MONITORING MANUAL

Community Monitoring of Health Services Under NRHM

Community based Monitoring of Health services under National Rural Health Mission

MANUAL FOR MONITORING

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Preface

The process of community based monitoring envisaged within the National Rural Health Mission (NRHM) involves capacity building of planning and monitoring committees at different levels to conduct an enquiry into the functioning of different components of NRHM and the uptake of key services. It is an empowering process for the community because it provides the community representatives knowledge of different entitlements, service standards and service guarantees that are provided within the NRHM. It also provides an opportunity to discuss the delivery status of services provided by health care providers and managers.

It is also an ambitious process because it depends on the ability of planning and monitoring committees at different levels to conduct an enquiry to provide credible evidence for such discussion. The challenge therefore was to develop a simple but robust mechanism of enquiry that could be done at the community level by community leaders. The broad operating principle adopted in developing the community monitoring enquiry process was that it should not require more than High School (Class Ten) level skills using paper and pencil technology. However, we also recognise that for the first time, this exercise may require facilitation.

A community level report card and a facility level report card are the basic instruments for community based enquiry into the functioning and uptake of services. A set of tools have been developed for generating scores in these report cards. This Manual includes step-by-step instructions for using these tools at the community and facility levels to gather information for preparing the report cards. For purposes of simplicity, the score cards use a simple system of traffic lights (red, yellow and green colours) to indicate the current status of functioning on any one indicator. There are provisions for making cumulative report cards at the block and district level. The change in the colours of traffic lights along different indicators can be used for reviewing services at a broader level.

These tools and report card methodology for community based monitoring has been used in over 1,500 villages and 300 facilities in the First round of community monitoring with some modification and adaptation. We encourage such modification, depending upon the status of services and their uptake and the ability of the community to conduct such exercises. Thus this tool-kit of exercises should be seen as prescriptive. We look forward to the successful application of this process across the country because we believe that it is an essential component of participation and communitisation envisaged in NRHM.

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Members of the different level of Monitoring and Planning Committees in the nine states
Members of the Village Health and Sanitation Committees

And

Citizens of India who were engaged in this process across the nine states

Contents

Glossary

ANM: Auxiliary Nurse Midwife
AWW: Anganwadi Worker
ASHA: Accredited Social Health Activist
ARI: Acute Respiratory Infection
AFB: Acid-Fast Bacilli
AIDS: Acquired Immuno Deficiency Syndrome

BPL: Below Poverty Line
BP: Blood Pressure
BCG: Bacille Calmette Guerin

CHC: Community Health Centre
CEDAW: Convention on the Elimination of All Forms of Discrimination Against Women
CMO: Chief Medical Officer
CBO: Community Based Organisation
Cu T: Copper T

DMO: District Medical Officer
DDK: Dai Delivery Kit
DPT: Diphtheria Pertusis Tetanus

EmOC: Emergency Obstetric Care

FRU: First Referral Units

HR: Human Rights
HQ: Head Quarter
HW: Health Worker
HIV: Human Immunodeficiency Virus

ICESCR: International Covenant on Social Economic and Cultural Rights
ICPD PoA: International Conference on Population and Development Program of Action
IFA: Iron & Folic Acid
IPHS: Indian Public Health Standard
IUCD: Intra-Uterine Contraceptive Device
IUD: Intra-Uterine Device

JSY: Janani Suraksha Yojana

LHV: Lady Health Visitor

MTP: Medical Termination of Pregnancies
MO: Medical Officer

NAC: National Advisory Council/National Advisory Committee

ObGyn: Obstetrics and Gynaecology
OCP: Oral Contraceptive Pills
OPD: Out Patient Department
OBC: Other Backward Classes
OC: Oral Contraceptives
OT: Operation Theatre

MPWs: Multi-Purpose Workers
MDGs: Millennium Development Goals
MTA: Mother Teacher Association
MP: Malarial Parasite
MHW: Male Health Worker

NRHM: National Rural Health Mission

PfA: Platform for Action
PRI: Panchayati Raj Institutions
PTA: Parent Teacher Association

RTI: Reproductive Tract Infections
RKS: Rogi Kalyan Samiti
RCH: Reproductive and Child Health
RT: Referral Transport
RBA: Rights Based Approch

STI: Sexually Transmitted Infections
SHG: Self-Help Group
SC: Scheduled Caste
ST: Scheduled Tribe

TT: Tetanus Toxoide
TB: Tuberculosis
TBA: Trained Birth Attendant

UDHHR: Universal Declaration of Human Rights

VHSC: Village Health and Sanitation Committee


NATIONAL-RURAL-HEALTH-MISSION

CHAPTER 1

Health care is our basic right!

All of us fall ill at some point of time in our lives, due to various reasons. We may need treatment to be cured of our illness. Sometimes, our illnesses may be cured with the help of simple home remedy. But at other times, we need medical intervention, which we seek from a clinic or a health centre. We are aware that food, water, shelter and clothing are the basic needs of every human being, which are fundamental to survival. Along with these, health care is also a basic need, which is essential for the survival of human beings.

The Indian Constitution explicitly mentions that providing health care to all citizens is the responsibility of the state. The Supreme Court of India, while giving judgement on several cases, has also clearly reiterated that providing basic health care to every citizen of the country is the responsibility of the state. To fulfil this obligatory function, the government has created structures at the district, block, PHC and sub centre levels, which provide various health services.

The purpose of this structure is to provide essential health services to the citizens of the country, free or at a nominal cost. The health system in our country performs the dual function of providing curative services for the main health problems, and planning for appropriate preventive and promotive services. The public health system includes human power like doctors, nurses, technical experts and administrative staff. Apart from this, medicines, and other equipment like ambulance, x-ray machines, laboratory equipment etc are also provided for by the Health Department. The government incurs large-scale expenses for all this on construction of buildings, appointment of staff, obtaining medicines and other equipment. But where does the government get all this money from?

We all Contribute to the Expense Incurred by the Government on Health Services

The government collects direct and indirect taxes from all citizens. We contribute to the government's treasury by paying house tax, agricultural taxes etc. Besides, when we purchase even small items like a matchbox, salt, or soap from the market we contribute part of the price of that item as tax to the government. In this manner the government collects money from us in the form of taxes and undertakes several development programmes with this money. Sometimes, the programmes are also run by raising money through loans and other forms of financial aid. All citizens of the country - whether a farmer with a small piece of land, or a worker working on shift duty in a factory - contribute to the government's income through their hard work. Any loans raised by the government are also paid off

with the help of this income. Thus, the government runs welfare programmes for people with the people's own money, which it collects in the form of various taxes. The same money is also used for running public health services. Hence, we all have collective ownership of the public health services, since it has been set up with our own money. Health problems need to be tackled through collective efforts of the public health system and the people.
However, we also need to realistically analyse that despite setting up a large public health system and the government pouring money into it, does every person have access to quality health services? Let us understand what we expect when we say that health care is a right and it should be available to all.

What is the Present General Condition of Public Health Institutions?

The people in the rural, remote and hilly areas are quite dependent on public health services. Many doctors have gained the confidence of people from remote areas by actually visiting such places and they have done a good job. There are examples of many ANMs and health workers who have done their work despite facing several obstacles. But the reality still is that satisfactory health services are not available to most people.

For example, snakebite is a very common incident in rural areas. It is mandatory for all PHCs to keep a stock of anti snake venom injections. But deaths keep happening because it has not been actually available to the patient at time of need. Similarly, dog bites or bites by other animals, is also a common occurrence. Such bites can result in the victim contracting a disease named Rabies. The anti rabies vaccine, which can prevent this disease, however, may be available only in the CHC or the civil hospital, which are far from the village. In fact, at several places, people may have to purchase this expensive vaccine, since it may not be available to them free of cost.

The buildings, which house the public health institutions, may be found in a dilapidated condition. Doctors and other staff may not always have good quality residential quarters with even the basic amenities. All medicines may not be available at all times in the public health institutions, so that patients often have to purchase medicines. The gaps in government health services have also been identified in several national surveys. There are efforts from the public health system to provide good health services, but one cannot deny that the above-mentioned shortcomings do exist. The fact that these incidents occur, indicate that our right to health care is denied.

The condition of health services at the village level is no different. The main aim of village visits made by ANMs and MPWs, is often found to be family planning and immunisation. In addition, these health workers should have medicines for simple ailments like fever, dysentery, body ache, common ailments of children. However, often they are unable to give these medicines. Due to this situation, the people may not be fully convinced about the importance and utility of the public health system. They may not feel a sense of ownership towards the health system. Hence, left with no option, they visit the private doctors in larger villages or taluka places. However, despite the hefty fees of these doctors, expenses on medicines, and transportation, there is no guarantee that they will get good quality health care.

When we claim that health care is our right, we expect that such situations where quality health care is denied should not occur anywhere for anybody.

Does Everyone have Access to Good Quality Health Services?

Our society comprises of several groups like rich and poor, men and women, physically able and physically challenged, apart from differences based on caste and region. Today, the situation is such that some of these groups, which are on a higher social and economic scale in society, have better access to health services, while the other groups, which are lower on this scale, may be denied good quality health services due to their marginalisation and vulnerability.

The poor tend to visit public health institutions because they cannot afford the fees charged by private doctors. But the quality of services provided by the public health institutions has often been wanting. On the other hand, private health services are developing rapidly. Due to this a poor person's right to health care may be denied. Also, there are several examples of people becoming debt ridden because of expenses they have incurred on health care.

There is mostly a shortage of female doctors in the public health system. So, women from rural areas visiting public health institutions are scared and embarrassed to share their problems related to menstrual cycle, or reproductive organs with male

doctors. Women's dignity may not be always respected when they are brought in for performing family planning operations. At times, certain staff in the public health institutions may behave in a manner with the poor, dalit and tribal people, which they find insulting.

On the whole, this means that despite the fact that the government has set up a huge public health system, today, everyone is not assured of good quality health services.

Every Indian citizen - irrespective of whether it is a man or a woman, irrespective of his/her economic condition, caste, religion, social status, and regional affiliation - must have access to good quality health services. To make this right a reality, the government, health system and people must come together.

The government should ensure that all people should have easy access to quality health services. Steps in this direction are being taken under the National Rural Health Mission (NRHM), recently launched by the Central Government.

Health for All' and the National Rural Health Mission

The Central Government has launched the National Rural Health Mission (NRHM), which is not just another health programme. Rather, it is an integrated expression of the government's commitment towards overall improvement in health services. The government runs several national health programmes, and the aim of the NRHM is to strengthen the public health system, integrate these programmes and remove the gaps in implementation. The government has declared that while removing these gaps the following issues will receive special attention:

- Sufficient budgetary allocation for public health.
- Providing quality and effective health services to the rural population with special focus on women, children and poor people.
- Improved access to health services.
- Strengthening and decentralisation of health services.
- Increasing people's participation in the health services.

Nutritious food, clean and safe drinking water, sanitation and public cleanliness are factors that directly affect health. The government has declared that it will make improvements in all these important determinants of health, under the NRHM. Besides, special health programmes will continue to be implemented for the health of women and children.

To put it all in a simple language - there is a promise and hope that we will move towards making 'Health for All' a reality. This promise includes for example, that pregnant women will be examined regularly to identify possible cases of difficult labour and during delivery they will be given necessary care through the public health system; patients will get necessary treatment and medicines through the public health facilities; the doctors and staff members would be available and responsive; safe drinking water will be available in every village; every child will have access to nutrition and essential health services; regular steps will be taken to prevent the spread of communicable diseases; health workers will regularly visit the villages and complete all the planned tasks; and people's opinion and priorities will be taken into account while planning and providing all health services.

The government has promised us all of these under the NRHM. As the above-mentioned promises get actually fulfilled in reality, we can say that the government is contributing to our realising the right to health care.

WHAT IS A RIGHT?

It is the minimum conditions/entitlements for the individual to live a life with dignity.

The underlying assumptions are:

- An authority which defines these minimum conditions.
- The recognition that everyone does not enjoy these minimum conditions.
- A mechanism for identifying the gaps - violation and non fulfilment of rights.
- A system that can fill the gaps, and provide JUSTICE.

AUTHORITIES AND RESPONSIBILITY

The Authorities:

- Must be articulated in constitution or law or recognised custom.

- Must emerge through international agreements and treaties.

The Responsibility of the Authority is to:

- Protect rights.
- Provide enabling conditions for exercising the rights.

Just as duty bearers require adequate capacity to perform duties, rights holders also require conditions necessary for claiming or demanding of rights to hold duty bearers accountable.

The Characteristics of Rights are:

- Rights are universal (for all; everywhere at all times).
- Equality and non-discrimination: All individuals are equal as human beings and by virtue of the inherent dignity of each human.
- Rights are inalienable (can't be taken away or given up).
- Participation is a fundamental right (everyone is entitled to demand their rights).
- Rights are indivisible and inter-dependant (denying certain rights undermines respect for others).
- Rights enable us to demand if necessary what is due, without having to beg for benevolence or compassion.
- Rights are associated with human dignity and respect for each and every person. A system and acceptance of rights contributes to personal self-esteem.

Sources of Health Related Rights:

- National Constitution, national Laws - criminal laws relating to consent, injuries, medical negligence, age at marriage, and so on.
- Policies - related to population, health, youth, women and so on.
- Programmes - reproductive health and other national programmes.
- International Law and Agreements - Right to Health UDHHR, ICESCR, CEDAW, ICPD PoA, Beijing PfA, MDG etc.

Three Generation of Human Rights Exist:

I. Civil and political rights - right to life, right to information, right to freedom of movement, right to peaceful assembly etc.
II. Economic social and cultural rights - right to education, right to health, etc.
III. Rights of disadvantaged groups - women's rights, child rights, tribal rights etc.

Successful development leads to respect for human rights. Respect for human rights contributes to sustainable development. The realisation of human rights is the goal of development.

RIGHT'S BASED APPROACH

Rights based approach (RBA) means holding people and institutions that are in authority accountable for fulfilling their responsibilities towards those who are under authority.

RBA aims to increase impact of programmes and strengthen sustainability by:

- Addressing root causes.
- Changing policies and practices.
- Working together towards common goals.
- Changing power relations.

RBA addresses violence and coercion and restriction of choices. It encourages people to demand their rights. It incorporates communication and behaviour change interventions that encourage equitable partnerships. It could make programmes accountable when rights are violated. Rights based approach begins when every health situation is seen in the context of human rights. This approach includes:

- Knowledge of rights and their sources.
- Identifying gaps in fulfilment and violations.
- Rights education and awareness.
- Claiming of the rights.

Rights Promoting Activities are:

- Rights awareness: community mobilisation, rights education of community and providers, leadership development of community and providers.
- Building evidence: case-studies, primary research, secondary data etc.
- Sharing information: briefing kits, fact sheets, pamphlets, plays etc.
- Media advocacy: press conference, stories, opinion, editorial.

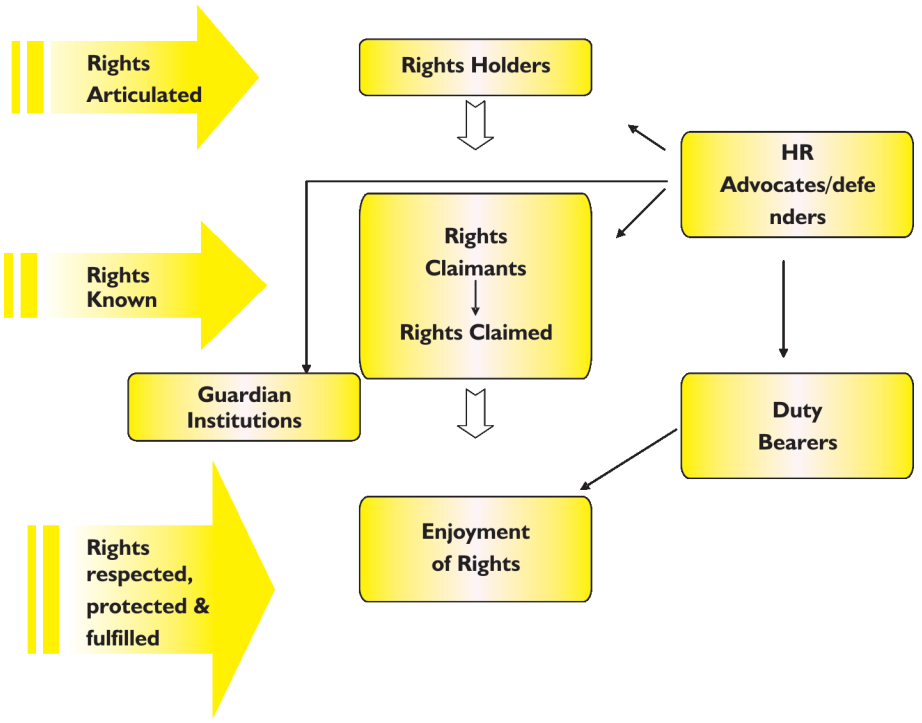
Claiming Health Rights Include:

- Asking for services, respecting the rules.
- Filing complaints or making suggestions.
- Dialogue with providers, managers, legislators, representation, delegation.
- Asking for grievance redressal or compensation.
- Public hearing, social audit, legal action.
- Direct action like dharna, protest, strike etc.

The Actors in Rights Based Approach Include:

- Rights holders - community (rights claimants).
- Duty bearers - service providers, managers, bureaucrats, other government functionaries, guardianship institutions like courts, commissions etc.
- Human rights advocates - us! (Civil Society Organization)

Illustration 1: Rights Based Framework



CHAPTER 2

Health System In India

The rural health care system forms an integral part of the national health care system. Provision of primary health care is the foundation of rural health care system. For developing vast public health infrastructure and human resources of the country, accelerating the socio-economic development and attaining improved quality of life, primary health care is accepted as one of the main instruments of action. Primary health care is an essential health care made universally available and accessible to individuals and acceptable to them through their full participation and at a cost the community and the country can afford.

National and State Levels

National level - Union Ministry of Health and Family Welfare has three departments; 1) Health, 2) Family Welfare, and 3) Indian System of Medicine and Homeopathy.

State level - The organisation at state level is under the State Department of Health and Family Welfare in each state headed by minister and with a secretariat under the charge of secretary or commissioner (Health and Family Welfare).

Review of Existing Public Health Infrastructure

The public health care structure in the country has been established as per the following norms:

SUB CENTRE

Sub centre is the first peripheral contact point between community and health care delivery system. A sub centre is managed by one female health worker (ANM) and one male health worker (MPW). One Lady Health Visitor (LHV) for six sub centres is provided for supervision at the PHC level.

Table 1- Health Centre & Population Norms

	Plain areas	Hilly/Tribal areas
Sub centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1, 20,000	80,000

Department of Family Welfare is providing 100 per cent central assistance to all the sub centres in the Country since April 2002 in the form of:

- Salary of ANMs and LHVs
- Rent@ Rs. 3000 per annum
- Contingency @ Rs. 3200 per annum
- Drugs and equipment kits

Currently there are 1,42,655 sub centres in the country.

Primary Tasks of ANM

- Registration of all pregnancies (ANM along with ASHA will ensure that all BPL women get benefits under Janani Suraksha Yojna).
- Ensure minimum four ante-natal check-ups, along with 100 IFA tablets and two T.T. Injections to pregnant women.
- Appropriate and prompt referral in case of high-risk pregnancies.
- Provide skilled attendance at home deliveries, post partum care and contraceptive advice.
- Newborn care full immunisation and vitamin-A doses to children, prevention and control of childhood diseases like malnutrition, infections etc.
- Curative services like treatment for minor ailments.
- Maintenance of all relevant records concerning mother, child and eligible couples in the area.
- Providing information on different family planning and contraception methods and provision of contraceptives.
- Counselling and correct information on safe abortion services.
- Coordinates services with AWWs, ASHA, Village Health & Sanitation Committee and PRI for observance of Health Day at AWW center at least once a month.
- Coordination and supervision of ASHA.
- The untied grant to the sub center is kept in a joint account, which is operated by the ANM and the local sarpanch.

The ANM is answerable to Village Health and Sanitation committee, which will oversee her work.

PRIMARY HEALTH CENTRE (PHC)

PHC is the first contact point between village community and the Medical Officer. Managed by a Medical Officer and 14 other staff, it acts as a referral unit for six sub-centres and has four to six beds for patients. It performs curative, preventive, promotive and family welfare services. These are established and maintained by the state governments. Currently there are 23,109 PHCs in the country.

COMMUNITY HEALTH CENTRE (CHC)

CHCs are established and maintained by the state governments. Managed by four specialists i.e. surgeon, physician, gynaecologist and paediatrician and supported by 21 paramedical and other staff, a CHC has 30 indoor beds with one OT, X-ray facility, a labour room and laboratory facility. It serves as a referral centre for 4 PHCs. Currently there are 3222 CHCs in the country.

District and Sub District Level

At the district level, the district officers (DMOs and CMOs) are overall in-charge of the health and family welfare programmes in the district. They are responsible for implementing the programmes according to policies laid down and finalised at higher levels, i.e. State and Centre.

At the sub-divisional/taluka level, some specialties are made available at the taluka hospital. At the taluka level, health care services are rendered through the office of Assistant District Health and Family Welfare Officer who is assisted by Medical Officers of health, lady medical officers and Medical Officers of general hospital. These hospitals are being gradually converted into Community Health Centres (CHCs).

ADEQUACY OF COVERAGE

All public health services depend on the presence of adequate basic infrastructure. The primary health care services in rural areas in the country are

Table 2- Adequacy of Health Centre Coverage

	Requirement (Numbers)	Existing (Numbers)	Shortfall (Numbers)
Sub centre	158792	142655	21983
PHC	26022	23109	4436
CHC	6491	3222	3332

provided through a network of health facilities. Although vast network of this infrastructure looks impressive - accessibility, availability of humanpower and quality of services, and their utilisation have been major issues in the public health care delivery system. Adequacy of coverage is an important issue. The number of facilities is not adequate when we consider the current population. New centres need to be established to cover the entire population of the country. These requirements have been estimated based on the population as per the 2001 Census ignoring the excess in some of the states.

PHYSICAL INFRASTRUCTURE

Buildings

Only 50 per cent of the sub centres, 84 per cent PHCs and 86 per cent CHCs are in government buildings. The rest are either in rented buildings or in rent-free panchayat or voluntary society buildings. It has been observed that the quality of work suffers if the facility in rural areas is located in the rented building as the space is inadequate. Adequate residential facility for the essential staff at these centres is also a problem. Electricity, water supply system and telephone facilities, referral transport, furniture etc. are also not optimal. Nearly 60,000 sub centres, 1700 PHCs and 320 CHCs currently functioning in rented buildings, need buildings of their own.

Repair and Maintenance

Repair and maintenance of the centres having their own buildings and ensuring 24 hours water supply and electricity will require a lump sum amount of approximately Rs. 2333 crore.

HUMAN POWER

At the sub centre and PHC levels, the vacancy position of ANMs is approximately 5 per cent. Taking into consideration the new and the existing sub centres and PHCs, there is a need for 1, 65,764 ANMs. Presently 1,38,906 are in position. Nearly 50 per cent of the existing sub centres do not have a Male Health Worker (MHW). This is because the state governments do not sanction the post of the MHW as the state bears the cost of the salary of the MHW. There has been a demand that like ANM and LHV, the Government of India should also pay the salary of the MHW. The National Advisory Council (NAC) has recommended for funding of 50 per cent of MHWs. However, the states demand funding of salary of all the MHWs (100 per cent). If so, the additional cost to Government of India will be Rs 2000 crore annually.

Primary Health Centre

Although the numbers of doctors sanctioned are more than the requirement, currently about 700 PHCs are without a doctor because of mal distribution, improper transfer policy of the state government, political interference, lack of basic amenities and incentives for working in rural/difficult areas. At the PHC level, ensuring availability of services of doctors in the PHCs, especially in difficult areas, is a major problem. The Ministry of Health and Family Welfare plans to make all the PHCs "24- hour functioning PHCs" in a phased manner. In view of this, there would be a need for two doctors at the PHCs (guidelines for operationalising a 24-hours functioning PHC for service delivery is in final stage). Number of doctors required, therefore, would be 52,044. Currently there are 21,974 Doctors available at PHCs. With the existing number of medical colleges and the annual turnover of MBBS Doctors, mainstreaming of AYUSH physicians, and with appropriate recruitment, posting and transfer policy, this requirement can be met.

Community Health Centre

At the CHC level, non-availability of specialists, lack of anaesthetists, improper manpower and transfer policy, absence of a specialist cadre in many states, lack of basic amenities, quality control, lack of referral policy/support, involvement of private sectors and professional associations, contractual appointments etc are the major concerns. Indoor facilities provided are not used to the desired level. There is a shortfall of 1074 Obstetric & Gynaecology (Ob & Gyn) specialists, 1121 surgeons, 1607 paediatricians and 1457 physicians even in the currently functioning CHCs. This requirement will increase if new centres are established as per the estimate. Service of anaesthetists is not available at present in CHCs, which seriously hamper the functioning of the surgical and (Ob & Gyn) specialists. Provision of services of anaesthetists is a daunting task.

A list of essential drugs, equipment and other supplies has been prepared. However, the states ordistricts may be given the flexibility to have their own list of essential drugs. The logistics aspect of these supplies needs consideration.

Understanding and Assessing Health systems

A health system refers to the people, institutions and resources arranged together to improve health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill health[1].

The health system of a country has the following characteristics :

- **Goodness:** Improvement of health status.
- **Responsiveness:** The extent to which health system meets a population's expectations of how they should be treated.
- **Fairness:** Fairness in the distribution of resources and outcomes.

They are expected to perform the following functions[2]:

- **Delivering services:** What services, delivered by whom and how.
- **Financing:** Generation and allocation of funds for health systems.
- **Creating resources:** Human resources, capital infrastructure, knowledge and technology, drugs and other consumables required to deliver services.
- **Stewardship:** Oversight, setting the rules of the game, collating and collecting information, regulation, consumer protection.

We can assess performance of all health systems for their:

- **Responsiveness:** Availability, access, acceptability and quality.
- **Efficiency:** Value for money.
- **Equity:** Investing in increasing access to health services of vulnerable groups; narrowing the health gaps between the top and bottom levels of population.

It is usual practice to distinguish between primary, secondary and tertiary levels of health care in a country. Primary health care is the first point of contact a person encounters with the health services. Secondary health care refers to those services particularly provided by hospitals and tertiary health care refers to those specialist services mostly provided by the medical profession.

The health system in a country consists of public and private sector. All health care initiatives and providers financed and managed by government are in the public sector. The private sector may be defined as comprising all providers who exist outside the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat or prevent disease. They include large and small commercial companies, groups of professionals such as doctors, national and international non-governmental organisations and individual providers and shopkeepers. The services they provide include hospitals, nursing and maternity homes, clinics run by doctors, nurses and midwives, paramedical workers, diagnostic facilities, e.g. laboratories and radiology units, and the sale of drugs from pharmacies and unqualified static and itinerant drug sellers, including general stores[3].

[1] World Health Report 2000
[2] Sundari Ravindran
[3] Mills, 2002


PRIMARY HEALTH CENTRE
JSY
जननी सुरक्षा योजना

CHAPTER 3

Communitisation Of Health Services

We are aware that health service is our right. But for this right to be actually realised, there should be regular dialogue between people and the system providing health services. It is not enough to demand rights only on paper. People should be able to assert those rights. For that, all of us must take the responsibility of making people aware about their rights. It is often said that the government's schemes always fail due to lack of people's cooperation. But then, if people are not explained the government's scheme and the purpose behind the scheme in detail, they will not cooperate. This is what also happens with health programmes.

Why People often do not Enthusiastically Support Government Health Programmes?

To understand this issue better, let us see an example of a public health activity.

In some areas, the government provides mosquito nets for protection from mosquito bites, especially where there is a high incidence of malaria. But it is found that these nets are also used for fishing in these areas. Actually a bed net is not always very suitable to living conditions of people in rural areas where they do not sleep on beds and often sleep outside the house. Where will they tie the mosquito net, considering the structure they live in; and how many members of the house can actually manage to sleep under the net? Several such questions need to be addressed when it comes to the use of bed nets in rural areas.

The fact is that due to poverty, people are also forced to migrate to other places in search of employment. The mosquitoes in the areas where they migrate bite them, and they thus contribute further to spread of malaria when they return to their original areas of residence. The government provides medicines to cure malaria but in reality people also need employment at their place of residence and nutritious food.

When people use mosquito net for fishing purposes, can we say that they are ignorant and are not able to understand the importance of health programmes, and that they are not interested in taking care of their own health?

While answering these questions, we must take note of the following things:

- Since people often don't have secure employment and resources, they depend on their surrounding environment to fulfil their needs. In their quest to fulfil the prime need of food, they are even ready to utilise any new means, which are available for this purpose. Without taking this into consideration, it would be inappropriate to blame people for the failure of health programmes.

- While implementing any health programme, people's participation should not be taken for granted without consulting with them beforehand. People also want a better life for themselves, but their opinions must be taken into consideration, while making any plans for improving their lives.
- It is not be enough to say 'our services are available to people.' Going further, health workers may say that 'everyone needs health services, but no health programme can be successful without your participation. So you help to plan the programmes and we will implement them with your guidance and co-operation'. This will boost the feeling among the people that they take ownership of the health service as their right and hence they should participate in its implementation for their own good.

The only way to seek people's views and opinions about the health programmes, is to establish a continuous dialogue with them. The health system holds certain experiences and views about people. Similarly, people also have their own views and experiences about the health system. To understand this issue regarding the health service, let us see what Bharati didi and Lakhan have to say.

Bharati Didi's Opinion

My name is Bharati. I work as an ANM in the PHC at Rampur. It is a tribal and hilly area. In our department, working in such a remote and tribal area is considered to be a punishment for the workers. People here are illiterate and sometimes do not understand simple things, even after explaining several times. As a rule, our PHC is supposed to provide health service for a population of 20,000 people, but in reality, we are providing health service to a population of 28,000 people. I have the responsibility of nine hamlets. It is a very difficult job for any ANM to fulfil all the stipulated responsibilities for people in nine hamlets. The heat and travelling is troublesome. Besides, there is no guarantee that one will meet the people even when one reaches the village after a tiring travel. How can I provide them health services on their farms, which are located in the far interiors of the forest? Despite going from door-to-door for vaccination, it is not possible to cover everyone.

Also, being a woman, I feel scared to make door-to-door visits. Several times, there is a risk of confronting drunken men in the villages. Identifying cases for family planning is such an important task in our work. But these uneducated people don't understand the importance of family planning, how am I expected to work in this situation? Please, tell me!

Now let us listen what Lakhan has to say

I am Lakhan. I am an adivasi and my village is in the hills. It can hardly be called a village. In fact, it is just a small hamlet. I have studied up to Class 11th and now I am working on the farm with my parents. I work as a rickshaw driver when there is no farm work. Often, I take people who are ill to the PHC at Rampur.

On many occasions, I have made the patients sit on the benches in the PHC and have gone to call the doctors. Once, a patient was so sick that he was unable to sit. So he lay down on the bench while the doctor was coming to see him. But then, one of the staff members in the hospital abusively told him, "Hey you drunkard, get up!" Why do these foresters, police, gram sevaks and government hospital staff treat poor people like us in such an insulting manner?

It is due to incidents like these that I have developed a negative opinion about the PHC. The nurse madam in the PHC - what work does she do when she visits the village? Are they supposed to do only two things when they visit the village - taking names for family planning operation and doing vaccination? People in the village need tablets for fever and diarrhoea and not just family

planning. But do they bring these tablets when they come to visit the village?

The doctor is not present in the PHC in the evening or nighttime. In the PHC, people often do not get the required medicine for their illness and have to buy it from far off medical stores. People will definitely give preference to the PHC if good doctors and sufficient medicines are made available. I know it has been set up by the government to benefit us.

We are aware of the opinions of Bharati didi and Lakhan. Both have different views about the same health services. But if both the sides come together and discuss the problems faced by them, misunderstandings can be cleared, and a solution can be sought to most of the problems. But for this to happen, following things must be ensured:

1. Understand the problems in the health system. People, public health employees and the medical officers should sit together and discuss the issues.
2. Solve the problems at local level with each other's co-operation.
3. Communicate to senior officials. Some problems cannot be solved at the local level and need the intervention of senior officials. Health workers and people should put the problem jointly in front of the senior officials.
4. Bridge gap between health employees and people. Health employees can get considerable cooperation from people. Some times when senior officials do not realise the difficulties in work at local level, people's representatives can follow-up in resolving these difficulties on behalf of the employees.

If health employees and people start thinking together about problems in the health system, the spirit of cooperation will be boosted. Also, people will get the space to express their opinion and articulate their problems. People in the village should also get the following assurances -

- Participation of local people will be sought in planning of health services.
- Villagers should help in solving problems faced by health machinery but, at the same time, the villagers would point out any negligence or mistake made by health employees while providing health service.
- Villagers should also be given information about what action has been taken to avert mistakes pointed out by the villagers to Medical Officer.

Dialogue as a Step towards Community Ownership

If the villagers are convinced that such participation will be allowed, they will be encouraged to help health employees and will be important actors in improving public health. It is essential to establish a regular dialogue between the health system and people to achieve this. But what is the expected direction of this dialogue? For example, we might expect that people would understand the systemic problems of the health system, like lack of sufficient supply of medicines, recruitments for staff in public health institutions being pending, etc. But having 'understood' these problems, do we expect people to just be happy with whatever health services they are presently getting from such a system, with all its gaps? Is this the kind of 'understanding' on which we wish to base the dialogue between the people and the public health employees?

No, this is not what we expect. We will not be able to change the current scenario of the health system if we limit ourselves to just dialogue, without addressing the problems in this system. **We need dialogue in order to jointly take action for solving various problems.** The National Rural Health Mission is inclined to make radical changes in methods of providing health services. It will be inappropriate if in the process of changing the methods of providing health services, the perspective of the health service providers is one-sidedly imposed on the beneficiaries. Rather, health service providers themselves may also have to modify and enlarge their perspective. 'Quality Health Services to People' will be the key focus of this new perspective.

People have the ultimate power in democracy. Hence, adopting a change in method of providing health services is nothing but providing health services while placing people at the centre. For this, we should move towards community ownership of health services, by organising a regular dialogue process between the health system and people.

What is Communitisation of Health Services?

There should be convergence between people and government health employees for reforms to take place in health services. Ownership and

management of health services should be enlarged; so that ownership moves beyond public health functionaries and involves the common people. The building which houses the public health institution, say a PHC or a rural hospital, is not owned by the doctor nor is the ambulance the private property of the employees of the public health institutions. All this is public property, which has been paid for by people and must serve the needs of the people.

This concept of communitisation of health services is based on the strong belief that the people own the entire health machinery. The problems identified in any area, such as spreading of communicable diseases, maternal mortality, child mortality or malnutrition should not be matters of concern only for the Health Department, rather these should become matters of people's concern. For this, people should have a proper orientation about the problems and also the health system working to address these problems. In order to achieve this, the health system has to adopt a policy of complete transparency and accountability.

"We have a right to health services, and we will assist in solving any obstacles which obstruct our realisation of this right. We will remain vigilant to ensure the good quality of these health services". This is the approach, which should be inculcated in people. When people have the freedom to decide what kind of health services they want, only then will they get the feeling that the health service is actually their baby, which they have to nurture and develop. When poor people approach a public health institution to avail health services, they might be treated as if the government is doing them a favour by running the institution. This attitude must change. To move towards communitisation of health services, the following things need to be done:

- People should be made partners in managing public health institutions. If certain infrastructure or services are not properly functional, community representatives should be involved in finding solutions. If government property is being misused, people should have enough confidence and powers that they can stop that misuse. But for this to happen, people should have a decision-making position, including powers for financial decision-making related to the health services. The health system should have faith in people's decision-making capacities. Community representatives should have a significant role in the day-to-day functioning of the health services at the local level.

- People should have clearly defined rights. People should be able to expect and demand basic services in keeping with their needs and expectations. If these rights are not fulfilled, it should be a cause of concern and concerted action for improvement by the public health system and community members.

- People should be given responsibility. People can take the responsibility to instil regularity in health services provided at the village level. People in the village can take up responsibility to support activities for vaccination in the village, etc. Community members should be provided training to be able to fulfil their responsibilities and realise their rights.

Communitisation of health services means that both public health employees and common people should develop a feeling that 'this health institution is ours,' at an equal level. This is the broader vision as part of which we can view monitoring of health services and realisation of the right to health care.

CHAPTER 4

What do we mean by community monitoring of health services?

Monitoring is an English word which means:

- **To keep track of systematically, with collection of information.**
- **To keep close watch over; supervise.**

In other words, someone is authorised to watch whether a decided activity is being completed in a proper manner. The progress of the decided activity is reviewed, based on information collected on a regular basis.

There are three major forms of monitoring of health services:

- **Internal monitoring:** Health employees and officials report regularly about their work to their seniors. How much work has a health centre managed to do as per the designated work is reported to the seniors. Large scale, regular information is collected through this.
- **Independent studies:** A particular organisation doing research is given responsibility of monitoring by the Health Department. Such organisation has its own autonomous status. It collects information through various methods and sources and presents a report with recommendations on the basis of this information.
- **Community monitoring:** Apart from the above two methods of monitoring, a third method is to seek the opinions of actual beneficiaries of health services. When the actual beneficiaries register their opinions through different methods, this can be referred to as monitoring by people.

We will be here discussing about the third method of monitoring. Some special features of this type of monitoring by community representatives are:

1. **To keep an ongoing watch -** Any particular work is started with a specific purpose. The review of progress of that work becomes important to ensure that the work is moving towards the

decided purpose, and the purpose has not shifted nor has the work got derailed in any way. Such a review can help identify obstacles in the work so that appropriate changes can be made to cross the obstacles. For example: One of the objectives of the health service is to minimise maternal mortality. But to achieve this, are all pregnant women being registered in time by the health system? Do they get the required vaccination, counselling, guidance and necessary medicines and treatment? Are high-risk pregnancies identified in time, and are these women given health services from a public health institution? A watch must be kept on these aspects. It is expected that people should keep a watch on these various objectives of health services through monitoring.

2. **To obtain information regularly -** Information is collected as part of monitoring to check whether work is being done as per specified objectives. But it is not enough to collect information only once in a year or two. Instead, if the information seeking process is ongoing and regular, then it is also possible to make timely improvements in the activities, while the work is in progress.

3. **Combination of monitoring and planning -** Representative committees should not limit itself to collecting information, but should also be involved in planning of health services at a local level. The aim of community based monitoring and planning is similar: To reform and improve health services at the local level. The recommended committees should fulfil both the responsibilities of monitoring and planning. Hence the committees are called monitoring and planning committees.

4. **Monitoring at multiple levels -** Monitoring and planning committees are formed at various levels such as Village Health Committee, Primary Health Centre, block and district level committees. These committees are supposed to be vigilant to ensure that people get good quality health services. It is also expected in the process that problems in accessing health services that can be solved at the local level are addressed there, while for other issues information should be sent to responsible higher officials for further follow-up.

People's representative committees are supposed to keep a special watch on following things during monitoring of health services -

- Do all people receive good quality health services as per the declaration of the government?
- Are there any gaps in health services? Do public health employees have any problems? Do people have any complaints regarding health services?
- What can be done to solve these? In events of denial of health services to people, we need to find the reasons for this and take steps to ensure that this does not happen again in the future.
- Planning of health services at the local level should take into consideration the specific health needs of the area, and should be done after proper consultation with people and through their cooperation.

Why Monitoring of Health Services by People is necessary

Let us assume that in a particular area, a large number of people are dying due to snakebite. To avoid these deaths, the government has decided to provide anti-snake venom in all the public health institutions of the area. It has also declared that the anti-snake venom and a doctor to administer it would be available at any time. But how would we be able to know whether this assurance by government has been fulfilled or not? People for whom this declaration was made by the government, can ask the following questions to see whether there has been some action on their problem -

1 Is anti-snake venom always available in the public health institution?
2 Even if the medicine is available, are the doctors and other staff available to provide actual treatment?
3 If a patient has not received the medicine, then why was it not available at that particular time?
4 During which period/season do maximum snakebites take place? Hence in which period/season should the anti-snake venom be made available on a larger scale?
5 What are facilities required in a health institution to ensure proper storage of the medicine?

Various health problems can be solved if information about these health problems can be sought through monitoring as mentioned for the problem above. The advantages of such monitoring are as follows:

Table 3- Advantages of Monitoring and Planning by the Community

Advantages for the Public Health System	Advantages for the People
People's view point /feedback about services provided can be taken into account.	People get an opportunity and space to put forth their complaints regarding health services and to give their opinion about the health services they need.
It helps in providing health services to a wider number of beneficiaries.	Unnecessary expenses on private doctor are avoided as improved public services are utilised.
A relationship of mutual understanding and cooperation is built between people and public health employees.	People learn in detail about the government's health services and schemes.
Objective review can be taken about the extent to which the objectives of the health services are achieved.	People do not remain mere beneficiaries of health services. Rather, they take on the active role of participating in the implementation of these services.
Obstacles in achieving the objectives of health services can be identified well in time.	Some health problems at the village level can be solved through everyone's cooperation.
Transparency in functioning becomes possible while providing health services. Employees and officers at all levels become proactive.	The health system becomes accountable to the people.

CHAPTER 5

Introduction To NRHM

The Government of India launched the National Rural Health Mission (NRHM) on 12th April 2005. The vision of the Mission is to undertake architectural correction of the health system and to improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care throughout the country with special focus on 18 states, which have weak public health indicators and or weak infrastructure.

The 18 special focus states are, Arunachal Pradesh, Assam, Bihar, Chattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa , Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

NRHM is a seven years programme ending in the year 2012. It has time bound goals and the government will report its progress publicly.

Some of the goals of the Mission are:

- Reduction in child and maternal mortality.
- Universal access to public health care services, along with public services for food and nutrition, sanitation and hygiene.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary health care.

Some of the core strategies through which the Mission seeks to achieve its goals are:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved health care at household level through ASHA.
- Health Plan for each village through Village Health Committee.
- Strengthening existing sub centre, PHCs and CHCs.
- Preparation and Implementation of an inter-sectoral District Health Plan.
- Integrating vertical Health and Family Welfare programmes at national, state, block, and district levels.

Unlike previous health programmes, the government has clearly defined the role of Non Governmental Organisations (NGOs) in the Mission. NGOs are not only included in institutional arrangement at national, state and district levels but they are also supposed to play an important role in monitoring, evaluation and social audit.

With the launch of NRHM, the Government of India

proposed Accredited Social Health Activist (ASHA) to act as the interface between the community and the public health system.

Since sub centers serve a much larger population than they are expected to and ANMs are heavily overworked, one of the core strategies of NRHM is to promote access to improved healthcare at household level through ASHA.

- ASHA is a health activist in the community.
- Every village will have one ASHA for every 1000 persons.
- She will be selected in a meeting of the Gram Sabha.
- She will be chosen from women (married or widowed or divorced between 25-45 years of age) residing in the village with minimum education up to Class eight.
- ASHA is accountable to the Panchayat.
- ASHA will work from the Anganwadi Centre.
- ASHA is honorary volunteer and she is entitled to receive performance-based compensation. Her services to the community are free of cost.
- ASHA will receive trainings on care during pregnancy, delivery, post partum period, newborn care, sanitation and hygiene.

Roles and Responsibilities:

ASHA is responsible for creating awareness on health including:

- Providing information to the community on nutrition, hygiene and sanitation.
- Providing information on existing health services sand mobilising and helping the community in accessing health related services available at health centers.
- Registering pregnant women and helping poor women to get BPL certification.
- Counselling women on birth preparedness, safe delivery, breast feeding, contraception RTI/STI and care of young child.
- Arranging escort/accompany for pregnant women and children requiring treatment or admission to the nearest health centre.
- Promoting universal immunisation.
- Providing primary medical care for minor ailments. Keeping a drug kit containing generic AYUSH and allopathic formulations for common ailments.
- Promoting construction of household toilets.
- Facilitating preparation and implementation of the Village Health Plan through AWW, ANM,SHG members under the leadership of Village Health Committee.
- Organising Health Day once or twice a month at the anganwadi with the AWW and ANM.
- ASHA is also a depot holder for essential services like IFA, OCP, condoms, ORS, DDK etc, issued by AWW.

COMMUNITY MONITORING IN NRHM

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 per cent 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 centre 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 organisations (CBOs), people's movements, voluntary organisations 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 and 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:

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, CHC.
5. Concrete Service Guarantees.
6. Citizen's Charter and so on.

Activities within the Community Monitoring Process

The following activities are envisaged within the community monitoring process at the community level

- Informing and mobilising the communities about the provisions of NRHM.
- Formation and strengthening of Community Monitoring and Planning Groups at the village (VHSC) and facility levels (PHC and CHC).
- Orientation and training of members of the Community Monitoring and Planning committees.
- Orientation and training of service providers about community monitoring.
- Conduct village level and facility level monitoring exercise.
- Preparation of village and facility level report cards.
- Sharing of report cards and experiences through VHSC RKS meetings and Public Hearings (Jan Samvad/Jan Sunwai).
- Planning for improvement.

CHAPTER 6

Frameworks For Community Monitoring In NRHM

As mentioned in chapter five that community-based monitoring of health services is a key strategy of the National Rural Health Mission (NRHM) to ensure that the services reach the needy, especially those residing in rural areas including women and children. Community monitoring is also seen as an important aspect of promoting community-led action in the field of health.

Provision for Monitoring and Planning Committees has been made at Primary Health Centre (PHC), Block, District and State levels. Adoption of a comprehensive framework for community-based monitoring and planning at various levels under NRHM places people at the centre of the process of regularly assessing whether health needs and rights of the community are being fulfilled.

Community monitoring is to review the progress to ensure that community is getting timely stipulated services. Such a review can help identify obstacles during activities so that appropriate changes can be made to meet the challenges.

CONCRETE SERVICE GUARANTEES

Concrete Service Guarantees that NRHM provide are the benchmarks against which mission functioning can be monitored and its success can be measured. Service Guarantees at Sub Health Centers (Sub Centres), PHCs and CHSs are as followed;

SERVICE GURANTEES FROM SUB CENTER

Services provided at the sub center are free of cost for a person from BPL family.

Sub-centres are expected to provide promotive, preventive and few curative primary health care services as below:

Maternal Health

Antenatal care

- Early registration of all pregnancies.
- Minimum four antenatal check-ups.
- General examination such as weight, BP, anaemia, abdominal examination, height and breast examination.
- Iron and Folic Acid supplementation.
- T.T injection, treatment of anaemia, etc.
- Minimum laboratory investigations like haemoglobin, urine albumen and sugar.

- Identification of high-risk pregnancies and appropriate and prompt referral.

Intra natal care

- Promotion of institutional deliveries.
- Skilled attendance at home deliveries as and when called for.
- Appropriate and prompt referral.

Postnatal care

- A minimum of two postpartum home visits (first within 48 hrs of delivery, second within seven to ten days).
- Initiation of early breast-feeding within half-hour of birth.
- Counselling on diet and rest, hygiene, contraception, essential newborn care, infant and young child feeding and STI/RTI and HIV/AIDS.

Child Health

- Essential newborn care.
- Promotion of exclusive breast-feeding for six months.
- Full Immunisation of all infants and children.
- Vitamin A prophylaxis to the children.
- Prevention and control of childhood diseases like malnutrition, infections, etc.

Family Planning and contracetion

- Education, Motivation and counseling to adopt appropriate family planning methods.
- Provision of contraceptive such as condoms, oral pills, emergency contraceptives, IUD insertions.
- Counselling and appropriate referral for safe abortion services (MTP) for those in need.
- Follow-up services to the Eligible couples adopting permanent methods.

Adolescent health care

- Education, counselling and referral.
- Assistance to School Health Services.

Endemic diseases

Control of local endemic diseases like Malaria, Kala azar, Japanese Encephalitis, Filariasis,Dengue etc.

Water Quality Monitoring

- Disinfection of water sources.
- Testing of water quality using Rapid Test.
- Monitoring of water quality in the villages.

Sanitation

Promotion of sanitation including use of toilets and appropriate garbage disposal.

Curative Services:

- Provide treatment for minor ailments including and first-aid in accidents and emergencies.
- Appropriate and prompt referral.
- Organising Health Day at Anganwadi centres at least once in a month.

Training, Monitoring & Supervision

- Training of Traditional Birth Attendants and ASHA.
- Coordinated services with AWWs, ASHA, Village Health and Sanitation Committee, PRI.
- Supervision of activities of ASHA.

Record of Vital events:

- Recording and reporting of Vital statistics including births and deaths, particularly of mothers and infants.
- Maintenance of all the relevant records concerning mother, child and eligible couples in the area.

Apart from above mentioned services, field visits and community need assessment is an essential part of the sub centres.

The sub centres are accountable to the Gram Panchayat and shall have a local committee for its management, with adequate representation of Village Health and Sanitation Committee.

ANM and Multi Purpose Health worker (MPW) work from the sub centre and deliver the above-mentioned services with the help of ASHA.

Funds Available

- The Gram Panchayat and SHC Committee has the mandate to undertake construction and

maintenance of SHC. An annual maintenance grant of Rupees 10,000 is available to every SHC.
- Every SHC gets Rs.10,000 as untied grants for local health action. The resources could be used for any local health activity for which there is a demand. The fund would be kept in a joint account to be operated by the ANM and the local sarpanch.

SERVICE GUARANTEES FROM PHC

All services provided at PHC are free of cost for BPL families.

Every PHC has to provide OPD services, inpatient service, referral service and 24-hours emergency service for all cases needing routine and emergency treatment including treatment of local diseases.

All services provided by sub centers are also provided by PHC. Some additional services provided in a PHC are as follows:

Maternal Health
- 24-hour delivery services both normal and assisted.
- Appropriate and prompt referral for cases needing specialist care.
- Pre-referral management (Obstetric first-aid).
- Facilities under Janani Suraksha Yojana.

Family Planning

- Permanent methods of family planning like Tubal ligation and vasectomy / NSV.
- Counseling and appropriate referral for safe abortion services (MTP) for those in need.
- Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions.
- Medical Termination of Pregnancies (wherever trained personal and facility exsits).

Treatment of RTI/ STIs

a) Health education for prevention of RTI/ STIs.
b) Treatment of RTI/ STIs.

Basic laboratory services

- Routine urine, stool and blood test.
- Sputum testing for TB.
- Blood smear examination for malarial parasite.
- Rapid test for pregnancy.

Referral services

Appropriate and prompt referral of cases needing specialist care including:
- Stabilisation of patient.
- Appropriate support for patient during transport.
- Providing transport facilities either by PHC vehicle or hired vehicle.

A Charter of Citizen's Health Rights should be prominently displayed outside all PHCs.

The PHC (not at the block level) will be responsible to the elected representative of the Gram Panchayat where it is located.

The block level PHC will have involvement of Panchayti Raj elected leaders in its management even though Rogi Kalyan Samiti would also be formed for day-to-day management of the affairs of the hospital.

The Mission seeks to provide minimum three staff nurses to ensure round the clock services in every PHC.

Funds Available

- Each PHC is entitled to get an annual maintenance grant of Rs 50,000 for construction and maintenance of physical infrastructure. Provision for water, toilets, their use and their maintenance, etc, has to be priorities. PHC level Panchayat Committee/Rogi Kalyan Samiti will have the mandate to undertake and supervise improvement and maintenance of physical infrastructure.
- Every PHC is entitled to get Rs 25,000 as untied grants for local health action. The resources could be used for any local health activity for which there is a demand.

SERVICE GUARANTEES FROM CHC

All services provided at CHC are free of cost for BPL families.

The CHCs are designed to provide referral health care for cases from the primary level and for cases in need of specialist care approaching the centre directly. All services provided by PHC are also provided by CHC. Some specialist services provided in a CHC are as follows:

- Care of routine and emergency cases in surgery

and medicine.
- 24-hour delivery services including normal and assisted deliveries.
- Essential and emergency obstetric care including surgical interventions.
- Full range of family planning services.
- Safe abortion services.
- Newborn care and routine and emergency care of sick children.
- Diagnostic services through the microscopy centers.
- Blood storage facility.
- Essential laboratory services.
- Referral transport services.
- All National Health Programmes should be delivered through the CHCs. E.g. HIV/AIDS Control Programme, National Leprosy Eradication Programme, National Programme for Control of Blindness.

Over the Mission period, the Mission aims at bringing all the CHCs on par with the IPHS to provide round the clock hospital-like services. According to IPHS, it is mandatory to display Charter of Citizen's Health Rights outside all CHCs. The dissemination and display of charter is the responsibility of Block Health Monitoring and Planning Committee.

According to IPHS, it is mandatory for every CHC to have Rogi Kalyan Samiti to ensure accountability. The Mission also seeks to provide separate AYUSH set-up in each CHC.

Funds Available

- Every CHC gets annual maintenance grant of Rs 1 lakh for construction and maintenance of physical infrastructure. Rogi Kalyan Samiti or Block Panchayat Samiti has a mandate to undertake construction and maintenance of CHC.
- Every CHC gets Rupees 50,000 as untied grants for local health action. The resources could be used for any local health activity for which there is a demand.

Indian Public Health Standards (IPHS)

IPHS are being prescribed to provide optimal expert care to the community and to achieve and maintain an acceptable standard of quality of care. These standards help in monitoring and improving the functioning of public health centers.

IPHS for CHCs provides for "Assured services" that should be available in a Community Health Centre along with minimum requirements for delivering these services such as:
- Minimum clinical and supporting humanpower requirement.
- Equipment.
- Drugs.
- Physical Infrastructure.
- Charter of patients' rights.
- Requirement of quality control.
- Quality assurance in service delivery and standard treatment protocol.

Similar standards are being developed for PHCs & sub center.

Over the Mission period, the Mission aims at bringing all the CHCs on a par with the IPHS in a gradual manner. In the process, all the CHCs would be operationalised as First Referral Units (FRUs) with all facilities for emergency obstetric care.

It will be for the states to decide on the configuration of PHCs to meet IPH Standards and offer 24X7 services including safe delivery. The RKS would develop annual plans to reach the IPH standards.

CHARTER OF CITIZEN'S HEALTH RIGHTS

Charter of Citizen's Health Rights seeks to provide a framework, which enables citizens to know.
- What services are available?
- The quality of services they are entitled to.
- The means through which complaints regarding denial or poor qualities of services will be addressed.

A Charter of Citizen's Health Rights should be prominently displayed outside all district hospitals, CHCs and PHCs. The IPHS makes the display mandatory for every CHC.
nation and display of Charter is the responsibility of Health Monitoring and Planning Committee at that level. For example, the Block Health Monitoring and Planning Committee are responsible for ensuring

display of the charter at CHC.
While the Charter would include the services to be given to the citizens and their rights in that regard, information regarding grants received, medicines and vaccines in stock etc. would also be exhibited. Similarly, the outcomes of various monitoring mechanisms would be displayed at the CHCs in a simple language for effective dissemination.

The Charter seeks to increase transparency that would help the community to better monitor the health services.

Model Citizens Charter for CHCs and PHCs

Preamble

Community Health Centres and Primary Health Centres exist to provide health care to every citizen of India within the allocated resources and available facilities. The Charter seeks to provide a framework, which enables citizens to know -

- What services are available?
- The quality of services they are entitled to.
- Means through which complaints regarding denial or poor qualities of services would be addressed

Objectives

- To make available medical treatment and the related facilities for citizens.
- To provide appropriate advice, treatment and support that would help to cure the ailment to the extent medically possible.
- To ensure that treatment is best, based on well-considered judgment, is timely and comprehensive and with the consent of the citizen being treated.
- To ensure just awareness of the nature of the ailment, progress of treatment, duration of treatment and impact on their health and lives.
- To redress any grievances in this regard.

Commitments of the Charter

- To provide access to available facilities without discrimination.
- To provide emergency care, if needed on reaching the CHC/ PHC.
- To provide adequate number of notice boards detailing the location of all the facilities.
- To provide written information on diagnosis, treatment being administered.
- To record complaints and designate appropriate officer, who will respond at an appointed time that may be same day in case of in patients and the next day in case of out patients.

Grievance Redressal

- Grievances that citizens have will be recorded.
- There will be a designated officer to respond to the request deemed urgent by the person recording the grievance.
- The aggrieved user after his/her complaint recorded would be allowed to seek a second opinion within the CHC.
- To have a public grievance committee outside the CHC to deal with the grievances that is not resolved within the CHC.

Responsibilities of the users

- Users of CHC would attempt to understand the commitments made in the Charter.
- User would not insist on service above the standard set in the charter because it could negatively affect the provision of the minimum acceptable level of service to another user.
- Instruction of the CHC's personnel would be followed sincerely.
- In case of grievances, users without delay would address the redressal mechanism machinery.

Performance audit and review of the charter

Performance audit may be conducted through a peer review every two or three years after covering the areas where the standards have been specified.

CHAPTER 7

Mobilising The Community And Formation Of VHSC

The village is the main focus for the community monitoring activities. In a block, 15 revenue villages are being included in the first phase of communinty monitoring project. Village is a heterogeneous entity, which has its own dynamics and population groups. To make the community monitoring process a success, involvement of the community is very essential. So instead of pushing the project from outside, we need to work towards the community owning the process and project and seeing it as essential for the empowerment of the village and the betterment of health services. Therefore, mobilisation of the communities is an important part of the community monitoring project.

Objectives of Community Mobilisation:

1. To make the communities aware of their health related entitlement within NRHM.
2. To have a shared understanding of the health issues of the community.
3. To facilitate the formation or expansion of the Village Health and Sanitation Committee.
4. Build ownership about public health service.
5. Develop awareness about determinants of health.
6. To prepare Village Health Services Profile

Proposed Activities:

(Assumption - the block level facilitating organisation is familiar with the village)

Mobilisation of the villages will include:

1. Distributing pamphlets to literate people.
2. Putting up posters in the common meeting places of the people (e.g. near temples, wells, market place, etc.).
3. Informal meetings with key people (leaders of CBOs, women leaders, Pradhan, in the village) to get an idea about;
   - General layout of the village.
   - Different social groups in the village and where they stay.
   - Key health problems of the community.
   - Key service providers of the area.
   - Expense related to health problems.
   - Communities' opinion and use of government health facilities and service providers.

4. Village meeting to share findings, share NRHM information and facilitate formation of VHSC
   - Share the village health services profile in the village.

- Inform community of NRHM and community monitoring in NRHM (share pamphlets and posters and leave multiple sets behind in the community).
- Elicit interest from members of the community about formation of Village Health and Sanitation Committee.

5. Organise Kala Jattha to raise awareness on various issues related to NRHM, on various health entitlements under NRHM and processes of Community based Monitoring and Planning of Health Services.

- Skits could be performed related to the health issues like, NRHM and role and provision of services by ASHA, Janani Suraksha Yojana, 24 hours services at PHCs, VHSC - its formation and role, untied fund etc.
- Songs could be composed and written on NRHM and community monitoring and perform by Kala Jattha team.
- The Kala Jatha teams should visit all selected villages and performed street plays. These performances attracted many villagers and proved to be very effective in mobilizing rural folks and raising awareness among them.

Composition & Role of Village Health and Sanitation Committee

This Committee would be formed at the level of the revenue village (more than one such village may come under a single Gram Panchayat).

The Village Health Committee would consist of:

- Gram Panchayat members from the village
- ASHA, Anganwadi Sevika, ANM.
- SHG leader, the PTA/MTA Secretary.
- Village representative of any Community based organisation working in the village.
- User group representative.

The chairperson would be the Panchayat member (preferably woman or SC/ST member) and the convenor would be ASHA; where ASHA not in position it could be the Anganwadi Sevika of the village.

Some roles of the Village Health Committee:

- Create public awareness about the essentials of health programmes with focus on people's knowledge of entitlements to enable their involvement in the monitoring.
- Discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community.
- Analyse key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present an annual health report of the village in the Gram Sabha.
- Undertake **"Participatory Rapid Assessment"** to ascertain the major health problems and health related issues in the village. Estimation of the annual expenditure incurred for management of all the morbidities may also be done. The mapping will also take into account the health resources and the unhealthy influences within village boundaries. Mapping will be done through participatory methods with involvement of all strata of people. The health mapping exercise shall provide quantitative and qualitative data to understand the health profile of the village. These would be Village information (number of households - caste, religion and income ranking, geographical distribution, access to drinking water sources, status of household and village sanitation, physical approach to village, nearest health facility for primary care, emergency obstetric care, and transport system) and the morbidity pattern
- Maintain village health register and health information board or calendar. The health register and board put up at the most frequented section of the village will have information about mandated services, along with services actually rendered to pregnant women, new born and infants, people suffering from chronic diseases etc. Similarly dates of visit and activities expected to be performed during each visits by health functionaries may be displayed and monitored by means of a village health calendar. This will be the most important document maintained by the village community about the demonstration of health status and health care services availability. It will also serve as the instrument for cross verification and validation of data
- Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW
- Receive a bi-monthly health delivery report from health service providers during their visit to the village. Discuss the report submitted by ANM

and MPW and take appropriate action
- Take into consideration the problems of the community and health and nutrition care providers and suggest mechanisms to solve it
- Discuss every maternal death or neo-natal death that occurs in their village, analyse it and suggest necessary action to prevent such deaths. Get these deaths registered in the Panchayat.
- Manage the village health fund.

Powers of the Committee

- The convener will sign the attendance registers of the AWWs, Mid-Day Meal Sanchalak, MPWs, and ANMs.
- MPWs and ANMs will submit a bi-monthly village report to the Committee along with the plan for next two months. The Village Health Committee would decide format and contents of the bi-monthly reports.
- The Committee will receive funds of Rs.10,000 per year. This fund may be used as per the discretion of the VHC.

Time Line: Three days have been assumed for mobilisation in the community monitoring proposal. These three days with one community/village need not be in one contiguous block.

Village Health Services Profile:

At the end of the mobilisation process, the village health services profile should be filled. This profile should be used by the facilitators and the VHSC members to familiarise themselves before they start with the monitoring process. The village health services profile will also help in comparing the changes that will be brought about after the community monitoring process. The expected changes are improvement in services, increased utilisation of government services and decrease in health related expenditure. The format for the village health services profile is given below.

Format 1- Village Health Services Profile

I. General Information		
1	Name of the Village	
2	Name of the Gram Panchayat	
3	Name of the Block	
4	Name of the District	
5	Name of Sub centre	
6	Name of PHC	

II. Demography		
1	Total Population	
2	SC	
3	ST	
4	OBC	
5	Primitive	
6	Minority Community	
7	Minority Community 1	
8	Minority Community 2	
9	Minority Community 3	

III. Key people/ Village groups

Sl	Key Persons	Groups		
		PRI	CBOs/ NGOs	Others
1	ST			
2	OBC			
3	Primitive Tribe			
4	Majority Community			
5	Minoriting Community			

IV. Information about Health Providers in the Village

a. Government

SL	Health Providers	Available	Health Reasons for Visiting Provider
1	ANM		
2	AWW		
3	Male Health Worker		
4	Any other		

b. Non Government

1	Traditional Healer		
2	Exorcist/faith healer		
3	Trained Dai		
4	Untrained Dai		
5	ASHA		
6	Quack		
7	Private Doctor		
8	Druggist		
9	Any other		

V. Health Facilities

Sl	Name	Distance (in Km)	Communication (Good/Bad)
1	Sub Centre		
2	PHC		
3	First Referral Unit		
4	CHC		
5	Sub Divisional Hospital		
6	District HQ Hospital		

Note: If the health facility is within the village, put zero in the distance column

VI. Community's Opinion of services provided by AWW, ASHA, ANM, PHC and CHC (Take information from Women & Excluded Groups)

Service Availability	Service Provided	Do you Utilise	Problems Faced
AWW	1. 2. 3. 4. 5.		
ASHA	1. 2. 3. 4. 5.		
ANM- sub centre	1. 2. 3. 4.		
PHC	1. 2. 3. 4. 5.		
CHC	1. 2. 3. 4. 5.		

VII. What are the Main Health Problems & Illnesses in the Village? (In order of commonness free list and then rank. List them from the Highest to the Lowest)

Women	Children	General

VIII. Health Expenditures Incurred

(Women & Excluded groups, write what the majority of women say)

1	Which are the diseases that cost the most? List 5 (including maternal & child health) or use prompts for including maternal & child health?	1. 2. 3. 4. 5.	
2	Where do you go for treatment usually?		
3	On what is the money spent the most (why was it so expensive)? (Tick the option which the majority say)	On overall treatment Doctor's Fee Drugs Transportation Time/daily wages lost due to this Repeated referrals Any other reason	
4	For the treatment how did you arrange the money? (Tick the option which the majority say)	I was able to pay of my own Borrowed from neighbours/friends/family members Borrowed from Bank/SHG loan Borrowed money from Sahukar/Mortgage assets Sold land and other belongings Any other reason	

IX. Expenditure for childbirth, diarrhoea, malaria (or any seasonal/endemic diseases). Write the amount in range.

	HOME BASED CARE	Clinic based (seen by doctor but no hospitalisation)	Hospital based care
Delivery			
Diarrhoea			
Malaria			

X. Water & Sanitation Facilities (Women and Excluded Group)

1	What is the main source of drinking water in the village?		
2	What is the main source of water for other purposes such as cooking and washing?		
3	What is the minimum distance to get safe drinking water?		
4	Does the village have community toilet facility?		
5	How many HHs have toilet facility (Total HH/HH having toilet)		

XI. Information of Social Exclusion & Main Health Problems

Group	Form of exclusion	By whom
SC	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
ST	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
Backward/ Minority Community	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
Widow	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.

Date:

Compiled by:

Approved by:

CHAPTER 8

Conducting Community Monitoring At The Village And Facility Levels

PREPARATORY ACTIVITIES

1. In a village meeting, conduct the formation of the VHSC. If VHSC already exists in the village, then promote active participation from weaker sections and CBO or NGO representatives.
2. Block coordinator with help from the block facilitator should arrange for a meeting with the VHSC members. In the villages where CBO or NGO has a strong grassroots presence, other community members could also be involved. In this meeting, a set of five pamphlets of the service guarantees that NRHM has promised, should be distributed.
3. Ask one or two members of the VHSC to speak about the service availability at the village and levels above and improvements that are necessary.
4. Describe the process of community monitoring in the pilot phase and beyond, and its relevance for community members.
5. Fix a suitable day for the activities for preparation of the village health report card.

PROCESS OF COMMUNITY MONITORING

- The community monitoring process results in the formation of a village health report card and a facility score card. The report card and the score card give a snapshot of the status of various health issues prevailing from the village to the district level.
- Village health report and facility score card would be broadly based on following indicators with emphasis on the service guarantees as mentioned in the NRHM.

Table 4- Themes for Community Monitoring & Source of Information

	Themes	Source of Information
1	Disease Surveillance	Group Discussion with Community Members
2	Curative Services	- do -
3	United funds	- do -
4	Child Health	Discussion with Women
5	Quality of Care	Discussion with Women
6	ASHA Community Perceptions	Discussion with Women
7	Adverse Outcome or Experience Reports	Interview and Group Discussions
8	Maternal Health Guarantees	Interview with JSY Beneficiary
9	Janani Suraksha Yojna	-do-
10	Asha Functioning	Interview with ASHA
11	Equity Index	Discussion with Women from General and Marginalised Communities
12	Infrastructure and Personnel	Facility Check List
13	Equipment and Supplies	- do -
14	Service Availability	- do -
15	Unofficial charges	Exit Interview
16	Quality of Care	- do -
17	Functioning of Rogi Kalyan Samiti	Interview with MO

- The frequency of preparing the village report card and the facility score card will be **once in every three months**. This report card and score card would be submitted to the PHC Monitoring committee.
- CBO/ NGO/ SHG representative in the extended VHSC and a Panchayat member should be nominated for preparing the village health report card and facility score card.
- Village health report card and the facility score card would be prepared in a span of two day.
- It is strongly recommended that at least for the first phase, block level coordinator should be present to demonstrate each monitoring activity. This would be crucial for equipping community members to participate in the activity of the village health report card and capacity development of the VHSC members to independently conduct village level meetings and the beneficiary interviews. This has relevance beyond the first phase.
- Activities mentioned in Table 5 will take place at the village level for the preparation of the village health report card and facility score card.

Details of the various activities and how the responses from the community can be recorded to prepare village and facility level score cards are given in the following pages.

ACTIVITIES AT THE VILLAGE LEVEL

Activity I: Group Discussion with community members

- Around 15-20 community members should be present for the Group Discussion.
- After describing the objective(s) of the meeting and detail discussion on the service guarantees that are offered in the NRHM, explain about the process of the community monitoring. Explain to the participants that meeting like this one, is

Table 5- Levels of Data Collection

Beneficiary	Community	Provider	Facility
Five Interviews with women who have delivered in the last three months. (JSY Beneficiary)	One Group Discussion with community members.	One Interview with PHC Medical Officer.	**Observation of sub centre using a checklist.**
	One Group Discussion with women.	One interview with CHC Medical Officer.	Observation of PHC using a checklist.
	One Group Discussion with marginalised communities.	Five Exit Interviews of the PHC patients.	Observation of CHC using a checklist.
	One interview with the ASHA.	Five Exit Interviews of the CHC patients.	

first in the chain of interactions that VHSC would be doing with the local community in the process of the community based monitoring.

- Questions regarding disease surveillance, curative services provided by outreach functionaries and untied fund should be asked. Please conduct the group discussion around the issues mentioned in the Format 2. During the meeting the responses can be recorded in a notebook.
- Conclude the meeting by mentioning that some more investigative activities will be conducted in the village and the results will be shared in a village meeting.
- Once the meeting is over, the responses should be recorded in the format and each response is scored. The corresponding score has to be written in the column named 'Score'. Tally the scores.

Format 2: Group Discussion with Community Members

Village Name: **PHC Name:**
Block Name: **District Name:**

Disease Surveillance (Maximum Score: 10)

S.No	Questions	Function of MPW	Response	Score
1.	Do you regularly get chlorine tablets from MPW for disinfection of the water sources?	To provide information to community on purification of water, regular surveillance of water sources and teach community members regarding the use of chlorine tablet.	**Everyone said yes: 2** **Some people said yes: 1** **None said yes: 0**	
2.	Does MPW regularly visit your village to collect information about the outbreak?	To continually collect information regarding cases of gastroenteritis, jaundice, measles, diarrhoea, malaria.	**Everyone said yes: 2** **Some people said yes: 1** **None said yes: 0**	
3.	Have you found MPW efficient in informing concerned authorities about outbreak of malaria, diarrhoea etc in your village?		**Everyone said yes: 2** **Some people said yes: 1** **None said yes: 0**	
4.	Do you report events like birth and death to MPW?	Register marriage, pregnancy, birth and death.	**Everyone said yes: 2** **Some people said yes: 1** **None said yes: 0**	
5.	Does MPW proactively approach you for registering vital events like birth and death?	Five Exit Interviews of the CHC patients.	**Everyone said yes: 2** **Some people said yes: 1** **None said yes: 0**	
	Total			

Curative Services Provided by Outreach Functionaries (Maximum Score: 12)

S.No	Questions	Responsibilities of Functionaries	Response	Score
1.	Did you receive tablets for fever, cough, and diarrhoea from ANM or ASHA?		**Everyone: 2** **Some people: 1** **None: 0**	
2.	Do TB patients in your village are receiving regular medication from ANM or ASHA?		**Everyone: 2** **Some people: 1** **None: 0**	
3.	Does ANM, ASHA and AWW organise Health Day in your village regularly?	Organising a Health Day at Anganwadi centers with the help of ASHA, PHC MO and Panchayat members.	**Everyone: 2** **Some people: 1** **None: 0**	
4.	In the event of accident do you regularly get first-aid treatment in your village?	Providing first-aid for accidents and emergencies.	**Everyone: 2** **Some people: 1** **None: 0**	
5.	Do you regularly get anti malarial tablet from ANM or MPW?	Provision of specific treatment to all MP positive cases.	**Everyone: 2** **Some people: 1** **None: 0**	
6.	Did ANM or ASHA refer someone to PHC or CHC for serious illness?		**Everyone: 2** **Some people: 1** **None: 0**	
	Total			

Untied Fund (Maximum Score: 8)

S.No	Questions	Usage of Untied Fund	Response	Score
1.	Are you aware that Rs 10000/- is allotted to your VHSC as an untied fund?		Everyone: 2 Some people: 1 None: 0	
2.	Do you get transportation allowance from the untied fund for referring serious patients to the PHC/ CHC?	Part of this fund could be used for transportation of serious patients to appropriate referral centers.	Everyone: 2 Some people: 1 None: 0	
3.	Does ANM/ASHA purchase medicine for dispensing in case of non availability?	ANM/ ASHA may purchase some essential medicines till it is supplied by the Health Department.	Everyone: 2 Some people: 1 None: 0	
4.	Has there been any awareness drive by VHSC in last three months?	VHSC is expected to conduct awareness drive on health related issues at the village level.	Everyone: 2 Some people: 1 None: 0	
	Total			

Activity II a. Group Discussion with Women of General Village Community

- Around 10-15 women from the dominant village community should be present in the group discussion.
- The woman representative of the VHSC should facilitate this meeting.
- After an initial round of introduction, the participants should be made aware about various entitlements that NRHM has promised, especially in the context of maternal and child health.
- After describing the objective of the meeting, explain about the process of the community monitoring. Explain to the participants that meeting like this one is first in the chain of interactions that VHSC would be doing with the local community in the process of the community based monitoring.
- Questions regarding child health, ASHA functioning, quality of care, adverse outcomes and any other key issues of concern surrounding maternal and child health should be asked. Please conduct the group discussion around the issues mentioned in the Format 3. During the meeting, the responses can be recorded in a notebook.
- Conclude the meeting by mentioning that some more investigative activities will be conducted in the village and the results will be shared in a village meeting.
- Once the meeting is over, the responses should be recorded in the format and each response is to be marked or scored. The corresponding score has to be written in the column named 'Score.' Tally the scores.

Note: The questions for group discussions with women of the general village community and marginalised communities are the same. The reason for having two group discussions for the same issues is to find out if there is a difference in perception and service delivery among the two groups. The information gathered will also be used to develop an equity index in the score card.

Activity II b. Group Discussion with Women of Marginalised Communities

- Around 10-15 women from the marginalised community of the village should be present in the group discussion.
- The woman representative of the VHSC should facilitate this meeting.
- After an initial round of introduction, the participants should be made aware about various entitlements that NRHM has promised, especially in the context of maternal and child health.
- After describing the objective of the meeting, explain about the process of the community monitoring. Explain to the participants that meeting like this one, is first in the chain of interactions that VHSC would be doing with the local community in the process of the community based monitoring.
- Questions regarding child health, ASHA functioning, quality of care, adverse outcomes and any other key issues of concern surrounding maternal and child health should be asked. Please conduct the group discussion around the issues mentioned in the Format 3. During the meeting, the responses can be recorded in a notebook.
- Conclude the meeting by mentioning that some more investigative activities will be conducted in the village and the results will be shared in a village meeting.
- Once the meeting is over, the responses should be recorded in the format and each response is marked or scored. The corresponding score has to be written in the column named 'Score.' Tally the scores.

Table 6- Immunisation Schedule for Reference of Facilitator

Age	Vaccine
Birth	BCG, Oral Polio
6 weeks	DPT, Oral Polio
10 weeks	DPT, Oral Polio
14 weeks	Measles
9 months	Vitamin A dose
1st dose at the age of 9 months every subsequent dose after six months till 3 yrs of age.	

Format 3- Group Discussion with Women (Marginalised & Generalised Community)

Village Name: **PHC Name:**
Block Name: **District Name:**

Child Health (Maximum Score: 16)

S.No	Questions	Responsibilities of Functionaries	Response	Score
1.	Does the ANM regularly visit your village for immunisation?		Yes: 2 Irregular: 1 No: 0	
2.	When was the last immunisation done?		< 1 month: 2 Between 1 to 3 months: 1 > 3 months ago: 0	
3.	Apart from Polio drops, is there any injection given on the arm?		Yes regularly: 2 Yes sometimes: 1 No: 0	
4.	Along with the Polio drops, is there any injection (DPT) given on the thigh?		Yes regularly: 2 Yes sometimes: 1 No: 0	
5.	Does the AWW do growth monitoring in your village every month?		Yes: 2 No: 0	
6.	Does the AWW give advice on diet and extra food for malnourished children?		Regularly: 2 Sometimes: 1 No: 0	
7.	Does the AWW inform parents if their children are underweight or malnourished?		Regularly: 2 Sometimes to some parents: 1 No: 0	
8.	Do the children below three years regularly (every six months) get Vitamin A dose?		Regularly: 2 Sometimes: 1 No: 0	
	Total			

ASHA Functioning (Maximum Score: 10)

S.No	Questions	ASHA's Function	Response	Score
1.	Does ASHA provide counselling on care during pregnancy, new born care etc?	ASHA should advice community members regarding care during the pregnancy, new born care etc	Yes: 2 Irregular: 1 No: 0	
2.	Does the ASHA accompany women for delivery to hospitals	ASHA should accompany women for institutional delivery	Yes: 2 Irregular: 1 No: 0	
3.	Does the ASHA visits household of woman who delivered within six hours?		Yes: 2 Irregular: 1 No: 0	
4.	Does the ASHA organise monthly Health Day for immunization and other health services		Yes: 2 Irregular: 1 No: 0	
5.	Does the ASHA provide medicines for simple illnesses like fever, diarrhoea, cough etc?	ASHA should provide first contact care for simple illnesses at the hamlet level.	Yes: 2 Irregular: 1 No: 0	
	Total			

Quality of Care (Maximum Score: 15)

S.No	Questions	Response	Score
1.	Are you satisfied with the behaviour of the ANM?	Very Good: 3 Okay: 1 Bad: 0	
2.	Are you satisfied with the behaviour of the Nurse of the PHC?	Very Good: 3 Okay: 1 Bad: 0	
3.	Are you satisfied with the behaviour of the Doctor at the PHC?	Very Good: 3 Okay: 1 Bad: 0	
4.	Are you satisfied with the services available at the PHC?	Very Good: 3 Okay: 1 Bad: 0	
5.	Does the ASHA provide medicines for simple illnesses like fever, diarrhoea, cough etc?	Very Good: 3 Okay: 1 Bad: 0	
	Total		

Adverse Outcome (Maximum Score: 0)

S.No	Questions	Response	Score
1.	Maternal death (death within 6 weeks of delivery).	Yes: -1	
		No: 0	
2.	Heavy Bleeding - (during labour or soon after delivery).	Yes: -1	
		No: 0	
3.	High fever soon after delivery.	Yes: -1	
		No: 0	
4.	Prolonged labour (more than one whole day).	Yes: -1	
		No: 0	
5.	Neo natal death (death within a week of delivery).	Yes: -1	
		No: 0	
6.	High fever soon after delivery.	Yes: -1	
		No: 0	
7.	Prolonged labour (more than one whole day).	Yes: -1	
		No: 0	
8.	Neo natal death (death within a week of delivery).	Yes: -1	
		No: 0	
	Total		

Key Issues of Concern around Maternal and Child Health

Maternal Health
1. **2.** **3.**

Child Health
1. **2.** **3.**

Any other concerns?

Activity III. Interview with Beneficiary

- The list of the beneficiaries can be gathered in the course of the group discussions. The beneficiaries are women who have received JSY money or should have received JSY.
- Those women who have delivered in the last three months, whether in an institution or at home should be selected from the beneficiary list for interview. Women could belong to both nearby and remote areas.
- The beneficiary should be made aware about various entitlements that NRHM has promised especially in the context of the maternal and child health.
- After describing the objective of the interview, explain about the process of the community monitoring. Explain that interview like this one, is first in the chain of interactions that VHSC would be doing with the local community in the process of the community based monitoring.
- Questions regarding maternal health guarantees, Janani Suraksha Yojana, adverse outcomes and adverse experiences should be asked. Please conduct the interview around the issues mentioned in Format 4. During the meeting the responses can be recorded in a notebook.
- Conclude the interview by mentioning that some more investigative activities will be conducted in the village and the results will be shared in a village meeting. Assure the beneficiaries about maintaining confidentiality if required by them.
- Once the interview is over the responses should be recorded in the format and each response is scored. The corresponding score has to be written in the column named 'Score'. Tally the scores.
- Women who have denied health care, their testimoney of "Denial of Health Care" should be recorded in Format 5.

Format- 4 Interview with Beneficiary

Village Name: **PHC Name:**
Block Name: **District Name:**

Maternal Health Guarantees (Maximum Score: 10)

S.No	Questions	Response	Score
1.	Did ANM register your name after pregnancy was confirmed?	Yes: 1 No: 0	
2.	Did ANM examine your BP and abdomen at least four times prior to your delivery?	Yes: 1 No: 0	
3.	Did ANM give you red tablets?	Yes: 1 No: 0	
4.	Apart from red tablets was there any other tablet given to you?	Yes: 1 No: 0	
5.	Did ANM give you a TT injection?	Yes: 1 No: 0	
6.	Did ANM examine your blood and urine?	Yes: 1 No: 0	
7.	Has ANM referred you to PHC or CHC for delivery?	Yes: 1 No: 0	
8.	Has TBA or ASHA attended you for a home delivery? (Applicable for home deliveries)	Yes: 1 No: 0	
9.	Has ANM visited you at least once after your delivery?	Yes: 1 No: 0	
10.	Did you receive regular diet from AWW?	Yes: 1 No: 0	
	Total		

Janani Suraksha Yojana (Maximum Score: 5)

S.No	Questions	Response	Score
1.	Did you have institutional delivery? If 'no,' go to Question 4.	Yes: 1 No: 0	
2.	Did the ASHA accompany you?	Yes: 1 No: 0	
3.	Have you received allowance of Rs. 1400 after delivery in PHC or CHC? (applicable if delivery is institutional)	Yes: 1 No: 0	
4.	If you had home delivery did you receive 500?	Yes: 1 No: 0	
5.	Did you have to pay any amount to ANM or in the PHC/CHC to get this allowance?	Yes: 1 No: 0	
6.	Did you face any harassment in getting the money?	Yes: - 1 No: 0	
	Total		

Adverse Outcomes (Maximum Score: 0)

S.No	Questions	Response	Score
1.	Heavy bleeding - (during labour or soon after delivery).	Yes: 1 No: 0	
2.	High fever soon after delivery.	Yes: 1 No: 0	
3.	Prolonged labour (more than one whole day).	Yes: 1 No: 0	
4.	Neo natal death (death within week of delivery).	Yes: 1 No: 0	
5.	Infant death (death within a month of delivery).	Yes: 1 No: 0	
6.	Still birth.	Yes: 1 No: 0	
6.	Any other - specify.	Yes: 1 No: 0	
	Total		

Any Adverse Experience or Denial of Service (Maximum Score: 0)

S.No	Questions	Response	Score
1.	Refused treatment at a government health centre.	Yes: 1 No: 0	
2.	Referred without providing referral sheet or ambulance support.	Yes: 1 No: 0	
3.	Abusive behaviour of staff at government hospital.	Yes: 1 No: 0	
4.	Health provider asked for money.	Yes: 1 No: 0	
5.	Any other, specify.	Yes: 1 No: 0	
	Total		

Note: If there is a life threatening adverse outcome or a grievous denial of service, please record the details The case studies could be presented in Jan Samvad/ Jan Sunwai after having consent.

Format 5 - Testimony of Denial of Health Care

Name of patient -
Age -

Address -
Sex -
Date of interview -

Details of care received at PHC/hospital		
◆ Location of the PHC/Location and type of hospital- ◆ Illness / complaints for which PHC/hospital was visited - ◆ Total Number of visits to PHC/hospital for this illness - ◆ Date of last visit -		
History of last visit in the patients'/attendants' words		
(Here we want to collect information regarding the main symptoms of the patient, who gave care and what kinds of examination, investigation and treatment were given) ◆ What were the perceived shortcomings or deficiencies in care? (as perceived by the patient or attendants) ◆ According to patient, was there any adverse outcome because of deficient care? (death, disability, continued or chronic health problem, severe financial loss e.g. major loan or sale of assets))		
Medical attention received		
◆ Name of the doctor who attended you - ◆ If the doctor was not available at that time, then who attended you - 1. Nurse/ANM 2. MPW 3. Pharmacist 4. Any other person, specify ◆ How long after you reached the PHC/hospital did the Medical Officer/doctor attend to you? ◆ Was examination/treatment/operation delayed or denied because of non-availability of a nurse, doctor or specialist? ◆ In case of an emergency, did the doctor immediately attend to the patient? During hospital stay, regarding conditions that required immediate care, was the doctor available to immediately attend to the patient? ◆ Were nurses or hospital staff available to attend to the patient as and when required? ◆ Do you think that non-availability of any crucial equipment or supply (oxygen, incubator, anaesthetic equipment, blood, emergency drugs etc.) adversely affected the quality of care? ◆ Were all the equipment required for the examination and treatment of the patient available in working condition in the hospital? DIAGNOSIS - (AS TOLD BY THE DOCTOR)		

Medicines		
◆ Did you get all the required medicines at the PHC/Hospital? ◆ Did you have to go to any private medical shop to buy some medicines? ◆ If so, which medicines did you buy from private medical shop? ◆ How much did it cost? ◆ Do you have the prescription? (If yes, obtain a photocopy of the same and attach)		
Expenditure		
◆ Case paper/card made - yes/no ◆ Case paper fee/indoor fee charged - yes/no ◆ Did you receive a receipt for the payment made? ◆ Were you charged excess money at the PHC / Hospital (more than specified rates)? ◆ If yes, how much excess money was charged? ◆ Did your family have to sell assets (land, cattle, jewellery etc.) or take loans to pay for treatment in the govt. hospital?		
Referral		
◆ Was the patient refused admission or referred to another hospital without giving first-aid care? ◆ If the patient was referred, was ambulance or other vehicle made available for the same? ◆ Did the govt. doctor ask you to avail of any private services (e.g. laboratory services, sonography/X-ray) while you were admitted in the govt. hospital? ◆ In case you had to take the patient to a private hospital, which hospital? (name and address of the hospital) ◆ What was the total expenditure on care at the private hospital/private lab or imaging centre? ◆ Did your family have to sell any asset (land, cattle, jewellery etc.) or take loans to pay for the private hospital charges?		

Activity V. Interview with ASHA

- The ASHA appointed for the village should be contacted and a suitable time should be taken from her for the interview.
- After describing the objective of the interview, explain about the process of the community monitoring. Explain that interview like this one, is first in the chain of interactions that VHSC would be doing with the local community in the process of the community based monitoring.
- Questions regarding her role and coordination with AWW and ANM should be asked. Please conduct the interview around the issues mentioned in the Format 6. During the meeting the responses can be recorded in a notebook.
- Conclude the interview by mentioning that some more investigative activities will be conducted in the village and the results will be shared in a village meeting.
- Once the interview is over, the responses should be recorded in the format and each response is scored. The corresponding score has to be written in the column named 'Score'. Tally the scores. If there are problems faced due to lack of support from Health system then subtract one point for each problem faced - maximum subtract three.
- At the end of the interview, the score of each question has to be added and written at the end of each format.

Format 6- Interview with ASHA

Village Name: **PHC Name:**
Block Name: **District Name:**

ASHA Interview (Maximum Score: 12)

S.No	Questions	Response	Score
1.	In collaboration with AWW have you organised a Health Day during last three months?	Yes: 1 No: 0	
2.	Has the ANM or other resource person conducted any refresher training of ASHA in last three months?	Yes: 1 No: 0	
3.	Do you provide advice to pregnant women about institutional delivery?	Yes: 1 No: 0	
4.	Did you go with the women in any of the cases?	All: 2 Some: 1 None: 0	
5.	Have you referred persons to the PHC/CHC in the last three months?	Yes: 1 No: 0	
6.	Have all the persons you have referred been attended properly at the PHC/ CHC?	All: 2 Some: 1 None: 0	
7.	Have you received financial incentives according to norms?	Yes fully: 2 Yes partially: 1 None: 0	
8.	Have you faced any problems in getting financial incentives?	No: 2 Some times: 1 Yes many times: 0	
	Total		

What problems do you face?

1.

2.

3.

ACTIVITY AT THE FACILITY LEVEL

As mentioned in Table 5 "levels of data collection" (page 47), the provider and facility level inputs will be gathered by means of interviews and facility level observation checklist.

Activity I. Observation

- For the observation the checklist format has to be filled. There are three levels of observation:
- Sub centre observation (using Format 7).
- PHC observation (using Format 8).
- CHC observation (using Format 9).
- The formats for the checklists at different levels are given in next page.
- Each item in the checklist that is present at the facility will get a score of one. At the end of each category, (infrastructure and personnel, equipment and supplies, service availability), the scores have to be added and the sum should be written at the end of the score column.

Format 7- Checklist for Sub centre

Name of Sub centre -
Block -

Name of the Village -
District -

Please fill this form through direct observation and through interview with staff. Note: While filling up the "Infrastructure" section of the format, it is recommended to physically observe the presence of the mentioned items.

Total number of hamlets served	
Total Population	
Distance from the farthest hamlet	
Distance from the PHC	

Infrastructure and Personnel	Present	Score
MPW (F) posted		
MPW (F) stays in the sub centre or within SC village		
MPW (M) posted		
MPW (M) stays in the sub centre or SC village		
SC is located in its own premises		
SC has regular water supply		
SC has a functional toilet		
Location within village (Y/N)		
Building is in good condition		
Regular electricity		
Cleaner/Assistant for MPW (F)		
Sub total 1		

Infrastructure	Present	Score
Table one.		
Chairs two.		
Examinable table/IUCD table with foam mattress - one.		
Torch with cell.		
IUCD Kit.		
Delivery table with rubber sheet- one.		
Delivery Kit.		
Weighing machine for adults.		
Weighing machine for infants.		
Functional stove.		
Tub, mug.		

Infrastructure	Present	Score
Covered container for waste disposal.		
Apron.		
Non electric autoclave.		
Instrument steriliser/boiler.		
Urine testing.		
RCH Kit A and B.		
BP apparatus.		
Fetoscope/Stethoscope.		
Gloves.		
Cu T.		
Nirodh.		
Oral Pills.		
IFA large/small.		
Bleaching powder.		
Cotton wool.		
Soap and detergent.		
Towels.		
Dressings.		
Vehicle for mobility.		
Registers/records.		
Sub total 2		

Service Availability	Present	Score
ANC services are available at the SC		
Delivery services are available at the SC		
Referral slips for difficult delivery is provided by the SC		
Immunisation for children are available at the SC		
Treatment for ARI is available at the SC		
Treatment for diarrhoeal diseases is available at the SC		
Referral for RT is available at the SC		
Oral pills/condoms and IUD being dispensed at the SC		
IUD insertion services are available at the SC		
Sub total 4		

Format 8- Checklist for Primary Health Centre

Name of the PHC: **Block:**
District:

Please fill this form through direct observation and through interview with staff. Note: While filling up the "Equipments and Supplies" section of the format, it is recommended to physically observe the presence of the mentioned items.

Population of PHC.	
Total number of sub centres under the PHC.	
Total number of villages covered by the PHC.	
Distance (in km) between PHC and CHC/ Referral Hospital.	

Infrastructure and Personnel	Present	Score
There is regular public transport available to come to the PHC.		
There is an all-weather road leading to the PHC.		
PHC is functioning in a government building.		
Ambulance is in working order.		
The building of the PHC is well maintained.		
There is regular piped water supply at the PHC.		
There is regular electric supply or working back up generator.		
There are functioning toilets in the PHC.		
There is a working telephone in the PHC.		
All female HW posted and present.		
All male HW posted and present.		
Medical Officers posted and present.		
Female doctor posted in the PHC.		
PHN/Nurse posted and present.		
Pharmacist posted and present.		
There is a functioning laboratory.		
Six beds in working condition.		
Staff quarters are available for paramedical staff.		
Paramedical staff are resident at staff quarters.		
Staff quarters are available for Medical Officer.		
Medical Officer resident at Staff quarters.		
Subtotal 1		

Equipment and Supplies	Present	Score
Oxygen cylinder.		
Vaccine carrier.		
B.P. Instrument.		
Stethoscope.		
Weighing machine.		
Microscope.		
Auto-Clave/ Steriliser.		
Ice lined refrigerator with temperature chart.		
Deep freezer with temperature chart.		
Essential newborn care.		
Suction aspirator.		
Labour room equipment.		
IUD insertion kit.		
Normal delivery kit.		
Em OC drugs.		
Measles vaccine.		
ORS packets.		
Mounted Lamp.		
Lubricated Nirodh stock.		
OC pills stock.		
IUDs stock.		
Tubal rings stock.		
Iron Folic Acid stock.		
All vaccine available in sufficient quantities.		
Anti-snake venom serum.		
Anti-rabies vaccine.		
Essential drug list available.		
Drugs on the list are available.		
Citizen's Charter displayed prominently.		
Registers/records.		
Subtotal 2		

Service Availability	Present	Score
Are antenatal clinics organised by the PHC regularly?		
Is the primary management of wounds done at the PHC?		
Are minor surgeries like draining of abscess etc. done at the PHC?		
Is the primary management of burns done at the PHC?		
Is the facility for normal delivery available in the PHC for 24 hours?		
Is the blood examination for anaemia done at the PHC?		
Is the urine examination for pregnant women done at the PHC?		
Is the facility for internal examination for gynaecological conditions available at the PHC?		
Is the treatment for gynaecological disorders like leucorrhoea, menstrual disorders available at the PHC?		
Is the facility for MTP (abortion) available at the PHC?		
Test for AFB?		
Waste disposal?		
Subtotal 3		

Format 9: Checklist for Community Health Centre

Name of the CHC: **Block:**
District:

Please fill this form through direct observation and through interview with staff. Note: While filling up the "Equipments and Supplies" section of the format, it is recommended to physically observe the presence of the mentioned items.

Total number of PHC under the CHC
Total number of villages covered by the CHC
Is this CHC designated as an FRU?
Distance of the CHC from the nearest town?

Infrastructure and Personnel	Present	Score
There is regular public transport available to come to the CHC?		
There is an-all weather road leading to the CHC?		
Ambulance is in working order?		
The building of the CHC is reasonably well maintained?		
There is regular water supply at the CHC?		
There is regular electric supply or working back up generator?		
There are functioning toilets in the OPD?		
There are functioning toilets in the wards?		
There is a working telephone in the PHC?		
There are a total of 30 beds in the wards?		
There is a labour room with delivery table?		
Operation theatre for major surgery?		
Minor OT?		
Laboratory?		
Obstetrician/Gynaecologist posted and present?		
Anaesthetist posted and present?		
Surgeon posted and present?		
Laboratory technician posted and present?		
Female doctor posted and present?		
Medical Officers/Specialists stay on the campus?		
Sub total 1		

Equipment and Supplies	Present	Score
Boyles apparatus in working condition?		
Filled oxygen cylinder present?		
Shadow less lamp present?		
Emergency Obstetric drug kit?		
Standard Surgical kit?		
New born care kit?		
Labour room kit?		
RTI/STI lab kit?		
IUD insertion kit?		
Tubal rings?		
Sub total 2		

Service Availability	Present	Score
Does the OPD function daily at the designated time?		
Are round the clock emergency services available?		
Are there patients admitted into the wards at this time who were admitted as an emergency?		
Does the CHC provide 24-hour emergency obstetric care services?		
Are Caesarean sections conducted in the CHC?		
Are MTP services provided at the CHC?		
Are infants, needing critical care for illnesses such as pneumonia, diarrhoea treated at the CHC?		
Does the CHC provide services for Reproductive Tract Infections (RTIs)?		
Sub total 3		

Activity II. Exit Interview

- The exit interview is taken from those persons coming out of the health centre after being seen by the doctor for their problem.
- After describing the objective of the interview, explain about the process of the community monitoring. Explain that interview like this one, is first in the chain of interactions that VHSC would be doing with the local community in the process of the community based monitoring.
- A total of five exit interviews have to be conducted at each level, PHC and CHC as given in Format 10.
- Consent for interviews should be taken from patient and attendant. Be considerate regarding the patient's status.
- The response to each question is scored. The corresponding score has to be written in the column named 'Score.' At the end of the interview, the scores of each issue have to be added separately and the sum should be written at the end of the column 'Score.'

Format 10- Exit Interview

Name of the PHC/ CHC: **Village name:**
Block Name: **District Name:**

Unofficial Charges (Maximum Score: 5)

S.No	Questions	Response	Score
1.	Have you been provided free medicines from the hospital?	Yes: 1	
		No: 0	
2.	Have you been asked to buy any medicines from outside?	Yes: 1	
		No: 0	
3.	Have you been asked to conduct any tests from outside?	Yes: 1	
		No: 0	
4.	Have you been asked to go to any outside doctor (govt./private)?	Yes: 1	
		No: 0	
5.	Has the doctor, nurse or other staff, other than fee for parchi, asked you for money?	Yes: 1	
		No: 0	
	Total		

Quality of Care (Maximum Score: 10)

S.No	Questions	Response	Score
1.	How long did you have to wait for the doctor to see you?	Took less than 30 minutes: 2	
		Took 30 minutes: 1	
		Took more than 30 minutes: 0	
2.	Are you satisfied by the examination and check-up done by the doctor?	Yes: 2	
		Somewhat: 1	
		No: 0	
3.	How did the doctor behave with you?	Good:2	
		Bad:0	
4.	How did the nurse and other staff behave with you?	Good:2	
		Bad:0	
5.	Did you find the hospital neat and clean?	Yes: 2	
		No: 0	
	Total		

Activity III. Interview with PHC/CHC Medical Officer (MO)

- One interview should be taken of the MO posted in the PHC and CHC.
- Prior appointment should be taken from the MO.
- After describing the objective of the interview, explain about the process of community monitoring. Explain that interview like this one, is first in the chain of interactions that VHSC would be doing with the local community in the process of the community based monitoring.
- Please refer to Format 11 for interview with MOs of CHCs and PHCs.
- Not all the questions are scored but for the questions that are scored, the corresponding score has to be written in the column named 'Score.' At the end of the interview, the scores of each issue have to be added separately and the sum should be written at the end of the column 'Score.'

Format 11: Interview with Medical Officer (Maximum Score: 10)

Name of the PHC/ CHC:
Block Name: **District Name:**

1. Ask the Medical Officer (MO) about the infrastructure, personnel, equipment and supplies and services offered and score accordingly.
2. Ask the MO about the functioning of the Rogi Kalyan Samiti.

S.No	Questions	Response	Score
1.	Does your facility have a Rogi Kalyan Samiti?	Yes: 1	
		No: 0	
2.	How many times has the RKS met since it was formed?	Yes (< 3 times in 1 yr): 1	
		No: 0	
3.	Does your facility have a patient's charter? (It says "Yes" check if it is placed)	Yes: 1	
		No: 0	
4.	When did the last meeting of the Rogi Kalyan Samiti take place?	Yes (within last 3 mths): 1	
		No: 0	
5.	Have you discussed the patient charter in any of your RKS meetings?	Yes: 1	
		No: 0	
6.	Do you have a mechanism to collect feedback from the patients/ community?	Yes: 1	
		No: 0	
7.	Has any feedback been collected and discussed at RKS?	Yes: 1	
		No: 0	
8.	What have been the important decisions taken at the RKS about the functioning of the hospital?	(1 point for each)	
9.	Expenditure Related to RKS Funds?		
10.	Step Taken for Patient Welfare?		
11.	Step Taken for Grievance Redressal of Patients?		
	Total		


REPORT SAYS ZERO DEATH!
MATERNAL DEATH
WHAT ABOUT RANI WHO DIED LAST MONTH ?
I CAN NOT FIND MATERNAL DEATH REPORT!

CHAPTER 9

Compiling Village And Facility Level Score Cards

Collation of Data in Village Report Card

The village report card consists of the issue and its corresponding status by means of a colour code. Green suggests good performing village, yellow suggests there is a cause for concern and red suggests that the village is performing bad.

Calculation

- To arrive at the colour code for each issue, a series of simple calculations are done. To come-up with the per cent of collated score following method could be followed.

$$\frac{\text{Total Score}}{\text{Number of Women} \times \text{Maximum Score.}} \times 100$$

- The **Maternal Health Guarantees** issue is derived from the interview with the beneficiary. So the number of women interviewed multiplied by 10 (maximum score for this issue) gives us the denominator against which the total score of the responses will be compared. The collation sheet given on next page helps in getting the score for the report card. Fill the score in the report card format given below. If the total score is more than or equal to 75 per cent, then the colour code is green; if the total score is between 50 to 74 per cent, then the colour code is yellow and if the total score is below 50 per cent, then the colour code is red for the village.
- The **Janani Suraksha Yojna** issue is also derived from the interview with the beneficiary. So again the calculations are similar. The number of women interviewed multiplied by eight (maximum score for this issue) gives us the denominator against which the total score of the responses will be compared. The collation sheet given below helps in getting the score for the report card. Fill the score in the report card format given below. If the total score is more than or equal to 75 per cent, then the colour code is green; if the total score is between 50 to 74 per cent, then the colour code is yellow and if the total score is below 50 per cent, then the colour code is red for the village.
- The questions relating to **Child Health** were asked in the group discussions with women and marginalised communities. The maximum score is 16. If the total score of the response is between 12-16, then the colour code is green, if the total score is between 9-11, then the colour code is yellow and if the total score is between 0-8, then the colour

code is red for the village. For disease surveillance the maximum score is 10. If the total score of the response is 8-10, then the colour code is green, if the total score is 5 - 7, then the colour code is yellow, if the total response is between 0 - 4 then the colour code is red. For curative services the maximum score is 12. If the total score of the response is 10 - 12, then the colour code is green, if the total score is 7 - 9, then the colour code is yellow, if the total response is between 0 - 6 then the colour code is red.

- The **Disease Surveillance, Curative Services and Untied Fund** issue was taken up in the group discussions with the community members. For untied fund the maximum score is eight. If the total score of the response is 7-8, The maximum score is 8 for each issue. If the total score of the response for each issue is 7-8, then the colour code is green, if the total score is 5-6, then the colour code is yellow and if the total score is between 0-4, then the colour code is red for the village.
- **Quality of Care and the Community Perceptions of ASHA** issue was taken up in the group discussions with women/marginalised communities. The maximum score is 15 for quality of care each group; sum of the score of both groups will be 30. If the total score of the response is between 23-30, then the colour code is green; if the total score is between 15-22, then the colour code is yellow; and if the total score is 0-14, then the colour code is red for the village. The maximum score is 10 of each group for community perceptions about ASHA. sum of the score of both groups will be 20. If the total score of the response for each issue is between 15-20, then the colour code is green; if the total score is between 10-14, then the colour code is yellow; and if the total score is between 0-9 then the colour code is red for the village.
- The questioning on the **Functioning of ASHA** was done in the interview with ASHA. The maximum score is 12. If the total score of the response for each issue is between 10-12, then the colour code is green; if the total score is between 6-9, then the colour code is yellow; and if the total score is between 0- 5, then the colour code is red for the village.
- The **Equity Index** is calculated by dividing the total score that was generated from the group discussion with the women from general community by the total score generated from the group discussion with the women from marginalised community. If the resulting number is less than 0.75 then the colour code is green; if it is between .99-.74, the colour code is yellow; and if the number is more than one then the colour code is red.

Note: We can also come-up with per cent of the collation of the scores in same way we did for maternal health guarantees, child health and JSY.

- The **Adverse Outcome/ Experience** is just counted in all the forms and the number written in the report card. There is no colour coding. The cases could be documented and presented in the Jan Samvad/ Jan Sunwai.
- The issues of concern are also listed out in the report card from the forms.

Table 7: Calculation: Village Health Report Card

S.No	Issue	Calculation	Interpretation
1.	Maternal Health Guarantees	Number of women * 10 = N	≥ 75% of N → Green 50-74% of N → Yellow Below 50% → Red
2.	Janani Suraksha Yojna	Number of women * 8 = N (be careful about the negative scores)	≥ 75% of N → Green 50-74% of N → Yellow Below 50% → Red
3.	Child Health	Total Score - 32	24 - 32 → Green 15 - 23 → Yellow 0 - 14 → Red
4.	Disease Surveillance	Total Score - 10	8 - 10 → Green 7 - 5 → Yellow 0 - 4 → Red

S.No	Issue	Calculation	Interpretation
5.	Curative Services	Total Score - 12	10 - 12 → Green 7 - 9 → Yellow 0 - 6 → Red
6.	United Funds	Total Score - 8	7 - 8 → Green 5 - 6 → Yellow 0 - 4 → Red
7.	Quality of Care	Total Score - 30	23 - 30 → Green 15 - 22 → Yellow 0 - 14 → Red
8.	Community Perceptions of ASHA	Total Score - 20	15 - 20 → Green 10 - 14 → Yellow 0 - 9 → Red
9.	ASHA functioning	Total Score - 12	10 - 12 → Green 6 - 9 → Yellow 0 - 5 → Red
10.	Equity Index	(Total score general community women)/ (Total score marginalised community women)	< 0.75 Favourable to marginalised group (Green) 0.75-1 No difference (Yellow) 1& above Unfavourable to marginalised group (Red)
11.	Adverse Outcome or Exp.	Total Score -	

Format 12- Village Level Collation Sheet

A. Beneficiary Interview Collation Sheet

Village: Block:
PHC: District:

S.No	Issue	W1	W2	W3	W4	W5	Total Score	Max Score	%	Response	Traffic Light
1.	Maternal Health Guarantees									≥ 75% of N -Green 50-74% of N-Yellow Below 50% -Red	
2.	Janani Suraksha Yojna									≥ 75% of N -Green 50-74% of N-Yellow Below 50% -Red	
3.	Adverse Outcome										
4.	Adverse Experience										

W1W5: Women 1-5

B. Group Discussion-Women

Village: Block:
PHC: District:

S.No	Issue	G	M	Total Score	Max Score	Score	Response	Traffic Light
1.	Child Health				32		24 - 32 -Green 15 - 23 -Yellow 0 - 14 -Red	
2.	Community perceptions of ASHA				20		15 - 20 -Green 10 - 14 -Yellow 0 - 9 -Red	
3.	Quality of Care				30		23 - 30 -Green 15 - 22 -Yellow 0 - 14 -Red	
4.	Adverse Outcome							

G: General Women Group Discussion
M: Marginalised Women Group Discussion

Format 13- Village Health Report Card

Village Name: Date:
Block Name: District Name:

S.No	Issue	Score	Interpretation	Traffic ghttion
1.	Maternal Health Guarantees		≥ 75% of N → Green 50-74% of N → Yellow Below 50% → Red	
2.	Janani Suraksha Yojna		≥ 75% of N → Green 50-74% of N → Yellow Below 50% → Red	
3.	Child Health		24 - 32 → Green 15 - 23 → Yellow 0 - 14 → Red	
4.	Disease Surveillance		8 - 10 → Green 7 - 5 → Yellow 0 - 4 → Red	
5.	Curative Services		10 - 12 → Green 7 - 9 → Yellow 0 - 6 → Red	
6.	United Funds		7 - 8 → Green 5 - 6 → Yellow 0 - 4 → Red	
7.	Quality of Care		23 - 30 → Green 15 - 22 → Yellow 0 - 14 → Red	
8.	Community Perceptions of ASHA		15 - 20 → Green 10 - 14 → Yellow 0 - 9 → Red	
9.	ASHA functioning		10 - 12 → Green 6 - 9 → Yellow 0 - 5 → Red	
10.	Equity Index		< 1 Favourable to marginalised group 1 No difference >1 Unfavourable to marginalised group	
11.	Adverse Outcome or Experience Reports			

Issues of Concern
Maternal Health
1.
2.

Child Health
1.
2.

Cumulative Village Report Card

- After the village report cards have been formed for each village, they are collated by the PHC, block and district level monitoring and planning committees.
- So according to the colour code for each issue in each of the village health report card, the greens, yellows and reds are added at each level.
- Please use Format 14 for cumulative village report card.

Format 14- Cumulative Village Report Card at PHC/Block/District Level

Name of PHC/Block/District - _____

Issue	No of Villages Green	No of Villages Yellow	No of Villages Red
Maternal Health Guarantees			
Janani Suraksha Yojna			
Child Health			
Disease Surveillance			
Curative Services			
United funds			
Quality of Care			
ASHA Community Perceptions			
Asha Functioning			
Equity index			
Adverse Outcome or Experience Reports			

Facility Report Card

- The facility report card is a snapshot of the status of the health facility in the village/block/district. The colour codes display the facility's level of performance. Green stands for good performance, Yellow stands for Cause for concern and Red stands for poor performance.
- For the Infrastructure and Personnel, Equipment and Supplies and Service availability issue, the observation checklist is used. The percentage of the sum of the scores is taken for each issue. If the score percentage is more than 75 per cent of the maximum score, then the colour code is green; if it is between 50-74 per cent then it is yellow; and if it is below 50 per cent it is red.
- For the Unofficial Charges issue, the scores of all the five exit interviews at each level are added. If the sum of the scores is more than 19, then the colour code is green; if it is between 13-18 it is yellow; and if it is 12 and below then it is red.
- For the Quality of Care issue, the scores of all the five exit interviews at each level are added. If the sum of the scores is more than 38 then the colour code is green; if it is between 28- 37 it is yellow; and if it is below 27, then it is red.
- For the Functioning of RKS issue, the scores of the interview are added. If the total score is more than 7, then the colour code is green; if it is between 5-7, it is yellow and if it is below 5, then it is red.

Table 8- Calculation of Facility Report Card

Issue	Calculation	Interpretation
Infrastructure and Personnel	N=Maximum Score	75% of N = Green 50% of N = Yellow Below 50% = Red
Equipment and Supplies	N=Maximum Score	75% of N = Green 50% of N = Yellow Below 50% = Red
Service Availability	N=Maximum Score	75% of N = Green 50% of N = Yellow Below 50% = Red
Unofficial Charges	Add points of all the persons interviewed (max 25)	≥ 19 - Green 13 - 18 = Yellow ≤ 12 = Red
Quality of Care	Add points of all the persons interview (max 45)	>38 = Green 28 - 37 = Yellow Below 27 = Red
Functioning of Rogi Kalyan Samiti	Total Points scored	>7 = Green 5- 7 = Yellow Below 5 = Red

Format 15- Sub Centre Report Card
Name of CHC/
Block /
District:

Issue	Score	Interpretation
Infrastructure and Personnel		75% of N = Green 50% of N = Yellow Below 50% = Red
Equipment and Supplies		75% of N = Green 50% of N = Yellow Below 50% = Red
Service Availability		75% of N = Green 50% of N = Yellow Below 50% = Red

Format 16- PHC/CHC Level Collation Sheet

PHC/CHC/
Block:
Exit Interview

Issue	P1	P2	P3	P4	P5	Total Score	Max Score	Score	Response	Traffic Light
Unofficial charges									≥ 19 - Green 13 - 18 = Yellow ≤ 12 = Red	
Quality of Care									>38 = Green 28 - 37 = Yellow Below 27 = Red	

P=Patient

Format-17 PHC/CHC Report Card
Name of PHC/ CHC/Block / District:

Issue	Score	Interpretation	Traffic ghttion
Infrastructure and Personnel		75% of N → Green 50-74% of N → Yellow Below 50% → Red	
Equipment and Supplies		75% of N → Green 50-74% of N → Yellow Below 50% → Red	
Service Availability		75% of N → Green 50-74% of N → Yellow Below 50% → Red	
Unofficial Charges		≥ 19 - Green 13 - 18 = Yellow ≤ 12 = Red	
Quality of Care		>38 = Green 28 - 37 = Yellow Below 27 = Red	
Functioning of Rogi Kalyan Samiti		>7 = Green 5- 7 = Yellow Below 5 = Red	

Cumulative Facility Score Card

After the Facility Score Cards have been formed for each facility, they are collated by the PHC, block and district level monitoring and planning committees. According to the colour code for each issue in each of the facility score card, the greens, yellows and reds are added at each level.

Format 18- Cumulative Sub Centre Report Card at PHC/Block/District Level
Name of SHC/PHC/Block / District:

Issue	No of Sub centres Green	No of Sub centres Yellow	No of Sub centres Red
Infrastructure and Personnel			
Equipment and Supplies			
Service Availability			

Format 19- Cumulative PHC/CHC Report Card at Block/District Level
Name of PHC/CHC/ Block / District:

Issue	No of PHCs/CHCs Green	No of PHCs/CHCs Yellow	No of PHCs/CHCs Red
Infrastructure and Personnel			
Equipment and Supplies			
Service Availability			
Unofficial Charges			
Quality of Care			
Functioning of Rogi Kalyan Samiti			

CHAPTER 10

Sharing The Results And Conducting Jan Sanwad

Conducting a Village Sharing Meeting

1. The meeting is to be called on behalf of the Village Health and Sanitation Committee after completing the village level community monitoring.
2. All the residents of the meeting, including members of all community based organisations, including SHGs, are to be invited to this meeting.
3. Before conducting the meeting, the village score card has to be completed.
4. Community level facilitators, for eg. ASHA must be present at the meeting.
5. Village level service providers, for eg. ANM, AWW are to be present at the meeting.

Objectives of Village Sharing Meeting:

1. To share the village and sub centre report card.
2. To create a common understanding on the key health issues of the village in terms of NRHM implementation.
3. To review and prepare action plans for improving NRHM implementation.

Steps in Conducting the Meeting:

1. The meeting will be presided by the Chairperson of the VHSC.
2. The VHSC will present the village score card and the key findings of the community monitoring exercise to all present.
3. Adverse experiences and adverse outcome will also be presented at the meeting.
4. The spirit of the meeting will be to improve service delivery and not fault finding with health care service providers.
5. The key problems will be discussed and action points will be suggested for improving the situation.
6. The village meeting should lead to village health planning.

The Meeting Proceedings to be Recorded in Format 20 given on page number 80.

The Village Report Card, The Adverse Outcome/ Experience Records and the Meeting Report will together comprise the documents emerging from one round of community monitoring.

CONDUCTING JAN SAMVAD

Objectives of a Jan Samvad:

1. To share the PHC and block report cards.
2. To create a common understanding among residents of a block on the state of implementation of NRHM in their area.
3. To highlight key issues emerging from the current implementation status.
4. To review and prepare action plans for improving NRHM Implementation.
5. To create awareness amongst the civil society organisations about the various health services which should be provided by the Government at different levels.

Preparatory Processes:

1. The process of village and facility level community monitoring should have been complete and the preparation of village and facility level score cards will also be complete.
2. The village level sharing meetings of the area will have been complete.
3. Screening of cases of denial of care (see below) for presentation.
4. Meeting of various representatives of NGOs/POs/local health committees should be organised to plan for the Jan Sunwai.

Organiser-Members of Block Community Monitoring and Planning Committee

Participants at the Jan Samvad

- Chief Medical Officer of the District or her/his representative
- Block Medical Officer
- Member of District Community Monitoring and Planning Committee
- Members of PRIs in the block
- Members of VHSCs
- Member of CBOs in the block

Conducting the Jan Samvad

The Jan Samvad can take place in four parts;

- Introduction to the Jan Samvad - by Chair of the organising group.
- Presentation of the Cumulative Village Report Card and discussion on implementation of outreach services in NRHM.
- Presentation of Facility Report Cared and discussion on improving facility level service utilisation.
- Presentation of Denial of Care / Adverse Outcomes - discussion on improving quality of care and support to cases.
- Preparation of list of recommendations for Providers, Facilities and Community.

Organisational Preparation for the Jan Sunwai/Jan Samvad

Mobilization of people from communities: Local organisations should mobilise people and active groups from the area, so that they come for the Jan Sunwai. Their presence is required so that they can act as a pressure group for fulfilling the demands made in the Jan Sunwai.

Inviting experts: Equally important the support of experts like teachers, lawyers etc.

Seeking Media attention for the event: In this process media can play a vital role in disseminating the findings. That is why it is important to contact media and sensitize them in the whole process.

Inviting Government Health Officials for the public hearing: The presence of Government Health officials is essential for the public hearing. The Medical Officers of different PHCs in the region, Civil Surgeon, District Health Officer, Additional Director of Health Services etc., should be given invitation of the public hearing and it should be ensured that they are present at the time of public hearing.

Dos and don'ts of Jan Sunwai/Jan Samvad

Dos	Don't
◆ Being familiar with issues emerging from community monitoring ◆ Presentation of report cards to be brief and objective ◆ Outlining the purpose of the Jan Sunwai/Jan Samvad in the beginning ◆ Concentrating on matters highlighted through community monitoring and in report cards ◆ Being familiar with points raised by the community ◆ Treating government officials and community with respect and dignity and addressing their points in a clear manner ◆ Requesting government officials to respond and articulate concrete steps they would take to improve the functioning of the health facilities ◆ Allowing all stakeholders to speak ◆ Briefing the person presenting the testimony about the process and the purpose. Making them comfortable and relaxed ◆ Constituting a panel of people from village or block whose opinion is respected and who hold some kind of social influence ◆ Briefing the panel about the purpose and process ◆ Developing a time bound follow-up action plan with owners on government at the end of Jan Sunwai/Jan Samvad	◆ Speaking out of context on issues that are not relevant to community monitoring ◆ Forcing aggrieved person to present the testimony. Not respecting their confidentiality ◆ Using jargon; not keeping language as simple as possible. ◆ Losing cool under pressure ◆ Confronting government ◆ Allowing service provider to pressurise or interrupting or asking question while the person is testifying or giving the testimony. ◆ Panel shouldn't be overtly side with government and should retain their objectivity

Format-20 Record of Village Sharing Meeting

Name of Village: Name of Block:
Name of District: Name of State:
Date of VHSC meeting:
Persons Present - VHSC members:
Representatives of CBOs:
Village residents (Numbers): Female: Male:

Review of Action Plan from Last Meeting

Changes in Signal Lights from Last Meeting

Improvement (Red to Yellow or Green; Yellow to Green)	**Same**	**Reversal** (Green to Yellow or Red; Yellow to Red)

Reasons for Improvement -

Reasons for Reversal -

Any other comments on follow-up of action points emerging from last meeting

Action Plan

Red Signal Issues

Issue	**Action to be taken at the Community level**	**Action to be taken by ASHA and VHSC**	**Action to be taken by ANM AWW or PHC**

Yellow Signal Issues

Issue	**Action to be taken at the Community level**	**Action to be taken by ASHA and VHSC**	**Action to be taken by ANM AWW or PHC**

Green Signal Issues

Issue	**Action to be taken at the Community level**	**Action to be taken by ASHA and VHSC**	**Action to be taken by ANM AWW or PHC**

Format 21- Record of Jan Samvad

Block -
District -
State -
Date -
Persons present :

Health Department-
Community Monitoring Mentoring Groups -
PRI members -
CBOs -
NGOs -
Names of villages from where participants have come -

Issues showing improvement (Number of villages in Red have reduced or Green or Yellow have increased)	**Same as last time**	**Issues showing reversal** (Number of villages in Red have increased or Green or yellow have reduced)

Reasons for Improvement -
Reasons for Reversal -

Action to be taken for Improving NRHM Implementation at Village Level

Issue	**Action to be taken by ASHA and VHSC**	**Action to be taken by ANM AWW or PHC**	**Action to be taken at District level**

Facility Review

Review of changes since last meeting

Issues showing improvement	**Same as last time**	**Issues showing reversal**

Reasons for Improvement -

Reasons for Reversal -

Issues of Concern	**Action to be taken at the Facility level**	**Action to be taken at District level**	**Action to be taken by Communities**

Denial of Care/ Adverse Outcome report

Identity	**Problem**	**Support to be provided**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Annexure I

SENSITIZATION AND MICRO HEALTH PLANNING

By Karuna Trust, Karnataka

Karuna Trust developed a training manual for VHSC members in Kanda. The training manual talks about Sensitization and Micro Health Planning (for complete manual please refer to resource CD). The chapters highlight on;

1) Prior preparation: Why? What/ How? Who? What should be done?

2) Creating an atmosphere: 1. Purpose. 2. What? 3. Why? 4. How? 5. Where? 6. Who?

3) Meeting of the Health and Sanitation Committee: 1. Why 2. Where 3. Who 4. Fixing a time.

4) Purpose of the micro planning : 1. What is the need for a micro health planning ? 2. How? 3. What are the things involved? 4. What sort of information should be collected? 5. Method of collection. 6. Analysis. 7. Decision-making 8. Preparing a project.

5) Village transect: Group meetings at every street, settlement, locality - and in scheduled caste / scheduled tribe settlements. Lack of facilities, look at the current situation, collection of information, documentation.

6) Social resource mapping: Why? How? What are the issues involved? Who should do it? What sort of information should be accessible?

7) Seasonal map (What? Why? How?): Collection of information regarding monthly rain - crop - work - festivals, diseases (vomiting, loose motion, cough, cold, malaria, cholera, chikkungunya, scheduled caste / scheduled tribe / children, women, analysis, decision-making, planning, relief.

8) Pie diagram (What? Why? How?): What is the income and expenditure of a household / village? Health, food, entertainment, bad habits, farming, clothes, festivals, savings, loans, education.

9) Chapati diagram (What? Why? How?): Availability and use of health facilities, far - near, Anganawadi, anganawadi worker, junior health assistant, native doctor / medicine, PHU, PHC, private, taluk, government hospital, taluk, private hospital, district government hospital, district private hospitals.Who are using / not using what facilities/ Why? Information, collection, analysis, decision-making, planning (relief).

10) Diagrams on 1) Transect mapping of water resources 2) Social resource mapping 3) Chapati 4) Seasonal mapping and 5) Transect mapping of village road, trees and fields

Annexure II

FEEDBACK ON SELECTED TOOLS

Tool	Was the compilation easy?	Has the adaptation been done?	Should remain part of CM?	Difficulties faced?	Suggestion for improvement
Interview with ASHA	Yes	Yes	Yes	◆ Dominant caste/background dominated the process. ◆ As VHSC was not constituted properly there was lack of support.	No suggestion
Compiling village and facility level score cards	Yes	Y es	Yes	◆ Difficult for VHSC members in understanding. ◆ Equity index isunclear , needs simplification. ◆ Per cent calculation was difficult. ◆ There was confusion on to how to collate issues around quality of care, child health and understanding of ASHA from each group discussion as one group secured red and other green on the same point	The two group discussions need to be presented differently in the score card.
Group Discussion with Community	Yes	Yes	Yes	Most of the questions in disease surveillance was not region specific.	MPW is not common in other states thus region specific name should be given. Common names of supplies like bleaching powder instead of chlorine tablets should be used.
Group Discussion with Women (Marginalised Generalised Community)	Yes	Yes	Yes	Lack of understanding about ANM/AWW register which affected monitoring process.	Training of VHSC member is needed with practical demonstration of different kinds of register and their entries.
Maternal health beneficiary	Yes	Yes	Yes	Confusion about JSY money among community which leads to wrong answers.	In JSY section the negative points need to be put differently as it has impact on other positive score and leads to red signal in spite of several positive points of JSY.
MO interview	Difficult for VHSC member to understand	Yes	Yes	Rogi Kalyan Samiti (RKS) is new thus community is not familiar with it in spite of training.	Tool needs to be simplified and questions like how many times has the RKS met since it was formed need to be added. Training is required about RKS functioning, objective, and composition.
Checklist - PHC	Yes	Yes	Yes	◆ Difficult to understand many medical equipment, medicine and supplies. ◆ Hesitation to interview MOIC/MO	Need time to be familiar with the functioning of health department and other related matters.
Checklist - Sub Centre	Difficult for VHSC member to understand	Yes	Yes	Use & terminology of medical equipment were difficult to understand.	Availability of immunisation for children should be deleted because it is given on fixed health day.

Note: Few organizations gave their feedback on selcted tools.

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