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CONTENTS

COMMUNITY MONITORING FOR STRENGTHENING RESPONSIBLE PARTICIPATION LEVERAGING ICT – EXPERIENCE OF AROGYA SHRENI IN KARNATAKA AND JAN AROGYA SHRENI IN JHARKHAND

Authors:
Basavaraju R Shrestha, Ananya Samajdar

GRAAM

Abstract

Monitoring, which has the goal of ensuring the implementation of activities vis-à-vis the plan, is often considered a fault-finding process. The essence of monitoring, however, is to be vigilant about the processes and align the project activities to achieve the planned outputs. Community is usually considered as a beneficiary or target of interventions, instead of being given the status of stakeholder. Community, in practice, is often either considered a policing entity or remains a passive service recipient group. The effort previously done by GRAAM through its Arogya Shreni project in Karnataka, and being done presently in Jharkhand through its Jan Arogya Shreni action research project, is to provide the community with 'stakeholder' status. Involving the community as part of the solution instead of seeing them as the reason for the problem is a paradigm shift in planning and thinking.

The National Health Mission recognises that the community should be an integral part of the public health system. Jan Arogya Samiti is one such platform at the grassroots level, created through the guidelines of Ministry of Health and Family Welfare, to enable effective community monitoring of Health and Wellness Centres. While expecting the community to participate in such structures, it is most important to create an enabling environment, build capacity and establish means and ways (process) for their engagement. The Jan Arogya Shreni action research project of GRAAM is one such initiative to establish processes of community engagement. Evidence from GRAAM's Arogya Shreni project in Karnataka shows how the community participates in a positive way if stakeholdership is provided. Initial insights from the Jan Arogya Shreni experiment in Jharkhand reveal that the community is interested in participating in planning and monitoring health care delivery. This paper elaborates the concept, design and outcomes of community participation in monitoring of health services at the grassroots level. The innovation in the whole process lies in how the project leverages simple communication technology for unbiased, free and efficient monitoring.

Keywords: Community monitoring, Participation, Health systems, Jan Arogya Samiti, Technology.

1. Community Monitoring – Meaning, Purpose and Spirit

Traditionally, Monitoring and Evaluation (M&E) has been the domain of experts who measure performance against predetermined indicators, using standardised procedures and tools (Dillon, n.d.). However, in recent years there has been an emphasis on participatory approaches to monitoring such as Community-Based Monitoring (CBM). In India, mechanisms of participatory monitoring have been implemented in multiple sectors such as health (Village Health Sanitation and Nutrition Committee or VHSNC and Jan Arogya Samiti), education (School Development and Monitoring Committee), livelihood (social audit under MGNREGA), and WASH (Jal Samitis or Water User Groups).

The term "Community-Based Monitoring" (CBM) is generally used for the relevant participatory mechanisms in the public health domain, though its features make it applicable to other development domains. The Global Fund defines CBM as "Mechanisms that service users or local communities use to gather, analyse and use information on an

ongoing basis to improve access, quality and the impact of services, and to hold service providers and decision makers to account" (Global Fund, 2020). A key principle of CBM is that communities decide what to monitor, and act upon the data collected (Global Fund, 2020) Garg & Ray Laskar (2010) define CBM as a process that involves "drawing in, activating, motivating, capacity building and allowing the community and its representatives e.g., community-based organizations (CBOs), people's movements, voluntary organizations and Panchayat representatives, to directly give feedback about the functioning of public health services."

CBM is thus needed to strengthen community oversight, ownership and expression of community voices with respect to service delivery. It can help to collect data that is essential for scrutinising public programmes and improving policies and programmes; the evidence and observations resulting from CBM can often be quite different from the results of monitoring undertaken or controlled by governments (Global Fund, 2020). The accountability that can be strengthened through CBM can in turn strengthen the access, quality and responsiveness of service delivery.

Monitoring is often considered a fault-finding process. However, the essence of monitoring is to be vigilant about the process and align the project activities to achieve the planned outputs. We term community monitoring as supportive supervision. It is to provide necessary support to make the program successful by supervising the inputs, process and outputs, periodically and responsibly. In its desired or ideal form, CBM is constructive in nature; the concept of CBM emphasises the spirit of 'fact-finding', 'learning lessons for improvement' rather than 'fault finding' (Garg & Roy Laskar, 2010) and being part of the solution.

In the world of development, community is usually considered as a beneficiary or target of interventions, instead of being given the status of stakeholders. Community, in practice, is often either considered a policing entity or remains a passive service recipient group. In CBM, however, the community is considered not just a service receiver but a stakeholder that can take responsibility to improve the health service delivery. CBM does not end with the members scrutinising service providers; it also includes acting on the evidence and observations gathered. Advocacy based on the evidence and observations gathered is thus an essential outcome of community-based monitoring (Global Fund, 2020).

An effective community-based monitoring system thus should lead to nuanced constructive feedback that can be a force for positive change, and can also make the community (or its representatives) find solutions to perceived problems.

2. Challenges in Community Monitoring

1. CBM has highly desirable features and objectives. However, as the literature and authors' practical experience with CBM experiments reveal, implementation of CBM may be ridden with challenges. These may lead to a gap between the intent and reality of CBM.
2. The foremost challenge is to make service providers appreciate the ability and wisdom of the community, consider them as stakeholders and not just beneficiaries, and foresee the long-term advantages (rather than initial challenges) of engaging with them.

3. The need to build the capacity of the members of the community who would be involved in CBM, and to ensure not just the transfer but also the sustained retention of the required knowledge and competencies
4. The difficulty of motivating, building and sustaining people's voluntary participation in meetings and various monitoring activities.
5. Lack of consistent and stable funding (Global Fund, 2020).
6. The possibility of elite capture or domination by powerful interests (Dillon, n.d.)
7. The processes involved in executing CBM are complex and require contextualising in response to local community structures, needs, and diversities.
8. Attitudinal change is necessary among all stakeholders in order to have more synergy. A paradigm shift is required in perceiving their role from 'questioning' to 'understanding'.
9. There is a need for effective coordination and strong partnership among all stakeholders. This may be difficult to achieve in social contexts which have divides based on caste, religion, ethnicity, class etc.

3. Mechanisms for Community Monitoring under National Health Mission: Communitization of Primary Health Care

The Communitization of health care (i.e., the promotion of community action in health care, especially primary health care) has been a longstanding priority under the National Health Mission (NHM). Under this priority, structures such as Village Health Sanitation and Nutrition Committee (VHSNC), Rogi Kalyan Samiti (RKS) and Planning and Monitoring Committee (PMC) were created for enhancing people's participation in planning, implementing and monitoring primary health care (details in Appendix I).

With the advent of the Ayushman Bharat and the conversion of Sub Health Centres and Primary Health Centres to Ayushman Bharat Health and Wellness Centres (AB-HWCs), a need was felt for creating a Health Facility Committee at the Sub Health Centre-Health and Wellness Centre (SHC-HWC) level, equivalent to the Rogi Kalyan Samiti at PHC level. The Jan Arogya Samiti (JAS), created at the level of the SHC-HWC, is supposed to serve as a platform for community participation in the management and governance of the SHC-HWC. One of the functions of the JAS is to "support and facilitate the conduct of activities pertaining to social accountability at AB-HWC in coordination with VHSNCs." (NHM, n.d.) Such a function implies that JAS have an important potential role to play in the community monitoring of SHC-HWCs. More details on the role and composition of JAS can be found in Appendix I.

4. The Arogya Shreni Experiment

4.1. Background

The Arogya Shreni experiment was conceptualised by Grassroots Research and Advocacy Movement (GRAAM) to create a platform and establish a process for community

engagement in public health delivery as a stakeholder. Information and Communication Technology (ICT) was leveraged to make the initiative scalable, cost-effective and interesting to the stakeholders. It facilitated Community Monitoring of rural Primary Health Centres (PHCs) in Mysore District, Karnataka. The endeavour was to experiment whether the community can really participate in monitoring the health system, which is perceived as a more technical subject that the common man cannot understand. The experiment also intended to understand whether 'community initiated' change through grassroots advocacy and dialogue is possible. The Planning and Monitoring Committee (PMC) platform was strengthened with necessary capacities related to monitoring as part of the experiment.

4.2. Project Framework

Arogya Shreni was designed as a 3-year action research project (2011-2014), covering seven talukas and 112 rural PHCs of Mysore district. It was intended to build the capacities of local communities in monitoring the PHCs. PMC members were the community monitors as mandated by NRHM. The selected PMC members participated by responding to a questionnaire about the availability and quality of services of their PHCs using Interactive Voice Response System (IVRS) technology. The responses to the questionnaire were used to construct facility scores and a ranking of PHCs in the district. With increasing awareness, the community members took a step beyond just monitoring. They were involved in carrying out advocacy efforts at the grassroots level to bring about changes in their PHCs. The project's field facilitators worked intensively with PMC members, facilitating regular meetings among the members, carrying out dialogue with health providers, identifying problems and strategizing on addressing them locally, or escalating the matter appropriately. These efforts yielded positive changes on the ground as well as in attitudes and perspectives.

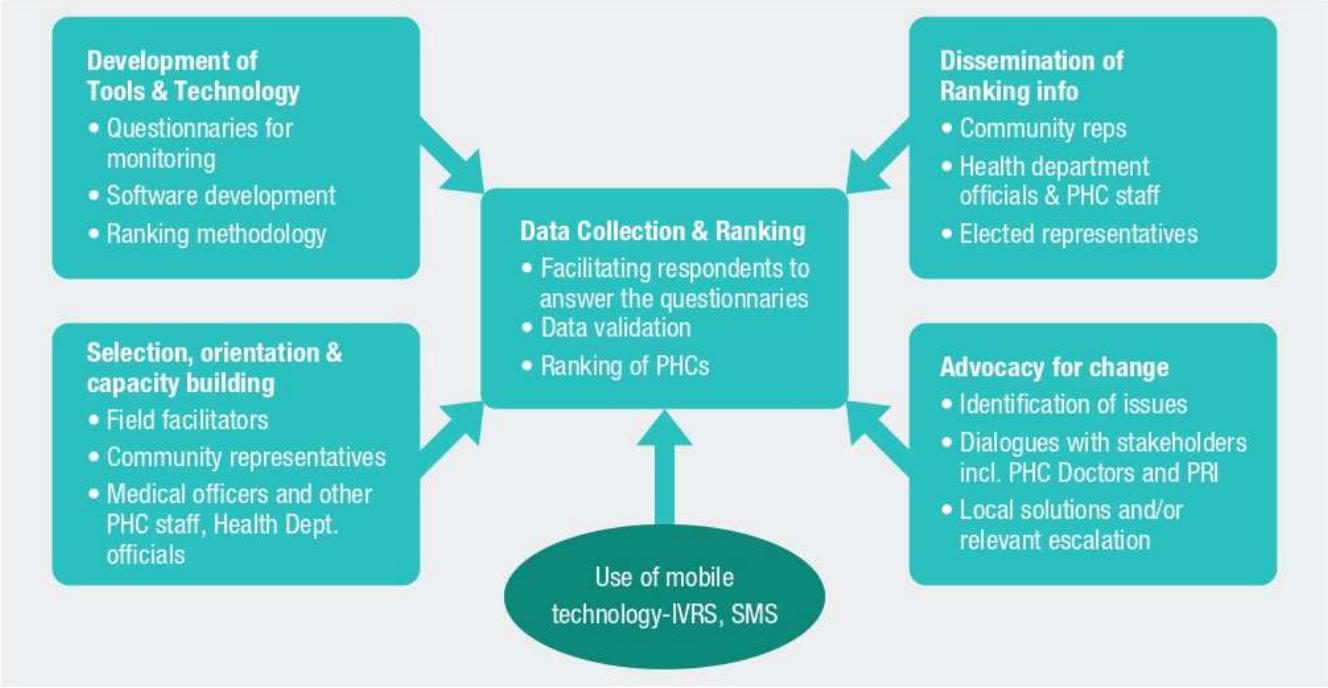

Fig 1: *Schematic representation of Arogya Shreni process*

Source: *Author*

4.3. Challenges faced in Arogya Shreni

Any new initiative at the field level faces numerous challenges. Arogya Shreni wasn't an exception from those systemic, implementation and community-level challenges.

1. The experiment brought the gaps in PHC service delivery to the fore, and created a fear of inspection and other repercussions among PHC staff.
2. The community representatives who participated in the CBM developed an expectation of change 'too early' and also of comprehensive transformation in the functioning of PHCs, which is not possible to achieve within the short or medium term.
3. Arogya Shreni required the participants to respond to monthly IVRS-based monitoring rounds. The participants needed convincing that responding at such frequency was necessary.
4. The technology-based CBM exercise was implemented through 'yes-no' responses on IVRS. A limitation of such responses is that they don't reveal detailed information on the service gaps that exist.
5. Certain issues could not be addressed or corrected through the CBM exercise which included matters where authority lay beyond the PHC. Deep-seated malpractice could also not be addressed.
6. Considerable time and efforts were needed for validation or back check of the IVRS generated responses and for the analysis of the responses obtained through IVRS

4.4. Outcomes of Arogya Shreni

The Arogya Shreni experiment generated a positive community response in terms of impressive participation in monitoring and advocacy. This proves that CBM experiments can be successful, provided that an enabling environment is available. The following positive outcomes were generated by the Arogya Shreni experiment:

- **Improved capacity and awareness**: Through consistent capacity building efforts of the project, communities could discuss the subject of health with a greater understanding of underlying factors. The communities were not only more aware of the facilities and schemes, but also of the health system and processes. Technology use played a positive role in kindling community interest and also in capturing comprehensive information of PHCs. The project demonstrated that communities need continuous hand-holding in the form of sustained coordination and motivation by organisations working at the grassroots.

> "We have seen a change in the way communities articulate the problems of their PHCs. From making ambiguous comments about their PHCs such as "this PHC is of no use" or "this is a bad PHC; nothing works here", the same community members now refer to specific issues, rather than making any sweeping statements. That is an important indicator of the success of the model." - Arogya Shreni Field Team

- **Dialogue and relationship building:** The platform provided by the project for dialogue helped the community members build and improve relationships with the doctors and other PHC staff significantly. This, in turn, led to a better articulation of the change desired and the mobilisation of resources required to address the same
- **Ownership and advocacy:** A sense of ownership drove community members to use their circle of influence innovatively and consistently follow-up till the issues were addressed. With increasing awareness and not being satisfied by merely responding to questions, the PMC members showed keen interest in addressing issues at their PHCs, including through their own efforts. For instance, land for the construction of a PHC was mobilised in a village (where a Primary Health Unit with only a rudimentary setup was converted to a PHC). Villagers were also seen to be taking out rallies to make people aware of the facilities in their PHC and encouraging people to use the PHC instead of going to private hospitals.
- **The use of technology and generation of useful data:** The use of technology generated a comprehensive database of responses on the perceived state of services in the PHCs that could be analysed and used for planning and monitoring in the primary healthcare domain.
- **Improvement in infrastructure and human resource availability:** Out of 34 PHCs selected for intensive advocacy efforts, positive changes in the availability of human resources (such as filling of vacancies) and infrastructure (such as provision of drinking water facilities) were noted in at least 26 of them as a result of community involvement in monitoring.

5. From Arogya Shreni to Jan Arogya Shreni

That communities have the willingness and the capacity to drive changes was effectively demonstrated in the Arogya Shreni experience. One of the lessons of Arogya Shreni was that community monitoring can be strengthened through capacity building at the grassroots level in partnership with reliable civil society organisations. Arogya Shreni also demonstrated the effectiveness of technology as a catalyst for strengthening community monitoring.

As mentioned earlier, with the advent of Ayushman Bharat Health and Wellness Centres in 2018, Government of India conceived a participatory mechanism known as Jan Arogya Samiti at the level of the SHC-HWC and issued guidelines for operationalizing the same. A need was felt to pilot test these guidelines in the field to understand the operational modalities and the ground realities that shape the functioning of such mechanisms. Having had the experience of executing the Arogya Shreni model in Karnataka, GRAAM was provided with an opportunity of piloting a CBM framework in 2 districts of Jharkhand, with the establishment and strengthening of Jan Arogya Samitis at the core of such framework. Supported by USAID - JHPIEGO PROJECT NISHTA, the goal of this 'Jan Arogya Shreni' project is to demonstrate community participation, ownership and monitoring mechanism at AB- HWCs so as to improve health service delivery and health outcomes.

5.1. Objectives and Design

The objectives of the Jan Arogya Shreni project are as follows:

- To facilitate the establishment of Jan Arogya Samiti (JAS) at 35 HWCs through a community consultation process.
- To build the capacity of JAS in effectively implementing community monitoring and 89social audit
- To demonstrate community engagement and monitoring through community structures such as Jan Arogya Samitis to create a vibrant healthcare system at the primary health care level
- To establish and demonstrate a framework of community accountability and social audit of AB-HWCs in line with the JAS guidelines issued by NHM.

The Jan Arogya Samiti project, like Arogya Shreni, is largely based on, but not limited to, the use of the technology-enabled mechanism (collection of IVRS based responses from JAS members on the state of health service delivery, human resources and infrastructure at the SHC-HWC) for strengthening CBM at the SHC-HWC level. It is essentially a replication of Arogya Shreni project done in Karnataka, with certain modifications

Table 1: Differences between Arogya Shreni and Jan Arogya Shreni

Arogya Shreni	Jan Arogya Shreni
Implemented at PHC level	Implemented at Sub-Centre-Health and Wellness Centre (SHC-HWC) level
Involved PMC members as participants	Involves JAS members as participants
Worked on the existing community structures (PMCs) and strengthening their capacity to monitor	Worked on establishing and constituting the new community structures (JAS) and building their capacities to monitor
Implemented in an area with relatively higher levels of socio-economic development	Implemented in relatively less developed areas with high tribal population
Limited to IVRS-based collecting of responses as a monitoring mechanism	Based on a comprehensive monitoring framework, including facilitation of Annual Public Dialogue and Social Accountability exercise
	Includes capacitating JAS to develop health planning and monitoring plan at the SHC- HWC Level

5.2. Outcomes of Jan Arogya Shreni

Jan Arogya Shreni aims to achieve the end of effective CBM through active Jan Arogya Samitis with pro-active people's participation. Given the nascent stage of the project, these outcomes are yet to be demonstrated. However, the following initial outcomes have been noticed:

1. Stipulated JAS meetings are being held in most places: Out of seven HWCs visited by the M&E team during a recent field visit, five centres had conducted both the meetings required to have been held by that date, and two centres had conducted only one meeting.
2. JAS is involved in health visioning and grassroots health planning: For better reflection of local needs in the functioning of the AB-HWC, the Jan Arogya Samitis have expressed their needs, preferences and health-related priorities through the health visioning exercise. As a next step, the participatory health planning exercise has also been piloted. Once the planning capacities of the JAS are developed, it is expected that they will play an important role in preparing locally grounded plans that are infused with the support of the local communities.
3. JAS have emerged as potential support for the HWC staff: It is expected that the constituted Jan Arogya Samitis will play an active role in guiding the management of the AB-HWCs and especially in organizing community-led health promotion activities. In this way, the HWC would be a valuable support structure to the HWC, especially for the Community Health Officers, a new cadre created to lead the HWCs.

5.3. Challenges

Initial efforts to facilitate the establishment of Jan Arogya Samitis and to get community representatives to attend the meetings and training programmes have encountered a number of challenges, which illustrate some of the possible challenges of CBM stated at the early part of this paper:

1. Some JAS members were not interested to attend the meeting as they have seen the non-functionality of the various committees formed in the past. It is also difficult to get JAS members together for meetings at times when they are busy with agricultural activities such as the harvest season.
2. For conducting training programmes, it is difficult to coordinate the availability of all JAS members on a single date
3. Some JAS members including health functionaries consider JAS as an additional burden in addition to their existing workload.
4. In Khunti district, the extremist Pathalgadi movement has affected the regularity of VHSNC meetings; similar factors are likely to constrain the Jan Arogya Samiti's meetings and functioning too.
5. As of now, the awareness of JAS among the larger community is low.
6. School teacher/school health ambassadors who are members of JAS require official letters to leave school duties and come for meetings.
7. Certain HWCs are far away from village areas and habitable land, and some are inaccessible. In such a context, there would be logistical difficulties in organising meetings and getting JAS members to attend them.

8. Some JAS members feel the need for financial remuneration for the time they spend on attending meetings.
9. Contextual adaptations have had to be made with respect to National Guidelines: the JAS guidelines issued by NHM don't mention the inclusion of customary or traditional authorities such as tribal leaders. It was observed on the field that in some places in Jharkhand, the tribal leader known as 'Munda' was included in JAS under the bracket of 'peer educator'. Munda is a powerful person in tribal contexts, and his inclusion is seen by the field implementation team as critical for enhancing the community acceptance of JAS.

6. Discussion: Learning from the Experience and Way Forward

GRAAM's experiences with Arogya Shreni and its initial observations from Jan Arogya Shreni reveal the following lessons:

1. In any kind of community involvement, people do expect to see some positive results. Once this is achieved, it helps build the confidence among the community to involve more intensively.
2. Community driven changes are possible with empowerment and consistent involvement. The importance of locally grounded civil society organizations to play the roles of capacity building, facilitation and constant handholding is very evident from the experiments.
3. Advocacy successes show that communities have the knowledge to use a wide variety of channels and engage with different stakeholders to bring changes.
4. The model has revealed the usefulness of a nuanced, non-confrontational and ownership-based approach to monitoring where the community itself takes responsibility to resolve certain issues.
5. Questionnaire-based survey is an important tool to help communities focus on issues and follow-up on identifying solutions. It is also a tool that helps them engage more qualitatively with other stakeholders
6. Rural communities have been able to successfully use a complex technology interface (IVRS + questions requiring numerical inputs). This implies that more advanced technology usage can be tested.
7. Acceptance of ranking cards by the health providers such as doctors is a way to successfully bring about healthy competition between PHCs, which in turn can lead to positive changes in the PHCs.
8. Advocacy successes show that communities have the knowledge to use a wide variety of channels and engage with different stakeholders to bring changes
9. The experiments have generated an enhanced understanding and re-affirmation of certain public health issues such as a) poor planning by the Govt. (less rational spatial distribution of PHCs and allocation of medicines to PHCs) b) lack of adequate focus on preventive health c) doctors are expected to be well-versed

with accounts, handling administrative issues, etc in addition to being culturally sensitive d) PHC infrastructure is not the sole determinant of quality healthcare services.

10. The experiments have generated an understanding of the diversity in behaviour and responses of community members, which is important at both institutional and individual levels.
11. The piloting of the model is needed in different regions/districts before a state-level rollout is tried. The same model may play out differently in different socio-economic contexts, and necessary process adaptations may be required. It is important to extensively document the processes followed in community engagement, CBM and troubleshooting of problems that arise on the ground so that such process documentation can become the basis for more refined and robust guidelines for CBM in a range of contexts.

Appendix I: Participatory Structures formed under NHM

- Rogi Kalyan Samitis (Patient Welfare Committees): These are participatory committees supposed to act as groups of trustees to manage the affairs of health centres such as the Primary Health Centres, Community Health Centres and other public hospitals.
- PHC Planning and Monitoring Committees (PMC): The function of the PMC is to monitor the availability of facilities and services at their PHCs, oversee the utilization of untied funds and carry out dialogue with the local health functionaries on issues affecting the health centre. The PMC comprises elected members of the Village Panchayat and VHSNC members.
- Village Health and Sanitation Committees (VHSNCs): VHSNCs are formed at the revenue village level. VHSNCs are required to comprise elected members of the Panchayat, health workers, and other community representatives. Their role includes community-based planning and monitoring.
- Jan Arogya Samiti (JAS): The Jan Arogya Samiti (JAS), created at the level of the SHC-HWC, is supposed to serve as a platform for community participation in the management and governance of the SHC-HWC. One of the functions of the JAS is to "support and facilitate the conduct of activities pertaining to social accountability at AB-HWC in coordination with VHSNCs." (NHM, n.d.) The suggested functions of the JAS (as per the JAS guidelines) reveal that JASs are intended to act as important stakeholder in the primary health care domain, going much beyond establishing the answerability of the health centre. JAS are also envisaged to lead community-led health promotion activities, mobilise funds from various sources such as panchayat and CSR funds, and support Gram Panchayats in undertaking health planning (NHM, n.d.).
- As per the JAS Guidelines, the Sarpanch of the Gram Panchayat (GP) falling under the AB-HWC area shall be designated Chairperson of the JAS. The Community

Health Officer (CHO) of the HWC is supposed to be the Member-Secretary. Sarpanches of the other GPs of AB-HWC area, President of VHSNCs, ASHAs and All Multi-Purpose Health Workers (Male and Female) of AB-HWC are supposed to be ex-officio members of JAS. Other JAS members are SHG representatives, peer educators, school health ambassadors and special invitees such as TB champion, youth representatives and a sterilised male (NHM, n.d.). The total number of members in a JAS is expected to range from 15-19.

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