Community Involvement in Reproductive Health:

Findings from an Operations Research Project in Karnataka, India

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Executive Summary

In July 2000, the Foundation for Research in Health Systems (FRHS) pilot tested a village health committee model in Hunsur block of Mysore district in Karnataka in collaboration with the state health department. Its impact was assessed in terms of community's involvement in planning of reproductive health services and their utilization in the community.

In this model, community selected committee members based on who had the time and interest in serving the community, as opposed to the earlier committees where ex-officio members were nominated to the committee. Adequate representation was ensured for women and disadvantaged population groups. Committees' role was to create awareness of health services; participate in community's health needs assessment, plan village level health activities and foster trust and cooperation between community and health staff. 64 health committees were formed, nurtured and evaluated in this pilot.

Community facilitators helped form these committees; provided them orientation and helped them undertake health activities in villages. The project provided one time grant of INR 2000 per committee to help initiate activities and conducted bi-annual meetings of all committee representatives where they shared ideas and experiences.

In one year, 57 out of 64 committees (89%) organized 172 health activities of different types. Activities ranged from awareness creation to diagnostic cum service camps. Attendance ranged from 50 to 350 people per activity. End evaluation showed improvement in nine out of ten health outcome indicators over 18 month period. Three-fourths of the committees enjoyed good relationship and active participation of health staff in their activities. Committees mobilized local resources and networked with local NGO for implementing health activities in the community. Half the committees remained active much beyond the project period.

Special features of these committees were: (i) people selected members through a participatory process, (ii) committees played collaborative and not controlling role vis-à-vis the health system. (iii) Committees saw themselves as active partners in the health program, responsible for periodically organizing health related activities in the community (iv) visibility and public appreciation were the only motivating factors that sustained their interest.

Factors identified for success of these committees were: (i) Credibility Building through community level activities (ii) Health system looking upon them as partners in health development. (iii) Public recognition and appreciation of committee members' volunteerism and (iv) Committees' networking capacity with local CBO and institutions.

I. Introduction

In April 1996, the government of India (GOI) decided to provide a package of reproductive and child health (RCH) services through its existing family welfare program[1]. To deliver those services GOI adopted a community needs assessment approach (CNAA) based on the ICPD principles that recognized women's right to reproduce and regulate their fertility; go through pregnancy and childbirth safely; and have sexual relations, free from fear of pregnancy and diseases[2].

To implement this approach, the GOI decided to introduce a decentralized planning approach in which health workers estimated reproductive health needs of women and prepared plans to meet those needs. Workers were also expected to involve community leaders in preparing those plans and promote community participation in the RCH program[3].

Several evaluation studies had shown that reproductive health services improved under the decentralized planning approach because health workers were relieved of the contraceptive target pressure though little was achieved in terms of promoting community involvement in the program[4]. GOI had provided guidelines to health staff on how to involve community in the decentralized planning but had not insisted on implementing them. Community leaders had no incentive to get involved as there was no devolution of funds to their level[5]. Health staff also did not like involving community leaders as they feared interference in their work[6].

Past experiences of community involvement

India has had three well-known experiences of involving community in health schemes. These were - Community-Based Distribution (CBD) scheme, Community Health Volunteer (CHV) scheme, and Link Worker scheme.

In the CBD scheme, village health committees selected "Sanyojak" (organizers) to function as depot holders, mainly for contraceptive methods. They received free supply of contraceptives from the government, which they sold for a small price. That small profit was their incentive to work as organizers.

In the CHV scheme (1977), village leaders selected health-volunteers from within villages. Government provided them training, medicine kits and a small monthly honorarium. CHVs provided treatment for minor ailment and motivated couples to accept contraceptive methods. This scheme was discontinued in 1983 when CHVs demanded absorption in government service. They considered themselves village level government

functionaries. Subsequently some state governments initiated similar schemes under different names like Sahiya, Sathin, Tai etc.

In the Link Worker scheme, government appointed volunteer couples from among villagers and paid them a small honorarium to function as contraceptive depot holders. They promoted contraceptive use in their communities as long as the government paid them the honorarium.

Community involvement in all these schemes meant appointing volunteers from the community. Volunteers performed certain tasks assigned to them. In return they received honorarium or incentive from the government. Non-government organizations who successfully involved community volunteers in their health programs also paid honorarium to volunteers. In addition they ensured that communities had significant role in selecting them and that volunteers received adequate training and support.

Some states governments adopted mechanisms such as *Mahila Swasthya Sangha* (MSS i.e. women's health group) and *Village Health Committees* to improve community involvement in health programs. A highly successful of such mechanism was Kerala's People's Plan. It involved the people in identifying development issues in their areas, in deciding resource allocations and in carrying out social audit of development programs. The state devolved 35-40 percent of its plan funds to local self-government as well as provided clearly articulated project formulation & resource allocation guidelines to help curb misuse of funds by local vested interests [(7)].

Compared to the Kerala experience, *Village Health Committees* and *Mahila Swasthya Sangha* (MSS) were much less effective in promoting community involvement in health. Studies showed that these committees were usually dominated by village elite; committees confined their roles to mobilizing people and support during pulse polio or family planning campaigns [(8)]. Health staff used them to spread health messages but rarely for planning or monitoring of health programs.

Government of Karnataka, under the Ninth India Population Project (1997-2002), had tried to form Sub-centre *Health Advisory Committees* to promote community participation in the health and family welfare program. Each committee consisted of 8-10 members, with *panchayat* leader as its president and female health workers as its member secretary. Other members were development functionaries like *mukhya sevika* (Nutrition worker appointed under the Integrated Child Development Scheme), local doctors and prominent women from community. The state government had directed female health workers to constitute these committees and had provided Rs.200 / per month to cover their meeting expenses. Most health workers however had either not formed those committees or had not activated them because they had no use for them.

The Foundation for Research in Health Systems (FRHS), which is a non-government health research organization decided to undertake an Action Research project aimed at making Health Advisory Committees

effective and useful in planning & implementing the government's reproductive and child health program. Government of Karnataka agreed to participate in this project, which involved modifying, activating and pilot testing the *Health Advisory Committee* concept in Hunsur block of Mysore district in Karnatak. The project was carried out from July 2000 to June 2002.

Action Research Setting and Design

Mysore district is located about 200 Km from Bangalore City in the southern most part of Karnataka, one of the progressive states in India. Its population is about 2.6 million, divided into 7 blocks (smallest administrative unit in rural India) one of which is Hunsur. Hunsur block has a population of about 258 thousand, spread over 216 villages. It has 14 primary health centres and 70 sub-centres of which 64 are rural sub-centres and 6 urban. Hunsur is the largest block in the district and has a mix of tribal and non-tribal populations, irrigated and non-irrigated areas, and different economic levels.

Hunsur town is well connected to Mysore City by road. Government buses ply on this route rather frequently though 25 percent of villages in the block are not connected to this route. Hunsur town is situated on the state highway linking Karnataka to the neighbouring state of Kerala. It is close to the Nagarahole National Park, a major tourist attraction. The block has a Tibetan refugee settlement spread over five out of its 64 rural sub-centres. Refugees live in small settlements (*Haadis*) away from main villages.

The project design required selecting a control block, which is similar to the experimental block in socio-economic conditions. The Government insisted on selecting Narsipur as the control block because it was similar in size and population composition though had somewhat better RCH indicators because a reputed NGO was already working in that area and was promoting community participation using WHO's rapid rural appraisal methodology. By taking Narsipur as the control block, the government wanted to also find out which approach worked better. The project used "before" and "after" measurements both from the experimental and control blocks.

To brainstorm about how to reactivate the "failed" Health Advisory Committee model, FRHS convened a meeting of health staff, active women *panchayat* leaders, local NGOs and representatives of youth groups and mothers' health groups (MSS). In this meeting, health staff voiced apprehensions about the project and its chances of success. Community leaders were largely supportive. They however all discussed what might and might not work and came to the conclusion that health committees would work only if:

- Committee members are selected by community and not by Government staff
- Committees have men and women as members and also caste representation
- Committees have some seed money to facilitate start-up activities
- Committees get help, at least initially to decide what to do or not to do

FRHS accepted all these recommendations and accordingly decided the committee structure, formation process and committee's role.

Committee structure

- Health Committees would be formed at sub-centre level with representation from all constituent villages
- Each member would represent a cluster of 50-60 households in a village
- Each committee would have at least fifty percent women members
- Committee members would select president and secretary from among themselves
- Health workers and anganwadi worker would be invitees to committee meetings but would not have formal role in it.

Formation process

- Health staff would use village maps to identify clusters of households of different castes and communities
- From each cluster of 50-60 households, health staff would suggest potential candidates for health committee
- This list would be discussed and the committee members would be finalized in the *gram sabha* meetings

Committee's Role

- Committees would undertake activities to create health awareness about health services
- Participate in identifying people's health needs and in developing activity plans
- Foster trust and understanding between community and health staff

To help implement this model, FRHS appointed Community Facilitators (CF), one per two Primary health centres. They were to form health committees, orient committee members in their roles and responsibilities and guide them in fulfilling their roles.

II. Implementation Process

Implementation of this project began with a baseline survey in the experimental and the control blocks. After the survey, CFs initiated the process of forming health committees.

1. Baseline Survey

A household survey gathered baseline data on awareness and utilization of RCH services in Hunsur (experimental) and T. Narsipur (control) blocks. The sample consisted of 1000 women of reproductive ages. Sample was selected from 30 randomly selected villages from each block using the same sampling technique

and survey instruments as were used in the RCH surveys [9]. The survey mainly showed that the beneficiary coverage in the area was reasonably high but service quality was rather low. For example,

- Contraceptive acceptance was 72% but about a third of the acceptors reported suffering from contraceptive side-effects.
- Almost all pregnant-women received antenatal care but less than one-third of them had received "full care" consisting of 3 ANC visits, TT and adequate supply of Iron Tablets.
- One in four women reported suffering from at least one symptom of RTI but less than one- third of them had sought treatment for those symptoms.
- More than half the women had heard about AIDS but did not know how it could be prevented.
- Child immunization coverage was high (96%) but practice of immediate breast-feeding was low (31%).
- Only one in five babies were weighed at birth; less than half of mothers knew about giving ORS to children during diarrhoea episode.

The experimental and the control blocks significantly differed only on a few indicators: contraceptive side effects, institutional deliveries, and women knowing about ORS. Hunsur block was below the district average on 6 out of 12 RCH indicators (Table 1).

Table 1: Summary of Baseline Survey

Sr	Indicator	Hunsur N1=1057	Narsipur N2=1048	Mysore	Karnataka
1	% Couples Using FP method	72.0	67.0	65.1	57.9
2	% Reported contraceptive side effects	34.0	17.0	10.7	16.2
3	% Pregnant women sought prenatal care	94.6	98.3	95.2	88.9
4	% Received 3ANC visits+ TT+ IFA	74.1	84.7	75.8	60.1
5	% Institutional deliveries	34.1	50.3	59.5	50.0
6	% Deliveries conducted by trained staff	40.1	55.8	64.9	60.0
7	% Sought treatment for RTI	33.2	29.2	50.5	53.8
8	% Women had heard about HIV / AIDS	62.2	69.4	53.1	60.7
9	% Reported immediate BF	31.9	15.0	37.2	31.7
10	% Babies weighed at birth	20.8	34.4	48.2	42.5
11	% Mothers knew about giving ORS to children with diarrhoea	47.3	19.4	41.3	38.3
12	Children fully immunized	96.0	97.0	92.7	71.8

2. Health Committee Formation

After the baseline survey was completed, CFs began the process of committee formation. Health workers mapped out all villages and marked clusters of 50-60 households that belonged to different castes and communities. Health workers, who were familiar with the area, recommend potential health committee members. Those, not familiar took help from Anganwadi workers in deciding potential members. Health workers then were to get those lists approved in the *gram sabha.* Instead they approached the *panchayat*

leaders to get those lists approved and found that *panchayat* leaders did not approve those lists. They suggested other names, which the workers did not agree to. They sometimes argued about who should be deciding health committee membership-- health workers because they had to work with committees; leaders because they knew what was good for their people.

That conflict led us to the idea of resolving this issue through an embedded experiment. We assigned three PHC-areas to *gram sabha* method, two to *health worker* method*;* two to *panchayat leader* method and in 7 PHC-areas we decided to try a combination method for selecting committee members.

In the ***Gram sabha*** method, CF in consultation with the panchayat president convened the *Gram sabha* to inform members about the project and the role of health committees. Members were then asked to suggest names of individuals from different clusters. If those individuals were present in the *sabha*, their consent was taken. These meetings typically lasted for one to two hours but took a long time to schedule. G*ram sabha*s often got postponed or cancelled due to wedding, death or festival in villages. We took over three months to form 16 committees. Also the method required substantial amount of CFs' time. *Panchayat* Leaders would call *Gram sabha* only if CFs requested them and only if CF agreed to be present at the *sabha*.

In the ***health workers*** method, the worker listed potential committee members and finalized the list by consulting a few formal and informal village leaders. Workers usually accommodated the changes leaders suggested, if any. In terms of time taken this method was efficient. Workers could form nine committees within one month, without making any demand on CF's time.

In ***panchayat leaders*** method, CF requested the leaders to nominate members to health committees who would represent each cluster of 50-60 houses. *Panchayat* leaders typically took time to consult other panchayat members. This method took about two months to form 11 committees because leaders were either busy or not available whenever CFs visited them.

In the ***combination method***, health workers listed potential committee members but instead of consulting a few village leaders individually, they called a meeting of panchayat leaders, members of SHG, youth groups, caste leaders, anganwadi worker and teachers to finalize the list. This way, they formed 28 committees in 3 months, without involving the CFs.

3. Orienting committee members

After committees were formed, CFs organized orientation meetings for them to discuss:

- Their roles and responsibilities
- Community Needs Assessment approach (CNAA) under the RCH program
- Problems people usually face in getting services at PHC
- Actions expected of health committees

PHC staff attended most of those meetings. Meetings typically began with CFs explaining the purpose of the project and health committees' role in it. They specially emphasized the "active-collaborative" role envisaged for the health committee for the benefit of the community.

Health workers would then inform committee members about Community Needs Assessment (CNA) approach under the RCH program and present health data collected from their villages. Most members would express satisfaction with the data; some would express doubts about its accuracy.

Committee members would then discuss problems people face in getting services at PHCs. They would complain about health staff not being friendly, doctors not giving free medicines, health staff demanding money or not being available etc. These complaints would sometimes upset the health staff but most of them would respond politely. During these discussions, CFs would repeatedly explain that committee's role was not to find fault with health staff but to work with them to improve the situation. Through such interventions, most orientation meetings would end cordially though they would have begun belligerently.

At the end of the orientation meeting, CF would ask committee members to decide on its first activity, which they would implement within a month or two. Since the key to activating health committee was success of the first planned activity, CF would urge them to select activities that were easy to implement. Later, CF followed each committee to find out if those activities were being implemented and help them in the implementation.

4. Inputs Provided to Support Committee Functioning

The project provided five inputs to support the health committees:

1. Community facilitators
2. A one-time grant of Rs. 2000 per committee
3. Identity cards for committee members
4. Bi-annual meetings of committee presidents
5. Publication of a monthly newsletter

Community Facilitators (CF) helped to form and nurture committees. CFs were young men and women with college education and experience of grass roots level development work. Of the 7 CFs appointed, five belonged to Mysore district and two came from elsewhere in the state. They all had good communication skills; were good listeners, respectful of community and were highly motivated to work as facilitators.

They attended all committee meetings and participated in all health committees' activities. Initially, they gave ideas to committee members about activities they could organize; identified local resource

persons/organizations who would provide support, and ensured that committees maintained accounts of funds collected and expenses incurred.

A one-time grant of Rs. 2000 was provided to each committee to meet its initial expenses. This amount was handed over to them during committee meeting and in instalments, according to committees' activity levels. Members collectively decided where to keep that amount and how to spend it. Committees spent that amount in organizing health activities and rarely on themselves, not even for reimbursement of their travel expense.

They maintained accounts of receipts and expenses and reported those to CFs every month. These reports showed that over 90 percent committees had spent the grant judiciously and more than half of them had mobilized additional resources through contributions from members and others.

Identity cards were given to committee members to legitimise their role and to boost their status in the community. District health officer supported this idea as a way of showing appreciation for their voluntary work. Some PHC doctors initially opposed the idea, fearing that members would misuse the card to demand special privileges for themselves. CF therefore, informed the members that the cards did not entail them any privileges and cards would be withdrawn if health staff complained about any misuse.

Presidents' meetings at block level gave them opportunity to share experiences among themselves and with district and state health officers. During these meetings, CFs paid a lot of attention to see that all committee presidents felt important and respected. They all sat around a large table. Each had a name-plate in front and each got 5-7 minutes to address the gathering. Health officers listened to them and promised cooperation. These meetings were very successful in terms of attendance and in stimulating presidents' interest in the project. Meetings were organized at the interval of 6-months. These meetings were meant to make health committees visible and to create a platform for meaningful dialogue between health officers and community representatives.

Monthly newsletter informed village health committees about different programs, especially innovative programs being organized in the project area, with names and photo. It also included other items such as a PHC doctor's speech on the World Population Day, nutritious recipe by an *anganwadi* worker, findings from a local study on hysterectomy, etc. The newsletter became a prime tool for motivating committees to do more and better programs. When the Newsletter, for example, reported about a committee organizing an eye-camp, five other committees followed the suit.

III Health Committees' Performance

In this section we present data on how well health committees performed under the three roles expected of them namely:

- Creating awareness and demand for health services
- Participating in community's health needs assessment and health planning
- Fostering trust and understanding between community and health staff

Role-1: Creating health awareness and demand for health services

Most health committees first focused on creating health awareness by organizing awareness cum service programs. In one year, 57 out of 64 committees (89%) had organized 172 programs of 18 different types (Table 3). On an average, committees organized three programs per year.

Committees decided on the program in consultation with the health staff. CFs encouraged them to undertake programs in RCH focus areas like adolescent health, family life education for newlywed couples, treatment of RTI/ STI etc. They also helped them incorporate games, songs, skits, quiz etc. to make programs interesting. Committee members followed popular traditional practices like inviting pregnant women personally by going to their homes and honouring them by giving fruits, coconut and token gifts. These special features made most programs very attractive, as one young mother said,

"I was reluctant to come but I am glad I came. They honoured me and made me feel good."

All programs were well attended. Attendance ranged from 50 to 350 people per program. Adolescent health was the most popular program. Over 60 percent committees had organized this program. Other popular programs were prenatal care and nutrition awareness program for mothers. Many of them got reported in local newspapers. As committees gained experience they moved on to diagnostic and treatment programs with the help of local service NGOs.

Table 3: List of programs carried out by committees as of June 2002

Sr.	Name of program	No. and % by type of program	% Committees carried out programs
1.	Awareness program for adolescent boys and girls	35	62
2.	Awareness program on ANC care	32	56
3.	Awareness program on nutrition for mothers	28	50
4.	Awareness program on diarrhoea control and ORS	13	22
5.	Village cleanliness drive involving school children	13	22
6.	Health awareness program for newly- wed couples	11	19
7.	Awareness program on government health services	09	16
8.	First –aid training for committee members	05	9
9.	Free eye check – up camp**	05	22
10	Awareness program on RTI/ STI	04	7
11	Getting water tank cleaned in the village	04	7
12	Awareness program on gender sensitisation*	03	5
13	Anti- malaria drive	03	5
14	Awareness on prevention, Control and treatment of ARI	02	3
15	Free health check- up	02	3
16	Celebrated World Health day/ Women's day	02	3
17	Training committee members to weigh newborn	01	1.7%
18	RTI/ STI detection & treatment camp**	01	5%
	Total programs	172 (100%)	89%

**: Even though there were only three programs specifically on gender sensitisation, gender issues have been addressed in all programs on nutrition, pregnancy, adolescents and newly- wed couples.*
*** 2-3 committees usually jointly organized diagnostic and treatment camps*

Role-2: Assessing communities' health needs

By organizing health awareness activities, health committee members had learned about various components of the RCH program but they were not involved in developing RCH plan. Some members sporadically accompanied health workers doing the needs assessment surveys. Some used that data to decide what activities to undertake. One committee, for example, planned mother care awareness program because the needs assessment data had shown low level of institutional deliveries in the area.

Committee members had different ideas about needs assessment than undertaking Needs Assessment Survey. Some wanted to give money for medicine, transport etc to the "real" poor during their health emergencies. They quickly however realized the danger in this approach. "*If we start giving money, everybody would claim to be poor. Then we would be inviting trouble*", they said.

- Some committees proposed the idea of helping the poor get benefits of various government welfare schemes such as the old age pension, rehabilitation for disabled persons etc.

One committee, for example, found many malnourished children among the poor. Since that village did not have an anganwadi, they decided to undertake growth monitoring of those children every alternate month with the help of anganwadi worker from the neighbouring village. Another committee found many physically challenged children among the "poor" households. They arranged an "awareness cum service" camp for them through the District Rehabilitation Centre. At the time of this evaluation, five committees had developed such plans.

Role 3: Building trust and communication with health providers

From the beginning, committees were oriented to viewing health staff as partners and to seek their involvement in committees' activities. Most committees invited health staff as resource persons to their programs. Local newspapers published health staff's names and photos when they attended committees' programs. This pleased the health staff and they started helping committees contact resource persons/institutions for their activities. One worker suggested the committee the idea of organizing an eye-camp because there were more than 40 cataract cases in the area. She also helped them contact the eye specialist at the Taluk hospital. The committee acted on her suggestion and organized an impressive camp, which became a model for other committees to follow. In another instance, a PHC doctor put the committee in touch with a charitable trust for organizing Eye-camps.

During the project, interaction between health staff and committee members increased, which brought many positive changes in health staff's attitude towards them. Out of 64 committees, 22 (34%) developed very good relationship with health staff while 23 (36%) developed moderately good relationships. This assessment was based on CF's observation regarding how regularly health workers attended committee meetings, participated in committees' activities and whether showed respect to each other. At the beginning of the project, only 20 percent of health staff had supported the health committee idea. In the end evaluation, nearly 80 percent of them had positive things to say about health committees. One health worker reported, "*if we are friendly with committee members they ease our burden in the field"*.

IV: Project Evaluation

After completing the 2-year project period in June 2002, the project was evaluated using some process and some outcome indicators (Box 1). Process indicators assessed were: community's involvement in health committees' programs; committees' ability to mobilize local resources and local CBOs, including *panhayats*, for health activities. Outcome indicators assessed were increases in awareness and utilization of RCH services. Data for evaluation was gathered from household survey, from interviews with health staff, committee members and panchayat leaders.

Box 1: List of Process and outcome indicators

Process Indicators
1. % Committees conducting health activities
2. % Committees mobilizing local resources for their activities
3. % Committees demonstrating networking capacity
4. % Committees having respectful and supportive relationship with health staff
Outcome Indicators
1. % Pregnant women received full pre-natal care and safe delivery
2. % Women self-motivated to use contraceptive methods
3. % Women knew about RTI/ STI and sought treatment in case of problem
4. % Women followed appropriate child care practices

Performance on Process Indicators

Process indicators measured the extent to which health committees succeeded in getting community involved in their activities, mobilizing local resources, networking with CBOs, and getting cooperation from health staff.

Community involvement in health Activities

Out of 64 committees formed, 57 were active at the time of this evaluation; 3 had stopped functioning and 4 had never become active. Two stopped functioning because of disagreements between health staff and committee presidents. The third one stopped functioning because the president did not take interest in it but controlled the fund. Four committees never became active because workers could not participate in committee meetings. Workers were too busy as they were holding additional charges of other sub-centres. Committee members were also not too enthusiastic.

The 57 active committees had carried out 172 programs in a period of 10 months, average one program per quarter. Among them, 17 were "very active" who managed to conduct health programs every alternate month. The remaining 40 were "moderately active", organizing programs once in 4-5 months (Table 4).

Moderately active committees had typically started off well by organizing large programs, attracting many participants. But then the fatigue set in and they organized smaller programs after considerable time gaps. The very active committees had organized manageable size program, more frequently.

Table 4: Activity level of committees by programs, attendance and expenditure

Activity Level of Committees	Av. Number of programs per committee	Average Attendance at programs	Average amount spent per program
Very Active (17)	4.88	50	403.8
Moderately Active (40)	2.23	45	401.6
Total Active (57)	**3.02**	**47**	**402.6**

"Very active" committees usually took up new types of activities. One of them had organized RTI/STI detection camp by inviting a local NGO to provide services. Another committee had organized an adolescent program; a third one took initiative in organizing an Eye camp. These activities became models for other committees to follow. All activities were very well attended; committees took care to see that these occasions became interesting and festive.

Of the 62 committees, 25 (40%) reported receiving encouragement from people within the community to do more. 32 committees (50%) needed some 'pushing' from CFs. They needed to be reminded, given ideas and support. For 7 committees, no amount of effort helped activate them.

Over 42 percent households reported knowing about health committee activities or having participated in them (table 5). People's participation was uniform across caste and education groups but it was less among the very poor households (29%). This finding was rather unfortunate though not entirely unexpected. The poor benefited the least because they could not afford the time for it. Many committee members were aware that the very poor were not participating. They constituted about 10 percent of the total households and they perhaps needed a different type of approach.

Table 5: Participation and knowledge about committee by household characteristics

HH Characteristics	No. of households N=1050	% Knew or had participated in committee activities
Illiterate or functionally literate women	690	48
Educated women (4 years +)	302	58
SC/ST	522	46
Other castes	512	52
Poor households	62	29
Not-so-poor households	988	50
Total	**1055**	**42%**

Missing data: Education level not known (58), Caste not known (16)

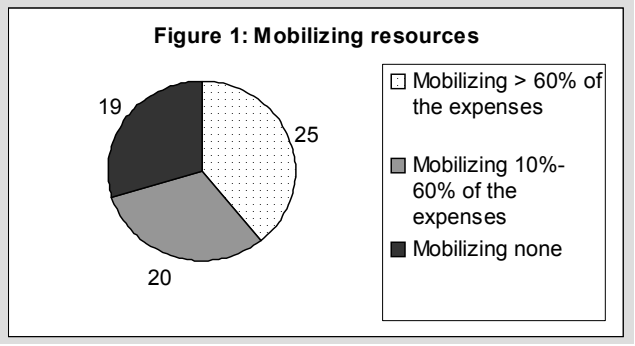
Mobilizing resources

FRHS had provided a one-time grant of Rs. 2000 to each committee to get them started. Many committees generated additional resources from local philanthropists, *gram panchayat*, SHGs, and religious establishments. They usually mobilized resources in kind or in services, to avoid cash transactions (Box 2).

Out of 57 active committees, 25 had generated over 60 percent of their expenditure locally, 20 had generated

Box 2: Illustrations of committees mobilizing resources

When *KM Halli* village committee decided to organize an adolescent awareness program in a local school, they invited teachers and headmaster to their monthly meeting. Headmaster and teachers agreed to allot one whole day for the program. The Committee president called State Resource Centre (SRC) in Mysore to confirm their availability. Committee members requested a local religious establishment to make food arrangements. They obtained a mike system free of cost and could hire a hall at a nominal charge because this was a social cause. *"We prefer to take help in kind because then everyone can see how we are using their contribution and there is no room for suspicion",* said the president.



less than 40 percent while12 had generated none (Figure 1).

Out of the initial grant of Rs. 92,500 they had spent about 21,000; had mobilized over 48,000 in kind and had saved about Rs.71,500 for future activities.

There were only three instances where presidents had kept some of the one-time grant

Networking with local CBO

More than half of the active committees showed capacity to network with other CBOs, NGOs and panchayats. Some of them organized joint programs. They invited other NGOs to help them carry out activities (Box 3). SHGs, Continuing Education Centres (CEC), and youth groups were active in nearly all committees.

Box 3: An Illustration of networking capacity

Ratnapuri village committee was a very enthusiastic committee. It conducted an ANC program within a few weeks of its formation. Their second activity was an eye camp. The committee president asked PHC Medical Officer (MO) to suggest whom to invite. MO put him in touch with a Trust he knew in Mysore, which was conducting eye camps for the District Blindness Control Society. President convened a meeting of PHC staff, Presidents of other health committees in that PHC, a local NGO, bankers association, transport owners' association, SHG facilitators, *panchayat* presidents and facilitators of Continuing Education Centers (CEC) to discuss arrangements and funds for the camp. Each group agreed to take up a particular responsibility. On the day of the camp, the CEC facilitators made the camp arrangements. SHGs listed persons with eye problems and brought them to the camp. *Panchayat* presidents supplied food. Transport Owners' Association made vehicle arrangement to transport 32 cataract patients to Mysore and back, free of cost. NGO made arrangement for publicity and Bankers Association contributed money. About 300 persons got their eyes examined in the camp.

Almost all committees enjoyed good relationship with panchayat leaders. *Panchayat* representatives regularly participated in committees' meetings and even contributed funds for some of the activities. Only in five cases, panchayat members had created trouble for committees. In one case, the trouble was because of factionalism in the panchayat. In remaining four cases, committee presidents were also the panchayat leaders who had no time for the committee work but would not allow other members to function without them.

Most committees had managed to strike a balance between involving panchayat leaders and not allowing them to control committees. Many panchayat leaders viewed committees as making meaningful efforts to improve people's health. As one of them said, "*we have learnt a lot from our health committees. This is the only time*

we have been meaningfully involved in improving health of our community". Some panchayats had transferred funds for chlorinating village water supply to committees, to carry out that work.

Relation with health staff

SF had paid special attention to see that health committees develop collaborative relationship with health staff. This task initially seemed difficult because 80 percent of health staff had opposed the "committee" idea. They had feared that committee would try to control them or interfere with their work.

Over time, 70 percent (55) committees managed to develop "average" to "very good" relationship with health staff; only 30 percent committees reported "poor" relationship. "Very active" committees reported "good" relationship while "non-active" had reported "poor" relationship (Fig 3). The credit (or discredit) for maintaining good (or poor) relationship was shared equally by health staff and committee members.

Committees reported "good" relationship when health staff gave them ideas and helped them conduct programs. Members were friendly with the staff, showed concerns for workers' safety, heavy workload, and family problems.

Committee with average relationship typically reported that health staff did not get involved in committees' activities because they were either too busy or not interested. Committee members also did not insist that they get involved. Both adopted a "live and let live" policy.

Where health staff was either too busy or not interested but committees insisted that they get involved, the relationships had turned sour. In two such instances, committee presidents had complained about health staff to district officers. In another, health staff had tried to disrupt committee activities by inciting community members not to participate.

Performance on Outcome Indicators

In terms of improvement in awareness and utilization of RCH services, the household survey showed gains over the baseline on all indicators except one. Significant gains were found in institutional deliveries (from 32 to 39 percent), women seeking treatment for RTI/STI (from 31 to 56%) and weighing of babies at birth (from 21 to 43%).

Table 6: Status of outcome indicators

Sr	Indicator	Experimental Block		Control Block	
		Baseline N=1057	Endline N=1050	Baseline N=1048	Endline N=1052
1	% Couples Using FP method	72	75	67	73
2	% Pregnant sought prenatal care	95	97	98	99
3	% Received 3 ANC visits + 90 IFA + TT	30.	37.	64	48
4	% Institutional deliveries	32	39	50	57
5	% Sought treatment for RTI ***	32	56	28	56
6	% Women knew about HIV/ AIDS	62	66	69	73
7	% Reported immediate Breast Feeding	32	34	15	32
8	% Babies weighed ***	21	43	34	50
9	% Women knew about giving ORS	47	23	19	13
10	% Children fully immunized	96	92	97	96

*** Significant improvement

However, there was a significant decline in the proportion of women saying, "they would give ORS to their child with diarrhoea" (from 47% to 23%) and increase in women saying "they would take child to doctor/hospital" (from 27% to 59%, not shown in Table 6). These findings came as a surprise because many committees had organized ORS programs, inviting health staff as resource persons. Those programs had demonstrated to women how to make ORS; held ORS making competition for school children and organized talks by health staff. Unfortunately, those talks had always ended with the message, "ORS is a primary level treatment. If diarrhoea persists take the child to doctor". Women perhaps had registered that message better than about giving ORS.

Additionally, the Experimental and the control blocks showed comparable performance on all 10 outcome indicators though the experimental block had started low on 4 out of 10 of them (Table 6). The control block was doing better at the baseline because it had a well established health NGO providing health services and promoting community participation through a WHO project. The experimental block recorded higher rate of gain on most indicators. From government's view point, Hunsur model was more efficient because it showed increased utilization of existing services.

Evaluation of Committee Formation Methods

Finally, we evaluated the four committee formation methods using 8 performance indicators (Table2). Since we considered all those indicators equally important we gave them equal weight to arrive at the overall performance score (Table 2).

Table 2: Committee performance by method of formation

Sr.	Indicators	Gram sabha	Health worker	Panchayat leader	Combo method
	Number of Committees	16	9	11	28
1	% Committees with >50% women members	75	56	27	43
2	% Committees with >40% SC/ ST members	56	33	64	50
3	% Committees conducted at least one program	94	78	100	86
4	% Committees maintained good relationship with health staff	82	78	36	75
5	% Committees Mobilized resources	88	56	63	79
6	% Committee meetings held regular meetings	58	45	53	54
7	% Members attended committee meetings	44	38	34	48
8	% Committees members shared tasks	69	30	64	71
	Total Score	566	414	441	506
	Average Performance score	**71**	**52**	**55**	**63**

This analysis showed the *gram sabha* method to be the most effective. It scored better than the "combination" method on all indicators except two (7 & 8). It performed especially well in giving representation to women because CFs had ensured that women participated in the *gram sabha* meetings and their voices were heard.

Though most effective, *gram sabha* method was also the most time-consuming. It had required a lot of CFs' time because health staff was not able to convene *gram sabha* meetings. CFs were able to because villagers responded to them better because they were outsiders. Health workers did not get the same response from *gram sabha* and hence this method did not seem feasible without outsider's involvement.

V. Discussion and Summary

Though the idea of village health committees was not new, this project tested a new model of health committee. Earlier health committees had village level functionaries like schoolteachers, Anganwadi teachers, Panchayat leaders, and influential community persons as members. Members' role was to attend meetings that health workers organized and sometimes helped them in Pulse polio campaign or in recruiting family planning cases.

In this model, members represented different clusters in the villages and they actively participated in organizing programs to improve awareness and utilization of health services. They had no financial or administrative power over the health staff. They were expected to work in collaboration with health staff.

Initially, health staff doubted committees' ability to actively participate in health programs. They were also worried that committee members would interfere in their work and harass them. The initial orientation meetings did confirm those fears when many members asked questions like, 'Why do doctors take money?' 'Why do they always give prescription? Who gets free medicines that government buys?' 'Why does health worker come late?' At that stage many doctors and health workers wanted to opt out of this project.

Fortunately the District Health Officer persuaded them to stay on saying, *"community participation is a government policy"*.

Community leaders wanted health committees to function as a watchdog of the health system and report on the functioning of health workers. However, the role envisaged for them in this model was that of a bridge between community and health staff, which they played rather well. This section describes the factors namely, *credibility, organization capacity and motivation* -- helped them play that role.

Credibility

Building of committees' credibility was very important to help them play the bridge role. Since the government had not formed these committees the health workers were not sure if they needed to cooperate with committees. *Panchayat* members also wondered why these new committees when they already had health standing committee (though not functioning). Committee members themselves were not sure about the legitimacy of their role.

Some committee members therefore requested for an ID card to legitimise their role. As they began to organize programs inviting health staff and as news about those programs began to appear in local newspapers, their credibility increased. NGOs in the area began to express interest in working with them.

The one-time grant, though small, also helped build credibility. They could spend some money up-front for their activities. It helped generate more funds by way of donations. As one member explained, *"because we had this money we could make our programs more interesting like having competitions and giving prizes. It helped to attract more people for our programs. After seeing our programs, now people are willing to help"*.

Bi-annual meetings of committee presidents also helped. At these meetings they met with state and district level officers who appreciated their efforts. After attending first such a meeting, one president said, *"I thought this was one of those committees that did nothing. But when I saw other Presidents talk about their work and District officers appreciating them, I realized this committee was different. That was when I decided to do something"*.

The credibility building process took about 8-10 months. Committees helped that process by guarding their reputation in financial matters and by not aligning themselves with any political interest or seeking political mileage out of their work. Only one committee had broken that rule by involving local MLA in taking action against a worker. That committee had lost the goodwill of health staff and was not been able to organize any programs since then.

Organizing Capacity

Community Facilitators contributed a great deal towards building committees' organization capacity. They gave them ideas about what programs to organize and how. They helped in identifying local NGOs and resource institutions. They advised committee members on how to get cooperation from health staff. Many committee members in the final evaluation mentioned, *CFs guided us about programs. They helped us to solve problems among ourselves and improve our relations with doctor".*

Newsletter was the other input that helped develop their organizing capacity. From newsletter, they learned about each other's experiences, which they found useful for organizing their programs. As one committee president said, *"From the newsletter we came to know about the VC Trust in Mysore for eye camp. We then contacted them for program in our village".*

Motivation

Sustaining committee members' motivation over a two-year period was a major challenge since all members were volunteers, receiving no payment for their time or effort. Public appreciation was their only reward, which they received mainly through the newsletter and newspapers. As one committee members reported:

"The village cleanliness drive that we had organized was reported in Arogya Midita (newsletter) along with our photographs. We showed it to the people in the village. After that people started participating in our programs in larger numbers ".

The Block-level meeting was another opportunity for committee presidents to display their work to a larger audience and to receive appreciation. This intangible reward strengthened their resolve to do more for their people. Describing how the Block- level meeting had helped him, one president said,

"People used to say if I was not getting anything (money) then why was I running around for health committee? I used to feel bad about it. But when I came for this meeting and saw so many presidents talk about their work. I felt very motivated. Then I felt that I should not care for what others say. I must work to make my committee successful"

The identity card was also a source of motivation for many. Members wore them during programs. Many carried them when they visited any health facility and found that health providers treating them respectfully.

"I had taken a relative to Bangalore for treatment at a private hospital. I was wearing the I- card. The doctor asked me about it. He was very impressed by our seva monbhavane (service motivation) and praised us. He also reduced the bill. I feel that social service also brings a lot of recognition."

All these inputs together sustained their motivation to a considerable extent. About 88 percent committees remained active for about two years and continued working even after the project was over. About 66 percent had mobilized local resources and felt confidant that they could do more. People, both inside and outside Hunsur, appreciated their efforts, which added to their motivation and desire to continue working.

This experiment showed that sustaining health committees requires sustaining committees' credibility, organizing capacity and motivation. NGO presence might help, albeit be essential to sustain health committees

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