NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

NRHM Newsletter

Vol.4 No.5 March - April 2009

Special Issue on
Community's
Monitoring of
Health Care Services

Empowering Communities for Improving Health

Progress under | NRHM

ASHAs

- 648516 ASHA/Link Workers Selected.
- 563462 ASHA given orientation training and 411855 ASHA have been positioned with kits.

Institutional Delivery

- **Janani Suraksha Yojana (JSY)** operationalised in all the States and received tremendous response. Against 29.31 lakh women benefited in 2006-07, the number of beneficiaries jumped to 72.01 lakh in 2007-08 & over 55 lakh till December 2008.

Monthly H&N Days in Anganwadi

- Over 29.7 lakh Monthly Health and Nurtrition Days have been organized at the Anganwadi Centres in various states during till Dec 2008-09.

Neo Natal Care

- Integrated Management of Neonatal and Childhood Illnesses (IMNCI) started in 219 districts.
- With the help of Neonatology Forum over 90401 health care personnel trained in Newborn Care in the country.
- Module for Home based new born care developed and ASHAs to be trained in Home based new born care.

Immunization

- JE vaccination completed in 36 districts in 8 states 16.48 million children immunized during 2006-07. The 11 districts of 4 states where JE vaccination was carried out in 2006 have introduced JE vaccine in Routine Immunization to vaccinate new cohort between 1-2 years of age with booster dose of DPT.
- Neonatal Tetanus declared eliminated from 7 states in the country.
- Full immunization coverage evaluated at 43.5% at the national level.(NFHS-III) Accelerated Immunization Programme taken up for EAG and NE States.

Village Health & Sanitation Committees

- 342801 Village Health and Sanitation Committees have been constituted by the States. They are being involved in dealing with health planning at grass root level.

Rogi Kalyan Samitis

- Over 23,100 Rogi Kalyan Samitis set up in various health centers and hospitals.

Infrastructure

- All Subcentres in the country (1,45,272) provided with annual untied funds of Rs. 10,000 each. Joint accounts of ANMs and Pradhans have been opened for utilization of annual untied funds.
- Out of 4045, 2788 CHCs have been selected for upgradation to IPHS and facility Survey been completed in 2698.

Manpower

- 10948 Doctors and specialist, 33719 ANMs, 20977 Staff nurses, 8645 paramedics have been appointed on contract by States to fill in critical gaps.

Management Support

- 1552 professionals (CA/MBA/MCA) have been appointed in the State, 576 District level Program Management Units (PMU) and 3477 blocks to support NRHM.

Mobile Medical Units

- Funds for one Mobile Medical Unit (MMU) per district released for 318 districts. The states have, till date operationalised 243 Mobile Medical Units with their own funds.
- Convergence with ICDS/Drinking Water/Sanitation/NACO/PRIs ground work completed.
- School health programmes initiated by 26 States.

Health Action Plans

- State PIP (for 08-09) received from all states, in final stages of appraisal & approval.
- Integrated District Health Action Plans (DHAP) have been finalized for districts.

Mainstreaming of AYUSH

- Mainstreaming of AYUSH taken up in the States. AYUSH practitioners co-located in 3908 facilities PHCs. AYUSH part of State Health Mission/Society as members.

Trainings

- Trainings in critical areas including Anaesthesia, Skilled Birth Attendance (SBA) taken up for MOs/ANMs. Integrated Skill Development Training for ANMs/ LMV/MOs, Training on Emergency Obstetrics care and No Scalpel Vasectomy (NSV) for MOs, Professional Development Programme for CMOs are on full swing.

Mother NGOs

- 345 Mother NGOs appointed for 404 districts till date are fully involved in ASHA training and other activities.

Health Resource Centres

- National Health Systems Resource Centre (NHSRC) set up at the National level.
- Regional Resource Centre set up for NE.
- State Resource Centre being set up by States.

Monitoring and Evaluation

- Web based MIS operationalised.
- NFHS III & DLHS results disseminated.
- Independent evaluation of ASHAs/JSY by UNFPA/UNICEF/GTZ in 8 States.
- Ground work for community monitoring completed.

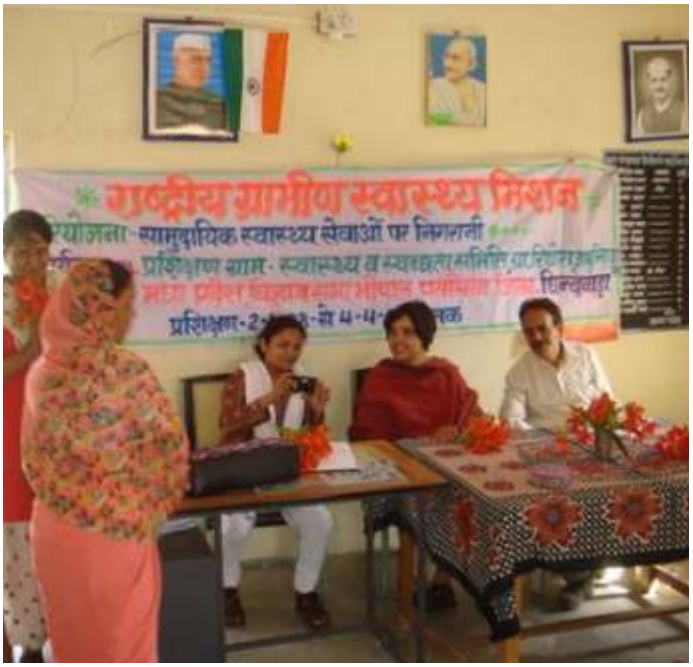
Financial Management

- Financial Management Group set up under NRHM in the Ministry.
- Financial management reports streamlined.

NRHM has boosted immunization coverage

Monitoring of Health Care Services by the Community

Under NRHM, there have been concerted efforts at making the health services accessible and accountable to the people. The efficacy of these efforts is judged against a variety of benchmarks. The NRHM has designed & operationalised many parallel systems to monitor the indicators.



The thrust of NRHM is on establishing a fully functional, community owned, decentralized health delivery system with inter sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities. From narrowly defined schemes, the NRHM is shifting focus to a functional health system at all levels, from village to district.

The NRHM is also about health sector reform. The architectural corrections envisaged under NRHM are organized around five pillars, each of which is made up of a number of overlapping core strategies.

a) Increasing Participation and Ownership by the Community. This is sought to be achieved through an increased role for PRIs, the ASHA programme, the village health and sanitation committee, increased public participation in hospital development committees and district health societies and in the district and village health planning efforts, special community monitoring initiative, and through a greater space for NGO participation.

b) Improved Management Capacity. The core of this is professionalizing management by building up management and public health skills in the existing workforce, supplemented by induction of management personnel into the system.

c) Flexible Financing: The central strategy of NRHM is the provision of untied funds to all level for the village health and sanitation committee, to the sub-

center, to the PHC, to the CHC and also to district hospital.

d) Innovations in human resources development for the health sector : The central challenge of NRHM is to find definitive answers to the old questions about ensuring adequate recruitment for the public health system and adequate functionality of those recruited. Contractual appointment route to immediately fill gaps as well as ensure local residency, incentives and innovation to find staff to work in hitherto underserved areas and the use of multi-skilling and multi-tasking options are examples of other innovations that seek to find new solutions to old problems.

e) Setting of standards and norms with monitoring: The prescription of the IPHS norms marks one of the most important core strategies of the mission. This has been followed up by a facility survey to identify gaps and funding is directed to closing the gaps so identified.

The second Common Review Mission (Nov - Dec 2008) has demonstrated that over the past three years, NRHM has revolutionized public health services in all states in the country. It has galvanized the systems for higher OPD, IPD, Institutional deliveries, Immunisation, diagnostics and referral ambulance service. The availability of skilled human resources, drugs & supplies, better, cleaner facilities has rejuvenated faith of the citizens in Public Health System.

> "The NRHM is thus also about health sector reform. The architectural correction envisaged under NRHM is organized around five pillars, each of which is made up of a number of overlapping core strategies."

NRHM has boosted immunization coverage

Community Action under NRHM

The community led action for health is the core feature of NRHM. As part of this initiative, over 3,61,000 Village Health & sanitation Committees have been constituted in the country. In order to ensure community ownership of the health facilities, 26,262 Hospital Management Societies (Rogi Kalyan Samitis (RKS)) have been set up at all health facilities. More than 90% District Hospitals and CHCs in the country have their own RKS, receiving annual corpus grants for improving the services at the respective facility.

Empowerment of the Community, through intimation of entitlements and establishing of organised forums for ensuring compliance to the service guarantees is the most important tool to ensure that the strategies of NRHM are implemented in letter and spirit.

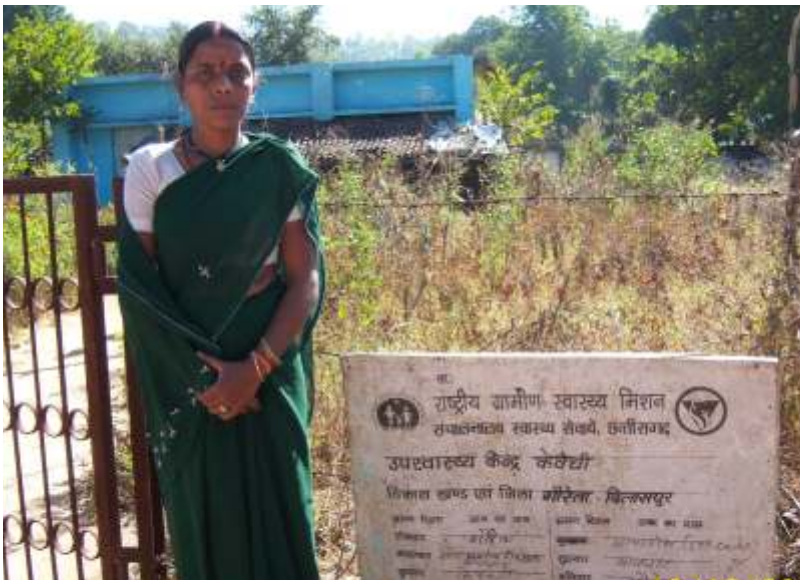
Under the Framework for Implementation of NRHM, community and community-based organisations are envisaged to monitor demand / need, coverage, access, quality, effectiveness, behavior and presence of health care personnel at service points, possible denial of care and negligence. This should be monitored related to outreach services, public health facilities and the referral system.

Arogya Diwas- (Health Awareness Day)

In the framework of community based monitoring it is suggested that from every village the Village Health and Sanitation Committee members should be trained, which has been followed by all programme implementing organisations in entire state. The 'objective behind this initiative was to get all sections of the people interested and involved in this programme and also create ownership of the programme beyond VHSC members'. On Arogya Diwas community members are informed about their entitlements in the Public Health facilities, responsibilities of the outreach functionaries and also role they have to play in the process of community monitoring. Occasion of Arogya Diwas was also used to do a constructive work like cleaning a well and digging soak pits, collective activity is a crucial community level process to create solidarity amongst community members. Considering the present response to the CBM, it seems that the Strategy of Arogya Diwas worked very well.

Under the Framework for Implementation of NRHM, community based monitoring should fulfill following objectives:

- It should provide regular and systematic information about community needs, which would guide related planning
- It should provide feedback according to the locally developed yardsticks for monitoring as well as key indicators. This would essentially cover the status of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies and levels of community satisfaction,
- It should facilitate corrective action in a framework of accountability.
- It should enable the community and



community-based organisations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system.

- It could be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.
- It should permit triangulation of data across the regular MIS of NRHM and the results of external surveys.

The framework for community monitoring should provide for concomitant authority at various levels i.e. the entity engaged in community monitoring should have the power to initiate remedial action also. Further, the information gathered as part of community monitoring is envisaged to be triangulated against the regular Health sector MIS and results of periodic surveys commissioned by the health system to gauge progress of select initiatives on thematic or geographic basis. The triangulation is intended to give intelligent and collatable feedback to the health system. This process is envisaged to suggest mid course corrections to strategies as well as give early warning signals of a input versus output mismatch. NRHM envisages community monitoring to be conducted through a series of community based committees at various levels. These committees are mainly composed of community representatives, and also have representation of the officials from the health system. This arrangement is expected to maintain continuity of the committees as well as formalize the reporting set up.

Under NRHM, Community monitoring is envisaged to provide systematic info about community needs as well as provide feedback according to locally developed yardsticks and key indicators. The long term goal of the initiative is to increase the involvement and participation of community in management of Health System. As a corollary, the community monitoring process is envisaged to validate the data which is collected and reported by ANM, AWW and other functionaries.

As part of the Community empowerment process, the community is envisaged to be made aware of the service entitlements under NRHM. An enlightened community can be encouraged to give responses relating to demand, need, coverage, access, quality, effectiveness, behaviour and presence of health personnel and possible denial of care and negligence. Such reporting would be the eventual output of the community monitoring process.

Features of Health System which are to be monitored

- demand
- need
- coverage
- access
- quality
- effectiveness
- behaviour and presence of health personnel
- possible denial of care and negligence.

Objectives of community monitoring

- provide systematic info about community needs
- provide feedback according to locally developed yardsticks and key indicators.
- increase involvement and participation of community
- Validate data collected by ANM, AWW and other functionaries

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Community Monitoring & Planning Committees

In order to create formal forums for community monitoring at various levels, the Framework for Implementation of NRHM gives detailed guidelines for creation of Community Monitoring Committees at various levels. The generic guidelines in this regard envisage a Village Level Community Monitoring committee for each revenue village (more than one such villages may come under a single Gram Panchayat). This committee comprises the Gram Panchayat members from the village, ASHA, Anganwadi Sevika, ANM, SHG leader, village representative of any Community based organisation working in the village and also user group representatives. At this level the Panchayat member is envisaged to be the chairman and ASHA / Anganwadi Sevika is envisaged to be the convenor.

Similar committee is envisaged at the PHC level where 30% members are expected to be representatives of Panchayati Raj Institutions (Panchayat Samiti member from the area; two or more sarpanchs), 20% members are envisaged to be non-official representatives from VHSCs with annual rotation to enable representation from all the villages, 20% members are envisaged to be representatives from NGOs / CBOs in the area and balance 30% members are envisaged to be representative of providers, MO, ANM. The Panchayat representative is expected to chair this committee and Medical officer of PHC is the executive chairperson. The NGO / CBO representative is envisaged to be the secretary of the committee.

At the Block Level, 30% members are expected to be representatives of the Block Panchayat Samiti, (Adhyaksha / Adhyakshika of the Block Panchayat Samiti or members of the Block Panchayat samiti, with at least one woman), 20% members are expected to be be non-official representatives from the PHC committees with annual rotation to enable representation from all PHCs over time, 20% members are expected to be representatives from NGOs / CBOs, 20% members are expected to be officials : BMO, BDO, selected MOs from PHCs etc and balance 10% members are expected to be representatives of the CHC level RKS. At this level Block Panchayat Samiti representative is expected to Chair the committee and the BMO is expected to serve as the executive chairperson. The NGO / CBO representative is envisaged to be the secretary of the committee.

At District Level, 30% members are envisaged to be be representatives of the Zilla Parishad (esp. convenor and members of its Health committee), 25% members are expected to be district health officials, including DHO/ CMO/ Civil

Surgeon and representatives from DPMUs, 15% members are expected to be non-official representatives of block committees, with annual rotation, 20% members are expected to be representatives from NGOs / CBOs and balance 10% members are expected to be representatives of RKSs in the district. At this level, the ZP representative (preferably convenor of the Zilla Parishad Health committee) is expected to Chair the committee with CMO / CMHO / DHO being the executive chairperson. An NGO / CBO representative is envisaged to be the secretary and provide operational leadership to the committee.

At the State Level, 30% members are envisaged to be be elected reps in legislative body (MLAs /MLCs) or Convenors of Health committees of ZPs by rotation, 15% members are envisaged to be non-official members of District committees, by rotation, 20% members are envisaged to be representatives from State Health NGO coalitions, 25% members are envisaged to belong to State Health Department including Secretary HFW, Commissioner Health, officials from Dt. of Health Services, NRHM Mission Director along with experts from SHRC / SPMU and balance 10% members are envisaged to be officials belonging to other related departments. The elected member (MLAs) would chair the committee with Secretary HFW being the executive chairperson. The NGO / CBO representatives are envisaged to be the secretary and provide operational leadership to the committee.

Role of Community Monitoring Committees at various levels

> “The presence of a vibrant Village level monitoring committee shall help ensure that ANM and MPW visit the village on fixed days.”

At Village Level, the Community Monitoring Committees are envisaged to assist in creating public awareness about the health programmes, discuss and develop Village Health Plan manage health fund, participate in rapid assessment to ascertain major problems and establish and maintain the village health register and health information board/calendar. The committee is expected to discuss every maternal & neonatal death in village and manage the untied funds of Rs. 10,000 for local health action in the village. The presence of a vibrant Village level monitoring committee shall help ensure that ANM and MPW visit the village on fixed days.

At PHC Level the committee is expected to assist in consolidation of the village health plans and charting out the annual health action plan & a PHC Health Plan. The PHC level committee is the key custodian of the physical resources at PHC and should review the functioning of Sub-centres operating under the PHC. The committee may initiate action on instances of denial of right to health care and take collective decision about the utilization of untied funds given to PHC for local action.

The committees at the higer levels are expected to undertake similar activities for their entire territorial catchment area and initiate action on instances of denial of right to health care. The State level Community Monitoring Committee is envisaged to also discuss programmatic and policy issues and review and contribute to State Health Plan. It plays a key role in sharing health system related information with the Government of India.

Advisory Group on Community Action

The AGCA is a standing Group under NRHM mandated to guide the NRHM in activities relating to community empowerment and action. The group comprises eminent persons engaged in community based action for health. The Group comprises the following members :

Shri A.R. Nanda, Population Foundation of India, New Delhi
Dr. Abhay Shukla, CEHAT
Dr. Abhijit Das, Director, Centre for Health & Social Justice
Dr. Alok Mukhodpadhyay, VHAI, Munirka, New Delhi
Dr. Dilip Mavalankar, IIM, Ahmedabad
Sh. Gopi Gopalakrishnan, Ex Programme Director, Janani
Dr. H. Sudarshan,VGKK, Karuna Trust, Karnataka
Sh. Harsh Mander, Social Activist
Ms. Indu Capoor, CHETNA, Ahmedabad
Ms. Mirai Chatterjee, SEWA Gujarat
Dr. Narendra Gupta, Prayas, Rajasthan
Ms. Prakashamma, Director, Academy of Nursing Studies
Dr. R.S Arole, CRHC, Jamkhed, P.O Ahmednagar, Maharashtra
Prof. Roy Choudhary, ICMR, New Delhi.
Dr. Saraswati Swain, Secretary General, NIAHRD
Dr. Shanti Ghosh, 5, Arbindo Marg, New Delhi
Dr. Sharad D. Iyengar, ARTH, Udaipur
Dr. Thelma Narayan, Community Health Cell, Bangalore
Dr. Vijay Aruldas, CMAI, New Delhi.

The Group has been in operation since early days of NRHM and has the following mandate :

1) To advise on ways of developing community partnership and ownership for the Mission.

2) To advise on the community monitoring of the various schemes taken up by the Mission.

The AGCA meets regularly every quarter and till date 13 meetings have already been convened. The meetings are of two day duration out of which the first day is a technical group meetings and the second day is the full AGCA where the Government of India is also represented.

The Population Foundation of India provides Secretariat Support to the Advisory Group, with suitable assistance from the Ministry of Health and Family Welfare. The AGCA has played the role of mentor in operationalising Community monitoring in the country. Presently in the first Phase the initiative has been operationalised in nine states. In view of limited capacity for organised action through community based institutions in states, it was decided that hand holding by GOI has to be more direct (at least initially). Accordingly the AGCA (with PFI as its secretariat) was requested to hand hold the operationalisation of Community Monitoring in nine states (Madhya Pradesh, Orissa, Chhattisgarh, Jharkhand, Rajasthan, Assam, Maharashtra, Tamil Nadu and Karnataka.).This has been termed as the first phase of Community Monitoring.

Scope of Phase 1 of Community Monitoring

The following indicators were expected to be in place at the end of Phase 1 of the Community Monitoring under NRHM in Nine states.

Input indicators:

- Material produced for informing community about entitlements and service guarantees in different languages
- Community Mobilisation protocols for Community Monitoring produced in different languages
- Protocols prepared for Village and Facility level monitoring and report card preparation
- Model tools, orientation material, curricula would have been prepared

Process Indicators:

- 9 State level CM Committees, 35 District level CM Committees, 105 Block level CM Committees, 315 PHC level CM Committees and 2250 village level CMCommittees would have been constituted.
- Orientation of members of all these committee would be complete.

Scope of Phase I

	Particulars	Number of Units
1	States	9
2	Districts	36
3	Blocks	108
4	PHCs	324
5	Villages	1620
6	VHSC formation	1620

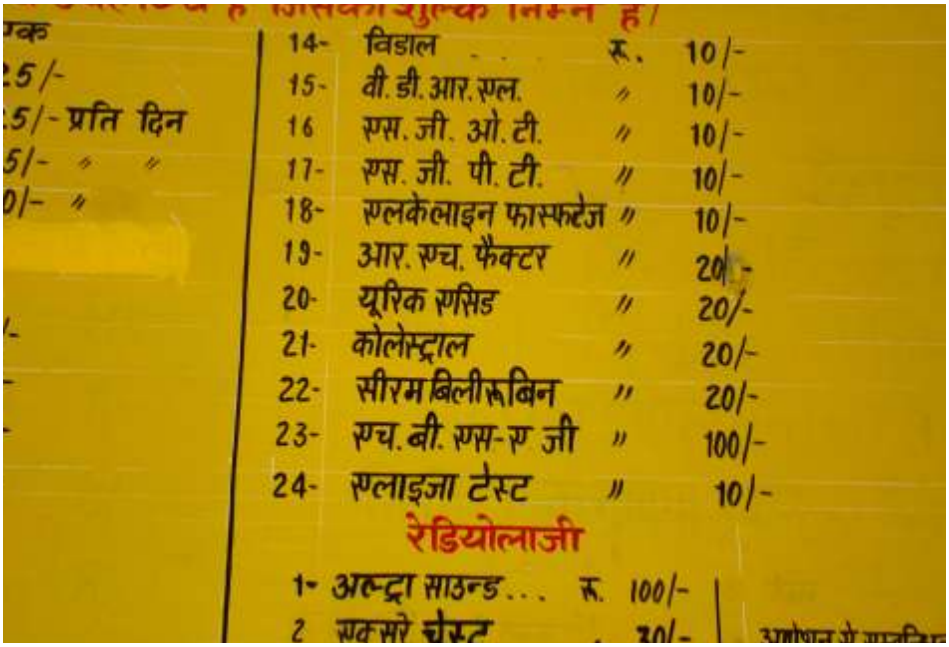
NRHM has boosted immunization coverage

- Orientation workshops held with service providers at the Block level for 75 blocks
- 30 orientation workshops held with stakeholders at the District level
- 40 Media workshops organised at the district and state levels

Output Indicators:

- At least one Jan Samwad would have been held in each of the 315 PHCs which are part of Phase 1 .
- 1000 Village level report cards prepared
- 200 Facility level report cards prepared
- 100 Jan Sanwads organised
- 200 media articles on NRHM functioning published in regional languages in 9 states

Nominal charges for tests displayed at a Health Centre



> "The need to establishing a viable protocol for community monitoring and planning has been understood to be critical by many states for achievement of the goals of NRHM."

After the conclusion of Phase 1, community empowerment and monitoring/planning activities are part of the overall NRHM Programme Implementation Plan of respective states. For this purpose, the Government of India has requested all the states where the first Phase has been undertaken to expand the initiative to other districts. The other states have been requested to undertake experience sharing meetings with the neighbouring states and operationalise the Community Monitoring initiative.

Many of the states have included this initiative in their respective Annual Programme Implementation Plans for FY 2009-10. The need to establishing a viable protocol for community monitoring and planning has been understood to be critical for achievement of the goals of NRHM. Over the next few years operationalisation of the strategy in all parts of the country shall assist in accelerating the achievement of the goals of the Mission.

Take Advantage!

Under the
National Rural Health Mission

Assured Service Guarantee

Facilities available at the Primary Health Centre

Full immunization and Vit A solution for children

At least 4 ante-natal check up for pregnant women, IFA tablets and 2 TT immunization for pregnant women

Facility for temporary and permanent methods of Family Planning, counselling how to avail these facilities

Referral Transport facility for cases needing special attention

Cleaning of toilets and disposal of waste to enourage hygiene around hospital

Every Primary Health Centre (PHC) is getting Rs 50000 yearly for its building maintainenace

Every PHC getting Rs 25000 untied funds for local health activities

PHC (not at block level) is answerable to the Panchayat members of the village where it is located.

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राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
(2005-2012)

Prototype developed by AGCA & Ministry of Health & Family Welfare

Empowering Communities for Improving Health

Dr Abhijit Das

The National Rural Health Mission is an ambitious effort to improve the health status of the poor in rural India. Community based monitoring is one of its most innovative components. When a public health manager wishes to strengthen health systems the obvious areas of intervention include providing improved and functioning health facilities, posting trained providers and ensuring the supply of appropriate drugs, equipment and supplies. NRHM not only goes a couple of steps further to include flexible financing mechanisms but also includes communtisation as a measure for ensuring transparency and accountability and improving community involvement. Theoretically community monitoring brings the community and health systems closer by improving communication and reducing misunderstanding between the providers and the community. However it can also increase tensions by highlighting inefficiencies, deficiencies and challenging existing status quo. Being fully aware of these contradictions, the Advisory Group on Community Action embarked on the preparations with cautious optimism.

> "An exercise of this nature, even on this limited scale, has never been attempted before in the Public Health Sector."

First Phase

The preparations began in April 2007 and a year and half later, the first phase of community monitoring was complete in over 1500 villages and 300 PHC covering 35 districts in nine states. It was a small beginning within a programme as large as the NRHM, but it had to be so, because an exercise of this nature had never before been attempted even on this somewhat limited scale. It may be worthwhile to recollect all that has happened in this period to understand the complexity of this process. First, a group of voluntary civil society organizations had to negotiate an agreement to this process with the state NRHM directorates. It is true they were given GO and circulars from the Mission Director NRHM, however they were also clearly non-governmental actors who were proposing to introduce a component within a government programme. It has been a very progressive step of the

NRHM has boosted immunization coverage

MOHFW to give the reins of the programme to NGO and this has been ably complemented at the state level with the full autonomy that has been provided by the State Mission Directors to the State Nodal NGO. Once the state level coordinating and monitoring mechanism was established, a set of transparent norms had to be devised to identify a new set of implementing organizations at the district level. The organizations were trained not only to mobilize and train the Village Health and Sanitation Committees but also to get the concurrence and support of the district health administration and health providers. As the process moved closer to communities the doubts regarding the even-handedness of the community enquiry became stronger, and these had to be laid to rest in all the districts, blocks and PHC in which this project was implemented.

Developing Tools

If settling doubts and recruiting supporters from within the health system has been one of the key challenges of this process, developing a simple robust tool for conducting the community monitoring of health services and facilities has been the other key achievement. In its most basic form community monitoring involves a process of community enquiry into the health status and service delivery at the village level and at the facility level. A series of exercises was designed to lead up to the creation of a village and facility level score card where for purposes of simplicity the scores were represented as traffic lights green for all okay; amber representing cause for concern and red denoting things need to improve. In order to facilitate easy triangulation with other forms of health statistics (annual health surveys and HMIS) the report cards also needed to include numerical scores which could be utilized by those responsible for monitoring the programme, and this challenge has also been successfully met. Members of all the village health and sanitation committees and other community planning and monitoring committees as laid down in the Implementation Framework were trained in conducting the enquiry and preparing the report card. In the first round these report cards have been prepared with the support of the block level facilitators, but it is expected that VHSCs will become independent by the next round.

> “In the first round these report cards have been prepared with the support of the block level facilitators, but it is expected that VHSCs will become independent by the next round.”

This period of a year and half has not only been a period of negotiations, development of tools and a series of training programmes, but we have small stories of success coming from different parts of the country. The successful process of community monitoring in nine states have helped upscale the project in other districts and blocks of the states. The Jan Samvad has led to infrastructural correction of the health facility centers and have ensured greater community participation.

State Specific Progress of Community Monitoring

Assam

Selected Districts	Dhemaj, Chirang and Kamrup - Rural
Nodal Agencies	
State Nodal NGO	Voluntary Health Association of Assam
District Nodal NGOs.	Rural Volunteer Centre, Dhemaji District, The ANT, Chirang District and GGSS, Kamrup Rural
Block Nodal NGOs	Jonai Block-North Star Club, Sissiborgaon Block -The Action for ChangeTrust(ACT) Socio economic Development Society-Dhemaji Bordoloni Block-Amateur Sidli Block-Bodoland Life establishment Club Bodobazar Block -The ANT Rangia Block-Fatima Development Centre Kamalpur Block-Rural Women's Development Society(RWDS), Boko Block-Prayas

Physical Progress of Community Monitoring Activities

Level	Achievement
VHSC	135
PHC	6
Block	2
District	0
Media Workshops	2
Jan Samwad	
Village Report Card	
Block Provider orientation Workshop	0

The process of community monitoring of health services under NRHM is a new initiative in the state and in that it shows promise of being replicated beyond the three pilot districts, Ruchira Neog AVHA; Assam

Chhattisgarh

Selected Districts	Bastar, Kabirdham and Koriya
Nodal Agencies	
State Nodal NGO	SANDHAN, Voluntary Health Association, Champa
District Nodal NGO	Mission Hospital and Population Foundation of India-Regional Resource Centre Chaupal Gramin Vikas Prashikshan evam Shoudh Sansthan, Koriya District Voluntary Association for Nature & Yokel Awareness, Bastar District
Block Nodal NGO	Sankalp Sanskritik Samiti, Kawardha District Janakpur (Bharatpur) Block-Chaupal Gramin Vikas Prashikshan evam Shoudh Sansthan Manendragarh Block-Adivasi Adhikar Samiti Khadgava Block Pahal-Social Action Research and Advocacy Institute (SARAI) Vastanar (Bade Kilepar) Block-Samajsevi Sanstha Darbha Block-Bastar Samajik Jan Vikas Samiti Kawardha Block-Emmanual Hospital Association - Tokapal Block Bharat Mata Seva Samiti Bodla Block-Zila Saksharta Samiti Lohara Block-Community Advancement and Rural Development Society (CARDS)- Sahaspur

Physical Progress of Community Monitoring Activities

Level	Achievement
VHSC	135
PHC	27
Block	9
District	1
State	1
Media Workshops	
Jan Samwad	
Village Report Card	0
Block Provider orientation Workshop	1

Jharkhand

Selected Districts	Hazaribagh, West Singhbhum and Palamu
Nodal Agencies	
State Nodal NGO	Child in Need Institute (CINI)
District Nodal NGO	Nav Bharat Jagriti Kendra (NBJK) ,Hazaribag District Ekjut, West Singhbhum, District Integrated development foundation (IDF) Palamu, District
Block Nodal NGO	Churchu Block-Nav Bharat Jagriti Kendra (NBJK), Katkamsandi Block-Ram Krishna Sharda Math and Mission (RKSM), Ichak block-PRAYAS, Chakradharpur block-Ekjut, Indira Adivasi Mahila Manoharpur Block-Vikash Samity, Tonto Block-Samekit Jan Vikas Kendra, Patan Block-Integrated development foundation (IDF), Chainpur Block-Jan Chetna Kendra, and Lesliganj Block-Gyan Vigyan Samity

Physical Progress of Community Monitoring Activities

Level	Achievement
VHSC	135
PHC	27
Block	9
District	0
State	0
Media Workshops	
Jan Samwad Conducted by the committes	
Village Report Card	
Block Provider orientation Workshop	6

The community based monitoring pilot programme was successfully conducted in 135 villages of Jharkhand. Each village came up with a village report card and had it discussed at the Health - Sub Centre and the Primary Health Centre. This process ensured a rejuvenation in the Village Health Committee, marked knowledge increase of schemes amongst the villagers, and many potential promises made by the system for improvement that needs to be followed up.The District authorities were pleased to have issues from the people brought to their notice and that they were able to dialogue with them. Suranjeen CINI; Jharkhand

Karnataka

Selected Districts	Tumkur, Gadag, Chamarajnagar and Raichur
Nodal Agencies	
State Nodal NGO	Karuna Trust
District Nodal NGO	AID INDIA , Tumkur District , Bharat Gyan Vigyan Samiti (BGVS) Gadag District, Karuna Trust , Chamarajnagar District and Community Health Cell (CHC), Raichur District
Block Nodal NGO	Tumkur Block-TAMATE, Madhugiri BlockJeevika, Gubbi block-BGVS, Rona Block-Samata, Gadag Block-KVK, Mundaragi Block-BGVS, Yelandur Block-Karuna Trust, Chamarajnagar Block-Karuna Trust, Kollegal Block-MYRADA, Raichur Block ROOVARI, Manvi Block-Jagrukta Mahila Sanghatan (JMS) and Devadurga Block-SAMUHA

Physical Progress of Community Monitoring Activities

Level	Achievement
VHSC	180
PHC	0
Block	0
District	1
State	0
Media Workshops	4
Jan Samwad conducted by the committes	6 PHC Level
Village Report Card	
Block Provider OrientationWorkshop	4

Madhya Pradesh

Selected Districts	Sidhi , Bhind, Guna , Badwani and Chhindwara
Nodal Agencies	
State Nodal NGO	Madhya Pradesh Vigyan Sabha
District Nodal NGO	Gram Sudar Samiti-Sidhi District, MPBGVS-Bhind District, MPVHA-Guna District, Ashragram Trust-Badwani District, MP Vigyan Sabba-Chhindwara District
Block Nodal NGO	Gurukul Shiksha Samiti-Sidhi,Majholi and Kusumi Blocks, MPBGVS-Gohad, Megaon and Bhind Blocks MPVHA-Guna, Bamouri and Raghogarh Blocks Ashagram Trust & SATHI CEHAT-Badwani, Pati and Pansemal Blocks, Madhya Pradesh Vigyan Sabha-Tamia, Junnardev and Parasia Blocks

Physical Progress of Community Monitoring Activities

Level	Achievement
VHSC	225
PHC	41
Block	12
District	1
State	1
Media Workshops	1
Jan Samwad	11 PHC Level
Village Report Card	
Block Provider orientation Workshop	15

Maharashtra

Selected districts	Amaravati, Nandurbar, Pune, Thane and Osmanabad
Nodal Agencies	
State nodal NGO	SATHI-CEHAT
District Nodal NGO	KHOJ (Knowledge Hope Opportunity and Justice) - Amravati District, Janarth Adivasi Vikas Sanstha - Nandurbar District, MASUM (Mahila Sarwangin Utkarsha Mandal) - Pune District, Van Niketan - thane District and Tata Institute of Social Sciences - Osmanabad District
Block Nodal NGO	Dharni Block - Apeksha Homeo Society, Achalpur Block - Mamata Bahu Udeshiya, Chikhaldara Block - KHOJ (Knowledge Hope Opportunity and Justice), Akkalkuwa Block - Lokpratishthan, Dhadgaon Block - Narmada Bachav Aandolan (NBA), Shahada Block - Janarth Adivasi Vikas Sanshta, Purandar Block - MASUM & Foundation for Research in Community Health (FRCH), Khed Block-CHAITANYA, Velhe Block - Rachana - Society for Social Reconstruction, Jawhar Block - Dr. Manibhai Desai Mahila Vikas Sangh (BAIF-Mitra), Dhahanu Block - KASHTKARI SANGHTNA, Murbad Block - VAN NIKETAN, Kalamb Block - LOKPRATHISHTAN, Tuljapur Block - HALO Medical Foundation, and Osmanabad Block - LOKPRATHISHTAN

Physical Progress of Community Monitoring Activities

Level	Achievement
VHSC	225
PHC	14
Block	0
District	0
State	1
Media Workshops	5
Jan Samwad	38 PHC Level
Village Report Card	
Block Provider orientation Workshop	15

Orissa

Selected districts	Mayurbhanj, Kendrapada, Nawrangpur and Bolangir
Nodal Agencies	
State nodal NGO	KCSD- KIIT
District Nodal NGO	Rairangapur Block - SODA Mayurbhanj, District, OMRAH (Orissa Medical Research and Health Services), Kendrapada District, KCSD-KIIT, Nawrangpur District and Jan Sawasth Abhiyan (JSA), Bolangir District
Block Nodal NGO	Rairangapur Block - Voluntary Action for Rural Reconstruction and Social Action (VARRASA), Bangirposi Block - Orissa Liberal Association for Movement of People (OLAMP) , Rasgobindpur Block - UNNAYAN, Derabisi Block - Joy Bharati Sathi Samaja (JBSS), Rajnagar block - BAT NET, Patamundai Block - Chale Chalo, Rajghar Block - Society for Agriculture, Health & Education, Animal Husbandry & Rural Development Action (SAHARA), Tentulikhunti Block - Association for Voluntary Action (AVA), Nawarangapur Block - Democratic Action, Muribahal Block - Social Empowerment for Welfare and Action (SEWA), Patnagarh Block - Palli Niketan - Loisingha Block and The Humanity

Physical Progress of Community Monitoring Activities

Level	Achievement
VHSC	180
PHC	36
Block	12
District	4
State	1
Media Workshops	4
Jan Samwad	
Village Report Card	
Block Provider orientation Workshop	12

Rajasthan

Selected districts	Jodhpur, Chittorgarh, Udaipur and Alwar
Nodal Agencies	
State nodal NGO	Prayas
District Nodal NGO	GRAVIS - Jodhpur District, Prayas - Chittorgarh District , ARTH - Udaipur Distrcit and IBTADA, Alwar District
Block Nodal NGO	Luni Block - Meera Sansthan, Bhagawan Mahaveer, Mandore Block - Sansthan, Osiyan Block - GRAVIS, Bhansroadgarh Block - Nav Nirman Sanstha, Chittorgarah Block - Prayas , Kapasan Block - Navachar Sanstha, Kotra Block - Sewa Mandir, Gogunda Block - ARTH, Manva Rojgar avam Sarada Block - Kshamta Vikas Samiti (MRAKVS), Laxmangarh Block - Bharat Gyan Vigyan Samiti, Umrein Block - Matsya Mewat Shiksha evm Vikas Sanstha and Ramgarh Block - IBTADA -

Physical Progress of Community Monitoring Activities

Level	Achievement
VHSC	180
PHC MPC	36
Block MPC	12
District MPC	4
Media Workshops	1
Jan Samwad	12-Block level 36 PHC level
Village Report Card	
Block Provider orientation Workshop	3

Tamil Nadu

Selected districts	Kanyakumari, Perambalur, Vellore, Thiruvallur and Dharmapuri
Nodal Agencies	
State nodal NGO	Tamil Nadu Science Forum (TNSF)
District Nodal NGO	Dharmapuri District Voluntary Agencies Network Initiatives (DHVANI) - Dharmapuri District, Voluntary Health Association of Kanyakumari (VHAK) - Kanyakumari District, Catholic Hospital Association of Tamil Nadu (CHAT) - Perumbulur District, TNSF - Thiruvallur District , and Darulselvi Community Based Rehabilitation (DCBR) - Vellore District
Bock Nodal NGO	Harur Block - Community Rural Development Society (CRDS), Nallampalli Block - SEEDS, Kariyamangalam Block - Rural Development Society (RDS), Agasteeswaram block - VHAK, Kuruthancode Block - Catholic Hospital Association of Tamil Nadu (CHAT), Killiyoor Block - TNSF, Perumbulur Block - Dawn Trust, Andimadam Block - Gandhi Gramodhaya Trust, Tirumanur Block - Udhaya Trust, Gumidipoondi Block - TNSF, Meenjur Block - Jeeva Jothi, Poonamalli Block - Pasumai Trust, Kandhili Block - DCBR, Pernampet Block - Voice Trust and Kaniyampadi Block - TNSF

Physical Progress of Community Monitoring Activities

Level	Achievement
VHSC	225
PHC	45
Block	15
District	5
State	0
Media Workshops	
Jan Samwad	
Village Report Card	
Block Provider orientation Workshop	

Jan Sunwais and Media Coverage

> “Just ensure Doctors are present in PHC on stipulated time and they behave properly with us.”
>
> A Village to Block Medical Officer at a Jan Sunwai.

One of the key activities in the CBM framework is organising of Jan Sunwais (public hearings). Perhaps for the first time in the history of Public Health sector, Jan Sunwai has been officially mandated by the State. This provision has been quite aptly used by implementing organisations and the community itself. Diverse range of issues came up during Jan Sunwai, e.g. availability of medicines, availability of medical personnel at the service point, ambulance services, irregularities observed in the provision of incentives, corruption, attitude of the service providers, instances of denial of health services and number of policy level issues. It is clearly visible through the community of upward movement in public health institutions. Similarly media coverage has also worked as a catalyst to respond to government officials. Total number of news items that are published in the leading National and the state level news papers are overwhelming.

Jan Sunwai is a potent tool to create social pressure on the authorities and also make them responsive. As a single effective strategy Jan Sunwai is very unique, it has led to one or the other positive change right from the district

level to the PHC level.

Many of us are well accustomed with a format of Jan Sunwai and know ways in which people present their grievance. However in Amaravati district of Maharashtra, Jan Sunwai was exception, for the first time a PHC MO came to present her grievance. (See Box)

"Please do not promise something which you know very well is impossible to provide, we don't want you to promise us guaranteed health services, just ensure that your Doctors are present in PHC on stipulated time and they behave properly with us."- One villager said to Taluka (Block) Medical Officer in PHC Jansunwai in Murbad to Taluka Medical Officer.

It has been a general experience that given the opportunity people do not hesitate to express themselves in the direct possible way. After every Jan Sunwai panelists have ensured that appropriate follow up mechanism is in place to ensure timely improvement in observed deficiencies.

Unusal testimony of a PHC Doctor

"How can you transfer an efficient doctor like Dr. Miraj Ali? What forced you to take this decision when people are against it? Sir we need an answer" Group of women from Dhamangaon Gadhi in the Amaravati district level Jan Sunwai, speaking to the DHO.

Many of us are well accustomed with a format of Jan Sunwai and know ways in which ordinary people present their grievances. However, Amaravati Jan Sunwai was exception, because it was the first time a PHC MO came to present her grievance. Her testimony exemplifies difficulties faced by well intentioned and sincere officers in the health bureaucracy and the way such a persons are systematically isolated. Following the brief description of the whole episode/

Dr. Miraj Ali has been working as a PHC MO in Dhamangaon Gadhi for the last one and a half year. People have reported that she has been quite instrumental in improving the health services of the PHC, this by no means a little achievement considering the fact that the same PHC was almost dysfunctional before she was appointed there. She has been staying in the PHC from the day of her appointment. Naturally, the number of OPD patients have increased significantly. Women in the area of this PHC have particularly benefited from the presence of a lady doctor in the PHC. In the Jan Sunwai around 20 men and women, including one Zilla Parishad representative, travelled from their village to Amravati and strongly protested against her unjustified transfer. In spite of warnings by the villagers that they would 'gherao' PHC if Dr. Ali was not reinstated, the DHO Amaravati who was present in the Jan Sunwai was quite dismissive and non-committal. Around 325 people residing in Dhamangaon have signed a petition to reinstate Dr. Ali and the Zilla Parishad member from Dhamangaon has also endorsed this demand. This petition was presented in a Jan Sunwai. What was striking was the way ordinary women from Dhamangaon supported Dr. Ali. We still remember a frail looking woman who came to Sunwai at her own expense and warned DHO not to play with sentiments of people in Dhamangaon since every house in the village knows about the contribution of Dr. Ali.

Dear Sir,

I am engaged in a PHC in extreme rural part of Tripura State as an AYUSH Medical Officer. I used to read NRHM Newsletter borrowing from other PHC. It is very informative and rich in information. We are working in highly malaria prone areas. I, therefore, request you to kindly mail me the magazine regularly.

Dr. Malay Rudrapal,
PO Howaibari,
Pechartal PHC,
North Tripura

Dear Sir,

I am working as a Staff Nurse in PHC since 1983. Your Newsletter is very informative. There is no end for health education. Kindly send me your Newsletter in English regularly.

Smt. L.N. Bhandarkar,
Staff Nurse, PHC,
Ramanguli 581 314
Ankola Taluk
Karnataka

Dear Sir,

You are requested to regularly supply the NRHM Newsletter to this organization for the benefit of the health workers/general public.

Honorary Secretary,
St. John Ambulance,
Orissa State Centre,
Qr. No. 4R, 6/2, Unit 3
Bhubaneswar 751 001

Dear Sir,

I am very happy to inform you that your NRHM Newsletter is very useful to me because I am working as a Deputy District Extension Media Officer in Srikakulam Distt. which is in Andhra Pradesh. My duty is to create awareness among the people on national health programmes through medical and health staff. But health education is not only a one day programme, it is a continuous programme. I would like to know more information through your NRHM Newsletter and new innovations which is needful to our society. Kindly put me on your mailing list for getting the Newsletter regularly.

Shri B. Mokhalingam,
Dy. Distt. Extension Medical Officer,
Door No. 2-2-10-1A1,
Pillalakrishna Rao Quarters,
Illisipuram,
Distt. Srikakulam 532 001
Andhra Pradesh

Dear Sir,

I am working as a Mukhya Prerak of Chhotkara, NCEC under Baraboni Block in Burdwan District. I read a copy of NRHM Newsletter from PHC. I am extremely benefited from that copy. I will be obliged if you kindly put my name and permanent address in your mailing list.

Shri Jiban Kumar Maji,
Vill. Chhotkara,
P.O. Panuria,
Distt. Purdwan,
West Bengal 713 315

Dear Sir,

I am posted at PHC, Tapri, Distt. Kinnaur (HP). I am a regular reader of the Hindi edition of your magazine. I find it very useful and informative to me and the staff here. Some of the staff members of this institute i.e. PHC, Tapri, Distt. Kinnaur will be able to understand English Edition of NRHM Newsletter better. Kindly also send us English Edition of the Newsletter.

Dr. Anup Negi,
Medical Officer I/c.
Primary Health Centre,
Tapri, Teh. Nichar,,
Distt. Kinnaur 172 104 (HP)

Dear Sir,

Recently I got several issues of NRHM Newsletter in a rural hospital which I found very informative. The special issues on Malaria & Chikungunia and Leprosy were of practical utility. Hope, the coming editions, as well, would be of practical relevance. Kindly include my name in your mailing list.

Dr. Jyotirmay Ghosh,
Mohan Bad (Prachi Pukur East),
Post Sripally, Distt, Burdwan,
West Bengal 713 103

Dear Sir,

We are an NGO engaged in the field of social service. We take up social projects on water, health and family welfare in rural areas from time to time. We wish to subscribe to the NRHM Newsletter to have update information about the projects and activities taking place from time to time. Kindly put us in your mailing list for regular supply of NRHM Newsletter.

Ln. (Mrs.) Preeti Daga,
Lions Club of Amravati,
Siddharth Bhavan, Morshi Road,
Amravati 444 601

Dear Sir,

I have been working as a Junior Health Inspector in PHC Elevanchery, Palakkad Distt, Kerala State for the last 5 years. I read your Newsletter. This Newsletter will definitely be useful for our institution and our routine work. I request you to kindly send me the Newsletter every month.

Shri Arun Arency, PHC Elevanchery
Kizhakkumari P.O., Nemmara (Via), Palakkad,
Kerala 678508

NRHM has boosted immunization coverage

Dear Sir,

I am working as a Health Inspector in Eruvadi PHC Tamil Nadu. I happened to read NRHM Newsletter. It is very informative and useful for public health staff. It gives clarity on our health status and the actions being planned. Kindly register my name in the mailing list for regular supply of the Newsletter.

Shri R. Murugan,
Health Inspector,
6/3A, North Police Station,
Kalakad 627 501
Tirunelveli Distt, Tamil Nadu

Dear Sir,

I recently went through the NRHM Newsletter and I am proud to say that it is really of international standard and very informative. The common reviews and articles on diseases are excellent. A suggestion is that the experiences of different categories of staffs of different states on implementation of NRHM may also be included. Kindly include my name and mailing address in your mailing list to ensure the regular supply of the Newsletter.

Shri G.B. Ratheesh,
Laboratory Technician,
Primary Health Centre,
Trithala, Palakkad

Dear Sir,

I am a Medical Officer (Ayurveda) working in Government Ayurveda Dispensary in remote area of Andhra Pradesh as a newly appointed physician under NRHM Scheme. I would like to have NRHM Newsletter on regular basis to keep myself up to date about the health & disease of rural India. So kindly put my name and address in the mailing list.

Dr. M. Krishna Murthy,
Medical Officer,
H.No. 4-1-67/4, Opp Venkateshwara Temple,
P.O. DORNAKAL, Distt. Warangal,
Andhra Pradesh - 506 381

Dear Sir,

I am working in Civil Hospital Rajpipla, Gujarat as a Medical Officer for the 3 years. I have read your NRHM Newsletter. It is very resourceful for all medical persons. Kindly enroll me in your mailing list and also request you to send all the previous issues.

Dr. Vishal B. Visava,
4, Paradise Park,
Near Water Filtration Plant,
Zadeshwar Road,
Bharuch 392 012

Dear Sir,

I found a copy of the NRHM Nov.-Feb 2008 issue during my recent visit to International Trade Fair held at New Delhi. It was really interesting and informative regarding the health scenario of different States of India. I am a practicing surgeon at Gaya and willing to help the Government in achieving goal of various health programs being conducted by both State and Centre. I would like to receive regular copies of this magazine to keep myself updated with latest programs. Hence I request you to put my name in the mailing list of this magazine.

Dr. Jayadeva Sinha,
Sushurut Hospital & Stone Clinic,
West Ramsagar Tank,
Gaya 823001, BIHAR

Dear Sir,

I am working as a Lab Technologist of RNTCP & NVBDC programme in Agartala, West Tripura. I have read your NRHM Newsletter. It is very useful and gives nice authentic information to all health workers who are keenly interested to exchange knowledge with common people for positive response about health. Kindly enroll me in your mailing list and request to send all the previous issues to my address.

Shri Rana Kumar Das,
Lab. Technician, Sanitala Airport Road,
Vill. Chhinaihani, P.O. Agartala Airport
Tripura (W) 799 009

Dear Sir,

I am working in Primary Health Centre as Ophthalmic Technician. I will be thankful if you enroll my name in your mailing list for receiving the NRHM Newsletter in English on a regular basis.

Shri R. Sivasubramaniyan,
Ophthalmic Assistant,
Government Primary Health Centre,
Naduveerapattu,
Cuddalore Dt., Tamil Nadu

Dear Sir,

Kindly put my name in your mailing list for Oriya version of NRHM Newsletter.

Dr. Rashmi Ranjan Mohanty,
Lecturer in Oriya,
P.S. College, At/PO Jharbandh,
Distt. Bargarh 768 042, Orissa

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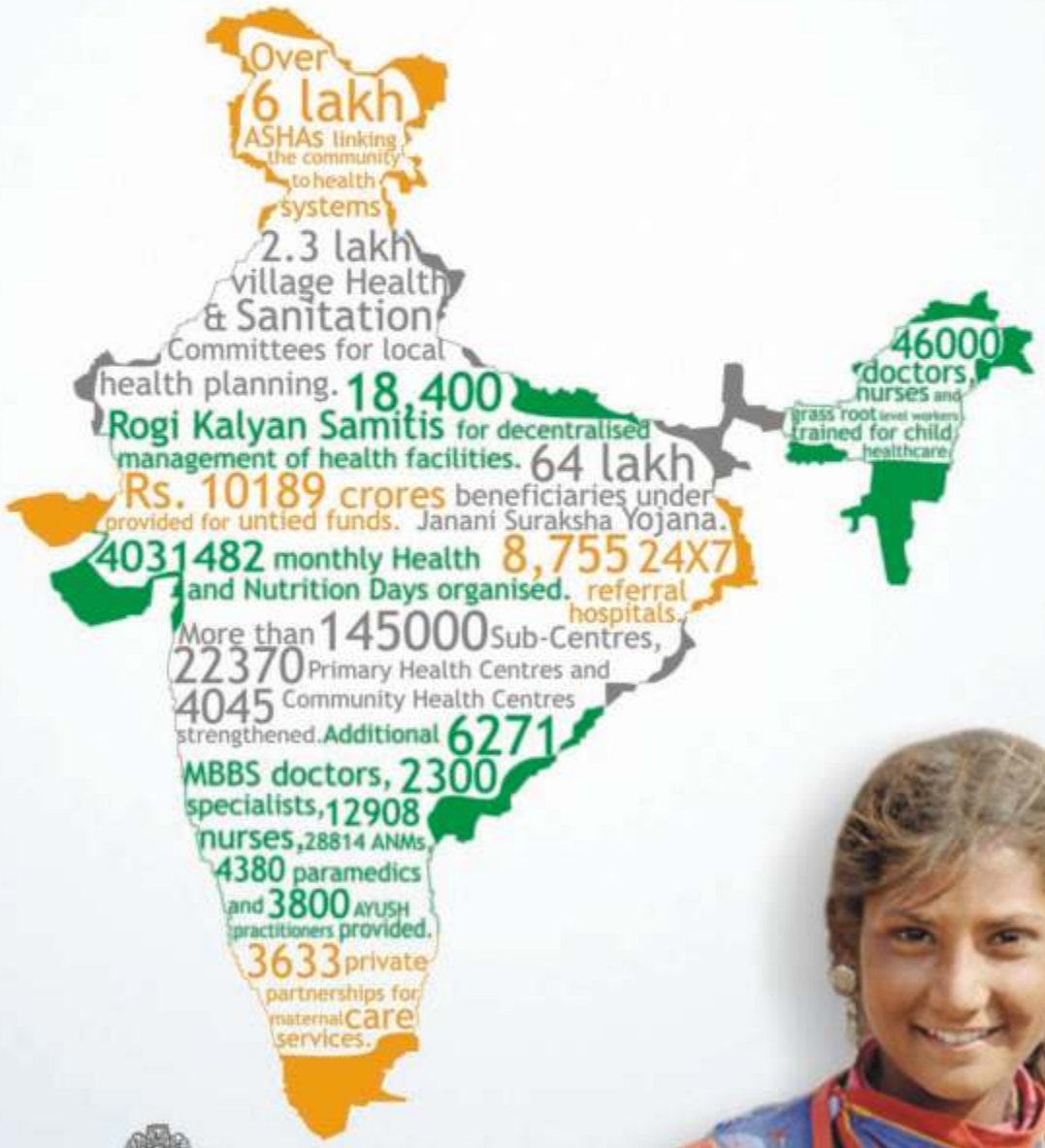
(2005-2012)

Shaping the nations' healthcare system

Overcoming the challenge of the health concerns of an entire nation with the three strategic A's, NRHM makes possible affordable, available and accessible quality healthcare to the people of rural India. Standing proud in the third year of its establishment, with the promise to do even better in the coming years.



सत्यमेव जयते

Ministry of Health and Family Welfare
Government of India