Rounds of data collection and trends of improvements

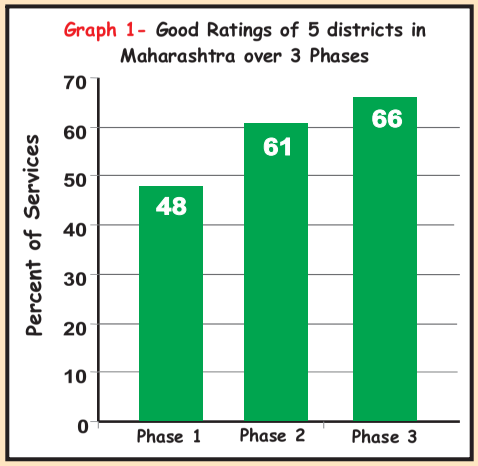
So far, four rounds of data have been collected at level of villages, PHCs and Rural Hospitals. The first round of data was collected in July-Aug. 2008, the second round in Mar.-Apr. 2009, the third round in Oct.-Dec. 2009 and the fourth round in Nov.-Dec.2010. Data from the first three rounds has been analyzed so far. This data has been collected from about 220 villages and about 40 PHCs covered under CBM across fifteen selected blocks in five districts of Maharashtra.

Here we are briefly analyzing the changes seen, based on analysis of three rounds of village and PHC level data over this period of about one and half year, (mid 2008 to end 2009) by comparing the data for each round. While significant improvements in certain services have taken place in the mentioned period, these are due to a combination of NRHM 'supply side' inputs and 'demand side' push by CBM. *Combined with NRHM related increased funds, administrative drive and reorganization 'from above', the* ***CBM process under NRHM has provided a matching yet critical 'push from below'*** *to help ensure that desired changes are actually implemented.* Availability of finances, supportive directions and untied funds give the basic inputs for improvement to the local health facilities, and do result in certain changes. But when combined with this, people collectively monitor the activities of ANMs and MPWs, periodically visit the PHCs and audit the availability of medicines and services, document the regularity of services and behavior of providers, point out irregular practices, and repeatedly raise these issues with officials at various levels, then the enabling climate created by NRHM is more likely to result in real improvements at the ground level.

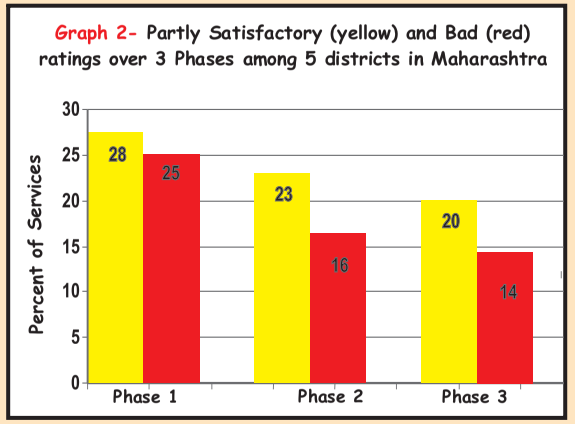
At the same time, not all aspects of the health system are amenable to improvement by Community based monitoring, and larger constraints like non-availability of skilled staff or medicines may limit the overall possibility of improvements. Such largely systemic problems highlight the need to sustain change and to ensure positive changes at policy levels. Below we have briefly analyzed the data gathered over a period of one and half year in first three phases of Community based monitoring.

1. Improvements in Village level health services

Regarding Village level report cards, nine key health services were rated by Village Health committee members as either 'Good', 'Partly satisfactory' or 'Bad'. This information was collected from the approximately 220 villages where report cards were prepared. Graph 1 shows the trend of good ratings for these services across 5 districts in Maharashtra over the 3 phases of CBM. 48% of the services were given 'Good' ratings in Phase 1, this increased to 61% in Phase 2 and further to 66% in Phase 3. Thus ***there has been a consistent overall improvement in Village health services in the CBM covered villages.***

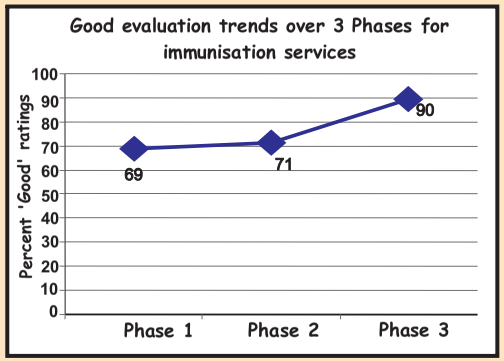


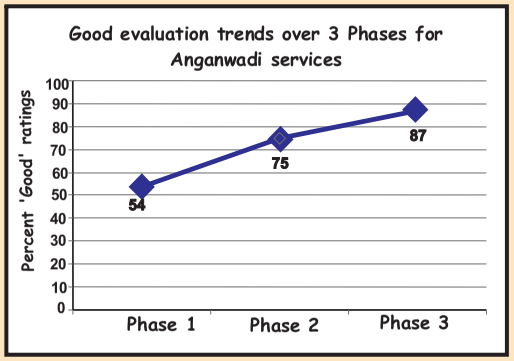
Similarly Graph 2 shows the concurrent reduction in 'Partly satisfactory' (yellow) and 'Bad' (red) ratings of services in these 5 districts over the 3



phases of CBM. Services rated as 'Bad' have reduced from 25% in the first phase to 14% in the third phase.

Certain health services have shown high and consistently improving 'Good' ratings across the five CBM districts over the 3 phases. At the end of Phase 3, 90% of districts received a rating of 'Good' for immunization services and 87% of districts received a rating of 'Good' for Anganwadi services. The following graphs display trends for these services.

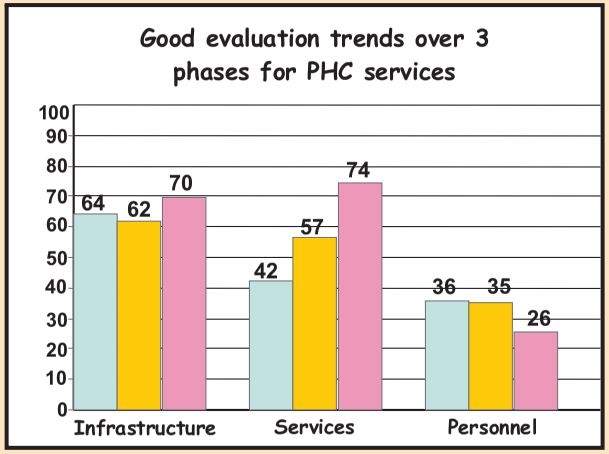




2. Changes in health services from Primary Health Centres (PHCs)

The data collected from PHCs in the CBM process can be divided into four broad categories: infrastructure, services, personnel and medicines. The following graph displays the aggregate PHC trends of 'Good' ratings across the 5 CBM districts in Maharashtra over 3 phases.

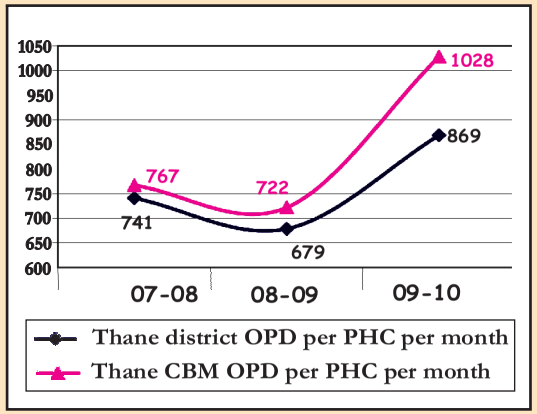
Parameters such as availability of electricity, water, cleanliness of toilets and the access to lab tests were evaluated under 'Infrastructure'. The graph depicts that the 'Good' ratings went up from 64% to 70% between phases 1 and 3. 'Services' refer to 24 hour delivery care, indoor patient services, lab service availability and ambulance for referrals. A steady increase in the 'Good' ratings for 'services' was observed. Only



42% of the ratings were 'Good' at phase 1, they increased to 57% and were calculated to be 74% at the end of phase 3. Lastly the category of Personnel included filled Medical officer positions, present paramedical workers, lab technicians, ambulance drivers. Although the proportion of 'Good' ratings for Personnel stayed the same from phase 1 to phase 2, they have decreased in phase 3 indicating some decline in availability of staff.

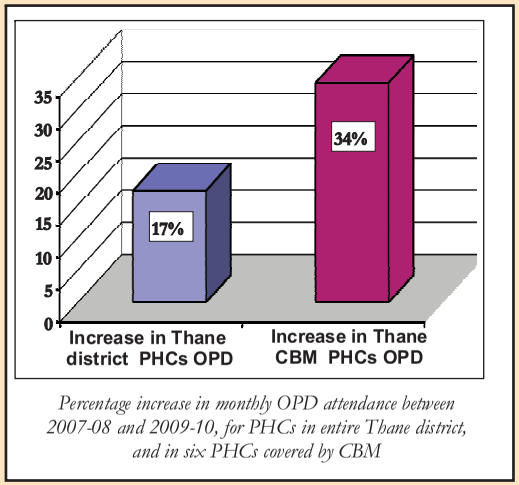
3. Significant increase in utilisation of PHC services – evidence from Thane district

Anecdotally, there have been several reports about increased numbers of people accessing local public health services, associated with the Community based monitoring (CBM) process in Maharashtra; of course such increases need to be located within the larger context of general improvements



in health facilities due to NRHM. Time trends related to utilization of PHCs covered by CBM were analysed in comparison with the average trends for PHC utilisation in the entire district.

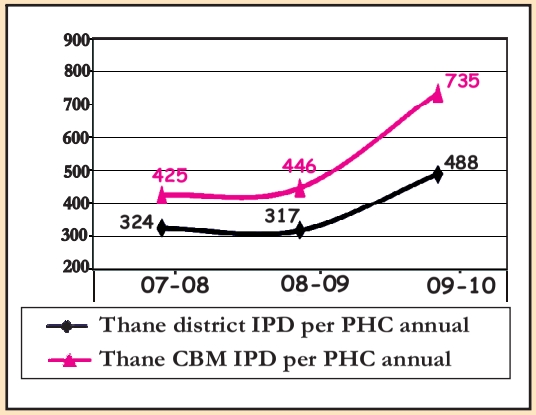
Three key utilization indicators: outpatient attendance, inpatient admissions and in-facility deliveries were analysed for three years – 2007-08, 2008-09 and 2009-10. This exercise was done for two districts - Thane and Pune, to start with.

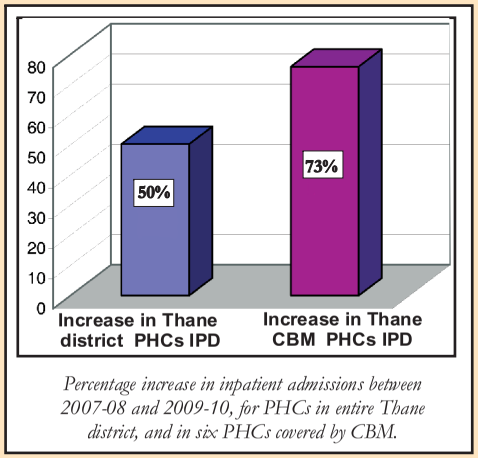


Percentage increase in monthly OPD attendance between 2007-08 and 2009-10, for PHCs in entire Thane district, and in six PHCs covered by CBM

The PHC utilization data for Thane district shows that baseline for OPD attendance in 2007-08 was similar for CBM PHCs and PHCs from the entire district. However between 2007-08 to 2009-10, the average increase in OPD attendance for PHCs in the entire district was 17% whereas the *increase in OPD utilisation in CBM covered PHCs was significantly higher at 34%.*

Simlarly, between 2007-08 to 2009-10, the average increase in inpatient admissions for PHCs in the entire district was 50%, whereas the *increase in CBM covered PHCs was significantly higher at 73%.* Further, between 2007-08 to 2009-10, the average increase in deliveries in PHCs in the entire district was 48% whereas the *increase in deliveries in CBM covered PHCs was significantly higher at*

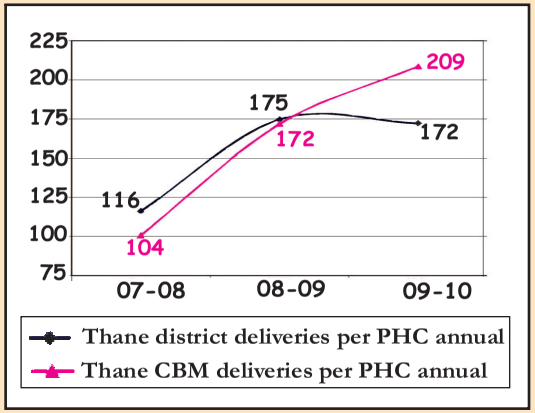


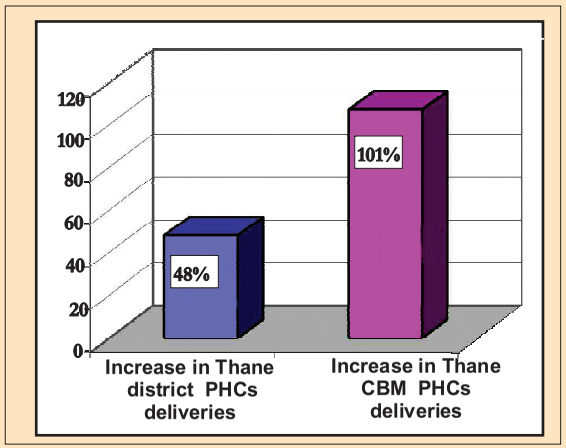


Percentage increase in inpatient admissions between 2007-08 and 2009-10, for PHCs in entire Thane district, and in six PHCs covered by CBM.

101%. Data from Pune district shows similar trends, of significantly higher increases in utilisation of CBM PHCs compared to average increases for PHCs in the entire district.

It seems that NRHM related improvements have led to some overall increase in utilisation of PHCs in recent years. Further, in PHCs covered by the CBM process, increased community level awareness along with additional improvements in services promoted by accountability processes seem to have induced more people to access PHCs for various types of care,





and this has reduced the 'public facility utilisation gap'. This has led to a ***significantly higher increase in utilisation of PHC services in CBM covered PHCs over the period 2007-08 to 2009-10, in Thane and Pune districts.***

4. Qualitative improvements due to CBM in five districts

As mentioned above, regular discussions and dialogue between health service providers and villagers, civil society representatives have resulted in a range of improvements and changes in health services. *The qualitative improvements listed below concern specific issues which were raised through the CBM process*; of course most of these improvements were actually made possible because of the larger framework and funds available under NRHM.

District	Sample of improvements reported at Public Hearings
Thane	•At the PHC level, laboratory services have improved, illegal charges have stopped and electric supply has improved by installing a generator. •In the outreach services, there is no longer a discrepancy between anganwadi records and independently taken weights of malnourished children. •Illegal charging by certain medical officers has stopped.
Pune	•Non-functioning subcenters are now functional. •The citizen's health charter has been displayed in every selected PHC. •As a result of repeated demands from the community through CBM, new ANMs and MPWs have been recruited in some PHCs.
Nandurbar	•Some PHCs have now display boards stating the availability of various medicines in the PHC. These displays are the result of state level discussions on the shortage of medicine in Nandurbar. •There is a documented improvement in the supply of essential medicines to PHCs. •Remuneration of beneficiaries under incentive based schemes such as Janani Suraksha Yojana (JSY) has improved in existing villages. •PHC staff attitudes toward patients have improved. •Immunisation coverage has improved in several villages.

District	Sample of improvements reported at Public Hearings
Amaravati	• New ambulances have been provided to some PHCs. • JSY beneficiaries are being paid the rightful amount of Rs. 700/- rather than the Rs. 500/- they were being paid before. •The number of out patients at PHCs has significantly increased in the CBM blocks .
Osmanabad	•The number of patients availing services from certain PHCs has roughly doubled since before CBM was launched. •The Health Rights Charter has been displayed in every selected PHC. •The names of the PHC monitoring and planning committee members have been displayed in some of the PHCs.

From Community based monitoring to planning of health services-

The existing health planning process is mostly top-down with very little input from communities or grassroots organisations. To change this situation qualitatively, one of the key future strategies for planning of health services would be to use information about local issues/priorities and resources identified during the community monitoring process. To achieve this objective process of enabling and empowering communities has been initiated recently.

Conclusions

At the time when the community monitoring process started (first round of data collection, mid-2008), it was found that there were significant gaps in services provided at the PHC and village levels across all districts. When the third round of data was collected (end 2009) ***considerable improvement in various health services across all 5 districts was observed***. However improvements regarding certain health services were not as expected, here systemic changes such as recruitment of staff and improving medicine procurement system are required.

NRHM's goal has been to make quality health services accessible at the village level. Given the above experiences, in order to meet these goals, along with improving provision of health services, it is necessary

to deepen and widen the Community Based Monitoring process which can greatly strengthen demand and utilisation, and can enable corrective feedback from the community to providers. Through the CBM process, communication between health system officials and providers and the rural public has improved significantly. Several positive outcomes associated with such improved communication are evident. However not withstanding these positive outcomes there is a need to address lacunae in the programme design and policy, and corruption at various levels. Hence there is a need to extend the concept of community based monitoring to a number of key processes of governance at higher levels, with monitoring ranging from block, district to the state level. It is also imperative that along with CBM activities at local level, there is civil society involvement to help resolve key systemic issues at the state level and to propose people-centred solutions and policies, which would help in assuring "quality health services for all".

District & Block Nodal NGOs implementing CBM -

District nodal NGOs - Amaravati- KHOJ; Osmanabad- Lok Pratishthan & Halo Medical Foundation, Nandurbar- Janarth Adivasi Vikas Sanstha; Thane- Van Niketan; Pune- MASUM.

Block Nodal NGOs-

1) **Pune- Purandar block-** MASUM**; Velha block-** Rachana- Society for Social Reconstruction; **Khed block-** Chaitanya

2) **Nandurbar- Shahada block-** Janarth Adivasi Vikas Sanstha; **Dhadgaon block-** Narmada Bachao Andolan; **Akkalkuwa block-** Lok Sangharsh Morcha

3) **Amaravati- Paratwada block-** Khoj Melghat; **Dharni block** Apeksha Homeo Society; **Achalpur block-** Mamta Bahudeshiya Society

4) **Osmanabad- Tuljapur block -**Halo Medical Foundation; **Osmanabad & Kalam blocks-** Lokpratishthan

5) **Thane -Murbad block-** Van Niketan; **Jawhar block-** Dr. Manibhai Desai Adivasi Mahila Sangh; **Dahanu block-** Kashtkari Sanghatana

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(Part of this short report is adapted from an article written by Abhay Shukla, Kerry Scott and Dhananjay Kakade; Deepali Yekkundi carried out analysis of data)

More information available at www.sathicehat.org

A detailed report of Community Based Monitoring of Health Services in Maharashtra may be accessed at:

www.sathicehat.org/uploads/CurrentProjects/CBM_Report_June10_ Final.pdf

For any further information SATHI team members may be contacted at

cehatpun@vsnl.com