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Using community-based evidence for decentralized health planning: insights from Maharashtra, India

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Health planning is generally considered a technical subject, primarily the domain of health officials with minimal involvement of community representatives. The National Rural Health Mission launched in India in 2005 recognized this gap and mandated mechanisms for decentralized health planning. However, since planning develops in the context of highly unequal power relations, formal spaces for participation are necessary but not sufficient. Hence a project on capacity building for decentralized health planning was implemented in selected districts of Maharashtra, India during 2010–13. This process developed on the platform of officially supported community-based monitoring and planning, a process for community feedback and participation towards health system change. A specific project on capacity building for decentralized planning included a structured learning course and workshops for major stakeholders. An evaluation of the project, including in-depth interviews of various participants and analysis of change in local health planning processes, revealed positive changes in intervention areas, including increased capacity of key stakeholders leading to preparation of evidence-based, innovative planning proposals, significant community oriented changes in utilization of health facility funds, and inclusion of community-based proposals in village, health facility-based block and district plans. Transparency related to planning increased along with responsiveness of health providers to community suggestions. A key lesson is that active facilitation of decentralized health planning and influencing the health system to expand participation, are essential to ensure changes in planning. Effective strategies included: identifying people's health service related priorities through community-based monitoring, capacity building of diverse stakeholders regarding local health planning, and advocacy to enable participation of community-based actors in the planning process. This combination of strategies draws upon the framework of 'empowered participatory governance' which necessitates combining a degree of 'countervailing power' and acceptance of participation by the system, for new forms of governance to emerge.

Keywords Capacity building, community mobilization, community participation, decentralization, health planning, health sector reform, health systems research, governance

KEY MESSAGES

- Health planning develops in context of highly unequal power relations; hence, formal spaces for participation are necessary but not sufficient.
- Existent processes for decentralized health planning in Maharashtra state of India were observed to face numerous barriers, preventing effective participation of non-official stakeholders.
- The project studied shows that active facilitation of decentralized health planning can ensure significant positive changes in the local health planning process.
- Such facilitation should desirably include identifying people's health service related priorities through participatory processes, capacity building of community representatives regarding local health planning and advocacy to enable participation of community-based actors in the health planning process.

Introduction

Health planning in India has a long history (Duggal 2002; Qadeer 2008). Perhaps the most comprehensive health plan in modern India was developed by the Bhore Committee, which laid out a detailed vision for a National Health Service in the country, which was however never implemented. After Independence in 1947, much of public health planning has been done by the national Planning Commission through its 5-year plans (Jeffery 1986), reflecting various phases of macroeconomic planning in the country. The tension between what is written into policies and plans, and what is actually implemented continues to this date.

Comprehensive health planning for a complex and mixed health system necessarily needs to be both integrated as well as intersectoral (Qadeer 2008), involving diverse stakeholders from different levels within the health system, as well from related sectors. To ensure that people's priorities are addressed by health systems, it is necessary to bring in the voices of communities as key stakeholders, who must actively contribute to the planning process. Acknowledging the importance of communities as stakeholders, the National Rural Health Mission (NRHM) launched in 2005 made a commitment towards decentralization (Government of India 2006). Amongst its core strategies were: 'to enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services' and 'Health Plan for each village through Village Health Committee of the Panchayat', thereby stipulating decentralized health planning with use of local evidence. The NRHM also mandated community oriented structures like Village Health, Sanitation and Nutrition Committees (VHSNCs), and Rogi Kalyan Samitis (RKS, i.e. health facility management committees). Each level is allocated 'untied' funds to meet their needs—the VHSNCs are allocated Rs. 10 000 per year (roughly USD 167), the PHCs flexible funds totaling Rs. 175 000 per year (about USD 2900) and so on. Key planning processes envisaged include bottom-up preparation of annual District and State Health Plans (Project Implementation Plans or PIPs), with information being collected from village and block levels, and plans being consolidated at district and state levels. While these spaces have been created through the NRHM, it is argued that their potential for genuine decentralized planning has largely remained unrealized.

There is much to be learnt from the diverse approaches have been adopted across the globe to expand involvement of community representatives in planning of local health services. Notable among these are the functioning of Health Councils at various levels in Brazil (Coelho 2004; Cornwall 2008; Cornwall and Shankland 2008). It has been noted that such mechanisms of public involvement play an important role in health system development by developing a compact between state and citizens, and constitute 'regulatory partnerships' which can help manage the complex reality of health care provisioning, while ensuring that the needs of ordinary citizens are not marginalized (Cornwall and Shankland 2008). However, dilemmas for Health Councils include those of autonomy (the extent to which councils are able to effectively hold the state to account), of representation (the extent to which councils reflect the diversity of social actors and interests) and of embedded inequalities of knowledge and power between citizen representatives and health workers and managers (Cornwall and Shankland 2008).

Another significant experience related to community involvement in management and planning of health facilities is that of Health Facility Committees (HFCs), especially in certain African countries (Training and Research Support Centre (TARSC) 2004; Goodman *et al.* 2011; McCoy *et al*. 2012). In a comprehensive review of HFCs (McCoy *et al.* 2012), key determinants of effectiveness of HFCs were described as follows—'number of community representatives, their skills and training, whether they are paid or not, and how representative of the community they are . . . the attitude of health care workers towards community members, the clarity of mandate and authority of the HFC, and whether or not the health system as a whole values and enables community participation in health . . . Many of the case studies of successful HFCs also suggest the importance of external support and facilitation.' (McCoy *et al*. 2012)

The process discussed here draws insights from the literature cited above. Several authors (Rosato *et al.* 2008) have discussed the evolving notions of community participation from 'passive participation as beneficiaries' to 'active, empowered engaged citizens'. Gaventa's work on citizenship and participation—how can poor and marginalized people exercise their agency as 'citizens', how can they occupy spaces, both 'invited' and 'claimed'—has informed the project to address issues of power between users of health systems and health care providers (Gaventa and Valderrama 1999; Gaventa and Cornwall 2001). McCoy's systematic review of HFCs (McCoy *et al* 2012) and a

Table 1 Key project interventions

Sr. No.	Type of activity	Details
1.	Structured learning course on evidence-based decentralized planning of health services	The year-long course conducted in 2011–12 included 30 participants who were primarily NGO/CSO representatives from CBMP districts. Six modules were developed in Marathi (vernacular language in Maharashtra) for the course participants, covering perspectives about rights, equity, gender, public health services, social determinants of health, use of evidence/information for planning and concepts of decentralized health planning. Three contact sessions of 2–3 days each were organized, related to each contact session progress made in the knowledge of the participants was objectively assessed with the help of pre and post tests. Between contact sessions, participants carried out assignments to apply in their field areas what they had learned through the course, to facilitate participatory, decentralized health planning in the six intervention blocks in the three districts
2.	Capacity building activities for MPCs and RKS members	District and Block level workshops were conducted in project districts for members of respective MPCs and RKS members, to orient them about their role and responsibilities regarding utilization of various flexible health funds
3.	Collection and analysis of evidence for planning	Evidence was collected in the project districts as an input for preparing health plans for the next year. Services and facilities which had been rated as unsatisfactory in community monitoring report cards were prioritized for decentralized planning inputs. Additional information required for plans was collected by visiting health centres, interacting with health officials and community members. Forums like public hearings were specifically used to discuss people's planning proposals. Primary analysis of evidence was done at the local level by facilitators of the nodal NGOs. Identification and prioritization of health issues based on such analysis was followed by formulation of related planning proposals
4.	Facilitation of processes for inclusion of community-based proposals in District Health Plans	To facilitate community participation in the preparation of PIPs in project blocks, meetings with local elected representatives and key health officials at different levels were organized to discuss proposals to be included in coming year's PIPs
5.	State-level advocacy workshops	State-level workshops were organized to discuss the proposals submitted in respective districts with state-level health officials, where inclusion of the community-level proposals in the final state health plans was discussed

review of community accountability at peripheral health facilities (Molyneux *et al.* 2012) provide valuable backdrops against which the results of this project are discussed. The vast body of literature on voice and accountability (PATHS and DFID 2008) as well as social power, participation and accountability in health (Loewenson and Tibazarwa 2013) shows that efforts at democratization of health systems are underway in many low income and middle income countries.

Given this background, this article describes a participatory action research project situated in Maharashtra state of India. This initiative aimed at enabling representatives of local communities to effectively occupy the spaces for decentralized planning provided by NRHM and engage with the planning processes.

The research questions that this project sought to answer were—A. What are the barriers to decentralized health planning in the Indian context (taking the example of Maharashtra)? B. What operational processes are required to translate the formal provisions for decentralized planning into actual changes in the planning process, towards making this more participatory? C. What are key enabling conditions to promote decentralized, participatory health planning in the current Indian context (drawing on the example of Maharashtra)? (Table 1).

Methodology

Key project interventions

The background to this project was created through the process of community-based monitoring and planning (CBMP) in Maharashtra, a regular participatory audit of public health services which facilitates involvement of people in assessing and demanding improvements in the public health system (Government of India 2006; Kakde 2010). NRHM has supported CBMP processes since 2007, which were implemented on a pilot basis in nine states of India, of which Maharashtra is one. As part of NRHM, in all states and villages of India, Village Health, Sanitation and Nutrition Committees have been formed, and health facility management committees known as 'Rogi Kalyan Samitis' (literally, 'Patient Welfare Committees') have been set up in all public health facilities, which are expected to manage annual untied funds for improved functioning of the facility. Further, as part of the CBMP process in selected areas of Maharashtra, multi-stakeholder Monitoring and Planning Committees (MPCs) including health officials, elected Panchayat Raj representatives, activists of civil society organizations (CSOs) and community members, have been formed at PHC, block and district levels in defined areas, linked with a MPC at the state level (see Figure 1). The MPC at each level collates the findings from the level below, monitors the health system at its own level, and passes the results and unresolved issues up to the next level. Periodic Jan Sunwais (public hearings) with mass participation are organized to promote accountability of health providers and officials (Support for Advocacy and Training to Health Initiatives (SATHI) 2012).

Annual PIPs are prepared at block level (covering roughly 100 000 to 200 000 population) which are based on information from all villages in the block (averaging 100–150 villages per block in Maharashtra). Block PIPs are collated and synthesized to prepare District PIPs.

During the period April 2010 to September 2012, the project 'Developing capacities for using community-oriented evidence towards strengthening health planning in Maharashtra state of

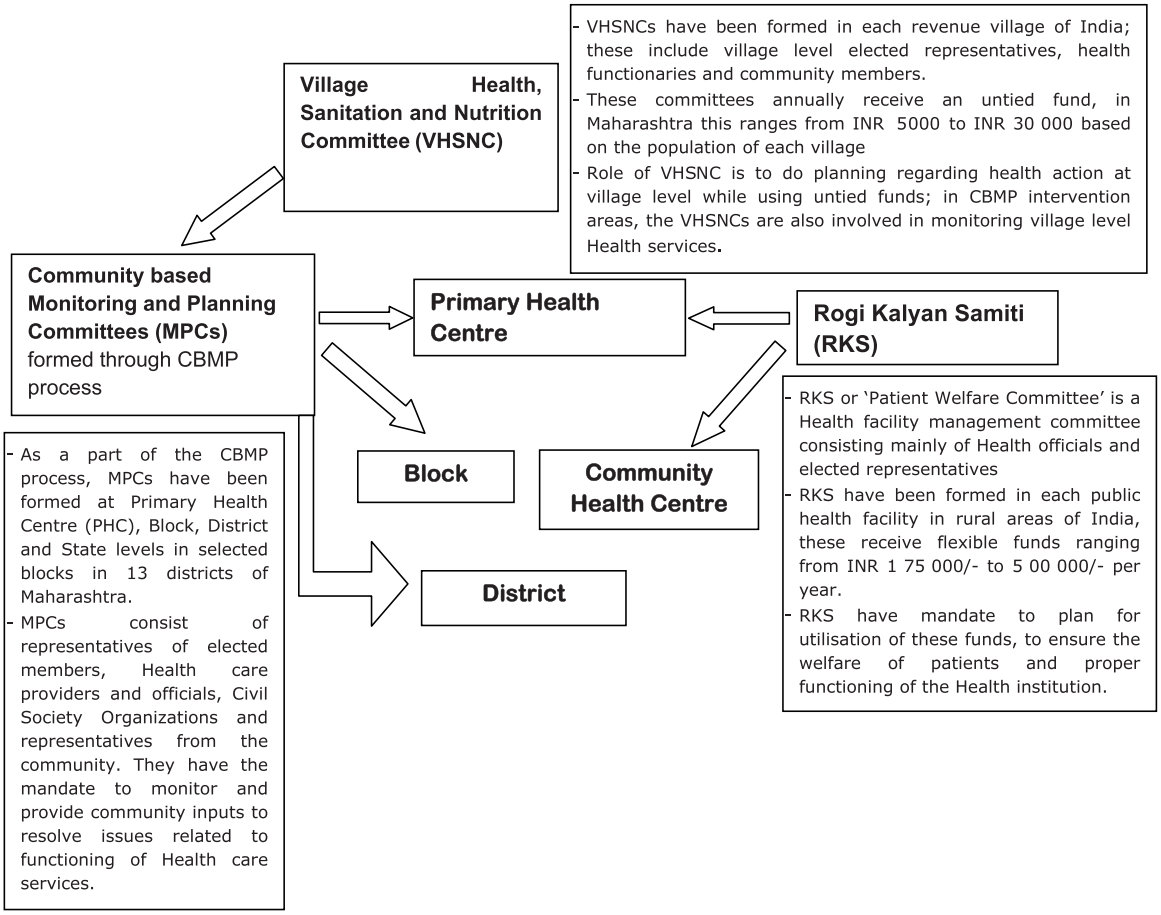

Figure 1 Outline of various committees involved in CBMP and decentralized health planning processes.

India' was implemented by SATHI in collaboration with partner CSOs in selected CBMP areas of Maharashtra. The project was financially supported by the Alliance for Health Policy and Systems Research (AHPSR) with technical support from the World Health Organization (WHO). The focus was on capacity building of community-based actors in six blocks of three CBMP districts, to promote decentralized health planning. These three districts of Maharashtra were selected based on the presence of CSOs with expressed interest in taking up decentralized planning, and demonstrated capacity for analysing local evidence and formulating suggestions to improve services, while ensuring that a range of social and health system contexts was covered by the selected districts. Main methods for capacity building were a structured learning course on decentralized health planning for CSO representatives, elected representatives and local health officials, and organizing workshops for members of MPCs and RKS (health facility committee) members.

Community-based monitoring generates evidence which is not generally available through conventional channels, namely, quality of provider–patient interface, 'informal' or illegal charges being demanded by certain providers, actual availability and time wise presence of health staff in field and in facilities, non-medical aspects of services, for example, levels of cleanliness, availability of drinking water, causes of patient dissatisfaction and so on. Capacity building activities centred around specific processes to ensure that such community-based evidence is fed into the local planning process including: community discussions to identify major areas of concern regarding health services; formulation of sets of proposals based on community evidence; active efforts to ensure spaces for participation by community-based organizations and grassroots NGOs(Non Governmental Organisations), including advocacy for issuance of state-level orders for CSOs in the RKS (Figure 2).

The strategies adopted for the project evolved as challenges emerged. Early efforts indicated that intervening in the PIP process was going to encounter resistance since planning formats with largely fixed structure were being transmitted from the Government of India to the state level, and from there to the districts, with insufficient time given for bottom up consultative processes. As a change of strategy it was decided to also focus on increasing community participation in the facility-level RKS committees, entailing capacity building of RKS members on how they could use untied funds more effectively for planning based on people's priorities.

Representativeness of project districts

The project intervention districts were purposively drawn from the larger pool of CBMP areas in Maharashtra, keeping in mind the feasibility of intervention linked with social presence of appropriate CSOs, as well as need to include a spectrum of

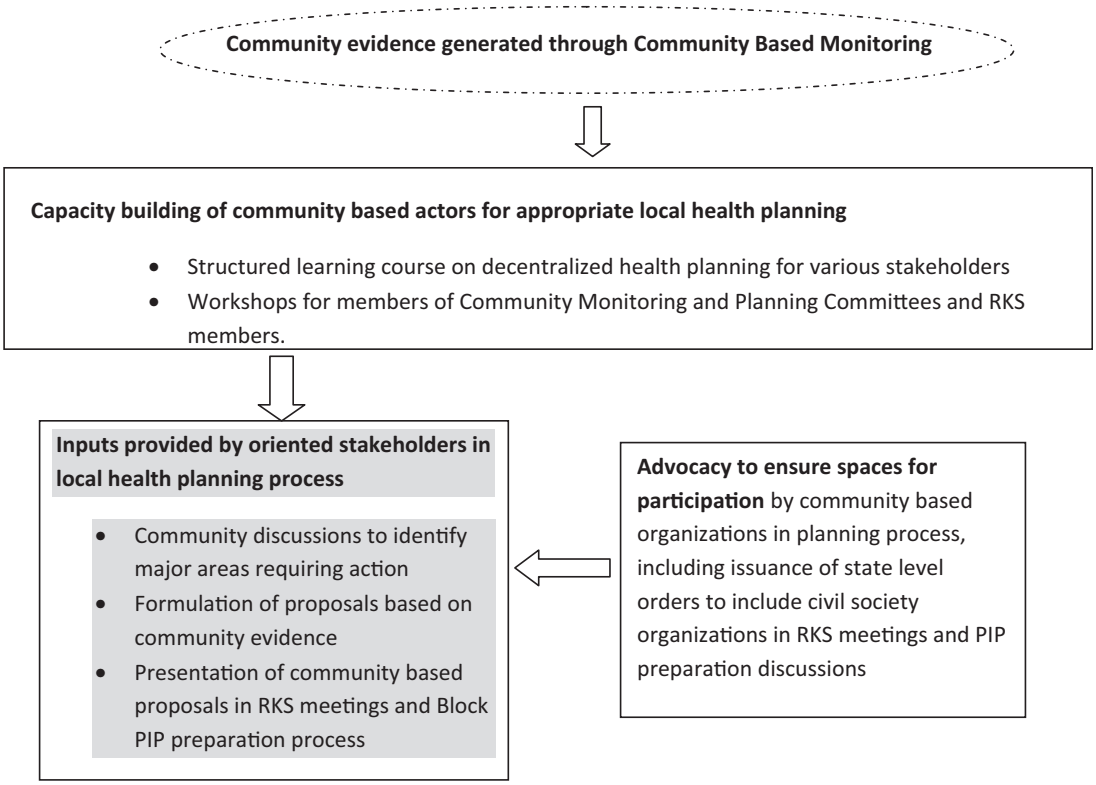

Figure 2 Relationship between key project interventions.

social and health system contexts which would reflect the broader social and health care scenario of the state. Of the three project districts, Pune is a developed district with among the best health care indicators in the state, Nandurbar is a predominantly tribal district with low levels of economic development and among the poorest health care indicators, while Amaravati has mixed tribal and non-tribal population, with intermediate health care indicators (Table 2).

Hence we can see that the project intervention districts encompassed a spectrum of contexts related to status of health service delivery in the state of Maharashtra; the three districts reflected relatively good, poor and intermediate level of access to health services, keeping in view the state averages for major health service indicators.

Evaluation methodology

An external evaluation of this action research project was carried out by three external evaluators in 2013. Since the project being evaluated was an action research project grounded in an empowerment framework, which does not lend itself easily to conventional assessment methods, the evaluation used a mixed methods approach with various qualitative and quantitative methods. Key dimensions of the evaluation included:

- Assessment of capacity building inputs: the structured learning course on decentralized health planning was evaluated by a public health specialist, by assessing the course content and resource material, and comparing the pre- and post-test scores of the participants. Further, in-depth interviews of various categories of participants were conducted, of which one aspect consisted of assessing change in their knowledge and skills regarding local health planning.
- Analysis of change in planning processes: another aspect covered by the in-depth interviews was experience of a range of actors about the results of the intervention in terms of changes in the planning process, linked with level of participation and appropriateness of planning, especially at the level of RKSs. This was the basis for documenting examples of specific positive changes in various health facilities, where decentralized planning had been implemented.
- Evaluation of planning outputs: this was carried out in detailed manner in one of the project districts (Pune) and included analysis of utilization of flexible funds available with the HFCs, with a 'before-and-after' comparative analysis of utilization of RKS funds, and comparison of PIPs in two project blocks and one non intervention block.

Thus multiple methods were used to improve the validity of the evaluation. Triangulation was attempted by eliciting perspectives of different stakeholder groups including health officials, elected representatives and civil society activists (who had significantly differing viewpoints regarding participatory planning), quantitative before-and-after analysis of RKS expenditures was carried out, and comparative analysis of PIPs in intervention and comparison blocks was conducted.

Key evaluation methods

In-depth semistructured interviews

These were conducted with a cross section of 24 participants, to gauge whether the inputs enabled them to play an enhanced role

Table 2 Key health service indicators for intervention districts and Maharashtra state

	% Children (12–23 months) received full immunization	% Women (15–49) who had institutional deliveries	% Women (15–49) who received full antenatal checkup	% Villages having subcentre within village
Nandurbar	17.0	25.4	24.3	26.2
Amaravati	61.8	63.6	38.8	30.3
Pune	86.1	83.2	52.7	57.1
Maharashtra state	69.0	63.5	33.9	37.5

Source: Indian Institute of Population Sciences and Ministry of Health and Family Welfare, Government of India 2010.

in the local health planning process. Participants included similar number of representatives from each stakeholder group (health officials, elected representatives, civil society members), covering two block-level MPCs and the district-level MPC, from each of the intervention districts. Selection of respondents was done purposively based on representation of different stakeholder groups, and the period of involvement of committee members in the decentralized planning process. The interview guide contained questions on knowledge about local health planning bodies, and experience of changes in the local health planning process. Interviews were conducted by a field investigator at the participants' workplaces. Informed consent was sought and based on consent, interviews were tape-recorded and transcribed. A senior evaluator analysed the interviews based on a set of model answers regarding knowledge of the planning process, and key parameters of change to assess any modifications in the planning process.

Comparison related to local health planning

Pune district was selected for detailed analysis of local health plans, since the SATHI team is located in this district, and has been in position to obtain less accessible information on budgets and expenditures from a number of health facilities and officials, which requires intensive follow-up.

Two forms of comparison were done during the evaluation. One was a before-and-after comparison in two blocks of Pune district, to assess frequency of RKS meetings, utilization of RKS funds, and whether community-based proposals had been included in RKS plans following the project interventions. Each of the expenditures made in RKS during the intervention year (2011–12) was analysed regarding whether that decision was linked with earlier discussion in any participatory forum such as multi-stakeholder committee meetings and public hearings. This was compared with the baseline year of 2009–10, which was prior to the planning-related capacity building interventions.

Secondly, a comparative analysis was done of proposed block PIPs (block-level annual health plans) from two intervention blocks and one non-intervention block in Pune district. The comparison block was selected keeping in mind its comparability with the intervention blocks in various respects. While Pune district has total of 15 blocks, these three blocks are contiguous and are part of a common sociogeographical region, i.e. south-western zone of Pune district. All three blocks are hilly, relatively forested, have significant proportion of remote villages with poorer physical access to public health services compared to most villages in other blocks in the district. Levels of literacy and electrification indicative of general level of socioeconomic development are similar in the study and comparison blocks. Comparison of plans was done based on analysis of the block PIPs for 2011–12, and interviews of key stakeholders in each block (health officials, elected representatives, civil society members) to identify components of the plan that had been introduced due to participatory interventions.

Some limitations and qualifications regarding the project intervention and evaluation study

This article is based on an action research project, where intervention areas have not been selected randomly, but primarily on the basis of presence of facilitating CSOs with capacity to carry out expected project interventions. However, as pointed out above, the intervention districts capture a wide range of social and health system contexts, are reflective of a broad spectrum of such contexts in the state of Maharashtra. Similarly, blocks and facilities taken for intervention and study within districts had been selected on basis of existing involvement of CSOs in these areas. Hence these areas were not selected in a strictly representative manner. This may tend to mask the overall level of impact seen in intervention areas when assessed through before-and-after comparisons, due to a somewhat better baseline of health system responsiveness in project areas, due to prior ongoing accountability work by the CSOs.

As mentioned above, standardized assessment frameworks have limited applicability in action research projects such as the one being discussed, which focus on empowerment as a major outcome (which is difficult to measure), and which are implemented in a manner that is closely tailored to complex contexts (which are difficult to compare with other settings). This needs to be kept in view while considering the validity of such studies. (McCoy *et al* 2012, Molyneaux *et al* 2012, Gilson 2012, Rifkin 2012).

Results

Results 1: Identification of barriers to decentralized health planning

From the analysis of data gathered during the evaluation, it became apparent that there are several barriers to inclusion of community priorities in decentralized health planning through current NRHM mechanisms:

- Narrow official understanding of planning, dealing only with aspects that have explicit budgetary implications, but not issues requiring health system action without financial outlays.

- Complicated structure and fragmentary formats for planning which are inaccessible for non-expert actors.
- Very little time available for developing plans, precluding consultative process required for decentralized planning; health functionaries fill formats at their level and prepare plans in a matter of few days or weeks.
- Meetings of RKS often convened irregularly and infrequently by responsible officials; inadequate orientation of RKS members, especially elected PRI members, about role and responsibilities
- Inappropriate expenditures controlled by specific officials or group of officials, 'suggested' from above.

Overall, strong vested interests tend to prevent power from being shared and planning from becoming truly participatory and decentralized.

Results 2: Increased capacity of key stakeholders to contribute to local health planning

In-depth interviews showed that there was increase in the knowledge levels of members of MPCs, which was lower among the few government officers and the elected representatives who took the training, and higher among CSO representatives. All those interviewed expressed that after the intervention, there was greater participation in the PIP process. A medical officer of a primary health centre states:

> ''Many things happened because of people's participation, e.g. repairs at the Sub Centre, staff at the PHC level, procurement of materials, were all added to the PIP. Contractually we filled up vacancies, one new Sub Centre was constructed, elected representatives were active at both village level and Taluka (Block) level while preparing PIP. Now the meetings (RKS) take place regularly. NGO representatives are invited. Funds are properly used for providing quality services. We have put up boards in facilities that have details of expenditure. This is for increasing transparency. We put labels on procured items that have details about funds, date of procurement etc. so people understand how funds are spent. It is better to let people know it before they question us. ... Number of patients have increased and so has our credibility''.
> Primary health centre medical officer in project area

Several positive changes were reported related to expenditures from the VHSNC Untied Funds. Members of CSOs reported that there was a background of several problems in the VHSNC—mainly that one of the signatories for the bank account is the Anganwadi Worker (village-level worker managing the Child Development centre) and the expenditure of the Untied Fund was strongly influenced by her superior officers belonging to the Integrated Child Development Scheme, who were giving instructions about how these funds should be spent. Training of VHSNC members on the use of the untied fund, emphasising that the fund needs to be spent on various health activities has led to the VHSNC fund now being used for organizing women's health camps in Pune district, and for transporting women to health facilities for deliveries in Nandurbar district. (Box 1 is a significant example from Pune).

Box 1: Decentralized Health Planning creates space for innovative uses of the Village Untied Fund

Informed and inspired through the orientation they received, the activated members of the VHSNC in village Degaon in Pune district expanded the Village Health, Nutrition and Sanitation Committee's mandate beyond the usual. Realising that anaemia is a serious problem among pregnant women in the village, they used the annual village untied fund to buy iron 'kadhais' (cooking vessels) for pregnant women, so that these expectant mothers could get a regular supply of iron in their diet.

The VHSNC is now also involved in inspecting quality of drinking water in the village water tank and well, and they used the untied fund for disinfecting the water and to organize house-to-house chlorination of drinking water. Part of the fund was also used to organize an educational visit of VHSNC members, to learn about use of organic fertilizers, vermiculture and kitchen gardens to improve nutrition in the village.

Source: Khanna 2013

Results 3: Preparation of participatory planning proposals

Analysis of a wide range of planning proposals prepared in the six intervention blocks showed that a spectrum of community-based issues had been effectively analysed, and then were converted into concrete planning proposals, taking into account local resources and realities, and scale of availability of funds. The plans in all blocks had been categorized as follows to enable appropriate action:

A. Plans related to need for improved implementation and responsiveness of services e.g. staff absenteeism, illegal charging, rude behaviour which could be addressed through local dialogue and actions by higher-level officials as part of the CBM process
B. Plans related to facility-level minor improvements which could be ensured through appropriate use of facility related flexible funds (RKS funds)
C. Plans related to major infrastructural modifications/construction and upgradation of facilities, which need to be addressed through the block and district PIP development process. (See Figure 3)

Results 4: Changes in use of RKS funds

In the six health facilities studied in two blocks of Pune District during 2011–12, between 21% and 59% of the RKS funds had been used for issues identified through participatory processes, compared with no such expenditures in the pre-intervention year 2009–10. Some common issues prioritized by communities included ensuring cleanliness and improving water supply in the health facilities. Given the earlier inadequate utilization of RKS funds, now expenditures from the RKS funds had increased. Total combined RKS expenditure in the three health facilities of Velhe block in 2009–10 was INR 352 318 which increased to INR 964 214 in 2011–12; since allocations had remained the same in this period, this reflected a major increase of 173% in funds utilization. Total combined RKS expenditures in the three health facilities of Bhor block had a much higher base in 2009–10 at INR 1 440 003, yet this also increased to INR 1 530 961 in 2011–12, showing a smaller

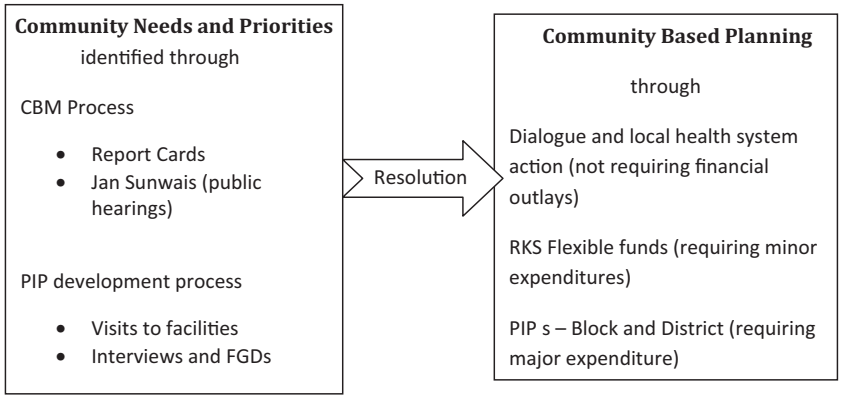

Figure 3 Planning based on community needs and priorities.

increase of 6%. The frequency of RKS meetings increased in both blocks and record keeping showed improvements in one of the two blocks. The findings indicate that spaces created for participatory planning were now being used much more effectively to resolve community-oriented issues through the RKS in the two blocks (see Box 2). In contrast, in health facilities in the comparison non-intervention block, it was observed that the RKS meetings were infrequent, with no contributions elicited from non-official members; related to drafting of the block PIP, decisions had been taken by officials at district level with no consultative processes within the block.

Box 2: Initiating decentralized planning in Nasarapur PHC in Bhor block, District Pune

Following the capacity building of RKS members, the following issues were identified and addressed in the primary health Centre during December 2011 to March 2012:

- To provide drinking water to patients, a water storage tank with inbuilt water filter was purchased.
- In order to make the laboratory more functional, a tank for water storage was purchased and a new pipe line for laboratory was constructed.
- Earlier there was no sign board showing the name of the PHC and new patients could not locate the facility easily; now a sign board was arranged through the RKS funds.
- The post of a sanitation worker was vacant and it was very difficult to ensure cleanliness of the premises. The RKS committee decided to appoint a sanitation worker to maintain cleanliness.
- Workshops on 'Right to Health' and 'Role of Adolescents in the Development of the Village' were conducted for adolescents through the RKS fund.

Source: Khanna 2013

Results 5: Action on community-based proposals included in block-level PIPs

An analysis of the issues raised through various participatory forums under CBMP in 2011–12 was done in Pune district, to see to what extent they were included in the final PIP for 2012–13. Table 2 shows the issues identified through CBMP and subsequently proposed in various PIPs. The issues mostly related to: construction of new buildings, repairs to existing buildings, ensuring water supply through new tanks and pipelines, and construction of residences for the PHC staff. These issues had emerged in CBMP processes like the Public Hearings, proposals from the monitoring committees, or through the decentralized planning workshops for PIP preparation. Table 3 shows that although the entire amount of what was asked for may not have been sanctioned, many of the issues proposed were addressed in the district PIP.

Here it is evident that significant number of local priorities in intervention blocks have been addressed through decentralized planning. However, Box 3 demonstrates that even when the state-level PIP process did not accept a proposal based on local health care needs, concerted action by diverse stakeholders within the district managed to mobilize the required resources from appropriate sources.

Box 3: Decentralized planning ensures availability of medicines for diabetes and hypertension in PHCs in Pune District

A workshop was conducted at Malshiras PHC as part of the decentralized health planning process. Among the participants were VHSNC members Radhabai and Sushilabai. With very low earnings and with no family support, they could not afford the cost of diabetic medicines, even Rs. 20 (USD 0.30) every 10 days, nor could they afford to travel to the nearest government hospital regularly to replenish their supplies. Based on suggestions given by the CBMP committee members, the medical officer started a monthly Diabetes and Hypertension Clinic in the PHC, with the help of a specialist.

After positive response from the community, to sustain this activity, a proposal was submitted by MASUM (the District CBMP nodal CSO) and the medical officer, for inclusion in the district PIP. However, the proposal was not accepted for inclusion in the state PIP. The issue was raised again in the District MPC meeting. After continuous dialogue with the Chairperson of District Health Committee (an elected person), he and the District Health Officer, decided to allocate funds from the Zila Parishad (district elected council) budget for these medicines on a pilot basis. Medicines to treat hypertension and diabetes are now available in 22 primary health centres of Pune district, a provision which is unique in the state.

Source: Khanna 2013

Table 3. Inclusion of community-based proposals in PIP for 2012–2013, Pune district

Serial no.	Types of proposals	Details	CBM forum in which presented	Results
1.	Construction of new buildings	1 rural hospital	Block PIP preparation workshop	Sanctioned in state PIP
		2 PHCs	Block MPC and RKS, public hearing	60–67% sanctioned in block and district PIP
		1 sub centre	Public hearing	100% sanctioned in block and district PIP
2.	Repairing of sub centre buildings	6 sub centres	Nodal NGO to block medical officer	100% sanctioned in block and district PIP
3.	Ensuring water supply in PHCs	4 PHCs	Public hearing	100% sanctioned in block and district PIP
4.	Building new staff residences in PHCs	3 PHCs	Public hearing	62–100% sanctioned in district PIP

Various instances of change outlined here, while appearing specific to particular blocks and facilities, are part of a wider process of change in intervention areas and exemplify the initiation of participatory processes for health planning. Keeping in view the documented baseline situation of RKS in Maharashtra, often characterized by inappropriate utilization of funds (Adsul and Kar 2013; NRHM Fourth Common Review Mission—Maharashtra, 2010) and inadequate community awareness regarding RKS (Adsul and Kar 2013), it may be stated that various positive changes taking place in intervention areas, though still on a small scale, constitute a definite step forward, from which appropriate lessons may be drawn.

Discussion

In the Indian context, despite the traditionally hierarchical and bureaucracy-dominated nature of health system planning, certain initiatives in the last few decades have shown directions for promoting greater community involvement. The decentralization experience in the southern state of Kerala linked with the People's Planning Campaign has provided a wide range of insights concerning how, with wider political facilitation and social mobilization, panchayats (local elected bodies) can take up people-based planning in various dimensions, including local health services (Isaac and Franke 2000; Elamon *et al.* 2004). In the state of Nagaland in the north-east of India, 'communitisation' of health, education and electricity services from 2002 onwards has promoted partnership between the government and the community with the aim of improving the delivery of public utility systems, based on the triple 'T' approach: to Trust the user community, to Train them to discharge their responsibilities, and to Transfer governmental powers and resources related to management (Government of Nagaland 2009; UNICEF and Government of Nagaland, 2004).

Given the background of these large initiatives to promote people oriented planning in certain states of India, it may have been expected that the RKS (Health facility management committee) model developed by NRHM would have effectively drawn lessons from such experiences. However, the evidence so far is that despite creation of certain formal spaces for participation, in practice minimal community awareness and involvement regarding functioning of RKS has been observed in diverse states such as Maharashtra (Adsul and Kar 2013), Uttarakhand (National Institute of Health and Family Welfare 2009), and Orissa (Public Health Resource Society 2009). Although levels and forms of social participation in the process of development of district health plans (PIPs) have not been studied much, there is evidence of multiple gaps and deficiencies in the district health planning process also (Centre for Budget and Governance Accountability (CBGA) 2011; Gayithri 2012).

In this context, observations emerging from this project emphasize that genuinely participatory and decentralized health planning cannot be assumed just on the basis of formal creation of bodies and issuance of official orders. Keeping in view the first research question, clear barriers have been identified which prevent people's participation in planning (Result 1), these need to be widely recognized and addressed. Some of these barriers have also been mentioned by Molyneaux *et al.* (2012) such as lack of clarity in roles and responsibilities of members of planning bodies, information and resource asymmetries between health staff and community representatives, and need for building trustful relationships in these contexts.

Related to the second research question, this project has shown that systematic capacity building and ongoing support for key stakeholders along with advocacy to expand spaces for participation can result in increased and effective participation of community representatives, and better utilization of available funds for local community-identified priorities. These findings are supported by Loewenson *et al.* (2004)—health centre committees act upon community priorities leading to improved primary health care services and improved health outcomes. Lessons from this project regarding the key role of wider community mobilization and external facilitation to make HFCs (RKS) operative, resonate with observations of major reviews of HFCs (McCoy *et al.* 2012). The project experiences underline that while organized knowledge and skills are necessary, they are not sufficient to open and democratize a closed system of power; in parallel, social processes and advocacy are essential to ensure that various relevant stakeholders are effectively included in the planning process. Involvement of active elected representatives was found to be a particularly significant facilitating factor for effective decentralized planning. The need for advocacy to enlarge spaces for participation also originates from the crucial role played by the relationship between health workers and committee members, concerning effective health facility accountability mechanisms (Molyneux *et al.* 2012).

Concerning the third research question on enabling conditions, in this study it was observed that there was greater likelihood that RKS could be activated with participatory inputs where the health facility was functional at a basic level, whereas in certain majorly under-resourced facilities, the RKS was also likely to be less functional. This is parallel to the finding that RKS are likely to be more functional in context of well performing health facilities compared to poorly performing

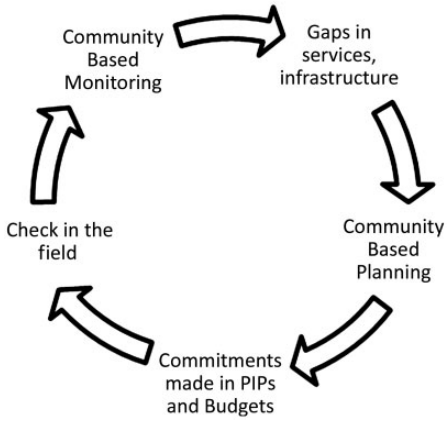

Figure 4 Community-based monitoring and community-based planning—a cycle of change.

facilities (Adsul and Kar 2013) and reconfirms the conclusion that strengthening of HCCs as a vehicle of community participation is closely bound with the strengthening of the primary care level of the health system (Loewenson *et al*. 2004).

Conceptually, it needs to be emphasized that community-based planning has been developed in continuation with community-based monitoring, and both are part of a continuous cycle having a two-way connection (Figure 4). While community-based monitoring presents the issues which should be addressed through planning, community-based planning also provides the material in terms of the commitments made that could be monitored by the community.

In summary, the project analysed in this article was found to have effectively deployed three complementary strategies to expand participation in the health planning process, namely—identifying and socially presenting people's priorities related to health services through community-based monitoring; functional capacity building of community representatives regarding local health planning; and advocacy to enlarge the spaces for participatory planning to ensure effective participation of community-based actors.

This combination of strategies draws upon the conceptual framework of 'Empowered participatory governance' (Fung and Wright 2003) which necessitates the combination of a degree of 'countervailing power' and a level of acceptance of participation by the administration, for new forms of governance to emerge. The process of community-based monitoring with its periodic public hearings and multi-stakeholder committees has fostered a level of 'countervailing power', in some areas. Capacity building of community-based stakeholders regarding local health planning has further contributed to empowerment of these stakeholders. In parallel, continued advocacy at various levels to ensure participatory spaces in the planning process has been crucial for initiating change in the governance framework. However, such initiatives for participatory governance are overall still nascent and they require much stronger promotion through policy measures outlined in the next section.

The need for further research in this emerging area has been pointed out by others (Abelson and Gauvin 2006; Molyneux *et al*. 2012) and this project highlights the potential to evolve better methods to assess the qualitative impacts of such complex interventions, by assessing how they change power relationships between community-based actors and health functionaries, and need for more refined causal analysis to understand how such community-based 'demand side' interventions interact with and complement health system-related 'supply side' interventions which synergistically result in improvements in health services.

Conclusions and policy implications

District and subdistrict planning in context of the public health system in India is a major domain of power, which has historically been largely monopolized by the bureaucracy. However, based on enabling conditions being created from above (facilitating frameworks and orders) and effective capacity building and local advocacy from below, health planning can be made more inclusive of community-based evidence, leading to significant positive changes in planning processes as well as improved functioning of health facilities.

Community-based monitoring has been an important precondition which has enabled community awareness generation around health issues, systematic identification of community-based priorities for planning and creation of pressure for change through community mobilization in events like public hearings. However, the next step of community-based planning is by no means automatic or straightforward, and this requires focused capacity building, processes for creation of consensus among main stakeholders around key priorities, and social processes as well as administrative support to ensure opening up and democratization of local planning forums.

Capacity building of local elected representatives (PRI members) needs to be a continuous, ongoing process since these representatives are periodically replaced through elections, and each new batch requires orientation to enable their effective involvement. Organized and formalized capacity building processes like a structured course on decentralized health planning are useful tools especially for civil society representatives, which need to be combined with less intensive and flexible capacity building processes like workshops and orientation meetings for stakeholders like elected representatives and local health officials, who may start with a lower level of interest, but have a very important role to play in decentralized health planning.

The existing process of nominally 'bottom-up' PIP (annual decentralized health plan) preparation, is highly centrally controlled and defined, allowing very little space for incorporation of suggestions from non-official, community-based stakeholders. There is urgent need to reconfigure this entire process at various levels, which would involve widening the planning process with effective and substantial inclusion of relevant non-official stakeholders. The strength of community-based actors and CSOs lies in their ability to collect local evidence and articulate community-based priorities, which may otherwise remain unrecognized.

Planning at the level of RKS (health facility-based committees) is generally tightly controlled by local officials, though often with formal assent of local elected representatives. However, with identification of key community concerns and capacity building of main stakeholders, including elected representatives, facility-level planning with use of flexible funds can be made more responsive to hitherto marginalized community needs. Here CSOs can play an important catalytic role by orienting political representatives, enabling them to act

on community-oriented priorities. However, civil society representatives need to be both capacitated and given some formal status in the planning bodies, to effectively exercise this catalytic role.

At policy level, based on such lessons there is need to critically review the entire health planning process from local to state levels. Ensuring adequate and regular capacity building of involved actors, enlarging space in planning bodies for diverse stakeholders including CSOs, and modifying processes for collecting evidence could ensure that organized communities and community-based groups can effectively participate in the health planning process, making decentralized health planning a reality.

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