able to correct this. Community monitoring reduces the numbers of 'left-outs' and 'drop-outs' from the various programmes. Thus community monitoring can help the people realise their rights to health services.

- *Community monitoring has to be linked to village health planning.* Not all this data is useful for the health system to monitor service delivery. Not even for validation of MIS data. But community monitoring is not only a tool for validation of data. It is a central tool of improving health status. One of the more important ways in which it would contribute to improving health status is by forming the situational analysis of village level planning.

The Village Health Committee should prepare an annual village health plan, where it specifies not only what the service providers would do, but what it would do itself. This should be further divided into monthly

plans that can be tracked and reviewed at the end of the month and during the meetings of the Village Health Committees.

WHO SHOULD DO COMMUNITY MONITORING?

There are many models of community monitoring activities. They range from community monitoring being done by students to Self-help group leaders, to volunteers to NGOs. Analysing these we can generalise that all of them have three common elements.

One is the presence of a committee structure, which is voluntary and local. It may be an existing community based organisation like a self-help group or a village level health committee formed for the purpose .To the extent that this committee is representative, it would be able to function better and use its monitoring outcomes to trigger action. To the extent that such a committee provides representation for those from the weaker sections, it would be more sensitive to equity concerns. To the extent that the committee has the sanction or participation of the service providers and those in relative privileged positions, it would be effective in ensuring that action is taken on its reports. Note that none of these requirements are 'all or none' – it is a question of how far they are so. It is also true that these three requirements pull in different directions and it may be difficult to negotiate one without losing the other!

Guidelines on Community Monitoring

An ideal set of guidelines that we may aim to achieve would be to include every member of the community when monitoring is done, to prevent the vulnerable population from being 'left-out'. The poor, scheduled castes and minorities need to be within the list of those being monitored. Therefore:

1. The membership of village health committee needs to be *balanced in the favour of the poorest.*
2. *Its membership should be made more broad-based* (that is going beyond the health sector) to include teachers, SHG representatives, youth group representatives and local NGO representatives.
3. The village health committee should consist of *over 50% women and must have more representation from the SC/ ST communities* in order to overcome the danger of subversion by men and higher caste groups.
4. *The village level committee should not have any representation from the service providers* i.e. ANM, Anganwadi worker etc.
5. It is desirable to have *hamlet-level committees to supplement village level committees.* The village committee could be constituted by representatives of such hamlet level committees. This is essential for large villages and those with far-flung hamlets.

The second common element of the local structure is the requirement of one or more sensitised and trained facilitators. The usual person most suited for this role is the community health worker or ASHA. But it could be an elected woman from a self-help group or an NGO worker. Such a facilitator is needed because there is considerable effort needed to initiate the process and to overcome hesitation and resistance. Also considerable capacity is needed both to understand the issues concerned and to organise the community and keep the committee effective. In a scaled up programme we cannot get so many facilitators unless there is middle level management. And if this middle level management is from the same chain of command that provides the MIS data, then of course the community monitoring will not be able to play any role in contributing to the validation process of reported data by the Health Staff – the so-called triangulation role. There is great merit, therefore, in getting an NGO to organise this middle level management team. The NGO will facilitate the process for a positive role of accuracy of reporting and problem solving if there is a lapse in the service delivery.

The third element is the definition of the statutory authority empowered to act upon the outcomes of community monitoring. This may be the statutory health committees of the Gram and Block Panchayats. To the extent that there has been decentralisation to give them powers over the health facilities in their area, they could use the feedback from community monitoring best. Failure to define this element and recognise its mandate is often a major problem in community monitoring strategies.

When (how frequently) should community monitoring be done?

Most past efforts have planned for community monitoring as a monthly activity, with some continuous aspects, and some annual evaluation aspects. There must also be mechanisms that enable local action on issues that affect people on a day-to-day basis vis-à-vis health care and facilities. The outcomes should be reviewed in the gram sabha meeting. Monthly reports could be sent from village to block and quarterly reports from block to district.

Where should the information from community monitoring be stored?

Community monitoring should be undertaken at the ward/hamlet and village level. Most importantly the data generated by the monitoring should be analysed and discussed at the village level. Good display of data in ways that are easily understood such as by using graphics, pie charts etc. could facilitate this.

The information collected can also be collated and should be stored at the Gram Panchayat office and should be accessible. If computerisation of information from community monitoring can be done at facilities equipped with computers then this could help in various analysis and data storing. The data at the Block level should be analysed and debated at the Block monthly meeting.

Learning from Successful Examples of Community Monitoring

There are many examples where community monitoring has been tried and where it has been reported to be working well. We describe some of these below and then draw out the objectives each of these case studies set for itself, the organisational structure they followed and the processes they followed. Then, in the next section, we use these lessons to make some general observations:

Red Alert project in Raichur and Gulbarga (UNICEF)

This project used the community to monitor key indicators (see Annexure 2) to monitor activities. It has shown very good results. Community members in the project area are critically aware of their rights, demand quality RCH care services and report system breakdowns when they occur promptly. An organised Neighbourhood Committee can be made responsible to oversee who is denied services and ensure equity.

NGO facilitators help mediate a constructive and non-threatening dialogue between community and the service provider when the system does not deliver efficiently.

Objectives: Access to key health services and change of certain health practices.
Key organisational structure: Neighbourhood committees
Process: Regular meetings using innovative tools for recording data.

Malaria Monitoring: Community Centre, Christian Hospital, Bissumcuttack, Orissa

The community volunteers record the names of all those who have a fever, they also record births and deaths. This has helped the villagers understand the pattern of malaria and take quick action when malaria strikes the village by ensuring medicine stock and preventive measures. Monitoring has shown a considerable reduction in malaria and malaria deaths. All the recordings were filled by a person trained by the Community centre.

Objective: Reduction of malaria prevalence
Key organisational structure: Community health volunteer and an informal committee structure.
Process: Optimal combination of

- Measuring fever prevalence using listing in a register,
- Interventions to change health practices (health seeking behaviour in response to fever) and access entitlements (medicine stock)
- Village planning

and by combining all three, showing demonstrable reduction of malaria by all these steps.

Low Birth Weight Project, Angara and Silli Block (Ranchi), Churchu block (Hazaribagh) and Sadar Block (Gumla), Jharkhand

In this project the community health volunteer called the Sahiyya monitored indicators related to ANC, childbirth, breast feeding and immunisation of the child. She filled green, red or yellow stickers in the register against pictures of services provided. The register is called a 'cohort' and has been successfully in encouraging discussions in the local village health committees. It was seen that indicators like registering for ANC, exclusive breastfeeding and immunisation rates increased after the initiation of community monitoring.

Objective: Reduction of low birth weight, improved child survival through combination of change of health practices and access to services.
Key Organisational Structure: Intensive effort in creating a functional Village health Committee and the trained community health volunteer – the Sahiyya.
Processes: Use of a monitoring village level register. Use of innovative methods for easy display and visual analysis.

Jan Swasthya Pahal, Rai Bareilli (Uttar Pradesh), Pithrogarh (Uttaranchal), Bharat Gyan Vigyan Samiti

In all villages of three blocks each village committees were organised. There was also a village health volunteer trained. Local leadership was provided by a trained woman facilitator, with about one facilitator for about 20 volunteers. Focus was largely on access to all health services provided by the ANM and health centers and on services provided by the ICDS. Some key health practices related to child malnutrition was also addressed. A measurable improvement in child malnutrition was recorded. In a similar project in Tamil Nadu (the Arogya Iyyakkam project, described in Book 3), the Tamil Nadu Science Forum showed a reduction of child malnutrition of about 14 to 20% in a year.

Objective: Reduction of child malnutrition used as index of improved child health and child survival.
Key Organisational structure: Village health activist supported by a trained facilitator and an informal village committee.
Key Process: the Village Health Register as measuring and triggering community action.

Chotti Sadari Block of Chittorgarh District, Rajasthan

Villagers were encouraged to participate in a Jan Samvad where Government officials present address personal grievances and problems in general services that are raised by the villagers. The organisation was done by the local activists of the state level NGO active in the area of health rights. This public hearing was held at periodic intervals.

Objective: Access to basic entitlements of health care services.
Key Organisational Structure: Village level unit of a state level NGO.
Key Process: Public hearings

School programme at Odanchataram, Dindugul, Tamil Nadu

School students were encouraged to help screening and monitoring of health programmes. The students were trained by facilitators. Teachers were also sensitised so that they could reinforce the message. The students were to identify people with health problems and report their own health problems. They could bring people, especially members of their own family to a health camp for check ups.

Objective: Improved utilisation of health services
Key Organisational Structure: the local school system
Key process: Child-to-family messages, mobilisation for health camps

Indicator-based Village Health Planning: Swasthya Panchayat Yojana, Chhattisgarh

This is described in some detail in the lesson on village health planning. Here a set of indicators were developed to measure the access to services and the health status – by hamlet, by village and by gram panchayat. These indicators are used to identify hamlets that are getting excluded or have difficulty in access. The indicators are used to draw up a plan to improve the health status and access to services. Since the 26 indicators in use are quite comprehensive the result is a rather comprehensive monitoring with a detailed plan of response all taking place as one single continuous activity. The limitation is that the frequency is annual. But the quality of validation of MIS data is very high.

Red to green strategy

In the Jharkhand Low Birth Weight Project, pregnant women and mothers were monitored for appropriate health behaviour. A red sticker was marked for those who did not follow appropriate health practices like washing hands before food or eating green leafy vegetables. If counselling from the health worker changed behaviour then a green sticker was placed over the reds. The programme monitored the number of reds changing into green to see the effectiveness of the health worker and the project.

How should community monitoring be done?

The study of a number of examples from the past gives us an idea of some basic principles and of some key processes.

One obvious fact is that most of them are a mixture of seeking to obtain entitlements and changing health care practices to add up to a demonstrable measurable change. It is not that these were the only models tried. There are many attempts which have worked on seeking to only monitor public services or to only address what the community can do by itself. There are

also many programmes where no attempt has been made to measure health changes and show that change occurred. The point is that such efforts do not quite succeed.

A programme that tried to focus only on securing entitlements is likely to come to grief simply because health services are not decentralised and there are so many problems of design and of poor governance that the community is powerless to change it. By combining with addressing health practices, it is able to sustain its activities. It is able to negotiate a greater acceptance by health care providers and build a larger social base from which to pursue its entitlements.

A programme that focuses only on monitoring health status and health care practices that the community can address by itself, creates an illusion that the major health care problems can be managed thus. It shifts the burden of the provision of essential health care services from the state to its own shoulders. It trivialises the health needs of the poor and fails to deliver any noticeable improvement and frustrates itself. (most community health worker programmes run by NGOs have their own base hospitals for managing referrals).

The requirement that measurable change be demonstrated is also a hall mark of successful programmes. It is needed to sustain investments – whether it is by the government or by funding agencies. After all a community does not cater to all its health needs from internal resources alone. And all external resources need to be negotiated. Measuring change is also needed for the programme to sustain its own vitality and enthusiasm. It is difficult to envisage a sustained community monitoring process where the village does not see any demonstrable improvement in its health status or measured improved in health care delivery.

Thus three important criteria for programming, and monitoring of programmes are:

1. monitoring (and securing) entitlements to health care services
2. monitoring (and securing better) health care practices and health status
3. demonstrating measurable change

These are clearly not absolutes. There are many successful programmes run by people's movements which do not need to do all three- simply because this is only a part of a much larger set of activities and objectives that they are pursuing.

A women's movement like the All India Democratic Women's Movement or the National Federation of Indian Women have village level branches that effectively raise issues like non-functional health facilities through petitions and even agitations. These are very effective forms of monitoring and do have an impact on accountability of health services even if they do not help in aims of validating data. Political movements and organisations also undertake such monitoring. They contribute to change by bringing health care issues onto the political agenda and they cannot be measured merely by what local change they create.

Processes of Community monitoring

There are some common processes that we can note from the examples given above.

1. Event Reporting in the Village Health Committee Meeting: The meetings of the village health committee become an important site and mechanism of gathering information. Here it may be recorded in the village health register. There are many programmes where this is the central and only activity and there are almost no programmes which attempts sustained work without some form or other of this activity.

2. Maintenance of Village Health Register: This is another major common feature of most programme designs. The village health register design is not a trivial issue. Many creative designs have evolved and it is worth comparing them. The use of such data for validating MIS data by the health system is both an opportunity and a threat. It is an opportunity because this is a large amount of data available of which much more effective use can be made. On the other hand village health registers are best used for local planning. Once it becomes used for monitoring there is pressure to make its design conform to monitoring needs and to falsify data to escape disciplinary action for poor performance.

3. Public Hearings *(Jan Sunwayi)*: This is a challenge to organise and requires good understanding on the side of the community organisation and on the responding government officers for it to be productive. Without such an understanding, the first *jan sunwai* which is relatively easy to organise, is usually the last! The level of conflict and resentment it triggers leads to government authorities withdrawing from subsequent attempts. However this does not prevent community based organisations and NGOs from going ahead with public hearings where an invited panel attends from elsewhere and with no engagement of the local health authorities. Such *jan sunwais* serve a mobilisational and awareness creation purpose- though there is little immediate impact on service outcomes.

4. Use of PRA and other Community Diagnosis Tools: These have been described in another lesson. They can be very useful for village level planning and for bringing out a much wider variety of health issues into the community gaze than what any register can do. It can also be used to identify issues of social exclusion. It could be very effective for social audit and for intermittently validating data. However it requires high skills.

5. Creative Community Monitoring: There has been widespread interest in developing tools of a wide variety to make community monitoring simpler, more easily understood and used and to evoke interest in the purpose. Some of it does sound gimmicky and not all of it can be scaled up. CARE had made good use of encouraging each village group to devise its own local monitoring tool and use it for monitoring the ICDS system- in addition to some common tools. Where it was useful, it helped. Where it did not, there was no loss. The lesson is not to enforce a single method as if it is the solution to all the problems of monitoring but to give space for creativity without getting carried away with it.

Praxis has developed some simple tools like Playing Cards and Spider webs to keep track of local services. Six playing cards with pictures of various services on them are prepared. The Village Health Committee picks up the cards one by one and discusses the availability and utilisation of that particular service. Utilisation is scored on a scale of 1 to 10 and mapped on a spider's web. Every month mapping is done and improvement noted.

Village Health Planning

Village health planning needs good situational analysis. And community monitoring provides the input for such analysis. Since village health planning is for response to the existing situation the relationship between community monitoring and its outcomes is much closer if community monitoring is a part of the village health planning effort. This however needs to be done keeping a correct balance between what resources and services it should receive from outside and what the community needs to do collectively.

What process outcomes/outputs can we lay down for Community Monitoring?

This would depend on the design of the community monitoring programme. In the context of the NRHM, the community monitoring programme may develop indicators appropriate to measure the following outcomes. These indicators would be a mix of quantitative and qualitative indicators.

1. Outcome: Local community has understanding of health status and awareness of its health service entitlements
   Indicators (examples- quantitative):
   a. % of decision makers/opinion leaders (decided on a prior agreed basis) who are aware of key health status indicators
   b. % of mothers and pregnant women who know where the immunisation and antenatal care can be accessed
   c. % of mothers who are aware of young child's entitlements from the ICDS
2. Outcome: Local health plans are made and they make use of data generated by community monitoring.
   Indicators (qualitative and quantitative): Number of village with village plans
3. Outcome: There is regular validation of health department's MIS data, leading to its correspondence to external surveys better.
   Indicators (quantitative):
   a. Gap between external surveys and internal data on measles immunisation, skilled attendance at delivery, fever related deaths (malaria deaths) is less than 10%.
   b. Both community monitoring reports and internal MIS reports – month to month variance on select indicators is available at the block and district office.

4. Outcomes: Instances of local collective/ corrective action having been triggered by community monitoring.
   Indicators (qualitative): focus group discussion (six monthly) shows an average of one instance per village at least
5. Outcomes: Action by public service providers is provided:
   Indicators (qualitative): Data from the scheme shows that information classified as locally actionable have been acted upon.

We are aware that the above list is far from adequate and far from satisfactory. This is because the use of community monitoring in regular validation is still a thing of the future. However we need to begin planning on this aspect.

Is the government keen on community monitoring? Will it be able to carry it through? What would be some fundamental constraints on in its use of community monitoring for validation.

Monitoring and evaluation based on the general understanding of triangulation is seen as an important and critical activity by the Government of India. The Prime Minister's Office is directly interested in receiving information on the progress of RCH 2 on three key parameters (i) Institutional Deliveries, (ii) Immunisation and (iii) Contraception Prevalence Rate (CPR).

The monitoring and evaluation strategy in the NRHM acknowledges six critical points:

(i) Information Systems within the government are generally weak.
(ii) Information that is collected is not acted upon.
(iii) Community Monitoring is seen as very important but there is little knowledge on how it can be done.
(iv) PRIs will be instrumental in community monitoring/
(v) Revised Community Needs Assessment Approach (CNAA), tried during RCH I, will be made operational in RCH II as the planning methodology.
(vi) Health MIES (Monitoring, Information, Evaluation System) will need fundamental changes in order for it to become responsive to people's needs and useful in improving public health services.

The recognition of these problems is itself a big step forward and an indication of seriousness.

However there is concern about how far such measures can be carried through. One of the fundamental problems is that there is an inherent interest in over reporting – as a necessary strategy of junior employees to cope with supervisory pressures which link poor performance only to order and discipline issues. HMIS alone can do little about this.

Community monitoring is sought to correct this. However we know from studies like the Coverage Evaluation survey of UNICEF that over reporting at the level of the ANM is less than 1%. Most over reporting occurs at higher levels- the level of the supervisor (ANMs report to supervisor or supervisors report to middle level management) or at the level of the middle level management.

Also, when we extend the scheme to scale, we will necessarily do so through the middle level management- and therefore whatever the community monitoring will throw up will not reach the higher levels. Therefore the chain of flow of information from the community to the higher levels should be parallel to the system all the way up, to the level where disciplinary action no longer threatens. This is usually the level of the Director of Health Services, or at least the level of the District Chief Medical Officer. But then this makes its use as a tool of local planning more difficult.

On the other hand, parallel structures get resisted and resented. One could use NGOs to create a parallel flow of information, but the choice of NGOs is also subject to pressures. There are no easy answers. The government would need considerable determination and innovation to get this going. And whether all the states would welcome such innovation and have such political determination to allow community monitoring is still an open question. (See Book 14 on power structures and perspectives for further discussion on this.)

Cautions on Community Monitoring

Any new programme tends to attract some hype from its proponents. There is need to put some cautions in place.

1. Community Monitoring should not become only fault finding. This can be used to weaken the public health system. Many votaries of community monitoring merely want to say, "I told you so – there is no alternative to privatisation." There is a need for a larger perspective and objectivity. Despite all the problems in many parts of India, the public sector is the only site of assistance to the poor and community monitoring also needs to capture what it does – not only what it does not do. One way out of this is comparisons between different sectors or blocks or panchayats – so that the weakest get the attention. Where no Panchayat is doing well there is most likely a structural problem.

2. Private sector gets left out of the gaze. Often community monitoring leaves out the private sector. Yet the cost and quality of care is a serious issue. In public private partnerships their adherence to the terms of the contract especially with regard to access to the poor needs to be monitored. The right to information also does not apply to the private sector. There is usually much less transparency. Also in the private sector there are problems like the costs of care, the ethics of care and the rationality of care – with pressures for over use. Thus if in the public sector access to surgery is a problem, in the private sector unnecessary hysterectomies and Caesarean sections are a plague. And monitoring this is inherently more difficult. We know for example in sex selective

abortions, the private sector is largely to blame, but despite all the legal pressures and the active resistance from number of women's organisations it is still difficult to reduce this illegal and criminal practice – let alone eliminate it.

3. Too often community monitoring lands up attributing all the problems to the lack of motivation or charges of neglect of the peripheral worker. The lacunae in programme design and policy and the impact of poor functioning at higher levels get completely missed out. The pressures on the workforce and the limitations they work under that handicap them from delivering quality service get missed out. There is therefore a need to extend the concept of community monitoring to a number of key processes of good governance at the block, district and state level.

"We are an NGO working in a district. How can we begin Community monitoring in our district?"

1. Dialogue with the community about the need and benefits of community monitoring.
2. Along with the community, prepare a simple format for gathering essential data which include common illnesses of public health importance in the area.
3. Decide on the contours of the programme – what are the tools that would be used, what would be the immediate health objectives, what would be monitored etc.
4. Discuss with the health authorities and see if synergy can be made. You can continue with community monitoring even if there is no cooperation, but it is much better if there is. One can also place the information in the public sphere so that there is a more informed public opinion.
5. Identify a member of the community who will be responsible for gathering the data and identify a community based committee to support the data collection and to use the data for planning. This should be preferably the Village Health Committee. If there are no committees already in place, help the committee identify an individual and that individual then constructs the committee. If there is a representative committee in place, then the committee identifies a coordinator for this activity.
6. Train the volunteers in the processes of community monitoring and help him/her to then discuss this with the village.
7. Collect the data as planned. One may have a household survey, or one may have a focus group discussion or one may use the various tools of community diagnosis described. Draw up a list of households (remember to include those who live in the peripheries especially the poor, dalits and minorities). Prepare a map to locate all the households.
8. Ensure a discussion on the data generated, especially on ways to improve the various indices.
9. Create a system to collate various village data to share at the Block and sub block levels.
10. Provide a feedback to those responsible to act on that data. One would need to prepare a written report.

I am the Chief Medical and Health Officer for the district. I have been asked to put community monitoring structure in place. How do I get started?

1. Identify NGOs who can take the lead on this. One could use a data sheet to find out about the NGOs. The NGO/ NGOs would provide the middle level leadership needed for the programme. Better to choose NGOs which are experienced and interested in advocacy and who are not dependent on the government for funding. This could be an additional project to them. Alternatively one could draw in self-help groups especially if they are federated, or any other group which is interested.
2. Arrange a sensitisation programme. Once the groups are selected, one would need to sensitise and train them to understand and play this role effectively. National health advocacy NGOs involved in community watch programme could help train state and district level NGOs for this purpose. The district and state health administration should also participate in such training.
3. Take the other officers and employees into confidence. This is a major requirement. There would be a lot of apprehensions and reluctance on part of the staff. The effort should be to project this as a form of improving community participation and health outcomes – not only of holding the department accountable. Where the staff is working reasonably such linkages could provide considerable facilitation of the work. Along with persuasion a government that does not mandate that such monitoring must be put in place, will find that it is unable to implement such a programme.
4. Work out mechanisms for collecting and acting on feedback: A regular review meeting, the data to be collected and the forms to be used are to be decided jointly. Such meetings should happen at three levels – the Gram Panchayat level, the Block Panchayat level and the District Panchayat level. It may take the form of reports to the statutory health committees at these levels.
5. Work out mechanisms for its use in validating data. Data from internal MIS and from community should be compared and there could be a participatory effort made at the village level and block level to reconcile these. It is not that one set of data is better than the other – but that these are two perspectives and one need to understand what they mean when taken together. There is little experience of doing such validation. One will need to experiment on this.

I. Review Questions:

1. What do we understand by the triangulation strategy for monitoring health programmes?
2. What are the strengths and limitations of internal MIS as compared to external independent surveys?
3. What are the objectives of community monitoring?
4. What are the various processes to be used in community monitoring?
5. What are the cautions in interpreting community monitoring only as village level monitoring?

II. Application Questions:

1. Examine the discussions on health in a state assembly. These papers can be got easily for one or two sessions. Is this a form of monitoring. What are the strengths and limitations of this?
2. How does media act as a tool of community monitoring. One could study media reports to understand this.

III. Project Work:

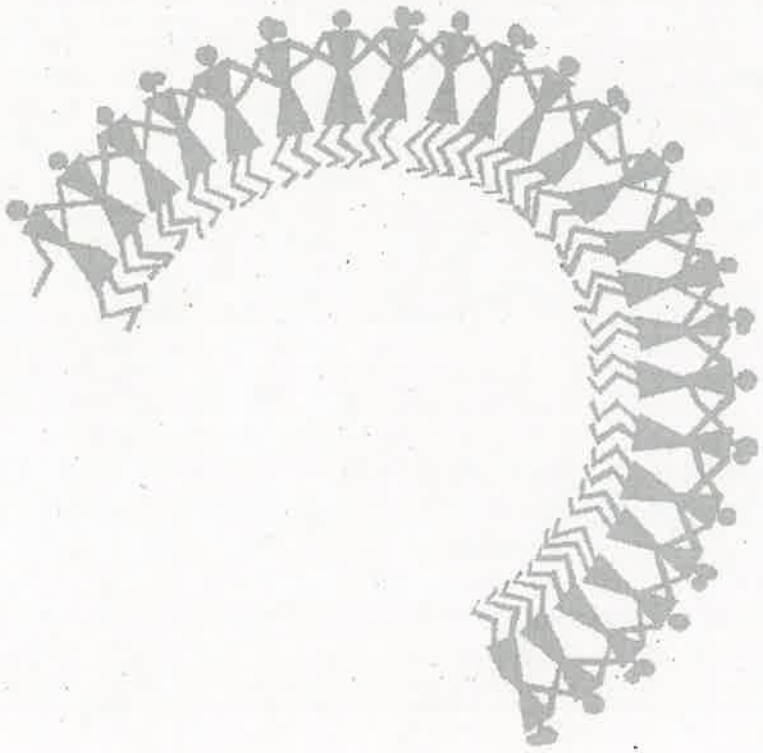
1. Go to Health Sub Centre and from the ANM's register select one of the four or five villages coming under that HSC. Go through the names and address of village wise beneficiaries for three sample services eg: Immunisation, Antenatal Care and Post natal visit or disbursal of Janani Suraksha Yojana (JSY) incentive of Rs.500/- Get the detailed address of such beneficiaries with landmark of such households from ANM. Then visit households of these beneficiaries (about 10) taking the help of a local youth or women leader, correctly identify the beneficiary. Corroborate the information given is correct or false. An immunisation card with dates tallying with the dates on the Sub centre register is conclusive. Same is the case with an entry on the card about an antenatal check up with balance of IFA tablets consumed by the beneficiary. A BCG scar is confirmatory of that immunisation. Again an entry of weight recorded within 24 hours of date of a home delivery is proof of an efficient Post natal visit to a mother baby pair.

OR

1. Compare MIS data with data from some village level studies or if available external surveys. (village level data is not often in the final reports, but may be available with the agency that has done the survey) Which data items show concordance. Which are very divergent? Is the difference due to minor differences in the definition of what is collected, or the way it is collected or due to reporting errors?

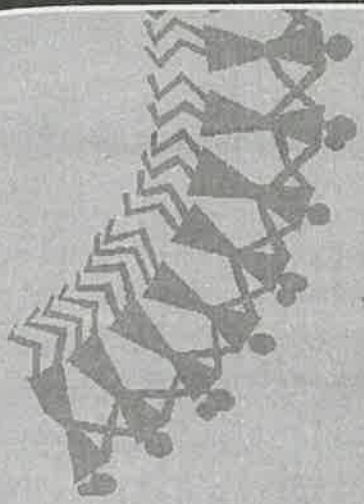
2. Write a proposal for an NGO led community monitoring effort in the district.

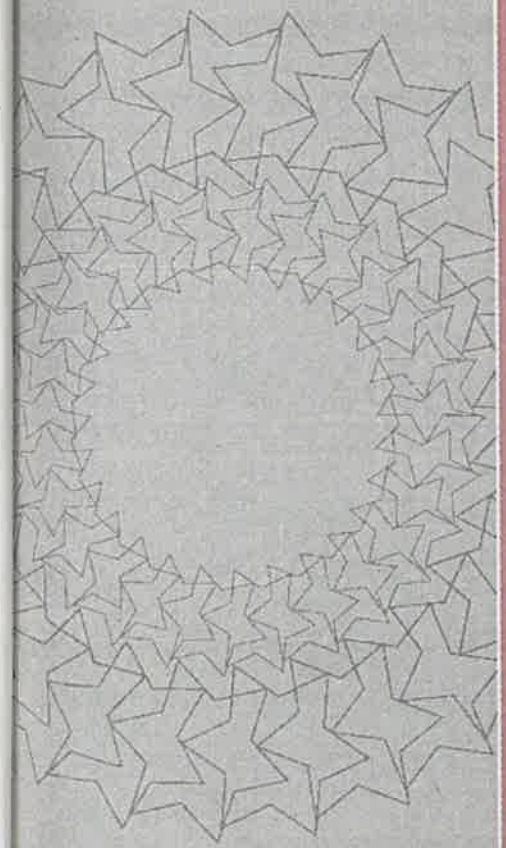
NOTES



Lesson EIGHT

Public Participation in Hospital Management and Health Administration





In this lesson we shall discuss:

- Spaces for community participation other than at the village level.
- The experience of Rogi Kalyan Samitis.
- Attempts to reform Rogi Kalyan Samitis.
- The experience of public participation in district health committees.
- Questions of public ownership.

INTRODUCTION

Community participation, this series has repeatedly stated; is not only about participation in implementing programmes or monitoring them. Community participation also extends to planning and management of health programmes and health institutions.

Now we add: community participation in planning and management is not only at the village level. It also extends to the management of hospitals and public health institutions.

What are the institutional spaces where such participation is possible – other than in village and Panchayat level committees?

One of the main forms of such public participation is the Rogi Kalyan Samiti or the Hospital Development Society. This is an example of public participation in hospital management. It is worth studying further for it brings out all the problems and issues of public participation in health care services and in health management.

ROGI KALYAN SAMITIS: THE GENERIC MODEL

In the year 2004, in a review of health sector reform in nine Indian states conducted by the Government of India, there were institutions of public participation in management in eight of them.[1] These were the Hospital Development Society in Kerala, the Medical Relief Society in Rajasthan, Chikitsa Prabandhan Committee in Uttaranchal, Aspatal Kalyan Samiti in Himachal Pradesh, the Rogi Kalyan Samiti of Madhya Pradesh and Chhattisgarh and the Patient Welfare Committees of Andhra Pradesh. These institutions were similar enough to warrant the assumption that they have common roots with the Rogi Kalyan Samitis - the first and most well known of these. Today, with the NRHM's support, all states have such functional committees for the management of its public sector hospitals.

The Rogi Kalyan Samitis have been extensively studied.[2] These studies describe the Rogi Kalyan Samitis in some detail. They also discuss the possibilities they offer and the concerns regarding their functioning. It is worth learning from them. The section below is taken from these studies especially the World Bank study and often even quotes from them – with some extrapolation and interpretation that we have added. We use the term Rogi Kalyan Samiti, but we need to note that we are using this as a generic term – not confined to the Madhya Pradesh experience alone with Rogi Kalyan Samitis.

Describing the Rogi Kalyan Samitis

1. Rogi Kalyan Samitis or equivalent bodies have been created for all district hospitals and for all CHCs (block PHCs). In some states like Madhya Pradesh and Chhattisgarh they are also created for all sector level PHCs.

1. Government of India (2004): "Health Sector Reforms in India: Initiative from Nine States", Ministry of Health and Family Welfare, New Delhi
2. Rajeev Sadanand and N.Shiv Kumar (2005): *Rogi Kalyan Samitis: A Case Study*, World Bank, and Suneeta Sharma and David R. Hotckkiss (2001): 'Developing Financial Autonomy in Public Hospitals in India: Rajasthan's Model', *Health Policy* 55 (2001) 1-18 (www.elsevier/locate/healthpol).

2. All of these bodies have been created as societies that are registered as autonomous organisations under the respective Societies' Registration Acts of the states. The Societies Act is the same under which most non government organisations are registered and was an act made for regulation of non governmental organisations. The Act provides for them to have a governing body and an executive committee. The Act also makes it mandatory for them to submit audited statements every year.

3. All of these societies involve both the district administration and the Panchayat bodies in different roles. The trend seems to be to put the district collector in the commanding position and the Zilla Parishad chief next in order – though in many states more politically correctly they would have the Zilla Parishad chief in command or at least as co-chair.

4. They also involve different concerned departments. Surprisingly, it is not the health related Departments but Departments concerned with civil works and infrastructure that are the common feature, for building and maintenance of infrastructure.

5. All of them provide for public participation. In the Madhya Pradesh case they are often limited to donors–people who make donations above a certain sum of money. In others there is place for non governmental individuals to be nominated by the chairperson - or administration usually under the guidance of the party in power. The party in power acts through the office.

We can see in the table on pg. 134 that the actual composition of the existing societies has enabled a greater role for local administration and coordination with different departments. But citizen participation is restricted to social workers nominated by the chairperson and donors. Not surprisingly, therefore, public participation is weak and the meetings become a formality as the District Collector has a commanding presence in the executive committee, and the Minister-in-charge and the Collector in the governing body.

Objectives of the Rogi Kalyan Samitis

Policy objectives of Rogi Kalyan Samitis may be stated as follows:

- Rogi Kalyan Samitis were expected to improve quality of services by better management – more participation of doctors, better support from district administration, greater leadership from senior district officials and more transparency
- Rogi Kalyan Samitis were to be a vehicle of public participation that would help improve the functioning of public hospitals and make them more accountable.
- Rogi Kalyan Samitis were to be able to raise resources that would go into improving the quality of services. The major routes suggested were by donations, by commercial use of premises, or by user fees. Somewhere in the mid-1990s, the last objective got over-emphasised. Rogi Kalyan Samitis or equivalent bodies were projected as a vehicle for cost recovery of services by charging user fees. They were to be seen as a way of alternate financing – that is funds other than budget support.

MEMBERS IN RKS GOVERNING AND EXECUTIVE BODY

District level	Tehsil and block level	Other Health Institutions / Dispensary/PHC
General Body		
I/C Minister of the District	MLA of the area *	Janpad Panchayat member of area*
President Zila Panchayat	S.D.M	President Nagar/Gram Panchayat
Mayor of Municipal Corp.	President Janpad Panchayat	President of Municipality.
Collector	President of Municipality	President of Health Committee of Nagar/Gram Panchayat
Superintendent of Police	President of Health Committee Of Municipality	Nagar/Gram Panchayat female Member
Chief Medical officer	CEO Janpad Panchayat	Sub Eng.. PWD & MPEB
MLAs of District	One Parshad of area	Two Donors (donated Rs.10,000) Nominated by Chairman
President of Health Committee	SDO. PWD & PHED	Tehsildar/ Nayab Tehsildar
Municipal corporation/ Municipality	Two Donors (donated Rs. 20,000)	I/C MO Hosp. &
Senior MO of Hosp.	Nominated by Chairman	
Municipal Commissioner	Sr. M.O. nominated by CMHO	
CEO Zila Panchayat	Block MO / I/CM& HO MO Hosp. &	
Ex. Eng. PWD & PHED		
Secretary Red Cross		
President IMA		
Two Donors (donated Rs. 50,000) Nominated by Chairman		
Two social workers nominated by chairman		

Executive Body		
Collector *	Sub Divisional Magistrate *	Tehsildar/Nayab Tehsildar *
Municipal Commissioner	President Janpad	President of Health Committee of Nagar/Gram Panchayat
CEO Zila Panchayat	CEO Janpad Panchayat	Sub Eng.. PWD & MPEB
Chief Medical officer	SDO. PWD	I/C MO Hosp.. &
Senior MO of Hosp.	Sr. M.O. nominated by CMHO	
Ex. Eng. PWD	Block MO / I/CM& HO MO Hosp. &	
One Donors (donated		
Civil Surgeon cum Hosp. Suptd & * Chair person & Secretary		

Though these are the various policy objectives, when policy becomes strategy, the way the objectives are expressed can change considerably. In the box below, we find the Rogi Kalyan Samiti objectives as laid out in the Madhya Pradesh context. Compare with the policy objectives stated above and see which are present and which are not. Note for example that community participation is one of them – but lower on the list.

Objectives as stated in the Rogi Kalyan Samitis[3]

1. To upgrade, expand and maintain health infrastructure, through own and borrowed resources.
2. To ensure maintenance of the hospital, wards, beds, equipments, and cleanliness of the premises
3. To develop unused assets with hospitals for commercial purposes.
4. To ensure ambulance services.
5. To ensure adequate and safe disposal of hospital wastes
6. To ensure equity through provision of free treatment to patients below poverty line.
7. To arrange for good quality diet, and drugs and stay arrangements for the relatives of the patients
8. To improve the management of the hospitals with community participation.
9. Monitoring and supervision of National Health programmes.
10. To ensure discipline and monitor accountability.
11. To establish public private partnership
12. To organise training and workshops for staff members.

Let us examine what each of these objectives mean and to what extent they are being achieved. But before that we would need to trace the way these objectives have been conceptualised at different stages of the development of this approach and in different states.

Historical Background to the Development of the Rogi Kalyan Samiti

When Crisis becomes an Opportunity, Indore 1994

"The initiation of the first Rogi Kalyan Samiti in Indore is credited to the crisis in public health and sanitation generated by the plague that hit the town of Surat, Gujarat in 1994. The plague-hit town was in a neighbouring state and several migrants from Indore worked in Surat. The citizenry were worried about the spread of the plague to their city and there was a demand for preventive action. The terror generated by plague moved public health and sanitation to the top priority on the agenda of policy makers.

The Collector of Indore had already launched a drive to clean up the city when the plague occurred. During the discussion on plague management it was pointed out that the biggest hospital in Indore, the Maharaja Yashwantrao Hospital (MYH), which would have to become the referral centre for treatment and care was itself in bad shape. It was infested with rats, which were the prime vector of the plague pathogen. The initiative for cleaning of the city provided a springboard for the hospital cleaning drive. The members associated

3. Rajeev Sadanand, N.Shiv Kumar Rogi Kalyan Samitis, A case study, World Bank, January 2005

with the cleaning drive assessed the situation at the hospital and realised that the clean up would involve shifting all patients to nearby hospitals. The clean up was a gigantic operation and a great success. It won media attention and was endorsed by the then Chief Minster and the Governor. It is doubtful if the Collector's attention would have been focused on the hospital, or that the support received would have been of the scale that it was, in the absence of the sense of urgency generated by a crisis. It is to the credit of the administration that they seized the opportunity to do a total clean up, and then used it to further revamp the functioning of the hospital. The degree of media and attention and defense by the Chief Minister against local detractors also appears to be the result of needing to be seen to respond effectively to a crisis."

This profuse attention also led to considerable support of wealthy patrons, many of whom were able to contribute liberally not only to the clean-up but to subsequent re-construction. There was a need to create a receptacle for such funds and to provide space for such patrons to be actively involved with the management. There was also a need for an institutionalised mechanism by which the district administration and other departments who had contributed to the clean-up and reconstruction could continue to contribute. Even the senior doctors welcomed a greater participation in management that the creation of such a body gave them. There was also a need to find funds to sustain these efforts and it was estimated that given the huge patient attendance, even a minimal user fee would raise considerable resources to supplement the state budgetary grant. For all these reasons what started as a crisis driven clean up operation became a new institutional arrangement – the Rogi Kalyan Samiti.

Scaling up Rogi Kalyan Samitis

"In 1996, the state government issued a formal GO institutionalising the RKS model across the state in all district and sub-district level government hospitals. The document provided the district administration a formal route map on how to set up RKS for hospitals in their jurisdiction. Standard bye-laws for each type of hospital/health centre and for the composition of the societies were also issued. It also gave RKS:

a. Ability to mobilise finances to augment the government budget of capital and revenue expenditure – in case of a short-fall – through user charges, leasing of assets and, if necessary, through loans from banks.
b. Freedom to apply the resources raised in what the local RKS deems to be the most useful activity (civil construction, purchase and upgradation of equipment, introduction of new services, etc.)
c. Powers to hire part-time and full-time staff on contract basis, as required.
d. Permission to enter into collaboration with the private sector for improving health services.
e. Space to improve the overall management of the hospital to make it more efficient and effective.

In all this, provision of free service to the poor and needy was given central importance. A method of 'self-certification' was introduced where the poor could themselves certify their income status and access the services at zero cost."

Current Achievements of the RKS[4]

Have there been more funds generated? Is there significant cost recovery? What are the resources being used for?

RKS have cumulatively raised Rs. 777 million - but that is about 3% of the health budget. Thus as cost recovery or alternate funding for the health system, they have had a marginal role to play.

However this 3% amounts to 44 percent of the total non-salary expenditure on government hospitals from the regular budget for the year 2001-2002. Though this is not a major strategy of cost recovery, as far as budget considerations go – there is no wonder that these funds are very welcome at the local level. The study also notes that the facilities visited still had major gaps in infrastructure, equipment and supplies – and though such problems had been reduced, they had not been eliminated. This is more true if we note the uneven development of RKS between facilities. A CHC in remote tribal block is much less likely to raise resources than one in prosperous urban setting though its needs would be more.

70% of all this income was from user fees, 16% was from donations, 12% from income generating activities – usually the rent paid by STD (phone) booths and pharmacy shops plus the general lease of space on the outer compound area for shops.

Of the user fees, much of it comes from diagnostics rather than from mere outpatient attendance. Most of the resources generated were at district or CHC level. PHCs, though far more in number, account for only 8% of the funds generated. In general and in all aspects of the Rogi Kalyan Samiti concept, this simply does not seem to work at the PHC level at all.

Of the money that is raised, utilisation is at 66% and the funds are largely spent on priorities decided by the state and Governing bodies and Executive body.

There are substantial amounts of funds that lie unspent in some of the facilities. The major use of the money has been for construction, purchase of equipment, repairs and maintenance of both infrastructure and equipment. There is also use of funds for local purchase of drugs in emergency situations and for transport needs. There are no specific ways of addressing equity concerns.

Has patient welfare improved?

The RKS does not seem to have had a major impact on usage. In fact there is a fall in out-patient attendance. However there was a small increase with in-patients. Patient satisfaction remains high – and

4. Rajeev Sadanandan and N. Shiv Kumar (2006): 'Rogi Kalyan Samitis: A Case Study of Hospital Reforms in Madhya Pradesh', in Vikram C. Chand (Ed.), Reinventing Public Service Delivery in India: Selected Case Studies, World Bank & Sage Publications, 2006 pp.186-225.

over 71% of the sample that were interviewed were happy with the quality of care. Both of these changes are not necessarily due to RKS. Poor people are known to be grateful if there is access to any form of care that they can access. There is no system of feedback from users in place.

Has more public participation been facilitated?

The finding of the study is that this has not really happened. Part of the problem is the way public has been defined. Where the public is represented by only a nominee of the chairperson, the party in power or a large-sum donor, it is unable to perform any of the functions expected of it. Part of the problem is the extreme reluctance of both the professional and the government employee to become subject to external participation. The professional finds little role for the non-medical government officer to interfere in hospital management, though they concede their uses for maintenance of buildings, power supply, water supply etc. They also resent the ability of the public to question the quality of care. In the doctor-patient relationship, the doctor demands an unquestioning trust, and public questioning of this is not acceptable. But in an era of commercialisation of medical care, the public is loath to put such trust, and the doctor is unable to keep such trust, by succumbing to various types of commercial pressures. The government officer is also part of a government that from the colonial time and even earlier, "rules over people", and therefore the republican notion of being "ruled by people" is still some distance away. Panchayat governance is thus resented in particular. Public participation is most acceptable if it is elite participation (those who rule – who can give donations etc.) and not citizen participation (representatives of self-help groups or people's movements etc.).

Is there a change in management practices?

The RKS was expected to lead to better management practices in a number of ways.

The RKS was to allow for better inter-departmental coordination. It was to allow more participatory management. Both of these have taken place to quite some degree.

The RKS was also to facilitate private tie-ups where required to close gaps. This surprisingly has not taken place much. It was expected that specialists could be contracted in where needed. There seems to be some reluctance of the public doctor with private practice to give space to his competitors in the market. Also there are established private referral networks and these do not change easily.

The RKS was meant to improve waste management. It was to maintain equipment better. These have largely not happened.

Capacity building activity of any type whatsoever has also not happened.

The RKS was meant to fill in vacancies when needed through contractual appointment. This has happened for a number of jobs. There are some important concerns in this. If the RKS is filling up a regular sanctioned vacancy, this is acceptable as a short term measure to tide over a gap, but not as a long term arrangement. This is because one is wasting a budgetary allocation (returning the money unspent) while making up the gap using collections from user fees that the poor are paying. If the RKS is filling up a potentially regular position, but which has not yet been sanctioned, then one can understand a longer term interim arrangement, as long as there is a clear commitment to create the post and fill it up at the earliest. A third situation is when the job itself is only temporarily or seasonally needed, like an extra laboratory assistant during the malaria season, and the RKS appointment is to help overcome this gap. A fourth situation is where the job is such that there are plenty of persons available in the local market, and there is no reason to go for a state service appointment for such persons. Ancillary services – kitchen, laundry, sanitation services – all fall into this group. The appointment could be made locally and the salary provision for the same could be transferred to the RKS if there is a budgetary source for this or it could be from locally raised funds. Of course minimum working conditions and salaries require to be in place.

Has RKS made access to the poor better?

The evidence is that it has not helped. Indeed there are serious concerns that it has reduced access. The systems put in place to protect the interests of the poor were mainly exemption of the poor (below poverty line) from paying any user fee. They only have to 'self-certify' that they are poor and below the poverty line. However the study reports that self-certification was never followed and BPL cards were insisted on.

The study also quotes from sources to state that though utilisation of public health facilities is good, in comparison to other states a lesser section of the poorest use public health facilities in Madhya Pradesh.

Varied Practices on Exemptions from User Fees

During tours to inspect hospital facilities, SHRC faculty found that in most facilities the BPL card is being insisted on, with some powers of the senior Medical Officer to grant exemption on grounds of poverty. Pensioners are also to be provided exemption. On the ground, practices of exemption would vary widely. Many hospitals are very strict on exemptions and strongly believe that if a few are permitted then everyone would demand such exemption. These administrators insist on the BPL card and may in addition have different screening criteria. If we look at the usage patterns of diagnostics, the poor are less likely to have been ordered diagnostics. Overall attendance is often limited by such strictness in user fees. On the other hand, other administrators are quite liberal with exemptions. They would be willing to take a risk and give exemption, if the patient asks for it, based on the appearance. Since they are required to enter a card number, they would manufacture such a number or leave it blank. Typically the proportion of people given exemption on diagnostics would be larger than the number exempted from the minimal OPD fee. And since such a hospital gets a poor-friendly image, attendance is usually very high and net RKS collections from user fees may be even higher.

EXPERIENCES FROM OTHER STATES

An evaluation of the **Himachal Pradesh** experience showed that since the society was constituted without consultation with major stakeholders it was opposed by employees, who feared it was privatisation through the back door, and by the public, who resented having to pay for services which were previously free of cost. The performance of societies varied; the crucial determinant being the presence of a creative and dedicated person in charge.

In **Kerala** too, during an interim period, government was forced to suspend collection of user fees due to political agitation. But when hospitals were handed over to PRIs for management user charges were reinstated as the PRIs found that additional resources were vital to improving services.

Rajasthan recovers 10-15% of the hospital budget, the rates charged at times going upto 50% of market rates. One innovation was to start Life Line Fluid stores to provide drugs and surgical items at no profit rates. In the Sahbhagini Nagar Vikas Yojana, the government matched public contribution for purchase of equipment up to 50% of the total cost. These initiatives were started by individual societies and then popularised by state government through government directives.

While the Medical Relief Society is perceived to have improved services, the challenges posed by lack of systems for proper utilisation of surplus funds to ensure free services for the poor, and perspective planning and accounting remain to be addressed. The lack of capacities among hospital administrators to create a participative, transparent and efficient system for collection, management and utilisation of resources; to draw up and execute contracts for outsourcing and procurement; and to prevent the government from reducing investment in health sector by discounting the resources collected are constraints that stand in the way of scaling up the role of Medical Relief Society in health sector in Rajasthan.

In **Andhra Pradesh**, the Health Sector Reform Strategy Document has discussed the experience with Hospital Development Committee's thus:

"One measure suggested has been giving autonomy to administration of the health facilities at the facility level and at the state level. At the facility level, the Hospital Development Societies were to do this. However the perception of the Hospital Development Society has become that of a vehicle for raising user fees and reducing government contribution and converting the staff's terms of employments from that of government employees to employees of autonomous self financed bodies. There was resistance to this for a mixed bag of reasons and the current government had to withdraw from this trend.(The charge of user fees had become a major issue in the last elections and the current party had promised to reverse this as part of its election strategy.) The point remains as to whether this autonomy, to the limited extent to which it was given, was "used" and if so how effectively was this autonomy exercised and what

were the constraints in it. Did autonomy help in making recruitment more flexible leading to fewer vacancies? Was management professionalised and decentralised? Was financing made more responsive to differing patient turnovers, local needs and variations? And for the future, the main question is that even if there are no user fees, autonomy is invaluable if it leads to decentralised management – but with the existing committees with its current set of powers, will the committee function in a participatory, technically sound and efficient manner?

Another measure suggested to improve facility functioning is user fees itself. There is a belief in administration that user fees makes the hospital and its staff more accountable to the public and would therefore improve quality of services. There is another belief that user fees makes the clientele value the services more – "as things given free are not valued" – and this would make for better appreciation and utilisation. There is a third trend that the user fee is a useful avenue of cost recovery, and one draft strategy paper even set a goal of 10% cost recovery for it. On the other hand, criticisms were raised that user fees excluded the poorest.[5] There is a consensus that the small sum of money gained from charging user fees is still a very valuable sum since it provides a small and very flexible pool of untied funds to the local hospital management - but on every other aspect there is a lack of consensus. The government has since implemented a decision that the amount of money the facilities were getting as user fees would be given as an untied grant –but permission to charge user fees would be withdrawn. The cost to the state worked out to only a very small Rs. 4.75 crores. It is not known whether attendance especially from the poorest improved after this withdrawal of user fees was made. It is also not yet known as to what this untied fund is being used for. There was criticism even earlier that though the user fee could be put to very good use, in practice many facilities were hesitant to spend the money. Also user fees for diagnostics, especially costly diagnostics seems to be gaining acceptance in a limited way — and there is little clarity of how 'limited user fees' would affect outpatient attendance."

Summing Up

There have been different interpretations and expectations of the Rogi Kalyan Samitis. Some of these are contradictory, some of these are wishful. Most of them have been achieved only in part.

On the plus side, it has made the management more participatory and made for better inter-department coordination and greater interest by the district administration. It has also provided a very flexible fund pool that is invaluable for addressing small local needs and usually hospital administrators are grateful for this.

One the debit side, there is no significant public participation. Even notional representation is to elite sections and not to sections that represent users or ordinary citizens. There is a trend to see the purpose of RKS as maximising cost recovery and not implement safeguards meant to ensure that access to the

5. Report of the National Commission on Macroeconomics and Health.

poor is not denied. The most important of these is self-certification and a liberal access to fee exemption on grounds of inability to pay. In a number of facilities money remains unspent and in most there is much lower expenditure than expected. There is usually no specific orientation to using it to promote equity concerns. The funds are enough for coping with many minor day to day issues but not enough for either long term planning or for major improvements. Facilities located in remote and poorer areas receive fewer collections and have more problems.

In addition to this certain concerns have been raised by those engaged in policy.

One issue of debate is user fees. There is considerable concern that the user fee funds are used for essentials like drugs and supplies and salaries that the government is committed to paying. It seems that making the poor pay for their health care is neither necessary *(for it contributed minimally to costs)* nor desirable *(it excludes a big section of the poor from access)*. The concern is that the government is doing this as a way of privatising health care- not ownership, but funding *(the public provisioning, private funding route)*.

Another concern is that by making it a registered society for public participation, the government would enhance the autonomy till it, for all practical and legal purposes, becomes an independent private body, which would be supported by a fixed grant for a pre-fixed level of service provision. This is what is known as the Managed Care Option. Once this is achieved, at the next step such bodies can be contracted out to private health management organisations. This may or may not go with charging user fees. In most such options the government enters into a contract with a private or NGO provider and stipulates that no user fee is charged (the private provisioning, public funding route). Whereas there are other possible arrangements where the rates are fixed or where the provider fixes the rate.

Another major area of concern is that that hospital quality of care requires technical inputs, good hospital administration skills and high degree of staff motivation. For achieving this, the management committee also needs to have an understanding of how to measure quality and how to plan to achieve higher level of hospital quality of care. In most such societies this dimension has not even entered the dialogue.

Despite all these problems, there RKS is a step in the right direction. It can be built on to provide better quality of care, more equitable care and to encourage public participation in hospital management. The need is to define how we can achieve this.

Reform of the RKS

Taking into account this understanding of the role of the hospital development committee the National Rural Health Mission is encouraging the strengthening of these institutions such that its three goals are achieved. Thus, the focus should shift from collecting user fees to improved quality of care through public participation and ensuring better access to the public health services by the poor.

The reform does not suggest an elimination of user fees. But it does ensure that the goal of such user fees is no longer cost recovery or even accountability – but only to enable better management and more rational allocation of resources. The main step through which it shifts the focus away from user fees is by the provision of an untied fund to each of these societies which are registered and functional. Though this is a big step forward, this by itself is not sufficient to make the hospital development committee deliver on its objectives. A larger set of RKS reform objectives would include:

1. **Establishing an active participatory management style** where representatives of local government and the community can participate. Some of the participants at least must be user groups well connected to the people who can provide feedback on patient satisfaction with the hospitals functioning and express peoples needs and concerns.
2. **Adoption of an annual or two-year plan of action** meant to improve the level of functioning of the hospital and to ensure good quality care. Such a plan is to be funded by a mix of budgetary allocation for known recurrent costs like salaries, drugs etc., an untied fund allocation meant for locale specific improvements, and locally generated resources.
3. **Adequate untied funds to implement the plan.** One part of the fund is a minimum handout to all facilities and the other part is linked to achievements and needs as expressed in the facility's annual plan.
4. **Active support from a 'Technical Assistance Agency'** (TAA) appointed for this purpose of assisting the RKS to develop, negotiate and adopt a hospital development plan. This TAA is also given the task of building capacities in the Hospital Development and Public Health Committees;
5. **Specific monitoring of the plans** and their implementation from the state and district level to ensure minimum quality standards and that equity concerns are being adhered to.
6. **Better financial management:** Use of a minimal user fee collection to track use of different services and allocate resources rationally within institutions and between institutions.
7. **Bringing in equity concerns:** Ensuring that there are enough safe guards against exclusion of the poor and there are indicators and means of verification to ensure that such exclusion is not happening.

Performance Rating and the Annual Facility Plan

In Chhattisgarh, the Rogi Kalyan Samiti has been revised as the Jeevandeep Samiti scheme. Many of the above concerns are reflected in this though public participation is still largely based on nomination and of an elite character.

One strength of the programme is the development of a rating scale. This scale has over 60 components on which the hospital is assessed. If they get more than 95%, the hospital is awarded a gold star. Between 75 and 95% the hospital is awarded a silver star and between 50 and 75 it is awarded a bronze star. Below 50% it is declared as having not achieved basic quality.

The performance rating is comprehensive and covers all aspects – the services delivered, and the state of supportive services and patient satisfaction. The very act of rating informs the public and the management of what is needed to achieve quality care. Once the rating is done, the Jeevandeep Samiti adopts an annual plan to improve its rating. The untied fund released has to be spent towards this plan. The State Health Resource Center provides technical support to the district hospital for its rating and in developing the district hospital plan. The district constitutes a three person Technical Committee to support the CHCs in doing this.

As of today, the hospital appraisal is completed and the drawing up the plans is underway.

PUBLIC PARTICIPATION IN THE DISTRICT HEALTH SOCIETY

The District Health Society is also like the hospital management committee; it is mainly a body of inter-departmental coordination, of participation by elected Panchayat representatives and a very limited public participation other than this. It has all the problems that we described for hospital development committees. It meets infrequently or not at all, much of the work being transacted on file.

There is not too much space to improve the composition of the District Health Society. At best, 3-4 members representing the public can be included. Though there are some NGOs or some activists who could contribute well it is difficult to lay down a rule that would ensure that such individuals are included in the District Health Society. Very often this becomes yet more opportunity for extending patronage. And there are, in practice, so many powerful persons to accommodate, that the formal committee meeting of the District Health Society does not provide space for detailed discussions and decision making.

A more feasible and functional solution is to create task forces or work teams for specific purposes. By virtue of listening and heeding to what they are saying and making space for them to contribute, an advisory committee without statutory powers can contribute more than an official committee with sanctioned powers. Another option would be to create a district advisory committee where they can contribute. The main advantage of this is that almost anyone interested can be accommodated and those who participate more can be given more space – even perhaps included in the District Health Society. The main candidates for effective contribution are NGOs working in the health sphere and some of the people's movements, especially women's movements.

The key problem in participation at this level is capacity. One needs to know a lot to be able to contribute effectively to district or even block level planning. An enlightened administration would try to make use of all those NGOs and interested individuals willing to contribute by building up their capacity and asking for their assistance in each block and even in village level planning. The question may be asked as to whether it makes sense in investing in capacity building of NGOs for their providing assistance in planning, rather than putting that investment directly into the bodies which are planning – be it government or

Panchayats. This decision rests upon our understanding of how change occurs and the way some element of external intervention/support is useful for fostering change at every level.

One possible route for managing this requirement for capacity building along with providing them the skills and motivation to act as change agents, is to recruit a technical assistance agency for assisting each district plan. Some of these could be from international and national government-related technical assistance agencies, but some of it could be from health NGOs or people's NGOs willing to play this role. We would thus require to develop a 'cadre' of technical assistance NGOs. This may seem ambitious and impractical but if we are serious about every village making a plan, every hospital making a plan, every block and every district making a plan – and all these forums also requiring guidance to implement these plans, then the requirement for such technical assistance multiplies many times over and there are really no other routes available!!!

CIVIL SOCIETY PARTICIPATION IN STATE AND NATIONAL PLANNING

Public participation in state and national health planning is both possible and desirable. Since this book is largely about district planning we do not go into the details.

Broadly the same pattern is seen. The State has a State Health Mission and a State Health Society. The latter has space for some representatives of civil society. The representatives chosen are useful to give it a broader character but because of either their time constraints (being usually senior busy persons) or because of their own views being consistent with the existing set up, there is little impetus for change from them. Where officers in charge of these societies are proactive they usually constitute some form of advisory forum or task forces from which they can get inputs to improve programme designs. Quite often no such forum is created, which then shuts out meaningful participation from all the public health expertise that is available in non governmental bodies.

At the National Level the NRHM has a governing body and steering committee which has similar representation of civil society. As can be expected this provides only limited space for influence and to some extent is more symbolic. The NRHM has however constituted a number of task forces and committees which allow a much more dynamic participation of civil society representatives. However these task forces and committees seldom have powers and their recommendations are not binding. Placing draft reports and recommendations on websites for a large feedback from the general public has assured greater transparency than before.

In contrast to these relatively informal mechanisms, the National Level also has active bodies like the Parliamentary Standing Committee for the Health Ministry where elected members of parliament are able to shape public policy on health.

PUBLIC OWNERSHIP OF HEALTH FACILITIES

Beyond the issue of mere participation is a more central question of ownership.

One form of public ownership – the least effective and most distanced way – is government ownership, where facilities are owned by either the state government or the central government. This is what is often equated with public ownership. In contrast to this, all other ownership is called private ownership. This may be corporate owners, small scale family level ownerships or it may be by not for profit trusts and societies. There is a need to discuss other forms of public ownership. And one may consider these higher forms of public/community participation.

One form of public ownership is where ownership is with local government bodies.

These include Municipal Corporations, District Panchayats, Block Panchayats and Gram Panchayats. In a state like Kerala all ownership except of medical college hospitals is with corresponding Panchayats.

In all the four major metropolitan cities,(Delhi, Mumbai, Kolkata and Chennai) many of the non-teaching college hospitals are under the urban local bodies. This is so in some other cities as well. In Kolkata the urban local bodies have established a very good network of nursing homes and dispensaries and diagnostic centers which are administered by management committees chaired by the elected chairperson of the municipality.

In the North East, especially in states like Nagaland, Arunanchal Pradesh and Mizoram there is a move called "Communitisation" of public health services. This has meant a substantial transfer of powers to hospital management committees with elected local bodies in leadership position. Even recruitment and salary fixation of staff can vary from facility to facility and is left to the management committee to decide.

Many large government-owned tertiary care health care facilities have been from the outset set up as autonomous organisations, usually registered as societies with a governing body and an executive committee where the government has considerable powers. There have been efforts to extend this logic to district hospitals and CHCs. In many states when this was tried there was popular resistance, largely from the employees who do not want to lose the status of being "government employees" and the job security it implies. The public for its part has been concerned that this heralds a move to reduce government expenditure and shift the burden of costs to user fees that such institutions would charge. We have discussed this tension in relation to the Rogi Kalyan Samitis. This apprehension of a government using this device to reduce its expenditure is well founded and the onus is on the state to be able to convince people not only of its current intentions but about a lesser likelihood of such a retreat happening in future too. Convincing the public is not impossible if a more broad based and democratic public participation is allowed and if there are legal guarantees against state withdrawal- but this requires a type of commitment that has not yet been made. Even the composition of the bodies is so overwhelmingly government (with some space for political

leaders), that the public is unable to understand why the creation of such an autonomous organisation is needed, unless it is as a device for the government to distance itself.

Other forms of ownership that could be brought into the understanding of public ownership are ownership by workers committees, trade unions, cooperatives of farmers or unorganised workers etc. There are some very good and inspiring examples of such hospitals in India and from the world – but they are at present only exceptions. The potential and desirability of making such ownership a mainstream option would be very controversial, to say the least.

One principle is however valid. That public ownership need not mean ownership by a centralised state. There is a possibility of creating alternate forms of public ownership and the experience has been that wherever this is done, results have been very good.

I. Review Questions

1. What are the policy objectives of creating Hospital Development Committees?
2. Who are the public that are currently participating in hospital development committee and district health societies? How can this be modified for better quality of public participation?
3. What are the pros and cons of hospital development committees and user fees?
4. How can one enhance outcomes from hospital development committees?
5. What are the forms of public ownership of health facilities?

II. Application Questions

1. Would government expenditure on public health facilities increase or decrease with the creation of hospital development committee? Discuss?
2. Hospital administration is now an important technical professional course. Can we expect such participatory committees of the public to make a difference in such a technically demanding area? What is the balance between professional inputs and people's participation?

III. Project Work

1. Study the functioning of one or more hospital development committees. In particular. note their structure, observe them during a meeting, review their minutes and look at the accounts to write up a report on the hospital development committee. Has funding to the hospital increased or decreased during this period? What is the ratio of people exempted from paying for X-rays (paying: non paying) as compared to those exempted from paying the minimal OPD fee? What percentage of people in each category (paying and non paying) were ordered X-rays? On what basis is the hospital deciding who is poor and needs to be given exemption? Use this to discuss the issues of access of the services to the poor.
2. List the NGOs and peoples movements in your district who could constitute a district advisory committee or at least the invitees for a meeting to construct a district health plan. After a sensitisation programme for them, what work could be given to them by which they could contribute to the district effort?

Annexure ONE

Eleventh and Twelfth Schedules of the Constitution of India

ELEVENTH SCHEDULE

Powers, Authority and Responsibilities of Panchayats
(Article 243G of the Constitution)

1. Agriculture, including agricultural extension.
2. Land improvement, implementation of land reforms, land consolidation and soil conservation.
3. Minor irrigation, water management and watershed development.
4. Animal husbandry, dairying and poultry.
5. Fisheries.
6. Social forestry and farm forestry.
7. Minor forest produce.
8. Small scale industries, including food processing industries.
9. Khadi, village and cottage industries.
10. Rural housing.
11. Drinking water.
12. Fuel and fodder.
13. Roads, culverts, bridges, ferries, waterways and other means of communication.
14. Rural electrification, including distribution of electricity.
15. Non-conventional energy sources.
16. Poverty alleviation programme.
17. Education, including primary and secondary schools.
18. Technical training and vocational education.
19. Adult and non-formal education.
20. Libraries.
21. Cultural activities.
22. Markets and fairs.
23. Health and sanitation, including hospitals, primary health centres and dispensaries.
24. Family welfare.
25. Women and child development.
26. Social welfare, including welfare of the handicapped and mentally retarded.
27. Welfare of the weaker sections, and in particular, of the Scheduled Castes and the Scheduled Tribes.
28. Public distribution system.
29. Maintenance of community assets.

TWELFTH SCHEDULE

Powers, Authority and Responsibilities of Municipalities etc.
(Article 243W of the Constitution)

1. Urban planning including town planning.
2. Regulation of land-use and construction of buildings.
3. Planning for economic and social development.
4. Roads and bridges.
5. Water supply for domestic, industrial and commercial purposes.
6. Public health, sanitation conservancy and solid waste management.
7. Fire services.
8. Urban forestry, protection of the environment and promotion of ecological aspects.
9. Safeguarding the interests of weaker sections of society, including the handicapped and mentally retarded.
10. Slum improvement and upgradation.
11. Urban poverty alleviation.
12. Provision of urban amenities and facilities such as parks, gardens, playgrounds.
13. Promotion of cultural, educational and aesthetic aspects.
14. Burials and burial grounds; cremations, cremation grounds; and electric crematoriums.
15. Cattle pounds; prevention of cruelty to animals.
16. Vital statistics including registration of births and deaths.
17. Public amenities including street lighting, parking lots, bus stops and public conveniences.
18. Regulation of slaughter houses and tanneries.

Annexure TWO

A sample of Questions used for monitoring Red Alerts in the Community Monitoring UNICEF Project in Raichur/Gulbarga District

Red Alert indicators – Health:

1. Women who has completed 5 months of pregnancy has not undergone 1st ANC checkup.
2. Woman in her 1st pregnancy has not received 2nd dose of TT after 7th month of pregnancy.
3. Women in 7th month for pregnancy not having a birth plan.
4. Women identified with danger sign of pregnancy not referred to a doctor yet.
5. Any new born not visited once within 3 days of birth by an AWW/ANM.
6. Any infant aged 5 months and above not vaccinated with DPT_3
7. Identified diarrhea and ARI cases of child age 5 years and below not receiving ORS or reaching ANM/PHC.
8. Any Infant below 6 months not exclusively breastfed.

For Village Leaders:

1. Has a monthly service delivery session by ANM taken place or not in the village?
2. Any medical emergency in the village not reached a hospital in time for want of transport or funds?
3. Any outbreak of diseases not reported to authorities yet ?

Acknowledgements

Editorial Coordination
Dr. T. Sundararaman, Dr. Vandana Prasad

PHRN Editorial Advisory Committee
Dr. T. Sundararaman, Dr. Vandana Prasad, Dr. K.R. Antony, Dr. Kumudha Aruldas, Dr. Madan Mohan Pradhan, Dr. V.K. Manchanda, Dr. Dileep Mavlankar, Mekhala Krishnamurthy, J.P. Mishra, Dr. V.R. Muraleedharan, Dr. Rajani Ved Arya, Sarover Zaidi, Dr. Suranjeen Prasad, Dr. Nerges Mistry, Dr. Sanjay Gupta

Other Contributors to this Volume
Anuska Kalita, Ajit Kumar Singh

Production Coordination
V. R. Raman, Abhijit Visaria

Networking Support Committee
V. R. Raman, Abhijit Visaria, Dr. Kamlesh Jain, Anuska Kalita, Rambir Sikarwar, Victor Soreng, Haldar Mahto, Farhad Ali, B.K. Rath, Biraj Patnaik, Rafay Khan, Dr. Sanjit Nayak, Dr. Ashis Das

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Public Health Resource Network
C/o State Health Resource Centre, Chhattisgarh
28, New Panchsheel Nagar, Near Katora Talab
Civil Lines, Raipur 492001, Chhattisgarh, INDIA

Tel: 91-771-6542905, 2236175. TeleFax: 2236104
E-mail: phrn.course@gmail.com, Web: www.shsrc.org

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