Maternal Health Entitlement Campaign

Note on Survey Implementors

Purpose – The purpose of the survey is to quickly grasp key issues relating to NRHM and JSY services, in relation with all deliveries that took place in a hamlet where the population is predominantly from a socially excluded group.

- The survey instrument is simple so please read it carefully and familiarise yourself with all the questions.
- The first level of analysis of the survey instrument has to be the district/ block. We have provided you tally sheets, leading to the preparation of district report cards.
- The survey formats can be later forwarded to State headquarters.
- The primary purpose of the questionnaire is not to answer research questions but to enable district level groups to understand to what extent are NRHM and JSY services are reaching the socially excluded groups in their district.

Who is going to be surveyed - The survey is going to cover all women who delivered in a 6-month period (ending one and half months prior to the start of survey period)- **April 1 to September 30, 2007** . This will include all women who survived and those who have not, and all children who were born, living or not. It is anticipated that 25 hamlets of roughly 1000 population each are going to be surveyed in each block, and two blocks surveyed in each district. This will mean roughly 25,000 * 30/ 1000 * 6/12 (= 375) deliveries will be covered in each block.

Sample – All deliveries in a specified time period in the designated hamlets where socially excluded communities are in the majority. This will include women who normally live there and not those who are visiting. The delivery may have taken place outside the village.
PLEASE IDENTIFY AND VISIT ALL HOUSEHOLDS WHERE A WOMAN WHO NORMALLY LIVES/LIVED THERE HAD A DELVERY DURING PERIOD APRIL 1 TO SEPTEMBER 30, 2007.

Steps

1. Identify the hamlets in the block in which the survey is to be conducted.
   – Task of district level group
2. Mark out all the households among the above where deliveries (including maternal deaths, still births, neonatal deaths etc) took place between **April 1, 2007** And **September 30, 2007** (Take support of local women's group)
3. As an alternative use a hamlet/ mohalla based key informant approach to pick up recent deliveries (Key informants will list the deliveries)
4. Make a hamlet wise list of all these families, women's name and husbands name
5. Conduct survey with the women. If women are unavailable talk to mother in law, sister in law, husband, father in law, brother in law etc.
6. If there is a grievous denial of rights and adverse outcome record a detailed case study
7. Collate data
8. Prepare block and district report card.

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Preparation (by field researcher)

- Please read the questionnaire carefully before you start the survey. Become familiar with all the questions of the questionnaire before you proceed for the interviews.
- Make a list of all accredited JSY centres for the Block – including all government and private providers and NGO providers.
- The interview must take place in the home of the respondent.
- First explain the purpose of the interview to the respondent before starting the interview. Take their permission before staring the interview
- After filling in the basic information about the woman (or other respondent in case the women is dead) and the place and provider at delivery – ask the remaining questions.
- Listen to the respondent carefully and fill in the answers for concrete service guarantees and JSY. You may need to crosscheck these answers with the respondent when you fill the form.
- Similarly when you mark your answers for the adverse outcomes / denial of care – confirm your responses with the respondent.
- You are required to put a tick on the correct response and/or fill in the blanks. You may also make a note of any relevant information that is not indicated in the form. Please tick the form in a way that it is clear which option is being ticked
- Answer all the questions

Some definitions to know before going for fieldwork:

Whom to interview: *All women in the hamlet that delivered in past 6 months – i.e. between April 1 and September 30, AND whose six months ended 6 weeks before the interview. Please interview women from excluded groups as well as women from non-excluded groups in the hamlet. Interview mother-in-law, sister-in-law or husband etc who can provide details of pregnancy and delivery if the woman has not survived.*

Place of Delivery – *We are trying to find out whether the delivery took place at home or at a JSY accredited institution so please mark the option accordingly. Use the list of JSY accredited private providers while compiling the data. Write the name of the facility if known, esp. in case of private provider.*

Home / Private Informal / Government Hospital SHC/PHC/CHC / Private Formal (JSY) / Private Formal (Non- JSY) on the way/ other… …

Provider at delivery – *We are trying to find whether any nurse / ANM or formal provider was present during the delivery. Please mark all providers who were involved*

Relative / neighbour / TBA (dai) / ANM / Nurse/ Doctor Formal / Doctor informal / ASHA / husband / **other**… …

Nature of delivery –

Vaginal delivery – Delivery takes place from the birth canal without any use of drugs or medicines

Complicated delivery - Delivery takes place from birth canal with the use of medicines or needs to be referred for expert (formal or informal) support

Small Operation – Delivery takes place from birth canal but there is a small operation in the birth canal. Forceps or tongs may also be used to bring the baby out

Caesar Operation – Delivery takes place after the abdomen is cut open by surgery.

Date of Delivery – *Check whether the day is between April 1 and September 30. Note the approximate date if exact date is not known.*

Concrete Service Guarantees

BP (Blood Pressure) – that is measured by tying a cuff over the arm that is then inflated with air by a balloon pump. Stethoscope is also used along with the cuff.

ANM, AWW, ASHA – are local health staff that provide advise or preliminary health care to the pregnant women or young mothers about their health practices, nutrition, information about health care services available and counsel them about various health conditions that need to be taken care of / danger signs when they need to consult a doctor.

Anganwadi registers a pregnancy in the village and provides supplementary diet to all pregnant and lactating women

ANM does a three ante-natal checkups that includes taking blood pressure, weight, abdomen examination, giving TT inj. etc. for the pregnant women and gives advise for institutional and safe delivery practices. She visits the women at her house within the next few days of her delivery, for health check-up of the mother and child and provide necessary advice.

ASHA works as a link worker between the women and ANM or AWW. She takes care of the health needs of the women and accordingly counsels her to make sure she utilizes the health services adequately. She also accompanies the women to the hospital during her delivery.

Janani Suraksha Yojna –

JSY is a government scheme under which women are provided monetary benefits immediately (or soon after) after her delivery. The money is given by a health staff of a government health centre or hospital, and in some places, by a private health institute accredited by the government for the purpose of JSY.

We want to know if the health care services and the benefits of the scheme are accessible to the women and if they face any harassment or discriminations in getting the services or the money.

Any adverse outcome

We want to know the outcome of the delivery – if the woman or the child suffered some adverse health event, during or after pregnancy, delivery or abortion.

Maternal death (death during or within 6 weeks of delivery)

Heavy Bleeding – (during pregnancy / labour or soon after delivery/ abortion)

High fever soon after delivery or abortion

Prolonged labour (more than one whole day)

Early Neonatal death (death within a week after birth)

Neonatal death (death within a month after birth)

Still birth (baby born dead. did not ever breath)

Any adverse experience or denial of service

We want to know about the experiences of women when they approach health care for their delivery.

If the adverse outcomes or adverse experiences are very severe or go beyond the options indicated in this form. and the researcher feels that it must be documented in detail as a case-study of health rights violation or denial of health care services – please document it as a case-study (in a format provided separately).

Instructions for Collating the Survey and preparing Block/District Report Report Cards

Three two types of collation formats and one format for preparing Block/ District Report Cards provided for your use. The two kinds of collation formats are the Village Collation Format and the Block/District Collation Format. Separate collation formats are to be filled for General Category. OBC category and Excluded Groups for each village. Specimens are provided for those as well.

Steps for Collation

1. Collect all the forms for one village in one place. Provide each form with a number which could be like UP/Az/At/V/W1 = Meaning State Name – UP; District Name-Azamgarh: Block Name – Atraulia; V – Village Name and W1 – number for the woman.
2. After numbering the forms please separate into three piles – General; OBC; and Excluded
3. Collate each category of form on a separate collation sheet. Strike one mark for each answer from the form. Put five markers into each column to help in totaling later.
4. Put the forms from one village together into one pile
5. Add the totals from the the three village files into the appropriate column of the Block / District Collation sheet. The name of the different villages can be put in the place V1; V2 V3 etc.
6. Take the totals for each collation sheet of Village V1 and write it down in the appropriate column - General. OBC. Excluded under that village name
7. When you have finished writing down the totals for each village in the appropriate column fill the total column in this manner. Add the appropriate column for any issue across villages to fill the answer in the same column in the total column eg. If you are counting women who have received BP check up in a particular block then add the General category of V1. V2. V3. V4... and write the total under General in the Total. Similarly add BP check up for OBC in V1. V2. V3. .. and write the total under OBC category in the Total for BP. Finally add Excluded category number in Villages V1.

V2, V3 … and write the total under Ext for BP check. Complete each row in the collation sheet in this manner referring to the three different village forms for each village.

8. Once the Block/ District Collation Sheet is completely filled you are ready to complete the Block/ District Report Card. Fill the first few lines of the report card from the district total data. For filling the Numbers Column of the table take the appropriate figure from the Block/ District Collation Sheet.
9. Calculating percentages : For calculating percentages we will calculate for any particular issue eg. BP or Institutional delivery for that category of woman

$$\frac{\text{No of women on one issue (eg. BP check / Institutional Delivery) from any category (eg OBC)}}{\text{Total number of women of that category (eg. OBC)}} \times 100$$

10. Interpreting the Block/District report Card – The Block/District report card allows the comparison of experiences of women across different categories – viz. General, OBC and Socially Excluded. The comparison of percentages for the different groups on any one issue will enable the researchers to compare the experiences of women across categories. Thus we can say what is the percentage of women going for institutional delivery among General category compared to women from Excluded Groups. Or Number of women facing harassment in OBC groups compared to women from Excluded Groups. Our hypothesis is that a larger percentage of women from Excluded Groups will not be getting services and will be facing harassment and extortion compared to general category women.

Wishing you all the best for the Survey and completing the District Report Card !

Unique ID – .....

Maternal Health Entitlement Campaign

Interview with Woman who has delivered between April 1 and September 30, 2007

(Woman who is a usual resident of the hamlet. woman may not have survived)

Name of the Women –.....

Husbands/ Father/ Head of Household's name –.....

Village - ..... **Hamlet.....**

(If woman is not alive) Name of the respondent / Relation with woman-.....

Social Group – General /OBC/SC/ ST/ Muslim / NT / Primitive Tribes/Other.....

Caste – .....

Economic status – BPL/APL

1. Where did you deliver?

Place – Home / Private Informal / Government Hospital SHC/PHC/CHC / Private Formal/ on the way/ other... ...

Name of the Facility if known -

2. Who conducted the delivery?

Provider at delivery – Relative / neighbour / TBA (dai) / ANM / Nurse/ Doctor Formal / Doctor informal / ASHA / husband / other... ... **(Please mark all involved)**

3. What was the nature of delivery?

Vaginal delivery/ Complicated delivery / small Operation / Caesar Operation

Date of Delivery (if not known approximate to the nearest month):.....

(for cross checking whether she belongs to the group we are interested in)

4. Sex of the child (from present delivery) – **male / female**

5 Concrete Service Guarantees

1. Did ANM examine your BP at least once prior to your delivery? Yes/ NO
2. Did ANM/AWW give you red tablets for improving your blood levels? Yes/ NO
3. Did ANM advise you to go to SHC/ PHC or CHC for delivery? Yes/ NO
4. Did the ASHA provide any advice during your pregnancy? Yes/ NO
5. Has ANM visited you at least once after your delivery? Yes/ NO
6. Did you receive regular diet from AWW during your pregnancy? Yes/ NO

6. Janani Suraksha Yojna

1. [If the woman had an institutional delivery (see Q 1 above)] Did the ASHA accompany you?
   – No / Yes
2. [If the woman had an institutional delivery (see Q 1 above)] Have you received allowance of Rs.1400/- after delivery in government health facility or other government recognised institute for the purpose – No / Full / Part (Rs ... ...)
3. If you had home delivery did you receive Rs.500/- – No / Full / Part (Rs ... ...)
4. Did you have to pay any amount to ANM or in the PHC/ CHC to get this allowance?
   –Yes / NO
5. If yes How much money?
   0 – 100
   101 – 250
   251 – 500
   501 and above (.....)
6. Did you face any harassment in getting the money? – Yes / NO

Any adverse outcome of delivery? *(Please tick the right answer)*

1. Maternal death (death within 6 weeks of delivery) - Yes / NO
2. Heavy Bleeding – (during pregnancy / labour or soon after delivery/ abortion) - Yes / NO
3. High fever soon after delivery or abortion - Yes / NO
4. Prolonged labour (more than one whole day) - Yes / NO
5. Early Neonatal death (death within a week after birth) - Yes / NO
6. Neonatal death (death within a month after birth) - Yes / NO
7. Still birth (baby born dead) - Yes / NO
8. Any other – Specify.....

Any adverse experience or denial of service

1. Refused treatment at a government (recognised) health centre? Yes/ NO
2. Referred from a government (recognised) health centre to another institution but without providing referral notes/sheet Yes/ NO
3. Referred from a government health centre to another institution but without ambulance support Yes/ NO
4. Harassment or Abusive behaviour by the staff at government (recognised) hospital

Yes/ NO

5. Government (recognised) Health provider asked for money for providing services -

Yes/ NO

5 a.) If yes how much money -0 – 100

101 – 250

251 – 500

501 and above (.....)

5 b.) How much money did you have to spend for

Medicines – .....

Supplies – .....

Travel expenses –.....

Fees to provider –.....

Any other expenses .....

Total for Delivery.....

6. Any other experience?

Specify.....

Maternal Health Entitlement Campaign

Village/ Hamlet Collation Sheet

State - **District**

Village - **Hamlet -** **Social Group -**

Question	5	5	5	5
Total Number of Women				
BPL family				
Place of Delivery				
Government facility				
Private (govt. recognized)				
Home				
Provider at delivery				
ANM / Nurse/ Doctor Formal				
Nature of Delivery				
Normal				
Complicated				
Operation (Small)				
Operation (Caesar)				
Concrete Service Guarantees				
BP taken during pregnancy				
Got iron folic acid tablets				
ANM/ AWW/ ASHA advised / referred to govt. institution for delivery				
ASHA provided advice				
ANM visited after deliver				
Supplementary diet from AWW				

Janani Suraksha Yojna				
ASHA accompanied for delivery				
Received full JSY allowance of Rs.1400/-				
Received part allowance				
For home delivery receive Rs.500 – Full amount				
For home delivery receive Rs.500 – Part Amount				
Paid any amount to ANM or in the PHC/ CHC to get this allowance?				
0 – 100				
101 – 250				
251 – 500				
501 and above				
Faced any harassment in getting the money?				
Any adverse outcome				
Maternal death				
Heavy Bleeding				
High fever soon after delivery				
Prolonged labor				
Early Neo natal death				
Neo natal death				
Still birth				
Any other infant health adverse outcome				
Any other maternal health adverse outcome				

Denied Services				
Refused treatment at a government health center				
Referred without providing referral sheet				
Referred without providing ambulance support				
Abusive behaviour of staff at government hospital				
Health provider asked money for providing services				
0 – 100				
101 – 250				
251 – 500				
501 and above				
Total Money Spent for Delivery				
Upto 1000				
1001 – 2500				
2501 – 5000				
5001 – 10000				
10001 and above				
Any other denial				

Any other issue in the village-

Name of women facing serious denial of services -

Maternal Health Entitlement Campaign

Village/ Hamlet Collation Sheet

State -
Village -

District
Hamlet -

Social Group – O

Question	5	5	5	5
Total Number of Women				
BPL family				
Place of Delivery				
Government facility				
Private (govt. recognized)				
Home				
Provider at delivery				
ANM / Nurse/ Doctor Formal				
Nature of Delivery				
Normal				
Complicated				
Operation (Small)				
Operation (Caesar)				
Concrete Service Guarantees				
BP taken during pregnancy				
Got iron folic acid tablets				
ANM/ AWW/ ASHA advised / referred to govt. institution for delivery				
ASHA provided advice				
ANM visited after deliver				
Supplementary diet from AWW				

Janani Suraksha Yojna			
ASHA accompanied for delivery			
Received full JSY allowance of Rs.1400/-			
Received part allowance			
For home delivery receive Rs.500 - Full amount			
For home delivery receive Rs.500 – Part Amount			
Paid any amount to ANM or in the PHC/ CHC to get this allowance?			
0 – 100			
101 – 250			
251 – 500			
501 and above			
Faced any harassment in getting the money?			
Any adverse outcome			
Maternal death			
Heavy Bleeding			
High fever soon after delivery			
Prolonged labor			
Early Neo natal death			
Neo natal death			
Still birth			
Any other infant health adverse outcome			
Any other maternal health adverse outcome------			

Denied Services				
Refused treatment at a government health center				
Referred without providing referral sheet				
Referred without providing ambulance support				
Abusive behaviour of staff at government hospital				
Health provider asked money for providing services				
0 – 100				
101 – 250				
251 – 500				
501 and above				
Total Money Spent for Delivery				
Upto 1000				
1001 – 2500				
2501 – 5000				
5001 – 10000				
10001 and above				
Any other **denial**				

Any other issue in the village-

Name of women facing serious denial of services -

Maternal Health Entitlement Campaign

Village/ Hamlet Collation Sheet

State -
District
Village -
Hamlet -
Social Group – F

Question	5	5	5	5
Total Number of Women				
SC				
ST				
Muslim				
NT				
DNT				
Other				
BPL family				
Place of Delivery				
Government facility				
Private (govt. recognized)				
Home				
Provider at delivery				
ANM / Nurse/ Doctor Formal				
Nature of Delivery				
Normal				
Complicated				
Operation (Small)				
Operation (Caesar)				
Concrete Service Guarantees				
BP taken during pregnancy				
Got iron folic acid tablets				

ANM/ AWW/ ASHA advised / referred to govt. institution for delivery				
ASHA provided advice				
ANM visited after deliver				
Supplementary diet from AWW				
Janani Suraksha Yojna				
ASHA accompanied for delivery				
Received full JSY allowance of Rs.1400/-				
Received part allowance				
For home delivery receive Rs.500 – Full amount				
For home delivery receive Rs.500 – Part Amount				
Paid any amount to ANM or in the PHC/ CHC to get this allowance?				
0 – 100				
101 – 250				
251 – 500				
501 and above				
Faced any harassment in getting the money?				
Any adverse outcome				
Maternal death				
Heavy Bleeding				
High fever soon after delivery				
Prolonged labor				
~~Early Neo natal death~~				
Neo natal death				

Still birth				
Any other infant health adverse outcome				
Any other maternal health adverse outcome				
Denied Services				
Refused treatment at a government health center				
Referred without providing referral sheet				
Referred without providing ambulance support				
Abusive behaviour of staff at government hospital				
Health provider asked money for providing services				
0 – 100				
101 – 250				
251 – 500				
501 and above				
Total Money Spent for Delivery				
Upto 1000				
1001 – 2500				
2501 – 5000				
5001 – 10000				
10001 and above				
Any other denial				

Any other issue in the village-

Name of women facing serious denial of services -

Maternal Health Entitlement Campaign
Block / District Collation Sheet
District

State -
Block/ District

Social Group –

Question	Village-wise totals											
	V1			V2			V3			V4		
	Gen	OBC	EXL	Gen	OBC	EXL	Gen	OBC	EXL	Gen	OBC	EXL
SC												
ST												
Muslim												
NT												
DNT												
Other												
BPL family												
Place of Delivery												
Government facility												
Private (govt. recognized)												
Home												
Provider at delivery												
ANM / Nurse/ Doctor Formal												
Nature of Delivery												
Normal												
Complicated												
Operation (Small)												
Operation (Caesar)												
Concrete Service Guarantees												

BP taken during pregnancy												
Got iron folic acid tablets												
ANM/ AWW/ ASHA advised / referred to govt. institution for delivery												
ASHA provided advice												
ANM visited after deliver												
Supplementary diet from AW												
Janani Suraksha Yojna												
ASHA accompanied for delivery												
Received full JSY allowance of Rs.1400/-												
Received part allowance												
For home delivery receive Rs.500 – Full amount												
For home delivery receive Rs.500 – Part Amount												
Paid any amount to ANM or in the PHC/ CHC to get this allowance?												
0 – 100												
101 – 250												
251 – 500												

501 and above											
Faced any harassment in getting the money?											
Any adverse outcome											
Maternal death											
Heavy Bleeding											
High fever soon after delivery											
Prolonged labor											
Early Neo natal death											
Neo natal death											
Still birth											
Any other infant health adverse outcome (Types)											
Any other maternal health adverse outcome (Types)											
Denied Services											
Refused treatment at a government health center											
Referred without providing referral sheet											
Referred without providing ambulance support											
Abusive behaviour of staff at government hospital											

Health provider asked money for providing services					J						
0 – 100											
101 – 250											
251 – 500											
501 and above											
Total Money Spent for Delivery											
Upto 1000											
1001 – 2500											
2501 – 5000											
5001 – 10000											
10001 and above											

Any Other Denials (types)

Block / District level Report Card

Name of State -

Name of District -

Name of Block -

Total number of hamlets surveyed –

Total number of women covered in the survey –

Total number of women from General Category-
Total number of women from OBC –
Total number of women from Excluded categories -

Social Exclusion faced by women Covered in the survey –
SC - ST - Muslim - NT - PT -
Other-

Economic Exclusion faced by women Covered in the survey (BPL families) –

	General		OBC		Excluded	
	No	%age	No	%age	No	%age
Total Number of women surveyed						
BPL						
Women who had an institutional delivery						
Women who have received support from ANM / Nurse/ Doctor Formal						
Adverse Outcomes						
Maternal death						
Women with heavy bleeding						
women with High fever soon after delivery						
women with prolonged labor						
Still Birth						
Early Neo natal deaths (7 da\s)						

Neo-natal death (28 days)						
Concrete Service Guarantees						
Women receiving BP examinations from ANM						
Women receiving iron tablets from ANM/ AWW						
Women referred by ANM to SubCetre, PHC or CHC for delivery						
Women who received advice from ASHA						
Women visited by ANM after delivery						
Women received supplementary diet from AWW						
Janani Suraksha Yojna						
Women accompanied by ASHA for institutional delivery						
Women receiving full JSY allowance for institutional delivery						
Women receiving Rs.500/- for home delivery						
Women who paid to get this allowance						
Women and her family who faced harassment in getting the money						
Women refused treatment at a government health center						
Women referred without providing referral sheet						
Women referred without providing ambulance support						

Women facing abusive behaviour of staff at government hospital						
Women whom health provider asked for money						
Health provider asked for money						
Health provider asked > Rs 250						
Total Expenses > Rs 2500						

Adverse Experience / Denial of Care Case-study Documentation

Issues for investigation eg. Refusal to attend delivery, delay/adverse experiences in referral from the community level by ANM, refusal or delay in admitting at Hospital, leading to prolonged labor, excessive bleeding infection, maternal death etc

Documentation format

Name of Village –

Name of the Woman

Name of her Husband/ Father –

Age –

Educational Status –

Marriage Status -

Years Married –

Number of Children alive Female -

Male –

Age of the youngest living child –

Give your own introduction . Explain the purpose of the interview . Take permission for the interview.

Permission given -

Permission refused -

What were the specific problems faced ? Why were these problems important to the client or her family ?

When did the problem start ? How did it increase ? (approx dates if possible)

What kind of medical help was requested? – Government/Private? If not Government why not? (with approx dates)

Time gap between the start of the problem and help seeking?

How many times were service providers approached (approx dates) ? What was their response?

What was the advice given by health providers if any? Treatment ? Investigation ?

Was it possible to comply with this advice? Investigations? Hospitalisation? (If not why not?)

Behaviour of the service providers?

Any refusal to help? What happened when there was a refusal if any?

Any demand for money?

Total costs involved? For what purposes ?

What was the dominant feeling when going through the experience?

What is the dominant feeling about the problem now?

Any documents?

Willing to share her story at the sharing?

Yes / No / May be / Will go but not share story / Will not or Can not go.

Date –

Case recorded by –

Certificates and documents seen (copied)

Type of Case – (Fill Later) –

Denial of health care through
1.

IF.

3

These cases can be presented as testimonies at a public hearing or as appendix to District Report Card

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A state wise activity update from August to December

Maharashtra

Publications/Materials:

- Brochure on Community based Monitoring under NRHM in Marathi
- Guidebook on Community based monitoring
- Four posters on guaranteed services at village, PHC and Rural Hospitals and patients rights designed

State level coordination:

- The second State Mentoring Team meeting was held on 8th August 07 to discuss and finalise the outline of structure and process of formation for Mentoring Committee at district, block and PHC level.
- MoU between State Nodal NGO and five District Nodal NGOs was signed and first installment was transferred to the five District Nodal NGOs in September 07.
- Maharashtra State level Training of Trainers (ToT) was held in Pune between 7th to 11th August 2007

District level activities:

- The formation of District Mentoring Committees, selection of P.H.Cs and Villages has been completed in the selected five districts.
- Meetings of District Mentoring Committees were held in all pilot districts, in which the District level workshops and the trainings of block facilitators were planned.
- District level workshops in the selected districts were held as follows –
  - Osmanabad – 10th October, 2007
  - Pune- 15th October, 2007
  - Amravati – 18th October, 2007
  - Nandurbar- 18th October, 2007
  - Thane- 15th November, 2007
- Press releases were circulated on launching of CbM activity during the District level workshop in Pune, resulting in coverage by newspapers.

Reports

- State workshop report is recieved
- ToT report is awaited.
- District workshop reports are awaited
- Block training reports awaited.
- Progress Report (Aug-Oct '07) recieved

Madhya Pradesh

Publications/Materials

- So far the state is using materials that has been developed by National Secretariat
- The state nodal agency proposed to come-up with Kala Jatha for community mobilization but couldn't do so due to lack of funds

State level coordination:

- The Madhya Pradesh state level Training of the Trainers (ToT) was held in Bhopal between 16-20th August 2007
- MoU between State Nodal NGO and five District Nodal NGOs was signed and first installment was transferred to the five District Nodal NGOs in September 07

District level Activities:

- The following activities have taken place in selected districts
  - Selection of District coordinator, Block Coordinator, Village facilitator
  - Selection of Block, PHC, Villages
  - District Mentoring Group
  - Block Mentoring Group
  - Village committees

- District level workshops in the selected districts were held as follows –
  - Chhindwada – 30th to 31st October, 2007
  - Guna - 25th September, 2007
  - Sidhi- 27th to 28th October, 2007
  - Bhind – 23rd to 24th November, 2007
  - Badwani – 18th October, 2007

Reports

- State Workshop & ToT reports have been received.
- Progress Report (Aug-Oct '07) received.

Orissa

Publications/Materials:

- Publication of Community Entitlement under NRHM (briefing kit) in Oriya
- Brochure on "What is community Monitoring" in Oriya
- Block level activities under NRHM in Oriya
- District level activities under NRHM in Oriya

State level coordination:

- Between August to October three mentoring group meeting have taken place
- One Sub committee meeting took place in September

- MoU between State Nodal NGO and four District Nodal NGOs was signed and first installment was transferred to the five District Nodal NGOs in September 07.
- Orissa State level Training of Trainers (ToT) was held in Bhubaneswar between 11th to 13th October 2007
- The civil society meeting took place on Dec 26th to discuss the progress made so far and to workout the future plan of action

District level activities:

- District level workshops in the selected districts were held as follows –
  - Bolangir - 31st October 07
  - Kendrapara - 8th November 07
  - Mayurbhanj - 30th October 07
  - Nawarangapur- 12th November 07

Reports:

- State workshop & ToT report is received
- All district workshop reports are received.
- Progress Report (Aug-Oct '07) received.
- Mentoring group meeting report (Aug-Oct' 07) received

Chhattisgarh

Publications/Material:

- So far the state is using materials that has been developed by National Secretariat
- Mentoring group members are in process of coming up with street play for community mobilization that will be finalized by Jan 10th 2008

State level coordination:

- The first State Mentoring Team meeting was held on 28th November 07 to discuss and finalise the ToT
- The state ToT took place from December 16th to 20th 2007
- Second mentoring group meeting took place on Dec 19th to look into the process of the Community Monitoring in the state as well as to review the ToT

District level activities:

- The selection of block level NGOs have been done
- The tentative dates for the district level workshops are from Jan 15 '08 onwards

Reports:

- State workshop report – received
- ToT report awaited
- Mentoring group meeting minutes – received
- Progress report – awaited

Rajasthan

Publications/Materials

- Four posters are in process, are gone for field test soon will be sent for printing

State level Activities

- 1st state mentoring group meeting was held on 5th October 2007.
- The five day state level ToT was held from 4-8th October 2007 in Jaipur.

District level Activities:

- District Workshops have been organized in three of the four districts
  - Alwar on 2nd Nov '07
  - Chittorgarh on 6th Nov '07
  - Jodhpur on 24th Sept '07
  - Udaipur on Dec 22nd '07
- Alwar district had its block facilitator's training from Dec 6th to 8th '07.
- Jodhpur district block facilitator's training took place from Dec 19th to 21st '07
- Chittorgarh district block facilitator's training is going on Dec 26th to 28th '07

Reports

- State workshop report and State ToT report have been received.
- Alwar, Jodhpur and Chittorgarh District Workshop Reports- received
- Progress Report and a checklist of the activities from April to December 2007 have been received.

Assam

Publications/Materials

- No work on this front has begun.

State level Activities

- State mentoring group meeting was held on 9th October 2007.
- A two-day state level workshop was held in Guwahati from 10-11th October 2007.
- The MoU is being processed.

District level Activities:

- The district level processes have not started.

Reports

- State Workshop report is awaited.

Jharkhand

Publications/Materials:

- The translation of the materials is not done yet

State level Activities:

- The GO has been issued with CINI as the nodal agency and the names of the state mentoring group members
- The first state mentoring group meeting was held on 5th November 2007 in Ranchi.
- The MoU is being processed.

District level Activities:

- The district level processes have not been started

Reports

- Mentoring Group meeting minutes are awaited.

Tamil Nadu

Publications/Materials:

- The state has not begun to translate the materials.
- Translation of tools into Tamil – completed
- Tools submitted to NRHM directorate - feed back got - incorporated

State level Activities

- The GO was issued after a long wait.
- A three day workshop cum ToT was organized from December 3-5th 2007.
- MoU has been signed with PFI

District level Activities:

- District level workshops in the selected districts were held as follows –
  - Kanyakumari on Dec 13th
  - Perambulur on Dec 21st and 22nd '07 district
  - Vellore on Dec 22nd and 23rd
  - Dharmapuri on Dec 26th and Dec 27th
  - Thiruvallur on Dec 26th and Dec 27th

Block level workshops as follows;

- Kanyakumari on Dec 19th, 20th and 21st '07
- Perambulur on Dec 27th, 28th and 29th '07
- Vellore on Dec 30th, 31s and Jan 5th
- Dharmapuri on Dec 28th, 29th and 30th '07
- Thiruvallur on Dec 29th, 30th and 31st '07

Reports

- A brief summary of the state level workshop cum ToT has been received.
- The district level workshop reports are awaited

- The block facilitator training report is awaited

Future plan in brief:
It is expected that block level workshops will be over by Dec 31st - except Pernambut (Vellore distrcit- fixed for 5th Jan)

- The village level activities - start in Jan and first round finish by 12th Jan
- Village committee formation and orientation - finished by end Jan.
- First round of monitoring - Feb
- Analysis and coming up with village level plans - March

Karnataka

State level Activities

- Two meetings with the civil society members on how to implement the project in the state.
- The state is waiting for the next installment of funds to start its activities.

Reports

- The minutes of the meetings have been received.

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Feedback on Implementers Handbook for Community Monitoring

- Each state could add the state level figures of existing physical infrastructure and manpower in chapter 2.
- Of the list of activities within the community monitoring process mentioned at the end of chapter 5, the handbook needs to give more details on a) orientation /training of members of the community monitoring and planning groups and b) orientation of service providers about community monitoring.
- Chapter 7 on Mobilizing the community and formation of VHSC could include information about VHSC composition, roles and responsibilities of VHSC (even if it has been mentioned in the Implementers manual) for better clarity.
- The format for the Village Health Services Profile should include Name of ASHA under section III Information about service providers & health seeking behaviour. Point 17 under section IV Information of social exclusion and main health problems could also include ranking the health problems in order of severity in addition to the order of commonness as it would help to highlight the mortality/morbidity causes in the area.
- Chapter 8 could include some details on orientation of VHSC members and service providers. Under the themes in table 1, maternal health seems to have been left out, which could be added with child health - discussion with women and added in the corresponding format as well. Also, while ASHA community perceptions is included, it would be good to include community perceptions of other providers and services at the PHC from discussions with women.
- The roles and responsibilities of AWWs could also be included at some point in the introductory pages.
- The facility checklists appear to have left out the availability of essential drugs (including availability of a list of the same). A question or two to find out PPP initiatives, if any within the facilities and its impact could also be added?
- It would be useful to include a list of acronyms and maybe a glossary of terms in the beginning as a reference. For instance in the facility checklist for sub-centres, under service availability is an acronym AGE that is unfamiliar (unless it is a typo!) and immediately under that is 'Referral for RT is available at the SC' which is probably RTI?

Workshops and Trainings

1. National Workshop: 3 days
2. State Workshop: 2 days
3. District Workshop: 1day
4. State ToT: 5 days
5. Block Facilitator's Training: 3days
6. Block Level Service Provider's Training: 1 day
7. VHSC Training: 3 days
8. PHC P& M committee Orientation: 2 days
9. Block P&M committee Orientation: 2 days
10. District P&M committee Orientation: 2days

National Workshop on Community Monitoring in NRHM
19th to 21st July 2007

Objectives:

1. Increase knowledge about entitlements and mechanisms for community participation and ownership within NRHM
2. Develop operational protocols for capacity building on community mobilisation and community monitoring
3. Develop efficient adminstrative and financial systems, including reporting mechanisms for effective implementation of the project

Duration : Three days

Venue: Caserina Hall, India Habitat Centre (19th & 20th July)
Jac II Hall, India Habitat Centre (21st July)

Workshop schedule:

Day 1		
Welcome	Member AGCA	10.00
Introduction		10.15
Expectations and objectives		10.45
Tea		11.15
Training for community empowerment in the health arena : An overview	Small Group discussion	11.30
Provision of equitable, quality health services for the poor: Principles and practice	Case study and discussion	12.30
Lunch		1.30
Community Ownership – Community Mobilisation – Community monitoring	Film show and discussion	2.30
Tea		4.00
Community participation and community monitoring mechanisms in NRHM	Discussion	4.15
Day 2		
Review of Day 1		10.00
Introduction to the Community Monitoring project	Representative of GOI	10.30
Tea		11.45
Roles and responsibilities of State Nodal Organisation, District and Field level partners and Resource persons		12.00
Lunch		1.30
Documenting and reporting mechanisms and		2.30

processes		
Tea		3.30
Financial systems	Mr Ramaseshan	3.45
Day 3		
Review of Day 2		10.00
Developing protocols for capacity building – TOT and other training	Discussion in small groups on draft training designs	10.30
Tea		11.15
Developing protocols for Mobilising communities and formation of community monitoring groups	Discussion in small groups on draft protocols	12.30
Lunch		1.30
Developing tools for community monitoring	Discussion in small groups on draft protocols	2.30
Tea		4.00
Developing a follow up plan		4.15
Valedictory		5.00

Agenda for State level Workshop

To be organised by: State mentoring team and State Health Mission

Objectives:

- To brief participants about the community monitoring process under NRHM that is going to be implemented in the state
- The explain the process implementation at different levels, the financial flow, the organizational set up.
- To finalise districts, blocks, civil society facilitating organizations
- To outline a workplan for the state

Participants:

- State Mission officials,
- District health officials
- PRI representatives from selected districts,
- NGO networks and civil society organizations (from these districts)
- NRHM GoI and AGCA representatives

Proposed / Tentative Agenda:

Session One : Introduction to the Workshop

- Welcome, Context and Objectives by Convenor State Mentoring Group
- Round of Introduction
- Inaugural address – State Mission Director , Chairperson of State Mentoring Group.

The inaugural address will describe in brief the progress of NRHM in the state and the role of this first phase of community monitoring in the overall context of NRHM in the state

Session Two – Introduction to Community Monitoring

- Presentation: Community Monitoring in NRHM (common powerpoint)
- Presentation : Progress of the Community Monitoring Project in different states and activities undertaken in the state so far (to be prepared by the state)
- Discussion and Q/A (Identify Moderator)

Session Three – District Level Activities

- Reading of the relevant section of the Manual in small groups facilitated/ moderated by members of the State Mentoring Groups with the purpose of understanding the process of implementation in detail.
- Sharing of understanding and clarification of any issues that may remain in the **plenary**

Session Four – Finalising the selection of Districts, Blocks and the concerned civil society facilitating organizations.

Session Five – Strategising for Community Monitoring in small groups.
Thematic groups can be organised around the following themes which will read the implementation manual and prepare a detailed work plan for their theme

- Mobilising the District and Block level Community Planning and Monitoring Committees
- Mobilising the Village Level Planning and Monitoring Committees
- Engaging with the District and Block Health machinery
- Developing a District and Block training strategy

(Briefing notes for each group will be prepared based on NRHM Implementation Framework and Manual of Community Monitoring)

Session Six – Finalising Community Monitoring workplan for the state

- Sharing the work plans prepared in groups in the earlier session.
- Discussion
- Finalising the workplans

Session Seven – Sharing responsibilities for implementing the next set of activities and setting a monitoring mechanism

Session Eight – Valedictory.

Outcomes

- Detail district level workplans will be prepared for community mobilisation and for formation of Monitoring groups at all levels
- A time line of activites at the state and district leve will be prepared
- An followup plan with responsibilities will be prepared

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Orientation on
Community Monitoring for Selected NGOs under NRHM, Orissa

Programme Schedule

Venue: SIHFW, Bhubaneswar

Date: 14th July 2007

Date and Timings	Session
09.30 AM to 10.00 AM	Registration
	Inaugural Session (Mission Director will preside)
10.00 AM to 10.10 AM	Welcome & Introduction to Participants by **Mr S Das, Nodal Officer AGCM, Orissa**
10.10 AM to 10.25 AM	Self Introduction by Participants
10.25 AM to 10.40 AM	Address by **Mrs. Usha Padhi, IAS, Director, W&CD, Government of Orissa and Member AGCM**
10.40 AM to 10.55 AM	Presidential address by **Mr. S. K. Lohani, IAS, Mission Director, NRHM, Orissa**
10.55 AM to 11.00 AM	Vote of thanks by **Prof S Swain, Co-chairperson, AGCM, Orissa**
11.00 AM to 11.15 AM	**Tea Break**
11.15 AM to 11.45 AM	**Salient Features & Space for Communitisation under NRHM** To be facilitated by **Mr. Sudarsan Das** To be Chaired by **Prof (Dr.) Saraswati Swain**
11.45 AM to 01.00 PM	**The Concept of Community Monitoring under NRHM** A. Why community monitoring B. Objectives C. Civil society & partnership D. The first phase To be facilitated by **Dr. Almas Ali & Ms. Sunita Singh** To be Chaired by **Prof (Dr.) Sashimani Panda**
01.00 PM to 1.30 PM	Open Discussion
01.30 PM to 2.30 PM	Lunch Break
02.30 PM to 3.00 PM	**Processes & Preparation of Action Plan** **To be facilitated by** Ms. Sashiprabha Bindhani, Mr. Basudev Panda & Dr. M. K. Mohanty To be Chaired by **Dr. Almas Ali**

3.00 PM to 4.00 PM	**Group Discussion** To be facilitated by **Group-I:** Mayurbhanj Ms. Sashiprava Bindhani Mr. Sudarsan Das **Group-II:** Kendrapada Prof (Dr.) Sashimani Panda Dr. Krishna Pattnaik **Group-III:** Bolangir Mr. Gouranga Mohapatra Ms. Sneha Mishra **Group-IV:** Nawarangpur Mr. Basudev Panda Ms. Usharani Behera
4.00 PM to 4.40 PM	Group Presentation by NGOs To be Chaired by **Ms. Sneha Mishra**
4.40 PM to 5.00 PM	**Discussion on Group Presentation**
5.00 PM to 5.05 PM	Vote of thanks by **Usha Rani Behera**

State Level Workshop on Community Monitoring on NRHM, Orissa

Programme Schedule

Venue: Hotel New Marion, Bhubaneswar

Date: 24th July 2007

Timings	Sessions
09.30 AM to 10.00 AM	Registration
Inaugural Session (Mission Director will preside)	
10.00 AM to 10.10 AM	Welcome & Introduction of Guests by **Sri. S Das, Nodal Officer AGCM, Orissa**
10.10 AM to 10.15 AM	Inauguration of the Workshop by lighting the lamp by **Mrs. Pramila Mallick, Hon'ble Minister, W&CD, GoO**
10.15 AM to 10.25 AM	Address by Guest of Honor, **Sri. Chinmoy Basu, IAS, Principal Secretary, , H & FW, GoO on NRHM in Orissa**
10.25 AM to 10.35 AM	Address by Guest of Honor, **Sri. Raghunath Mohanty, Hon'ble Minister, Panchayatiraj, GoO**
10.35 AM to 10.45 AM	Address by Chief Guest **Mrs. Pramila Mallick, Hon'ble Minister, W&CD, GoO**
10.45 AM to 10.55 AM	Presidential address by **Sri. S. K. Lohani, IAS, Mission Director, NRHM, Orissa**
10.55 AM to 11.00 AM	Vote of thanks by **Prof. Saraswati Swain, Co-chairperson, AGCM, Orissa**
11.00 AM to 11.15 AM	**Tea Break**
11.15 AM to 11.30 AM	**Self Introduction**
Technical Session-I: NRHM & Community Monitoring To be Chaired by **Ms. Usha Padhi, IAS, Director, W& CD, GoO**	
11.30 AM to 11.45 AM	Presentation on **NRHM & Community Monitoring by Dr. Almas Ali, member AGCM, Orissa**
11.45 AM to 12.00	Open Discussion
12.00 to 12.15 PM	Presentation on **Community Monitoring in Orissa: Process & Progress by Mr. Sudarsan Das**
12.15 PM to 1.00 PM	Sharing of views by concerned districts (Collectors/CDMOs)
Technical Session-II: Process & Activities at different level To be Chaired by **Dr. Usha Pattnaik, Director, HS, GoO**	
1.00 PM to 1.45 PM	Presentation on activities at Village- **Sri. Basudev Panda** PHC-**Ms. Sashiprava Bindhani** Block-**Mr. Gouranga Mohapatra** District-**Dr. Manmath K. Mohanty**
1.45 PM to 2.45 PM	**Lunch**
2.45 PM to 3.15 PM	Group Discussion (District Wise) Chaired by **Respective Collectors/CDMOs/DSWOs** Facilitated by respective group leaders
3.15 PM to 4.15 PM	**Presentation on Plan of Action by districts** Chaired by **Prof. (Dr.) B. C. Dash, Director, SIHFW** (15 Minutes each presentation)
4.15 PM to 4.45 PM	Open Discussion
4.45 PM to 5.00 PM	Summing up by **Dr. Krishna Pattnaik**
5.00 PM to 5.05 PM	Vote of thanks by **Usha Rani Behera**

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M.P. State level workshop on Community Monitoring
Schedule

Day- 1 – 29/ 05/ 07

Date and Timings	Session	Facilitator	Mode of Presentation
10.00 – 10.30 Am	**Registration**		Power Point Presentation By Dr. Abhay Shukla
10.30.AM to 11.30 am	**Inauguration and Introduction** i. Welcome note – Dr. Ajay Khare (5 min) ii. Inaugural Address and Role of State Health Department in Community based monitoring - Dr. Yogiraj Sharma (20 Min) iii. Detailed presentation on Community Based Monitoring in the National Rural Health Mission – Framework, Methodology of Pilot Phase, Service Guarantees and community Monitoring, Shared ownership of the programme – Dr. Abhay Shukla – (25 Min) iv. Presidential address Pro Udai Jain, Ex Vice Chancellor Rewa University (10 Min)	Dr. Ajay Khare Presided by Prof Udai Jain Ex V.C. Rewa University	
11.30 to 11.45	**Tea Break**		
11.45 to 1.30 PM	A broad outline of the ambit and scope of community monitoring at different levels – **A. Village level (15 min)** i Formation and composition of Village Health Committees. ii. Members of the village health committees, and activities of Village Health committees iii. Tools for monitoring, and Powers of the Village Health Committee, Ms. Belu George **B. PHC level (15 min)** Formation, constitution and composition of PHC committee. Power of the committee, Yardsticks for monitoring and tools for monitoring at the PHC level- Dr. Shailendra Patne **C. Block Level (CHC) (15 Min)** i. Formation, constitution and composition of PHC committee. Power of the committee, Yardsticks for monitoring and tools for monitoring at the CHC level- Dr. Sunil Nandeshwar **D. District Level (15 Min)** i. Role and Responsibility, Formation, constitution and composition of PHC committee. Power of the committee, Yardsticks for monitoring and tools for monitoring at the CHC level- Dr. Rahul Sharma **E. State level Committee. (15 Min)** Role and Responsibility, Formation, constitution and composition of State committee. Power of the committee, Yardsticks for monitoring and tools for monitoring at the State level. State mentoring team and the State level monitoring team – Distinction between Roles and Responsibility - Dr. Ajay Khare. **Open Discussion (30 min)**	Shri. Atul Kulshreshtha Chair Person Dr Yogi Raj Sharma Director NRHM	Power point presentations
1.30 to 2.30	Lunch Break		
2.30-3.45	Specific activities related to community monitoring i. Jan Samvad /Jan Sunwai- Amulya Nidhi (20 min) ii.Demonstrated community monitoring experiences- Dhananjay Kakde (20 min) iv. Peoples Rural Health Watch in Madhya Pradesh – Dr. Ajay Khare (20 min) v. Open Discussion- 15 min	Shri. Rajiv Kumar Chairperson Dr.I.C.Tiwari, Ex.Advisor (Health) Planning Commission Govt. of India	Power point presentation

3.45 to 4.30	Role of Panchayat in the process of community monitoring : Pilot community Monitoring Process in the State and the role of the Panchayat Raj institutions- Mrs Leena Singh(30 Min) Discussion (15 Min)	Ms. Asha Mishra Chair person CMO	Power Point presentation
4. 30 to 4.45	**Tea Break**		
4.45 to 5.15	Training and Capacity building at each level of Community Based Monitoring. Preparations of manuals and orientation materials for all committee members – Dr. Abhay Shukla	Ms. Asha Mishra Chair person CMO	Power Point
5. 15 to 5. 30	**Summary and review of 1st day – Dhananjay**		

Day- 2 : 30/ 05/07

Date	Session	Facilitator	Mode of Presentation
10.00 to 10.30	Broad Schedule of activities, List of resource persons required for training at various levels of community based monitoring, Plan State level TOT - Dr Ajay Khare and Dr. Dhananjay kakde	Ms Sudeepa Das	Power Point
10.30 to 1.00	Preparation of District plan - **Group Activity** a. Selection of blocks. b. Planning for the District level workshop c. Planning for the training of block level facilitators. d. Plan for formation of the village level, PHC level, block level and district level monitoring committees. e. How suggested tools and methods for monitoring (incl. Jan Sunwai) at various levels would be used? f. District specific issues. Other relevant issues coming out of the discussion.	Overall facilitation- Ms. Asha Mishra Resource team members.	
1.00. to 2.00	Lunch		
2.00 to 4.00	Presentation of district plans- Group presentation. 15 minutes each district presentation, followed by clarification for 5 min.	Mr.S.R.Azad Chairperson Dr.I.C.Tiwari, Ex.Advisor (Health) Planning Commission Govt. of India	Flip chart or power point
4.00 to 4.15	Tea break		
4.15 to 5.00	**Concluding Session** Dr.V.S.Niranjan, Commissioner, Panchayat – Role of Panchayats in implementation of NRHM. Concluding Remarks by Dr Abhay Shukla Facilitation and Vote of Thanks Mr S R Azad		

Managers Orientation workshop
' 2 DAYS'

Day 1

S No	Activity	Time	Facilitator	Mode
1	Registration	10.00 AM - 10.30AM	State Nodal NGO	Register, Registration form Materiel distribution
2	Inauguration	10.30- 11.00 AM	Health Dept. officials Panchayat Dept officials AGCA members State Nodal NGO	About NRHM and Community Monitoring Commitment of state health and Panchayat Dept.
3	Breakfast	11.00 – 11.15AM		
3	NRHM and Community Monitoring	11.15- 12.00 Noon	AGCA members Resource persons	Power point presentation on Right to health care, CM in NRHM and its importance followed by discussion
4	Organogram of CM and role of different stake holders	12.00 – 01.45 PM	Resource person	Structure of CM frame work from AGCA to villages. Role of Stake holders. Power point presentation Followed by discussion
5	Composition, Role of various committees (AGCA, Mentoring Group, State District , Block, PHC and village)	1.45- 2.30 PM	Resource Person	Power Point presentation Followed by Discussion
6	Lunch	2.30 – 3.15PM		
7	Composition,	3.15 – 4.00 PM	Resource person	Power Point

	Role of various committees(AGCA, Mentoring Group, State District , Block, PHC and village			presentation Followed by discussion
8	Role of stake holders	4.00 PM- 4.45PM	Resource person	Power point presentation Followed by discussion
9	Open discussion	4.45 – 5.30 PM	Resource person	Discussion

Day 2

S No	Activity	Time	Facilitator	Mode
1	Recap	9.30- 10.00AM	Resource person	Individual reporting
	Organization of Jan Samvad / recording of Positive and negative experience	10.00- 10.45	Resource Person	Experience sharing
	Selection of District, block, PHC, villages(if possible)	10.45- 11.30AM	Facilitator in each group	Group discussion as per districts
	Tea Break	11.30- 11.45AM		
	Presentation of group discussion	11.45- 12.15PM	Group facilitator	Flip charts / Power point
	Introduction of tools	12.15 -01.30PM	Resource Person	Distribution of tools and explanation
	Lunch	01.30 – 2.30PM		
	Budget	02.30- 3.15PM	Resource person	Power point presentation
	Time frame	3.15- 4.00PM	Resource Person	Power Point
	Concluding Session	4.00- 4.30PM	Govt. officials AGCA members, Nodal NGO	Reporting of two days activity / participants

				presentation

Participants

		No
1.	Director, Health Dept / Nodal officer	1
2.	AGCA members	2
3.	Mentoring group members (Approx)	5
4.	Resource group members (Approx)	5
5.	CMOs of selected districts	-
6.	State officials of Panchayat and Social Welfare Dept	1.
7.	Zila Pachayat Chairperson / Chairperson of Health sub committee of selected Districts	-
8.	Representative of state Nodal NGO	2
9.	District Nodal NGO coordinators	-

Total Participants Approx 30-35

Suggestions

1. It is better to decide about resource persons and inform them regarding their sessions for their preparation.
2. All material like flip chart, sketch pen, CDs should be arranged before organizing workshop
3. for group discussion responsibility should be given to resource persons as per number and requirement of groups.
4. Health Department and Panchayat department should be contacted and participation ensured.
5. After workshop all power point presentation should be given to all participants in CD.

Suggestive Schedule for District workshop
Sidhi

First Day : 27.10.07

S No	Time	Topic	Facilitators
1	10-10.30 AM	Registration	
2	10.30- 11.00AM	Inauguration	Chairman Zila Panchayat, Collector, CMO, Mr Arun Tyagi
3	11.00-11.15AM	Tea	
4	11.15-12.00PM	NRHM and Community Monitoring of Health Services	Dr Ajay Khare
5	12.00-1.00PM	Formation and composition of various committees	Mr V N Tripathi
6	1.00-1.30PM	Discussion	Mr V N Tripathi
7	1.30-2.30PM		
8	2.30-3.15PM	Role and Responsibility of committees	Mr Amit Singh
9	3.15-4.00PM	Role and responsibility of stake holders	Mr Bhaskar
10	3.45-5.00PM	District plan	Mr Bhaskar

Second Day:28.10.07

S No	Time	Topic	Facilitators
1	10.00-10.30AM	Recap of previous day	Mr Prakash
2	10.30-11.15AM	Village health and sanitation committee	Dr Ajay Khare
	11.15-11.30AM	Tea	
	11.30-12.15PM	Work to be done by VHSC	Mr V N Tripathi
	12.15-1.00PM	Discussion	Mr Bhaskar
	1.00-2.00PM	Lunch	
	2.00-2.15PM	Formation of PHC & Block Monitoring Committee	Mr Prakash
	2.15-3.00PM	Jan Sunwai and recording of adverse experience	Mr Bhaskar
	3.00.3.45	Discussion	Mr Bhaskar
	3.45-4.00PM	Tea	
	4.00-5PM	Discussion and finalization of District plan	Mr Arun Tyagi

State TOT
5 Days

1st Day

S No	Activity	Time	Facilitator	Mode
1	Registration	10.00-10.30AM	Nodal NGO representative	Register entry, Registration certificate Other material distribution
2	Inauguration	10.30-11.00AM	AGCA members, Health , Panchayat and Social Development, State Nodal NGO	NRHM, State Govt involvement, PAnchayat Dept role etc, Speeches
3	Tea break	11.30-11.45AM		
4	Ice breaking and expectation	11.45-12.15PM	Resource Person	Cards, introduction of partner etc
5	NRHM and community monitoring process, Right to health care, NHRC process etc	12.15- 1.00PM	Resource Person	Power point presentation Followed by discussion
6	Experience sharing of CM in other states	1.00- 2.00PM	Resource Person	Experience sharing and Discussion
7	Lunch	2.00- 3.00PM		
8	Film show on CM	3.00- 3.45PM	Film Show	LCD
9	Tea break	3.45 – 4.00PM		
10	Discussion on film show and experience sharing of participants	4.00- 5.00PM	Resource Person to coordinate	Participants opinion about denial to health care and their experience
11	Process of community monitoring, difference between CM and other monitoring	5.00- 5.30PM	Resource Person	Power Point or discussion

Day 2

S No	Activity	Time	Facilitator	Mode
1	Recap	9.30-10.15AM	Resource Person	Individual sharing
2	Composition and role of District Mentoring Committee, Block Mentoring Committee,	10.15-11AM	Resource Person	Power Point presentation and discussion
3	PHC, Block, District CM Committee	11.00-11.45AM	Resource Person	Power Point presentation and discussion
4	Tea Break	11.45-12.00 Noon		
5	Role and Responsibility of State Nodal NGO, District Nodal NGO, Block NGO, Block Facilitators,	12.00-12.45PM	Resource Person	Power Point presentation and discussion
6	Role and responsibility of Health Dept Discussion on need emerging from districts	12.45 – 1.30PM	Resource person from health Dept	Power Point presentation and discussion
7	Lunch	1.30- 2.30PM		
8	Role and Responsibility of PRI, strengths and weakness and need to involve them	2.30 – 3.15PM	Resource Person from Panchayat or PRI activist	Power Point or discussion
9	Formation and functioning of Village Health and Sanitation Committee, role and responsibility	3.15- 4.00PM	Resource Person	Power Point followed by discussion

10	Tea break	4.00- 4.15 PM		
11	Open Discussion	4.15- 5.30PM	Resource person	Discussion

3rd Day

S No	Activity	Time	Facilitator	Mode
1	Recap	09.30- 10.00 AM	Resource Person	Individual sharing
2	Organisation of Jan Samvad / Jan Sunwai	10.00- 10.45 AM	Resource Person	Power Point presentation and discussion
3	Village Level data collection, Tools and their filling	10.45- 11.15 AM	Resource Person	Explanation and filling of tools
4	Tea Break	11.15 – 11.45 AM		
5	Tools applicable at PHC, CHC and district level	11.45 – 12.30 PM	Resource Person	Explanation and filling of tools
6	Under standing of tools and filling	12.30- 1.30 PM	Resource persons in each group	Participants will be divided in 4 or 5 groups where tools will be given to understand and fill it
7	Lunch	1.30- 2.30PM		
8	Reporting process VHSC – PHC- CHC- Dist. – State -AGCA	2.30- 3.15 PM	Resource Person	Formats to be explained
9	Reporting of data	3.15 – 4.00 PM	Group discussion	Group discussion
10	Tea Break	4.00 - 4.15PM		
11	Recording of positive and adverse experiences	4.15- 5.00PM	Resource Person	Power point
12	Group formation for field visit	5.00- 5.30PM	Group activity	4 groups to be formed 1. Village data collection which will also visit Anganwadi, ASHA, VHSC,ANM 2.FGD etc 3. PHC 4.CHC

4th Day

S No	Activity	Time	Facilitator	Mode
1	Field Visit 1. Village team	10.00- 1.00PM	Resource Person	Will see all records of Anganwadi, ASHA, ANM, VHSC
2	2.Focussed Group discussion with SHG/ SC/ ST/ Women (may have discussion with one group and explore situation	10.00- 1.00PM	Resource Person	Impact of schemes, positive or adverse experience recording
3	3.PHC visit	10.00- 1.00PM	Resource Person	PHC in charge interview, Visit of PHC and observation, interview with OPD and admitted patients if any
4	4.CHC visit	10.00- 1.00PM	Resource Person	CHC in charge interview, Visit of CHC and observation, interview with OPD and admitted patients.
5	Lunch	1.00-2.00PM		
6	Group discussion and presentation of reports Report cards should be filled up and presented	2.00- 5.00PM	Resource Person	Group discussion it will be better if PHC, CHC, ANM and Anganwadi worker, ASHA etc are present in the meeting

5th Day

S No	Activity	Time	Facilitator	Mode
1	Recap of previous day and explaining the queries	9.30-10.15AM	Group discussion	Group discussion
2	District activity plan Various trainings, schedules	10.30- 11.15 AM	Resource Person	Power point
3	Tea	11.15- 11.30 AM		
4	Preparation of district activity plan	11.30 – 12.30 PM	Resource Persons in each group	Participants will be planning as per district
5	Financial Management and fund flow	12.30- 1.30PM	Resource person	Presentation and discussion
6	Lunch	1.30- 2.30PM		
7	Responsibility distribution among mentoring group and resource persons	2.30 – 3.15PM	Resource Person	Discussion
8	Open discussion plan to giving information to community	3.15- 4.00 PM	Resource Person	Individual opinion sharing
9	Concluding program	4.00- 4.30 PM	Dept of health, Panchayat, Nodal NGO, AGCA member	Speeches

Suggestions

1. It is better to decide about resource persons and inform them regarding their sessions for their preparation.
2. All material like flip chart, sketch pen, CDs should be arranged before organizing workshop
3. for group discussion responsibility should be given to resource persons as per number and requirement of groups.
4. Health Department and Panchayat department should be contacted and participation ensured.
5. After workshop all power point presentation should be given to all participants in CD.
6. For field visit CHC, PHC, village should be decide earlier and in charges of PHC, CHC be informed for cooperation. Ask them to be with you during report presentation. It will not only have their

better involvement but it will also give experience of their reaction to ground realities to your participants.

Participants:

Participant	No.
1. State Officials of Health Department, Panchayat Department	2
2. Mentoring Group members	5
3. Resource persons	5
4. CMOs / DPMs of selected districts or some other in charge for CM in that district.	-
5. AGCA members	2
6. State Nodal NGO	2
7. District coordinators	-
8. Block Coordinators(3 x Number of districts)	-

Total number may be 30- 35.

State TOT
Draft Schedule

Day 1 Dated 16.08.07

Time	Subject	Mode	Facilitator
10.00-10.30 AM	Registration	Individual Reg.	Mr Johnson
10.30-11.15AM	Introduction & Inauguration	Self introduction and guests speech	Dr Ajay Khare
11.15-11.30AM	Tea Break		
11.30-12.30PM	NRHM & Community Monitoring	Presentation	Dr Abhay Sahukla
12.30-2.00PM	Role and responsibility of various committees State, District, Bloch, PHC and Village	Presentation and group discussion	Dr Dhananjay
2.00-3.00PM	Lunch		
3.00-4.15 PM	Role and responsibility of various committees State, District, Bloch, PHC and Village	Presentation	Ms Asha Mishra
4.15- 4.30PM	Tea break		
4.30-6.00PM	Film **Show**	Note Comments	

Day 2 Dated 17.08.07

Time	Subject	Mode	Facilitator
9.30- 10.00AM	Recap of previous day	Individual response	Mr Rajeev Kumar
10.00-11.15AM	Role of Stake holders State, District Nodal NGO, Block facilitator/ committee	Group Discussion	Mr Rajeev Kumar, Mr S R Azad, Ms Belu, Dr Ajay Khare, Dr Dhananjay. Mr Amulya Nidhi
11.15-11.30AM	Tea Break		
11.30- 12.30PM	Presentation of group discussion	Group facilitator	Ms Indu Capoor
12.30-2.00PM	Presentation of CBM Experiences	Maharashtra, Rajasthan & Gujrat	Dr Narendra Ms Indu Capoor Dr Dhananjay
2.00-3.00PM	Lunch		

3.00- 4.30	Role of Health Dept Need emerging from Districts	Dr Yogi Raj Sharma	Dr.K.M.Ojha
4.30-4.45Pm	Tea Break		
4.45- 6.00PM	Discussion on indicators, Tools CHC, PHC , Patients interview Village group discussion etc	Group Discussion	Dr Ajay Khare Mr Belu George Dr Dhananjay Dr Narendra Gupta Dr Rahul Sharma Mr Amulya Nidhi

Day 3 Dated 18.08.07

Field Visit

Time	Subject	Mode	Facilitator
9..00	Visit to Barasia		
10.30- 2.00 PM	CHC PHC Sub Centre Village-Anganwadi, ASHA, Group Discussion	Interview Group Discussion	Dr Ajay Khare Mr Anil Sharma Dr Rakesh Verma
2.00-3.00 PM	Lunch		
3.00-5.00	Group Discussion	Open discussion	Dr Abhay Shukla
5.00-8.00	Site Seeing		

Day 4 19.08.07

Time	Subject	Mode	Facilitator
9.30- 11.00AM	Formation of committee and training needs	Group discussion	Group facilitators
11.00.11.15AM	Tea Break		
11.15- 12.30PM	Training skills and practical problems and strategy to over come them	Presentation and discussion	
12.30-2.00PM	Preparation of report card at Village and PHC level	Group activity	
2.00-3.00	Lunch		
3.00-4.15PM	Preparation of report card at CHC and District level	Group activity	
4.15- 4.30PM	Tea Break		

4.30-6.00PM	Discussion on Film show and experiences on CBM	Open discussion	Dr Ajay Khare

Day 5 Dated 20.08.07

Time	Subject	Mode	Facilitator
9.30-10.**15AM**	Recap of previous day	Group leader presentation	Mr Rajeev Kumar
10.15AM- 11.30AM	Role and responsibility of Panchayat	Presentation and group discussion	Mr Shayam Bohre
11.30-11.45AM	Tea Break		
11.45-12.30PM	Planning for district activities	Group discussion	Group facilitators
12.30- 2.00PM	Fund flow		
2.00 - 3.00PM	Presentation of district activities Feeding information back to community	Presentation	Ms Asha Mishra
3.00-4.15PM	Responsibility of Resource persons	Open discussion	Ms Belu George
4.15-4.30PM	Tea Break		
4.30-5.30PM	Concluding program	Speeches and presentation	Dr Ajay Khare

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के तहत स्वास्थ्य सेवाओं की समुदाय आधारित निगरानी प्रशिक्षकों का राज्य स्तरीय प्रशिक्षण

4 से 8 सितम्बर 2007

स्थान– राज्य स्वास्थ्य एवं परिवार कल्याण संस्थान, जयपुर

सम्भावित कार्यक्रम विवरण

प्रथम दिवस – दिनांक 04/10/07

समय	सत्र	विधी
09.30 से 10.00	पंजीयन	
10.00 से 11.15	परिचय एवं उद्घाटन सत्र अतिथियों द्वारा उद्बोधन	स्वयं परिचय एवं वक्तव्य
11.15 से 11.30	चाय	
11.30 से 12.30	स्वास्थ्य के अधिकार के बाधक तत्व तथा स्वास्थ्य के सामाजिक – आर्थिक निर्धारक	कहानी पर समुह चर्चा, एवं खुली परिचर्चा
12.30 से 1.30	राष्ट्रीय ग्रामीण स्वास्थ्य मिशन क्या है ? स्वास्थ्य सेवाओं की समुदाय आधारित निगरानी क्या है ?	पावर प्वाइंट प्रस्तुतिकरण
1.30 से 2.30	भोजन अवकाश	
2.30 से 3.45	सामाजिक विषमताएं एवं स्वास्थ्य की मांग के राजस्थान के अनुभव	पावर गेम एवं पावर प्वाइंट प्रस्तुतिकरण
3.45 से 4.00	चाय	
4.00 से 5.30	राजस्थान में राष्ट्रीय ग्रामीण स्वास्थ्य मिशन एवं इसमें समुदाय आधारित स्वास्थ्य सेवाओं की निगरानी	पावर पॉइन्ट प्रस्तुतीकरण

द्वितीय दिवस – दिनांक 05/10/07

समय	विषय	कार्यक्रम प्रकार
9.00 से 10.00	पिछले दिन का पुर्नस्मरण	व्यक्तिगत प्रतिकिया
10.00 से 11.00	स्वास्थ्य सेवाओं की समुदाय आधारित निगरानी के विषय, प्रकियाएं, मुद्दे एवं सुचकांक	समूह चर्चा, पावर प्वाइंट प्रस्तुतिकरण एवं चर्चा
11.00 से 11.15	चाय	
11.15 से 1.00	समुदाय की भागीदारी एवं गांव स्वास्थ्य समिति का गठन एवं गांव स्वास्थ्य समितियों की प्रशिक्षण प्रकिया	समूह चर्चा
01.00 से 2.00	भोजन अवकाष	
2.00 से 4.00	समुदाय आधारित स्वास्थ्य सेवाओं की निगरानी कैसे करें ? तथा समुदाय आधारित स्वास्थ्य सेवाओं की निगरानी के लिए सहभागी प्रशिक्षण की प्रकिया एवं सिद्धान्त	पावर प्वाइंट प्रस्तुतिकरण एवं चर्चा
4.00 से 4.15	चाय	
4.15 से 5.15	गांव स्तरीय बैठक, समूह चर्चा, आशा, ए. एन. एम. एवं लाभार्थी साक्षात्कार के द्वारा जानकारी इकठ्ठा करने के प्रपत्रों पर चर्चा	प्रस्तुतिकरण एवं चर्चा
5.15 से 6.30	सामुदायिक स्वास्थ्य केन्द्र, प्राथमिक स्वास्थ्य केन्द्र, उपस्वास्थ्य केन्द्र, मरीजों से बातचीत के द्वारा जानकारी इकठ्ठा करने के प्रपत्रों पर चर्चा तथा फिल्ड विजिट के लिए समूह विभाजन	प्रस्तुतिकरण एवं चर्चा

तृतीय दिवस – दिनांक 06/10/07

समय	विषय	कार्यक्रम प्रकार
8.00	फिल्ड विजिट के लिए रवानगी	
9.30 से 2.00	सामुदायिक स्वास्थ्य केन्द्र प्राथमिक स्वास्थ्य केन्द्र उपस्वास्थ्य केन्द्र आंगनबाडी, तथा गांव में चर्चा	केन्द्र प्रभारियों एवं गांव निवासियों से चर्चा तथा निरीक्षण

2.00 से 3.00	भोजन अवकाष	
3.00 से 5.00	फिल्ड विजिट के अनुभवों पर चर्चा	चर्चा एवं प्रश्नोत्तर
5.00 से 8.00	फिल्म प्रदर्शन	

चतुर्थ दिवस – दिनांक 07/10/07

समय	विषय	कार्यक्रम प्रकार
9.30 से 10.00	पिछले दिन का पुर्नस्मरण	समूह चर्चा
10.00 से 11.00	प्राथमिक स्वास्थ्य केन्द्र, ब्लॉक एवं जिला स्तरीय समिमियों का गठन एवं प्रशिक्षण	समूह चर्चा
11.00 से 11.15	चाय	
11.15 से 11.30	गांव तथा प्राथमिक स्वास्थ्य केन्द्र की रिपोर्ट कार्ड बनाना	समूह चर्चा
11.30 से 12.30	सामुदायिक स्वास्थ्य केन्द्र एवं जिला स्तरीय रिपोर्ट कार्ड बनाना	प्रस्तुतिकरण एवं चर्चा
12.30 से 2.00	जिला योजना का निर्माण	समूह चर्चा
2.00 से 3.00	भोजन अवकाष	
3.00 से 4.00	जिला योजनाओं का प्रस्तुतिकरण एवं जानकारी वापस जनता तक पहुंचाने की प्रकिया – जन संवाद – कार्यशाला	समूह चर्चा
4.00 से 4.15	चाय	
4.15 से 5.15	समुदाय आधारित स्वास्थ्य सेवाओं की निगरानी में स्वास्थ्य विभाग की भूमिका	प्रस्तुतिकरण एवं खुली चर्चा

पांचवां दिवस – दिनांक 08/10/07

समय	विषय	कार्यक्रम प्रकार
9.30 से 10.00	पिछले दिन का पुर्नस्मरण	व्यक्तिगत प्रतिक्रिया
10.00 से 11.00	सन्दर्भ व्यक्तियों की जिम्मेदारी तथा प्रशिक्षण दक्षताएं तथा व्यवहारिक कठिनाइयां एवं उनसे उबरने की रणनीति	प्रस्तुतिकरण एवं चर्चा
11.00 से 11.15	चाय	
11.15 से 12.00	परियोजना के अन्तर्गत फंड फ्लो एवं वित्तीय प्रबन्धन	समूह चर्चा
12.00 से 12.30	खुली चर्चा	
12.30 से 01.00	समापन कार्यक्रम अतिथियों द्वारा उद्‌बोधन	वक्तव्य
01.00 से 2.00	भोजन	

COM H 92A

Block Facilitator's Training

Participants: Block facilitator's, block coordinator's

Programme	***Time***
Day 1	
Context Setting 10-1030	30 mins
Introductions 1030-1115	45 mins
Tea	
Expectations setting 1130-1215	45 mins
Understanding health services system 1215-1300	45 mins
Lunch	
Universal access and Social exclusion 1345-1445	60 mins
Understanding Barriers to health 1445-1530	45 mins
Tea	
Understanding Rights 1545-1630	45 mins
What is a Rights based approach 1630-1715	45 mins
Tea	
Introduction to NRHM (Entitlements, IPHS, Charters) 1730-1800	30 mins
Introduction to Community Monitoring (Movie Show)1800-1845	45 mins
Tea	
Day 2	
Review of Day 1 0900-0930	
Community Monitoring in NRHM (Project & Framework) 0930-1030	60 mins
Tea	
Community Mobilization 1045-1115	30 mins
Community Monitoring tools 1115-1245	90 mins
Communication skills 1245-1315	
Lunch	
Practising the tools and formation of report card & score card at village level & collation of the score card at PHC and block 1400-1700	
Tea	
Day 3	
Review of Day 2 0900-0930	
Presentation of the report card and score cards 0930-1000	
Jan Samvad 1000-1100	
Tea	
Planning for Community Monitoring: Next Steps 1115-1230	
Evaluation of the Workshop 1230-1300	
Valedictory 1300-1330	
Lunch	

Outcomes

1. **Increase knowledge about NRHM, especially on entitlements and mechanisms for community participation and ownership**
2. **Develop an understanding on community monitoring within a framework of health rights**
3. **Develop skills in applying tools for community monitoring**
4. **Prepare an action plan for implementing the community monitoring programme**

monitoring

Day 1

Session 1: Introductions (45 minutes)

Objectives of the session

This session will give participants an opportunity to know each other.

Process

This could be done in any innovative way which the training organizers feel comfortable, provided participants could get enough time to understand each other including their skills.

Guidelines for facilitator

An easy and conventional way of conducting introductions is as follows:

- Write pen, paper, needle, thread, coffee, tea, black, white, sun, moon, day, night, sweet, salty on small chits. Fold the chits and put them in a box. Each participant takes one chit and finds his/her partner.
  Pen and paper, needle and thread, coffee and tea, black and white, sun and moon, day and night, sweet and salty.
- Ask pairs to learn as much as possible about one another (name, profession, skills, place of origin, etc.). Give them 10-15 minutes.
- Ask each participant to introduce very briefly the person she or he has been with in the last 5-10 minutes.

Facilitator may find out how the different skills of participants could be utilized during the training. If there are members from the marginalized and vulnerable groups as participants, do not introduce them as members of those communities.

COM H92A

Session 2: Expectation setting (45 minutes)

Objectives of the session

This session will list out training objectives and clarify the scope of the training.

Process

The facilitator asks the participants to write their expectations from the workshop in a small chit. Stick all responses on the wall or on a board. Similar expectations can be grouped. Read the list of expectations when it is complete. After this exercise, facilitator clarifies which among these expectations are going to be met and which ones are not going to be met. This session should conclude by explaining the learning objectives of the workshop preferably through a single slide in a power point presentation. (See ppt BFT-1)

Session 3: Understanding health services system of the state (45 minutes)

Objective of the session

This session will give clarity to participants regarding the structure and functions of the health system at micro and macro level. Participants will know the nuances of the entity which they would be monitoring later.

Process

The facilitator makes a power point presentation on the health services system in the country. See ppt BFT-2.

Session 4: Understanding Universal Access (60 minutes)

Objective of the session

At the end of the session participants will be able to better understand the various levels of social stratification existing in the society and how such stratification and social exclusion would limit universal access to health.

Process

The session includes an exercise called *Power walk* (See details below). After the exercise, participants will brainstorm on 'how social exclusion can adversely impact access?' Facilitator concludes the discussion with a definition of universal access.

Guidelines for **facilitator**

1. Facilitator should have prepared cards with names of different categories of population. The names of population categories written on the card are –
   - Tribal man
   - Tribal Woman

- Physically challenged woman
- Female Vegetable seller
- Landless daily wage earner – male
- Mother of 3 daughters
- Father of three daughters
- Rickshaw driver – male
- Shop owner (male)
- Male Bank Officer
- Street beggar – female
- Widow (housewife)
- Widower
- male sex worker
- female sex worker
- transgender (Hijra)
- school teacher (woman)
- school teacher (man)
- Business Person (man)
- Business person (woman)
- domestic servant (female)
- domestic servant (male)
- Doctor
- PLHIV
- agriculture laborer (female)
- agriculture laborer (male)
- Illiterate manual worker (male)
- illiterate manual worker (female)
- adolescent school going girl
- Adolescent school drop out girl etc.

2. Participants are asked to stand in a single row and the cards are distributed to all the participants. During the exercise, everyone should try to get in to the roles of those categories mentioned in the card and should act as instructed by the facilitator.
3. The facilitator then read out certain statements (see below) and if a participant agrees to the statement, she/he should take one step ahead from where they stand and if a participant disagrees to the statement she/he should remain wherever they are. Read the statements slowly giving the participants time to listen understand and then respond. The statements to be read out are:

- I can read daily news paper every day morning
- I can negotiate with my partner for doing safe sex
- I can complete my school education
- I will be received at a hospital/clinic with respect and dignity
- I can purchase a contraceptive whenever I want
- I have passed class X?
- I can go out in the evening at dusk time without the fear of being molested?
- In case I had a Red itchy spot in my genitals I will be able to approach a doctor easily
- I can negotiate with my partner with regard to the number of children I would like to have like

- If I am tired and did not feel like doing the housework I would be able to let it be
- If I am hungry and nobody else in the house had eaten I will be able to eat?
- In case I were not in the mood for sex I would be able to avoid having sex with my partner

4. After reading out all the statements and participants taking their positions, participants will be asked to disclose their identities and look at where they are and also explain to others why they remained where they are or why they have moved ahead. What are the factors which do not let them take a step forward?
5. After this participants could go back to their seats and share their further thoughts in the whole group regarding various levels of social stratification existing in society and how it would lead to social exclusion and marginalization and finally restricting their access to health services, information and commodities.
6. Facilitator should conclude the discussion by providing a definition on universal access.

Universal access can be defined as a **situation in which the services of an organization reaches the poor, marginalized, socially excluded and underserved groups living within defined geographical/ administrative boundary.**

Session 5: Understanding Barriers to Health (45 minutes)

Objectives of the session

This session will bring out the details of the barriers to health in detail. Participants may also start thinking 'how to address such barriers' in their area.

Process

1. Participants are divided in to 4 groups.
2. Groups select a moderator and a reporter from the group. Facilitator provides copies of 4 different case studies to members of the 4 groups. The moderator reads out the case study and then facilitates a discussion. The case studies are available
Discussion points (30 minutes)
   - How do you feel about experiences of the main character of the case-study?
   - Do you think they deserve to go through such experiences?
   - What are the different barriers that are present in the story which hinder good quality service delivery and good health outcomes?
   - List number of barriers on health

3. Ask the groups to present the results of their discussion in turn– one barrier of each kind which emerges from the story from one group – then the next group – then the next – and over and over till all barriers are exhausted. (30 minutes)

4. Write down the responses of the groups in the following format
Feelings–

Personal and community level	Health system level barriers	Provider attitudes and behaviour

barriers		

Guidelines for facilitator

It is better to take a case study related to barriers to health in the area where the trainees belong to.
While listing out barriers, it is important to see that the analysis of barriers is not confining to general issues like 'poverty', 'illiteracy' etc. only. The analysis should use an 'onion peel approach' by which the specific barriers to health are identified. An example[1] of barriers identified through this approach is as follows:

Personal level	Health Systems level	Community level
Lack of knowledge: Consequences of un protected sex Signs of pregnancy Availability of Services Vulnerability: Economic Lack of Education Migrants – No support systems Family responsibility	Attitudes of service providers who scold patients Untrained Providers Not sensitive / No rights based understanding Rude behaviors Lack of medicines Services do not reach poor Bureaucratic systems Unregulated private practitioners Referrals from Health centre to tertiary level ineffective	Early marriage Too many children Children too soon Lack of male involvement Housework in pregnancy Stigma – sin/marriage of siblings reputation Poverty Migration Lack of civic amenities

5. Ask the Participants to identify any rights that are being violated at different levels referring to the list of barriers. List down the barriers and rights. (15 minutes)

Barrier	Right

[1] Adapted from a audit report prepared by Family Planning Association of India

6. Ask the participants to define what they mean by a 'right' (Plenary discussion). Consolidate the participant's definitions into an acceptable definition of rights. (15 minutes)

7. The facilitator can go into the next session on rights and right's based approach.

Module 3: (90 minutes)

Session 6: Understanding Rights (45 minutes)

Objectives of the session

At the end of this session, participants will be able to know what rights are, from where rights are coming from and how human rights are integrally related to community monitoring and finally how important it is to realize rights to achieve development.

Process

Power point presentation, followed by discussion (See a power point presentation DFT-3)

Session 7: What is a 'Rights based Approach' (45 minutes)

Objectives of the session

This session will demonstrate and explain the meaning of rights based approach.

Process

The session should start with *Killer Pool* exercise for which all the participants should stand in a circle. The facilitator stands on a chair and asks participants to assume that the space in front of them is a pool. Facilitator throws pile of balls made of props of paper into the 'pool' and tells the participants that the balls represent babies and the participants should save the babies from dying in the pool at any cost. Facilitator shouts: "Quick, babies are drowning". Facilitator keeps throwing the balls very fast. The participants usually bend down to pick up balls of paper from the 'pool'. The activity may continue for about 1-2 minute and then facilitator suddenly stops the exercise and asks why the participants did not stop the facilitator from throwing the babies in to the pool, by grabbing his/her hand. (In some cases one participant might try to grab facilitator's hand and try to stop him/her from throwing any more babies in to the pool. In this case facilitator could ask him to explain why he did so. Obviously this participant is the most enlightened of them all as he could move ahead from 'rights awareness' to 'rights based action'). In many developing countries, "with limited resources, and in the face of urgent situations, many individuals and organizations get caught up – understandably - in 'rescuing the drowning babies' without looking up to see who is throwing them in the river in the first place"! All participants now go back to their seats to continue the discussion and the facilitator concludes the discussion by highlighting the need to proceed further from mere knowledge of rights to right based action on the basis of a rights based approach.

Talking points for facilitator

The rationale of community monitoring lies in adopting rights based approaches as it raises questions about responsibilities and accountability of development agencies. Rights based action[2] includes:

- Identifying what rights are not realised ..., researching and mapping, making visible ...
- Identifying why, they are not realised
- Identifying who or which institution bears responsibility
- Identifying what the responsibility consists of
- Identifying the constraints and obstacles to meeting responsibilities .. Capacity .. legislative, resources, attitude, ... ?
- Identifying how best to change ... what strengths can be reinforced, how will all involved
- participate, what additional needs to be done, or done differently, who with ?

See Implementor's Manual and the ppt DFT-3 for a discussion on rights based approach

Module 4: Understanding the concept of community monitoring

Session 1: The characteristics of community monitoring (45 minutes)

Objectives of the **session**

This session will clarify the need, advantages, objectives and actors of community monitoring. It will also give participants an opportunity to see how a pioneering attempt on Social Audit was held with people's participation within the framework of inclusiveness and accountability.

Process

The session should begin with screening of a documentary film of a social audit. This is about a social audit conducted by an NGO social movement named MKSS in India. After screening the movie participants will be asked to share what they feel about the movie. From the feed back of participants and through brainstorming, the facilitator will be able to explain the characteristics and advantages of community monitoring.

The discussion can be summed up by a power point presentation. (See ppt DFT-4)

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[2] Courtsey: Doortje Braeken, IPPF

Tentative Agenda for TAG meeting
11th-12th January 2008
ISI, Bangalore

Objectives

1. To review the progress of the Community Monitoring processes in each state
2. To review project timelines/budget based on progress and funding disbursements
3. To review and finalise the broad framework of community monitoring processes as outlined in the Implementors Handbook
4. To review and finalise the capacity building framework for community monitoring
5. To discuss tasks of TAG vis a vis decentralised planning and community action.

Day 1	
Session	**Time**
Welcome and Context	0900-0910
Introductions	0910-0940
Review of progress (4 states) (Statewise presentation (5-7mts each state)	0940-1040
Tea	1040-1100
Review of progress (5 states) (Statewise presentation (5-7mts each state)	1100-1200
Review of timelines/budget	1200-1300
Lunch	1300-1400
Review of community monitoring framework	1400-1600
Tea	1600-1615
Review of capacity building framework	1615-1730
Group work on finalizing community monitoring and capacity building frameworks	
Day 2	
Presentations of group work	0900-1100
Tea	1100-1115
Role of TAG vis a vis community planning and action	1115-1300
Any other matter	1300-1400

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National Secretariat- Status Report

August to December 2007

Tasks	Status
Material for Awareness Generation	• A CD containing the PDF and print-ready version of all the posters, pamphlets, briefing kit and manual was sent to all the 9 states. • Six type of posters designed by Nat Sec were dispatched to MP, Maharashtra, Orissa, Jharkhand, Chattisgarh and Rajasthan • Five types of pamphlets – Village health committee, untied fund to sub centre, PHC, Health and Nutrition day, and NRHM-Know your rights and demand your rights
Model Curriculum for Trainings and Workshops	• Implementor's Handbook in English • Implementor's Handbook in Hindi • Translation of monitoring tools into hindi • Translation of village health report card into Hindi • Design for block facilitator's training
Developing Tools	• Community Mobilisation protocols finalized • Community Monitoring protocols finalized
Documentation Formats	Prepared monthly state reporting format National secretariat is constantly in touch with state nodal agencies and has collected activity reports.
Assist AGCA members and State NRHM directorates for State NGO networks for State preparatory Phase	Regular contact maintained with concerned AGCA members and state contact persons. Multiple field visits made to each state
Website on community based monitoring of processes and access to services under NRHM	Materials to be uploaded on the website sent to the **Ministry**
Technical support to State Nodal Organisations	Being provided on a regular basis through visits telephone and email- providing materials, information. Also constant support has been given as resource person for ToT, workshops and various

	activities.
Preparation of MoUs for the second installment	Finalised and being executed
Financial oversight, collation and finalisation of accounts of first installment	Done
Disbursal of grants	Ongoing
Quarterly reporting	Ongoing

Challenges:

1) The process of mutual communication is not yet been set-up
2) Technical support from TAG hasn't been properly institutionalized or regularized
3) Functioning feedback mechanism has not been established with the state
4) Difficulty to keep timeline in absence of timely financial disbursement.

disbursement.

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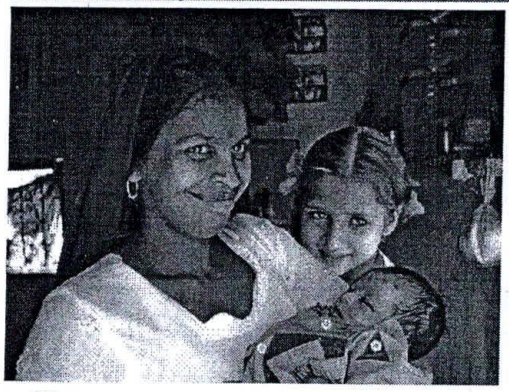
Evidence on Community and System Strengthening Approaches for improved health and nutrition



State Consultation on Community Mobilization

Bhopal, August 11, 2010

Laxmikant Palo
Senior Technical Advisor
The Vistaar Project
New Delhi

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An Overview

- Purpose and Objectives
- Evidence Review Approach
- Project Strategy
- Progress and Lessons

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Project Purpose

To assist the Government of India

and State Governments of Uttar Pradesh and Jharkhand

in taking knowledge to practice

to improve maternal, newborn, and child health and nutritional status

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Purpose of Evidence Review

- Foster knowledge sharing on interventions
- Facilitate consensus and collaboration around evidence based approaches
- Generate recommendations and action
- Identify capacity building areas and approaches

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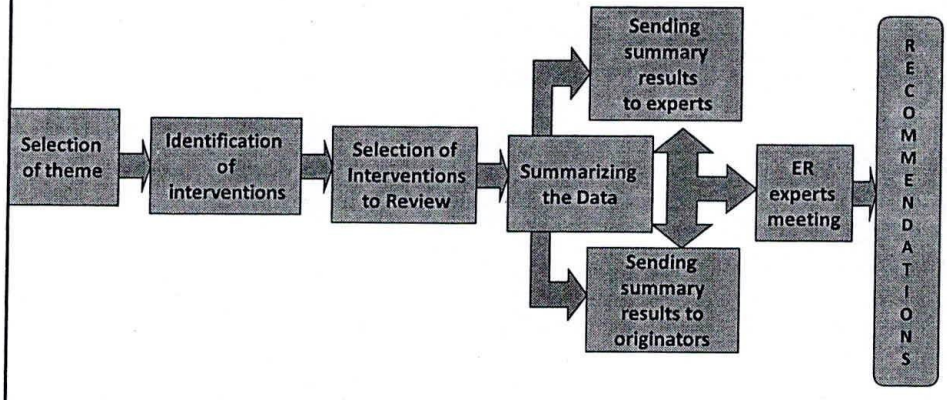
Evidence Review Process on VHCs



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Selection Process

Interventions identified for initial review

Interventions had monitoring and/or evaluation information available & accessible

Interventions meet the project team's criteria for the evidence review:
showed evidence of outcome or impact results

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Lessons Learned

- Community orientation to the role of VHCs takes time
- Community representation in the VHCs is crucial
- Civil society participation and support to VHCs is essential
- Village ownership of the VHC and the Village Health Plan is very important
- Involvement in implementation and monitoring of the Village Health Plan
- Linking the VHC with Government systems and services

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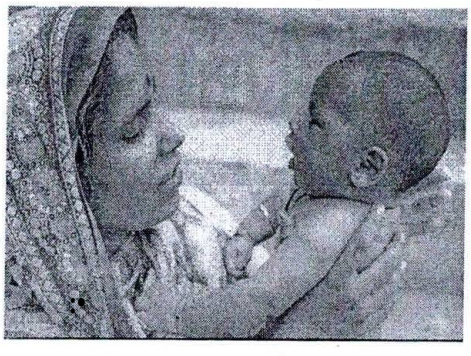
Guiding Principles for TA Design

- Based on Evidence Reviews
- Working within the system at scale
- Cross Cutting –Costing, Equity and Gender
- Considered replicability aspect



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Goal of Vistaar Nutrition TA in Jharkhand and Uttar Pradesh

- To improve nutritional status of pregnant and lactating women and adolescent girls
- To improve nutritional status of children specially children under two

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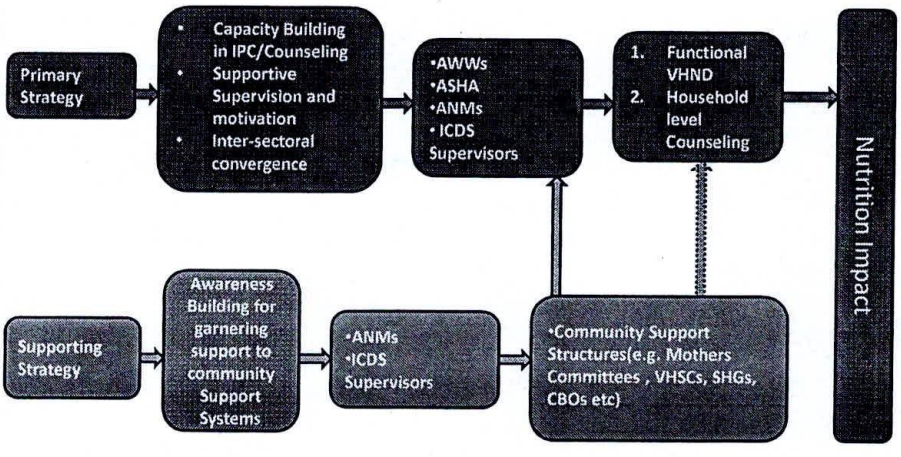
Nutrition TA Framework



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Key Project nutrition strategies

- Enhance IPC skills of frontline workers
- Promote Community mobilization
- Enhance the knowledge and skills of mid-level managers
- Strengthen supportive supervision skills
- Promote inter-sectoral coordination
- Improve Nutrition monitoring
- Mainstream equity, gender and inclusion perspective

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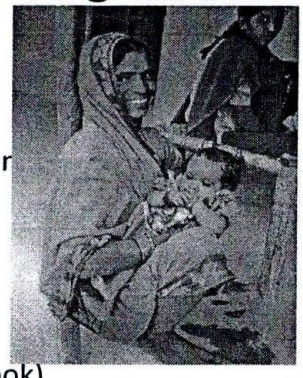
Interpersonal Communication/Household Nutrition Counseling

- Point of home visit
- Planned follow-up visit
- Training on nutrition IPC
- Onsite counseling session observation ar feedback
- Record keeping(visit #1 and follow-up visits)
- Review at the sector meeting
- Counseling tools (Guidebook and flip book)



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Household Counseling-Lessons Learned

- Need for quality counseling training and onsite support to frontline providers
- It needs to be sustained by supportive supervision, motivation and monitoring
- Need for a supportive environment (family and community)
- Adoption of behaviors should be from feasible to ideal
- Services and products must be accessible
- It should be timely, as per their need and planned follow-up

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Challenges in Household Counseling

- Counseling is not considered an essential service
- Inadequate knowledge and skills of service providers
- Home visits are not happening as per the client's preferred time
- Inadequate timely onsite support
- Inadequate mobility support to supervisors
- Lack of active involvement of family and community
- Less engagement of *Panchayat*

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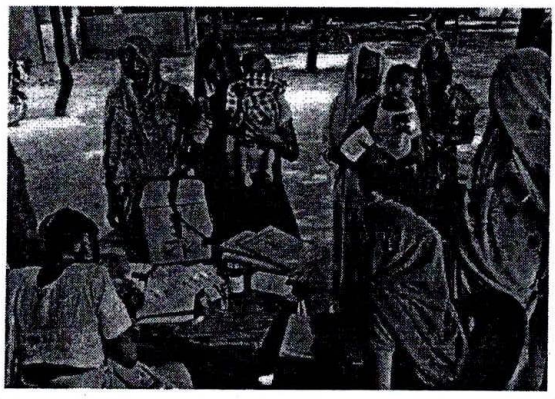
VHNDs

Evidence indicates that VHND is an excellent available platform for the community to access a range of MNCHN services on an assured basis



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Technical Assistance Strategies for VHND

- Orientation of frontline workers on VHND guidelines & clarification of roles
- Joint (HFW &WCD) district level micro planning for VHND incorporating unreached villages
- Enhancing community awareness on VHND
- Institutionalizing mechanisms for regular and structured observation and supervision
- Convergence with other development departments
- Improving allocation and use of funds for VHND

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VHND- Lessons Learned

- Build on Government priorities
- Sensitize district officials and assist them in orienting frontline workers on the guidelines
- Develop the Microplan jointly and share it with frontline workers
- Regular review and use of monitoring data is important
- VHND should be a standing agenda item for the District Health Society review meetings
- PRI and Education Department can play a greater role

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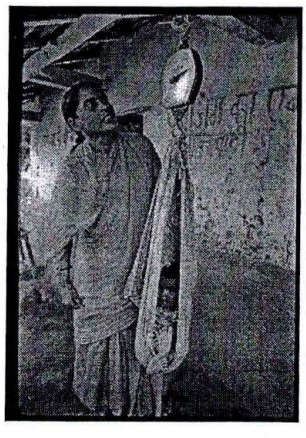
Challenges in VHND Strengthening

- Frontline workers not aware of the guidelines and their roles in VHNDs
- Lack of convergence between WCD & HFW Departments
- Lack of tools & mechanism for structured observation and monitoring of VHNDs
- Lack of community awareness
- Lack of necessary equipment and supplies



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Thank You!

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8/10/2010

The Ekjut Initiative

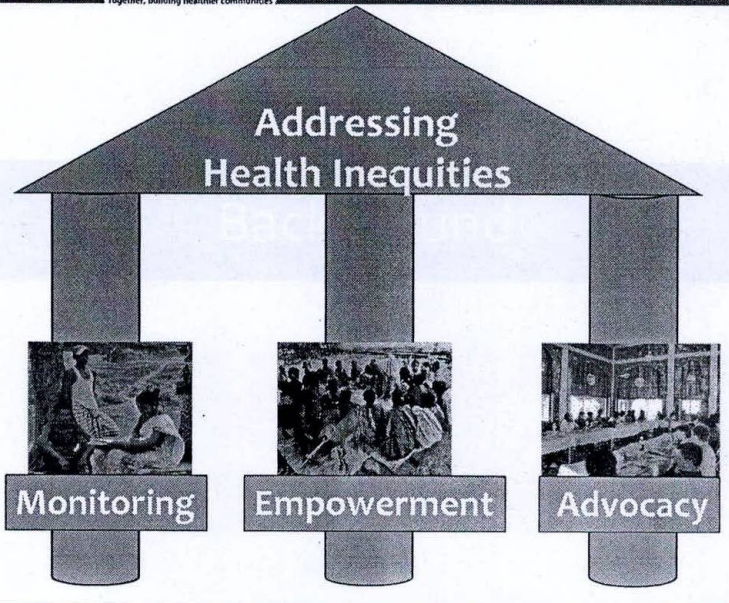
Dr. P.K.Tripathy & Dr. Nirmala Nair

State level consultation on

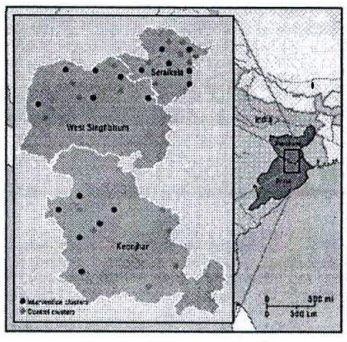
'Community Mobilization: foundation for better health and nutrition outcomes'
at **Bhopal** on **11th August 2010**

organized by - MP TAST (with DFID support)

WORK of Ekjut STANDS ON 3 PILLARS



TRIAL STATES



Jharkhand & Orissa (~ 66 million pop)

40 % in J&O live below the poverty line[1]

63 % of women cannot read

	JHARKHAND	ORISSA	INDIA
NMR (per 1000 livebirths)[2]	49	45	39
MMR (per 100,000 livebirths) [2]	371	358	301

1.NFHS-3 (2003 data), India, 2. Indian Sample Registration System (2001-2003), 2006. World Bank, 2007.

INCLUSION CRITERIA & TIMELINE

STUDY PARTICIPANTS:

All women of reproductive age (15-49):

- Residing in the project area
- Who gave birth between 31st July 2005 – 30th July 2008
- Who gave consent for involvement in the project

BASELINE	YEAR 1	YEAR 2	YEAR 3
Nov 04- Jul 05	Aug 05- Jul 06	Aug 06- Jul 07	Aug 07- Jul 08

PROSPECTIVE SURVEILLANCE OF BIRTHS & DEATHS TO WRA

THE TRIAL DESIGN

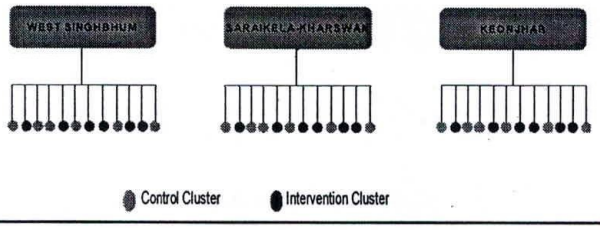
36
Clusters
Cluster health committees

18
Intervention Clusters
Women's groups + PLA

18
Control Clusters
Women's groups

36 clusters of ~ 6330 pop

Total population: 228,186



SURVEILLANCE SYSTEM

Select one key informant per 250 households

Pay informant incentive to identify births and deaths to women of reproductive age

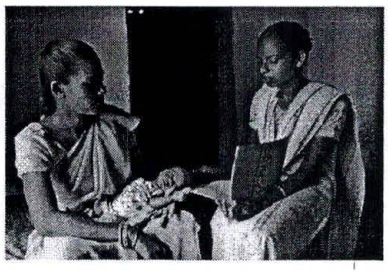
Interviewer visits informant monthly to collect list of identifications

Interviewer verifies identifications and pays informant

Interviewer interviews once at six weeks after delivery

Interviewer collects identifications from government records every month

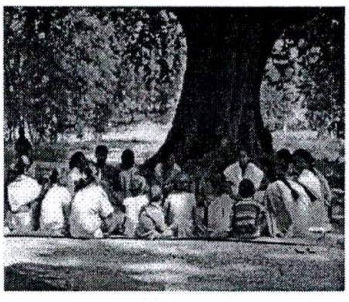
Women who are interviewed are 'snowballed' for other identifications



The approach

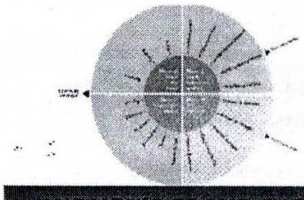
Women's Group intervention

CONTROL CLUSTERS



EXISTING GROUPS = 203

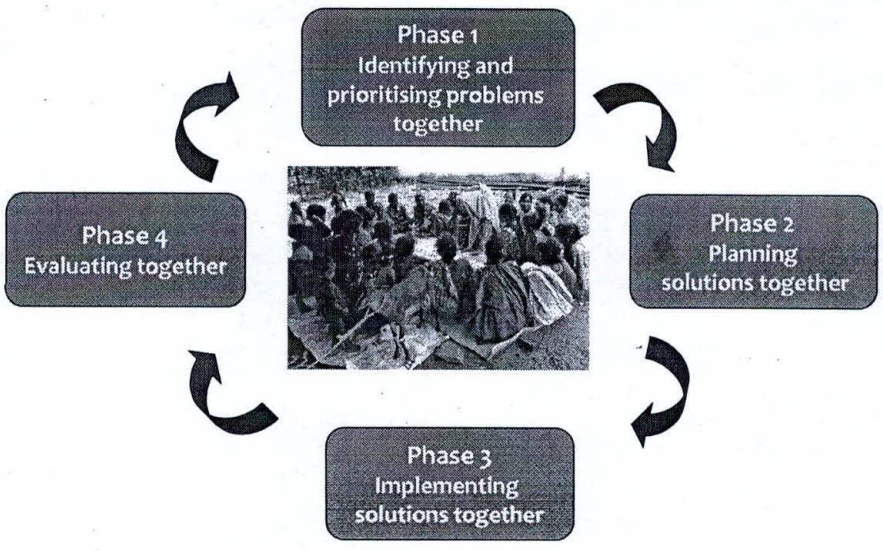
INTERVENTION CLUSTERS



WOMEN'S GROUP CYCLE

EKJUT WOMEN'S GROUPS ≡244

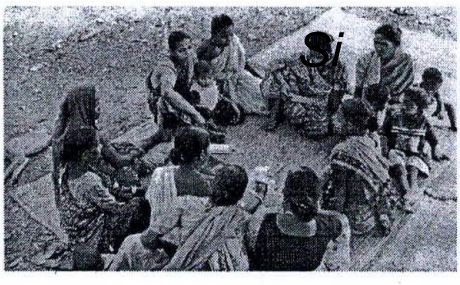
4 Phases of intervention

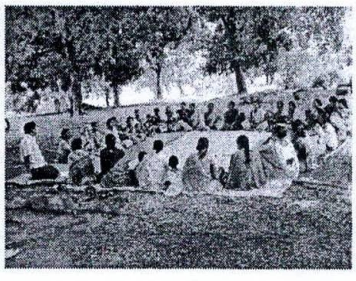


MEETING CYCLES
(first 2 phases)

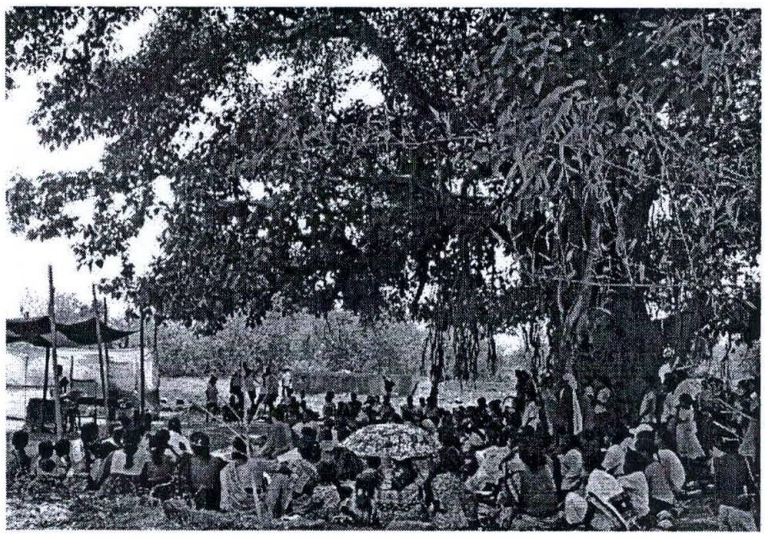
1st to 5th Meetings : Identifying & prioritizing problems with the help of picture cards

6th to 9th Meetings : Planning strategies to solve the problems through story telling and bridge game





Community Meeting - 1



Phases 3 & 4

Phase 3-
Implementation of Strategies – 9 meetings

Cluster level Community Meeting

Cluster level community meeting

Phase 4-
Evaluation of impact – 2 Meetings

Evidence of impact

- A cRCT is the most rigorous way of measuring effectiveness of an intervention
- Ekjut trial published in The Lancet in March'10

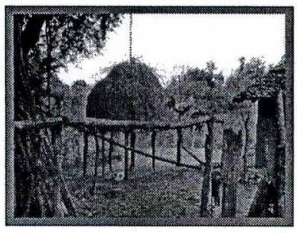
Tripathy, P et al. The Lancet **2010,375:1182-1192**

Effect of participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster randomised controlled **trial.**

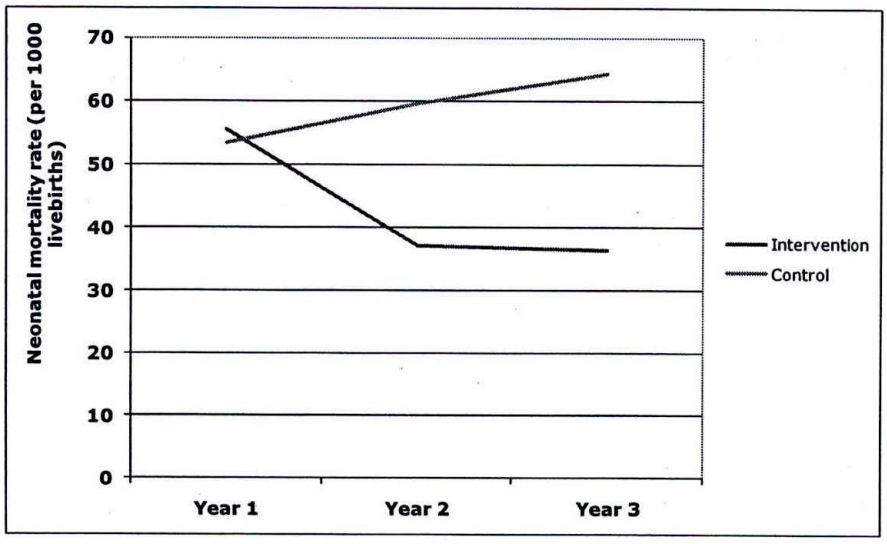
BASELINE RESULTS

- NMR: 58 per 1000 live births
- MMR: 510 per 100,000 live births

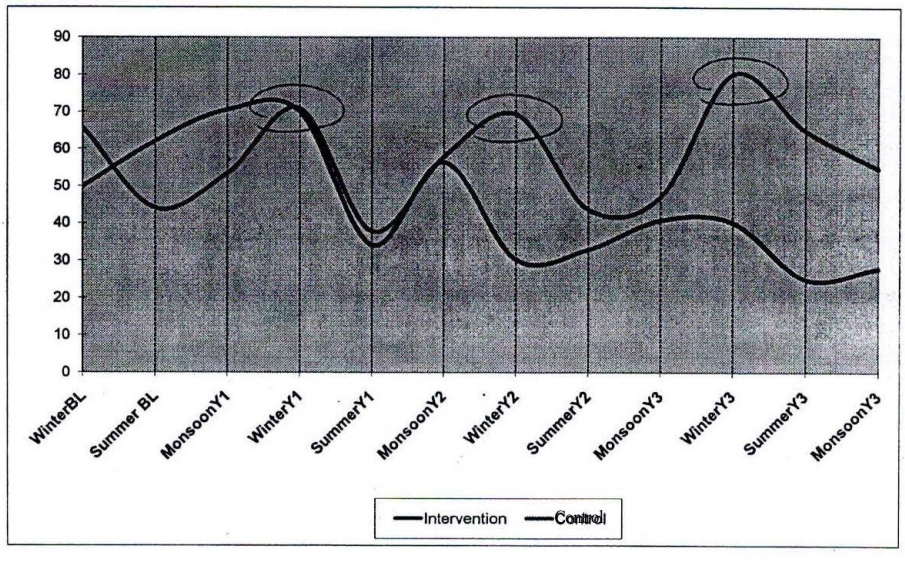
- 40% of women did not have any ANC
- 15% had 4+ ANC visits
- 85% of deliveries took place at home



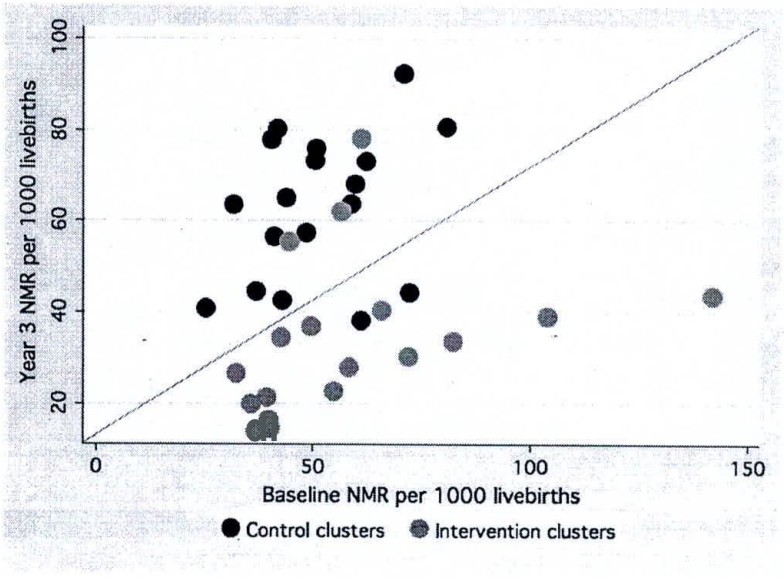
IMPACT ON NEONATAL MORTALITY



NMR- Seasonal Variations

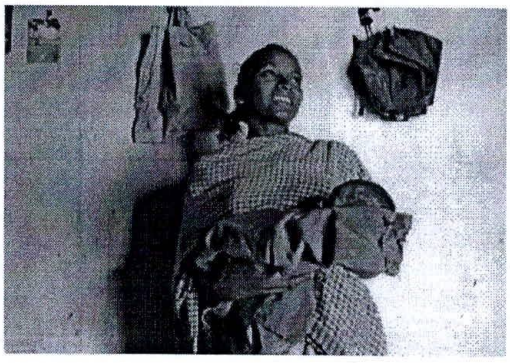


IMPACT ON NEONATAL MORTALITY



Ekjut trial NMR district

IMPACT ON NEONATAL MORTALITY



YEARS 1-3:

32% reduction in NMR

OR: 0.68 (95% CI:0.58-0.78)

YEARS 2-3:

45% reduction in NMR

OR: 0.55 (95% CI:0.46-0.66)

PERINATAL MORTALITY RATE

PNMR/YEAR	Y1	Y2	Y3
Intervention	67.5	57.3	47.6
Control	65.2	75	73.5

32% reduction

OR: 0.68

(95% CI: 0.56-0.79)

Years 2& 3

STILLBIRTH RATE

SBR/YEAR	Y1	Y2	Y3
Intervention	30.9	34.7	26.6
Control	30.1	31.9	28.6

Years 2&3:

OR: 1.01

(95% CI: 0.80-1.28)

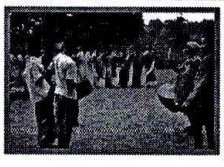
HOME CARE PRACTICES

	Intervention N (%)	Control N (%)	OR years 2&3 (95% CI)
Home deliveries	**8084**	**7034**	-
Birth attendant washed hands	3291 (40.6)	1583 (22.5)	2.50 (1.35-4.62)
Safe delivery kit used	2594 (32.1)	1284 (18.2)	2.28 (1.27-4.09)
Plastic sheet used	2088 (25.8)	560 (8)	2.98 (1.84-4.81)
Cord tied with boiled thread	2559 (31.7)	786 (11.2)	4.33 (2.06-9.11)

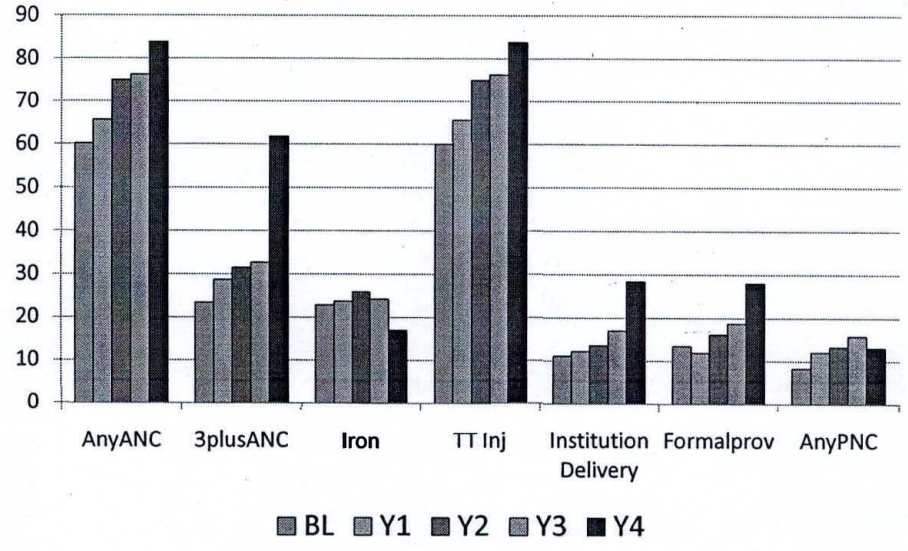
Infants alive at 1 month	**8807**	**8119**	-
Exclusive breastfeeding at 6 weeks	7022 (79.7)	5611 (69.1)	1.74 (1.03-2.94)

CARE SEEKING

	Intervention	Control	OR years 2&3 (95% CI)
All births	9468	8867	
3+ANC visits	3001 (31.6)	3621 (41)	0.68 (0.37-1.24)
Visited facility in case of illness in pregnancy	945 (10)	922 (10.4)	0.80 (0.39-1.65)
Any of 3 infant illnesses (cough, fever, diarrhea)	1739 (19.7)	2388 (29.4)	0.61 (0.35-1.06)
Visited facility in case of infant illness	940 (54)	1050 (44)	1.55 (0.79-3.04)



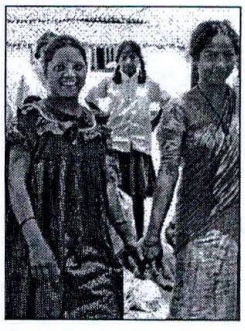
CARE SEEKING-Intervention



MATERNAL DEPRESSION (YEAR 3)

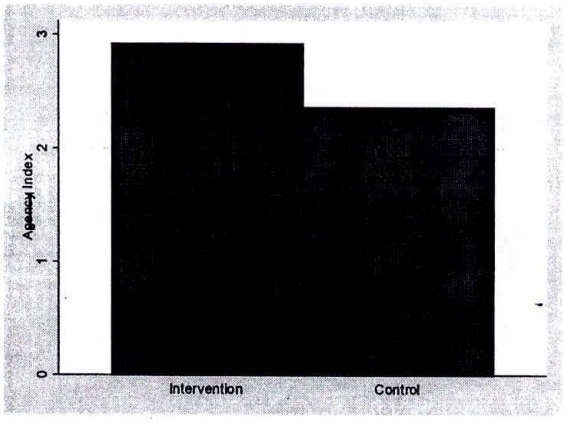
57 % REDUCTION

IN MODERATE DEPRESSION



	Intervention N (%)	Control N(%)	Adjusted OR (95% CI)
Mothers	3120	2963	
No/mild depression (10-15)	2962 (94.9)	2665 (90)	2.33 (1.25-4.38)
Moderate depression (16-30)	154 (4.9)	293 (9.9)	0.43 (0.23-0.80)
Severe depression (31-50)	4 (0.2)	5 (0.1)	0.70 (0.15-3.31)

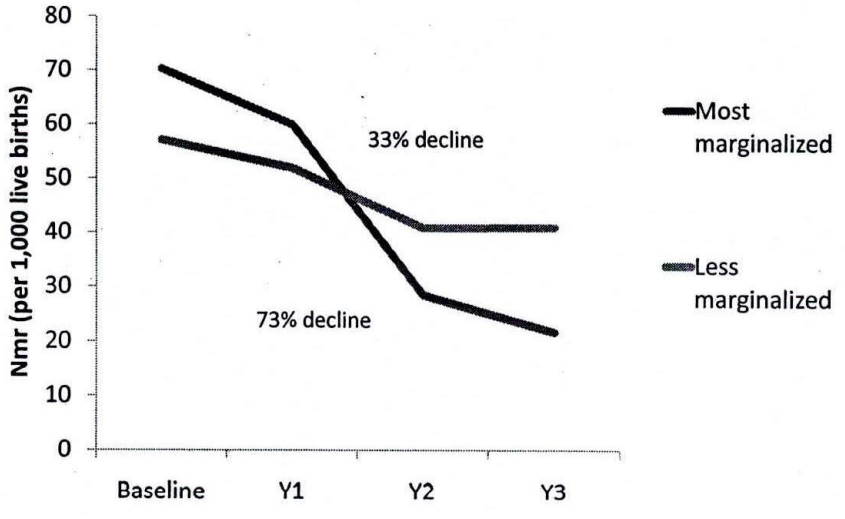
AGENCY



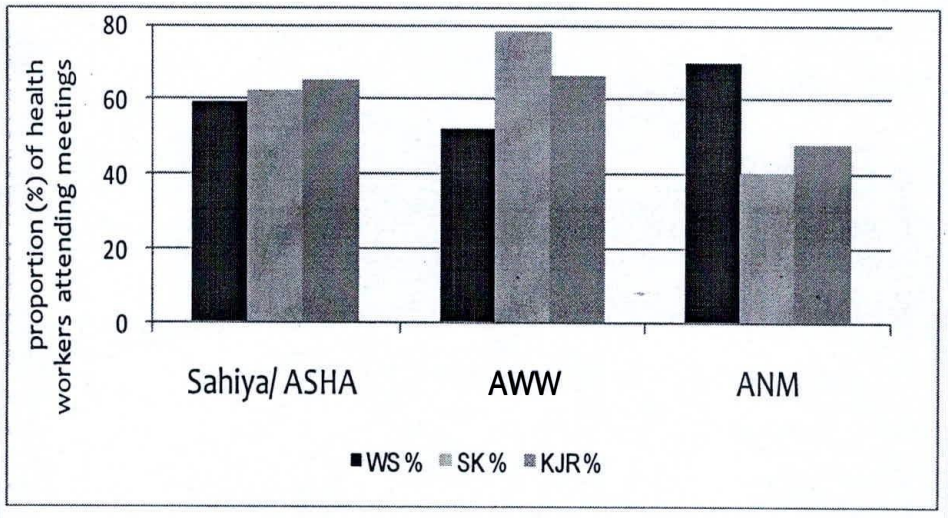
- Care seeking
- Visiting a provider unaccompanied
- Going to the shops unaccompanied
- Expenditure for daily necessities
- Less frequent expenditure
- Expenditure on expensive items

Years 1-3

NEONATAL MORTALITY TREND: Marginalisation (intervention areas)



Support from within the system - Attendance at Ekjut WG meetings



Replication taken into consideration during design

- Women's groups (SHGs) are an untapped available resource – facilitation through local women at each site
- The trial covered 2 states and 3 districts, spread over 20,000 sq km with several different indigenous groups
- 3 district teams managed independently
- Concomitant process evaluation explaining the context, method, implementation and mechanism

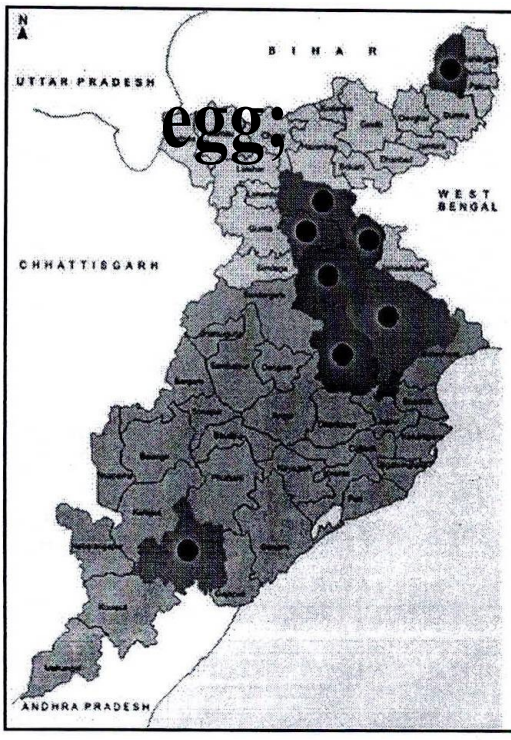
Replication taken into consideration during design

- User friendly facilitator's manual for universal application
- Picture cards developed with visual literacy in mind
- Replication in 8 districts - only supportive supervision and TOT

Scaling up ..

- **Ethical scale up :** intervention extended to ex-control areas
- **Quantitative scale up :** extended to 5 new districts
- **Functional scale up:** working beyond newborn period to include Under-5 and combating malnutrition
- **"Political" scale up:** dissemination workshops, engaging with media, ministries, funders and intermediary agencies, etc.

Source: Uvin and Miller (1996)



3 Old districts
5 New districts

Total Population= 599 289

Total groups = 899

Scaling up

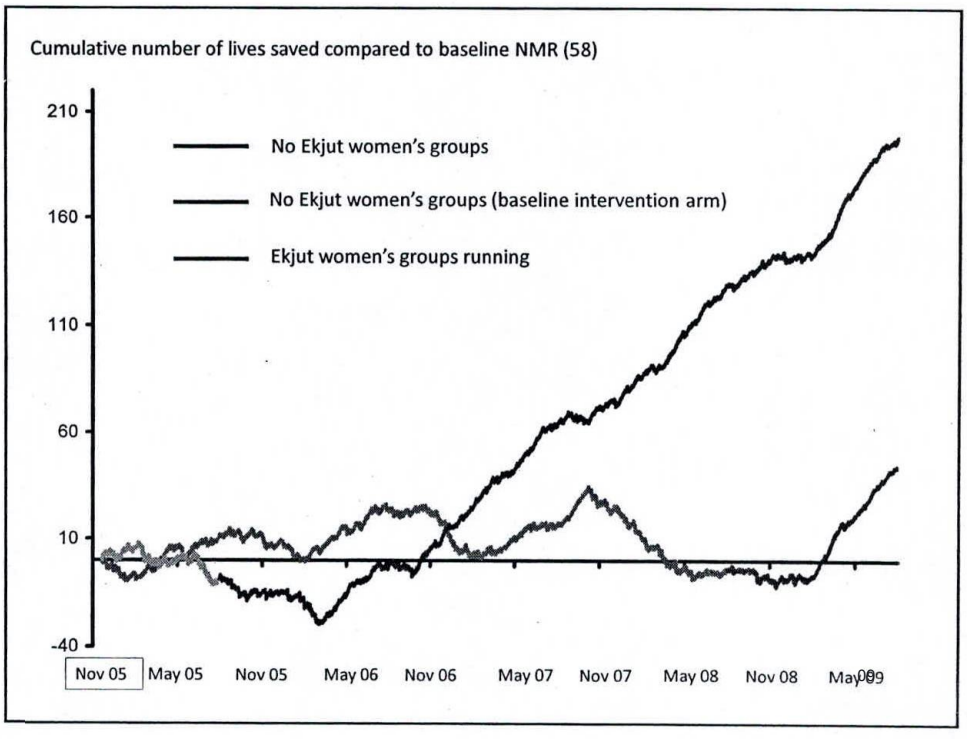
- Community mobilization plan for Orissa
- Proposed study - with ASHAs as facilitators
- Dissemination meetings at district, state, national & international level
- Local, National & International media coverage

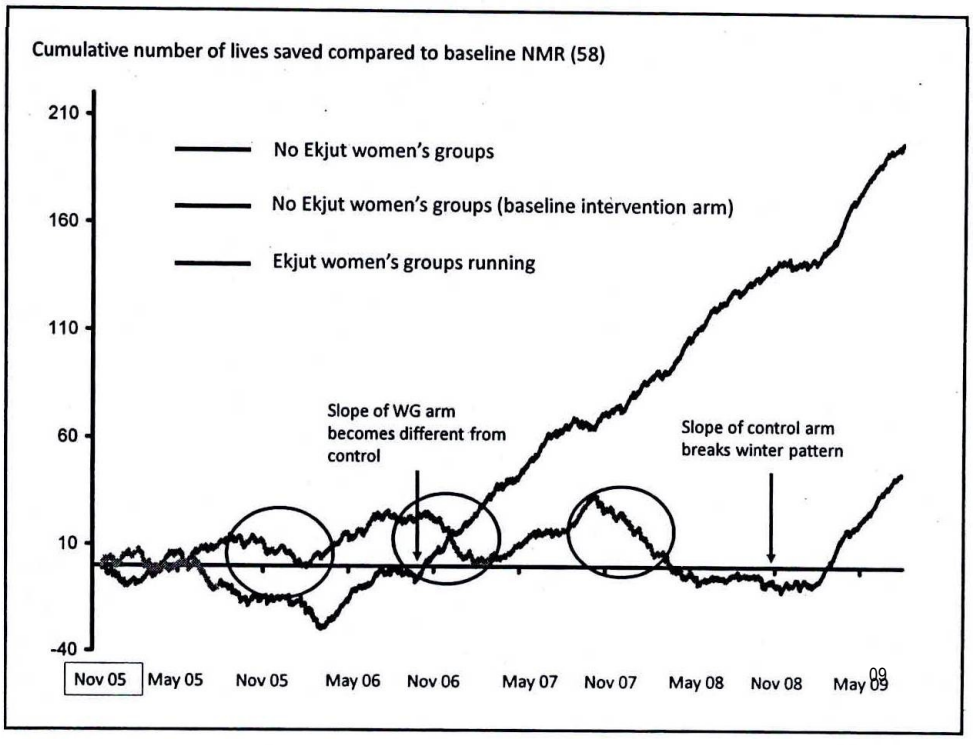
Has it been scaled up successfully?

ex- intervention clusters – post-trial - holding the gains of improvement from year 3

Scale up in ex- control clusters –

- Raw data analysis for the first year shows a 25 % reduction in NMR already
- Lag period for improvement reduced from about 1 year to 4months
- Moderate Postnatal depression rates fell sharply from 10.1% to 6.8% after intervention was started





COST-EFFECTIVENESS

	Cost per newborn life saved	Cost per life year saved
EKJUT (INDIA)	US$ 910 (US$ 1308 with HSS)	US$ 33* ($48 with HSS)
MIRA (NEPAL)	US$ 3442 (US$ 4397 with HSS)	US$ 111* ($142 with HSS)
PROJAHNMO (BANGLADESH)	US$ 2995 including HSS costs	-

* The World Bank - interventions <$127 per DALY are the most cost-effective.

Note: Trial covered a large , dispersed area over 20,000 Sq kms in 3 districts, therefore cost of 3 district teams was necessitated

KEY MESSAGES

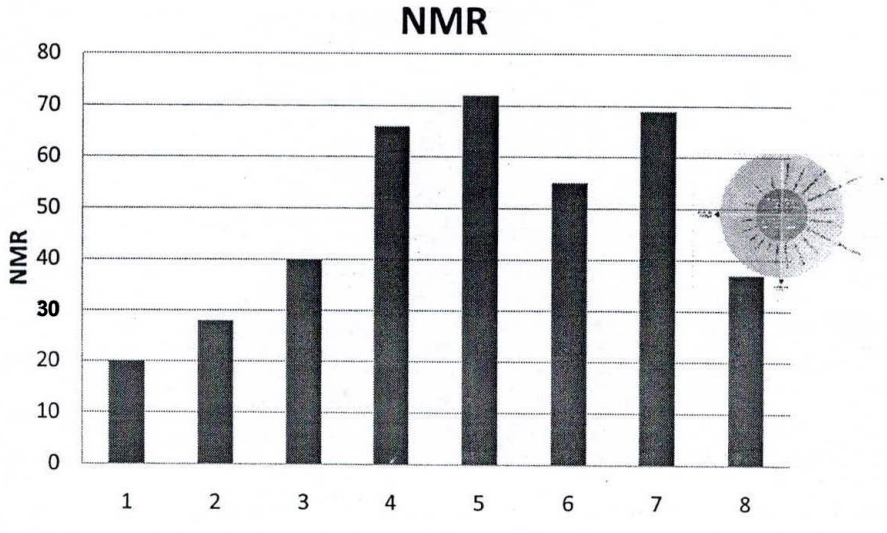
Community mobilization through women's groups

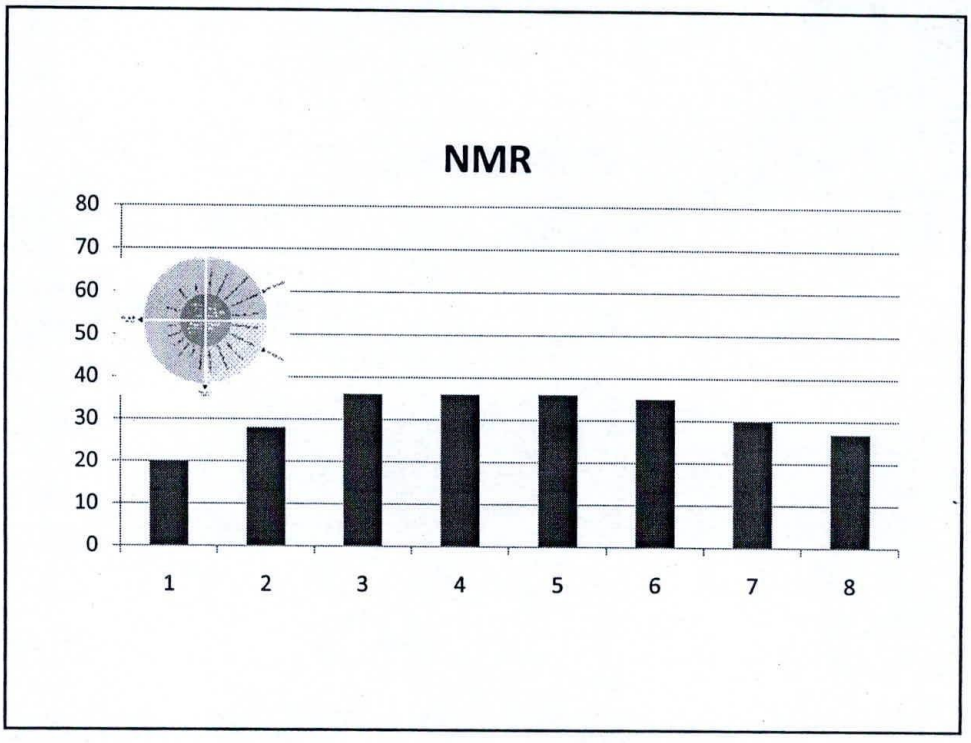
1. Empowered community groups can effectively ensure peoples' right to access and monitor progress of health services
   - benefit the most marginalized
2. Community mobilization through women's groups can reduce newborn mortality, be equitable and increase decision making among women
   - reduced newborn mortality
   - reduced postnatal depression and
   - increased decision making power (Agency) among women

Can be used in high mortality settings

3. Major contribution was by women in both the processes

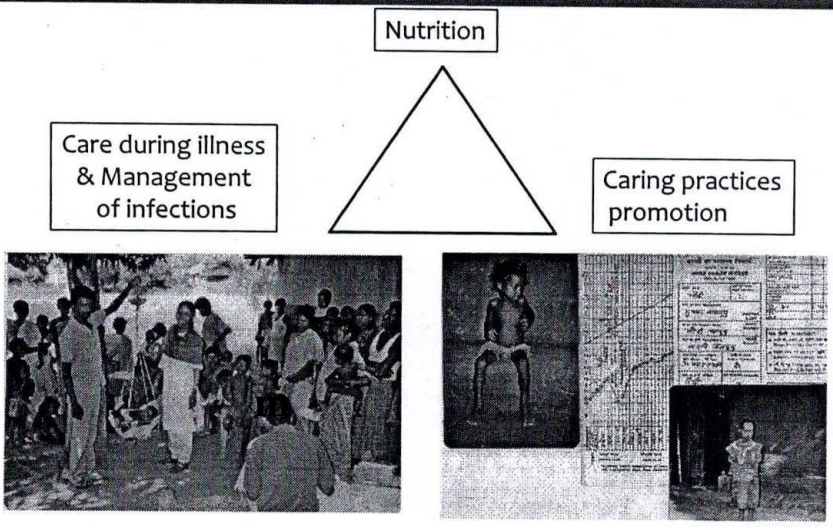
The intervention is highly cost-effective





Can empowered Women's groups help improve nutritional status among children ?

Community based intervention in combating malnutrition-
South Bihar(Now Jharkhand)'93 – '95



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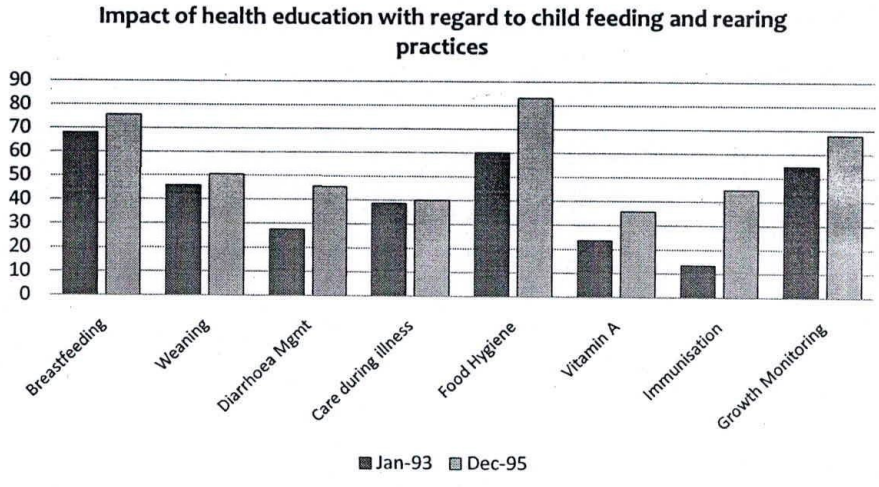

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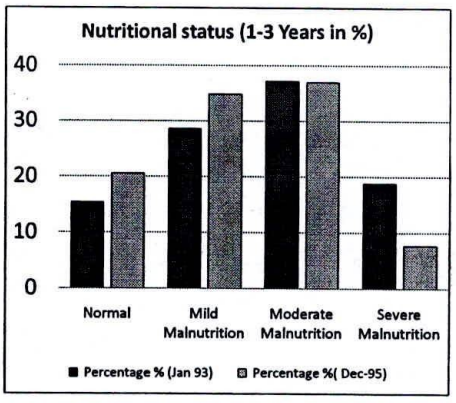
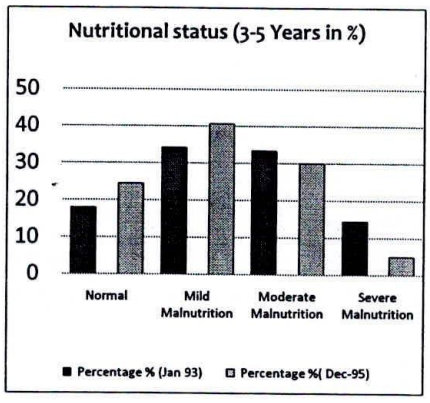
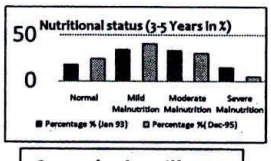
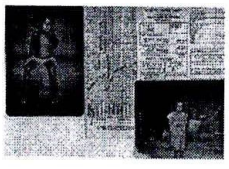




Community Mobilization: foundation for better health and nutrition outcomes'



Nutrition



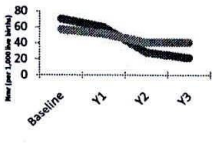
Care during illness & Management of infections

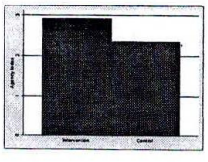
Caring practices promotion

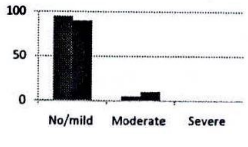
Addressing inequities

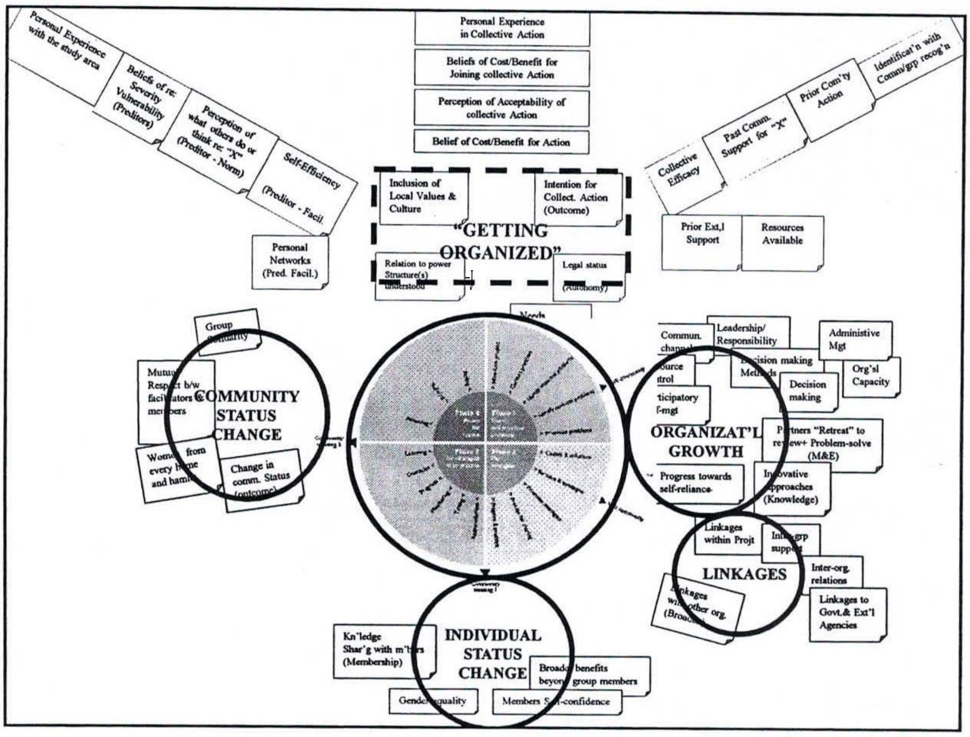
Improved Agency

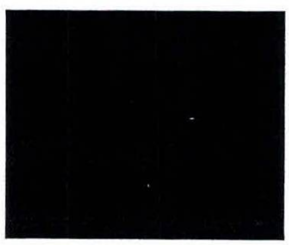
Improved self-efficacy








Personal Experience in Collective Action
Beliefs of Cost/Benefit for Joining collective Action
Perception of Acceptability of collective Action
Belief of Cost/Benefit for Action
Personal Experience with the study area
Beliefs of re: Severity Vulnerability (Preditors)
Perception of what others do or think re: "X" (Preditor - Norm)
Self-Efficiency
Personal Networks (Pred. Facil.)
Inclusion of Local Values & Culture
Intention for Collect. Action (Outcome)
"GETTING ORGANIZED"
Relation to power Structure(s)
Legal status
Identificat'n with Comm/grp recog'n
Prior Com'ty Action
Past Comm. Support for "X"
Collective Efficacy
Prior Ext,l Support
Resources Available
COMMUNITY STATUS CHANGE
Change in comm. Status
Leadership/ Responsibility
Administive Mgt
Org'sl Capacity
Decision making
ORGANIZAT'L GROWTH
Progress towards self-reliance
LINKAGES
Linkages within Projt
Inter-org. relations
Linkages to Govt.& Ext'l Agencies
INDIVIDUAL STATUS CHANGE
(Membership)



Tripathy, P et al. **Effect of participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster randomised controlled trial.**
The Lancet **2010;375:1182-1192**

Improving Newborn Survival in Low-Income Countries: Community-Based Approaches and Lessons from South Asia
Nirmala Nair1, Prasanta Tripathy1, Audrey Prost2, Anthony Costello2, David Osrin2* . PLoS Med 7(4): e1000246. doi:10.1371/
journal.pmed.1000246Barnett S, Nair N, Tripathy PK, Borghi J, Rath S, Costello A.
A prospective key informant surveillance system to measure maternal mortality–fi ndings from indigenous populations in Jharkhand and Orissa, India. *BMC Pregnancy Childbirth 2008;* **8: 6.**
http://www.biomedcentral.com/1471-2393/8/6/prepub

Website: www.ekjutindia.org

Com H 92.A

Mitanins becoming Nurses.....A journey from community health volunteers to health providers

Back ground and Rational - In Chhattisgarh more than 59000 Mitanins are serving as community health volunteers (CHVs) in their hamlets for last 6 years. During this period their competence (knowledge and skill) has been enhanced on child health, maternal health, first contact curative care, local herbal remedies, local health planning, management of neonatal and childhood illnesses, home based neonatal care, infant and young child feeding practices, women empowerment , behavior change communication etc. Their work has shown a visible impact like reduction in infant mortality and gains in key behaviors' viz. early and exclusive breastfeeding, complementary feeding etc. It has been found that almost 2500 CHVs have passed 10^{th}/12^{th} class.

In contrast to this effective community mobilization, our state is facing a great paucity in the availability of staff nurses, ANMs, GNMs. On the one hand state capacity is less in developing the new ANMs, GNMs etc. and on the other hand the available nurses are more interested to go outside the state or to join private institutions. Taking this availability of qualified community health volunteers and lack of nurses in the state, as part of NRHM architectural correction of health system, functional provision has been made in NRHM state PIP 2009-10 to give chances and priority to MITANIN-CHV to become staff nurse/GNM/ANM through admission to courses in government and private colleges. State government has taken an important decision that not only CHV, but also Mitanin trainers and district resource persons of the Mitanin Program will be sponsored for the courses of staff nurse/ANM/GNM.

Process- In Aug 09 a state level motivation drive has been organized to mobilize all the 12^{th} passed class (biology group) Mitanins to appear for a written test organized by a group of private nursing colleges affiliated to department of medical education, government of Chhattisgarh. More than 125 Mitanins has appeared in this exam and 55 Mitanins has exhibited their caliber as successful participant. State Health Resource Centre (SHRC) has facilitated the whole process of listing, motivating, screening, counseling and providing admission list to colleges, in close coordination with department of medical education and NRHM State Program Management Unit.

The commencement of a new journey- As a result of the above process, 24 Mitanins, 10 Mitanin trainers and 4 district resource persons of Mitanin program have finally made it to the 4 year course of B.Sc. Nursing through SHRC and NRHM. For each Mitanin Nursing Student NRHM CG will support a yearly amount of sixty five thousand rupees to pay for of their food, hostel charges, text books & uniform etc.

Currently their study has started and a new era commenced among the saga of community health volunteers in Chhattisgarh. Continuous hard work of last six years is blooming now. At the same time a lesson also learned that close hand holding will be required to support these Mitanins to complete their four year course timely and successfully. SHRC is instrumental in hand holding them, which currently includes managing their key problem of lack of proficiency English language (which is medium of instruction in all colleges). We are arranging special private tuition for Mitanin Students.

What next- Now the state is planning to facilitate more CHV to take up courses of ANM/GNM in the coming Jan 2010 with NRHM funding supports. More than 2500 skilled and experienced CHVs will get opportunity to get sponsorship for these courses through NRHM and realize their dreams come true.

State Health Resource Centre, Chhattisgarh

COM H 92.A

Presentation Structure

1. how program designed (study of best practices as well as failure etc)
2. Program implementation Across in state – How and what worked in Mitanin program
3. Sate level implementation
   Cost of the program
4. Impact of the program

""TJ

Presented by Avinash in Bhopal Consultation

Part 1.How program designed (study of best practices as well as failure etc)

Chhattisgarh 2001 Background-Gaps in Health Service Provisions

Demand Side Gaps:

- Poor awareness at community level.
- Poor utilization of health services at SHC/PHC/CHC level.
- Need for behavior changes.
- Need for greater community participation.

Supply Side Gaps:

- Poor infrastructure.
- Human Resource/ Manpower (only 60 pediatricians in state).
- Governance Issues.
- Skills, capacities and Motivation.
- Drugs, Supplies and Equipments.
- Weak Referral arrangements.

Other Critical issues:

- ANMs Workload and limitations in expanding with MPW force.
- Limited coverage of Anganbadi centre, large number of neighborhood villages left out.
- Limited connectivity - Weaker linkages of Panchayats with health system.

Three Days State level consultation – Jan 2002

Participants

- Health Department officials
- Civil Societies
- NGO's
- Leading health activists.
- European Commission representative and Action Aid

Results

- *Agreed 15 point Health Sector Reform agenda with role of civil society partners.*
- *Decision for a **state wide community health volunteers program***

Basic exercise- Successful NGO experiences

Some pioneers in CHW program

- Jamkhed
- SEWA- Gujarat
- RUHSA- Vellore
- SEARCH- Gadchiroli
- RAHA- Chhattisgarh etc

Learning's from pioneer CHW programs

- **Referral linkages,**
- **Duration of project,**
- **active support and training throughout the program.**
- **women as health providers especially at the community**

Basic exercise- Learning's from past failure esp. Govt large scale programs

Community health worker (1977)
Community health volunteer (1977)
Village health guide (1983)
Malaria Link Volunteers
Jan Swasthya Rakshak (Madhya Pradesh 1996)

- –CHWs were largely men.
- –Selection was left on the Panchayat head or to the ANM.
- –There was no continuous learning and support provided to the CHW?
- –Many CHWs become less qualified practitioners (quacks?)

Important gradients- Ready to start

- **Supportive Political Leadership** (Indira Swasthya Mitanin program).
- **Great Administrative Support** (New state) .
- **Full Financial Support-** MOU between state and European Commission under State Investment Program .
- **State – Civil partnership** { SHRC formed(MOU between State government and Action Aid), partner ship in piloting blocks with local NGOs} It continued in all phases and levels.
- **Technical preparedness –** Based on past learning and current health indicators.
- **Need of the State** A community health volunteer Program in form of Health Sector Reform.

Mitanin Program Designed and Implemented

1. Improve health education and **health awareness**
2. Improve **utilization** of existing public health care services .
3. **Promote local measures** of immediate relief to health problems of weaker sections of society- curative and preventive.

Families

****

4. **Organize** community ,especially women and weaker sections on health and health related issues.

Institutions

5. **Sensitize Panchayats** (the local self-governing institutions) and build up its capabilities in planning and placing health on Panchayat's agenda.

Part 2.Program implementation Across in state –
1.How and
2. what worked in Mitanin program

Scaling Up across Sate-Piloting and phase wise Implementation

- **May 2002 in 16 pilot block in partnership with NGO.**
- **Till March 2003 in 64 blocks, phase -I,**
- **Till March 2004 in rest 66 blocks - phase –II**

Implementation done by Health Department in technical support of SHRC. Now the program implemented through DHS under NRHM.

How – role of SHRC

- **Module and all training material development (design, approval , production).**
- **Conducting training of(i.e. TOT) state trainers/district trainers/block trainers.**
- **Support in Mitanin training through District Nodal Officer (Mitanin Program)**
- **Monitoring of the program at all level.**

What worked in Mitanin Program

1. Important feature of design
2. Key Strategies
3. Key operational activities
4. Monitoring strategy

What worked in Mitanin Program

1. **What's in a name?..... Shakespeare** But if it is to be owned by the community, the NAME surely creates ownership. So the *Mitanin()means more than a friend,* emerged in Chhattisgarh
2. **Not a LINK worker but Health Activist.....**Mitanin-ASHA (nearer to community)
3. **Approach adopted for Community Participation-** Empowering the community to plan and work for their development.
4. **Important ground work** Selection process & SOCIAL MOBILIZATION(KALAJATHA, COMMUNITY GROUP MEETING, GRAMPANCHAYAT INVOLVEMENT, MITANIN SELECTION)

What worked in Mitanin Program

5. **Continuous Training's Strategy** Camp based training, On-the-job training ,Combating Key Challenges Related to Transmission Loss at Various **Levels.**
6. Adopted Modular Approach for Training- covering Chhattisgarh need based subjects, till now covered- **1.**public health/child health, **2.**health resources, **3.** women health, **4 .** National programs(Malaria), **5** First contact curative care-Drug kit, **6.** National programs(leprosy and TB), **7.**good governance (micro planning- Swasthaya Panchayat Yojana) **8.**social security/food security, **9.** Local harbal Remedies (AYUSH) **10.** Home Based Neonatal Care, Integrated Management of Neonatal and Childhood Illnesses , **11.** Village health planning, **12** Infant and Young Child Feeding , **13.**Counseling (Behavior Chang Communication Kit)..... **In process 14.** Malaria and leprosy **15.** TB and HIV/AIDS.
7. **State government and civil society partnership** at all level- state, district, block, sector, implementation of program in 28 blocks in NGO partnership.
8. **A Mentoring cascade of 3650 local trainers across state-** In each block 20 Mitanin (ASHA) trainers and 3 block coordinators, and a district coordinator on an average 5 blocks

Scale at all level-State government and civil society partnership and A Mentoring cascade of 3650 local trainers across state

What worked in Mitanin Program

9. Just Process monitoring (Action by Mitanins)

- **Mitanin visits every newborn family on first day. Now visiting every neonatal on 1/3/7/14/21/28 days as per IMNCI protocol. Also do convey some HBNC skills to family members.**
- **Every pregnant woman's family is met in the last month, the birth is planned- JSY .**
- **Every child with diarrhea, ARI, Fever is visited for appropriate home care through Mitanin Drug Kit on first day and referred If required. Ensuring herbal remedy if required. Mitanins are DOTS providers.**
- **Attends the Immunization Day, supports in key activities output, ex. immunisation of left/drop outs, THR, weighing etc.**
- **Visits every malnourished child in her hamlet - for counseling on preventive, curative care and feeding practices.**
- **Holds a hamlet level women health committee meeting every month. Addressing the problem through WHC of Para on social security issues.**
- **Leading VHSCs as convener as well as joint signatory. Provide Support to Local Bodies in health planning.**

What worked in Mitanin Program

10. **"Action Formulas" for action** since conception of the program- Four contacts, Six messages for child nutrition , seven messages for newborn etc.
11. **No reporting, only mentoring**- reports are generated by Mitanins trainers and block coordinators.
12. **Regular strengthening processes**- monthly hamlet level meeting, cluster meeting, two block level meetings of Mitanins trainers every month, Block coordinators monthly district level meeting, monthly state level training of district coordinators, monthly state level meeting of CMHOs.
13. **Books design –** it were useful in training, daily reading by Mitanins and her family members used for family counselling.
14. **Continuous Technical , Financial, political, administrative, Media support-** SHRC provides continuous technical support, Initially funded by European commission till 7th round than managed by NRHM till now, all ruling party supported the program, continuous Media support etc.
15. **Volunteerism**- all 60000 Mitanins are volunteer, Incentive started in late 2007.

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What worked in Mitanin Program

16. **KEY STRATEGIES for Mitanins *Motivation Solidarity And Sustainability***

- **Mitanins mutual sharing** through newsletter
- **Refilling of vacant places** of MITANINS, MT, DRPs,
- **Development of Mukhyamantri Mitanin Welfare KOSH**.
- **Strengthening the referral practice -** through Mitanin Help Desk.
- **Providing career opportunity** in health sector- ANM,GNM etc.
- Empowering them as community leader- VHSCs convener. Promoting Mitanins for PRI member

Part 3. State level Implementation Cost of the program

Yearly Cost- Mitanin Program

S.No	Essential activities	Yearly Fund required
1	Yearly training cost for 60000 Mitanins for average 8 days	8 Cr
2	Training cost for TOT of 3500 MT/Block coordinators for 10 days	2.1 Cr
3	Compensation to 3000 MTs @1800 per Month for 12 month	6.48 Cr
4	Compensation to 300 Block coordinators @4200 per month	1.43 Cr
5	Contingency cost for monthly meeting at block / district and social mobilisation-	1.5 Cr
6	Cost of printing Material etc	0.5 Cr
7	App. Yearly cost	20 Cr

Part 4.Impact of the program

Impact

- **Advocacy-Policy formulation-** A national level community health worker initiative named as ASHA (Accredited Social Health Activist) program has been introduces in more then 18 states of India in April 2006.
- **Health sector Reform** - true demand generation resulted in to-Primary health care improved with better services. In all 60000 hamlets of state community health volunteers are extending the first contact curative care for fever, cold , pneumonia, diarrhea etc.
- **Technical Human Resource -** 60000 women community health volunteer, who are trained on preventive and curative aspect of health -Health right, Child health and maternal health, First contact curative care, local herbal remedies, National health programs- VBDCP,RNTCP,NLEP etc., Counseling skill and Nutrition, Food security, Micro health planning etc.
- **Micro level Planning-** 60000 hamlets level information on 32 HDI collected, analyzed and used at village level health planning since last 4 years.

Impact

- **Women Empowerment /Social Capital -** 60000 women community health volunteers leading the 60000 women health committees and 19000 village health and sanitation committees, which are addressing effectively the issues like- deforestation, anti liquor movement, public distribution system, employment guarantee scheme, maternity benefit scheme etc.
- **Governance.** improving health supply system/ more then 2000 Mitanins are PRI representative like Janapad Sadasya, Sarpanch, Panch etc in current election 2010/improving the quality of the services under different programs- PDS/MDM/NREGA/ICDS services etc.
- **Improvement in health indicators-** Please see NFHS III/ SRS data. State has received Country level 4th JRD TATA award in Jan 2009 based on 14 indicators etc.

Thank you.....

....to everyone here, and to the 60,000 Mitanins-ASHAs

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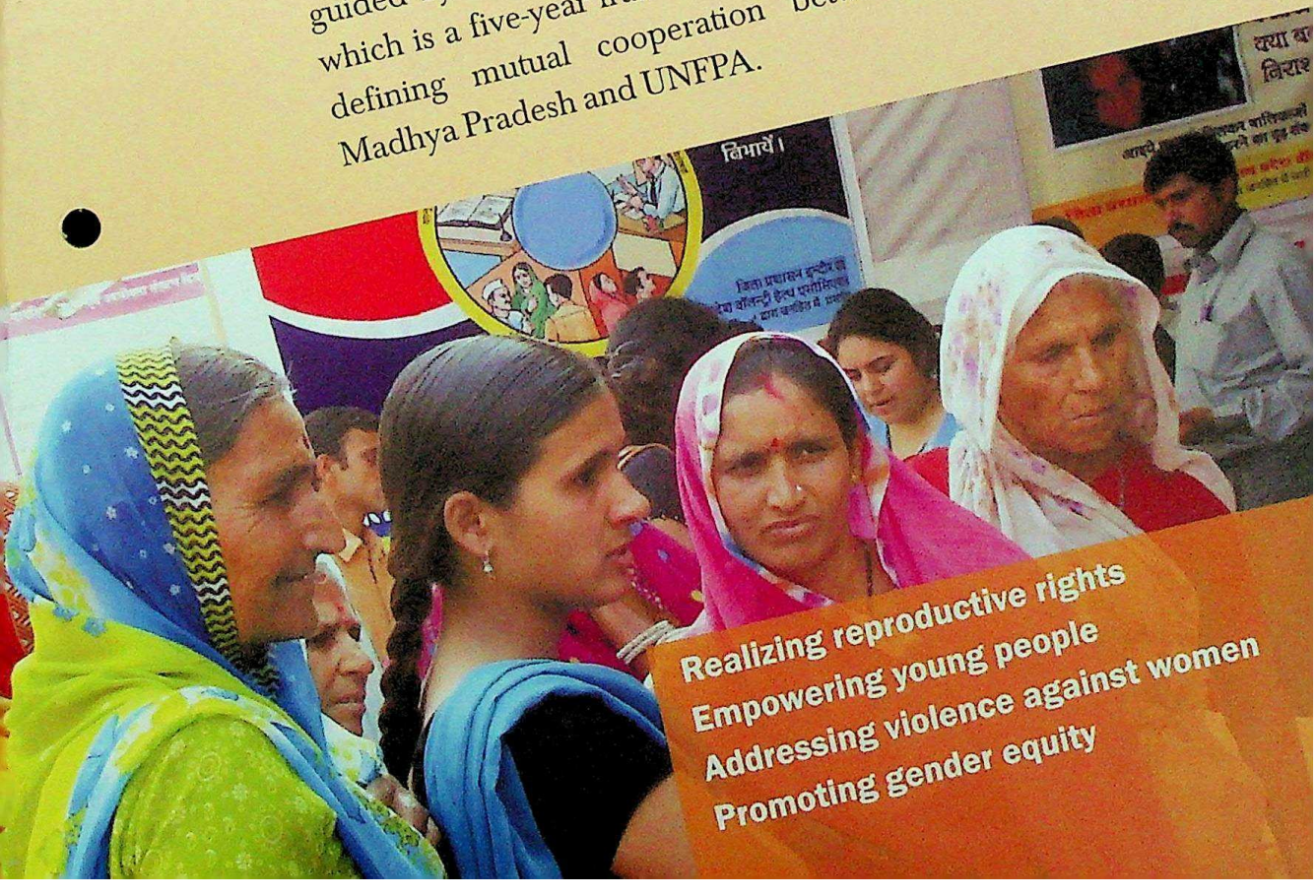
CATALYZING CHANGE

UNFPA's Support in Madhya Pradesh

The UNFPA State Office for Madhya Pradesh provides support to the state in three broad areas; improving reproductive health service delivery, strengthening the demand side interventions and addressing issues related to skewed child sex ratio. This support is guided by the State Program Action Plan for Madhya Pradesh, which is a five-year framework covering the period 2008 to 2012 defining mutual cooperation between the Government of Madhya Pradesh and UNFPA.



Realizing reproductive rights
Empowering young people
Addressing violence against women
Promoting gender equity

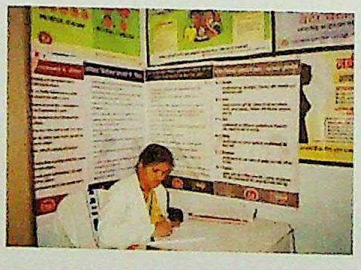
The UNFPA State Office works in close collaboration with the state government and other partners for

realizing reproductive rights

empowering young people

addressing violence against women

promoting gender equity



Along with providing technical assistance in agreed upon thematic areas at state level, the following are the direct activities and interventions of the UNFPA state office:

- Capacity building of family planning counselors and block programme managers
- Process documentation/assessment/evaluation of key RH initiatives and innovations
- Capacity building of programme managers in the area of Family Planning
- Training of trainers for operationalizing integrated SBA trainings
- Organizing advocacy events and activities to observe special days
- Working with NGOs and professional bodies for advocacy on sex selection issues and PC&PNDT Act
- Capacity building of public prosecutors on sex selection issues and PC&PNDT Act
- Advocacy and communication material on sex selection issues
- Conducting training of district accounts managers and district data officers on RCH/NRHM physical and financial reporting
- Advocacy efforts on gender equity
- Supporting the process of development and implementation of district and state project implementation plans
- Supporting the implementation and monitoring of RCH/NRHM interventions in the state

Communitization of NRHM in Two Districts of Madhya Pradesh

Implementing Partner

Madhya Pradesh Voluntary Health Association, Indore

This pilot intervention was initiated in Khargone and Dhar districts from July 2008 for increasing active participation of community stakeholders in planning, management and monitoring of National Rural Health Mission initiatives and increasing their stake in decision-making process by developing capacity of Village Health and Sanitation Committees.

Objectives

- To improve knowledge and understanding of members of VHSCs on reproductive health issues impacting RH outcomes
- To build capacity of VHSCs on development of village health plan
- To monitor RCH services during village health and nutrition days

Activities

- Capacity building of VHSC members through training and continuing education
- Orientation of health care providers
- Establishment and functioning of village information centers
- Issue based campaigns on women's access to health care, adolescent health, immunization, breast-feeding and family planning
- Recording and monitoring of vital events in the villages
- Community based planning and monitoring for strengthening health care services
- Public dialogues
- Experience sharing meetings and workshops

Initial Results

- 100% response to trainings and continuing education programmes
- 87% utilization of untied funds by the trained village Health and Sanitation Committees in the project area
- 82% Village Health and Nutrition Days organized regularly
- Increased community involvement in planning and monitoring of health services
- Increased demand for health care services
- Youth fertility is being addressed with creative approaches

Empowerment of Adolescents and Youth with Knowledge and Life Skills for improved Reproductive and Sexual Health in Sehore district of Madhya Pradesh

Implementing Partner

Samarthan, Centre for Development Support, Bhopal

This intervention aims at enhancing knowledge of adolescents and youth on key RH issues and developing their life skills. The project was started in Sehore district in July 2008 wherein youth groups were formed and continuous education is being imparted to the members of youth groups through a trained cadre of youth facilitators.

Objectives

- To improve understanding of youth on RCH issues through life skills approach
- To contribute to demand generation and utilization of RCH services by active participation of youth groups
- To develop capacities of youth in planning, management and monitoring of RCH services in the villages
- To address youth fertility through involvement of youth groups

Activities

- Capacity building of youth facilitators
- Continuing education of youth groups in villages through monthly meetings
- Orientation of PRIs to create an enabling atmosphere for youths
- Development of training and communication material
- Community based monitoring of RH and key health services
- Orientation of health care providers
- Youth conventions on reproductive health issues
- Special events, campaigns and experience sharing workshops
- Addressing youth fertility

Initial Results

- Youth groups formed in 100% villages of project area
- 98% members of youth groups and youth facilitators trained
- Increased demand for and uptake of youth friendly health services
- Changes in behavioral patterns of youth regarding personal hygiene and reproductive health
- Improved reproductive health service delivery in project area

Operationalization of the Protection of Women from Domestic Violence Act 2005 in two districts of Madhya Pradesh

Implementing Partner

Action Aid Association, Bhopal

This intervention is being implemented in Sidhi and Chhatarpur districts of Madhya Pradesh. The strategy adopted under this project is capacity building of key stakeholders like protection officers, service providers, police and judiciary, women's organizations and Gram Panchayat members.

Objectives

- To operationalize the Protection of Women from Domestic Violence Act 2005 in two districts of Madhya Pradesh
- To sensitize community and concerned stakeholders and bring down the incidences of domestic violence in the society

Activities

- Capacity building of protection officers and service providers
- Orientation of officials from police department and judiciary
- Capacity building of support groups/Panchayat representatives and women's groups
- Fellowship support to village women to raise awareness in community and strengthen networking with NGOs and women's organizations
- Meetings of community stakeholders on the issue of domestic violence and provisions of the Act
- Development of IEC and resource material on domestic violence
- Advocacy events and issue based campaigns

Initial Results

- Orientation of 96% protection officers and NGO service providers completed in the project area
- Capacities and skills of protection officers and NGO service providers enhanced
- The Act implementation structure strengthened in the intervention districts
- Increased awareness about the Protection of Women from Domestic Violence Act 2005 in project area
- Positive change in mindset of community regarding domestic violence and the Act

Strengthened response to addressing sex selection and PC&PNDT Act implementation in Indore district of Madhya Pradesh

Implementing Partner

Madhya Pradesh Voluntary Health Association, Indore

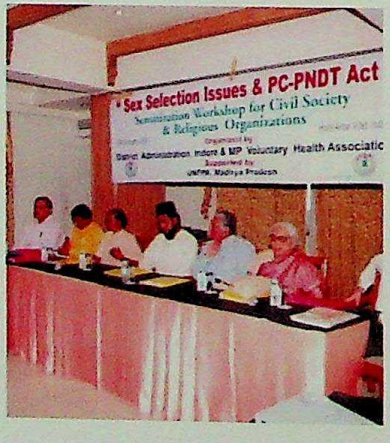
This pilot aims towards capacity building of key stakeholders like - members of district advisory board, judiciary, medical community, media, religious leaders and civil society organizations on community mobilization and implementation of PC&PNDT Act. One of the key strategies is regular monitoring of registered USG centers. The pilot also aims at capacity building of NGO partners in ten districts of M.P. having skewed child sex ratio.

Objectives

- To facilitate proper implementation of PC&PNDT Act through advocacy and action
- To sensitize the community and concerned stakeholders on sex selection issues and importance of girl child

Activities

- Capacity building of NGO partners engaged in IEC/advocacy and vigilance activities
- Working with District Appropriate Authority, Indore for advocacy and action
- Monitoring records of USG centers and setting up of telephone help-line
- Sensitization of medical community, members of district advisory board and judiciary
- Sensitization of media representatives, religious leaders and civil society organizations



Initial Results

- 100% NGOs selected for the intervention received orientation
- Large number of different stakeholders sensitized
- Four court cases filed and 20 show cause notices issued by Appropriate Authority, Indore
- Corrective measures taken by 14 centers
- Registration of two USG centers suspended for 1 month with Rs.10000/- penalty
- Registration of 2 sonologists suspended for 1 month
- Show cause notice issued to Sonosite Company
- Significant positive change in the mindset of community in general and medical fraternity, judiciary, media and civil society in particular

INTERVENTIONS STARTED IN 2010

1 PC&PNDT Act Implementation Strengthened through Capacity Building and Sensitization of Judicial Officers and Legal Professionals in Madhya Pradesh

In order to promote efficient and effective handling of PC&PNDT cases in the courts in all districts of Madhya Pradesh, this intervention was started from February 2010 in collaboration with National Law Institute University, Bhopal. This intervention is aimed at sensitizing judicial officials, public prosecutors and legal professionals on sex selection issues and galvanizing Act implementation processes.

2 Raising Awareness on Reproductive Health Issues in Tribal Areas of Madhya Pradesh through Community Radio

The partnership with Vanya (an organization established by the Department of Tribal Welfare, Government of Madhya Pradesh) is intended at information dissemination of general health and specifically on Reproductive health issues through Vanya community radio in the mass media shadow tribal areas in Dindori and Dhar districts.

3 Targeted Intervention for Female Sex Workers in Jhabua and Neemuch districts to increase their access to prevention, care, and treatment services for STI and HIV/AIDS

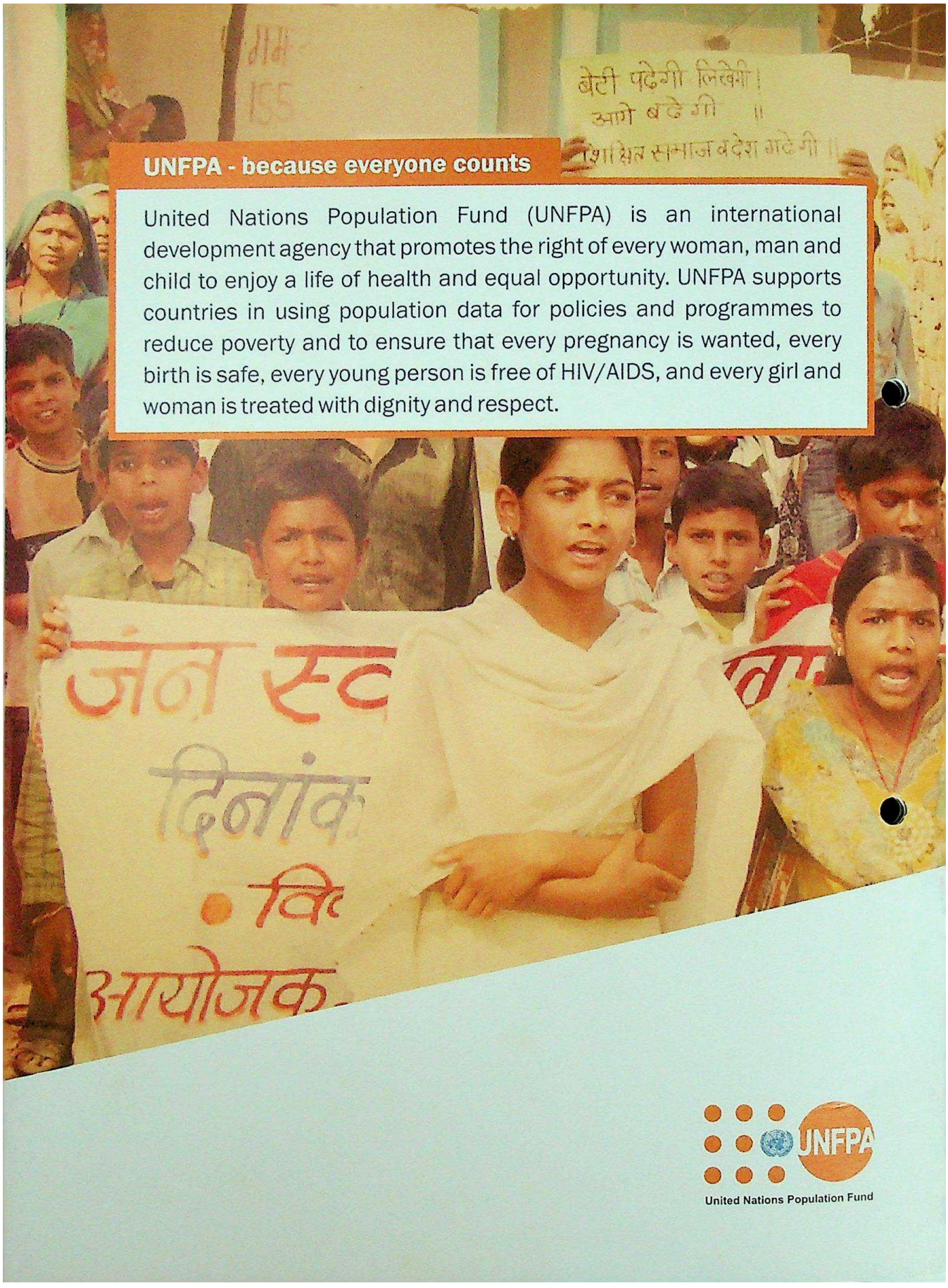
This intervention is initiated in Neemuch and Jhabua districts since February 2010 in partnership with Jeevan Jyoti Health Services Society for increasing female sex worker's knowledge and awareness regarding STI and HIV/AIDS and; and increasing their access to prevention, care, and treatment services for STI and HIV/AIDS.

For further information please contact

Dept. of Public Health and Family Welfare
Government of Madhya Pradesh
Satpura Bhawan
Bhopal - 462 004

National Rural Health Mission
State Health Society
Bank of India Building
3rd Floor, Arera Hills
Bhopal - 462 011

United Nations Population Fund
UN House, 2nd Floor,
Plot No. 41-42, Polytechnic Colony
Shyamla Hills
Bhopal - 462 013
Phone: +91-755-2661246 / 2661247
Fax: +91-755-2661245
Email: india.mp@unfpa.org
Website: http://india.unfpa.org



UNFPA - because everyone counts

United Nations Population Fund (UNFPA) is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.

UNFPA

United Nations Population Fund

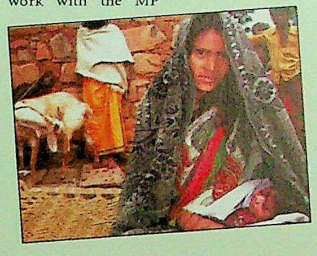
Madhya Pradesh the heart of India

health plans, which have enabled districts to assess their own situations and recommend priorities. The first phase of DFID support to health in MP encouraged districts to try out innovations in service delivery and some of these (such as Janani Express - emergency transport scheme for expecting mothers) have been extremely successful. State expenditure on public health, which is 0.9% of the GDP at present, is committed to grow at 10% per annum which together with higher allocations from the national government will strengthen the public health system.

Bringing positive changes to health

Technical Assistance Support Team (TAST)

DFID has funded and engaged a Technical Assistance Support Team, or TAST, to work with the MP government to take forward the reforms programme envisaged under the HSRP. The TAST is made up of a multi-disciplinary team of experts who work closely with government officials and other stakeholders to bring positive changes to the health situation in MP.



The MP TAST provides expertise in –

- Policy Development
- Public Health and Hospital Management
- Maternal and Neonatal Health
- Nutrition
- Governance
- Organisational Development and Human Resources
- Social Development
- Monitoring and Evaluation including MIS
- Resource Allocation and Financial Management
- Public-Private Partnerships

TAST supports the Department of Public Health and Family Welfare and the Department for Women and Child Development in achieving the objectives of the Health Sector Reform Programme.

TAST works with the MP state government to plan, monitor, and implement the health sector plan. The MP TAST is co-managed by Options and IPE-India, both leading development sector consultancies and partners in bringing about change in the health sector in Madhya Pradesh.

MP TAST
A/5 BDA Colony, Opposite J.P. Hospital, Tulsi Nagar
Bhopal - 462016, Madhya Pradesh
Phone: +91-755-2550219, +91-755-2550229
www.indiahealthtast.org

Health Sector Reform Programme

Quality Health Care for All

TAST for Madhya Pradesh Health

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Madhya Pradesh

the heart of India

Madhya Pradesh is a medley of ethnic groups and tribes, castes, and communities. Its population of 60 million includes indigenous people and migrants from other states. Dalits and Scheduled Tribes form 35% of the population, together accounting for two-thirds of the poor. While it has a bustling commercial centre in Indore and a lavish green capital in Bhopal, Madhya Pradesh is one of the poorest states in India with over 37% of its people living below the poverty line.

MP's child and maternal mortality rates and morbidity rates are amongst the highest in the country. The child malnutrition rate also remains persistently high. The 3rd round of the National Family Health Survey registered an increase in children under 3 years old who are underweight, from 54% to 60%, the highest in India.

The reasons for poor health indicators are poverty, social deprivation, illiteracy, lack of information, and inadequate access to health services. Worrying statistics, along with a health system searching for ways to address the needs of its people, called for the state government to relook at the ways it was reaching out to

individuals and communities. The way ahead lay in reforming the health sector to bring about real change to people's lives.

A platform for change

Health Sector Strategy

To better respond to the health needs of its population and to deliver on its health priorities, MP's Department of Public Health and Family Welfare formulated a 5-year Health Sector Strategy (2007-2012) focusing on initiatives directed towards poor and marginalized communities. The Strategy ensures that relevant government bodies come together to make services more people-oriented, effective, and efficient. The main issues the Strategy addresses are:

1. Infant mortality
2. Maternal mortality
3. Total fertility rate
4. Making health outcomes and utilisation of services more equitable
5. Addressing malnutrition among children
6. Reducing morbidity and mortality from common communicable diseases such as malaria, leprosy, and tuberculosis

Supporting reforms in Madhya Pradesh

The DFID Commitment

The UK Government's Department for International Development (DFID) has been working in Madhya Pradesh since early 2000 and has a diverse portfolio of programmes. It started working in the health sector in MP in 2004 through the District Health Management and Sector Reform Programme (2004 – 2006).

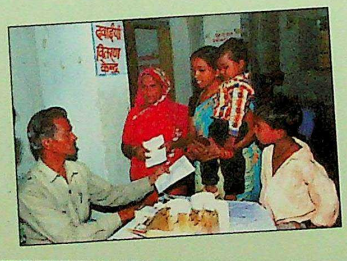
DFID's budgetary commitment of £60 million to health reforms supports the Government of Madhya Pradesh to undertake a series of critical measures. These include upgrading health infrastructure, particularly in the 10 poorest districts and tribal areas, increasing the supply of essential drugs, augmenting staff resources, building staff capacity, financing innovative schemes such as vouchers for emergency transport, encouraging public private partnerships, introducing health insurance for the poor, establishing Auxiliary Nurse Midwife schools in tribal areas, and developing Anganwadi Centres (village nutrition centres) into Village Health Centres.

Equitable, affordable, quality health care for all

Health Sector Reform Programme: 2007-2012

Madhya Pradesh is committed to achieving the Millennium Development Goal targets related to health and the targets set under the National Rural Health Mission. The State aims to reform its health systems to achieve equitable, affordable, and quality health care for all.

The Madhya Pradesh Health Sector Reform Programme (HSRP), a DFID initiative, aims to bring about increased use of quality health services, especially by the poorest people and in underserved areas. The programme has six main outputs –



1. Improving equitable access to quality public healthcare services
2. Improving accountability of health services
3. Strengthening organisational structure and human resource management systems
4. Ensuring adequacy and effectiveness of funding
5. Participation and regulation of private service providers
6. Ensuring integrated service delivery to reduce malnutrition and improve child health

The HSRP aims to –

- Reduce the Infant Mortality Rate (IMR) to 60 per 1000 live births (the IMR is 70 per 1000 live births, as per the Sample Registration System, or SRS, of October 2009)

- Reduce the Maternal Mortality Rate (MMR) to less than 220 per 100,000 live births (the MMR is 335 per 100,000 live births as per SRS, 2006)
- Bring down the Total Fertility Rate (TFR) to 2.1 (the TFR is 3.1, as per SRS 2006)
- Reduce inequalities - socio-economic, schedule caste and schedule tribes, rural-urban, and gender - in health outcomes and utilisation of services
- Reduce malnutrition amongst children to 35% from 60% and severe malnutrition to less than 1%
- Bring down morbidity and mortality rates caused by common communicable diseases

Challenges

The Government's vision to provide accessible, affordable, equitable, accountable, effective, and quality health care, especially to poor and vulnerable communities, requires significant strengthening of the health system.

MP's Health Sector Reform Programme aims to address constraints on the demand and supply aspects of the health system, and the health care market. Some challenges are:

Demand: Improving health-seeking behaviour, ensuring that social and financial barriers to accessing services are removed, encouraging community engagement in planning and delivering primary health services.

Supply: Higher public expenditure on health, addressing gaps in infrastructure and human resources, improving performance, quality, and accountability of services, better coordination with private providers, improving health information systems.

Health care market: Effective stewardship of the private health care market, creating awareness about the market, promoting risk pooling mechanisms.

A kaleidoscope of reforms

Higher allocation for public health, support for decentralized governance, greater autonomy to hospitals through Rogi Kalyan Samitis, thrust on district-level planning and piloting of insurance schemes for poorer groups have been the key reform themes in Madhya Pradesh. The state is committed to empowering Panchayati Raj Institutions (PRIs) and its benefits are visible in education and Integrated Child Development Schemes.

MP has been the first state to develop district

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Role of Village Health Committees in Improving Health and Nutrition Outcomes: A Review of Evidence from India

Evidence Review Series 4

March 2008

Context

The Government of India is promoting a decentralized approach through changes in major programs such as the National Rural Health Mission (NRHM) and the Integrated Child Development Scheme (ICDS). The NRHM places significant focus on creating and supporting Village Health Committees (VHCs) to promote decentralization.

The VHC is intended to be a part of the local self-governance structure of the *Panchayati Raj* Institutions specifically the Village Council called the *Gram Sabha*. The purpose of the VHCs is to build and maintain accountability mechanisms for community-level health and nutrition services provided by the Government. The NRHM provides guidelines on the framework, functions and responsibilities of VHCs and has provided for a flexible "untied fund" of Rs.10,000 per health sub center facility to support local actions. The role of the VHCs, as mentioned in the NRHM guidelines is

- To create awareness in the village about available health services and their health entitlements
- To develop a Village Health Plan based on an assessment of the situation and priorities of the community
- To maintain a village health register and health information board and calendar
- To analyze key issues and problems pertaining to village level health and nutrition activities and provide feedback to relevant functionaries and officials; and
- To present an annual health report from the village to the *Gram Sabha*

The NRHM guidelines suggest that the VHC should include representatives from the village *Panchayat*, Community-Based Organizations and NGOs, other community representatives and village health and nutrition workers and they note that the committee should include members from disadvantaged communities (e.g., scheduled castes, scheduled tribes, minority groups). The VHC is also expected to oversee the work of village health and nutrition functionaries such as the Auxiliary Nurse Midwife (ANM), *Anganwadi* Worker (AWW) and Accredited Social Health Activist (ASHA) and to be involved in managing the local sub-centre, which is accountable to the *Gram Sabha*.

This paper provides highlights from an evidence review on VHCs. The purpose of the evidence review was:

> *To analyze the available evidence to determine the key lessons learned in the area of the role of Village Health Committees in improving health and nutrition outcomes.*

Evidence Review Process

Considering the importance of VHCs for decentralization and achieving improved health and nutrition, leaders from the central and state Government (including Health and Family Welfare and Women and Child Development Department officials) agreed that it was important to conduct an evidence review on this topic. The USAID-funded Vistaar Project facilitated the evidence review, which was conducted by national experts in this field.

The Project team identified existing evidence within India for the review, through a literature review as well as direct requests for information from many experts working in this field. The team initially identified over 30 interventions that

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had a focus on community involvement and VHCs and then short-listed seven of them, based on these criteria:

- The intervention should have a focus on community involvement similar to the NRHM concept of a VHC
- There should be enough data and documentation on the effort to understand the inputs as well as the outputs and outcomes (e.g., data on indicators such as regular meetings of VHC, development of village health plans, monitoring of village health plans)

Of the seven interventions selected for the review, two were led primarily by the Government, one by a medical college and four were collaborative efforts of multiple non-Governmental agencies. See Table 1 for more information about the interventions reviewed.

Table 1: Overview of Interventions

Intervention Name	Lead Agencies	Focus Areas
Community-Led Initiatives for Child Survival (CLICS) [6, 8, 9]	Dept. Community Medicine, Mahatma Gandhi Institute of Medical Sciences	Fostering partnerships between "Village Coordination Committees" and the Dept. of Community Medicine, using a social franchising model in Wardha, Maharashtra
Improving Community Participation in Decentralized Planning of RCH services [18]	Foundation for Research in Health System and Dept. of Health & Family Welfare (Government of Karnataka)	Supporting community involvement and decentralized planning in Mysore, Karnataka
Integrated Village Planning Model [11, 22, 23]	Government of Uttar Pradesh and UNICEF	Establishing mechanisms to foster collaboration between the community and Government service providers in Lalitpur, Uttar Pradesh
Communitization of Grass-root Health Services [1, 19]	Government of Nagaland	Supporting and promoting community ownership of public resources and assets and decentralizing authority over service delivery in Nagaland
Community Mobilization for Improving Mother and Child Health through Life Cycle Approach [2-5, 7, 12, 13]	Child in Need Institute (CINI) and Govt of Jharkhand	Promoting community level social mobilization networks in Ranchi, Hazaribagh and Gumla districts of Jharkhand
"Swajal" Project (Village Water and Sanitation Committee component) [10]	Government of Uttar Pradesh, Government of Uttaranchal and World Bank	Supporting demand driven community participation in seven districts of Uttar Pradesh and 12 districts of Uttaranchal
Community Health Activist *(Mitanin)* Program [17, 20, 21]	Government of Chhattisgarh	Introducing and supporting a cadre of village health activists to increase demand for health services and improve health service delivery in Chhattisgarh

The Vistaar Project team prepared summaries of the selected interventions including available data on effectiveness, efficiency and expandability of these interventions. These summaries were provided to the lead implementing agencies for their feedback and then shared with the expert reviewers prior to the expert review meeting. (These summaries are available on the IntraHealth website: https://www.intrahealth.org).

The team worked with Government officials and recognized experts to form a panel of experts in this field to conduct the evidence review. The expert group included Government officials and representatives from NGOs, academia, donors, professional associations, and other sectors. (See Table 2)

A group of 24 recognized technical experts met for two days on August 29 and 30, 2007 to review the seven selected interventions. The experts worked in a consultative manner to achieve the following objective:

To analyze the available evidence to determine the key lessons learned in the area of fostering strong village health committees.

Table 2: List of Experts

Mr. AkhileshTewari	Sarthi Development Foundation, Uttar Pradesh	**Dr. Rajiv Tandon**	USAID, New Delhi
Dr. Anant Kumar	Xavier Institute of Social Service, Jharkhand	**Ms. Ruth Vivek**	Centre for Health and Social Justice, New Delhi
Mr. Anup Hore	Krishi Gram Vikas Kendra, Jharkhand	**Mr. S. P. Sinha**	Ministry of Health and Family Welfare, Government of Jharkhand
Mr. B. B. Goel	State Innovations in Family Planning Services Project Agency, Uttar Pradesh	**Ms. Sarovar Zaidi**	ICICI, Mumbai
Dr. Deepak Raut	Central Bureau of Health Intelligence, Government of India	**Ms. Sonali Sinha**	Ministry of Health & Family Welfare, Government of Jharkhand
Dr. J. L. Chittoria	Directorate of Family Welfare, Government of Uttar Pradesh	**Prof. Subodh Sharan Gupta**	Dpt. of Community Medicine, MGIMS, Maharashtra
Dr. Madhulika Jonathan	UNICEF, Jharkhand	**Dr. Suranjeen Prasad**	Child in Need Institute, Jharkhand
Ms. Manjiri Bhawalkar	Abt Associates Inc., Cambridge, MA, USA	**Dr. T.B. Prasad**	TATA Steel Rural Development Society, Jharkhand
Mr. Mukesh Kumar	CARE India, New Delhi	**Dr. T. Sundararaman**	National Health System Resource Center, New Delhi
Dr. Nirmala Murthy	Foundation for Research in Health Systems, Karnataka	**Ms. Tanvi Jha**	Child in Need Institute, Jharkhand
Ms. Paromita Das	Vikas Bharti, Jharkhand	**Ms. Uma Prakash**	Dpt. of Women Empowerment & Child Development, Government of Uttarakhand
Dr. Prakash Gurnani	UNICEF, Jharkhand		
Mr. Rajan Kumar	Ministry of Health & Family Welfare, Government of Jharkhand		

Note: Other invited experts were unable to attend.

Lessons Learned

The expert reviewers identified a number of lessons learned about VHCs for application within the framework of NRHM and grouped them into the categories of:

- Community orientation to the role of VHCs
- Community representation in the VHCs
- Civil society participation and support to VHCs
- Village ownership of the VHC and the Village Health Plan
- Village Health Plan development
- Implementation and monitoring of the Village Health Plan
- Linking the VHC with Government systems and services

Community Orientation to the Role of the VHC

- The evidence from these interventions shows that successfully establishing a VHC is a long and formal process. It takes time to gain acceptance and generate community participation and ownership and there are complex local socio-political issues that may need to be addressed

Community Representation in the VHCs

- The VHC should have wide representation from different sections of the village population, including women, different castes and classes, and adolescents to ensure responsiveness to the various health needs in the village
- The evidence shows that it is important to have gender sensitive leadership of the VHC to enhance outcomes

Civil Society Participation and Support to VHCs

- The support of civil society agencies, such as NGOs, CBOs, Self Help Groups can be very helpful in setting up of the VHCs and meeting related NRHM objectives

Village Ownership of the VHC and the Village Health Plan

- It takes time and skills in facilitation and communication to lead to a village's understanding and ownership of a VHC and Village Health Plan
- There are challenges, but the VHC can improve the functioning of the Government service delivery at Primary Health Centers and Community Health Centers
- The VHC may function better and have better relationships with the Government health services if the VHC is established and able to help select their own health and nutrition functionaries (e.g., ASHA)
- Regular meetings of the VHC are associated with more successful outputs and outcomes

Development of the Village Health Plan

- The evidence shows that it is helpful for the VHC to identify local health problems and gaps, focusing on both the demand and the supply side
- Gathering the needed information and preparing a Village Health Plan requires considerable, sustained effort

Implementation and Monitoring of the Village Health Plan

- It seems advisable for the VHC to start with a simple, feasible Village Health Plan that has clear objectives and targets
- The VHC should develop a monitoring mechanism, with a few simple indicators, to monitor progress on the plan
- Outcomes have improved where the VHC has linked with the Government to support service providers and where the VHC has linked with block level officials

Linking VHCs with Government Systems and Services

- The VHCs can consider using the citizen's charter mechanism to establish linkages with the Government systems and institutions [including the *Panchayati Raj* Institutions (PRIs)], as well as with Government health services (e.g., for transport, referrals)
- The VHC seems to work better when it supports and serves as an ally with the health system (e.g., supporting the community-level health and nutrition workers such as the AWW and ANM), rather than acting mainly as an outside critic or activist group

Other Lessons

- It is helpful if there is seed money available to use for start-up activities of the VHC
- One model for use of the "untied fund" of Rs.10, 000 (made available under the NRHM) that appears successful is for a village health worker (e.g., ANM) and the VHC to have a joint account with the elected head of the *Gram Sabha* or *Sarpanch*
- Existing groups like SHGs and livelihood groups can help form a VHC or form the basis for a VHC

Evidence Gaps

In addition, the experts identified several important evidence gaps, where additional knowledge is needed. These are:

- The best roles for outside groups like CBOs and NGOs
- Strategies to include adequate representation from distant or isolated hamlets and very vulnerable and marginalized groups in the VHC
- Lessons about the working relationship between the VHC and the *Gram Panchayat*
- Evidence with more outcome level data to show what works in terms of VHC

In Summary

The evidence review process is a useful approach to build consensus among experts and program leaders, inform program planning, and assist with decision making. The Vistaar Project experience shows that this process is most valuable when:

- It is conducted in an open, inclusive and participatory manner
- The focus is on learning lessons, not identifying the "best model"
- The audience is clear, and the evidence is reviewed from their perspective (i.e., in this case, the evidence was reviewed for application in Government programming)

The Vistaar Project greatly appreciated the opportunity to be a part of this evidence review and is honored to join with the technical experts, implementing agencies, and Government program leaders and implementers who are using evidence to improve MNCHN program impact.

INTRAHEALTH INTERNATIONAL

Vision

We believe in a world where all people have an equal opportunity for health and well-being.

Mission

To mobilize local talent to create sustainable and accessible health care

The Purpose of the Vistaar Project is:

To assist the Government of India and the State Governments of Uttar Pradesh and Jharkhand in taking knowledge to practice for improved maternal, newborn, and child health and nutritional status

IntraHealth International, Inc. is the lead agency for the Vistaar Project

Disclaimer: This publication is made possible by the support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of IntraHealth International, Inc. and do not necessarily reflect the views of USAID or the United States Government.

Photo credit: Page 1: Laxmikanta Palo

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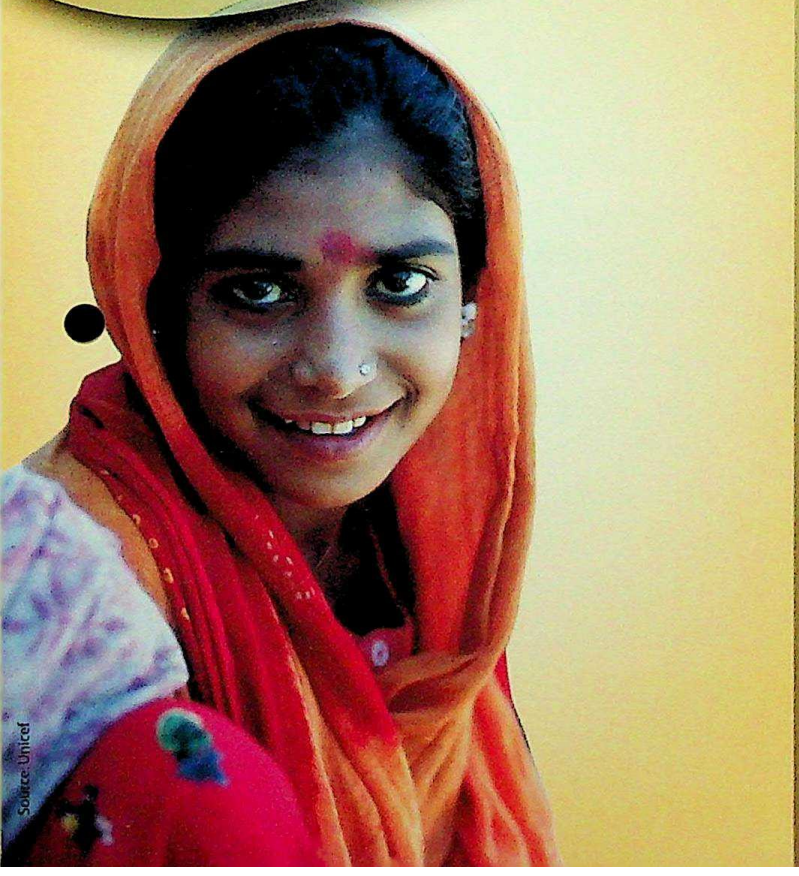
FROM THE AMERICAN PEOPLE

विस्तार vistaar
ज्ञान से व्यवहार तक
From Knowledge to Practice

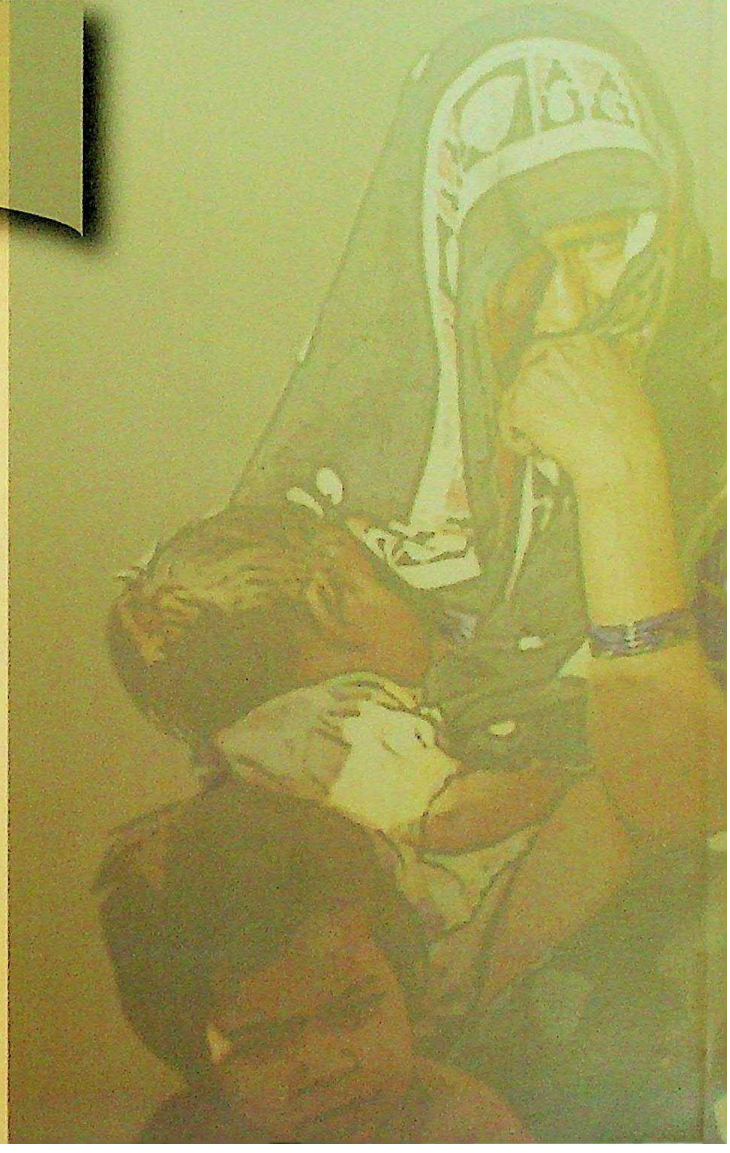
The Vistaar Project
विस्तार परियोजना

From Knowledge to Practice
ज्ञान से व्यवहार तक

Assisting Government of India and the State Governments of Uttar Pradesh and Jharkhand in taking knowledge to practice for improved maternal, newborn and child health and nutritional status



Source: Unicef



Why

is the Vistaar Project needed?

Despite knowledge of many simple and proven interventions, maternal, newborn and child health and nutritional (MNCHN) status is still unacceptably poor in many parts of India. The Vistaar Project assists the Government maternal, newborn and child health and nutrition programmes, in taking knowledge to practice at scale.

Who

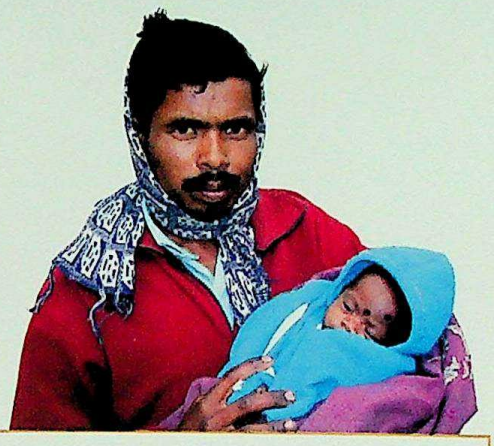
is the Vistaar Project?

The Vistaar Project is a five year project funded by the USAID and led by the IntraHealth International Inc., a US based non-profit health and development organisation, with support from international and national partners. The Project works closely with Government departments at the national and state levels including the Ministry of Health and Family Welfare, the Ministry of Women and Child Development, the National Health Systems Resource Centre, the National Institute of Health and Family Welfare and the National Institute of Public Cooperation and Child Development.

What

are the Project's main activities?

The Vistaar Project provides evidence based technical assistance in priority areas selected by the national and the state Governments (See below).



Project Focus Areas

Technical Areas	Objectives
1. Community-based Newborn Care	1. Provide strategic technical assistance
2. Nutrition (Complementary Feeding & Anaemia)	2. Generate knowledge and evidence about working at scale
3. Delayed Age of Marriage	3. Advocate for improved MNCHN programming
4. Skilled Birth Attendance	

To achieve its purpose, the Project is focusing on three main efforts:

Technical Assistance (TA): Providing strategic TA to strengthen MNCHN programmes of the Government of India, Government of Uttar Pradesh and Government of Jharkhand

Generating Evidence: Generating evidence about effective, efficient and expandable MNCHN interventions based on TA experiences

Advocacy: Advocating with Government of India, Government of Uttar Pradesh and Government of Jharkhand for increased priority and improved, evidence based programming in MNCHN, especially in the areas of nutrition and newborn care

The Project also has two cross cutting focus areas:

- Equity and Gender: Ensure that the Project efforts focus on improving MNCHN for the most needy and vulnerable
- Knowledge Management: Ensure that Project work is based on evidence and that the Project actively promotes and shares evidence to improve MNCHN

How

does the Project work?


Source: USAID

Overview of Programme Approach

- Providing strategic technical assistance to strengthen Government MNCHN programmes
- Generating evidence and knowledge about what works at scale
- Advocating for evidence based approaches

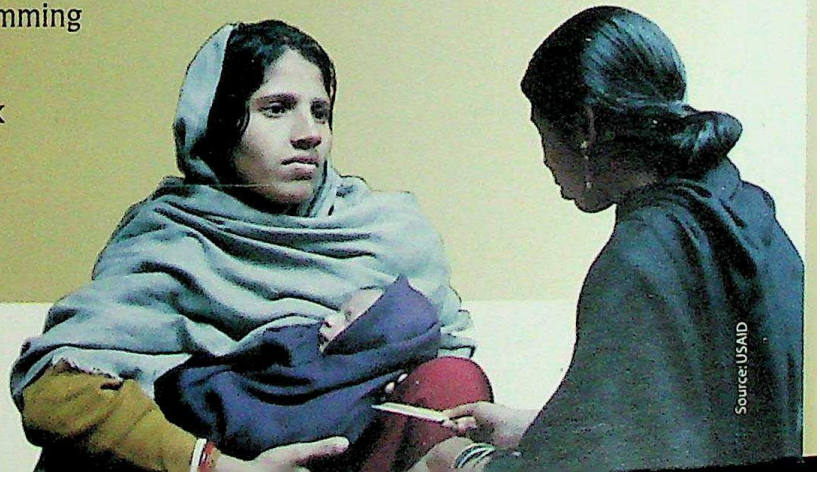
→ Effective Implementation Approaches at Scale →

Improved MNCHN

- Newborn health
- Nutrition
- Age of marriage
- Skilled birth attendance

The Project is committed to the following principles and work approaches:

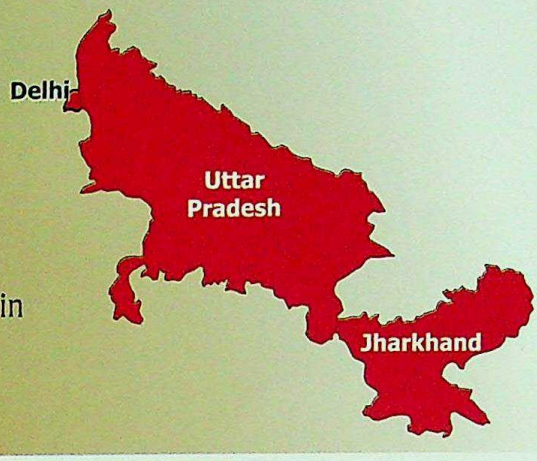
- Responsive technical assistance to Government MNCHN programmes
- Use of evidence in MNCHN programming
- Knowledge sharing
- Collaborative and participatory work processes
- Dedication to the values of integrity, learning and respect


Source: USAID

Where

does the Vistaar Project work?

The Project works nationally at Delhi and at the state level in Uttar Pradesh and Jharkhand.



Coalition for Sustainable Nutrition Security in India

The Vistaar Project serves as the Secretariat for the Coalition for Sustainable Nutrition Security in India, which is a high level advocacy group of policy, programme and political leaders, such as Government Ministers and senior representatives from the Planning Commission, media, NGOs, national and international development partners and the private sector. This group is committed to raising awareness, fostering collaboration and advocating for improved programmes to achieve nutrition security in India. Professor MS Swaminathan, an internationally recognised and respected leader in agricultural sciences and nutrition, and a Member of Parliament, chairs the Coalition.

The Coalition has prepared a Leadership Agenda for Action, the purpose of which is to increase efforts to address nutrition security and to provide Indian programme leaders with the most effective, evidence based recommendations to improve nutrition security in India.

For more details of the Coalition please visit: www.nutritioncoalition.in

INTRAHEALTH
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Vision
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Centre for Health and Social Justice

Strengthening the Evidence Base for Advocacy on Health Policy and Practice for Social Justice

Centre for Health and Social Justice (CHSJ) stands to further the fundamental right to health as promised by the Constitution, as well as international human rights treaties. Instituted by a group of researchers, development professionals, social activists, public health specialists, CHSJ has adopted a multi-pronged approach to strengthen the evidence base needed for advocacy on health and social justice issues through research and building leadership and operational capacities. CHSJ believes that constructive engagement with alliances of non-governmental and voluntary organizations and people's movements on the one hand and government and international organizations on the other is essential for empowerment, fulfillment of rights and for the functioning of a vibrant democratic p[illegible].

Mission

To promote human development, gender equality, human rights and social justice with specific reference to the field of health, in its widest interpretation.

Objectives

CHSJ is involved in influencing the discourse and practice of public health by:

- Building evidence on the impact of existing policies and programmes on the core health concerns of the marginalised, especially women.
- Identifying emerging issues and priorities for delivering accessible, quality health care services for women and other marginalised people.
- Strengthening advocacy for changes in health related policies and practices.
- Developing leadership and operational capacities for improved design, delivery and monitoring of quality, accessible health care services.

CHSJ's activities are currently divided into four broad thematic areas and two strategic interventions.

Thematic Areas

Reproductive and Sexual Health and Rights

CHSJ is engaged in building evidence on the impact of policies and programmes on reproductive and sexual health and rights, exploring and strengthening alliances on these issues and supporting advocacy action to change policies; which impact adversely on marginalised sections. Key areas of work under this theme are-

Securing Maternal Health Rights - CHSJ is actively engaged in addressing maternal health issues using the rights framework. Evidence building on understanding the roles and limitations of institutional delivery, women's entitlements and practices of traditional birth

attendants and advocacy on strengthening their roles in policies is done with the help of alliances and partners.

Ensuring the Right to Safe Abortion - CHSJ contributes to the discourse of women's right to safe abortion and campaign against sex pre-selection by providing support in terms of research, training and advocacy to ongoing campaigns and coalitions.

Improving Quality of Care and Informed Choice in Family Planning Services - CHSJ is involved in addressing the issue of informed choice and violation of rights due to systemic barriers through research and advocacy.

Addressing Coercive Population Policies - CHSJ holds the secretariat of National Coalition Against Two Child Norm. This is a network of organisations working on PRI issues, women's health & rights, human and Dalit rights. It aims to advocate with the state governments of Bihar, Rajasthan, Orissa, Maharashtra and Andhra Pradesh to repeal the two child norm.

ICPD@15 - CHSJ hosts the secretariat for a civil society review process of the ICPD@15 in India. It aims to take stock of gains and gaps as well as emerging issues in the policy and programmes related to population, reproductive, sexual health and rights issues.

Health Rights and Marginalised Groups

Social inequities and social marginalisation have a mutually reinforcing relationship. This impinges upon the health rights of these groups especially their access to and quality of health care services. CHSJ undertakes research and builds partnerships with such marginalised groups to consolidate local level advocacy and sensitize policymakers and donors. Key areas of work under this theme are:

Socially Vulnerable Groups and Public Health Programmes - Currently we focus on issues of access to and quality of health services availed by marginalised groups, under public health programmes pertaining to maternal health, family planning, tuberculosis, malaria and HIV/AIDS through research and advocacy.

NRHM Independent Review - CHSJ has been working with state and field level partners to build their capacity to undertake Social Auditing of NRHM. A long term programme on capacity building in Rapid Assessment of Health Programmes for civil society organizations has been initiated in collaboration with the University of Washington, Seattle (USA) and UNFPA (India).

Maternal Health and Social Exclusion Campaign - CHSJ is a key actor and part of Health Technical Advisory Group (TAG) of Wada Na Todo Abhiyan. Currently we provide technical support to a study on maternal health and social exclusion in six states.

Tracing Pharmaceuticals in South Asia - In collaboration with University of Edinburgh, CHSJ had undertaken research to trace the journey of oxytocin, rifampicin and fluoxetine from

production to consumption and to study the reasons for their use/misuse. This will be followed by advocacy action.

Men and Gender Equality

Challenging patriarchy and working towards gender equality is an integral part of CHSJ's mission. We believe that working towards gender equality must include working with men and boys to understand their privileges as well as the compulsions that they face within a patriarchal system. This understanding is essential to promote equality at all levels; i.e. individual, community and state through:

Research - A multi-country research in collaboration with SAHAYOG (India), International Center for Research on Women (ICRW) and PROMUNDO (Brazil), is in process to understand the current domain of state policy in the context of gender equality and inclusion of men.

Networking - CHSJ is the network secretariat for two emerging networks around men and gender equality- FEM (Forum to Engage Men), a national network and MenEngage South Asia and "Partners for Prevention" at South Asian level. We actively participate in the MenEngage global alliance process.

Capacity Building - CHSJ is involved in building capacity of institutions working with men and boys on issues of gender equality and addressing violence against women. The activities carried by us so far include providing technical support to research and educational projects as well as developing course curriculum.

Supporting Community Action - CHSJ is supporting community level action for developing leadership among men to address declining sex ratio and developing risk perception among youth around migration and HIV.

Community Action for Health Rights

This theme emerged as a result of systematic efforts of community monitoring process that was carried out across nine states in India. We understand community action as periodic surveys and studies, community based monitoring of health services and community ownership within accountability framework. The key areas of work include-

Promoting Community Action Under NRHM - CHSJ strives to empower, strengthen and motivate people to claim their health rights. We believe that in order to bring changes at the policy level and to influence the programme and policy makers, communities should take ownership of the programmes meant for them and assess whether or not their health needs and rights are being met.

The community monitoring process involves a three way partnership among health system, health providers and civil society (CBOs, NGOs and PRIs).

Social Auditing of NRHM - CHSJ has been facilitating annual feedback on the NRHM with special emphasis on RCH -2 components through social audit process. We build capacities of civil society organisations to conduct social audit of health services.

Strategic Interventions

Capacity building and information management are two important focus areas of strategic interventions that help in building partnerships and developing field capacities to raise accountability issues.

Capacity Building - It is a key strategy in the process of empowerment of people and building evidence base, both crucial for policy change. We conduct trainings on advocacy and leadership and also offer internships that enable evidence building.

Information Management - Systematic organisation and dissemination of knowledge and information are essential for building and sharing knowledge, raising consciousness, creating consensus, receiving feedback and pushing for change. This is accomplished through web enabled services such as CHSJ Website, Reprohealth_India - an interactive listserv, and a weekly health news update. Along with this, we also prepare study reports and resource materials.

Organisational Structure

We have the following institutional mechanisms for improving organisational efficacy and accountability.

- **Governing Board** - The governing board provides active support and technical inputs during planning and review of all CHSJ's activities.
- **Advisory Groups** - Independent advisory groups exist for projects especially for research based activities.
- **Core Group** - It has been appointed to deal with functional matters and maintain quality.
- **Team** - The CHSJ team comprises full time professionally trained staff, consultants and research interns.

Partnerships and Collaborations

The work of CHSJ has been enriched by partnerships that have been developed with a wide range of organisations, networks and coalitions at the state, national and international level.

- **International** - ARROW, Liverpool School of Tropical Medicine, Population Leadership Programme, University of Edinburgh, University of Washington
- **National** - AIDAN, CENTAD, Chetna, CommonHealth, FPAI, ICRW, IPPF, MASVAW, NIHFW, PFI, PRAYAS (Rajasthan), SAHAYOG, SUTRA

- **Networks** - FEM, Gujarat Dai Sangathan, Healthwatch Forum, Human Rights Law Network, Janadhikar Manch, Jan Swasthya Abhiyan, MenEngage South Asia and "Partners for Prevention", National Campaign on Dalit Human Rights, Wada Na Todo Abhiyan

Financial Support

CHSJ's work has been financially supported by - Ford Foundation, OXFAM (India), Packard Foundation, Population Foundation of India (PFI), SAHAYOG, Sir Dorabjee Tata Trust (SDTT), UNFPA, UNIFEM, UN Resident Commissioner Office, UN Trust Fund.

Governing Board

- Abhijit Das - Director, CHSJ and Clinical Assistant Professor, Department of Global Health, University of Washington, Seattle (USA).
- Amar Jesani - Founding Trustee, Anusandhan Trust. Founder of the Forum for Medical Ethics Society.
- Rajani Ved - Public Health Specialist.
- Renu Khanna - Founder Member, SAHAJ, Baroda.
- Satish Kumar Singh - Deputy Director, CHSJ. Convenor, MASVAW.
- Subhash Mendhapurkar - Director, SUTRA.
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Centre for Health and Social Justice is registered under the Indian Trust Act (Trust No. 2956, dt. 22/03/06)

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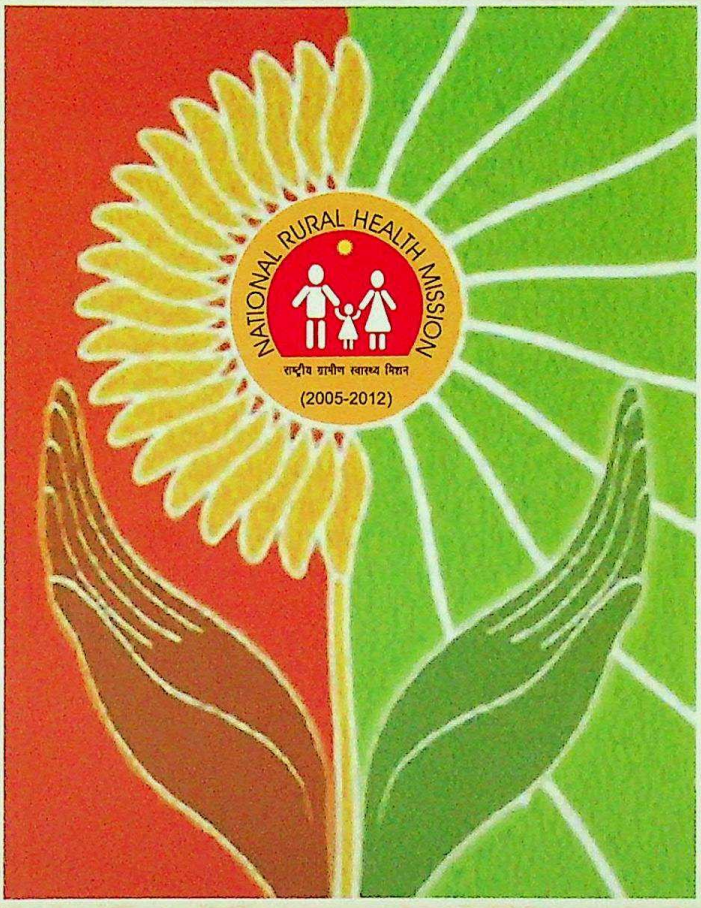
Community Based Monitoring of Health Services Under NRHM First Phase 2007



National Secretariat on Community Action-NRHM
Population Foundation of India (PFI) & Centre for Health and Social Justice (CHSJ)

Community based monitoring of Health services under NRHM First Phase 2007

Community Monitoring in NRHM - The National Rural Health Mission (NRHM) was launched on the 12th of April 2005 with the goal of improving the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. In order to ensure that the services reach those for whom they are meant the NRHM proposes an intensive accountability framework that includes Community-based Monitoring as one of its key strategies. According to the Timeline of Implementation proposed in the Framework of Implementation the system of community monitoring is supposed to be implemented to the extent of 50% by 2007.

The accountability framework proposed in the NRHM is a three pronged process that includes internal monitoring, periodic surveys and studies and community based monitoring. Community Monitoring is also seen as an important aspect of promoting community led action in the field of health.

The provision for Monitoring and Planning Committees has been made at PHC, Block, District and State levels.

The adoption of a comprehensive framework for community-based monitoring and planning at various levels under NRHM, places people at the center of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.

Process of Community Monitoring - The exercise of "Community monitoring" involves drawing in, activating, motivating, capacity building and allowing the community and its representatives (e.g. community based organizations, people's movements, voluntary organizations and Panchayat representatives) to directly give feedback about the functioning of public health services, including giving inputs for improved planning of the same. The community and community-based organisations will monitor demand/need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. The monitoring process will include outreach services, public health facilities and the referral system.

Some of the frameworks on which Community Monitoring may be done, and which are included within the NRHM are as follows:

1. **Village Health Plan, District Health Plan**
2. **Entitlements under the Janani Suraksha Yojna**
3. **Roles and responsibilities of the ASHA**
4. **Indian Public Health Standards for different facilities like Sub Centre, PHC and CHC**
5. **Citizen's Charter and so on.**

Initiating the Community Monitoring process

The Advisory Group on Community Action (AGCA) is a Standing Committee within the NRHM. The AGCA has proposed a detailed proposal for Community Monitoring to the Union Ministry of Health and Family Welfare. The Union Ministry of Health and Family Welfare (MoHFW) has accepted this proposal and has initiated the First Phase of the Community Monitoring from March 2007. It has been decided that the first phase will be of eleven months (March 07-Jan 08) and cover eight states (Assam, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu).

In the first phase Community Monitoring will cover a selected number of districts in each state (depending upon the size of the state). In each of these districts, three blocks will be covered and within each block 3 PHCs will be covered and within each PHC area, 5 villages will be covered. This will lead to a total of 1350 villages, 270 PHCs and 90 blocks being covered for Community Monitoring in the first phase.

The entire process of Community Monitoring will be implemented as a partnership between the Health Department and Civil Society Organisations. This process will be supervised at the National level by the AGCA and at the State level by a joint State Community Monitoring Mentoring Group to be set up specifically for this purpose. The AGCA will play the role of facilitation and support to the entire process, working with the mentoring teams and organizations at state level. A National Secretariat has been set up jointly by Population Foundation of India and

Centre for Health and Social Justice to implement this pilot programme in consultation with the AGCA and the Mission Directorate.

Role of Civil Society Organisations in Community Monitoring

- The civil society organisations will have three kinds of roles in this process - firstly, as members of monitoring committees; secondly, as resource groups for capacity building of monitoring committees; and thirdly, as facilitating agencies assisting the process of setting up the monitoring committees and for the collection of information. To ensure wider participation, a diversity of civil society networks and organizations with experience of rights based activities and accountability enforcing activities are sought to be involved in this first phase.

The overall responsibility for implementing the first phase of Community Monitoring also rests with Civil Society Organizations.

Photographs courtesy: KRITI Resource Centre, Lucknow

Activities within the Community Monitoring Process

The following activities are envisaged within the Community Monitoring process

At the National Level through the National Secretariat

1. Developing Curriculum and Materials for orientation process at different levels.
2. Developing a common protocol for community monitoring including tools for adaptation at the state level, if necessary.
3. Developing a system of documentation for the entire process.
4. Supporting state level implementation.

At the State Level

1. Setting up of the State Community Monitoring Mentoring Group.
2. Identifying state level secretariat and district level implementing NGOs that will facilitate the activities given below.
3. Formation, orientation and activation of monitoring committees at village, PHC, Block and District Level.
4. Training of Block level facilitators and further orientation of Community Monitoring teams at all levels.

5. Conducting Community Monitoring at the Village, PHC, Block and District levels on a periodic basis.
6. Public sharing of information through Jan Sunwai/ Jan Sanwad.

It is anticipated that the process of community monitoring initiated in the first phase will lead to formulation of bottom-up District Action from the subsequent year (2008) in those districts.

Timeline of Activities

The first phase of Community Monitoring is an intensive eleven month process starting from March 2007 and ending in January 2008. The time line of activities for this phase is as follows:

* **March 07 to May 07** - Preparatory Phase - Setting up National Secretariat, State level Community Monitoring Mentoring Group established; First draft of materials, curriculum and tools ready.
* **June 07 to November 07** - State level activities initiated and first round of Community Monitoring and Sharing has been completed in all 8 states.
* **December 07 to January 08** - Review and Evaluation.

It is anticipated that the second and extended phase of Community Monitoring can be implemented in the next year.

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August 2007

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AGENDA

State Level Consultation on Community Mobilization
Bhopal, 11th August 2010
Venue: Hotel Noor-Us-Sabah
VIP Road Bhopal

Time	Session	Resource Person
9:15 am to 9:25 am	Opening address	Mamta Kohli, DFID India
9:25 am to 9:40 am	Objectives of the consultation	Priti Dave Sen, MP TAST
9:40 am to 10:00 am	Community centric focus of DFID in India	Anne Philpott, DFID
10:00 am to 10:20 am	Communitization approaches in Madhya Pradesh	Anil Mishra, MP TAST
10:20 am to 10:40 am	Community mobilization approaches and lessons from CARE	Satish Kumar, CARE
10:40 am to 11:00	QA session on CARE presentation	Open for the group Facilitor-Anil
11:00 am to 11:10 am	**TEA**	
11:10 am to 11:25 am	Child to Child to community mobilization- UNICEF experience	Bhai Shelly, UNICEF
11:25 am to 11:30 am	QA session	Facilitator Dr Rajesh
11:30 am to 11:50 am	Lessons from EKJUT/UCL trial	Ms Nirmala Nair, Dr Prasanta, EKJUT
11:50 am to 12:10 pm	QA session on EKJUT/UCL presentation	Open for the group Facilitator-Priti Dave Sen
12:10 pm to 12:30 pm	Community mobilization approaches in SURE START (PATH)	Kumar Vikrant, PATH
12:30 pm to 12:50 pm	QA session on PATH presentation	Open for the group Facilitator-Sanjay Kumar
12:50 noon to 01:10 pm	Lessons from Chhattisgarh- Community mobilization through Mitanins	Avinash Loomba-SHSRC, Chhattisgarh
01:10 pm to 01:25 pm	QA session on Chhattisgarh presentation	Open for the group Facilitator-Mamta
01:25 pm to 02:00	[illegible]	
02:00 pm to 02:30 pm	Evidence on Community and System Strengthening Approaches for improved health and nutrition- VISTAAR	Laxmikant Palo, VISTAAR
02:30 pm to 03:00 pm	Policy environment and national perspective on community action	Dr Abhijit Das, Centre for Health & Social Justice (CHSJ)
03:00 pm to 03:30 pm	Common discussions on presentations	Facilitator- Ms Thelma Narayan
03:30 pm to 03:45 pm	TEA	
03:45 pm to 04:45 pm	Panel discussion – contextualizing proven community mobilization	Mr SR Mohanty Ms.Thelma Narayan, MS Loveleen

	approaches to MP situation-inputs for developing draft strategic framework	Kacker, Dr Abhijit Das Ms Nirmala Murthy DFID Representative
04:45 pm to 05:45 pm	Concluding remarks	Chair Person
05:45 pm to 06:00 pm	Structured Feedback session	Entire group
06:00 pm to 06:05	Vote of Thanks	GS Sachdev, MP TAST
06:05 pm	**TEA**	