ORIGINAL ARITICLE

Assessment of community - based monitoring under NRHM in Nainital district of Uttarakhand

Kumar S[1], Jha SK[2], Rawat CMS[3], Awasthi S[4], Semwal V[5], Bano M[6]

[1]JR-3, [2]Associate Professor, [3]Professor & Head, [4]Associate Professor, [5]JR-III, [6]Assistant Professor, Department of Community Medicine, GMC, Haldwani-263139, Uttarakhand

Abstract | Introduction | Methods | Result | Conclusion | References | Citation | Tables

Article Cycle

Address for Correspondence: Dr Sunil Kumar, JR – III, Department of Community Medicine, GMC, Haldwani-263139, Uttarakhand
E Mail ID: drsunilkumar778@gmail.com

Citation

Kumar S, Jha SK, Rawat CMS, Awasthi S, Semwal V, Bano M. Assessment of community - based monitoring under NRHM in Nainital district of Uttarakhand. Ind J Comm Health, 25(4); 354 - 361
Source of Funding : Nil, **Conflict of Interest:** None declared

Abstract

Background: The government of India started the Community-Based Monitoring (CBM) under National Rural Health Mission (NRHM) which allow the community and its representatives to directly give feedback about the functioning of public health services. Uttarakhand was the 10th state where CBM system under NRHM implemented in 2010 in all 13 districts as pilot project. **Objective:** To assess the composition and training of Community Monitoring Groups (CMGs) at sub-centre and block level, the capability of the CMG to prepare the report card at sub-centre and facility score card at PHC and to study the improvement in quantitative aspects of health services in study areas. **Methodology:** This community based prospective study was carried out in two selected Haldwani and Bhimtal blocks of Nainital district. The period of study was from July 2011 to June 2013. Multi-stage random sample design was adopted to select 54 CMG members. **Results:** About 91% CMG members belong to General Category. Out of 54 CMG members, majority 45(83.3%) had received training and among them 80% did not have clarity about training guideline. The activities of preparing Report cards, Facility score cards and conducting Jan-Sunwais were done once in a year. Concurrent reductions in yellow (partially satisfactory) and red (bad) rating of series were not seen in 2011-12 to 2012-13 at all centres. **Conclusion:** The composition and training of the CMGs at all sub-centres and at PHCs were not as per guidelines of NRHM. The activities of preparing the Report card, the Facility score card and conducting Jan-sunwais were not done as per guidelines by NRHM. Majority of sub-centre indicators scored yellow colour and only few scored green.

Key Words

Community-Based Monitoring; NRHM

Introduction

The National Rural Health Mission (NRHM) was launched on April 12, 2005 by the Government of India 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.1 NRHM has to improve the health status of the rural population, mainly by strengthening the public health system. 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 (CBM) as one of its key strategies.

The CBM process involves a three-way partnership between the health system, the community and community-based organizations (CBO), Non-Government Organizations (NGOs) and Panchayati Raj Institutions (PRI).2 Looking at the quantum of national health programs under NRHM, the existing monitoring systems are inadequate to bring out optimal trend analysis of key performance indicators. Answers to these questions lie in CBM through involvement of local beneficiaries.3 The CBM involves drawing in, activating, motivating, capacity building and allowing the community and its representatives e.g. CBOs, people's movements, voluntary organizations and Panchayat representatives, to directly give feedback about the functioning of public health services.4 The emphasis is on the developmental spirit of 'fact-finding' and 'learning lessons for improvement' rather than 'fault finding'. 3

The CBM is a new concept, currently being piloted in nine states of India; Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu.5 Uttarakhand was the 10th state where CBM system under NRHM implemented as pilot phase in 475 sub-centres of 95 blocks in all 13 districts of the state in 2010. The NGOs were selected in all the districts of the state for coordinating the CBM activities. Community Monitoring Groups (CMGs) was formed by NGO at three different levels (sub-centre, block PHC and the district).

As per guidelines of NRHM, at the village/sub-centre level the committee should consist of Gram Panchayat members from the village, Accredited Social Health Activist (ASHA), Anganwadi Sevika, Auxiliary Nurse Midwife (ANM), Self Help Group (SHG) leader, village representative of any CBOs working in the village. In the CMGs at block level, 30% members should be representatives of the Block Panchayat Samiti, 20% members should be non-official representatives from the PHC health committees, 20% members should be representatives from NGOs / CBOs and 20% members should be officials such as the Block Medical Officer, the Block Development Officer and 10% members should be representatives of the CHC level Chikitsa Prabandhan Samiti/Rogi Kalyan Samiti.6 The activities carried out to strengthen CBM are the preparing the report card and facility level score card three monthly and holding public hearings/dialogues (Swastyaya Samwad Divas) six monthly at all three levels.

The Uttarakhand state government sought technical help from the Department of Community Medicine, Government Medical College Haldwani, Nainital as Technical Resource Person. Limited studies had been conducted to assess the CBM in India.

Aims

The investigators decided to conduct the present study in the Nainital district with the objectives to assess the composition and training of CMGs at sub-centre and block level, the capability of the CMG to prepare the report card at sub-centre and facility score card at PHC and to study the improvement in quantitative aspects of health services in study areas.

Methods

This community based prospective study was carried out in two selected Haldwani and Bhimtal block of Nainital district. The period of study was 24 months (July 2011 to June 2013). Multi-stage random sample design was adopted to produce a representative sample of CMGs. All the Eight block of the district Nainital were listed. All the blocks were categorised into hilly and plain zones. Haldwani block from plain and Bhimtal from

hilly zones were selected. One PHC (Motahaldu) from Haldwani block and one PHC from Bhimtal block were randomly selected. Three Sub-centres were randomly selected from each PHC. 54 CMGs members were selected from the study areas. Nine and Twenty CMGs members were interviewed at PHC of Motahaldu and its three sub-centres respectively while five and Twenty CMGs members were interviewed at PHC of Bhimtal and its three sub-centres respectively.

The study was started only after taking permission from the institutional ethical committee. A verbal informed consent was taken from the participants. For primary data collection, tools were developed, pre-tested, and administered to the subjects. Techniques used to collect the data were interview using semi-structured schedules. The secondary data was collected using a separate check list that included observation of records maintained by CMGs and NGO of the district.

Separate questionnaires were prepared to interview the CMGs and some members of the community in the study areas to prepare the report card and facility level score card. Scoring system for Disease Surveillance, services by ANM, ASHA and Aangan Wadi Worker (AWW), Untied Fund, Child Health, Quality of Care, Adverse outcome, Maternal Health Guarantee, JSY, Infrastructure and manpower at sub-centres and PHCs was prepared as per guidelines of community monitoring.3 The data analysis was done using SPSS version 20.

Result

Table 1 shows that out of 54 CMGs members for the study, maximum 34 (63.0%) were in age group of 31-40 years followed by16 (29.6%) in 41-50 years of age groups. Each extremes of age group i.e. 21-30 years and 51-60 years were represented by only 3.7%. The mean age of the study subject was 39.17± 4.74 years. Approximately half and half of the members represented male and female respectively. Maximum CMG members 17 (31.5%) were graduate followed by 14 (25.9%) whose education was intermediate. Maximum CMG members were belong to General Category 49 (90.7 %) followed by SC Category 05 (09.3%).

Out of 54 CMG members, ASHA, Community members (CM) and gram pradhan were in same proportion of 14.8%. About 11 % each were represented by ANM and AWW. Ward members were seen as 7.4 % and 5.6% were block pramukh. BPM, SHG president and MOIC were seen as supporter in equal proportion of 3.7% of the CMG members. SHG and Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) and kanisht pramukh represented a same proportion of 1.9% (Table 1). Out of 54 CMGs members, majority 45(83.3%) had received training and the duration of training was only for two hours in a day. Rest 16.7% of CMG members did not receive any training. Among those who received training, 80% did not have clarity about training guideline. No training modules were given to the CMG members.

Report cards and Facility score cards were prepared once a year and similarly the activity of Jan- Sunwais was also conducted once in a year at all sub-centres and PHCs. Almost all the report cards prepared by CMG members and researcher were not matching.

Table 2 shows that the maximum series were given yellow (partially satisfactory) rating at all the sub-centres at Haldwani block in 2011-12 (phase I) and 2012-13 (phase II). Concurrent reductions in yellow (partially satisfactory) and red (bad) rating of series were not seen. Table 4 shows that at the sub-centres of Bhimtal, majority of series were given yellow (partially satisfactory) rating and minimum series were given green (good rating). At some of sub-centres of Bhimtal, disease surveillance and

untied fund indicator were under red (bad) rating.

Table 4 shows that at Haldwani block, the infrastructure and manpower, equipment and supplies, and service availability was under good in 2011-12 (phase I) and remained so in 2012-13 (phase II). Unofficial charges and quality of care was under partially satisfactory in phase I and continued in phase II. Functioning of CPS was scored in yellow colour in phase I and improved to good in phase II. At Bhimtal block, the rating of infrastructure and manpower was green (good) and rest was scored yellow colour in 2011-12 (phase I). Service availability improved to green in 2012-13 (phase II) and rest remained yellow.

Discussion

Maximum CMGs members belonged to General Category 49 (90.7%) followed by SC Category 9.3% (Table 1). There were no members from OBC and ST categories. NRHM guidelines states that there should be adequate representation of members of SC, ST, and OBC in formation of committee. The finding may reflect the caste composition of the population of the sample blocks. But, Caste is a major institutionalized source of structural inequalities in India.7

Out of 54 CMG members, ASHA, Community members and Gram Pradhan were in same proportion of 14.8% (Table1). About 11% each were represented by ANM and AWW. Ward members were seen as 7.4% while and block Pramukh was 5.6% of members. BPM, SHG president and MOIC were seen as supporter in equal proportion of 3.7% of the CMGs members. SHG and AYUSH and Kanisht Pramukh represented a same proportion of members (1.9%). NRHM states that the Committee at Village level should consist of Gram Panchayat members from the village, ASHA, Anganwadi Sevika, ANM, SHG leader and village representative of any CBO working in the village. The chairperson should be the Panchayat member (preferably woman or SC/ST member) and the convener should be ASHA; where ASHA is not in position it should be the Anganwadi Sevika of the village. 6 The compositions of members at village level are representing the CMGs according to NRHM guidelines.6

The criteria of NRHM for formation of CMGs at PHC/Block level are different. About 30% members should be representatives of Panchayat Institutions, 20% members should be non-official representatives from the village health committees, coming from villages under the jurisdiction of the PHC, with annual rotation to enable representation from all the villages. About 20% members should be representatives from NGOs/CBOs and people's organisations working on Community health and health rights in the area covered by the PHC. About 30% members should be representatives of the health and nutrition care providers, including the Medical Officer-PHC/CHC and at least one ANM working in the PHC area and 10% members should be representatives of the CHC level Chikitsa Prabandhan Samiti (Rogi Kalyan Samiti).6 The composition of the present study shows that members were taken from all sectors but not in proportion fulfilling NRHM guidelines. No annual rotations were done in formation of CMGs to enable representation from all the villages.

Out of 54 CMGs members, majority 45(83.3%) had received training and the duration of training was only for two hours in a day. Among those who received training, majority members, 80% did not have clarity about training guidelines. It was found in the present study that guidelines were not clear to CMG members. Field testing and finalization of tool was not conducted and no training modules were given to CMG members. The duration of

training was only two hours which is too far from the guidelines of NRHM which is of two days. This finding is in contrast to the published report of Maharashtra state nodal agency. In training at Maharashtra, district coordinators and block facilitators were trained in the skills and tools required in CBM. In the same training session, they were also informed about related aspects of NRHM with specific emphasis on the service guarantees. On the second day of the training, other sessions were conducted on role and responsibilities of various committees for CBM at the village, PHC, block & district level.8

Preparation of Report cards, Facility score cards and the activity of Jan-Sunwais were conducted once a year by CMG members at all sub-centres and PHCs. As per guideline of NRHM, the Report cards and Facility score cards should be prepared quarterly and the activity of Jan- Sunwais is proposed twice in a year.6 Almost all the report cards prepared by CMG members and researcher were not matching. It indicates that they were not trained properly.

At sub-centres of Haldwani block, the maximum series were given yellow (partially satisfactory) rating at all the sub-centres in 2011-12 (phase I) and 2013-14 (phase II). Concurrent reductions in partially satisfactory and red (bad) rating of series were not seen (Table 2). At sub-centres of Bhimtal, majority of series were given partially satisfactory rating and minimum series were given green (good rating). Some of sub-centres were under bad rating for disease surveillance and untied fund (Table 3).

At Haldwani block, the infrastructure and manpower, equipment and supplies, and service availability was under good in 2011-12 (phase I) and remained so in 2012-13 (phase II). Unofficial charges and quality of care was under partially satisfactory in phase I and continued in phase II. Functioning of CPS was scored in yellow colour in phase I and improved to good in phase II. At Bhimtal block, the rating of infrastructure and manpower was green (good) and rest was scored yellow colour in 2011-12 (phase I). Service availability improved to green in 2012-13 (phase II) and rest remained yellow (Table 4). The finding of the present study is in contrary to the findings in Maharashtra (2007-10) where certain health services have shown high and consistently improving good ratings across the five CBM districts over three phases. In Maharashtra, at the end of round three, 90% of districts received a rating of good for immunisation services and 87% of districts received a rating of good for Anganwadi services.8 After the first round of monitoring exercise in Rajasthan, the second round of monitoring experienced shift in colour score. A substantial shift was seen from red to yellow and yellow to green. In the second round, observed red in the first round shifted to yellow colour and green colour.9 A report on the first phase of the community monitoring in Karnataka analysis of the score cards shows that the perception of community members on various health and health service parameters had changed, red signs decreased while yellow and green signs increased.10

Conclusion

The composition and training of the CMGs at all sub-centres and at PHCs were not as per guidelines of NRHM. Majority of participants did not have clarity about training guideline. The activities of preparing the Report card, the Facility score card and conducting Jan sunwais were not done as per guidelines by NRHM. Majority of sub-centre indicators scored yellow colour and only few scored green. Disease surveillance and untied fund of some sub-centres scored red colour. Unofficial charges and quality of care was under yellow colour in phase I and continued so in phase II.

References

1. National Rural Health Mission 2005-2012. Mission document. Available at http://www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf. (Accessed on 12 August, 1013).
2. Garg S, Laskar AR. Community-based monitoring: Key to success of national health programs. Indian J Community Med 2010; 35:214-6.
3. Implementers Module for NRHM Drawing from NRHM Framework of Implementation Prepared by Task force on Community Monitoring of Advisory Group on Community Action Based on the Proposal Sanctioned by Mission Directorate of NRHM, MOHFW GOI.
4. Akshara Foundation Annual Report 2006-07, Swaasth Plus Community Monitoring Project, Karnataka.
5. Health Sector Reforms workshop. Jaipur: SIHFW; 2008. Community Based Planning and Monitoring of Health Services. June 18.
6. Task force on Community Monitoring, of Advisory Group on Community Action. Managers' Manual; Community Monitoring of Health Services under NRHM, 2008. Available at: http:// www.nrhmcommunityaction.org. (Accessed 25May, 2013).
7. Kumar, A. Health Inequity and Women's Self-Help Groups in India: The Role of caste and Class.
8. Report on First Phase of Community Based Monitoring of Health Services under NRHM in Maharashtra; Dr. Dhananjay Kakde with inputs from other SATHI-CEHAT team members and District nodal NGOs Published by SATHI CEHAT; December 2008.
9. Rajasthan State Report by Prayas, Rajasthan a first phase of community monitoring Under NRHM.
10. Community Planning and Monitoring of Health Services -Karnataka Experience; H. Sudarshan Upendra Bhojani Govind Madhav N. Prabha On behalf of, State Mentoring Monitoring Group & State Nodal NGO; 2009.

----------x----------

Tables

TABLE 1: CHARACTERISTICS OF THE CMGS (N=54)*

Characteristics		Frequency	Percent
Age (Years)	21-30	02	03.7
	31-40	34	63.0
	41-50	16	29.6
	51-60	02	03.7
Sex	Female	26	48.1
	Male	28	51.9
Education	Primary and middle	05	09.3
	High school	09	16.7
	Intermediate	14	25.9
	Graduation	17	31.5
	Post Graduation	09	16.6
Caste	General	49	90.7
	SC	05	09.3
Designation	ANM	06	11.1
	ASHA	08	14.8
	AWW	06	11.1
	CM	08	14.8
	Gram Pradhan	08	14.8
	Block pramukh	03	05.5
	Kanishat pramukh	01	1.85
	BPM	02	03.7
	BDC member	03	05.5
	Ward member	04	07.4
	MOIC	02	03.7

	AYUSH	01	1.85
	SHG president	01	1.85
	VDO	01	1.85
Training received	Yes	45	83.3
	No	09	16.7
Clarity of CBM among trained CMGs (n=45)	Yes	09	20%
	No	36	80%

ANM: Auxiliary Nurse Midwife; ASHA: Accredited Social Health Activist; AWW: Aangan Wadi Worker; AYUSH: Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy; BDC: Block development coordinator; BPM: Block programme manager; CBM: Community Based Monitoring; CM: Community member; CMGs: Community Monitoring Groups; MOIC: Medical Officer in Charge; SHG: Self Help Group; SC: Schedule Caste; VHND: VDO: Village development officer.

TABLE 2: REPORT CARD*OF SUB-CENTRES AT HALDWANI BLOCK

Particulars	Sub-centre1		Sub-centre2		Sub-centre3	
	2011-12	2012-13	2011-12	2012-13	2011-12	2012-13
Disease Surveillance	Red	Red	Red	Red	Yellow	Yellow
Curative services	Yellow	Green	Yellow	Green	Green	Green
Untied Fund	Red	Yellow	Red	Yellow	Yellow	Yellow
Child Health (GW)	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Child Health (DW)	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
ASHA functioning (GW)	Green	Green	Green	Green	Green	Green
ASHA functioning (DW)	Green	Green	Green	Green	Green	Green
Interview with AWW	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Interview DOT provider	Green	Green	Green	Green	Green	Green
Quality of Care-GW	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Quality of Care-DW	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Adverse outcome	0	0	0	0	0	0
Maternal Health Guarantee	Green	Green	Green	Green	Green	Green
JSY	Yellow	Yellow	Yellow	Green	Green	Green
Infrastructure Manpower	Yellow	Yellow	Yellow	Green	Green	Green

*Green (Good, if score ≥ 75%), Yellow (Partially satisfactory, if score 50 to 74%), Red (Bad, if score < 50%), GW (General Women), DW (Deprived women), JSY (Janani Suraksha Yojana)

TABLE 3: REPORT CARD* OF SUB-CENTRES AT BHIMTAL BLOCK

Particular	Sub-centre 1		Sub-centre 2		Sub-centre 3	
	2011-12	2012-13	2011-12	2012-13	2011-12	2012-13
Disease surveillance	Yellow	Yellow	Red	Yellow	Yellow	Yellow
Curative services	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Untied Fund	Red	Yellow	Yellow	Yellow	Red	Yellow
Child Health(GW)	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Child Health(DW)	Yellow	Yellow	Yellow	Green	Yellow	Green
ASHA functioning (GW)	Green	Green	Green	Green	Green	Green
ASHA functioning (DW)	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Interview with AWW	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Interview with DOT provider	Green	Green	Green	Green	Green	Green
Quality of Care (GW)	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Quality of Care (DW)	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Adverse outcome	1	0	0	0	0	0
Maternal Health Guarantee	Yellow	Green	Yellow	Green	Yellow	Green
JSY	Yellow	Green	Green	Green	Yellow	Yellow
Infrastructure Manpower	Yellow	Yellow	Yellow	Yellow	Green	Green

*Green (Good, if score ≥ 75%), Yellow (Partially satisfactory, if score 50 to 74%), Red (Bad, if score < 50%), GW (General Women), DW (Deprived women), JSY (Janani Suraksha Yojana)

TABLE 4: FACILITY SCORE CARD AT PHCS

Subject	Haldwani block		Bhimtal block	
	2011-12	2012-13	2011-12	2012-13
Infrastructure & Manpower	Green	Green	Green	Green
Equipment and Supplies	Green	Green	Yellow	Yellow
Service Availability	Green	Green	Yellow	Green
Unofficial Charges	Yellow	Yellow	Yellow	Yellow
Quality of Care	Yellow	Yellow	Yellow	Yellow
Functioning of CPS	Yellow	Yellow	Yellow	Yellow