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# **Community monitoring**

A strategy to watch out for

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There is an increasing recognition that, despite significant improvements in health parameters such as life expectancy at birth and the reduction of infant mortality, people in many parts of India continue to have very poor access to health-care services and their health status remains abysmal. Public spending on health in India, especially on preventive and promotive health, is also very low. Conversely, private and out-of-pocket expenditure on health is very high – about three times higher than public expenditure. Furthermore, there is the need to transform the health system into an efficient, transparent and accountable system delivering affordable and quality services. The National Rural Health Mission (NRHM, or the Mission) has been conceived and is being implemented to bring about these fundamental changes in the way health-care services are delivered to the rural poor (Managers' manual on community based monitoring 2008).

The NRHM was launched in 2005 on a nationwide scale by the Ministry of Health and Family Welfare in the Government of India. It has a vision to provide universal access to equitable, affordable and high-quality health care, while also being accountable and responsive to the needs of the people, especially those residing in rural areas, the poor, and women and children ('Community monitoring of health services takes off' 2007). The NRHM aims to undertake structural changes to the health system to enable it to effectively handle increased financial allocations, as promised under the National Common Minimum Programme. It also seeks to promote policies that strengthen public health management and service delivery to rural populations throughout the country, with a special focus on 18 states that have weak public health indicators and/or weak infrastructure. The NRHM is an umbrella program under which all national health programs and health strategies of the Government of India are implemented. The major stakeholders in the NRHM are Accredited Social Health Activists, Auxiliary Nurse Midwives and Anganwadi (health) workers, Panchayati Raj Institutions (PRIs) and non-governmental organisations, district administrations and state governments. In its very short eight-year journey, some very significant gains have

already been made. For example, Rogi Kalyan Samitis (Patient Welfare Committees, responsible for establishing and overseeing proper management structures) have been implemented in 570 district hospitals, 4210 community health centres and 16 920 primary health centres ('NRHM – The progress made so far' 2011).

In order to achieve its goals and objectives, the Mission seeks to forge effective partnerships between the central, state and local governments. Flexible mechanisms and engaged practices have been built into the Mission so that local needs and priorities can be identified and addressed and local initiatives promoted. Different strategies and initiatives have been tried and successfully implemented in communities to facilitate active community participation. These initiatives include household and health facility surveys; local health camps; periodical public hearings, where people share their experience of seeking health care; training and orientation sessions for village health teams; and involving self-help groups, community-based organisations (CBOs), parent-teacher associations, literacy volunteers, etc. (Manual on community based monitoring 2006). This article explores one particular aspect of these responsive processes – community ownership and participation in management – which has been seen as an important prerequisite for the long-term success of the NRHM.

The contributing authors have practical experience under different NRHM programs, namely: National Vector Borne Disease Control Program; Revised National Tuberculosis Program; Integrated Disease Surveillance Project; Reproductive & Child Health phase II, including Janani Suraksha Yojana (a Government of India scheme for reducing maternal and infant mortality rates); Rogi Kalyan Samitis; Community Based Monitoring; and National Family Welfare Program. In all these health-care delivery programs, the authors have held managerial and administrative roles, which have contributed to the successful implementation and evaluation of the programs. The Sri Balaji Vidyapeeth University is also helping the Department of Community Medicine with the implementation of different programs incorporated under the NRHM. Health-care centres have been established in rural as well as urban areas for the delivery of these services to the community.

### **OBJECTIVES OF COMMUNITY-BASED MONITORING**

Community-based monitoring is being implemented under the auspices of the NRHM with an objective of providing regular and systematic information on community needs, which can be used to guide the planning process. It is also meant to provide feedback on the status of fulfilment of entitlements, the functioning of various levels of the public health system and service providers, gaps and deficiencies in services and levels of community satisfaction, in order to facilitate corrective action in compliance with a framework of accountability. In this way the community and community-based organisations become equal and active partners in the

planning and responsive functioning of the public health system (Managers' Manual on CBM 2008).

### **FUNDAMENTALS OF COMMUNITY-BASED MONITORING**

To ensure that health services reach those for whom they are intended, the NRHM has an intensive accountability structure consisting of a three-pronged process: internal monitoring; periodic surveys and studies; and community-based monitoring (CBM). This latter element places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled (Managers' Manual on CBM 2008). CBM is also seen as an important vehicle for promoting community-led *action* in the field of health. The primary means for establishing and ensuring the implementation of CBM was the creation of Monitoring and Planning Committees at all levels of health provision: PHC (on-the-ground basic health units that provide integrated curative and preventive health care to rural populations); block (about 100 villages and a population of about 80 000 to 120 000); district (a type of administrative division usually made up of multiple blocks managed by a local government); and state. The monitoring process involves a three-way partnership between health-care providers and managers (the health system); the community/CBOs/NGOs; and Panchayati Raj Institutions (a three-tiered structure of rural local self-government in India, linking the village to the district).

CBM involves drawing in, activating, motivating and building the capacity of the community and its representatives, so that they may directly give feedback about the functioning of public health services, including input to improving planning of those services. The monitoring process covers outreach services, public health facilities and the referral system (Community based monitoring of health services under NRHM 2006). The focus of the monitoring process is mainly on 'fact finding' and 'learning lessons for improvement' rather than on 'fault finding' (Manual on community based monitoring 2006).

### **STAGES OF COMMUNITY-BASED MONITORING**

In a nutshell, CBM comprises five stages: preparatory activities; capacity building and training of trainers at district level; community assessment; interface meetings; and the evaluation of feedback (Manual on community based monitoring 2006).

Of foremost importance in the first stage are the identification of stakeholders and the formulation of a task force. This group must include representatives from civil society, policy-makers and coordinating agencies. It is responsible for planning, designing, advising and overall monitoring of the community process.

The second stage deals with capacity building and the training of trainers at the district level. This is important because most districts have weak health delivery systems, incomplete health-related information and inadequate healthcare workers/

logistic support/health financing. Thus, the district is the unit most in need of strengthening. Trainers from the health system, Panchayat (village council) representatives, beneficiary representatives, NGOs and CBOs all receive training through district level workshops. NGOs and CBOs are trained as they assist in the collection of information during the assessment process (stage 3) at all levels, from the village to the state. This includes monitoring demand, coverage, access, quality, effectiveness, behaviour and the presence of healthcare personnel at service points, as well as any possible denial of care and negligence. In addition, participants need to be trained in the clear-cut demarcation of roles and responsibilities, accountability building and health rights, which have to be defined at the outset of the assessment process.

The third stage focuses on the development of tools and techniques that are to be used in the community assessment. These include in-depth interviews, focus group discussions (FGDs), case studies, record reviews and colour-coded 'report cards'. The colour-coded report card is used to generate feedback on the degree of a citizen's satisfaction with the quality of service provided by public agencies. It helps in identifying weak or deficient areas requiring immediate attention within an agency. It also encourages initiation of consumer-friendly practices and policies and increased transparency in services. A colour-coded report card is used to indicate the progress of activities. For example: green = 75–100 per cent of activities completed or on track; yellow = 50–74 per cent of activities completed or on track; red = 1–49 per cent of activities completed or on track. A community score card (CSC) empowers citizens to provide immediate feedback to the providers. The CSC can then be used as a tool to achieve social and public accountability as well as responsiveness from service providers. These cards are tools that encompass the best of social audit and citizen report card techniques.

The fourth stage represents the crux of CBM. This is where the data and feedback are discussed. Community monitoring exercises at both primary health centre (PHC) and block levels include a Jan Samvad (public dialogue) or Jan Sunwai (public hearing). Here, individual assessments and testimonies by local CBOs/NGOs are presented. These are facilitated by district and block facilitation groups in collaboration with village representatives.

The fifth and final stage of CBM deals with the evaluation of feedback obtained from different levels of Monitoring and Planning Committee meetings (including data entry and analysis, followed by report submission, review and documentation). Data is compiled, collated and analysed in a standardised manner at different levels depending upon the availability of services, so as to aggregate data and obtain specific information about the individual service. This stage has a special significance from the program manager's point of view: based on the final analysis, corrective measures are planned and then directed

towards villages whose report cards show either the red or yellow colour. Finally, the Monitoring and Planning Committee at state level conducts an annual public meeting, which is open to all civil society representatives. Here the state's NRHM report and independent reports are presented and reviewed, which enables corrective action to be taken (Managers' manual on community based monitoring 2008).

Significant improvements in health services have been achieved since the introduction of CBM, mainly due to a combination of NRHM 'supply side' inputs and 'demand side' push by CBM. For example, if the Government wants to improve the immunisation coverage in a district with the help of CBM, the following steps will be phased in:

The community-based monitoring process will be implemented under the overall supervision of the specially constituted Task Group of the Advisory Group on Community Action. In addition, a State Mentoring Team will be formed consisting of 7 to 11 members, of whom at least 4 to 7 will be civil society representatives. One of the state level NGOs will be secured to work under the direction of the State Mentoring Team.

A workshop will be organised by the Mentoring Team for state and district health officials, as well as PRI representatives and NGO networks from the districts. Training of the trainers for the facilitating teams (from the district(s) where immunisation coverage will be monitored) will be conducted by voluntary sector facilitators and state government officials.

In the district(s), the process of community-based monitoring will be facilitated by NGOs, district health officials and PRI representatives. Initially, community Monitoring Committees will be formed beginning with village committees, then PHC, then block, and then district committees. A few members from the village community will be included in the PHC committee; similarly, a few PHC committee members will be included in the block committee; and so on. Adequate representation of women, scheduled castes and scheduled tribes is required in the various committees.

Community-based monitoring of health service provision occurs next, with results (e.g. number of field immunisation sessions carried out; number of beneficiaries; any increase in the rates of adverse effects following immunisation; etc.) shared at all levels, including via a public dialogue or public hearing, which is moderated by the district and block facilitation groups in collaboration with Panchayat representatives.

Finally, review and collation of summary reports occurs, with further in-the-field interaction. Based on the evaluation, measures will be taken for the improvement and reorganisation of the health services. In the case of immunisation, all of the identified shortcomings/hurdles will be individually addressed and corrective measures will be taken to improve upon the results. The modified plan will be re-implemented in the area and again will be discussed in subsequent public hearings.

### **PARAMETERS FOR THE SUCCESSFUL IMPLEMENTATION OF COMMUNITY-BASED MONITORING**

CBM brings people together from different groups, castes, religions and sectors to form partnerships. Through these partnerships, the community can identify their common concerns and possible solutions through the collection, evaluation and sharing of information. CBM networks can often help in the development of meaningful collaborations between citizens and government, thereby improving public involvement in community decision-making. CBM can also help in the enhancement of local governance structures by bringing together the creativity, skills and resources of many different individuals. The community monitoring exercises and collation of information are organised at various levels – primary health centre, village, block, district – and the aggregated information is then passed upwards to the state government. This comprehensive information not only helps the program managers to build strategies to suit local needs on a sustainable basis, but also allows community members to increase their knowledge about local health problems. Communities can then use this information to set their own limits on development and measure whether they are met. Ultimately, CBM can contribute towards building ‘social capital’ and resilience in participating communities.

From the in-the-field experience of CBM, a number of factors have been identified which, if monitored systematically, can ultimately lead to promising results over the long term. The most important factor is that, in order to engage the community in the process, the approach has to be context specific (i.e. the approach that is planned for tackling a problem should not be a generalised solution; rather it should suggest what should be done in that particular local setting to reduce that specific problem). This approach needs to be complemented by a continuous process of community mapping and an assessment of community participation and capacity building. Secondly, the establishment of an information delivery mechanism that includes identification and communication of the community’s information needs is necessary, as community-based monitoring programs are often demand driven and the acquired new information is integrated into decisions and policies for the benefit of the society. Thirdly, the gained experience should be meaningful for participants (Lefler 2010).

For any public health initiative to be successful, coordination among all stakeholders is critical. This should be encouraged right from the grassroots stage and mechanisms should be in place for effective communication, facilitation and negotiation. In order to achieve long-term benefits from CBM, another indispensable element is the development of strong partnerships, which not only facilitates capacity building but also the pooling of resources. Collaborative approaches are further developed by encouraging forums for discussion with all stakeholders and by implementing a process of community visioning to define common goals and challenges (Lefler 2010).

## **MOVING FORWARD: CURRENT STATUS AND FUTURE CHALLENGES**

The process of developing and implementing CBM is a delicate one that needs to be handled carefully. Community mobilisation experiences in the health sector show that the initial response of community representatives is often to assertively point out a whole range of problems, deficiencies, gaps and even alleged cases of denial of health care which may be quite difficult for the health officials to digest and absorb in the right spirit – and can, at times, lead to a virtual breakdown of dialogue. Maintaining the vitality and authenticity of the process, and not allowing complete polarisation, which would disrupt the dialogue and convergence process, requires sensitivity. Launching the CBM process on a large state-wide scale may conceivably lead to potentially disruptive situations and even the de-motivation of health functionaries; it is hoped this can be avoided by first working out the process in pilot areas and building appropriate checks and balances into the methodology before moving to generalisation.

Community-based monitoring is still an emerging concept, being piloted in nine states of India. The program has achieved success in Karnataka and Orissa States (Gaitonde et al. 2007; National dissemination meeting 2010). In Maharashtra, with the collaboration of the NGO, Support for Advocacy and Training to Health Initiatives (SATHI), the initial implementation of CBM was believed to be a unique 'social experiment' where, for the first time, community accountability, feedback and health sector dialogue mechanisms were systematically implemented on a significant scale within spaces supported by the public health system. Thus, CBM was viewed as a significant opportunity to deepen, broaden and make sustainable the processes for community accountability for health services and establishment of health rights (Kakde 2010).

However, while considerable strides toward implementing community-based monitoring have been made, some aspects of the process continue to prove challenging in several communities. These include achieving long-term commitment by all stakeholders to community monitoring; identifying information needs of the decision-makers and establishing links with the local decision-making structures in order to achieve persistent influence; establishing an integration mechanism for all the gathered information to ensure a comprehensive assessment of the local health scenario; developing improved systems for managing data; and, finally, gaining the long-term commitment of government for scientific support, coordination, advice and assistance.

Apart from all the above challenges, in order to ensure the continuation and growth of community-led monitoring, support activities must continue at a national scale in the areas of capacity building for monitoring; regular training sessions; development of advanced techniques and strategies for information management, data evaluation and reporting; facilitation of capacity building as a means to develop and nurture networks and partnerships,

leadership skills, advocacy, negotiation and communication; and continuous monetary support to initiate, facilitate and contribute towards collaborative initiatives.

## CONCLUSION

Community-based monitoring of health services is a key strategy of the National Rural Health Mission to ensure that services reach those for whom they are meant. This proposed framework is usually consistent with the 'Right to Health Care' approach since it places the health rights of the community at the centre of the process. It seeks to address the gaps in the implementation of various programs and thereby enhance the transparency of the system right down to the grassroots level.

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