



Health

Maternal and Child Health
Community



Solution Exchange for the Maternal and Child Health Community Consolidated Reply

Query: Tools for Community-Based Health Management Information System - Experiences

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**From Subodh S. Gupta, Sushila Nayar School of Public Health, Sewagram
Posted 6 March 2008**

The National Rural Health Mission (NRHM) has placed strong emphasis in addressing local issues and solutions and making it community centric through the involvement of Panchayati Raj Institutions. In the process, a committee, Village Health Nutrition and Sanitation Committee (VHNSC), has been constituted at the village level and has been provided with the responsibility of assessing community health needs and preparing village health plans. These committees will not only be involved in the formulation process but also in implementation and monitoring of the program. Therefore, a Community-based Health Management Information System (CHMIS) is a necessity at village level. This management information system at village level should be developed in such a way that it forms the basis of decision making at village level. The adoption of a comprehensive framework for community-based monitoring and planning will empower the committees to regularly assess whether the health needs and rights of the community are being fulfilled.

The NRHM proposes two types of tools to be used by VHNSC for this purpose - Village Health Register and Village Health Calendar. However, after searching for these tools on internet, I have not found any documents, which gives a format for them. Therefore, I request the colleagues on this Community to share:

- Experiences testing and using these tools, including the format
- Suggestions for developing these two tools (village health register and village health calendar)

At the Dr. Sushila Nayar School of Public Health, MGIMS, Sewagram, we are providing technical input for the implementation of VHNSC at the district level in Wardha district of Maharashtra. The inputs from members will help us in planning, developing and implementation of these tools in Wardha district.

Responses were received, with thanks, from

1. [Alivia Biswas](#), MedicaSynergie Pvt. Ltd., Kolkata

2. [Sandeepan Bhatia](#), Johns Hopkins Hospital, Baltimore, USA
3. [Atanu Ghosh](#), CINI ASHA, Kolkata
4. [Uday Pathak](#), Mahavir Vatsalya Aspatal, Patna
5. [Upendra Bhojani](#), Institute of Public Health, Bangalore
6. [Dilip Jha](#), Advent Healthcare Private Limited, New Delhi
7. [Gurusamy Gandhi](#), National Insurance Academy, Pune
8. [Dinesh Agarwal](#), United Nations Population Fund (UNFPA), New Delhi
9. [Arun Gupta](#), Breastfeeding Promotion Network India- (BPNI), New Delhi
10. [Kannan Srinivasan](#), Achutha Menon Centre for Health Sciences, Trivandrum
11. [Laxmikant Chavan](#), Gujarat State AIDS Control Society (GSACS), Ahmedabad
12. [Ajit Kumar Singh](#), Micronutrient Initiative India, Patna
13. [Sharad Chaturvedi](#), CARE-Rajasthan, Bharatpur
14. [Hiren Patel](#), Tribal Development Department, Government of Gujarat, Ahmedabad
15. Subodh Gupta, Sushila Nayar School of Public Health, Sewagram ([Response 1](#); [Response 2](#))
16. [Toms K. Thomas](#), Evangelical Social Action Forum (ESAF), Trichur
17. [Johnson Rhenius Jeyaseelan](#), WaterAid India, Bhopal
18. [Gurpreet Singh](#), Municipal Corporation of Delhi, New Delhi
19. [Rakhee Nongrum Yadav](#), Micronutrient initiative (MI), Bhopal
20. [Anand Lakshman](#), Micronutrient Initiative, New Delhi
21. [Rushi Bakshi](#), Royal Netherlands Embassy, New Delhi
22. [Smita Bajpai](#), Centre for Health Education, Training and Nutrition Awareness (CHETNA), Ahmedabad
23. [Sarwat Hussain Naqvi](#), State Mainstreaming Unit, Chhattisgarh State AIDS Control Society (CGSACS), Raipur
24. [Ravishwar Sinha](#), Independent Consultant, New Delhi
25. [Prabir Chatterjee](#), United Nations Children's Fund (UNICEF), Raigunj
26. [Ruchi Mishra](#), Government of Gujarat, Mandla
27. [Shyam Chaturvedi](#), United Nations Children's Fund (UNICEF), New Delhi
28. [Surendra Kumar Yadav](#), Vikram University, Ujjain
29. [Madan Mani Dhakal](#), Government of Sikkim, Sikkim
30. [Marine Mukherjee](#), Department of Panchayats and Rural Development, Government of West Bengal, Kolkata*
31. [Biswajit Padhi](#), SRUSTI, Orissa *
32. [Rajesh Sood](#), Centre for Health Promotion, New Delhi *

* *Offline Contributions*

Further contributions are welcome!

[Summary of Responses](#)
[Comparative Experiences](#)
[Related Resources](#)
[Responses in Full](#)

Summary of Responses

Responding to the query on "tools for community-based health management information system (MIS)" in National Rural Health Mission (NRHM), members shared various ways for facilitate community monitoring, identified indicators to include in Village Health Register (VHR) and Village Health Calendar

(VHC). They mentioned experiences of using various MIS tools and suggested ways for making these tools more meaningful.

Respondents explained that under NRHM Village Health and, Nutrition, Sanitation and Water Supply Committees (VHNSC) are supposed to formulate village health plans and monitor the implementation. **Community-based Health Management Information System (CHMIS)** is a planned system for collecting, storing and disseminating data to carry out management functions, which is dependant on the desired local outcomes. Members highlighted that in NRHM documents the [VHNSC's responsibilities](#) are mentioned and include maintaining the VHR and health information board/calendar (VHC) but it does not say what to monitor, assuming that following a village mapping and Participatory Rapid Appraisal (PRA) the VHNSC would decide, develop and monitor community specific indicators.

However, discussants underscored that emphasis on community ownership and monitoring is new in the health sector and in most villages, issues related to health, nutrition and sanitation are not a priority. Thus, to involve community members in the appraisal, analysis and action process, respondents recommended using culturally sensitive and scientifically appropriate monitoring mechanisms, incorporating community concerns into the process and including them in decision-making. Members also suggested before developing a format for monitoring tools, it is necessary to explain to community members the purpose of maintaining VHRs and VHC- clarifying who will maintain it, and how frequently it needs to be updated. This they felt would help in field-based monitoring and ensuring supportive supervision.

Discussants stressed that VHR should not duplicate the efforts carried out by other functionaries while collecting primary data. Instead, it needs to be simple and flexible with limited indicators, drawn from secondary data (collected by AWWs, ASHAs, ANMs, etc.). Members also suggested including service provision information such as total population, demographic profile, and recent outbreaks into the health register. Some recommended that the VHR could have a separate register for each family and be divided beneficiary wise (i.e. ANC mothers and follow-up register, newborn, child health); to reflect better the village health needs. Further, they suggested making SHG members, ASHAs and panchayat members alternatively responsible for managing the register. They also advised using Lady Health Visitors (LHV) and Anganwadi workers to help maintain the VHR and VHC; and making the VHC a part of the village health register.

Other suggestions by members included:

- Including information other than schedule of village health days (VHDs) in the VHC i.e. disinfection of water sources, meeting dates of VHNSC, number of home visits, services provided, and timeline of services, as the continuous updating of this calendar could guide the development of an appropriate strategy to meet community health needs
- Incorporating a monthly plan for ANMs/AWWs for delivering services in VHC, such as location, timing and type of services, so that the VHSNC can easily verify them
- Developing color codes for key outcome indicators for using in MIS, such as IMR/underweight at one year, initiation of breastfeeding at one hour and exclusive breastfeeding for six months
- Conducting village mapping to determine the appropriate utilization of financial resources by VHNSC, so it ensures financial inputs as effective monitoring systems require
- Exploring the possibility of using free on-line tools from the Internet and other technologies like personal digital assistant (PDAs), Global Positioning Systems (GPS) and mobile phones, which allow the rapid collection of data and action

Discussing various MIS tools, members shared **successful comparable experiences** utilizing different monitoring indicators and reporting systems. In [Bihar](#), an agency supported the operationalization of VHNSC by writing key health indicators on a public blackboard and in [Gujarat](#), every month the local health workers update the figures on ANC coverage, number of institutional deliveries, pregnancy registered, etc. on the village display board. Another approach shared were different organizations

working with communities to develop data collection and monitoring tools. For example, in [Bihar and Jharkhand](#) an agency helped introducing a community-based monitoring mechanism to improve community participation and ensure data collection; in [West Bengal](#), an NGO trained SHGs to maintain records and registers, helping the Gram Panchayats register vital events. While in [Rajasthan](#), another NGO is using a “report card” as monitoring tool for mobilizing the community in gram sabhas towards improving the nutritional status of children.

Some members also shared experiences using traditional paintings on house walls as monitoring tools like drawing a “flower” in [Madhya Pradesh](#) to evaluate progress of health worker’s round in management of nutritional status of children. They shared use of Chand Tare, Tulsi Chowra and Dhan Jhool paintings by individuals and health service provider in [Chattisgarh](#) for self-monitoring (i.e. month of pregnancy, IFA intake and ANC done by ANM). These tools were successfully used with participatory approach by the service provider and the participants, who are registered for the services with initial handholding.

Moreover, in [Madhya Pradesh](#), the “Community Needs Assessment Approach” helped in identifying health indicators for monitoring, while Multi-purpose Health Workers developed tools for data collection and planning interventions to facilitate delivery of services. Another experience highlighted the work of an NGO in [Gujarat and Rajasthan](#) facilitating the involvement of Panchayat members and leaders of self-help groups (SHGs) in developing a material on maternal health entitlements to enhance monitoring and providing training for a facility survey.

Along with sharing experiences, members raised questions to consider when planning the format for these monitoring tools and implementing them:

- How is the untied fund of Rs. 10,000 perceived to be used in village health plans using VHR and VHC?
- Are the VHC and VHR essentially bound with untied funds? What happens if the health needs of a village (for sanitation, nutrition, safe water, essential drugs, etc.) is more than the amount allocated? Is there a scope for raising additional funds?
- Who asks for this additional money and from which sources?
- How will one prioritize in competing demands for curative care from villages in a block or even in a district?

In summary, respondents stressed the importance of mobilizing community participation in using monitoring tools. They suggested including representatives from every section of the community, especially vulnerable and socially excluded groups (women, scheduled caste and tribes) in the process of developing the tools, pointing out that most of the time they are developed ignoring the needs and problems of the community, and thus are unrealistic and programs are unable to achieve objectives.

Comparative Experiences

Bihar

Maintaining Database by Responsible Youth for VHNSC, Vaishali (from [Alivia Biswas, MedicaSynergie Pvt. Ltd., Kolkata](#))

UNICEF supported the operationalization of VHNSC to do village health planning by maintaining and displaying indicators like registered births, deaths, cases of diseases, ANM visits, AWC activities, etc. on a public blackboard. Responsible youth are maintaining and compiling this database for monthly VHNSC meetings and the Gram Sabha takes issues to panchayat meetings. Regular follow up and handholding by UNICEF has motivated villagers to continue to participate in and maintain this process. Read [more](#)

West Bengal

Village Micro Plan by Trained SHG Members, Murshidabad (from [Atanu Ghosh](#), CINI ASHA, Kolkata and Marine Mukherjee, Department of Panchayats and Rural Development, Government of West Bengal)

Child In Need Institute and the Department of Panchayat and Rural Development, Government of West Bengal formed a Village Micro-Plan to assess the health needs of the community, using the Community Health Care Management Initiative (CHCMI). Through CHCMI, trained SHG members maintain records and registers on local vital events. This is helping the Gram Panchayats to register vital events and Health Assistants/ANM at Sub-Centre to update the Eligible Couple and Children Register (ECCR). Read [more](#)

Madhya Pradesh

Monitoring Tools Developed by MPHWs, Dhar District (from [Dilip Jha](#), Advent Healthcare Private Limited, New Delhi)

A DANIDA funded programme used the Community Needs Assessment Approach (CNA) to identify health indicators, while Multi-Purpose Health Workers (MPHWs), in the pilot block of Dhamnod, developed tools for data collection and planning interventions. MPHWs maintained two village level registers and used them to plan their service delivery. The pilot results showed data collection was accurate and that the village health committees were using the data for planning and monitoring.

Innovative Scheme using Flower as Monitoring and Awareness Tool, Panna district (from [Rakhee Nongrum Yadav](#), Micronutrient Initiative (MI), Bhopal)

The district DWCD with District Extender of CINI- MI VAS project developed Flower Scheme, where Anganwadi worker draws a flower on the wall of house as a monitoring system to evaluate progress of the round while creating community awareness on management of nutritional status of children. Seeing the benefits of the scheme in ensuring delivery of services Damoh, Datiya, Sagar, Raisen, Vidisha, Rajgarh districts have already adopted and replicated it. Read [more](#)

Chhattisgarh

Using Traditional Painting as Monitoring Tool, Raipur (from [Sarwat Hussain Naqvi](#), State Mainstreaming Unit, State AIDS Control Society (CGSACS), Raipur)

CARE India created few community based self-monitoring tools like Chand Tare, Tulsi Chowra and Dhan Jhool, depicting the tradition of paintings on housewall. These were used by individuals and health service provider, for self monitoring i.e. month of pregnancy, IFA intake and so far ANC done by the ANM etc. These tools were successfully used with participatory approach by the service provider and the participants, who are registered for the services with initial handholding.

Rajasthan

Using Report Card as a Tool for Mobilizing Community, Bharatpur (from [Sharad Chaturvedi](#), CARE-Rajasthan, Bharatpur)

CARE mobilized community to improve immunization coverage using a report card for 0 to 1 year old under weight children during gram sabhas. This initiative of maintaining and tracking the immunization status proved useful in making health a priority on political agenda of panchayats. It also enhanced capacities at community level to demand accountability from service providers for basic services, such as regular immunization and helped PRI members to ask for capacity building on health issues. Read [more](#)

Gujarat

Village Display Board Serving a Monitoring Tool (from [Hiren Patel](#), Tribal Development Department, Government of Gujarat, Ahmedabad)

Every month the ANM/MPHW add data to the village display board on ANC coverage, number of institutional deliveries, pregnancies registered, immunization coverage, number of births, number of participants in "Mamta Day" or "Health and Nutrition Day." This has proved an effective tool for community monitoring. The health committee then discuss the community's status during gram sabha meetings to develop a plan to strengthen health delivery in the village through the ASHA and Gram Mitra.

Gujarat and Rajasthan

Facility Survey and Monthly Meetings to Improve Services (from [Smita Bajpai](#), Centre for Health Education, Training and Nutrition Awareness (CHETNA), Ahmedabad)

CHETNA is working with elected representatives (ER) of the panchayat and SHG leaders. They developed a training module and picture books on maternal health entitlements to enhance the community's monitoring skills, provided hands-on training on conducting a facility survey and also held discussions at quorum meetings. The ERs now monitor and ensure service delivery to women at health facilities and SHG members conduct monthly meetings to discuss access to services at the PHC. Read [more](#)

Bihar and Jharkhand

Community Based Monitoring Mechanism Brings Positive Changes (from [Ajit Kumar Singh](#), Micronutrient Initiative India, Patna)

UNICEF introduced the "Dular Strategy," which uses a community-based monitoring mechanism to ensure community participation and strengthen the healthcare system. It also serves as tool for collecting data. Community members, acting as volunteers and "peer educators," bring about changes in their socio-economic environment by participating in the monitoring system. The strategy was recognized as one of the best community participation approaches in the health and nutrition sector. Read [more](#)

Related Resources

Recommended Documentation

From [Upendra Bhojani](#), Institute of Public Health, Bangalore

Community Based Monitoring under NRHM

Proposal; Ministry of Health and Family Welfare, Government of India

Available at http://mohfw.nic.in/NRHM/Documents/Community_monitoring.pdf (PDF Size: 259 KB)

Details process of initial facilitation and capacity development for community-based monitoring and planning at various levels to regularly monitor the progress of NRHM

Framework for Implementation: 2005-2012: National Rural Health Mission: Meeting People's Health Needs in Rural Areas

Framework; Ministry of Health and Family Welfare, Government of India; 2005

Available at <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf> (PDF Size: 448 KB)

Describes timeline for NRHM activities, critical areas for concentrated action, along with the institutional arrangements, human resources needed for monitoring and review format

NRHM: A Promise of Better Healthcare Services for the Poor

Summary; by A. Das, *et. al.*; Ministry of Health and Family Welfare, Government of India

Available at

http://mohfw.nic.in/NRHM/Community_monitoring/Entitlement%20Kit/Entitlement%20English.pdf (PDF Size: 529 KB)

Guidelines for NRHM highlighting its key components to ensure equitable, affordable, and effective management system of community based primary health care for rural people

5 x 5 Health Matrix (from [Gurusamy Gandhi](#), National Insurance Academy, Pune)

Matrix; by Gurusamy Gandhi

Available at <http://www.solutionexchange-un.net.in/health/cr/res06030801.doc> (Document Size: 211 KB)

Health matrix-a tool for the management of community health systems, by monitoring age wise and disease wise health status

Flower Scheme- An Innovation by Panna District, Madhya Pradesh (from [Rakhee Nongrum Yadav](#), Micronutrient initiative (MI), Bhopal)

Scheme Details; The Women and Child Development Department; Government of Madhya Pradesh

Available at <http://www.solutionexchange-un.net.in/health/cr/res06030802.doc> (Document Size: 141 KB)

Explains "Flower Scheme"- a monitoring tool to be used by Anganwadi workers to create community awareness regarding management of the nutrition status of children

From [Anand Lakshman](#), Micronutrient Initiative, New Delhi

Pregnancy Tracking Register

Register; National Rural Health Mission, Government of Bihar

Available at <http://www.solutionexchange-un.net.in/health/cr/res06030803.pdf> (PDF Size: 838 KB)

Monitoring tool to be maintained by ASHAs, ANMs and Anganwadi workers for filling in details of the local women during pregnancy

Newborn Tracking Register

Register; National Rural Health Mission, Government of Bihar

Available at <http://www.solutionexchange-un.net.in/health/cr/res06030804.pdf> (PDF Size: 1.5 MB)

Monitoring instrument for ASHAs to use to keep record the health condition of both the mother and the newborn, including the diet of mother, vaccinations for the newborn, etc

Dular Strategy (from [Ajit Kumar Singh](#), Micronutrient Initiative India, Patna)

Project Details; United Nations Children's Fund (UNICEF)

Available at http://www.unicef.org/india/health_963.htm

Details how UNICEF introduced a community-based monitoring mechanism for community participation and system strengthening in the health care management

Recommended Organizations and Programmes

Care India-Rajasthan, Jaipur (from [Sharad Chaturvedi](#))

D-53, Hathi Babu Marg, Bani Park, Jaipur 302016 Rajasthan; Tel: 0141-2281893/95, 5102027/5113091;

Fax: 0141-2202975; cbox-ra@careindia.org;

<http://www.careindia.org/ManageAboutUs/VisitAboutUs.aspx?CategoryID=23>

Mobilized community and helped PRI members for better management of health system by improving immunization coverage through maintaining records of under weight children

CHETNA, Ahmedabad (from [Smita Bajpai](#))

B-Block 3rd Floor SUPATH-II, Opposite Vadaj Bus Terminus Ashram Road, Vadaj, Ahmedabad 380013

Gujarat; Tel: 079-27559976/77/, 2769100/01, 27559978; chetna456@gmail.com, chetna456@vsnl.net;

<http://www.chetnaindia.org/About%20CHETNA.htm>

Developed two tools, training module and picture books, for community based health management system to enhance the monitor skills of various service providers

United Nations Children's Fund, (UNICEF), New Delhi (from [Alivia Biswas](#), MedicaSynergie Pvt. Ltd., Kolkata and [Ajit Kumar Singh](#), Micronutrient Initiative India, Patna)
73 Lodi Estate, New Delhi 110003; Tel: 011-24690401/1410; Fax: 011- 24627521, 24691410;
newdelhi@unicef.org; http://www.unicef.org/india/overview_4075.htm

Supported community-based monitoring mechanism for collecting data to ensure community participation in strengthening the healthcare system

Community Led Initiatives for Child Survival, Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences, Sewagram (from [Subodh Gupta](#), [response 1](#))
Sewagram 442102 Wardha District, Maharashtra; Tel: 91-7152-28434/5 Ext: 240; Fax: 91-7152-284730;
bsgarg_ngp@sancharnet.in; <http://www.clics.org.in/management.htm>

Introduced community-based health management information system to fulfill the health information needs of Village Coordination Committee

WaterAid India, United Kingdom (from [Johnson Rhenius Jeyaseelan](#))
47-49 Durham Street, London SE11 5JD, United Kingdom; Tel: 44-0-20-7793-4500; Fax: 44-020-7793-4545; http://www.wateraid.org/international/what_we_do/where_we_work/india/

NGOs working in Bhopal maintained health register for recording information of affected persons to reduce diarrhoeal diseases resulting in management of better sanitation in the community

Child In Need Institute (CINI), Kolkata (from [Atanu Ghosh](#))
PO Pailan, Via Joka, Kolkata 700104 West Bengal; Tel: 033-24978192/ 8641; Fax: 033-24978241;
cini@cinindia.org; <http://www.cini-india.org/about.asp>

Trained members of Self-Help Groups (SHG) in data collection and managing records for the management of the health information system of the community

Institute of Public Health (IPH), Bangalore (from [Upendra Bhojani](#))
12 / 28, 32nd Cross, Jayanagar, 7th Block, Bangalore 560082 Karnataka; Tel: 080-26645232;
mail@iphindia.org; <http://www.iphindia.org/index.asp>

Academic institution managed by health professionals, developed a pilot project for community based monitoring for better health status of weaker sections through public health interventions

Development Research Foundation (BAIF), Pune (from [Gurusamy Gandhi](#), National Insurance Academy, Pune)

Dr. Manibhai Desai Nagar, Warje, Pune 411058, Maharashtra; Tel: 020-25231661; Fax: 020-25231662;
baif@vsnl.com; http://www.baif.org.in/aspx_pages/index.asp

Developed various simple tools for community based health management system to evaluate the quality of health services provided to the rural masses

National Institute of Health and Family Welfare (NIHFW), New Delhi (from [Laxmikant Chavan](#), Gujarat State AIDS Control Society (GSACS), Ahmedabad)

Baba Gang Nath Marg, Munirka, New Delhi 110067; Tel: 011-26165959/6441, 26107773; Fax: 011-26101623; <http://www.nihfw.org/>

Technical Institute provides training at the community level on management information systems for promotion of health and family welfare programmes

Related Consolidated Reply

Developing Large Scale HMIS, from Richa Som, Independent Consultant, Bhopal (Experiences). Maternal and Child Health Community. Issued 26 December 2006

Available at <http://www.solutionexchange-un.net.in/health/cr-public/cr-se-mch-26120601-public.pdf>
(PDF, Size: 124 KB)

Discusses issues related to implementing large scale health management information system (HMIS), with some experiences from Indian states

Responses in Full

Alivia Biswas, MedicaSynergie Pvt. Ltd., Kolkata

As part of my organization, I was involved in decentralized NRHM planning in northeastern states of Meghalaya, Tripura and Sikkim. In Bihar, I was involved in NRHM Planning of Vaishali district.

In all these states, the VHNSC was non-existence and the concept of community ownership and community monitoring is new to community in aspects related to health. Community has lot of ownership in issues related to development of roads, infrastructure and education but when health, nutrition and sanitation were discussed, PRI representatives did not show much interest other than the Rs. 10,000/- annual local action fund that each and every VHNSC is entitled to. This availability of fund, again poses questions related to utilization of funds and appropriate utilization of fund as well. I am not aware of any guidelines or any handholding available to build the capacity of the community to utilize these financial resources appropriately. Hence maintaining calendars and registers without these guidelines would be a challenge.

But keeping apart these issues related to institutionalization of the concept, I can give a unique example I observed in Bihar. UNICEF was supporting Village Health Planning in Vaishali. Through this initiative, each and every village had a VHNSC, functional in village community halls/common ground. Village information Committee was integral part of the VHNSC. They maintained the figures on a blackboard displayed openly in the VHNSC. The blackboard had very simple indicators listed on them:

- New Births Registered
- Deaths
- Reported cases of specific diseases (Malaria, Kala Azar, Dengue, Diarrhoea, etc.)
- ANM Visit
- AWC activities
- Bore Well Maintenance etc.

Responsible youth in the village are held responsible in maintaining the database and compiling them at the month end in the monthly meeting of VHNSC. The Gram Sabha takes up the issue to Gram Panchayat meetings and things move forward. This is something I have come across during visit to the blocks of the district and what struck me is the motivation of the villagers and participation in maintaining the same. The catalyst was of course regular follow up visits and handholding by the implementing partners of UNICEF.

Sandeepan Bhatia, Johns Hopkins Hospital, Baltimore, USA

As per my experience while working with state government in Haryana, WHO and even U.S. organizations, MIS is very challenging and crucial for the success of any program. If developed properly the results are not only fabulous but long lasting too. 'MIS' is a planned system of collecting, storing and disseminating data in the form of information needed to carry out the functions of management. It totally depends upon what you want to achieve, ensuring that worker understood what is required from them (rational behind it).

Suggestions:

Representative of every community especially minority (women, schedule caste and tribes) must be the active contributor in developing these, because most of the time they are developed unrealistically, ignoring the need and problems of the community, and that is the reason most of the program unable to achieve its objectives.

It should be some how flexible, on the basis of local need as same solution can not be perfect for same problem in different context, and on the other hand it also should not disturbed the main format otherwise will be a big problem while consolidating the same at higher level.

Let the community owns the program by letting them actively involve, respecting there concern by incorporating them in tool development and decision making as they are the best person to bring out the reason for failure, and also the effective solution if channelized properly.

Atanu Ghosh, Child In Need Institute (CINI) ASHA, Kolkata

I would like to share the experience of Child In Need Institute (CINI) (www.cini-india.org) in formulating Village Micro Plan to assess the health need for the village community. This was done in the Murshidabad district or West Bengal. It was a joint effort of Department of Panchayat and Rural Development (PRD), Government of West Bengal and CINI.

CINI staff members had imparted training to the members of Self-Help Groups (SHG) for data collection. Apart from basic demography and health related indicators, information was collected on education and livelihood issues. The questionnaire was developed through joint consultation of PRD and CINI and printed by the PRD. For the detail process documentation and questionnaire, you may contact us.

Uday Pathak, Mahavir Vatsalya Aspatal, Patna

For any project, it is essential that it be based on facts, and the reality on the ground. The sheer lack of data in the fields of health precludes any meaningful health program creation or implementation. The NRHM has certain ideas that have been stated at the outset, such as reducing infant mortality, under five mortality and morbidity, etc.

As far as I am aware, there is a certain data form that comes to every hospital in the State of Bihar with some indices that they are following. The form can be seen on the Bihar state health society website. It comes with pretty confusing data headings such as number of completed immunizations (number mention of what is complete? for 6 month old, or for a 15 year old), number of cases of suspected TB, suspected malaria and suspected kalaazar (whatever it means). Suspicion cannot be quantified. There is no mention of anthropometrics or malnutrition indices.

Ultimately, all these programs will have to run at the grassroots, and not installed from the top. The people themselves will have to prioritize what they think is important, and what data needs to be collected. Data collection and mining for information needs financial inputs. At present in most villages, health is not a priority. They are looking for jobs and basic infrastructure. Interest in having an internet kiosk for revenue generation is a greater priority for them than opening a health clinic. They too realize that there is no money to be made in that field and at the village level any individual who plans to run a health clinic will go broke in no time, and in any case their is a lack of trained and dedicated manpower available. They have all migrated to towns and cities.

It seems that meaningful data gathering has fallen under the lot of NGOs, operating in the field of primary health care. With the convergence of technology such as PDAs, GPS units and mobile phones rolled into one, it will be possible to rapidly collect data and act on it. At present, it takes about 5 years from so called collection to publication of data and any meaning is lost with the 5 year plans.

Upendra Bhojani, Institute of Public Health, Bangalore

These two links provides details on framework and implementation of community based monitoring under NRHM:

1. Community based monitoring under NRHM http://mohfw.nic.in/NRHM/Documents/Community_monitoring.pdf
2. Framework for implementation of NRHM <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

Also there is a printed book "NRHM, A Promise of Better Healthcare Services for the Poor", this booklet is basically a guide for community monitoring of NRHM- first phase.

Village Health Register and Village Health Board/Calendar are some of the outputs along with village health plan that are expected to be prepared and maintained by VHSC or so called VHNSC. I don't think that explicit format has been developed as to what to monitor and what not. The assumption is that following the village mapping and PRA by VHSC, VHSC should decide, develop and monitor the indicators that they feel important for their village, so that it should be community driven.

However, I could find a single paragraph talking about Village Health Register and Village Health Calendar in one of the above documents as follows:

"Some roles of VHSC: Maintenance of Village health register and health information board/calendar, the health register and board will have information about mandated services, along with the 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 village health calendar."

At the Institute of Public Health (IPH), we did a consultancy to help Orissa Government to develop a pilot project for community based monitoring and for that, we did a brief review of some of the examples of CBM in India. Please feel free to go through a PPT on the same: <http://www.iphindia.org/phforum.asp>

Dilip Jha, Advent Healthcare Private Limited, New Delhi

I had a chance to work on developing planning and monitoring system in Dhar District, Madhya Pradesh under DANIDA funded programme and later under the MoHFW funding during 2002-04.

The purpose was to develop a monitoring system based on Community Needs Assessment Approach (CNA). While the indicators for monitoring remained the same as under the CNA, the tools for data capturing in the field and planning interventions was developed by the Multi-purpose Health Workers (MPHW) of the pilot block. The system required maintenance of only two (village level) registers instead of 10 or more. MPHWS maintained both the registers during their visit to the villages. The 9-month pilot implementation showed amazing results in terms of accuracy of data collection and its use in planning. The MPHWS of the pilot block (Dhamnod in Dhar) on their own took collective decision to modify the monitoring tools to suit their data requirement. The system did work in spite of the lack of support from supervisory level people. The experimentation proved that the monitoring can be effective only when the data from monitoring is utilized immediately at all levels. In this case, MPHWS used the monitoring data for their day-to-day service delivery planning.

The above system although did not involve community, the village health committee in many cases used the data for planning and monitoring.

Gurusamy Gandhi, National Insurance Academy, Pune

As I was engaged in some micro-health insurance research work and have been interacting with community health provider organizations like BAIF Development Research Foundation, Pune and so on, I have noticed many such simple tools have been evolved to evaluate the need as well as quality of community health services provided/to be provided for the rural mass. May be they are sample studies undertaken by these organizations, which I hope would provide you a starting point.

As far as the theoretical concepts are concerned, I feel the **5 x 5 Health Matrix** (<http://www.solutionexchange-un.net.in/health/cr/res06030801.doc>) (Size: 211 KB), may throw some light on the manner in which a good health budget should be evolved by the welfare state and the areas requiring attention by the health providers whether it be rural or urban.

Further discussion on this topic by the elite group members would enrich our knowledge in this aspect as these are still in rudimentary levels and yet to take off in our country.

Dinesh Agarwal, United Nations Population Fund (UNFPA), New Delhi

It is high time that we reach some consensus on the issue of how village health plans will be formulated and what will be format for village health register and village health calendar. I will like to flag following issues for the consideration of community members at this juncture:

- Is the plan we are talking about, will be work plan for expending Rs 10,000 to be made available as untied funds to Village Health and Sanitation Committee in an year?
- What happens if the health needs of villages i.e. sanitation, nutrition, safe water, essential drugs etc require more money?
- Who asks for this additional money and from which sources?
- How do you prioritize in competing demands for curative care from villages in a block or even in a district? In absence of any resource, envelop being indicated in advance to planning teams, planning process may go haywire.
- Village health Registers: How do we wish to use this register. Does this provide a framework for recording of events of births and deaths in villages, outbreaks of diseases or this is an annual survey like Eligible Couple (EC) surveys being conducted in the past! We need more clarity on the purpose of the register, who maintains and how frequently is this updated. I am sure this is not an OPD register!
- Similarly, we need to understand as what will be included in the village health calendar (VHC) other than schedule of village health days (VHDs), disinfection of water sources, and meetings of VHSC.

Good, that [Dr Subodh Gupta](#) has raised these issues and we look forward to have more views on firming up these tools.

Arun Gupta, Breastfeeding Promotion Network India (BPNI), New Delhi

I have a suggestion for development of tools that could generate community mobilization, as well as something to ask for publicly.

If we had Village Child Health Report Card displayed in Red; Yellow or Green colour based on key outcome indicators i.e. IMR/Underweight at 1, early breastfeeding at 1 hour and exclusive breastfeeding for 6 months.

The card could also be sued as political weapon to achieve the GREEN for vote of the village. The village gets a colour and others compete for this. It could then be put on web if we had these report cards.

Kannan Srinivasan, Achutha Menon Centre for Health Sciences, Trivandrum

We may explore free on-line tools from the Internet. The Google calendar seems to be very effective. We are using it for the class scheduling for our PG students. For effective use of this one need to have Internet connectivity or mobile connectivity. Google mobile has synchronization with mobile service providers.

About the register, are we looking for an on-line one? If so, there are forms freely available in the name of gears. One may explore them. I have tried some for online registration for conferences. As we are going to deal with community data, we have to be cautious. One may develop similar tools with minimal expenses.

Laxmikant Chavan, Gujarat State AIDS Control Society (GSACS), Ahmedabad

The very purpose of Health Registers and Calendar has its own mandates as said by [Upendra Bhojani](#). I had experience of working at PHC level as well fortunately received NRHM training from National Institute of Health and Family Welfare (NIHFW). This is my personal opinion sharing with you all.

However, the Village Health Registers can have registers as per Family and within that, beneficiary wise (i.e. ANC mothers and follow up register, New Born, Child health) health needs. Each Family of village should be assessed and recorded in the Health Registers as Baseline information. This will be Village Health Assessment Registers. (e.g. ANC register should have information on all aspects: Age, PID No, Date of Visit, demographic details, ANC details, Health aspects till date of delivery / outcome of pregnancy). With the availability of human resources (ASHA, ANM, MPW, HA, AW etc) and technical experts, it will reflect the Village Health needs and resource allocations in due course of time.

To meet the requirements of health needs, the activities like Visits/Services provided/timeline of services provided/ etc can be taken in Calendar and should be updated (As a continuous procedure). This can be a Calendar register.

The Health Register doesn't mean only health issues, it should also involve Sanitation, Nutrition and Safe drinking water, which are major issues in Rural/ Tribal areas.

Ajit Kumar Singh, Micronutrient Initiative India, Patna

The philosophy of Community based monitoring is based on the Appraisal, Analysis and Action (AAA) concept. The concept is based on value of synergy, which is incorporated in decentralized planning and Participatory Rural Appraisal methodology. We always think that monitoring system should be based on feedback mechanism and that feedback must be utilized by expert or a literate person that's why we are always in the process of developing format, register or printed materials in the field of community development.

But I think community based monitoring system is a process by which we can ensure community participation in community development programme. We must learn from the political movements where community rhythm is the core concept of social action. Gandhi used *charkha* in freedom movement in India as a tool of community participation. This tool was widely accepted in the country because it is culturally sensitive and scientifically appropriate mechanism.

So that community based monitoring tools should be based on community rhythm for example in Bihar the Maithil community use *Ritumati Aripan* (a kind of Alpana) to teach adolescent girls the importance of menstruation cycle in women life and the Magahi community use *Kohber painting* for the counseling of newly married couple as a tool. We must think that this kind of culturally sensitive and scientifically appropriate monitoring tools are required for community based monitoring system and with the help of

such tools we can generate discussion in community on health and nutritional issues by which we can collect facts through existing formats of health and ICDS departments.

Community based monitoring mechanism is an important tool for a process of community participation and system strengthening rather than a tool of fact collection through developing register or other MIS. For example, the utilization of community growth monitoring chart at AWC level is still a challenge. DULAR strategy in Bihar & Jharkhand is one of the best practicing examples for community based monitoring system in Health and Nutrition field.

Sharad Chaturvedi, CARE-Rajasthan, Bharatpur

I have a small experience for mobilizing community on gram sabhas through report card of 0-1yr under weight children on immunization. It is very useful and very innovative as health is never a priority in political agenda. Even community has no issues to discuss on their health on such occasions.

It was really very alarming for all PRIs when they faced locals from the village asking the support for regular immunization. Even many PRI members came forward to ask for capacity building on health and nutrition issues as they were facing this first time. Using such tools will enhance capacities at community level to raise demand and accountability of service provider for providing basic services.

Hiren Patel, Tribal Development Department, Government of Gujarat, Ahmedabad

As per my experience in Gujarat, the most effective tool for the community monitoring is the village display board in which every month ANM or multi purpose health worker add data regarding the ANC coverage, number of institutional deliveries, number of pregnancies registered, immunization coverage (male and female), number of births, number of participants in "Mamta Day" or "Health and Nutrition Day". This board will be displayed at the public places at village level where in villagers access this information.

Monthly status will be discussed by the health committee in the gram sabha based on that village health committee, ASHA worker and Gram Mitra will develop action plan for the next month. As per my experience and knowledge village, display board will become the tool for community participation and initiate dialogue between community and health service provider to strengthen the health delivery system at village level.

Subodh Gupta, Sushila Nayar School of Public Health, Sewagram (response 1)

I am really excited with all the responses to the query raised by me. I have received excellent ideas and lots of good resources, thanks to all of you, especially to Mr. [Upendra Bhojani](#) for excellent resources and [Dr. Dinesh Agrawal](#) to refine the issues further to the members.

I am writing this mail to express my opinion regarding the community monitoring proposed under NRHM. Sometimes, it appears that the 'Village Health Register' proposed under NRHM will become another detailed register for collection of primary data. However, I am worried that there are several functionaries who maintain this kind of data at village level. Why do we need to duplicate the efforts made by other functionaries; e.g. ANM, AWW? Moreover, if this responsibility goes to Village Health Nutrition and Sanitation Committee (VHNSC), where is the manpower to maintain the huge complicated registers?

In my perception, the village health register should be very simple and should generate limited indicators, which are required for decision-making for the VHNSC. More efforts should be directed in building capacity of members of VHNSC in use of the indicators for making decisions. It may not essential that

VHNSC collects primary information at village level. The format may be developed in such a way that the VHNSC is able to make decisions utilizing the secondary data received from other sources; e.g. AWW, ASHA, ANM etc.

At Sewagram, we have experience of introducing a community-based health MIS to fulfill the health information needs of Village Coordination Committee. I will share with you the details of formats developed under the program within a few days.

Toms K. Thomas, Evangelical Social Action Forum (ESAF), Trichur

I have been in to public health for more than 12 years and I am giving you my experiences.

I think the questions you raised are very important. Village health register and the Village health calendar are two different things.

Village Health Calendar: I think this you need to develop based on the health problems of the community based on the timing of various health problem occurrences. The calendar should guide you to develop appropriate strategy to meet the public health needs.

The health register is mainly the service provision register where you impart various health services and this register can be later used for developing a health calendar. I would be happy to help out if needed to develop a calendar.

Johnson Rhenius Jeyaseelan, WaterAid India, Bhopal

A village health register helps us to know the disease pattern in the village, the reduction in diseases over the years and also creates awareness among communities on various diseases. Our water and sanitation projects maintained a health register at village level, which recorded name of the person affected, age, disease name, reasons, and treatment given, if any. Over a project period of three years, we were able to track the reduction in diarrhoeal diseases.

Thus, I suggest that as we are focusing on nutrition and sanitation we should record water related diseases and diarrhoeal diseases as these affect person's health and due to which malnutrition occurs mostly. Recording all diseases will not solve purpose, but focusing on certain diseases will be easy and sustainable. If SHG members are represented in the VHNSC then they can be trained to maintain the same. ASHA's in the villages/panchayats should also be in this committee and be made responsible for this register alternatively.

The village health calendar should be part of the village health register and not a separate one.

Gurpreet Singh, Municipal Corporation of Delhi, New Delhi

I think village/community health register should have simple information like - Total population, demographic profile, information on major health issues like water and sanitation, recent outbreaks and health set up available including private/NGO sector. It should also have village map.

Advance monthly plan of ANM/AWW in the area should be available. The plan should have information on location, timing and type of service planned. It is expected that this will be verified by members of the village health and sanitation committee and others visiting the area. It should also include list of JSY beneficiaries.

The register should also have comments by visitors to the area, who have monitored some of these issues. The idea is to make everyone including visitors aware of health issues in the area and services being provided so that the same can be verified.

The indicator wise data is always available in ANM register and so need not be duplicated in Village health register.

Rakhee Nongrum Yadav, Micronutrient Initiative (MI), Bhopal

I would like to attach Flower Scheme- an innovation by Panna district, Madhya Pradesh (<http://www.solutionexchange-un.net.in/health/cr/res06030802.doc>) (Size: 141 KB), where concept of drawing a flower for monitoring of houses was visualized because it is customary in India to make colorful flowery designs on the walls or floors of houses during any festivals known as "Rangoli".

Anand Lakshman, Micronutrient Initiative, New Delhi

Reacting to [Dr Subodh's](#) concern, please find attached the pregnancy tracking register (<http://www.solutionexchange-un.net.in/health/cr/res06030803.pdf>) (Size: 838 KB), and newborn tracking register (<http://www.solutionexchange-un.net.in/health/cr/res06030804.pdf>) (Size: 1.5 MB), for ASHAs in Bihar.

How many more registers will we put in to the system and what all is going to be tracked? In many states, the terminology ASHA is subtly changing to ASHA worker.

Rushi Bakshi, Royal Netherlands Embassy, New Delhi

Dr. [Rakhee Yadav's](#) "Flower Scheme" is fascinating for its simplicity and effectiveness, and gives many possibilities with contextualization of this very simple yet effective visual scheme.

Smita Bajpai, Centre for Health Education, Training and Nutrition Awareness (CHETNA), Ahmedabad

We are working with the elected representatives (ER) of Panchayat and leaders of self-help groups (SHGs) in six districts of Gujarat and Rajasthan. We have developed a training module for monitoring capacity building of these two stakeholders. We have also developed picture books on maternal health entitlements. These tools are used to enhance monitoring skills by providing hands on training for facility survey and discussion at the quorum meeting of Panchayats. Some of the outcomes with support from local CBO partners are:

- ER monitors the facilities and their services on a monthly basis and take corrective action e.g.; opening of the centres and availability of service providers.
- ER identifies women and work with the system to ensure that services are not denied to women.
- SHGs conduct their monthly meeting at the PHC to discuss issues surrounding access to services.

The idea of village health register is great and it certainly is a very useful tool. However, I would also suggest keeping a track of vulnerable and socially excluded groups. We have conducted few studies in Gujarat and Rajasthan and have noted exclusion of marginalized groups when accessing services, even though the overall access to services was better in the entire population.

Sarwat Hussain Naqvi, State Mainstreaming Unit, Chhattisgarh State AIDS Control Society (CGSACS), Raipur

When I was working with CARE India we created a few community based self-monitoring tools and Village level resource Mapping and Block level resource mapping Tools for Community-Based Health Management Information System. These worked successfully with initial handholding.

This was basically used by the individuals and health service provider, for self monitoring we innovated tools like Chand Tare (Moon & Star), Tulsi Chowra and Dhan Jhool (an attractive design made by paddy to feed the bird etc in backyards) which is a tradition in the state like Chhattisgarh to depict paintings in the house wall which can based on its completion can tell you lot of things like month of pregnancy, IFA intake and so far ANC done by the ANM etc.

These tools were successfully used with participatory approach by the service provider and the participants, who are registered for the services.

Ravishwar Sinha, Independent Consultant, New Delhi

Thank you for bringing up this very important issue. I agree with the views expressed and am appreciative of the NRHM initiatives in this regard. I welcome the suggestion that it should not be imposed from above but should be developed at the community level.

It is the challenge for all both at the community and implementers and planners, and I congratulate the NRHM formulators for recognizing and showing the determination to do something positive to improve the situation. I will not repeat of the very valuable suggestions and welcome the references highlighted.

I would like to make the following suggestions.

- The Village level committees for health and sanitation should be able to participate in planning of the service delivery and be recognized for it.
 - The village level functionaries should be in a partnership with the Panchayat Raj Institutions, cultural and social organizations, and positive service providers. The village level functionaries, ANM, AWW, ASHA should be facilitated in doing her work and supported in overcoming the problems/hurdles that may come their way. There is perhaps no other mechanism which is community representative and empowered at the community level than the Panchayati Raj Institutions to oversee and facilitate the process.
 - The earlier MIS system did not deliver as expected-- why???-- I think this should be a lesson learnt exercise (it varies from state to state) and should be incorporated so as the same things do not happen again.
 - Feeding data in computers is very good and welcome but this brings forth an expectation from the community that has helped generate the data. If this does not lead to improvement actions on behalf of the managers of the services--, it will soon loose credibility in the community. This calls for effective decentralization and empowerment of peripheral institutions.
 - Development of systems to translate concept into reality is essential.
 - Field based monitoring and supportive supervision is most important
-

Prabir Chatterjee, United Nations Children's Fund (UNICEF), Raigunj

In early 2007, there were Gram Panchayat wise meetings in which health, ICDS, NGOs and panchayat members participated. Plans were actually made at this level for 2007-08. Prior to this, booklets were prepared in Bengali for sub-centre/ Gram Panchayat, Block and District levels. Trainings were undertaken in which Panchayat, administration, Health and ICDS representatives' participated at all three levels.

Budgeting was mostly at block and higher levels- though the Panchayats and sub-centres thought over and described how they would spend the 10,000 rupee untied fund for instance. It was participatory and

took a few months (December 2006 to February 2007) to complete. The allotment came late- final budgets were approved only in September 2007!

So again, they are trying to spend one year's funds in 6 months. This year the elaborate trainings have not been held and there is less enthusiasm- since last year's process yielded no visible results at sub-centre level (in West Bengal one Gram Panchayat covers 3 sub-centres on an average).

Ruchi Mishra, Government of Gujarat, Mandla

As for as plans for village level health committees are concerned it is still to find the momentum, but every state is preparing its own health action plan at district and state level. The issue of regularizing the activities of village health committees can be addressed here while formulating the plans.

Shyam Chaturvedi, United Nations Children's Fund (UNICEF), New Delhi

The issues raised by [Dr Ajit Singh](#) are very relevant and pertinent. I agree with him.

Surendra Kumar Yadav, Vikram University, Ujjain

Lady health visitor (LHV) and Anganwadi worker of concerned area/village can help for Village Health Register and Village Health Calendar.

Madan Mani Dhakal, Government of Sikkim, Sikkim

I think village health register is a good concept and should be implemented, but the classification of the diseases remains a problem.

Marine Mukherjee, Department of Panchayats and Rural Development, Government of West Bengal*

In West Bengal, we are, for quite sometime experiencing convergence of Health and Panchayat through various means. And as Mr. [Atanu Ghosh](#) from CINI-ASHA writes, Murshidabad is an example. But before we go deep into the tools for MIS we need to understand the initiative of decentralization and the character of devolution that is happening over here.

In West Bengal, Gram Panchayat (the lowest tier of LSGI) is the lowest planning unit found at the village level. Now within the Gram Panchayat we have five Sub-Committees (we call them Upa-Samiti here in West Bengal), among which Siksha O Janasasthya Upa-Samiti (Education and Public Health) takes care for the health matters. It is said that the Gram Panchayat Plan should comprise the individual plans of four Upa-Samitis (the 5th one is the Artha O Parikalpana Upa-Samiti, the apex body), as these take care of the sectors (economic and social) affecting rural life in Bengal (like Agriculture, Animal Husbandry, Industry, Infrastructure, Women and Child Development etc.).

So the Gram Panchayat plan is a sector-based, Upa-Samiti based plan, of which health is one.

Now the Gram Panchayat in West Bengal is quite big with an average population of 17,000. And the Gram Panchayat is divided into several smaller units; we call them Gram Sansads where in fact they are polling stations. Each Gram Sansad is curved out of habitations comprising of 700 odd voters (this has been recently delimited to 900 voters per Sansad for the coming 2008 Panchayat Election) from where representatives are elected and sent to Gram Panchayat, Panchayat Samiti (the Block Panchayat) and the Zilla Parishad (District Panchayat).

So in a different way, the Gram Panchayat Plan is the sum-total of all Gram Sansad Plans plus some thing more (the Sansads, during annual plan would take up low-cost-no-cost and no-tech-low-tech activities, while the Gram Panchayat in its part would take up bigger projects)

Now as a representative body of the Gram Sansad, Gram Unnayan Samiti's (Village Development Committees) have been formed (for each Sansad); this again is divided into Functional Committees (to quote legally "with such number of Functional Committees as may be required") that we call Karyakari Samiti. One of these is the Jana-Sasthya Karyakari Samiti, which would plan, take care and manage the health initiatives as the Sansad level. Gram Unnayan Samitis remain accountable to the Gram Sansad.

It might seem to be a bit complex, but the idea is, the Sansads would take up plans, which would merge into the holistic Gram Panchayat plan, which could be segregated into Upa-Samiti Plans, or sector based plans. Interestingly, just by shifting the matrix a bit, this holistic plan would easily render itself to the 11-sector based plans as mandated by the Planning Commission.

So regarding health, we have a sub-plan curved out of the GP holistic plan. We have to keep in mind that neither the Gram Panchayat (GP) nor the Gram Sansad is what is known as the Revenue Village or Mauza (Census Village). A Sansad may be comprised of one, part or even multiple Mauzas.

Now about the management part: as part of the Health and Panchayat merger, the state has been trying to make the services more accessible to the rural community; and the Panchayats and Rural Development Department and the Health and Family Welfare Department has shown remarkable progress on this line. As joint initiatives following are some of the measures taken by the two Departments under the bigger umbrella of NRHM and matching orders have been published on these lines:

- Maintenance and minor repair of Sub-Centre, PHC, BPHC, given to Panchayats (relevant tier as may be applicable)
- Formation of Gram Panchayat Head Quarter Sub-Centre (within the premises of the Gram Panchayat or GP); Health Supervisor to sit there
- Health Assistant (Male and/or Female) at the Sub-Centre would be a part of Siksha O Janasasthya Upa-Samiti of Gram Panchayat
- Health Monitoring Sector restructured and made coterminous with GPs
- Health system MOs are to hold clinic in (remote) GPs twice a week
- 100 remote GPs (w/o any government health service delivery system) in state authorized to engage private MOs as retainers for running clinics in GPs
- GPs authorized to engage Homeopathy / Ayurvedic / alternative medicine doctors (Sanctioned for 1175 GPs, 975 Homeopathy, 200 Ayurvedic)
- Sub-Centre Untied Fund ; GP Pradhan & ANM ; Joint Signatory
- Allocation of money for Janani Suraksha Yojana ; District Health & Family Welfare Samiti to calculate the tentative number of beneficiaries and transfer an equivalent amount to the GPs; Funds for JSY to be transferred from State Health and Family Welfare Samity to District HFWS and then directly to GPs with an intimation to BMOH/Block Health and Family Welfare Samity; Money is to be given as advance to the ANMs from the Gram Panchayat every month, based on the expected number of deliveries; ANMs will submit statement of expenditure to the GP every month after disbursement of funds to the beneficiaries, who in turn will send the Statement of Expenditure (SOE) (countersigned by Health Supervisor) to the Block Health & Family Welfare Samiti and it in turn will send the same to the District H&FWS
- Disbursement of Janani Suraksha Yojana through ANM ; GP Pradhan to attest the Left Thumb Impression in case of an illiterate beneficiary; JSY Card to be signed by ANM and countersigned by GP Pradhan during disbursement of the fund to the beneficiary

- Fourth Saturday Health Meeting at GP & V AWW, ANM, Health Supervisors and ICDS Supervisors to attend (Health Sector Monthly Monitoring) and plan the health initiatives for the GP locality, and discuss and monitor the progress made on this count.
- GPs have a definite role in selection of ASHA, initiated in 115 ITDP blocks in West Bengal; this has been scaled up under RCH-II in other blocks of the districts.
- Each tier of Panchayat has representative in the Rogi Kalyan Samiti, Block Health and Family Welfare Samiti, and District Health and Family Welfare Samiti (GP Pradhan, Panchayat Samiti Sabhapati and Zilla Parishad Sabhadhipati).
- Regarding financial devolution health related Untied Fund has been given to around 16770 Gram Unnayan Samitis (Rs. 10,000 per GUS per year) in the state from Dept. of Health & family Welfare.

Apart from these state wide initiatives, the Department of Panchayats and Rural Development has for quite some time been implementing a programme called Community Health Care Management Initiative (CHCMI, in Bengali we call it Jana-Udyoge Jana Sasthya) in some select districts/blocks of the state, where the management of Health initiatives has been entrusted upon Self Help Groups. Here apart from initiatives in promotive and preventive health, and community mobilization for better health awareness and health seeking behaviour, SHGs are maintaining records and registers for vital events within the locality (Para) which is yet again helping the GP in registration of the vital events and the Health Assistant (ANM) at the Sub-Centre to update the ECCR as well. This programme has an elaborate capacity building arrangement for the stake holders at various levels which include the MIS for each tier (here again the Gram Unnayan Samiti, elected GP member from the Sansad area, Gram Panchayat general body and the higher tiers of Panchayat have definite roles and responsibilities). CINI has been a partner (with PRDD) in this CHCMI programme in the district of Murshidabad.

Shifting the focus of Panchayats from infrastructure to issues of social development is almost moving the Juggernaut and other programmes in the state are trying much on this line too. Here I would only briefly mention the Strengthening Rural Decentralization Programme (of Panchayats and Rural Development Department) which has institutionalization, and implementation of Gram Sansad plan based Gram Panchayat plan as one of its Output. Within the output, we are trying to shift the focus more towards social development, and encouraging Gram Panchayats to devolve funds (mostly from Twelfth Finance Commission, Second State Finance Commission, Own Source Revenue of Gram Panchayats, Untied Poverty Fund) to Gram Unnayan Samitis so that they are enabled to take up plans for addressing issues of health, nutrition, women and child development, nutrition garden, nurseries etc. Part from that, for the community to own the initiatives, contributions from their end are also encouraged to bridge critical gaps in these social development issues for which there are no specific scheme.

As a programme these however are not very old and I will not go into much more detail, but success stories are pouring in from all over the state including districts like Murshidabad, Dakshin Dinajpur and Purulia.

Subodh Gupta, Sushila Nayar School of Public Health, Sewagram (response 2)

This is for information that an important document on "Manual on Community based Monitoring of Health services under National Rural Health Mission" is available on NRHM site. This document gives a framework for implementation of community monitoring as well as the guidelines for implementation. The link to the document is http://mohfw.nic.in/NRHM/Community_monitoring/Implementers_Manual.pdf

Biswajit Padhi, SRUSTI, Orissa *

Frankly speaking, there are 27 registers for the Anganwadi workers and more than 30 for the ANM, still we haven't made any rapid strides. We should stop managing registers instead and the community based health management system should be put in the hands of independent authorities.

Rajesh Sood, Centre for Health Promotion, New Delhi *

Thanks for posting the useful resource.

I would also be interested to learn if "village health plans" have been made, and how they reflect the people's priorities? Does the village health committee involve the people in the process? Do the workers make plan on the same model of RCH and get it endorsed? Kindly share your experiences.

If we are interested in increasing utilization of primary health care, we have to start from the community involvement in planning and reflecting their aspirations in plans, consolidating the people's plans and reflecting needs in district and state plans.

Monitoring of a government scheme without any community ownership would be self limiting; and futile beyond a certain point.

** Offline Contributions*

Many thanks to all who contributed to this query!

If you have further information to share on this topic, please send it to Solution Exchange for the Maternal and Child Health Community in India at se-mch@solutionexchange-un.net.in with the subject heading "Re: [se-mch] QUERY: Tools for Community-Based Health Management Information System - Experiences. Additional Reply."

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