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Activating Spaces, Scaling Up Voices: Community-based Monitoring and Planning of Health Services in Maharashtra, India

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Cover photo: Community members and civil society organization (CSO) activists from a district coordinating organization prepare a community report card on Primary Health Center services in Nashik district, 2010.

Credit: Voluntary Association for Community Health And Nurture (VACHAN)

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Civil Society Organizations Involved in Coordinating CBMP Activities in Districts of Maharashtra (2007–2020)

District	Civil Society Organization
Ahmednagar	Centre for Studies in Rural Development (CSRSD)
Amaravati	Mamta Bahuddeshiya Society
Amaravati	Apeksha Homoeo Society
Amaravati	KHOJ (A quest for Knowledge Hope Opportunity & Justice)
Aurangabad	Abdul Salam Pathan Gramin Vikas Sanstha
Aurangabad	Society for Education in Values and Action (SEVA)
Aurangabad	Marathwada Gramin Vikas Sanstha
Beed	Samata Pratishthan
Beed	MANAVLOK (Marathwada Navnirman Lokayat)
Chandrapur	Prakruti Mahila Vikas Kendra
Chandrapur	Youth Awareness Rural Development Society (YARD)
Gadchiroli	Indian Institute of Youth Welfare (IIYW)
Gadchiroli	Amhi Amchya Arogyasathi (AAA)
Kolhapur	Social Association of Network Voluntary Actions and Development (SANVAD)
Kolhapur and Sangli	Sampada Grameen Mahila Sanstha (SANGRAM)
Nandurbar	Lok Samanvay Pratishthan
Nandurbar	Janarth Adivasi Vikas Sanstha
Nandurbar	Narmada Navnirman Abhiyan (NNA)
Nashik	MAGMO Welfare Society
Nashik	Voluntary Association for Community Health and Nurture (VACHAN)
Osmanabad	Disha Samajvikas Sanstha
Osmanabad	Lok Pratishthan
Osmanabad and Solapur	Halo Medical Foundation
Palghar	Kashtakari Sanghatana
Palghar	AROEHAN
Pune	Rachana Society for Social Reconstruction
Pune	Mahila Sarvangeen Utkarsh Mandal (MASUM)
Pune	Chaitanya
Raigad	Nirmittee and Sarvahara Jan Andolan
Raigad	Disha Kendra
Sangli	Gram Vikas Bahuddeshiya Sanstha (GVBS)
Solapur	Astitva Samajvikas va Sanshodhan Sanstha
Thane	Navoday
Thane	Dr. Manibhai Desai Adivasi Mahila Sangh
Thane and Palghar	Van Niketan
Yavatmal	Gramin Samasya Mukti Trust (GSMT)
Yavatmal	Rasikashray Sanskrutik Kala Va Bahuddeshiya Sanstha

Abbreviations List

AGCA	Advisory Group for Community Action
ANW	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi (childcare center) worker
CAH	Community Action for Health
CBMP	Community-based Monitoring and Planning
CBO	community-based organization
CSO	civil society organization
IYW	Indian Institute of Youth Welfare
INR	Indian rupees
JSA	<i>Jan Swasthya Abhiyan</i> (People's Health Movement – India)
NGO	nongovernmental organization
NHM	National Health Mission
NRHM	National Rural Health Mission
PHC	Primary Health Center
SATHI	Support for Advocacy and Training to Health Initiatives
SHSRC	State Health Systems Resource Centre
VHSNC	Village Health, Sanitation, and Nutrition Committee

Summary

From 2007, the Indian government's National Health Mission (NHM) supported civil society networks to carry out large-scale participatory monitoring to improve health service access and quality under the Community-based Monitoring and Planning (CBMP) program. In the state of Maharashtra, this social accountability initiative created networks both within society and with service providers. It reached many regions across a very large state and endured more than a decade and a half, despite constraints and uncertain government funding. Civil society networks developed under the program retained autonomy and reinvented themselves during the Covid-19 pandemic to enable citizens to access health services.

The CBMP program in Maharashtra supported state-wide civil society networks to enable active citizen participation in health oversight committees. It began with an intensive period of promoting grassroots awareness about health service entitlements. It was rooted in a broad network of diverse community-based organizations (CBOs) and civil society organizations (CSOs) that work with socially excluded communities, led by Support for Advocacy and Training to Health Initiatives (SATHI). The program involved processes of state–society collaboration that were especially intensive in the early years and then ebbed and flowed, before experiencing a revival during the pandemic response.

The CBMP network combined many social accountability tools into a multilevel strategy, using community assessments of health services and local meetings with clinic staff to inform problem-solving efforts at local, district, and state levels of the health system. This government-funded civil society initiative worked with local officials to convene public dialogues and to activate previously dormant official local, multistakeholder oversight bodies, animated by a parallel network of autonomous monitoring committees active at multiple levels of the health system. The CBMP reached approximately 1,000 villages in 17 districts across the state, operating at multiple levels by escalating problem-solving advocacy from lower to higher levels of the health system when needed.

This study presents SATHI's analysis of the CBMP program's strategy and institutional dynamics, and documents its lasting effects on two participatory oversight institutions: Village Health, Sanitation, and Nutrition Committees (VHSNCs)—part of local government—and *Rogi Kalyan Samitis* (Patient Welfare Committees)—part of the health system.

The field research, carried out shortly before the pandemic, compared the activation of these hybrid oversight bodies in areas with and without a legacy of intensive CBMP action. The key research findings include:

- Official participatory spaces for citizen engagement with the health system were much more active in districts where CBMP networks had intensively promoted grassroots capacity for voice.
- Health system responsiveness was higher in districts where CBMP was active.
- Frontline health system responsiveness to issues that could be addressed locally—identified as 'CBMP-sensitive'—was very high. Community concerns that required decision making at higher levels of the health system—such as increased staffing for service provision—required "escalation" of advocacy. Yet the health system's degree of responsiveness to problem-solving efforts decreased at higher levels.
- The period of intensive CBMP effort to build grassroots awareness and capacity was limited to six years. Nevertheless, that effort had lasting effects on the levels of activity of local hybrid health oversight bodies.

- The CSO networks' proactive emphasis on enabling voice and recognition of women, Dalits, and tribal communities contributed to addressing "micropower" imbalances, which often weaken official participatory spaces.
- The pandemic revealed additional evidence of the medium-term survival and institutional impact of CBMP-enabled social networks (both at community levels and with frontline health service providers). In response to the pandemic crisis, CSOs reactivated CBMP social networks and launched innovations to improve citizens' access to health systems, addressing ongoing health needs during the crisis phase of the pandemic.

SATHI's analysis of the CBMP experience in Maharashtra state suggests broader propositions about social accountability. It supports the proposition that effective collaborative social accountability requires multistakeholder representation operating across multiple levels, combined with active facilitation mechanisms that have a degree of autonomy from the state. If such critical ingredients are lacking, the process can become formalistic and ineffective. Some mutually reinforcing ingredients for effective collaborative social accountability include:

- Enabling of participatory spaces, to ensure some level of parity among diverse participants, and allow for expression of diverse views, dialogue, and deliberative decision making.
- Multistakeholder representation in such spaces, to enable countervailing power.
- Systematic capacity building of social actors, enabling them to effectively engage in such officially endorsed spaces, and to reduce dependence on government-funded or controlled facilitation.
- An enabling environment for active mechanisms for facilitation of community action that enjoy some autonomy from the state.
- Linkages between participatory bodies and processes across multiple levels of the health system hierarchy, to allow for reinforcement between enabling government directives (from higher to lower levels) and the escalation of advocacy on issues requiring resolution (from lower to higher levels).

The CBMP experience suggests that an intensive wave of widespread capacity building for micro-level power shifts—together with the activation of local, representative institutions—can contribute to health system responsiveness that can, to some degree, survive higher-level policy changes. In the context of changing policy environments, the longer-term sustainability of large-scale, official social accountability processes may depend on the organization, empowerment, and autonomy of collective grassroots actors, to exercise countervailing power in the public interest.

1. Introduction

The global Covid-19 pandemic broke the sectoral silo that once limited public discussion of public health systems. Access to health care—and trust in the capacity of governments to protect their citizens—rose to the top of many agendas for both citizens and policy makers. In this study, health rights advocates share lessons from their long-term efforts to improve health system responsiveness.

In India, a comprehensive policy reform, initiated in 2005—the National Rural Health Mission (NRHM, later expanded into the National Health Mission, NHM)—called for the widespread creation of local public oversight committees, and enabled state-wide civil society networks to encourage active citizen participation in those committees (in nine pilot states). This initiative came to be called the Community-based Monitoring and Planning (CBMP) program. This study offers a practitioner-led analysis of this initiative in Maharashtra, the state where the model of civil society-facilitated community-based monitoring and planning was implemented consistently for the longest period. Years later, this initiative's social networks reinvented themselves to help health systems respond to citizen needs during the Covid-19 pandemic.

1.1 Social accountability at scale in international context

For more than two decades, around the world, social accountability strategies have encouraged citizen voice and action to improve public services. One of the most widely attempted approaches involves government programs that convene community-based committees to monitor and engage with local-level public service providers—most notably in the health and education sectors. Yet such efforts often have mixed results, ranging from energizing responsiveness from service providers, to having little or no impact. As it turns out, official local oversight committees often exist only on paper, are captured by local elites, or are too weak and isolated to contribute to improved service provision, even when they are participatory. This raises the question: what does it take to enable broad-based, participatory, officially mandated citizen oversight, at scale?

This study contributes to an international research literature on social accountability that is often limited by four main factors. First, the literature that is internationally referenced refers primarily to donor-funded efforts. Second, evaluations that get international attention focus more on bounded local projects than on national programs or policies. Third, few studies address the multilevel dynamics of many civil society advocacy and problem-solving efforts. Fourth, conventional evaluations of donor projects do not address their longer-term implications or ask whether they have lasting effects.

This study addresses these gaps by analyzing the evolution of a large-scale, government-funded initiative over more than a decade in Maharashtra—India's second-largest state, by population. The CBMP pursued a multilevel strategy with broad territorial reach, social roots, and embeddedness in local governance bodies.¹

As a state-wide initiative backed by a national *policy* mandate, CBMP differed from social accountability *projects* led by either CSOs or donors. Yet because the policy was originally accompanied by intensive grassroots capacity building, it also differs from the top-down official creation of local “invited spaces” that often turn out to be empty.²

The NHM policy, including the CBMP, was originally made possible by mutually reinforcing interaction between reformers both inside and outside the government.³ India's national and state governments collaborated with CSOs

and CBOs to combine independent monitoring of health services with public dialogues to discuss findings and promote problem-solving efforts, all at multiple levels of the health system.⁴

The CBMP embodies “collaborative social accountability,” defined by the Global Partnership for Social Accountability as “a process that engages citizens, civil society groups, and public sector institutions in joint, iterative problem solving to improve service delivery, sector governance, and accountability” (Guerzovich and Poli 2020, 2). This approach focuses on combining three “levers” that are intended to work together: civic mobilization, interface spaces between citizens and the state, and information (Granvoinnet, Aslam, and Raha 2015). The distinctive CBMP process in Maharashtra combined these levers with grassroots capacity building, civil society autonomy, multilevel actions, and flexible adaptation to changing policy context—four features that are especially relevant to the international field of social accountability.

- 1. Intensive CSO support for grassroots awareness and capacity building addressed power imbalances to encourage health system responsiveness to the socially excluded.** Significant, proactive capacity-building efforts are needed to address power imbalances within government-convened spaces for citizen participation (sometimes known as “invited spaces”).⁵ The CBMP approach to social accountability was grounded in representative organizations of the socially excluded (especially women, tribal communities, and Dalits) embedded in longstanding traditions of grassroots mobilization.⁶ With funding from the public health system, the community-based monitoring strategy was led by a state-wide network of rights-based local organizations, which engaged in sustained capacity building and accompaniment of diverse grassroots actors. They emphasized social inclusion to bolster voices of under-represented groups in their engagement with service providers. This mentoring-oriented approach promoted inter-related transformations at three levels: ‘micro-level’ power shifts *within* communities and among community-based actors; changes in the interaction *between* communities and the health system involving the official recognition of voice; and improved health system responsiveness.
- 2. Government-funded CSOs sought to balance collaboration with autonomy.** From 2007, national health policy and financial support enabled the state-wide CSO/CBO network to build grassroots capacity to both monitor and engage with the health system. The network managed the delicate balance of combining a collaborative stance with the autonomy needed to sustain participatory spaces. This is notable in the comparative international context, because elsewhere, civil society participants in collaborative social accountability initiatives have often lacked autonomy from their government counterparts, which is crucial for being able to speak truth to power. The CBMP process combined coalition-building with some authorities and service providers, while questioning them at other levels to ensure accountability. This adaptive, context-driven approach is different from the conventional approach in the social accountability field, which labels advocacy strategies as necessarily *either* collaborative or adversarial. In practice, the CBMP strategy involved both, with variation across different levels and agencies in government, as well as change over time. The CBMP experience is especially distinctive because it pursued this combination of collaboration with autonomy while relying on government funding.⁷
- 3. Citizen oversight strategies combined problem-solving initiatives at multiple levels of the health system, escalating advocacy from local to higher levels when needed.** Research on social accountability experiences in health often focuses on local health committees that engage with the last mile of public service delivery. The CBMP, in contrast, convened multistakeholder bodies at each level of health system decision making, in order to pursue problem-solving at the level where the relevant decisions were actually made. Findings from monitoring and problem-solving at different levels also informed health system planning, to address service delivery issues that could be addressed “upstream” with systemic improvements, rather than only reacting to the symptoms of problems. In the social accountability field, this coordination of civil society problem-solving efforts across multiple levels is known as vertical integration—a systemic approach that addresses underlying causes of accountability failures, rather than responding only to symptoms.⁸

4. Flexible approaches to both discourse and action responded to a changing policy context. The national government that launched the NHM was replaced following a general election in 2014, and this posed challenges to the sustainability of the CBMP process. While the NHM umbrella continued, specific policies, budgets, and ‘acceptable’ discourses changed. The CBMP in Maharashtra adapted, both in terms of its interface with the health system and its public profile. The more overtly confrontational elements of the CBMP program were moderated over time, as CSOs managed the tensions and trade-offs between accountability and collaboration. For example, even terms like ‘monitoring’ turned out to have become controversial, and public hearings were renamed as public dialogues. Uncertain public budget allocations and inconsistent disbursements posed additional challenges, as the state government gradually reduced the scope of the more autonomous actors within the CBMP process.

1.2 Organization of the study

This study addresses three main sets of questions. First, what was the CBMP and how was its strategy carried out in practice in Maharashtra? How did its multiple moving parts fit together, and how did it innovate in response to challenges and changes over time, including those in the funding landscape? Second, how did the CBMP’s efforts to activate and enable local health oversight committees fare in areas with and without CBMP capacity-building activities? Third, how did the practitioners who implemented the CBMP understand the way that changes in micropower relations can promote access to health services?

The paper is organized in four main sections. The first explains the origins and broader context of the CBMP, and SATHI’s strategy for implementing it—both as it was designed, and as it was carried out in practice. The second section presents the findings of field research that documents the strategy’s medium-term impacts through a comparison of official participatory oversight committees in areas that had and had not benefited from the capacity-building stage of the program. In the third section, CBMP strategists reflect on *how* its implementation influenced power relations at the local level, while drawing some insights from this process. The final section is an epilogue that addresses how the CBMP legacy of social networks that bridge communities and health system authorities enabled quick action in response to the pandemic crisis.

To sum up, the CBMP experience shows that health system responsiveness to groups who are socially deprived and excluded can improve if service providers and social actors collaborate within an accountability framework through participatory forums. Such spaces can be effective when they are based on balanced dialogue at multiple levels, with proactive social inclusion and respect for autonomy.

2. CBMP: Origins, Operating Context, and Strategic Implementation

The CBMP in Maharashtra adopted strategies to promote community responsiveness and effectiveness of rural public health services. The government's NHM mandated a state-wide network of CSOs, in collaboration with state government health authorities, to convene efforts to support official citizen oversight bodies. This section first discusses the origins of the CBMP in the context of the NHM, and the funding trajectory of the program between 2008 and 2020. It goes on to focus on SATHI, the nongovernmental organization (NGO) that coordinated implementation in Maharashtra from 2007, describing the CBMP implementation strategy and discussing significant changes in implementation over time.

2.1 Origins of the CBMP: the evolution of the National Health Mission

The National Rural Health Mission (NRHM) was launched in 2005 and in 2012 was combined with an Urban Health Mission to constitute the National Health Mission (NHM). This major health sector reform program aimed to provide affordable, accountable, and effective primary health care to India's poor and marginalized populations, by structurally reconfiguring the public health system through facilitating decentralized management and greater community involvement.

NRHM/NHM had five key approaches: capacity building to improve health system management; innovations in health system management; flexible financing and decentralization of health-related decision making; creation and strengthening of grassroots participatory bodies; and monitoring progress against public standards through independent review and monitoring processes.⁹

The CBMP was a novel initiative that was included in the NRHM for two key reasons. First, its architects wanted to fill a gap in its validation system. CBMP was designed to act as the “third leg” in the monitoring system, joining the internal management information system¹⁰ and external evaluation surveys and audits¹¹ (Shukla, Scott, and Kakde 2011, 78). Second, it was the result of sustained people-oriented advocacy on the right to health care, community involvement, and social accountability, through networks such as *Jan Swasthya Abhiyan* (JSA, People's Health Movement – India).

JSA is a national health sector coalition of CSOs and networks, formed in 2000. In 2004, it collaborated with the National Human Rights Commission to organize a series of public hearings across the country on the right to health care, while advocating for strengthening of public health services. JSA activists also engaged with official processes related to the design of the NRHM in 2005–06, proposing various modifications, including a component of community-based monitoring to promote health rights, which was incorporated in the NRHM framework for implementation (Ministry of Health and Family Welfare 2005). The NRHM's civil society Advisory Group for Community Action (AGCA) designed a policy framework, leading to the 2007 launch of CBMP with financial and operational support from NRHM (SATHI 2012, 6). Between 2007 and 2009, AGCA facilitated and technically led the piloting of CBMP in nine states.¹² In each, a “state nodal NGO” was entrusted with facilitating the CBMP process, engaging other CSOs to implement participatory processes in selected areas; in Maharashtra, this role was taken on by SATHI. In this phase, the national government's AGCA Secretariat directly funded state nodal NGOs, giving them substantial autonomy from state government health departments, along with providing significant technical support to the process.

After the pilot phase ended in 2009, state governments were given the option of supporting CBMP processes. Some states discontinued the CBMP, while others chose to continue certain community-based activities, while substantially downsizing the role of nodal CSOs. In Maharashtra, unusually, the state government decided to continue implementing the CBMP through a state-wide network of nodal CSOs at multiple levels (state, district, and block).

During the post-pilot phase, consensus emerged at national level that the CBMP should develop beyond its primary focus on 'community monitoring', which was perceived as being relatively confrontational, to give greater emphasis to collaboration between communities and health systems. This included activities like local-level participatory health planning. From 2014, participatory activities supported by NHM became referred to as 'community action for health' (CAH) rather than 'community-based monitoring and planning' (CBMP).

The NHM continued to be a national policy despite a change in government in 2014, but especially from 2018 onwards, priority shifted to a new flagship health program, *Ayushman Bharat*. This decline in the NHM as a national policy priority meant even less official attention to the relatively minor CBMP/CAH component within it. Although the focus on Village Health Committees continued in many states, there was a less central role for nodal CSOs or multilevel social accountability processes. In this context, CAH processes in Maharashtra became an outlier nationally, since SATHI and its associated civil society network continued to play a significant role in facilitating community-based monitoring and planning processes from village level up to state level.

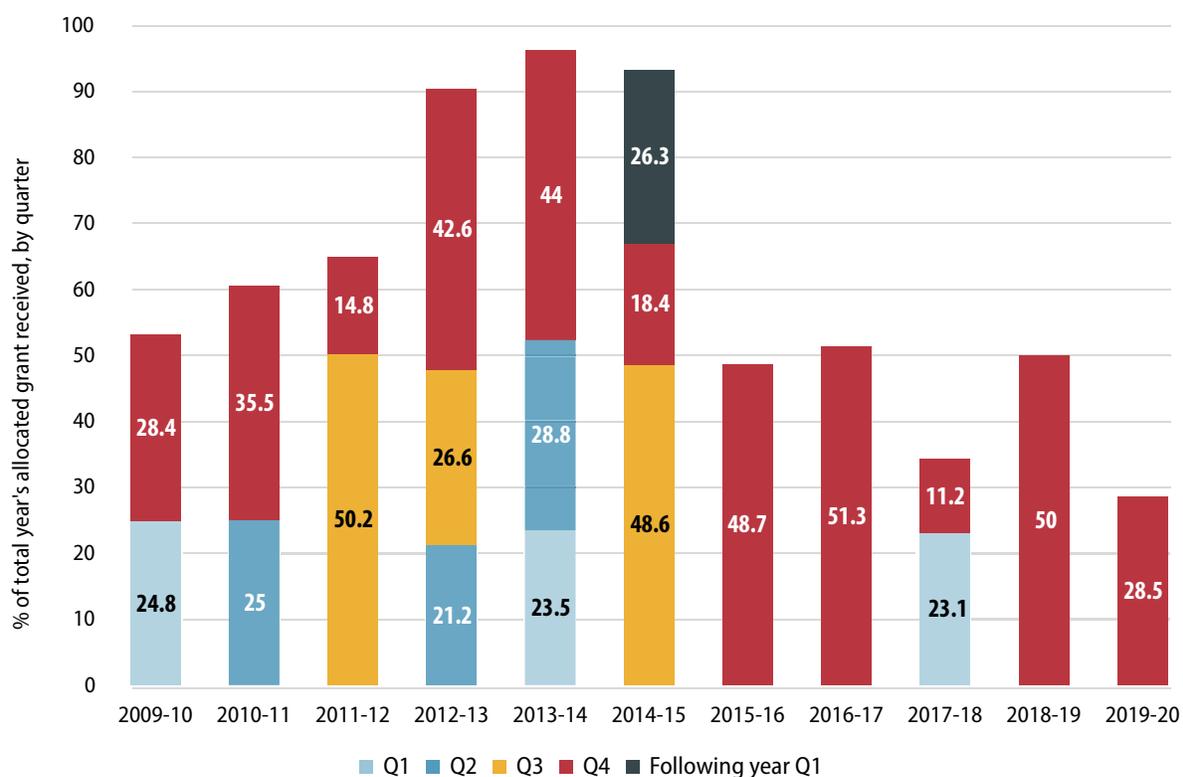
These shifts in policy priorities had major impacts on CBMP processes in Maharashtra. In a context of shrinking space for action by rights-based CSOs, SATHI and other CSOs in the network tried to maintain the degree of independence needed to voice community demands and concerns, while also collaborating with the health department. The organizations have walked this tightrope with only partial success.

2.2 CBMP operating context and funding trajectory

The policy shifts outlined above are also a factor shaping the trajectory of funding for the CBMP—the state government's support for the program has varied significantly over time. Examining this trajectory explains the CBMP's operating context and some of the constraints under which it operated. Further analysis of spending per primary health center (PHC) illustrates how the scale of the program changed over an 11-year period.

Several years of increasing support during the heyday of the NHM were followed by significant reductions and delays, which directly affected the scope and intensity with which the CSO and CBO networks could carry out their work in hundreds of villages. The allocated budget should have been disbursed equitably over each quarter of the year. Figure 1 shows the overall trend of delayed grant disbursements over the 11 years until the pandemic (2009–20). In each year after 2015–16, only around half of the allocated budget was released.¹³ This significantly impeded implementation of CBMP processes. The receipt of funds in the first quarter was on time in only 2 of those 11 years. In 6 of the 11 years, first installment of funds were not received until the third or fourth quarter.

Figure 1. Timing and Proportion of Total Allocated Grant Disbursed by NHM for CBMP, by Quarter, 2009–20



This pattern of delays forced the CSO/CBO network to operate for over half of the year using their own limited resources, with uncertainty as to whether they would eventually be reimbursed. In 2014–15 there was an exceptional delay, with part of the funds received after the end of the financial year. These delays especially hampered resource-intensive activities that needed to be spaced out during each year as part of an ongoing cycle of processes, such as field-level review and planning workshops, field-level data collection, district-level orientation and capacity-building workshops, block-level mentoring and monitoring meetings with officials, and organizing public dialogues. These delays in the release of funds, with large amounts released shortly before the end of the financial year, paradoxically led to unspent budgets despite the need for timely resources on the ground.

Table 1 shows a steady decline in grant per PHC from 2015–16 onwards. Although the geographic scale of the CBMP process increased nearly four-fold over 11 years, the budget allocation did not increase in proportion—and only approximately half of the allocation was received after 2015–16. In the same period, the budget per PHC fell sharply, reaching a low of 20,000 Indian rupees (INR) per PHC area in 2017–18.

Table 1. Trend of Grant per CBMP Primary Health Center

Financial year	Number of CBMP PHCs	Grant per year per PHC area (INR)
2009–10	45	304,994
2010–11	53	391,657
2011–12	53	465,679
2012–13	60	367,680
2013–14	90	306,849
2014–15	75	352,457
2015–16	75	387,678
2016–17	114	64,503
2017–18	189	20,086
2018–19	189	69,189
2019–20	180	76,589

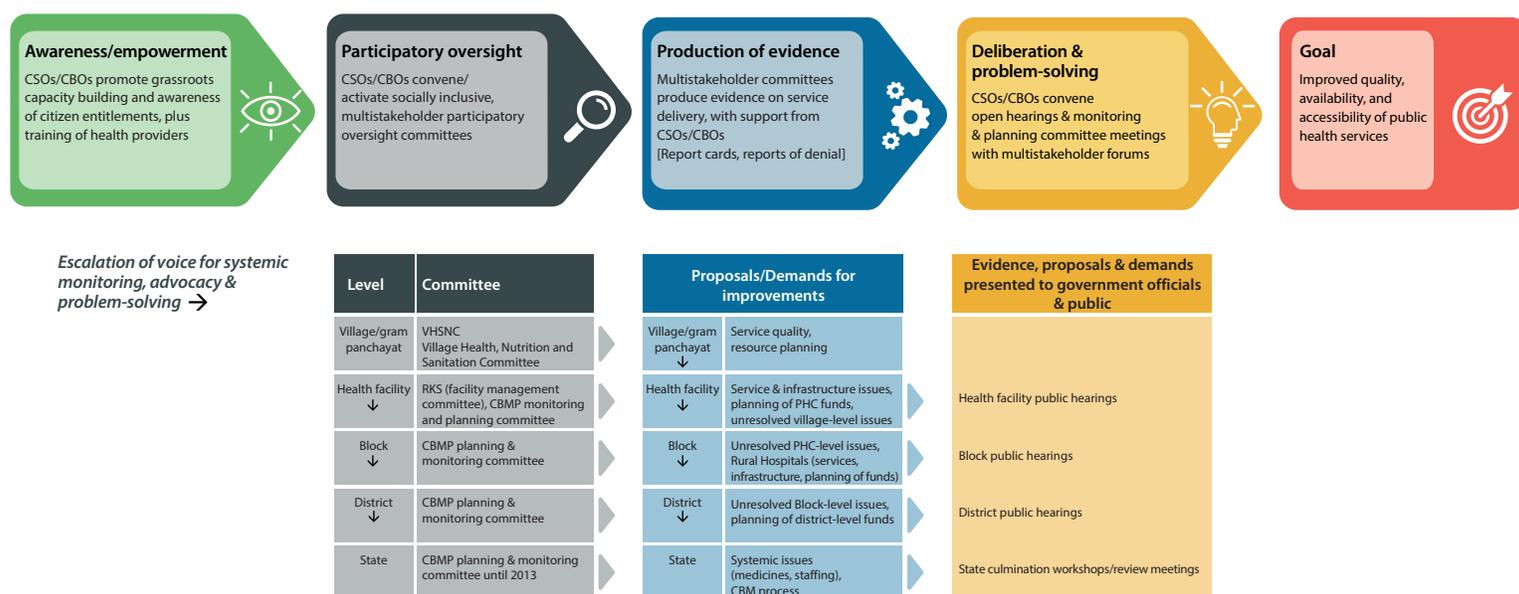
Source: SATHI data analysis, 2020.

Despite this funding landscape and the constraints it presented, SATHI and its partners were able to implement a substantial set of multilevel activities at a very wide scale for the duration of this period. The CBMP constantly evolved and adapted its activities according to political and financial changes. The next section examines in detail the activities and the strategic adaptations made by the CSO networks in order to continue their efforts to improve public health services over this lengthy period.

2.3 CBMP implementation: SATHI's strategy for improving public health services

Figure 2 shows SATHI's overarching strategy for community-based monitoring and planning, created collaboratively with implementation partners. It illustrates the different levels and spaces in which the CBMP was implemented over time.

Figure 2. SATHI's Multilevel Strategy for Community-based Monitoring and Planning



Source: Authors.

This strategy, developed in 2007, included:

- promotion of grassroots awareness of citizen health service entitlements by a broad network of CBOs and CSOs, with an emphasis on socially excluded groups
- concerted efforts to activate existing local official multistakeholder oversight committees such as Village Health, Sanitation, and Nutrition Committees (VHSNCs), while also constituting multistakeholder monitoring and planning committees (CBMP committees)
- community assessment of health services through report cards and documenting cases of denial of services
- convening participatory deliberative spaces in the form of *jan sunwais*—large-scale public forums that draw on widespread Indian civic traditions. Health system authorities at different levels participated to respond to community concerns

As indicated in Figure 1, at each level of the public health system, committees and public forums transmitted evidence collected from community monitoring and assessment activities and conveyed community concerns to higher levels of the public health system.

The rationale for this vertically integrated monitoring and advocacy system is that the scope of decision making at each level of the health system varies. Improving availability of and access to frontline services requires influence on health system decision making at higher levels.

SATHI's multilevel CBMP strategy relied on the concept of escalation. When CBMP activities identified problems not being addressed at local levels, the CSO network escalated problem-solving efforts, putting the issues on the agenda of discussions with more senior health system authorities. For example, while some of the issues identified through community assessment were addressed at the block or district level with advocacy support by partner CSOs, others involved budget allocations or changes in policy beyond the district. Notably, issues that are key for under-served areas—like creating or filling health staff positions—are often out of reach of the mid-level and local health staff; only state-level officials have the decision making power and resources to create change (Shukla, Scott, and Kakde 2011, 84–85).

Developing and putting into practice this multilevel strategy required a range of activities and capacities that have evolved and adapted for more than a decade. These are outlined in the next section.

2.4 What did SATHI and its partners do?

SATHI's multilevel CBMP strategy has been centered on activities that include producing community-based evidence and promoting participation of local stakeholders to inform health system planning. Below we describe: the preparatory and monitoring activities that were part of the original CBMP strategy (2007–09); the expansion of the CBMP to more districts, and increasing involvement in participatory health planning and budgeting; SATHI's activities and responsibilities in the unique 'state nodal NGO' role; and how activities were modified and adapted in response to SATHI's 'learning by doing' approach and the changing policy context.

2.4.1 Preparatory and monitoring CBMP activities

Building community awareness. With the launch of the CBMP in 2007, SATHI and its partner CSOs and CBOs used village meetings, cultural programs, and awareness campaigns to generate community awareness about the NRHM, the services available under different national health programs, and the structure of the health system (Shukla and Sinha 2014). The goal was to make people aware of their entitlements so that they could monitor whether they were delivered. Community assessment tools (report cards) generated awareness about the state of public health services.

Formation and revival of stakeholder committees. Government-sponsored multistakeholder bodies are key to the CBMP process. These committees exist at several levels (see Figure 1), beginning in villages, where they are part of local government (Ministry of Health and Family Welfare 2013). Under the NRHM, pre-existing official Village Health and Sanitation Committees expanded their scope to include nutrition (becoming VHSNCs), receiving public funds to prepare village-level plans to improve health and sanitation based on local priorities (see Box 1).

Box 1. Activation of Village Health, Sanitation, and Nutrition Committees

The Village Health Committees were originally supposed to work primarily for improving maternal and child health indicators, and the Water and Sanitation Committees were primarily responsible for ensuring sources for safe drinking water and improving sanitation. The new VHSNCs, one for each village government, funded by the Health Department under the NRHM, combined the two and added nutrition to their work. Based on the size of the village population, VHSNCs were provided with between INR 7,000 and 10,000 annually for village-level activities. In Maharashtra, the account was jointly managed by the elected local government leader (*sarpanch*) and the Anganwadi worker (AWW), the female community worker who staffed the village childcare center.

CBMP civil society facilitators engaged with the VHSNCs in their areas and often found that although these committees had been constituted on paper, they were not participatory or active—leading to domination by service workers and underspending of available funds.¹⁴ To activate them, the CBMP process led the following activities:

1. At least two or three joint meetings were conducted with VHSNC members and the community, to understand their current status and functioning.
2. To address the generally non-existent participation and lack of information among the community concerning the VHSNCs, CBMP facilitators proposed adding a few community representatives for discussion in the meetings with community and VHSNCs. These meetings also led to the nomination of additional VHSNC members from the community.
3. The expanded VHSNCs' composition was then shared and finalized in the *Gram Sabha* (village-level meeting with statutory power held by village government), while promoting a more active role of the VHSNC.
4. The CBMP then provided VHSNC members with training on their roles and responsibilities.



VHSNC meeting, Madigale village, Kolhapur district in 2010.

Credit: SATHI

A government evaluation of the CBMP program describes how challenging it was for nodal CSOs to ensure the activation and full staffing of these committees, because of limited childcare center staffing and frequent turnover in local government (State Health Systems Resource Centre 2013).

VHSNC support for the CBMP program was crucial. The process of activating these village committees took a year and a half. As indicated in Figure 1, the VHSNCs were supported by a vertically integrated monitoring structure of CBMP committees, from the PHC up to block, district, and state levels. Each monitoring and planning committee was led by a collaboration between a civil society activist, an elected local government representative, and a health official. At each level, the monitoring and planning committee reviewed and discussed reports on health service delivery, sent periodic reports to the committee above its level, and facilitated the organization of public dialogue events.

Capacity development of key stakeholders. The nodal CSO for each block organized workshops for key stakeholders (including all health officials from the local to the district levels, elected local government representatives, retired health workers, and local journalists—many of whom were also members of CBMP monitoring and planning committees) to share information on community-based monitoring activities, health rights entitlements, and the role of health officials in CBMP work.

Community assessment of health services. The key CBMP community assessment tool involved official report cards applied at village and PHC levels to track, record, and report on the state of public health services. These regular objective records of shortcomings gave legitimacy to people’s sense of being entitled to better services; they were defined in specific terms, and grounded in evidence.¹⁵ The report cards also brought a renewed sense of hope; no longer was denial of services expected and unremarkable (Shukla, Scott, and Kakde 2011). Recording problems, especially on government-supplied report cards, implied that something could and should be done about them. The report cards and the awareness that surrounded them helped to generate the community-level mobilization needed for the *jan sunwais*.

Jan sunwais (public hearings). The CBMP process was the first time the popular strategy of *jan sunwai* had been incorporated into a national health policy. With the legitimacy and convening power that came from their official mandate, the CBMP *jan sunwais* helped implementing CSOs to bridge the gap between citizens and the public health system. In many places, these hearings were the “first opportunity that communities had to publicly share their views” about the local health services (Shukla, Scott, and Kakde 2011, 80). CBMP *jan sunwais* were organized at multiple levels of the health system, as indicated in Figure 1. From 2007 to 2009, more than 200 *jan sunwais* at different levels of the health system enabled villagers to question health staff and functionaries about service delivery (Shukla, Saha, and Jadhav 2015). Since the PHC-level hearings were followed up by block- and district-level dialogues and were chaired by both elected and administrative officials, lower-level health authorities had to take them seriously, knowing their supervisors would hear of the problems reported. The district-level *jan sunwais* provided a mechanism for rural people to report the actions of their local health officers directly to the district health officer and civil surgeon. The district medical officers were able to use the public dialogues to check if their staff were doing their jobs. In cases where district-level health officials were not enthusiastic about attending *jan sunwais*, state government officials issued specific instructions that they must attend. Activists added legitimacy to the district-level hearings by raising their findings at state-level dialogues.



From 2012 onwards, the *jan sunwais* evolved into *jan samvads* (public dialogues). In these dialogues, CSOs and CBOs were asked to submit questions and information about problems identified in advance to officials. This modification was partly due to resistance from health facility and block-level health staff. SATHI strategically made use of the evolved platform to shed light on policy issues and to encourage cooperation of health officials. SATHI adapted its approach to these public deliberations to avoid calling out frontline staff for problems that were caused at higher levels of the system. As the dialogues evolved, issues were specifically raised only at the level of the health system where they could be effectively redressed, to avoid antagonizing local health staff—a process of *selective escalation* of problem-solving efforts.

Periodic state-level dialogues. SATHI and its implementing partners built support for CBMP inside the state health department through dialogues with state-level officials. Prior to CBMP, there was no regular forum to facilitate the interface between the state level and civil society in the health sector. These dialogues were a key forum to escalate issues that were pending at lower levels of the health system. They encouraged district-level health officials to be upwardly accountable to their superiors. This upward accountability was augmented with downward accountability processes such as community report cards, multilevel monitoring and planning committee reports, and *jan sunwai* reports. These community accounts enabled state officials to verify reports from their district offices (Shukla, Scott, and Kakde 2011, 81).

2.4.2 Participatory health planning

As noted in the previous section, in the first phase of the CBMP program (2007–09) the emphasis was on developing a system of community-based monitoring. In 2009, the national government expanded the scope of CBMP to 14 of Maharashtra's 36 districts.¹⁶ Simultaneously, in preparation for the expansion, SATHI began 'lower intensity' voluntary CBMP work in more than 20 blocks across 9 additional districts, some of which expanded beyond CBMP's coverage. The primary objective of the voluntary CBMP work was to vet local CSOs and CBOs that could be included as implementing partners in the new districts. Beginning in 2010, SATHI also built on the monitoring work to include a component of community-based health planning. This involved, for example, collectively verifying how health facility-level budget committees used the funds under their control.

Participatory audit process. From 2011 onwards, SATHI focused its efforts on building the capacity of local stakeholders, such as members of the *Rogi Kalyan Samitis* (Patient Welfare Committees), to influence local health planning (see Box 2). SATHI and its partners learned that funds allotted to local bodies such as the Patient Welfare Committees were often spent without the approval or knowledge of their members. With the aim of improving health budget spending, SATHI and its partners organized special orientation events with elected government representatives and health staff, and insisted on regular Patient Welfare Committee planning meetings, which circulated decisions to all members (SATHI 2012). To consolidate the work of activating Patient Welfare Committees, participatory audits were also organized in three districts (Thane, Nandurbar, and Raigad). CBMP partner organizations accessed and analyzed Patient Welfare Committee fund details and prepared posters, displaying them at 'special social audit meetings' organized to share audit findings. Multiple stakeholders participated in these meetings, including Patient Welfare Committee members, elected representatives, local CSOs, and state-level officials. Through these audits, community members were able to ask officials questions, and get them to explain and justify their use of funds. The lessons from these audits fed into the health planning process. This CBMP focus on disclosing health facility committee budgets and activities combines two key elements from the broader social accountability field. CBMP promoted "targeted transparency"—an approach that emphasizes disseminating relevant and actionable information, while also creating a forum in which citizens could question local authorities.

Box 2. Policy Impact of the CBMP: Patient Welfare Committees Expanded to Include CSOs

One of the small but significant systemic impacts of the CBMP program has been the expansion of the Patient Welfare Committees. Early in the CBMP program, implementing CSOs learned that Patient Welfare Committees had significant financial powers in the form of flexible funds earmarked for upgrading and improving the health facility. The spending patterns of these closed committees, dominated by health officials, did not always reflect community needs (Marathe 2013).

In a state-level review meeting in July 2009, SATHI and partner CSOs advocated that community suggestions must be taken into account during Patient Welfare Committee planning. The state-level National Rural Health Mission Director responded by issuing a circular to district officials, stating that all Patient Welfare Committees in five CBMP districts must permanently invite a representative of a CSO associated with CBMP to their meetings at four levels, from PHC to district hospitals.

This inclusion improved the functioning of the Patient Welfare Committees in CBMP areas, increasing the frequency of meetings and making spending more transparent. Numerous community-based proposals began to be presented during Patient Welfare Committee meetings, not only by the civil society representatives but also by the Panchayat officials, who had become more oriented to community health priorities through the CBMP process. Patient Welfare Committee funds began to be used to resolve numerous local issues.

Following the CBMP's subsequent expansion to 17 districts, another official circular invited CBMP CSOs to join the Patient Welfare Committee executive committees. The addition of just one civil society representative reoriented these committees' priorities.

Strengthening decentralized health planning. To ensure that health budget priorities reflected local priorities, the NHM also included a mandate for decentralized health planning through formulation of program implementation plans at village, block, district, and state levels. In 2015, SATHI carried out a survey study to assess decentralized health planning in two blocks of Gadchiroli district (SATHI 2016). The findings were significant: elected members of local government councils were mostly unaware of the preparation process for the program implementation plan, and the process was largely bypassing local bodies. No government training was provided to either local governmental or civil society participants involved in preparing health plans. SATHI focused on providing training and ensuring spaces for CSO participation in health planning processes as well as for promoting inclusion of community proposals in health plans. This process combined educational and capacity-building activities with advocacy efforts, with CBOs making proposals at different levels of the health system. At the state level, SATHI's advocacy efforts focused on obtaining formal approval for CBOs to participate in Patient Welfare Committee meetings and program implementation plan preparation processes, as well as advocating for community proposals to be included in state-level plans (Shukla, Khanna, and Jadhav 2014). Various state level activities were carried out in collaboration with SHSRC, which played a coordinating role with district health officials as well as CSOs.

2.4.3 The “nodal NGOs”—facilitating and coordinating civil society networks¹⁷

As state-level coordinating organization since the inception of the CBMP program, SATHI shouldered two levels of responsibility in implementation: coordinating with district and block-level CBMP partner NGOs, and liaison with the state health department. This involved: providing mentorship to partner CSOs; developing strategies in

consultation with partners; using data as an input to inform follow-up; providing consolidated reports of community feedback to state officials; and engagement with state officials to address issues at multiple levels. District-level coordinating CSOs linked the state- and block-level coordinating organizations. They were responsible for tasks such as guiding block-level NGOs in their implementation work, including problem-solving, organizing district-level training workshops and public hearings, and forming district mentoring committees and district-level monitoring and planning committees. District-level NGOs also followed up with relevant officials on issues escalated up from the block level. Block coordinating CSOs worked closely with local CBMP partners. They were primarily responsible for public hearings at the health facility level, facilitating meetings of block- and facility-level monitoring and planning committees, and local-level service delivery problem-solving.

The CBMP process has involved significant local adaptation and elaboration of community-based processes, which were broadly defined at the state level and were then further implemented in diverse socioeconomic contexts across the state. Reflecting the diversity of civil society in Maharashtra, CBMP coordinating CSOs came from varied backgrounds, often bringing their unique strengths to the process. These CSOs could be categorized in the following groups, with some overlap across categories:

- **Mass organizations** (*sanghatanas*) that are membership based, primarily working on livelihood issues (demanding forest and land rights, resisting displacement, ensuring rehabilitation of displaced communities, etc.), with a strong track record of rights-based mass mobilization, including in Adivasi communities (over 9 percent of the population of Maharashtra consists of tribal communities, giving it the second largest tribal population among Indian states). Health was not their primary focus, but they took it up as part of the CBMP process.
- **Rights-based NGOs** that work primarily with socially excluded groups, including women, children, or sex workers. These organizations usually drew support through institutional funding (rather than through membership contributions) and engaged in certain rights-based mobilizations. Health was usually part of their existing agenda, as an important part of their broader agenda to ensure rights for their constituencies.
- **Community health NGOs** with a strong track record of working with communities around health issues, often having some background of training and collaboration with the health system. They were traditionally not focused on rights-based mobilization but were willing to engage in a certain level of participatory dialogue with public agencies to improve services.
- **Developmental NGOs** that had not primarily worked on health issues prior to engagement in CBMP, but had strong community roots through social development work. They were often involved in promoting local participatory governance, such as working with Panchayat members. Many also worked on livelihood issues, often involving Dalit or Adivasi communities.

Despite this diversity among these local coordinating CSOs, they shared a common characteristic, which enabled them to effectively develop and implement CBMP activities: a focus on social equity, including proactive inclusion of socially excluded groups. Their significant grounded community roots enabled them to mobilize grassroots actors and ordinary people around health issues. This social equity focus was generally linked with a degree of autonomy from the government, although the capacity and willingness of local coordinating CSOs to confront authorities to demand entitlements varied considerably.

The local coordinating CSOs contributed to adapting the CBMP program to local processes and priorities, raising specific issues and demands that were unique to local circumstances (e.g. health service issues concerning the specific barriers for remote, upland forest villages). They identified diverse social allies (including frontline health staff, local government members, local political leaders, teachers, and journalists) and devised innovative methods to work with them.

They also made creative use of official forums and funds beyond the ambit of health services to promote improvements in health services. CBMP organizations work with general developmental bodies, including District Planning and Development Committees, *Nav Sanjeevani* committees, and village-level Panchayats Extension to Scheduled Areas (PESA) funds¹⁸ in tribal areas, to leverage the additional national funds allocated to local governments.

These local adaptations of the CBMP process, described in the next section, have played a critical role in furthering community-based accountability and problem-solving.

2.4.4 Learning by doing: adaptive phases of the CBMP

Over the past decade, SATHI's CBMP strategy has evolved with changes in national health policy, state government support, and the changing political operating environment. This adaptation included adding health system planning to the monitoring work, promoting inclusionary approaches to collaboration with health facility management committees, and efforts to replicate these innovations by institutionalizing them.

Community-based monitoring launched with a strong initial impetus (2007–09). During the first phase, community-based monitoring helped to raise awareness among community members about their health rights, it activated and expanded participatory bodies, engaged and informed elected representatives about health rights entitlements under the NRHM, improved healthcare delivery, and led to attitudinal shifts among health workers and outreach officials (Shukla, Scott, and Kakde 2011). There was strong support from government at both national and state levels. Officials from the Maharashtra state health department displayed a high level of genuine investment in the initiative; they attended many meetings, and attempted to address complaints and issues in a timely manner. This contrasted with some other states, where health departments were less open to community accountability (Shukla, Scott, and Kakde 2011). Since CBM activities were completely new, positive impacts were high. But at the same time, some district-level health officials viewed the monitoring activities as confrontational and were less supportive and receptive. SATHI also realized that CBM activities could 'plateau' and new tactics would be needed to influence policy-level actions (Shukla, Scott, and Kakde 2011). Planning was not yet an emphasis.

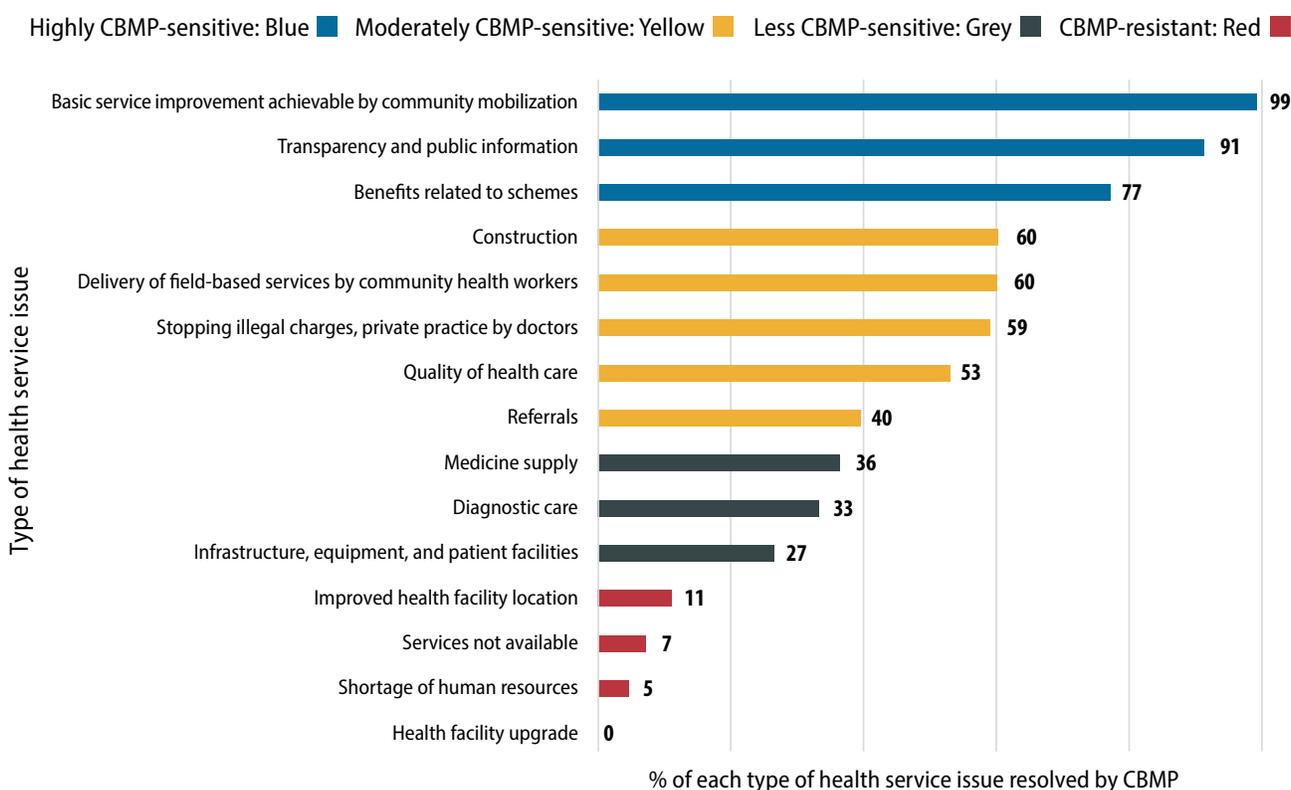
According to a study by SATHI using report card data covering 225 pilot villages, in its first two years (2007–09), CBMP was remarkably effective at promoting improved healthcare delivery, generating attitudinal shifts among government health workers, and increasing community awareness of health entitlements (Shukla, Scott, and Kakde 2011). Key indicators of improved delivery included: disease surveillance; curative services; prenatal and postnatal care; immunization; and health center staff behavior, among others. The study noted that state and civil society actors interpreted CBMP differently: government saw it as a means of "generating data", while CSOs saw it as a "key component of community-led action." The study recommended greater synergy between the two.

Adapting CBMP based on community evidence and health system responsiveness (2009–12). From 2009 to 2012, SATHI adapted its multilevel strategy in response to learning. To prepare for expansion to new districts, CBMP activities were extended to 'voluntary' blocks. A new set of CSOs were trained on rights-based perspectives, and how to encourage effective problem-solving with health system counterparts. SATHI also encouraged better collaboration between the village-level community health workers and VHSNC members to improve services. Yet, after a strong initial start, health system responsiveness to issues raised in public hearings and committee meetings began to decline. State officials decided to discontinue state-level public hearings and instead suggested videoconferences. SATHI also adapted its advocacy related to community assessment and jan sunwai findings. To avoid antagonizing frontline health staff, the CBMP network decided to raise issues only at the level of the health system where they could be effectively addressed.

Innovations for citizen oversight: multiple approaches to institutionalizing community-based monitoring and planning (2013–17). In 2013, following a government evaluation (SHSRC 2013), SATHI was asked to provide an ‘exit policy’ to phase out or significantly modify the role of CSOs in the CBMP process. Simultaneously, it was asked to suggest a strategy for expansion of CBMP across the state, with government agencies replacing CSOs as the main facilitators. Although it remained the sole state-level civil society coordinating organization for CBMP activities in Maharashtra until 2017, between 2013 and 2016, SATHI endeavored to take on board learning about which strategies for engagement were likely to be most fruitful, and to develop new strategies for engagement within the new demands resulting from the government evaluation.

Analysis of data for the 2014–15 financial year—the year after SATHI’s peak funding year—shows where the issues raised by the CBMP were being resolved and where there were bottlenecks. Using a classification developed by SATHI (Shukla and Sinha 2014), which categorized health system challenges in CBMP areas as either ‘CBMP-sensitive’ or ‘CBMP-resistant’,¹⁹ SATHI analyzed the proportion of 2,446 service delivery issues, classified into 15 different types, that were either resolved or not resolved (Figure 3).

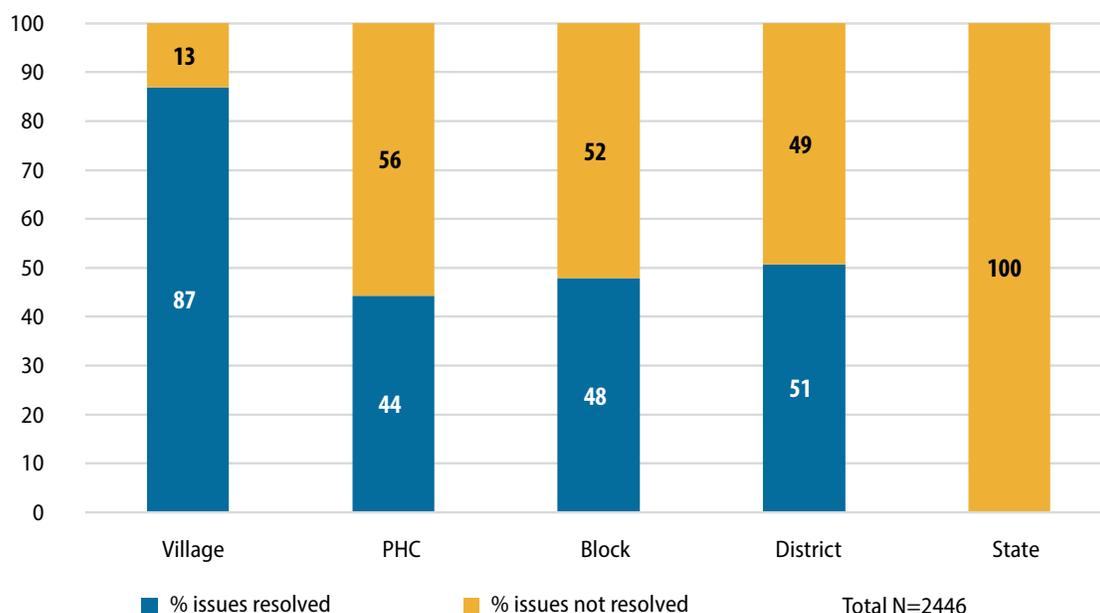
Figure 3. Sensitivity and Resistance of Health Service Delivery Issues to CBMP Intervention



Source: SATHI 2015.

Figure 4 looks at resolution rates of the 2,446 issues by the level at which the issue was raised—village, PHC, block, district, and state. Taken together, Figures 3 and 4 show that CBMP sensitivity is strongest at the lower levels of the health system, and decreases as the level rises.

Figure 4. Issue Resolution through CBMP Process at Different Levels, 2014–15



Source: SATHI 2015.

This analysis contributed to SATHI and other CSOs piloting various innovations intended to develop institutionally sustainable approaches to citizen oversight by building on its existing networks, at the same time as building on its knowledge of CBMP-sensitive issues (Box 3).

Box 3. Progressing towards Expansion and Institutionalization of Citizen Oversight

1. Expansion to local voluntary community groups

During 2014, the role of 'nodal CSOs' was scaled down, and community-based approaches to sustain monitoring and engagement were needed. A less resource-intensive variant of the CBMP process expanded beyond the existing CBMP areas. Thirty-three new organizations were identified for capacity-building workshops, followed by lower intensity, block-level CBMP processes for awareness-raising, data collection, and organization of *jan samvads*. Existing active CBMP committees created Community Health federations in some blocks. Most organizations continued to be active for two years without funding.

2. Block-level grievance redress mechanisms

Since CSOs were shifting towards a progressively less intensive role, an institutionalized, well-functioning grievance redress mechanism at block level was needed. In several blocks, CBMP organized multistakeholder Grievance Redressal Facilitation Cells, with three members drawn from the existing block monitoring and planning committee, one member each from public health officials, local government, and civil society representatives (e.g. in Dharani block of Amaravati district). Based on their local knowledge and capacity to investigate and follow up promptly, this initiative successfully resolved several local complaints. The state government did not support CBMP proposals to replicate these local grievance redress mechanisms in all 26 blocks of 14 CBMP districts.

3. Mobilization of youth volunteers to promote community action for health

In two blocks, SATHI took the initiative to train and deploy youth volunteers to facilitate community awareness, mobilization, and data collection—inspired by social audits run by youth volunteers in India's rural employment guarantee program in Andhra Pradesh and Telangana. This intervention encouraged people in a much larger number of villages beyond the existing CBMP villages to use government health services, while publicizing NHM entitlements and the grievance redress system.

4. Decentralized health planning

In 2015, SATHI and the district nodal organization *Amhi Amchya Arogyasathi* (AAA) initiated decentralized health planning in two blocks of the Gadchiroli district, to promote CSO and community participation in the health planning processes. This promising start was followed by an attempt at rapid replication of the process to cover all 14 CBMP districts (2016–17), under the leadership of the State Health Systems Resource Centre. As responsibility for leading the process passed into the hands of district- and block-level health authorities, however, critical ingredients of participatory planning were diluted, compromising active involvement of local coordinating CSOs working with communities.

5. Participatory audit and planning

Gaps in the utilization of health facility Patient Welfare Committee funds showed the need for active member participation (see Box 2). CBMP adapted the concept of social audit to health facilities and Patient Welfare Committees with a new, inclusionary participatory audit and planning process. It was conducted in 9 health institutions in 2014–15 and 65 in 2015–16 to improve their overall functioning. They improved participatory allocation, recording, transparency, and use of Patient Welfare Committee funds (Marathe, Yakkundi, and Patil 2018).

SATHI's proposed new CBMP strategy of integrated innovations was intended to retain the core elements of autonomous facilitation of community action, and extend the program to new blocks, while modifying and reducing the role of CSOs. SATHI and partner organizations presented this approach to NHM Maharashtra in early 2016. But criticism of CBMP by some officials, especially in districts with rights-based people's movements or *sangathans* as local partners, had been growing since 2013. By 2016–17, the state government decided to significantly reduce the coordinating and implementing role of CSOs in CBMP, with a greater role to be played by the official State Health Systems Resource Centre (SHSRC). In 2017–18, this state agency, together with district health officials, also assumed the leadership of decentralized health planning.

During this period, continued delays in release of funds impeded the CBMP innovations proposed by the civil society network (see Section 2.2). Resource limitations forced many partner CSOs to either scale down work or to opt out of CBMP, constraining efforts to scale up the range of promising, people-centered pilot initiatives shown in Box 3.

Growing state control, shrinking space for civil society and communities (2017 to early 2020). From 2017 onwards, the state government's budgetary and contractual delays increasingly slowed the CBMP process. The government's approach to institutionalization substantially constrained civil society leadership and sidelined community participation. The government appointed a second state nodal NGO (Sosva Training and Promotion Institute) to lead the CBMP in Maharashtra alongside SATHI; it had worked in health training and promotion in close collaboration with the government. The state health department now insisted that the CBMP processes should demonstrate their contribution to improving health indicators.

An SHSRC pilot for CBMP institutionalization began in five blocks, involving block-level official actors as coordinators and implementers, and although the civil society block-level coordinators attempted to promote implementation of key community activities, the responsible officials' response was weak and delayed. As government funding declined even further, community-based activities were sidelined and the pilot was discontinued.

The decentralized health planning initiative described in Box 3, led by SATHI and its partner CSO in Gadchiroli district, AAA, had positive initial impact, and was planned to expand to all 14 CBMP districts. The SHSRC took over resource management, through district health officials. The decentralized health planning process was extremely time-sensitive, with a very short window for developing community and block-level proposals. There were procedural delays in funding for the community participation process and no community-based proposals could be included in the 2016–17 state plan. This led to demoralization of the CBMP civil society network. A similar pattern of events in the following year dampened motivation of civil society facilitators, especially since higher-level officials were not very receptive to the proposals emerging from participatory processes in the district- and block-level health plans. The participatory component of the decentralized health planning process was tapered off, even though this has continued as a formal activity conducted mainly within the government bureaucracy.

Shrinking space for civil society and communities is also reflected in changing language. The term 'community-based monitoring and planning' (CBMP) emerged from the enabling environment of 2006–07, when the national government recognized that communities should complement official information systems and evaluations with regular feedback on the delivery of health services. In the subsequent period, accompanying the changes in government and modified policy emphasis, such an 'assertive' approach to accountability became progressively less acceptable in the health system. 'Community action for health' (CAH) replaced CBMP in national and state government documents from 2014 onwards, and the 'fuzziness' of this term created the potential for different actors to take forward their own agendas. Yet when a shared concept contains the scope for contestation of meaning by various actors involved, that can lead the more powerful actors to define the meaning in practice. This is what happened, as the official health system has used the rubric of CAH while simultaneously

'owning' and, to a significant extent, controlling the community-oriented processes in Maharashtra that had originated with CBMP.

Despite the challenges of delayed and reduced funding and preponderance of officials during decentralized planning, the CBMP civil society coalition continued to work with communities to promote people's health rights in diverse forms, with a focus on improving maternal health indicators.

In response to concerns about how to ensure institutionalization, sustainability, and replication of community oversight, from 2018 to 2020 SATHI experimented with multistakeholder social audits. These processes attempted to bring together public oversight of multiple public services such as healthcare, education, nutrition, and food security under the umbrella of social accountability. The process was piloted in 30 villages in three districts of Maharashtra, through locally grounded CSOs and the formation of village social audit groups with 8–10 active community members each, networked into block-wide federations. The experience suggests that multistakeholder social audits can be applied as an effective strategy to enhance implementation, expand beneficiary base, and promote accountability concerning frontline public services (Jadhav et al. 2020).

When Covid-19 erupted in March 2020, participatory health processes and innovative grassroots responses led by civil society groups experienced a major upsurge, indicating that the sparks of participatory networks initiated by CBMP might have been dimmed, but were not extinguished; they were revived as the pandemic took hold. However, given the narrowing of the official CBMP space, vibrant community-based initiatives sprang up mostly outside the ambit of the official CAH framework, as described in the Epilogue (Section 5).

The aim of CBMP was to ensure direct involvement of people from communities in processes of dialogue and joint action with health systems. Weak state responsiveness eventually limited the CBMP's presence in the field, which affected the nature of community participation and activism.

The next section presents findings from field research carried out several years after the initial, more intensive phase of CBMP efforts to activate official citizen oversight bodies, to begin to understand their longer-term effects. Remarkably, some of those efforts had positive effects that survived the gradual constriction of support from the state and reduced intensity of efforts by civil society networks.

3. Research Findings: Outcomes of Strengthening Local Committees

Field research focused on one main element of the broader, multilevel CBMP program strategy: whether and how the CBMP has bolstered the VHSNCs and the Patient Welfare Committees.

Both committees officially existed prior to the CBMP, but in practice their functioning was limited; CBMP efforts to activate them are described in Section 2. This study assessed the influence of CBMP interventions to strengthen VHSNCs and Patient Welfare Committees on three outcomes: (1) committee members’ awareness of health service entitlements; (2) participation of community-based actors in VHSNCs and Patient Welfare Committees, and their resulting empowerment; and (3) responsiveness of the public health system to community claims.

The field research was carried out three years after the most intensive period of the CBMP process had finished; it began in late 2018 and continued into early 2019. As such, the findings inform discussions of the sustainability of progressive institutional changes. Although official health monitoring systems provide indicators for some health services, these mostly concern accessibility and availability, rather than the participatory problem-solving that was a characteristic of the CBMP. The research was designed to take an in-depth look at the influence of the CBMP.

We adopted a mixed-methods approach, primarily utilizing a paired comparative case study method. Field research compared the functioning of local oversight committees in CBMP areas with those in non-CBMP areas, using qualitative interviews and quantitative results from structured interviews. One block where CBMP had been facilitated continuously by SATHI since at least 2012 was randomly selected from five districts (see Table 2). For comparison, a matching number of adjacent or nearby blocks from non-CBMP areas were also selected. The main unit of analysis was the primary health center (PHC). To further maximize comparability, criteria for matching the CBMP and non-CBMP PHCs also included: presence of at least one permanently posted Medical Officer; population covered by the PHC; proportion of Scheduled Caste/Scheduled Tribe populations covered by the PHC; and distance from PHC to block headquarters. One health sub-center, each staffed by at least one regular auxiliary nurse and midwife, was also selected randomly from each selected PHC.

Table 2. Study Locations

Region	District	CBMP block	Non-CBMP block (adjacent)
Aurangabad	Beed	Ambajogai	Parli
Konkan	Thane & Palghar	Shahapur	Wada
Nagpur	Gadchiroli	Armori	Desaiganj
North Maharashtra	Nashik	Trambak	Igatpuri
Pune	Kolhapur	Bhudargad	Radhanagari

In-depth interviews and surveys of diverse local informants documented the degree of CBMP stakeholder participation in VHSNCs and Patient Welfare Committees, and the responsiveness of the health system to that participation. Interviewees included 67 members of VHSNCs, Patient Welfare Committees, and village governments, as well as CSO and frontline health system staff (Taluka Health Officers and PHC Medical Officers). The surveys covered larger numbers of Patient Welfare Committee members (n=87) and VHSNC members (n=270).²⁰ To assess health system responsiveness, an additional survey documented the experiences of mothers who had recently given birth in PHCs (n=100, 10 per PHC).²¹ Direct observations at PHCs (n=10) and sub-centers (n=10) also examined the availability of facilities and services. SATHI also conducted 11 in-depth interviews with representatives of local partner organizations covering CBMP districts, to understand their experiences, concerns, and challenges.

All interviews were conducted and transcribed in Marathi, the state's most widely spoken language. Ethics approval was obtained from the Institutional Ethics Committee of Anusandhan Trust and from the Institutional Review Board of American University.

The comparison of CBMP and non-CBMP blocks showed consistent differences. Three years after the peak of the program, CBMP blocks showed substantially greater community awareness, participation, and activity in both VHSNCs and the Patient Welfare Committees—but also in all other available channels for citizen participation. CBMP areas also showed more examples of health system responsiveness (measured in terms of availability of physical facilities and utilization of maternal health services for childbirth).

3.1 Animating existing structures: strengthening VHSNCs and Patient Welfare Committees

This section summarizes the impact of the CBMP's work to strengthen VHSNCs and Patient Welfare Committees (described in Section 2) by contrasting CBMP and non-CBMP areas.

Awareness of roles and responsibilities (VHSNCs). In CBMP areas, 70 percent of VHSNC members surveyed were aware of their roles and responsibilities. However, in non-CBMP areas, field researchers were unable to locate 37 percent of the reported members of VHSNCs, despite significant efforts, suggesting that they were essentially inactive. Among those we were able to survey, nearly half (44 percent) reported that they were unaware of their own roles and responsibilities. Whereas 58 percent of respondents from CBMP areas were aware of public funds received by their village for services such as health, nutrition, water, and sanitation, only 20 percent of respondents from non-CBMP areas reported such awareness. In terms of capacity building, 50 percent of the respondents from CBMP areas had received formal training compared to 8 percent of respondents from non-CBMP areas.

Committee functioning (VHSNCs). Survey questions documented the frequency of VHSNC meetings, patterns of expenditure of funds, financial record-keeping, and annual planning of VHSNC activities.

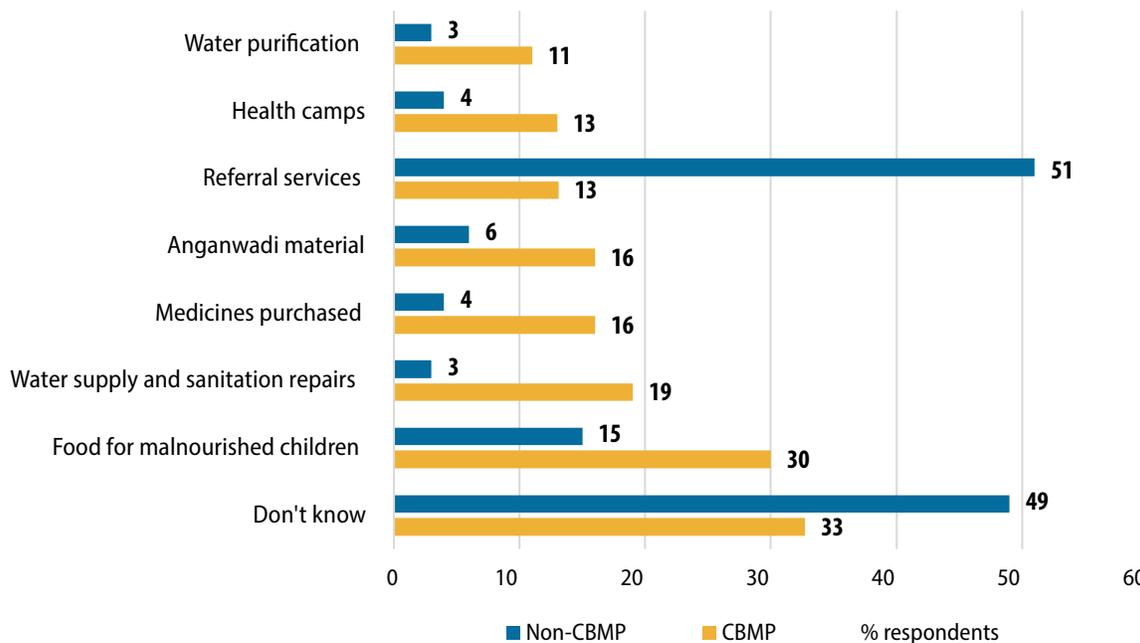
Though VHSNC rules call for monthly meetings, this practice is not followed in either CBMP or non-CBMP areas. However, CBMP areas fared better, with 46 percent of respondents reporting 6–12 meetings a year, in contrast to the 28 percent of respondents in non-CBMP areas reporting that VHSNCs had not met at all in the past year. According to one VHSNC member in a non-CBMP area, “meetings are done only at the time when funds are received. The proper committee has not been formed. Only AWW [Anganwadi workers] and *sarpanch* are managing the funds.”²²

Some interviewees noted that due to power and caste hierarchy in the community, some VHSNC members found it difficult to convene committee meetings, stating that the *sarpanch* and other upper caste local government leaders would not respond to their invitations. However, with the help of local CSOs, some VHSNC members became able to convene meetings themselves. For example, according to a Dalit frontline health worker, “I belong to SC

[scheduled caste] category and was quite apprehensive about how I could gather people for the meetings, and who would come to a meeting called by me. But with active support from CSO *karykarts* [activists], I was able to facilitate those meetings well.”²³

VHSNC funds are flexible, and can be spent (for example) on food supplements for malnourished children, referral services for patients, medicine purchase, and water and sanitation repairs. When asked whether they deliberated over how to spend their committee’s funds in VHSNC meetings, almost two-thirds (64 percent) of members in CBMP areas stated that they had, while only 21 percent of respondents in non-CBMP areas had done so—and half of the non-CBMP respondents could not answer this question at all. More VHSNC members in non-CBMP areas (49 percent) than CBMP areas (33 percent) responded that they did not know how the funds were actually used (Figure 5), although there were generally more views on where resources had been spent in CBMP than non-CBMP areas.

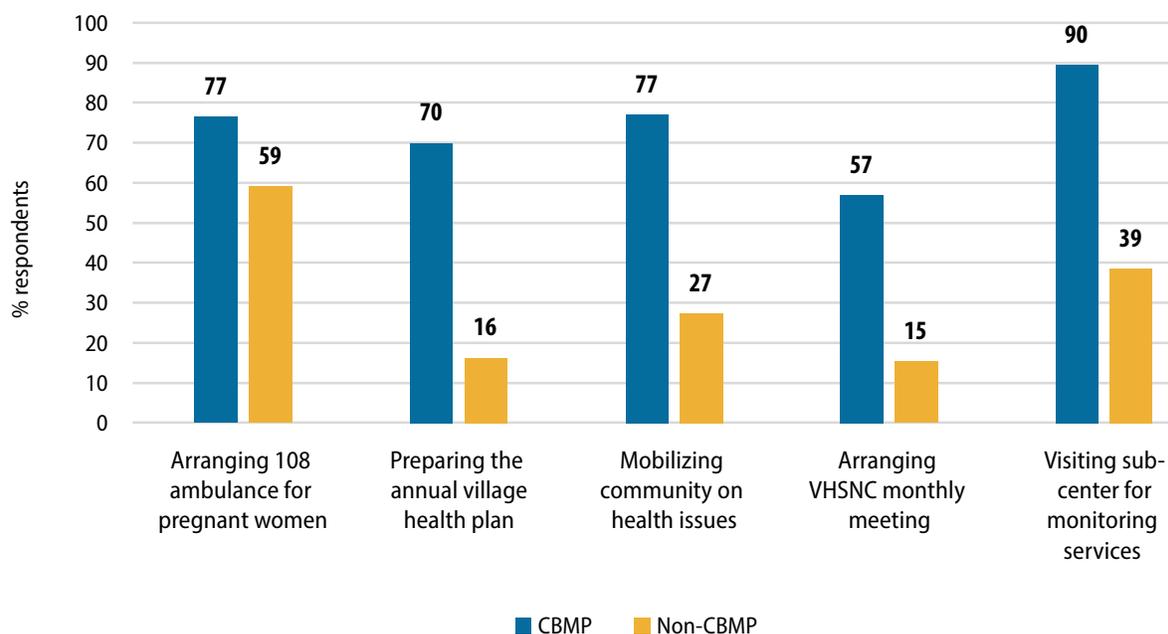
Figure 5. VHSNC Members’ Views on How Funds were Spent



Participation in committee meetings and village-level activities (VHSNCs). VHSNC members in CBMP areas participated more frequently in committee meetings than VHSNC members in non-CBMP areas; nearly half of members in CBMP areas reported attending 3–6 meetings a year. In non-CBMP areas, more than half of VHSNC members reported not attending even a single meeting in the previous year.

Far more VHSNC members in CBMP areas than in non-CBMP areas reported participating in village-level activities such as accessing the 108 helpline²⁴ for arranging ambulances for pregnant women, mobilizing the community on health issues, and carrying out monitoring visits to sub-centers (Figure 6).

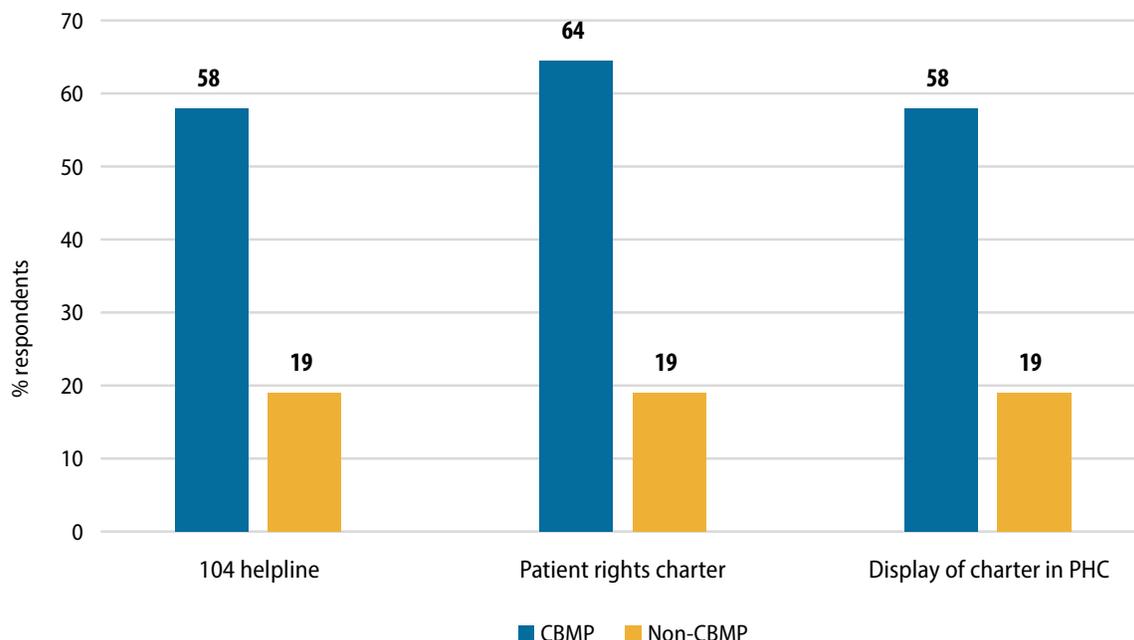
Figure 6. VHSNC Members' Participation in Village-level Activities



Awareness of roles, responsibilities, and facilities (Patient Welfare Committees). For Patient Welfare Committee members, CBMP made a big difference in terms of training about the role of official oversight committees. In CBMP areas, 67 percent of Patient Welfare Committee members reported receiving formal training, in contrast to not a single respondent from non-CBMP areas. In CBMP areas, 71 percent of respondents shared that local CSOs held capacity-building workshops, and 10 percent of respondents mentioned receiving information from health staff. Of Patient Welfare Committee members surveyed in CBMP areas, 93 percent knew whether they belonged to the governing body that is responsible for policy formulation and oversight, or the executive committee that implements policy decisions towards patient-centered services. In contrast, 31 percent of Patient Welfare Committee respondents in non-CBMP areas were unaware of which committee they belonged to. Only 4 percent of Patient Welfare Committee members from CBMP areas were unaware of their roles and responsibilities, in contrast to 36 percent of Patient Welfare Committee members in non-CBMP areas.

A clear majority of Patient Welfare Committee members in CBMP areas also reported high levels of awareness about the 104 helpline (a toll-free number to seek help in critical situations) and the Patient Rights Charter, as well as the need to display it in the PHC, in contrast to less than one-fifth of Patient Welfare Committee members in non-CBMP areas (see Figure 7).

Figure 7. Patient Welfare Committee Members' Awareness of Key Facilities

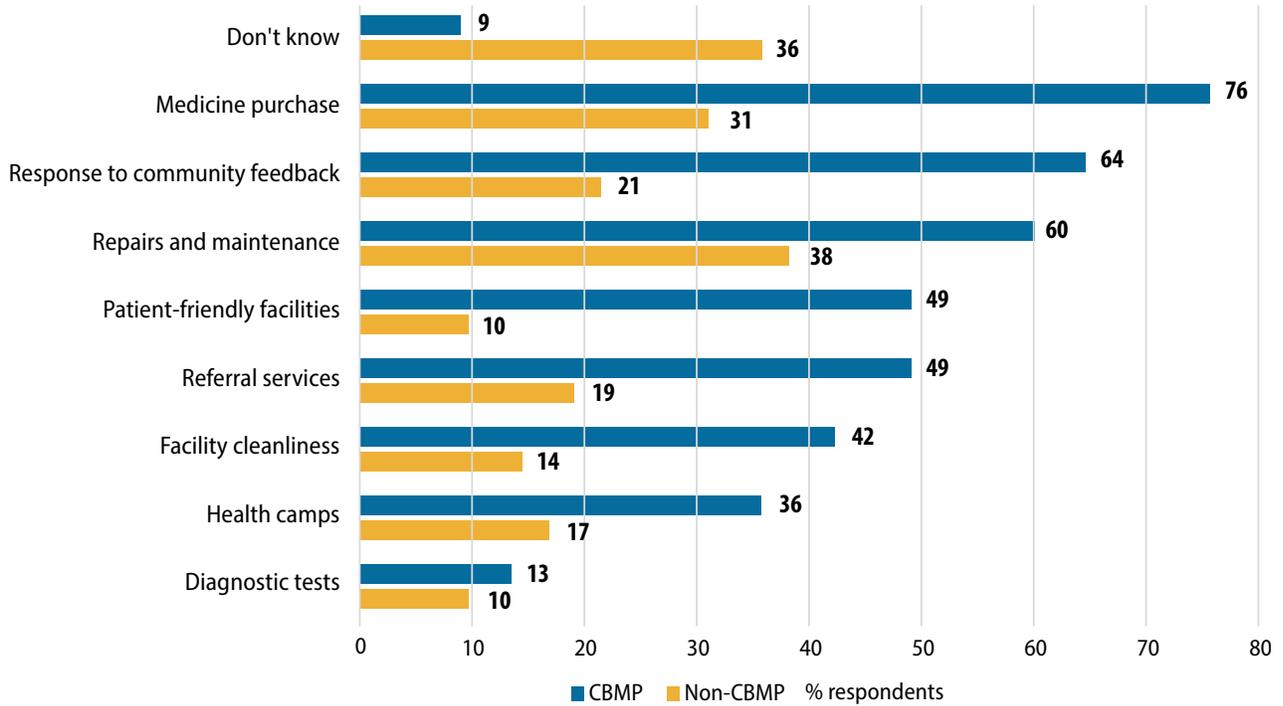


According to a CSO representative from Aurangabad, when the CBMP program started, people were not aware of how to use the 104 helpline. To make this important government initiative accessible to the public from rural and remote areas, public education is necessary.

Committee functioning (Patient Welfare Committees). To assess the functioning of Patient Welfare Committees in CBMP and non-CBMP areas, the indicators addressed the frequency of Patient Welfare Committee meetings, the required public display of a public information board with Patient Welfare Committee members' names and contact numbers, as well as what Patient Welfare Committee funds were used for. In CBMP areas, Patient Welfare Committee met regularly; 87 percent of members reported meeting monthly to quarterly, compared to 43 percent of respondents reporting regular meetings in non-CBMP areas. In CBMP areas, 93 percent of Patient Welfare Committee members reported that their names and contact information was displayed at the entrance to the PHC, compared to 57 percent of members in non-CBMP areas.

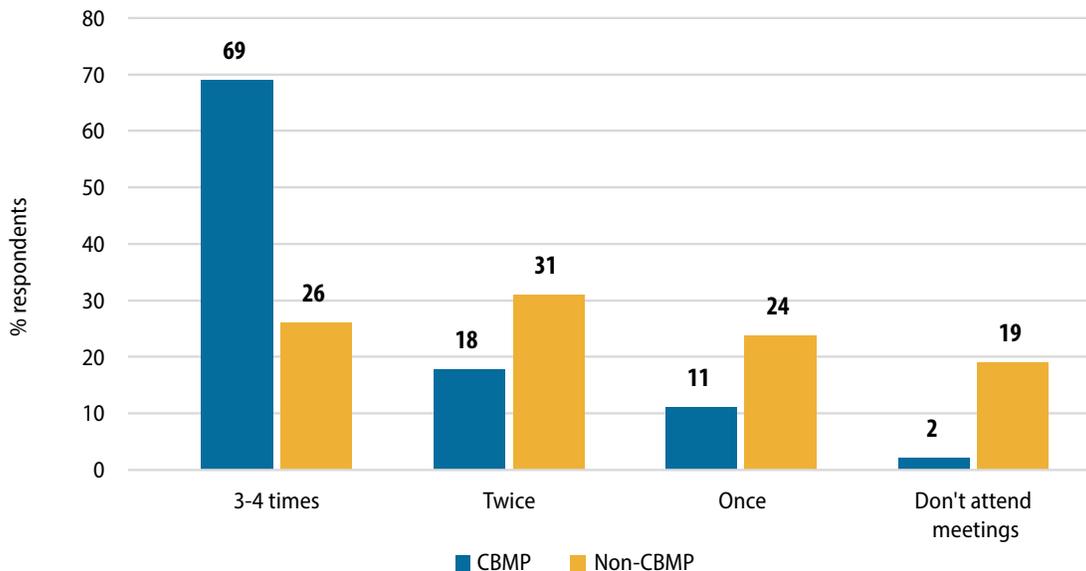
Patient Welfare Committee access to official funds also varied significantly: 71 percent of respondents reported that the Patient Welfare Committee received funds regularly, compared to 48 percent of respondents in non-CBMP areas. Respondents in CBMP areas also reported greater awareness of Patient Welfare Committee expenditures (9 of out 10 compared to 2 out of 3 in non-CBMP areas). Patient Welfare Committee members in CBMP areas also reported much more diversified patterns of Patient Welfare Committee expenditures. In CBMP areas, 64 percent of respondents reported spending on "patient-centric" services (such as drinking water facilities, toilets, seating, and food for patients) compared to just 21 percent of respondents from non-CBMP areas (see Figure 8).

Figure 8. Patient Welfare Committee Members' Knowledge of How Funds are Spent



Participation in meetings (Patient Welfare Committees). Patient Welfare Committee members in CBMP areas reported much more frequent meeting attendance than members in non-CBMP areas, with 69 percent reporting that they attended three or more meetings in the previous year, compared to 26 percent in non-CBMP areas. One in five members in non-CBMP areas reported never attending Patient Welfare Committee meetings (see Figure 9).

Figure 9. Frequency of Attendance at Patient Welfare Committee Meetings in the Previous Year



The dynamics of members' participation in Patient Welfare Committee meetings were also very different in CBMP areas. Almost 9 in 10 members in CBMP areas reported that they were involved in decision making (89 percent). For example, a Patient Welfare Committee member from Gadchiroli district said, "We collectively take decisions. If the chairperson takes any decisions and we members don't agree, then we do object to it sometimes." By contrast, a Patient Welfare Committee member from a non-CBMP area explained that "Members hardly speak in the meetings and decisions are taken by president of Patient Welfare Committee." We found that 44 percent of Patient Welfare Committee members in CBMP areas participated in activities such as health camps, awareness rallies, poster exhibitions, and wall paintings, as well as raising health-related issues in existing participatory local government forums (such as *gram sabhas*), compared to 15 percent of respondents from non-CBMP areas. Among those participants, 53 percent of respondents from CBMP areas reported raising issues through those platforms, compared to 20 percent of respondents from non-CBMP areas.

3.2 Use of multiple forums for community feedback: supporting participation

This section discusses the VHSNCs and Patient Welfare Committees as part of a widely available set of official channels for citizen voice, which also include complaint boxes, hotlines, and official village meetings (*gram sabhas*). These official channels cover both CBMP and non-CBMP areas; strengthening them was a core element of the CBMP process. Public dialogues (*jan samvad*) and CBMP committees—distinctive, core elements of the CBMP process—provided additional grievance redress mechanisms in those areas. The research looked across this range of mechanisms, contrasting how they are used in CBMP and non-CBMP areas.

According to key stakeholder interviews, CBMP interventions contributed to increasing community participation toward improving health services. For example, PHC Medical Officers and Taluka Health Officers reported that the CBMP process provided them with feedback from the grassroots regarding the functioning of health centers. They also noted that CBMP made PHC Patient Welfare Committee meetings more effective and supported follow-up action with officials. According to the Taluka Health Officer of CBMP PHC from Gadchiroli, "CBMP is useful in getting people's feedback, to understand the people's needs, issues they face."

Table 3 summarizes the stakeholder assessments of the level of use of various existing mechanisms for community feedback, comparing PHCs in CBMP and non-CBMP areas. The comparative analysis shows that all the possible official channels for voice were much more widely used in CBMP areas than in non-CBMP areas. The Patient Welfare Committees were an exception, reporting moderate levels of activity in three of five non-CBMP areas.

Table 3. Use of Existing Forums for Community Feedback

Forums		Level of use of existing forums for community feedback/raising issues				
		Beed PHC	Nasik PHC	Gadchiroli PHC	Kolhapur PHC	Pune PHC
Complaint box/ register	CBMP	Moderate	High	High	High	High
	Non-CBMP	Low	Not applicable	Low	Not applicable	Low
Use of reporting hotline 10	CBMP	High	High	High	High	High
	Non-CBMP	Low	Not applicable	Low	Not applicable	Not applicable
Direct contact with doctors (Medical Officer or Taluka Health Officer)	CBMP	High	High	High	High	High
	Non-CBMP	Low	Low	Moderate	Low	Low
Village assemblies (<i>gram sabha</i>)	CBMP	High	High	High	High	High
	Non-CBMP	Moderate	Low	Low	Low	Low
Patient Welfare Committee	CBMP	High	High	High	High	High
	Non-CBMP	Moderate	Moderate	Low	Moderate	Low
VHSNC	CBMP	High	High	High	High	High
	Non-CBMP	Low	Low	Low	Low	Low
PHC level CBMP committee (only in CBMP areas)	CBMP	High	High	Moderate	High	High
	Non-CBMP	Not applicable				
Public dialogues (only in CBMP areas)	CBMP	High	High	High	High	High
	Non-CBMP	Not applicable				

Source: SATHI synthesis of key informant interview findings.

Interviews also reported change over time. In the early years of the CBMP, elected local government representatives were not actively involved in the program. Some even thought that the CBMP was “against them”²⁵ or felt that they were “being burdened with a new responsibility.”²⁶ With the help of local CSOs, they learned that raising community issues through the *gram sabha* could boost their image. According to one CSO partner from Osmanabad district, people’s representatives “started seeking issues from us in the *gram sabha* and their faith in us increased.”²⁷

The CBMP’s distinctive, additional public dialogues were attended by large numbers of community members and diverse stakeholders such as health staff, officials, local government leaders, and CSO representatives. The forums allowed people to present their experiences and issues regarding health services in the presence of health officials and panelists from various fields, and officials were expected to respond and resolve the issues raised.

According to the stakeholders we interviewed, the public dialogues contributed to increased community engagement to improve health services, changing power relations between citizens and officials. For example, in 2012, around 500 people attended a public hearing on issues related to the Nandurbar district hospital. A panel of officials from the district and block levels, as well as CSO representatives, presided over the proceedings. A mother testified

about denial of care for her son, who had eye cancer. The participants collected donations at the *jan sunwai* for the child's treatment. The district officials also ensured to do "whatever was possible at the district and state level [health] facilities." In other *jan sunwais* covering five rural hospitals in Pune district, health officials allowed use of Patient Welfare Committee funds to address issues such as doctor absenteeism and the lack of appropriate waiting facilities. The absenteeism issue required follow-up by activists in the state-level dialogue to redress the complaint. According to a clinic staffer in a CBMP-area PHC in Pune district, the "public hearing is certainly beneficial, people present issues quite frankly. It's a platform for people to speak out [about] issues, through which communication takes place among users and officials."

Use of complaint boxes was high in all CBMP areas except for Beed district.²⁸ CSOs also provided additional information about grievance redress mechanisms, such as the health system information hotline (104). For example, according to the CBMP Coordinator in Beed district, "104 is being used by people for making complaints but we also inform people that 104 is not just to make complaints but also to consult, get guidance on health issues, for example, if child has suddenly developed a fever, one can call 104 and ask for suggestion."²⁹

The information hotline was used less in non-CBMP areas and complaint boxes were absent in some districts, such as Kolhapur and Nasik. According to the Taluka Health Officer from a non-CBMP block in Kolhapur district, the "complaint box is not placed, people don't even complain through other platforms, rather people just tolerate."³⁰ In the CBMP PHC for the same district, a CSO representative collaborated with the clinic medical staff and active villagers to create a local grievance redress unit. According to the Taluka Health Officer of the CBMP-PHC in Kolhapur district, "people mostly call up CSO representatives, who then inform us about the complaint and necessary actions are taken to resolve those issues."

3.3 Health system responsiveness to the CBMP

How did the health system respond to the CBMP? Responsiveness ranges from one-off actions in response to specific complaints, to more in-depth responses that address underlying cases of community problems at multiple levels of the health system. As noted in Section 2.2 (Figure 1), issues that could be addressed in the local arena ('CBMP-sensitive') generated a high degree of health system responsiveness (87 percent of total cases in 2014–15). The field interviews reconfirmed those patterns (Figure 3, in Section 2.4.4). These issues—which included small purchases to address shortage of medicines or equipment (e.g. blood pressure devices), repairs, staff behavior, frontline workers not making home visits, irregular attendance of Medical Officers at the PHC, and the responsiveness of the 108 helpline—were largely resolved at the local and block levels. Patient Welfare Committee funds were used to address locally manageable issues such as smaller medicine purchases in both CBMP and non-CBMP areas. In CBMP-area PHCs, public hearings allowed villagers to raise more difficult issues (such as staff absenteeism) with health system authorities. For example, in Beed district, the PHC put up a board displaying availability and time for the Medical Officer after the issue of absenteeism was raised in a public hearing. By contrast, these difficult issues were rarely raised in non-CBMP areas.



CBMP committee members gather to lock the PHC as a protest against the absenteeism of the medical officer, Amaravati district, 2014.

Credit: CSO activist working with CBMP.

Health system responsiveness to issues raised in CBMP areas was partly due to the presence and support of local CSOs, as well as the activation of PHC-level CBMP committees. Follow-up involved a range of actions at multiple levels, including repeatedly raising issues in committee meetings, and reminding concerned members or officials to implement the decision taken for resolving the problems. For example, according to a CSO representative from the CBMP-PHC in Gadchiroli district, “We followed up with the District Health Officer and wrote nearly 130–140 letters to him, after which now two water tanks were given and one well is being constructed.”³¹ According to a VHSNC member from Beed district, in the absence of public hearings, those who are “strong and aggressive they go to PHC and complain ... or present [their grievances] in committee meetings, but the poor people ... approach the AWW [childcare center worker], or Manavlok [local CSO] person” with their complaints about doctors’ behavior and lack of access to medicines. According to a Taluka Health Officer from Kolhapur district, “Driver refused to take a pregnant lady to the rural hospital saying there was no diesel. Later the issue was raised in Patient Welfare Committee by CSO representative-CBMP person, and medical officer was given instructions to always keep extra diesel in stock. Afterwards no such complaint or no such reason was given regarding the vehicle.”³²

Illegal fees charged by Medical Officers are a problem in rural Maharashtra.³³ Yet, we find an improvement in CBMP areas, where stakeholders reported that accusations of illegal fees were raised in Patient Welfare Committee meetings, as well as in public *jan sunwais*, and were resolved at the block and district levels. Local- or block-level health system responses to illegal fees were often ineffective, leading to escalation to the district level. However, intervention by more senior officials could strain relations between the community and the health staff. According to a CSO representative from Kolhapur district, in the CBMP PHC, the Deputy Director and District Health Officer ordered the transfer of a Medical Officer when they received complaints about illegal charges. After the erring official was transferred, the post remained vacant. A local CSO helped the community to articulate the need for sustained changes in staff functioning rather than resorting to specific errant staff being transferred elsewhere. They raised a slogan: “We want change in the situation, we don’t want just transfers.”³⁴ The local CSO also created awareness about misuse of funds and illegal fees. Meanwhile, the erring Medical Officer was re-posted and gradually stopped his practice of illegal charging.

Shortages of medicines in the health facilities are an ongoing issue that came up in multiple forums, including at Patient Welfare Committee meetings, PHC-level CBMP committees, as well as in public hearings. To address this, either PHCs exchange medicines across facilities or they use Patient Welfare Committee funds for local purchase of medicines. For example, medicine shortages in the CBMP PHC in Beed district were addressed by the proactive efforts of the Taluka Health Officer, who initiated an inter-exchange of medicines between PHCs with excess stock and those experiencing a shortage of medicines. These issues are often raised at district and state levels because medicine procurement is a policy-level issue.

Escalation of issues from local committees to block and district levels had mixed results. At the district level, local issues were included in the annual program implementation plan, but often remained unaddressed at the state level. According to the Taluka Health Officer from the CBMP PHC of Gadchiroli district, “Issues escalated to district level do get resolved but often require consistent follow-up and hence causes delays in decision making. District officials often have long and pending list of proposals for sanction. Hence, follow-up must also be well done in CBMP area through an additional platform of CBMP committee.”³⁵ According to one CSO partner from Thane district, “Issues were resolved at the local level, but those that went from block to district level remained unresolved ... issues about infrastructure, vacancies ... nothing seemed to move at the State level. Due to this, village-level activists who had done a lot of work, created pressure, were disappointed. The local health officials would ask ‘what can we do if the state does not appoint doctors?’”³⁶

Another example of limited results from escalation involves ambulances. According to a CBMP committee member from Kolhapur district, “Community members have declared that if essential issues remain unresolved, then they will protest. Regarding 108 [ambulance helpline], out of six ambulances, five don’t have insurance; most are in bad

shape, with bad tires, etc. We realized that 90 percent of ambulances are in poor condition. We raised the issue about receiving money from state's medical insurance scheme in Patient Welfare Committee and we were told that it cannot be [addressed] through Patient Welfare Committee but from a separate department at district level. We did a lot of follow-up, but it was no use, then told officials about possibility of organizing a protest. We also gave news in media. And after all this, now they are doing some process. But [the outcome is] not yet clear."³⁷

Community actors participated actively in raising and resolving issues at the local level. As shared by a CSO representative from Pune: "In PHC level CBMP committee meeting, the issue of sub-center (SC) repair was also raised and followed up with MO [Medical Officer] and THO [Taluka Health Officer] and got the repair done. Interestingly, the SC repair was monitored by CBMP person as well as *sarpanch*, other committee members, by making visits to construction site. The issue of vacant post of sister [female health worker] in SC was also raised to MO, and to THO, and resolved at their level by suggesting the staff adjustment with other PHCs." According to the CSO partner from Palghar district, "People started receiving good health services, PHCs became cleaner, non-functional PHCs started working, doctors started to work in PHCs where they were previously absent." However, when the proposal of filling vacant post of sister for this SC was sent to DHO [District Health Officer], issue remained pending with DHO response, which says, government is not filling these posts."³⁸ Sometimes persistent follow-up by CSO representatives and active community members helped to resolve certain issues. According to a CSO representative from Kolhapur district, the health centers "were facing a severe shortage of Medical Officers, CSO representatives along with Patient Welfare Committee and CBMP committee members followed up this issue to the state level also and finally, the Deputy Director was given special power to appoint MO as an exceptional case to resolve the issue effectively."³⁹

In Beed district, the local-level CBMP monitoring committees and CSO played an important role in reopening an unused PHC, a sub-center, and a childcare center. They raised the issue with elected local government representatives until the PHC was inaugurated and became functional. According to the representative from the local CSO, Samata Pratishthan, as people were informed about their entitlements and services at PHCs, sub-centers and childcare centers, they started to function properly. In another district, a sub-center was repaired after follow-up by CBMP committee members. They monitored its construction, and then raised the issue of the vacant post of an auxiliary nurse/midwife. Their follow-up led to a temporary staff adjustment, though district health officials still did not resolve the issue with a more permanent solution.

In non-CBMP areas, medical staff in some health centers were proactive and cooperative and they followed up continuously with district-level officials. Yet the overall responsiveness of health authorities at block and district level in PHCs in non-CBMP areas was, in general, much lower than in CBMP areas. For example, in a non-CBMP PHC in Kolhapur, issues like repairs of washrooms, a labor room, and water tanks were raised to district level but remained unresolved. Poor coordination of ambulances with the 108 hotline went unaddressed, as with most issues raised.

While problem-solving efforts produced some results, policy-level issues remained unresolved, resulting in demotivation and frustration among local CSO partners and CBMP activists, especially at the village level. According to one CSO partner from Thane district, "Village-level activists engaged in follow-up activities and dialoguing at higher levels felt that things remained stagnant at the state level." According to another CSO partner from Gadchiroli district, which worked in 60–65 villages, CBMP interventions attracted attention of community members from non-CBMP areas: "People are keen to know about it." The CBMP committees created by the CSO partner, Indian Institute of Youth Welfare (IYW), motivated people to participate. However, according to a representative from IYW, in some places, despite active committees, people were demotivated as issues were not resolved: "We have not succeeded in resolving issues at the policy level."⁴⁰

3.4 Discussion

The process of implementing the CBMP focused on improving the interface between citizens and the public health system, which enhances health system responsiveness. The strategy activated the two existing health system spaces for community representation, engagement and oversight—VHSNCs and Patient Welfare Committees—with support from a parallel, multilevel web of autonomous citizen action oversight committees, and invested in pursuing responses from the health system.

The CBMP pursued a multistakeholder strategy to encourage community leaders, health service providers, and local government officials to collaborate, at multiple levels, to address both short-term problem-solving and deeper systemic gaps. The interviews and survey findings showed that the CBMP process led to significantly stronger activity and awareness in the official committees, compared to their functioning in comparable non-CBMP areas. This included orientation to encourage service providers to respond constructively to accountability initiatives, as well as greater recognition by communities and CSOs of the constraints providers faced.

Key respondents noted that CBMP interventions—awareness campaigns, rallies, and village-level meetings—were useful in generating awareness about community health rights and entitlements. The increased awareness and dialogue in these two official oversight committees converted health officials from ‘adversaries’ of CBMP to supporters, since they came to understand that CBMP can support them too, with the broader objective of improving health services with community participation. Many respondents especially appreciated the CBMP process for raising staffing issues, such as vacant positions, which were taken up by Patient Welfare Committee members and CSO representatives in most CBMP areas.

In CBMP areas, community members, non-official VHSNC and Patient Welfare Committee members were more informed about health entitlements and participatory processes related to health services. In contrast, in non-CBMP areas, these same actors were poorly informed about health entitlements and participatory processes related to health services. In CBMP areas, community members of VHSNCs and Patient Welfare Committees enhanced their participation in those committees. In non-CBMP areas, those bodies were either inactive, dominated by government officials, or did not take action on problems identified by the community.

The timing of this research—three years after the most intensive period of strengthening committees, and investing in increasing use of the existing oversight infrastructure—shows a lasting effect on local institutions for community engagement with the health system.

4. Insights and Strategic Lessons from the CBMP program

CBMP has been a complex, enduring, and contested process that has changed over time at multiple levels, informed by cycles of innovation and learning. The overarching state-level CBMP framework was continuously adapted, translated, and expanded by frontline CBMP implementers, in diverse local contexts. Local CSOs who were cognizant of grassroots-level power dynamics used diverse approaches to implementation in their efforts to expand participation for health service improvements. This section shares insights on outcomes and lessons learned about this unique initiative, from the perspective of those who implemented it.

4.1 ‘Sandwich’ approaches to activate participatory spaces

From the outset of the CBMP program, it became clear that state government orders to expand participatory processes were formally necessary to open up institutional spaces at lower levels of the health system, but not sufficient. District and block health officials often displayed bureaucratic inertia, with strong tendencies to maintain closed systems of decision making that excluded nongovernmental actors—for example, from Patient Welfare Committees. Some officials kept away from mass accountability events (public hearings, or dialogues), thus threatening to sabotage accountability processes. In response, the CBMP process deployed a kind of ‘sandwich strategy’⁴¹ with civil society implementers combining action ‘from above’ and ‘from below’.

The official mandates to enable participation ‘from above’ included official state orders or circulars for expansion of membership in the Patient Welfare Committee and for broad-based convening of public hearings. The CBMP program accompanied these orders with systematic capacity-building processes for officials and representatives, among others. In-person workshops and trainings helped to improve compliance by local health system authorities, proving more effective than written orders.

Parallel actions ‘from below’ included community mobilization and the production of evidence on service delivery, which enabled CSOs and community-based actors to effectively ‘occupy’ and utilize the participatory spaces decreed through orders from above. Even though local civil society only had limited representation in Patient Welfare Committee meetings, when they presented compelling community-based evidence, they were often able to gain enough standing to be heard and shape decision making.

Local advocacy used facility-level information and participatory audits of the use of Patient Welfare Committee funds to make the case for listening to nongovernmental voices. Local advocacy, captured by the narrative “use patient welfare funds for actual welfare of patients,” pointed out how funds were either not being used, or being used with no focus on patient needs. Participatory audits revealed inappropriate expenditures or use of resources, such as the purchase of an expensive dentist chair in a health center that had never employed a dentist, and the refrigerator provided for the health center being discovered at the residence of one of the health staff. Presenting such critical information empowered civil society activists to strongly raise questions in Patient Welfare Committee meetings, and to reshape the spending of local patient welfare funds in a spirit of social accountability.

Joint meetings between the Patient Welfare Committee and the local CBMP Monitoring and Planning Committee also contributed to enabling the participatory spaces, acting as a channel between community monitoring and the official committee. In several PHCs, these joint committees developed a protocol of starting every meeting with a ‘participatory round’ of walking through the health center, and talking to the patients, caregivers, and staff who were present. This simple activity made obvious to committee members the many gaps in the health center that

needed intervention. For example, one common issue that was identified through such participatory processes was the lack of proper drinking water for patients and relatives in many health centers, which was subsequently remedied through purchase of water filters and coolers from Patient Welfare Committee funds.

Large turnouts at public hearings also encouraged health officials to listen, including to credible patient testimony. The presence of district health officials was essential to ensuring that community voices led to problem-solving. Sometimes 'direct influencing' was used to ensure participation of officials, which was essential for dialogue. For example, in the initial phase of CBMP, senior officials in certain districts were reluctant to participate in public hearings. In one case, the date had been confirmed well in advance with the District Health Officer. However, on the day of the hearing, despite more than 300 people turning up for the event at the district headquarters, this official chose to stay away. Yet their presence during the hearing was critical to ensure that several district-level issues would be resolved. Local CSO organizers generally responded to missing officials by informing the state-level coordinating CSO, which informed the state-level health authorities, who then instructed the District Health Officer to attend the hearing. On this particular occasion, the civil society organizers went a step further and took the 'direct route for accountability' to ensure the mandated presence of the missing official. His mobile phone number was given to all the participants present for the hearing, and dozens of them started messaging him constantly, 'reminding' him about the need for his presence in the hearing. As a result of this collective action from below, the official eventually turned up and the public hearing was carried out effectively.

4.2 Building common ground with frontline health workers: from hostility to strategic alliance

When community-based actors begin to monitor public health facilities, it is often a contentious process. Such monitoring is frequently considered an unwelcome intrusion by frontline health workers, who are held responsible for service delivery on the ground even if they are not responsible for gaps in the delivery of those services. Given this context, it is not surprising that there was significant initial resistance to the CBMP process from frontline health service providers in some areas. In Nandurbar district, the Medical Officers' Association initially declared a collective boycott of CBMP public hearings. Such reactions were not amenable to resolution just by reiteration of state-level orders. The cooperation of local health workers was critical to ensure much-needed health service improvements. In response, local CSOs developed innovative alliances with frontline health workers in many CBMP areas, often through identifying and taking up shared agendas including raising issues which concerned frontline health workers themselves.. Such alliances had not existed before, and the processes they developed were often novel.

The broader context of inadequate resources for public health services provided common ground between frontline workers and CSOs, since it affected both staff and service users. Another area of mutual concern was the gaps identified between state-level plans and local-level implementation, as was the delayed or substandard construction of healthcare facilities. Frontline staff themselves also lacked formal spaces in the health system to present suggestions and proposals, or to dialogue with more senior officials in collaborative problem-solving mode. The deliberative platforms created by the CBMP process opened up spaces for local improvements that would enable health workers to function more effectively, while also addressing the constraints they faced.

Frontline women health workers often approached CBMP committees and activists to address their problems. For example, during a CBMP public hearing in Nashik district, an Accredited Social Health Activist (ASHA, a female community health worker) presented her complaint of harassment and abuse of power by a more senior local male health worker. Several other ASHAs supported her complaint and shared similar experiences. During the public hearing, the panel immediately appointed an inquiry committee consisting of a Medical Officer, a representative of the ASHA union, and a woman representative from the district Monitoring and Planning Committee. This team interviewed people in the affected village and confirmed that the male health worker had abused several young

women, including the ASHA who had raised the complaint. The committee reported to the next meeting of the district Monitoring and Planning Committee, where the responsible district official issued orders to suspend the employee in question. Many ASHAs breathed a sigh of relief, since this action taken through the CBMP platform curbed the harassment of one of their colleagues, while sending a broader message that such misbehavior would not be allowed in the health system.

The CBMP process also created viable working conditions for a health worker in a village in Beed district, where she was posted as the sole service provider. Neglect of the sub-center prevented her from being able to work. The building had deteriorated, and the electricity supply had been disconnected because of unpaid bills. Taking advantage of this situation, some anti-social elements had turned the sub-center building into a drinking club. The Village Health Committee of the CBMP process used local government resources to upgrade the sub-center building. At the same time, a complaint to the police brought the anti-social elements in line. Within a few months, the sub-center was transformed with proper electricity and water connections, new flooring, roofing, tiling, and paint. The elected village leader followed up with the electricity department and restored the electricity supply. Two vacant health worker positions were also filled.

The pilot phases of the decentralized health planning process also provided a platform for building alliances between CSO representatives and frontline health service providers. Preparation of various PHC and block-level proposals involved joint identification of problems and innovative proposals drafted through collaboration between CSO activists, local government representatives, and frontline health staff.

4.3 Escalating issues for effective problem-solving

There are two reasons why escalation of advocacy efforts from local to district and state levels was adopted for effective problem-solving in CBMP areas.



State mentoring committee meeting, Mumbai, 2017.

Credit: CSO activist working with CBMP program

First, lower-level officials often lack jurisdiction or powers to address certain problems, so they need to be raised at higher levels, where policy makers have the necessary authority. During the CBMP process, in some cases the local officials themselves suggested that CSO facilitators should escalate issues to higher levels. For example, in one decentralized planning workshop at a health center in Pune district, two elderly women participants asked the health center to provide their regular anti-diabetic medicines. They could not afford to spend frequently on travel to the distant government hospital to obtain their medicines. In response, with support from CBMP committee members, the Medical Officer responded with a temporary solution. With the help of a specialist doctor, he started conducting special camps once a month at the health center to treat people with diabetes and high blood pressure. After positive feedback about this localized initiative, the district-level CBMP committee realized that regular treatment of people with diabetes and high blood pressure was a much larger issue that required sustainable solutions. The district-level CBMP CSO (MASUM) collaborated with the health center Medical Officer to propose this for inclusion in the district annual health plan. The issue was also strongly raised in the District Monitoring and Planning meeting, as well as during discussions with the elected chair of the District Health Committee. This district-level representative consulted with health officials and arranged for allocation of funds from the district elected council (*Zilla Parishad*) to regularly purchase and supply these medicines at PHC level. Due to this escalation and persistent follow-up, medications for high blood pressure and diabetes were made available at health centers across Pune district, benefiting thousands of rural patients.

Second, escalation of advocacy may also be needed because of irregularities in functioning or dereliction of duties at lower levels, which naturally cannot be acted upon by appealing to the same officials. Even immediate superior officials may lack the powers, or the necessary distance required for objectivity, to take the necessary punitive action. Here again, the participatory audits of the Patient Welfare Committee funds were key, as when a health center Medical Officer in Aurangabad misused funds, hampering key services. The local CBMP coordinating CSO raised this issue, but no action could be taken at the block level. Then the CBMP process raised the issue in the District Mentoring committee, which included the District Health Officer and the Chief Executive Officer of the District Council. While these officials appreciated the problem, taking disciplinary action required the issue to be further escalated to the regional-level Deputy Director of Health Services. This official initiated proceedings against the Medical Officer involved, leading to recovery of INR 70,000 from the Medical Officer, who returned this entire amount of misappropriated funds to the Patient Welfare Committee.

4.4 Mobilization of public resources beyond the health sector: knocking on many doors

With limited resources for comprehensive delivery of health services, the CBMP process raised expectations by encouraging calls for improvement. One response has been to seek more effective utilization of flexible health facility funds, including from the Patient Welfare Committee. At the same time, in many areas the CBMP process led to increased resources from public funds beyond the health sector.

In CBMP areas, multiple levels of government contributed resources to improving health facilities, from beyond the usual health department resources. At the most local level, elected Village Councils responded to Village Health Committees by using their special local government grants, which have grown since 2015. Village Councils have considerable autonomy in deciding how to use such funds to improve basic services. For example, the Village Health Committee became active due to the CBMP process in one of the remote tribal villages in Gadchiroli district. The village health sub-center faced a shortage of medicines, sanitary pads for adolescent girls, and special food supplements for children suffering from malnutrition. These issues were first discussed in the Village Health Committee, and were then presented in the Village Council, which decided to allocate INR 59,000 from special decentralized grants⁴² in response to these health needs.

Sometimes elected legislators responded. In one of the PHCs in Yavatmal district, the ambulance was 13 years old and not functioning, leaving 41 villages without a patient transport service. This issue was regularly raised through the CBMP process in the health center Monitoring and Planning Committee and in the Patient Welfare Committee. The cost of a new ambulance, however, far surpassed the local health system's budget. Indeed, new ambulances were required at 15 different locations across the district. Advocacy with the district's Member of Parliament led him to persuade the well-funded District Mineral Foundation to buy them.

The same PHC also needed urgent repairs of its building and sanitary facilities. The PHC Monitoring and Planning Committee discussed this need, which was also repeatedly voiced in public hearings. The Patient Welfare Committee funded some minor repair work, but this was not sufficient. Finally, problem-solving efforts continued at the block and then district levels, which led a senior elected representative to present this issue in the District Council (*Zilla Parishad*). In response, the district allocated INR 1.5 million from its general development funds, which completely upgraded the PHC building, including fresh paint, renovated flooring, washroom repairs, and new wiring.

The Covid-19 pandemic increased the urgency of various health needs, including the local purchase of medicines, meeting healthcare expenses for patients with serious illness, and procuring masks and sanitizer for ASHAs and Anganwadi workers. SATHI has documented that village health funds and 14th Finance Commission grants were utilized in 545 CBMP villages across the state. SATHI estimates that in total, more than INR 5.9 million was mobilized from such village-level funds to meet urgent local health needs during the 2020-21 period of the pandemic.

4.5 Addressing social exclusion

In India, traditional caste hierarchies often constrain the delivery of public services and programs, perpetuating the exclusion of the most marginalized communities, especially Dalits (members of the most oppressed castes) and Adivasis (indigenous people, also known as tribal communities). Practices of social exclusion by official health services are often subtle yet significant. The CBMP process deliberately placed such marginalized communities at the center of the community monitoring process. Such emphasis on tackling social exclusion through the CBMP has been operationalized through efforts at two levels.

The CBMP program's selection of districts, blocks, and nodal organizations was strongly shaped by the need to involve civil society groups with demonstrated capacities and experience of mobilizing marginalized communities around health rights. Most CBMP coordinating CSOs have a track record of working with Adivasi or Dalit communities to tackle social exclusion at the frontline, including a focus on ensuring women's rights. In the 14 districts where the CBMP program has been implemented since 2011, the CBMP blocks in 8 have predominant or significant Adivasi populations. In the less developed and drought-prone Marathwada region, most of the CBMP coordinating organizations are anchored in Dalit communities, which have a history of mobilization around land rights and against discrimination.

The CBMP also targets social exclusion with guidelines that specify that all assessments of village health services must be primarily carried out in Dalit and Adivasi neighborhoods. Community discussions and report cards addressed the availability of public health services such as maternal care and nutritional supplements, which empowered local activists to demand equitable delivery of health services (Khanna and Pradhan 2014). For example, in a CBMP village in Pune district, a Dalit activist noted that the ANM (Auxiliary Nurse Midwife-female health worker) used to only visit the higher caste neighborhoods but would never visit homes in the Dalit community. His own wife requested the ANM to come and check her at home, but she was refused. He raised this in a public hearing, complaining that the ANM was not visiting Dalit households in the village. While the ANM denied any intention of discrimination, it was decided that from that point onwards, the ANM must regularly visit the Dalit neighborhood to provide health services. In the ANM's next visit to the village, she was invited to the home of the same woman

patient who had been previously denied a visit. When the ANM was offered a cup of tea in the Dalit household, she accepted it, breaking down a critical social barrier. This ANM started regularly visiting the Dalit locality to provide services.

In another case, in one of the CBMP villages in Solapur district, the village council decided to install two new streetlamps in the Dalit neighborhood, which definitely required illumination at night. However, when it came to installing the lamps, the powerful *sarpanch* ordered the lamps' cement base to be built in his preferred location in a higher caste locality, even though this area already had street lighting. One of the local CBMP activists belonging to the Dalit community found out about this unjustified change during the social audit process. The activist raised this issue with the social audit group, in a public dialogue event, and with some village government representatives, insisting that the lamps must be installed in the Dalit locality as originally planned. Within a month, the 'unwritten order' of the *sarpanch* was reversed, and the street lamps were finally installed in the long-neglected Dalit neighborhood.



Community members reading the report card of PHC services, Beed district, 2012.

Credit: CSO activists working on CBMP implementation program

4.6 Strategic use of local information

Local activists often supplemented the standard CBMP protocol of the village-level interviews, group discussions, and preparation of report cards with additional kinds of information to inform their problem-solving efforts. For example, local CBMP activists in Nandurbar district suspected that a PHC was being built with substandard quality concrete. They proved this by testing samples in the local district laboratory and then raised the issue in various CBMP committees. As a result, the building was reconstructed with good-quality construction material. Similarly, a public hearing in Kolhapur district raised the issue of the complete lack of availability of doctors in several remote PHCs. Officials responded that it was difficult to get doctors to work in exceptionally remote, hilly areas. CBMP activists persisted in raising this issue in official forums, searched for options, and inquired about measures being taken in other districts. During a meeting of the District Mentoring Committee, they shared the approach taken in neighboring Sindhudurg district, where the elected council provided special, additional financial incentives to doctors who worked in especially remote PHCs. The Kolhapur District Council approved a special grant of INR 2 million annually for incentives for doctors who worked in 12 remote PHCs, benefiting tens of thousands of people. Such innovative use of local information emerged spontaneously in multiple CBMP areas, as part of processes for collaborative problem-solving.

4.7 The unstable dynamics of collaboration at the state–civil society interface

Though the CBMP program maintained a delicate collaboration between the CSO coalition and the public health system, its initial phases may be regarded as the relatively 'provocative' period (2007–13). The stream of 'questioning' activities included community mobilization and generation of health demands, display of community-based

assessments (report cards), and presentation of such critical evidence in newly created accountability spaces for public dialogue. As originally envisaged under the NHM, this strategy advanced social accountability process, in combination with advocacy and collaboration with national and state-level official bodies.

From 2013–14 onwards, larger developments at national and state levels led the CBMP civil society coalition to significantly change its approach. Central government support for NHM levelled off, budgets for improving public health services were less expansionary, and the effectiveness of CBMP accountability processes plateaued. CBMP adapted pragmatically to the more limited space for assertive social accountability processes with a shift in emphasis from community-based monitoring to community-based planning. The pilot phase of the decentralized health planning process showed how the impetus unleashed through community monitoring could promote a more cooperative strategy of joint planning to address community health priorities.

As noted earlier, CBMP piloted this process in 2015–16 in Gadchiroli district, one of the least developed and most remote districts of Maharashtra, with a large tribal population. Key steps included community mobilization to identify, analyze, and prioritize people's demands, and drafting action plans to convert demands into proposals to guide action at different levels. At each stage, three kinds of stakeholders worked closely together: community groups and civil society organizations, elected village leaders, and public officials. The process evoked enthusiastic community responses, with hundreds of people participating in the village-level consultations. A total of 499 demands related to various public services were generated, out of which 146 were related to health services. They were then analyzed and classified into various categories, to determine the relevant level of action and possible funding sources. Some of these community priorities were addressed, including:

- Some sub-centers gained access to proper water supplies
- Pregnant women in rural and sub-district hospitals gained access to weekly sonogram services for the first time
- Patients with sickle cell anemia began to receive regular medicine in their villages, from health workers
- Some sub-centers created separate delivery rooms for mothers
- PHCs made available special toilets for differently abled persons and pregnant women

Despite the potential of the pilot to make planning processes more participatory, and an official decision in 2016 to scale up the process by 2017–18, the State Health Mission handed over coordination of decentralized health planning to the official State Health Systems Resource Centre, and the entire flow of official funds for related activities (earlier managed by CSOs) was allocated to district and block health officials. This change led to the decline of participatory planning processes at the community level, and relegated CSOs and grassroots actors to the periphery of planning discussions. The transfer of control of decentralized health planning to officials diluted the participatory dynamic that had been initiated during the pilot phase and the first year of scaled-up implementation. Although district health planning processes have continued in a formal manner, the vital participatory component that initially showed great promise was not continued.

In 2018 and 2019, in response to the state government's insistence that coordinating CSOs should 'exit' from their facilitation roles, the authorities sought to institutionalize CBMP processes by steering a 'transition' process by transferring CBMP activities and resources to state actors in five blocks (a kind of 'reabsorption into the system'). In the words of a senior CSO representative from one of the 'transition' blocks:

The transition process in our block started in 2018. The role of the facilitating NGO was now very much reduced, and entire responsibility for planning and execution of CBMP activities was handed over to the Taluka Health Officer. After this change, the entire process became 'governmentalized' (सरकारीकरण झाले). We cannot expect the system to mobilize people for questioning their own system! Key meetings of Village Health Committees, Patient Welfare Committees and the Block Monitoring and Planning Committee became irregular, and sometimes the nodal civil society organization was not even invited for meetings.

The continuity of the process was lost. Previous practice of regular follow-ups to resolve issues was interrupted. Village-level activities were practically stopped. The process became formalistic, and it lost its vitality (दम राहिले नाही). We have continued to raise demands voiced by communities, and some Panchayat representatives and journalists have remained active. However, the intensity of participation by various social actors has declined. Because of this transition, the previously regular CBMP activities in this block have been greatly reduced. It seems as if nobody is now responsible for the process. Those who have the power are not interested, and those who are interested no longer have mandate and resources to steer the process.

Block Coordinator in Pune district, February 2019

All the transition blocks that had active CBMP processes prior to the official 'transition' reported similar disappointing experiences after officials took control of the process. Despite positive efforts by SHSRC to entrust these officials with leadership of the process, they seemed unable to prioritize community action and multi-stakeholder meetings amid their many existing responsibilities. In addition to the shift of control, huge administrative delays undermined the entire CBMP process. At the same time, as two CSO representatives describe below, community health issues continue to be raised in grassroots spaces like Patient Welfare Committees and Village Health Committees, and civil society actors remain active for social accountability from 'outside the system'—which indicates the lasting effect of the CBMP's initial intensive wave of activity.

In the later period we have faced problems because of the delay in contract, which would then delay the entire program. We were facing a dilemma whether to continue with the process, the activists were demotivated due to delays in fund disbursement. Some activists left.... Currently we are facing a problem of funds shortage, but we are continuing work without thinking about money. Even though money is important, the close relations we have developed with people and community as a part of this work, help us to overcome the funds crisis.... We don't look back despite some obstacles, the work continues.

CSO representative, Kolhapur, March 2019

2008 to 2012 was a golden era [for CBMP].... From 2012 onwards, problems like delay in contract, reducing funds, are troubling us. Earlier, after the contract was made, immediately we would get 50 percent of the funds and contracts would get done by April or May. Now there are too many delays, and activists need honorarium to work, so funds are necessary.... Even if the government funds do not come, we continue to work. Even if we withdraw from this project, our work on the issue will continue, as that is what our organization is known for. People will continue to come to us with their health-related problems and we will assist them.

CSO representative, Osmanabad, April 2019

The CBMP experience in Maharashtra shows that collaborative social accountability processes are both essential and vulnerable, in two ways. First, they need facilitation mechanisms that have robust autonomy from the state. If this critical function of fostering countervailing voices at community and higher levels is collapsed into the official implementation system, then genuine participation gets suffocated and will be ultimately extinguished. Maintaining a strategic yet critical tension in the strings that connect state and non-state actors is essential to produce the music of participatory dialogue. Too much tension can lead to breakdown of dialogue, while elimination of this tension by imposition of state hegemony can also effectively close down dialogue. The contentious but essential conversations

between diverse actors get replaced by official monologue, which excludes all other voices. Second, these experiences also reveal a limitation of the CBMP program's design and operationalization under the NHM. Diminishing political and administrative support over time for participatory processes led to a major constriction of resources for CSO-led facilitation of community mobilization.

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Reading these two lessons together presents a paradox.

On one hand, autonomous, CSO-led facilitation is deemed to be essential, but on the other hand, it is highly vulnerable if it is significantly dependent on state support. Collaborative social accountability processes might appear inherently fragile due to this contradictory reality. How do we reconcile these observations to advance collaborative social accountability processes in the real world? It is clear that there are no simple answers to this question, especially in contexts where intensive accountability activities require significant human resources, and states are becoming increasingly intolerant of questioning by social groups and civil society actors. That said, the CBMP experience, as well as other significant initiatives for collaborative social accountability in India, suggest some tentative responses to this dilemma.

While thinking about sustainable local facilitation, we need to reflect on the attempts to create federations of monitoring committees in some CBMP blocks from 2015 onwards, following the government's insistence that nodal CSOs should step aside from facilitation of the CBMP process. These block-level federations brought together members of Village Health Committees, PHCs, and Block Monitoring and Planning Committees to form a broader, participatory local network that could take ownership of community accountability processes, even as the nodal CSO moved into a support rather than a convening role. These federations included Panchayat representatives, members of social action groups, journalists, and other civically engaged individuals, and activists from other local CSOs who had been participating in CBMP activities. It is notable that these federations decided to take up not only health service issues, but also other grassroots concerns, such as ensuring entitlements to education, employment (through the Employment Guarantee Scheme), and food security (through the Public Distribution System).

While the initial experiences of such federations were quite encouraging, these new formations required significant time and effort for incubation and consolidation. The disruption of CBMP funding starting in 2015 made it difficult even to continue core activities. Though these federations as budding vehicles for autonomous facilitation of social accountability processes could not be sustained, the idea of "community-based federations" deserves further exploration. Their sustainability may be greater if they were enabled from the early stages of collaborative social accountability initiatives.

Another notable model for facilitation of social accountability linked with state-led processes is the Society for Social Audit, a semi-autonomous state agency created as part of the Mahatma Gandhi National Rural Employment Guarantee program (MGNREGA) in Andhra Pradesh and Telangana (Aakella and Kidambi 2007). Here, large-scale, state-led social audits have survived the vagaries of major political changes over more than a decade. They have created an enabling environment for autonomous collective action on accountability of public programs, led by local auditors and NREGA workers; the national government Auditor General has mandated other states to create similar agencies (Pande 2022).

The state of Kerala has consolidated another approach to institutionalize community voice for responsive service provision, based on substantial devolution of power to Panchayats, and combined participatory local public planning processes—including health services (Thomas Isaac and Franke 2021). These politically anchored governance systems are a product of decades of social mobilization, yet despite Kerala's distinctiveness and certain limitations,

they demonstrate how social responsiveness of frontline public services can be embedded in decentralized governance mechanisms.

All three models—local federations of participatory committees, state-supported society for social audit, and empowered Panchayats—are centered around a significant collective actor that enjoys autonomy from the government implementation machinery. Further discussion is required to compare the merits, limitations, and potential for wider generalizability of such models, while exploring additional new directions for developing sustainable collaborative social accountability processes.

The CBMP process in Maharashtra also underscores the significance of combining scale with both intensity and authority—enabled by policy support and funding from the national and state government, especially from 2007 through 2014. In this case, scale involved ‘system-wide,’ macro-level processes that generated a certain level of ownership from both state and society. Such processes were relatively effective because they *reached from state to community level* in terms of issuing of various enabling orders, creation of diverse participatory bodies, and intensive capacity building of different social actors. These processes also *reached back from community to state level* in terms of providing grounded feedback from marginalized communities and healthcare users to various layers of the health system, ranging from local health workers to state health officials, prompting a wide range of actions.

As we have also seen, the 2013–17 period was a phase of shrinking of resources for the CBMP program, which also provided the setting for various forms of social experimentation to sustain social accountability and problem-solving processes in the health sector.

Since 2017, CBMP activities have faced continued financial delays and constriction of resources. The earlier ‘system-wide’ collaborative social accountability processes, which involved stronger state-level ownership of the process, were pushed into hibernation. However, as this study’s findings show, micro-level processes such as activation of the Patient Welfare Committees and Village Health Committees at grassroots level have continued, contributing to a degree of health system responsiveness in spite of the less conducive policy environment.

It is also heartening that the substantial social networks, local alliances among civil society actors, Panchayat members and frontline health staff, and capacities of grassroots social actors created by CBMP, have continued at the ground level in many areas. As described in the next section (the Epilogue), the CBMP’s intensive period provided fertile ground for a remarkable range of community-oriented, bottom-up collaborative health responses to emerge independently of the state’s official structures during the Covid-19 pandemic. This resurgence of participatory health initiatives in many CBMP areas during Covid confirmed that the ‘saplings’ of participatory democracy planted through this process over the past decade have struck roots, which not only survived but were also capable of raising new shoots during the unprecedented Covid crisis. In a more conducive policy environment, these numerous strands of participatory democracy could join together and anchor the renewal of state-wide processes for social accountability in the health sector. Until then, the CBMP legacy will continue to energize grassroots collectives—microcosms of democratic functioning that can promote social accountability even in the most challenging times.

5. Epilogue: The Spirit of Community-based Monitoring and Planning Lives on During the Pandemic

The Covid-19 pandemic affected health services in an unprecedented manner in India. In terms of Covid cases and deaths, Maharashtra was the worst affected state. Nevertheless, nearly 15 years of civil society action had left a legacy of local social capital and larger networks that allowed communities to proactively respond to pandemic challenges with their own resources. The CBMP—and, as it had become known since 2014, Community Action for Health (CAH)—had catalyzed longstanding social networks of collaboration with frontline public healthcare providers and local governments that enabled civil society groups to actively intervene to support people’s access to healthcare, despite restrictions imposed by the pandemic.

During the first wave of the pandemic (March to November 2020), the government health authorities who were preoccupied with crisis management, did not leverage the CAH framework to catalyze and support participatory responses. In April 2021, the NHM stated that only certain Covid-related activities (prevention and vaccination) should be continued as part of its officially supported program. The officially organized CAH eventually responded to the pandemic in June 2021, by supporting hospital-based helpdesks, which civil society initiatives had already set up a year earlier.

This epilogue describes a few of the innovative initiatives launched by CAH-associated CSOs, made possible by their longstanding relationships with local health officials and local elected government representatives (Panchayat members). Local CSOs that had long partnered with health providers did not wait for changes in national and state health policy to undertake a range of useful and timely initiatives to promote access to health services for people in rural areas. Most of these activities remained largely ‘below the radar’ of state government health officials during the peak periods of intervention, at least until the official CAH framework began to support the helpdesks in June 2021.

5.1 Operating helpdesks in rural public hospitals

The pandemic worsened access to health care in rural Maharashtra, due to the exclusive focus of scarce public health resources on Covid control efforts. This included the conversion of public health facilities into exclusive Covid hospitals, multiple disruptions due to lockdowns, and hampered patient transport. Vulnerable rural communities urgently required some facilitation to access even basic health care. In response, one of the CAH nodal organizations (*Samvad*) and field-level health activists in Kolhapur district launched an innovative initiative during the upheaval to create helpdesks in public hospitals, to guide and enable patients from the rural localities to access required care in hospitals (see, for example, Box 4). They were launched during the peak of the first wave of widespread Covid transmission, in July 2020, when there was significant risk to anyone interacting daily with scores of patients in a hospital setting.

Box 4. And Finally, Grandma got the Oxygen Bed!

An elderly woman was brought to Junnar rural hospital by her grandson in September 2020, after she tested positive for Covid. Doctors told her that she must immediately be taken to the Covid center. The grandson was concerned about availability of transport facility and got in touch with the helpdesk in that hospital. The helpdesk facilitator guided them with all the necessary information and also inquired about bed availability in the nearby Covid center. Unfortunately, there were no beds available. The helpdesk facilitator then suggested another Covid center in the block.

The relatives managed to take the woman there, but by that time her condition had worsened. The doctor there informed them that now she needed oxygen support, but an oxygen facility was not available at that center. The grandson again contacted the helpdesk facilitator, who reassured him that they would try to locate an oxygen bed somehow. Over the next few hours, the helpdesk facilitator made more than 100 calls to different numbers at various health facilities. Finally, with all these efforts, they were able to access an oxygen bed in a Covid care center in Pune city, and the grandma received proper treatment and recovered.

After running from pillar to post, the helpdesk's timely efforts were able to secure a hospital bed for the grandma, which helped to save her life.



A Covid helpdesk in Pune guiding patients on referral services, 2020.

Credit: CSO activist working on CBMP implementation program

Documented by SATHI staff, Junnar block, Pune district

SATHI rapidly scaled up this innovation through the existing CAH-related civil society network. These helpdesks guided tens of thousands of patients to access rural public hospitals, Covid health centers and referral services. From June 2020 through August 2021, SATHI collaborated with partner CSOs to operate helpdesks in the health facilities, both in CAH and in non-CAH blocks, with some nongovernmental funding. Despite this limited support, helpdesk volunteers in dozens of blocks came forward and took up this responsibility in the face of considerable personal risk, even when observing all precautions. The fact that local health officials enabled the rapid operationalization of this initiative in each block where it was proposed—without imposing any bureaucratic hurdles—is testimony to the level of social capital that had been generated by CSOs across the state through the CBMP/CAH process.

At the peak of this activity, 40 block-level helpdesks operated across the state, providing information on access to health services to more than 80,000 patients and caregivers by August 2021. After SATHI's engagement and prominent newspaper coverage (Patil 2021) brought this initiative to the attention of state health authorities, they ordered the implementation of helpdesks in CAH areas in June 2021, followed by official CAH approval of helpdesks in the 35 blocks where the program was already functional.

5.2 Reactivating social networks to organize virtual communication and rapid response mechanisms

One of the key challenges during the Covid-19 pandemic in India—especially during the earlier phases of the first wave—was reducing fear and misunderstanding among ordinary people and frontline health workers by providing accessible, authentic, and updated information. There was also an urgent need to ensure real-time feedback from communities to local government officials to address gaps.

Given their long experience of health service-related problem-solving and facilitation of dialogue among local health stakeholders, the civil society network associated with CBMP/CAH was well placed to rapidly respond to these needs. Within two months of the first wave of Covid, SATHI had reactivated collaborations with partner organizations in 28 blocks to convert their existing direct interaction-based networks into virtual communication networks. SATHI reached into its database of phone numbers and organized around 30 WhatsApp groups involving thousands of local health committee members, village panchayat members, and local health service providers, to regularly communicate updated government decisions and information related to the Covid situation. The SATHI team also coordinated with local CAH-associated activists to organize online Covid-related trainings for several hundred VHSNC members and frontline community health workers during the early stages of the first wave. To support such online trainings, SATHI developed digital training modules and posters in Marathi as well as locally spoken tribal languages, dealing with community health concerns related to Covid-19.

Following up on the trainings and keeping in view many concerns expressed by community members and local activists, the SATHI team also developed rapid online survey questionnaires for VHSNC members and community health workers (see Box 5). This network carried out four online surveys about health services during the peak of the first wave in July and August 2020. The first three surveys identified challenges faced by frontline health workers during the pandemic. The fourth survey was conducted with the community with the help of VHSNC members, to understand challenges in accessing the Public Distribution System based food ration entitlements announced by the government during the lockdown.⁴³

Based on the findings of this rapid digital survey, the SATHI team set up a rapid communication and feedback system involving block coordinators and community actors such as VHSNC members and ASHAs, to address service gaps with local authorities. With the inputs from SATHI team-supported block coordinators, these local groups established contact with block-level local officials by creating WhatsApp groups at block level. These joint state–society groups acted as digital dialogue platforms during the lockdown situation when physical dialogue was not possible, including *Gram panchayat* and *Panchayat samiti* members, Taluka Health Officers, PHC Medical Officers, police officers, and other block-level officials. In some cases, where feasible, block coordinators made personal visits to resolve complex challenges. This process identified a total of 160 service-related issues, and 100 were resolved through such feedback and linked interventions.

Box 5. Virtual Survey Leads to Actual Problem-Solving

SATHI and associated partner organizations used simple digital data collection tools like Google forms to carry out participatory surveys during the strict lockdown conditions of the first wave of Covid-19 (mid-2020). As part of this process, in Lohara block of Osmanabad district, activists working with the CAH-associated civil society organization HALO Medical Foundation facilitated the survey process, prompting local troubleshooting wherever necessary. Through the survey, in villages, ASHA workers reported that the supply of emergency medicines and personal protective equipment (PPE) kits was completely insufficient, causing many problems in their work. PHCs and sub-centers were focused on Covid containment efforts, disrupting other routine health services. ASHA workers were being approached for medicines and consultations more than usual, but they were feeling the strain of working in an unsafe environment with inadequate masks, sanitizer, and drugs. CSO activists followed up with the Taluka Health Officer, pointing out the consequences of such village-level shortages for communities who were cut off from public health centers during the lockdown situation. Soon thereafter, ASHAs were provided with adequate stocks of essential medicines, mobilized from the PHC and block level stocks.

In the meantime, health department supplies of masks and sanitizer to ASHAs were running short, so CSO activists and VHSNC members initiated discussions with the village government leaders to solve this problem at the local level. A consensus was reached to procure masks, sanitizers, pulse oximeters, and thermometers for ASHAs right away by using local government funds. ASHAs in 12 villages of the block were immensely relieved when they received the PPE through such efforts, which enabled them to do their tasks without any apprehension. They also appreciated the initiative taken by the community to ensure their safety and work better in such a time of crisis.

5.3 Block-level joint task force for Covid control

Pune district had the highest number of Covid deaths in the state of Maharashtra. A broad-based coalition of CSOs and community groups in Pune responded with grassroots initiatives. In August 2020, they proposed the formation of a Task Force on Social Action for Covid Control, involving government departments, public health experts, and representatives of diverse social organizations. The goal was to operationalize government–community interfaces for strengthening mass awareness, to promote social support for pandemic control measures, and to enable community feedback to the health system. The principles underlying this task force included enhancing public trust in public health measures, motivating citizens to be actively involved in efforts to control the spread of the virus, while also facilitating people’s feedback to strengthen various official initiatives to tackle the pandemic. Although there was no direct linkage between the urban Pune task force and the rural-oriented CBMP/CAH process, the task force’s principles were very similar to the CBMP/CAH approach, and SATHI team members and CBMP rural health activists provided inputs to the task force.

The Pune district task force encouraged local task forces—as in Velhe and Bhor blocks (see Box 6), where local officials invited members of the CAH CSO to join. Using the space of this task force, these civil society activists facilitated various collaborative pandemic response initiatives related to health and nutrition, including providing nutritious food and medicines for malnourished children in villages during lockdown, with the help of local elected representatives. The task force also set up two local quarantine centers in rural areas of the block, equipped to house around 120 people. This task force continued working during the second wave of Covid, facilitating the vaccination of thousands of people in Velhe and Bhor blocks.

It was quite positive that CAH-associated civil society groups, with their proven track record of working on community health action, were invited to be part of the official task force in Pune, which emerged during the pandemic. As task force members, they could draw on their CAH experiences to contribute to joint initiatives with government officials.

Box 6. Task Force and Activists ‘Cure’ the Management of Covid Care Center

During the pandemic, the government started Covid Care Centers in both rural and urban areas. Some, however, were mismanaged. In August 2020, people complained about the Covid Care Center in Bhor block of Pune district. There were reports that people who may have had Covid were being kept in the same ward as people who had already tested positive for Covid, greatly increasing their risk of exposure. There were also reports that quarantined people were walking around the center without wearing masks, breaching quarantine rules. Staff and doctors were acting irresponsibly, not heeding requests to monitor admissions, and to ensure that Covid-positive patients were kept separate from everyone else. Naturally, many patients were feeling anxious, scared, and confused. An activist associated with the CAH process heard about this issue from a patient there. She visited the center, together with VHSNC members, to verify the complaints and speak to the doctor in charge, but they were all summarily dismissed.

The activist then decided to approach the block-level task force members and asked them to intervene. They took cognizance of the complaint, and a delegation comprising the *sarpanch*, Police *patil* and members of the PHC Monitoring Committee visited the Covid Care Center, while following all due precautions. The delegation got first-hand feedback from the patients about their experiences. Due to the pressure and continuous follow-up by CAH-associated activists and village-level committee members, the concerned health officials were compelled to take action and issued directives to the Medical Officer in charge to take immediate corrective measures. As a result, the management of the center was significantly improved, with separate wards for people who were confirmed to have Covid, those who were suspected to have Covid, and those who were quarantined, including monitoring of new admissions to avoid mistakes. The center started to function properly, with patients reporting a positive change in staff behavior as well.

These are just a few examples of community-level pandemic responses involving CBMP/CAH activists. These examples show that even though the official CAH framework’s response to Covid was quite delayed, CAH-associated civil society activists and village-level actors were proactive in their problem-solving. They also illustrate the resilience of the social capital generated through the earlier CBMP/CAH process, even when official support to the process was delayed or weakened.

The CBMP-associated civil society groups across Maharashtra took the initiative and responded successfully within the context and constraints of the pandemic. Their networking with local doctors, health staff, community health workers, and various government officials, as well as their connections with elected representatives and the community, were useful in raising and following up on pandemic health service issues. Furthermore, their credibility among government officials as CBMP/CAH implementers, as well as their knowledge about details of health services and community health needs, enabled them to respond to the challenges posed by Covid at the local level. This was exemplified by the prompt upscaling of helpdesks, active initiatives taken by the block-level task force, and the setting up of virtual communication and feedback networks to activate Covid responses. We can definitely say that the spirit of community-based monitoring and planning in Maharashtra has continued ‘from below’, undeterred by the crisis, and has risen to the occasion during the pandemic.

Notes

1 For more discussion of the differences between tactical and strategic approaches to social accountability, see Fox (2015). For a contrast between the limits of a formally evaluated field experiment and a broader campaign strategy, see Bailey and Mujune (2021). For ARC's broader portfolio of applied research on participatory oversight institutions, see: https://accountabilityresearch.org/participatory_oversight_institutions/.

2 For more on the concept of “invited spaces,” see Cornwall and Coelho (2006).

3 CBMP was an emblematic case of what political sociologists call ‘state–society synergy’—dynamic processes where pro-change actors mutually enable one another across the state-society divide (Fox, Robinson, and Hossain 2022). For comparative international analysis of diverse cases of where openings from above enabled collective action from below, see: <https://accountabilityresearch.org/sandwich-strategy-research/>.

4 On the origins and dynamics of the CBMP as part of NRHM, see Gaitonde et al. (2017), Shukla, Scott, and Kakde (2011), and Kakoti et al. (2022). For further discussion of the CBMP in Maharashtra in the early years, see Shukla, Khanna, and Jadhav (2014), and Shukla and Sinha (2014). On the CBMP in Tamil Nadu, see Gaitonde et al. (2019). For a report of a witness seminar on Community Action for Health in India, see Kakoti et al. (2022).

5 The extensive ethnographic research literature on local health committees in India underscores the significance of power imbalances both within communities, and between communities and health service providers (see, for example, Madon and Krishna 2017, and Scott et al. 2017a).

6 Note that the CBMP's early intensive focus on building grassroots capacity contrasts with more widely studied social accountability efforts whose capacity-building inputs were limited to brief “light touch” visits by facilitators, and information-sharing meetings (Fox 2015).

7 International donors used to promote ‘constructive engagement’ to describe government–civil society collaborations to promote social accountability (Fox 2022). For a comparative analysis of a CSO health rights monitoring initiative that combined more versus less collaborative stances across districts, see Hernández et al. (2019).

8 See Fox and Acheron (2016), and Fox (2016). Conventional evaluation frameworks address citizen voice initiatives at either local or national levels, whereas in practice, civil society advocates often seek to build linkages both across localities (horizontally) and upwards across levels of decision making (vertically). Recent comparative analysis of CSO health rights monitoring and advocacy through the lens of scale finds numerous examples of multilevel approaches, though that dimension is often not highlighted in research or evaluations (Gebremedhin 2023).

9 These are known as Annual Common Review missions.

10 A web-based monitoring system to monitor the National Health Mission and other health programs for policy formulation and appropriate program intervention (<https://hmis.nhp.gov.in/#!/aboutus>).

11 Annual Common Review mission exercises are carried out with support from the National Health Mission in a number of states, with a uniform review methodology used by teams of officials and experts who are drawn from outside the state. Further, major national surveys such as the National Family Health Survey (NFHS) and District Level Health Survey (DLHS), conducted by independent agencies, throw light on the status of delivery of health services in various states and districts.

12 The nine states were Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, and Tamil Nadu. For one of the few state-level studies of CBMP in states other than Maharashtra, see Gaitonde et al. (2019) on Tamil Nadu. For reviews of CBMP covering multiple states, see Ramanathan (2017), and Lahariya et al. (2020).

13 Such shortfalls in disbursement of approved budgets are known in the field of public financial management as issues of “budget credibility”. See the International Budget Partnership website: <https://internationalbudget.org/issues-lab/budget-credibility>.

14 For discussion of these challenges, see Azeez et al. (2021), Madon and Krishna (2017), and Scott et al. (2017b).

- 15 The report card had three color codes based on the status of implementation of various activities and delivery of services. (Green = 75–100 percent of activities completed or services delivered; Yellow = 50–74 percent of activities completed or services delivered; Red = 1–49 percent of activities completed or services delivered.) Data on service availability were compiled, collated, and analyzed in a standardized manner at different levels, to present an aggregate picture and also to have specific information about the individual services. Subgroups of the committees carried out additional monitoring of implementation in the field. The committees sent a periodic report (six-monthly or yearly) to the next higher-level committee for information and action (Shukla, Saha, and Jadhav 2015).
- 16 In larger Indian states, an average block may typically have a population of between 100,000 and 200,000, while districts might typically have rural populations in the range of 1 million to 2 million, not including their urban centers.
- 17 In CBMP discourse, this coordination role is known as “nodal NGO”.
- 18 The Provisions of the Panchayats (Extension to Scheduled Areas) Act, 1996 or PESA is a law enacted by the Government of India for ensuring self-governance through traditional *gram sabhas* for people living in the Scheduled Areas of India.
- 19 ‘CBMP-sensitive’ describes aspects of health service delivery that significantly improve in response to citizen voice and assessment; ‘CBMP-resistant’ refers to unresolved systemic issues that are being raised repeatedly without much response.
- 20 The field interviews and surveys were carried out between February and May 2019 by Shailaja Aralkar, Nilima Gawde, Sachin Pullawar, Ashish Ingole, Anand Ingole, Kamlakar Mandve, and Bhagyashri Khaire, in coordination with SATHI.
- 21 The original sampling strategy was to interview ten women who had delivered in public health facilities in the past six months, in each PHC area. While we could locate and interview such women in all CBMP areas, despite significant efforts, in some non-CBMP PHCs we could not locate the required number of women who had delivered in public health facilities in the past six months. We modified the inclusion criteria to interview women who had delivered in public facilities in the *past year*, to ensure an adequate number of respondents per PHC.
- 22 VHSNC member, non-CBMP PHC, Beed, April 9, 2019.
- 23 Anganwadi worker, CBMP PHC, Beed, April 9, 2019.
- 24 108 is a toll-free telephone number in many Indian states, to summon emergency ambulance services.
- 25 Prashant Bhosale, Sangram, Kolhapur district, July 17, 2019.
- 26 Shripad Konde, Rachna Samajik Punar Bandhini Sanstha, Pune district, July 16, 2019.
- 27 Javed Sheikh, Halo Medical Foundation, Osmanabad district, July 18, 2019.
- 28 According to staff and users in Beed, the hotline was used frequently and that is why the complaint box was used less.
- 29 CBMP coordinator from partner CSO, Beed district, July 18, 2019.
- 30 Taluka Health Officer, CBMP PHC, Kolhapur district, March 25, 2019.
- 31 CSO representative from CBMP PHC, Gadchiroli district, April 16, 2019.
- 32 Taluka Health Officer, CBMP PHC, Kolhapur district, March 26, 2019.
- 33 Health services, including medicines from PHCs, are supposed to be available free of cost. However, in some health facilities, people have to pay for these services, which we refer to as illegal fees.
- 34 CSO representative, CBMP PHC Kolhapur district, March 25, 2019.
- 35 Taluka Health Officer, CBMP PHC, Gadchiroli district, April 15, 2019.
- 36 Indavi Tulpule, representative, Vaniketan, Thane district, July 17, 2019.
- 37 CBMP committee member from Kolhapur district, March 27, 2019.
- 38 CSO representative, CBMP PHC, Pune district, April 5, 2019.

39 CSO representative, CBMP PHC, Kolhapur district, March 26, 2019.

40 Manohar Hapat, Indian Institute of Youth Welfare, Gadchiroli district, July 16, 2019.

41 'Sandwich strategy' describes an interactive process in which reformers in government encourage citizen action from below, driving virtuous circles of mutual empowerment between pro-accountability actors in both state and society (Fox, Robinson, and Hossain 2022).

42 Based on recommendations by the 14th National Finance Commission, which dealt with distribution of funds to various levels of government in India during 2015 to 2020, special grants have been made available to each *Gram panchayat* (elected Village Council). These government grants potentially made available substantial additional funds for each Village Council, while allowing them considerable autonomy in deciding how such funds could be used to improve basic services. Due to local health needs being articulated in Village Health Committees in many CBMP areas, these general funds have now been specifically utilized to meet community health priorities.

43 Respondents to the rapid online survey to assess the status of health, nutrition, and food security services at village level included 1,806 VHSNC members, 957 community health workers, and 892 childcare center workers.

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