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Empowerment Through Community Based Monitoring

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by

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4/9/2012

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SUMMARY

Community Based monitoring (CBM): How facilitators can help Dalit and Adivassi communities in rural villages to participate in government programs to improve their health, educate their children, receive social security benefits and pensions, access rural work programs, enroll in pre and post natal care programs, and buy from government sponsored discount shops for basic necessities.

In many parts of rural India the Dalit (lower caste) and Adivassi (tribal) populations are unjustly discriminated against and denied access to many government sponsored programs that could greatly improve their lives. Unnati is a NGO based in Gujarat with a location in Rajasthan. From the Rajasthan office, Unnati and partner organizations worked through facilitators to help citizens in 50 different villages form citizen collectives. These collectives were trained in basic community based monitoring techniques. Through CBM (Community Based Monitoring), these citizens with help from their facilitators, Unnati, and partner NGOs begin taking a more active role in six government sponsored programs or schemes.

The facilitator manual I helped create is being used to further train current facilitators in Rajasthan and Gujarat. The manual will also be shared with other NGOs so that this program can be replicated with ease. The manual consists of an introduction to CBMs, criteria for being an Unnati facilitator, the facilitator roles and responsibilities, facilitator and village collectives' goals, and a case study of two villages.

Unnati asked me to undertake this project so that documentation exists for best practices as the CBM project continues. The CBM project began in April 2011. Survey results were recorded beginning in May. In June, surveys were reformatted and the current format has remained in place till December of 2011. Additionally, a part of the manual includes survey results as a model of correct and incorrect ways to document information as well as to show the importance of each question and what it indicates in terms of overall community health.

INDEX WORDS: COMMUNITY BASED MONITORING, FACILITATOR, MANUAL

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EDUCATION

Georgia State University **Atlanta, Georgia** **May 2012**
Masters in Public Health, Certificate in Disaster Management, Certificate in Nonprofit Management

Emory University **Atlanta, Georgia** **May 1996**
Bachelor of Arts, Psychology and Bachelor of Arts, Philosophy

PROFESSIONAL EXPERIENCE

Sutra Lounge **Atlanta, GA** **10/2004 – Present**
Managing Partner

- Generated an average of $1.5 million in gross annual revenue
- Recruited, trained, supervised, scheduled and motivated staff of 30 employees, including a Director of Marketing and Events and an Assistant General Manager
- Designed marketing plans to increase visibility in sales
- Managed $50,000 weekly inventory; estimated and maintained target food and beverage budgets; planned and implemented a variety of special events
- Accountable for cost controls, payroll, budgeting, general accounting, monthly owner financial reports, and comparative analysis of sales figures
- Won several 'Best of Atlanta' awards and Named in the Top 100 Clubs in America by Nightclub & Bar Magazine

Chubbs Holdings LLC **Atlanta, GA** **2004-Present**
Owner/President

- Consultant with various for profit and nonprofit companies such as Buckhead Bottle Bar & Bistro, The Nook on Piedmont Park, Atlanta G Spots, Inflict Training, Sweet Sarah's Chargers, Voice Today, Big Brothers & big Sisters, etc.
- Assisted in organizing and coordinating launch of websites, transition of new owners, established systems to increase profitability
- Organized and led a variety of fundraisers
- Provided feedback on programs and application to the community

JLazo Concepts, LLC **Atlanta, GA** **2004-Present**
Partner

- Boutique brand management company focusing on on-line advertising solutions, website maintenance, social media presence, and SEO
- Clients include Ambery Animal Hospital, Buckhead Bottle Bar & Bistro, Sutra Lounge

Haitian American Caucus **Croix Des Bouquets, Haiti** **December 2011**
Intern

- Researched, analyzed, and consolidated information about available water resources
- Conducted home visits, interviewed citizens, and completed case studies to observe and create a survey

- Provided several consulting sessions with the leadership of HAC to streamline and begin critiquing business practices

Unnati-Organization For Development Education
Intern **Jodhpur, India** **06/2011-08/2011**

- Researched, analyzed, and consolidated information about governmental programs offered to rural communities
- Conducted village visits, interviewed facilitators and citizens, and completed case studies to observe and critique processes present in the Community Based Monitoring (CBM) program
- Created and designed informatics systems to aggregate data and track trends
- Developed a Facilitator Training Manual in English that will be translated into Hindi
- Trained facilitators to appropriately utilize the Training manual and teach during village visits

Bailey's Pub & Grill **Kennesaw, GA** **11/2001 - 10/2004**
Assistant General Manager

- Effectively managed a casual dining restaurant, increasing sales by 10% through quality food, exceptional service, family value and adept promotions
- Maintained expenses below budget through accurate planning, purchasing and cost-effective operating procedures
- Trained 50 service staff members to enhance customer service and increase profits through suggestive selling
- Investigated and resolved food/beverage quality and service complaints, ensuring customer satisfaction and repeat business
- Ranked in the top 15 out of 49 stores in the company nationwide every month

AFFILIATIONS

Martial Arts Training & Understanding While Returning to Education
Advisory Board Member 05/2011-Present
Crohn's Colitis Foundation of America
Volunteer 12/2009-Present
Aga Khan Volunteer Corps
Crisis Management Volunteer 05/2009-Present
SafeHouse Outreach
Good Neighbor Award 03/2011
Advisory Board Member & Volunteer 03/2009-Present
Public Health Institute Student Association, Georgia State University
President 05/2010-05/2011
Grand Rounds Chair 01/2010-05/2010
Midtown Alliance Member 03/2006-Present
Midtown Neighbors Association Member 03/2006-Present
Partnerships In Action/Golf Member 12/2009-Present
Embraced Atlanta, Inc Advisory Board Member 02/2009-01/2010
Plaza Midtown HOA Board Member 03/2006-03/2008

LANGUAGES

Gujarati (Medium proficiency), **Hin**di (Beginner), and **Tajiki** (Beginner)

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Chapter I

INTRODUCTION

In a 2004 Indian Supreme Court Study, 100% of boys and 93% of girls in Rajasthan were at risk of mortality. 15 million people in the State of Rajasthan live below the poverty line. As of 2005 70% of women gave birth at home in unhygienic conditions. In 2001 Rajasthan had the highest maternal mortality ratio "and the fourth highest infant mortality rate among the major states in India." Between 1998-1999 Scheduled Castes (legal designation of lower caste population; protected by the government; entitled to programs; untouchables; Dalit) had a 98.4 per 1000 infant mortality rate and Scheduled Tribes (legal designation of indigenous people of India; protected by the government; entitled to programs; untouchables; Advivassi) had a 95 per 1000 infant mortality rate in Rajasthan (PAIRVI & DCNC).

Besides not receiving basic services through governmental programs, local villagers are at the mercy of local politicians who often times take advantage of their lack of education and lower caste status. "The caste system is the traditional, hereditary system of social stratification of India in which social classes are defined by a number of hierarchical, endogamous groups. It is a major institutionalized source of structural inequalities (Kumar)."

In the summer of 2011, I had the privilege of working with Unnati- Organization for Development Education in Jodhpur, Rajasthan. My primary role was to work on the existing Community Based Monitoring (CBM) program, adjust the questionnaire being used, and to train the facilitators from partner organizations that were working directly with local villagers. I then set up spreadsheets to track data and helped the Unnati staff develop action plans from the data collected so that feedback could be given to the villagers through the facilitators.

The specific project goals included the following:

- Entering and analyzing the data collected to date
- Creating a system for the future entering of data
- Creating a feedback mechanism with specific action items for the facilitators to take back to the villagers
- Visit two villages in which the CBM program was being conducted so that best practices could be identified and documented
- Present the identified best practices to the current facilitators and help them become more effective in their work

Chapter II

Background

Unnati began the CBM initiative in 2011. It has its roots in a drought and emergency services monitoring of government services related to the drought relief effort undertaken in 2009-2010. It was quickly realized, that monitoring of services should not be limited to emergency services only, but should include all services as most of these villages were missing the most basic essentials to live. Second, monitoring cannot exist in a vacuum or over a short period of time. Services need to be monitored over the long term to ensure that deprived villagers were availed basic services, especially those that were a part of government schemes. And third, that the community itself should monitor these services. By teaching the villagers how to monitor, this program would help them take a more active role in their own governance, educate them on their rights and entitlements, and to hold gram Panchayat (village level government) and block level administrations accountable for providing them. By doing so and encouraging active involvement, it was hoped that corruption, discrimination, and elite capture would be reduced at the village level (*Community Monitoring of Basic Services*, n.d.). Elite capture is but one form of resource pilfering that occurs when outside agencies or funders work through local leaders to direct materials or resources rapidly to rural communities (Platteau & Gaspart, 2003).

As more data were collected and more villages came on line with the program, advocacy efforts would be increased across the board from the village to the block to the district to the state level.

The first step in setting up the CBM program was to decide which villages out of the many that need help would be monitored, how would these villages be monitored, and what services would be monitored. Unnati worked through three partner organizations that had worked extensively in three specific blocks. These blocks were chosen because of the prior work and relationships these three NGOs

had with the villagers. Balotara and Sindhri are in the Barmer district while Phalodi is in the Jodhpur district.

- Balotara Block: Partner NGO is IDEA (Institute of Development, Education & Awareness). The initiative was undertaken in 17 villages. One village was split in two parts due to its large Dalit and Adivassi population. So there are a total of 18 monitoring areas.
- Phalodi Block: Partner NGO is URMUL Trust (Uttar Rajasthan Milk Union Ltd.). The initiative was undertaken in 14 villages.
- Sindhri Block: Partner NGO is Prayas. The initiative was undertaken in 17 villages.
- An additional 3 blocks, with 10 villages in each block, were added in July 2011. This brought the grand total CBM program to 79 monitoring locations over 6 blocks.

Next the structure of the CBM program was to be decided: which services would be monitored and on what indicators of each service should be monitored. Through workshops conducted in December 2010 for interested female citizens from the villages and in February 2011 for facilitators it was determined that the five indicators would be:

- Accessibility of services
- Quality of services
- Discrimination in accessing services
- Status of mandatory people's committees under the various schemes and Acts with respect to their monitoring role
- Proactive disclosure of information as mandated under Right to Information (RTI) Act

And the six services that these indicators would be monitored through would be:

- Anganwadi (An area in each village where the Anganwadi worker can help "bridge the gap between individuals and organized healthcare, and to focus on the health and educational needs of children aged 0-6 years." An Anganwadi worker is a para-health worker that acts as a social worker/health care consultant (Humairah, 2011).
- Primary Health-National Rural Health Mission (NHRM)
- Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA)
- Fair Price Shops under the Public Distribution System (PDS). Shops that receive special stock from the government to be sold at discounted rates based on ration cards.
- Social Security
- Primary Education-Right to Education (RTE) Act

These six services were not randomly chosen. Through prior Unnati work, the following basic issues kept arising:

- Auxiliary Nurse Midwife (ANM) is not coming to vaccinate our children. The ANM works at the village level and is another para-health worker. She is usally trained in basic nursing, immunizations, and pre/post natal care,
- Teachers are not showing up to teach our children
- Pregnant women are not receiving medical care
- Widows and older aged females are not receiving their pensions
- Work has not started under MGNREGA in our village
- The PDS shop keeper is charging higher rates or is out of stock
  Additionally when asked what they thought should be monitored, the women participating in the December workshop expressed over and over again that these basic rights were not being met in their villages (*Community Monitoring of Basic Services*, n.d.).

In the facilitator workshop in February, after finalizing the indicators and services, there was a discussion of who should conduct the monitoring. Keeping in mind that end goal was to have villagers themselves do the monitoring, not outsiders, the group settled on the women's village level Citizen's Collective that were already being promoted in the targeted villages to make efforts for their empowerment so that they could participate appropriately in decisions affecting them and also act as vehicles of social change. The collective comprised 12-20 women and adolescent females. Each scheme would be assigned 2-4 people to make up that sub-committee. For example:

- Primary Education sub-committee would include a mother of school children and an adolescent female attending school.
- Social Security sub-committee would include an old-age woman who was collecting pension, a widow collecting pension, and an adolescent female to help them monitor.

As many of the villagers were illiterate, uneducated, and had never travelled outside of their immediate few kilometer area, the question of how the monitoring would take place was a major issue. The solution was for the facilitators to first enter the village and discuss the CBM program with the

villagers. It was determined that information would have to be primarily collected in pictorial rather than written format. It could then be converted to written format by the facilitators for further compilation and sharing with administrations to facilitate systemic changes. With the facilitators help, the villagers drew social maps of the village. These maps included each household (HH) in the monitoring area, numbered starting at 1 in their proximity to the road and major landmarks (roads, wells, schools, Panchayat office, etc.

Social maps drawn by villagers are usually done on the ground, very large in size, and they use local materials, colors and symbols to denote various landmarks and spaces. The map is then translated onto paper by the facilitator. A key at the bottom inserted by the facilitator helps to read the map. The use of this medium thus resulted in diverse, colorful social maps with varying symbols. As the maps would have to be used repeatedly for information collection and analysis, it was necessary that the map could be photocopied for repeated use. Color would be lost and dependence had to be on symbols solely to depict information. Also, the symbols needed to be uniform for analysis across villages and at the same time easily drawn by women and adolescent females.

A workshop was organized for the village collective leaders at Unnati where they drew pictures or symbols that represented certain things: male teacher, female teacher, vaccination, Anganwadi worker, pregnant female, etc. Having the adolescent females, who had some elementary education, involved helped tremendously, as they were able to draw what the women were saying. Unnati then assembled these pictures and a “language” was created.

The social maps were then taken back to the villages for verification and creation of a baseline with respect to the six services. It was realized that analysis of baseline information resulted in an action agenda for the village collectives. The information contained in this would not change every month but would definitely change as a result of:

- Affirmative action by government machinery
- Action by village collectives
- Change in responsiveness of service provider or awareness of service user prompted by the CBM initiative (*Community Monitoring of Basic Services*, n.d.)

It was thus decided to review baseline information at six-month intervals to capture changes. Information that was likely to change every month was to be captured on a monthly basis. To ensure that all monthly information was collected and there was no confusion regarding time, it was decided to collect data relating to the preceding month. In the case of monitoring it is necessary to share findings in a determined time frame without the lapse of too much time. Thus, a monthly schedule for collection, compilation, analysis, and sharing of information was set.

Facilitators met with each village once a month between the 1st and 20th to help them collect the data needed. Each sub-committee had a copy of the social map upon which they would answer the questions (monthly or bi-annually) by drawing the corresponding pictures/symbols on their social map. The facilitators would assist them, with the eventual goal being that the villagers would conduct this process on their own.

Between the 21st-25th, the facilitators would translate the symbols from the social maps onto the questionnaire sheets and submit those through a physical copy or via email to Unnati. Initially, data was driven to Unnati's offices every month by the facilitators. The data was hand written and sometimes unreadable. Before I left another Unnati staff member was tasked with teaching each of the facilitators how to fill out in Excel on their laptops the spreadsheets I created and then email those in. Between the 26th-29th, Unnati would analyze the data and provide feedback and action plans for the facilitator meeting on the 30th. After this meeting, the facilitators would return to the villages with an action plan of certain things to follow up on with the villagers. The goal here was to get the villagers to a

point where they complete the social maps them. They answer the questions on their own and based on those answers, make reports or file grievances at the Panchayat level or block level as needed.

The goals for the CBM program can be summarized as follows:

- Provide guidance and support to village collectives in monitoring and holding local service providers accountable for services offered.
- Reduce corruption through active community participation in their own governance.
- Empower the marginalized and socially excluded people to have a voice in their affairs.
- Create direct links between the community and service providers so that grievances can be handled more efficiently and in a positive manner.
- Institutional reforms that are inclusive and citizen centric need to be promoted so that the citizens, especially the poor and disenfranchised, express and voice their needs and governing institutions respond to their needs and are accountable to them (*Community Monitoring of Basic Services*, n.d.).

The flow of information is depicted in the diagram below:

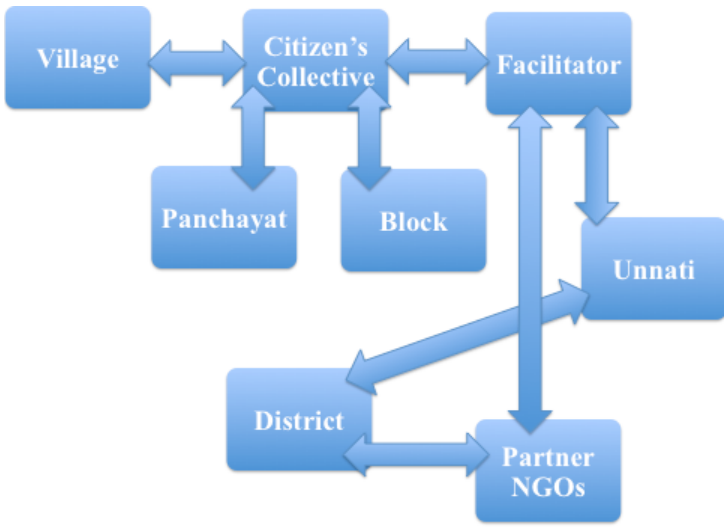

Figure 1-Facilitator Training

Chapter III

Literature Review

In my research for this paper, I was unable to find much information on any similar forms of community based monitoring. To my knowledge and to the knowledge of those at Unnati, the type of CBM program and the extent in which it has been carried out is the first of its kind in India. However, there are themes that this CBM project and others do have in common. The literature review will focus on:

- Why a community based monitoring program met the needs of the community.
- How the CBM program empowers the community and specifically the women and adolescent females in the communities.
- How this program addresses the problem of elite capture and allows the community to benefit from the resources and the progress made.

Björkman and Svensson, in their 2009 paper on CBM in Uganda focused on "mechanisms through which citizens can make providers, rather than politicians, accountable. [They did] not study the design or allocation of public resources across communities, but rather how these resources [were] utilized (Björkman & Svensson, 2009)." Local NGOs "initiated a process aimed at energizing the community and agreeing on actions to improve service provision" through two series of community discussions. (p. 767)." Further, they documented larger employment of resources and "improved health outcomes. (p. 767).

The Unnati CBM program was structured in a similar fashion. There were no resources being allocated or re-allocated. Rather, the community was being empowered by learning the details of the six basic services that the state government had mandated local governments provide; but that the local block and district level officials had failed to do so. Next the community was instructed in how to monitor these services by asking questions of the villagers and providers. Providers in this case were: teachers, ANM workers, Anganwadi workers, PDS shop keepers, etc. While some of these people are government employees, they are the providers of the services and the direct contact for the villagers. A

question that was raised in the Uganda study and will be raised in the future about the Unnati program is: Did the positive results come from more monitoring or more interaction with providers or did more involvement from citizens lead to better relations with providers ((Björkman & Svensson, 2009)? In Uganda, they found that citizen involvement led to an immediate replacement of ineffective staff (p.747).

Besides interacting with providers, CBM programs also help to develop good governance practices and self-guided improvement ("A Review of Community-Driven Development and its Application the the Asian Development Bank," 2006; Padawangi, 2010). The government of Rajasthan has already granted the citizenry the legal means to improve their lives through these six services by funding them and providing the services. The CBM program helps empower them and to benefit future generations and investments (Albright & De Soto, 2007).

Conrad and Daoust explore CBM frameworks and how they apply in modern societies of the first-world. They stress that most CBM programs are reactionary, that they “attempt to force action on an issue (2008, p.361) and are advocacy based. The Unnati program differs in that we are setting the local citizenry up to monitor services and basic needs. This bottom-up approach ensures that when Unnati leaves this area of Rajasthan or if another NGO begins doing work in these villages, the citizens themselves will have the knowledge and the skillset to further their own positions.

Mansuri and Rao point out there are at least two problems with the traditional use of the word community as it applies to the Indian setting. First, geographically, there are no true definitions of where one community begins and where another ends. Also, these communities may overlap or those of lower caste may keep to their own areas within a community. Second, the fiscal and communal capacities of citizens may differ based on their social standing (Mansuri & Rao, 2004). The Unnati program specifically defined the area in which partner facilitators worked by the specific habitation area

of those in the scheduled caste or scheduled tribal sections of the village and the providers that serviced them. We did not involve those areas of higher caste communities.

Not everyone is a proponent of CBM programs. In two separate papers, Dill and Garg & Laskar explore weaknesses in CBM programs in Tanzania and Uttar Pradesh. Both papers stress the following as caveats for CBM programs:

- Lack of specialized training to uneducated or illiterate citizens
- Lack of plans for involvement of lower caste or Dalit communities
- CBM may be a great idea, but monitoring is done by elites or outside agencies
- CBM programs have tended not to be community oriented
- By using elites or outsiders to do the monitoring, CBM's can become exclusionary and corruption can flow from local officials to CBM officials (Dill, 2009; Garg & Laskar, 2010)

Care must be taken in the development of the CBM program to avoid several common pitfalls: corruption, elite capture, and the benefit of the privileged because of their close proximity to funders. These leaders oftentimes feel it is their right to take more than their share, even if they are being compensated by the outside agency. In fact, the citizenry themselves have bought into this philosophy that the leader should reap the extra benefits they take.

NGO's that stress quick results and that are resistive to quantitative evaluations can be held to blame for most cases of elite capture (Platteau, 2004). Unnati's CBM design combatted this by first not providing any funding to the communities. There is no direct financial gain for anyone by interfering in the CBM program. Second, Unnati held meetings with the citizens and women leaders to determine what services needed to be monitored. Unnati then sought ought partner organizations that were already active in the communities and worked through them to design the CBM program.

By using the village collective, Unnati and the partner NGO's ensured the continuations and longevity of the CBM program. The village collective is made up of women and adolescent females from the village. All members are of the same caste and socioeconomic background. Depending on the

region and the NGOs involved, these village collectives can also be called Self-Help Groups, Sangha, Samooh, Mandal, Dangham, or Samiti (Kumar). The village collective is "a grass-root organization [that] encourages the women to come together to analyse their issues and problems and to fulfill their needs in a participative approach (Torri & Martinez, 2011)." By involving the adolescent females as well, the elder women are able to pass on their knowledge to the younger generation; both generations are strengthened, and undergo a "social learning process (Torri & Martinez, 2011)." Additionally, since the adolescents are attending primary school, they can help the elders that may be illiterate in writing reports, monitoring services, taking role of whether teachers came to class, etc. The strengthening and empowerment of the community has immediate benefits as service providers are held accountable as well as future benefits as best practices can be gleaned from these experiences.

Chapter IV

Methodology

My role in the process began in the summer of 2011, June to be specific. My first task was to enter and aggregate all the data collected to date and then analyze it so that action plans could be made and feedback could be given to the facilitators. This feedback included better monitoring and interaction techniques, more involvement from all of the villages in a block, increased participation of women and adolescent females in the village collective.

As I entered the data from April and May, I came across numerous issues in the setup of the spreadsheets as well as inconsistencies in the questions being asked and most importantly, the overwhelming numbers of questions facilitators were to be asking each month.

We went through each question and determined if it was vital to ask it monthly or bi-annually. How much would the information change from month to month or was it relatively stable? And could it be asked twice a year and still produce adequate results. The questions that were determined to be monthly questions were asked in June as a test.

Next, we examined each question individually and determined what information we were trying to glean from it and was the wording understandable. It is important to note that the answers to these questions would be translated to the social map and then facilitators would use the information to fill in the spreadsheets giving us our data. Wording was changed and tested with Unnati staff members who were familiar with the villagers and the facilitators.

Concurrent to this process, I developed a facilitator training session that entailed going over each question and the data collected to date to share with the three facilitating agencies what we had

found and what needed to be corrected and changed in order to provide us with better data. The flow of information depicted above was created for this session.

Once we completed both the training and the examination of each question, we provided the facilitators with the new spreadsheets and questions so they could begin asking them in July.

There was a tremendous amount of data collected in the 59 villages over four months. I will next examine two areas that I deem extremely important and will depict some of the results as more and more villages came on line with the program, facilitators became better at gathering data, and village collectives begin buying in more to the process.

Chapter V

Data

The two topics I will use as examples of the process are Anganwadi and Primary Health. Specifically, within each of these broad topics, I examined the base line data from the bi-annual survey for each subject and then specific questions within each topic from the monthly survey. I chose the Balotara Block as an example since the facilitators were most effective and they had the most complete data of all three blocks involved in the CBM program. Within this block are 18 villages consisting of 779 households. Of these, 337 or 43.26% were considered BPL or Below the Poverty Line.

Most of the questions regarding Anganwadi were on the monthly survey rather than the bi-annual (baseline) survey because Anganwadis are required in every habitation, affects children directly, and we wanted to track progress monthly. The average distance of the existing Anganwadis in the 18 villages was 1.28 km from the households within the habitation. Only seven or 38.89% of the Anganwadis had drinking water available at the location.

The monthly data collected is summarized in the table below.

Table 1-Anganwadi

Monthly Questions	April		May		June		July	
Girls 0-5	74		306		312		327	
Girls 0-5 not linked to Anganwadi	56	75.68%	121	39.54 %	115	36.86%	98	29.97 %
Boys 0-5	66		353		395		406	

	Boys 0-5 not linked to Anganwadi	50	75.76%	136	38.53 %	159	40.25%	121	29.80 %
	Anganwadis open	1	5.56%	7	38.89 %	11	61.11%	12	66.67 %
	Average # of days Anganwadis open	26		26		26		26	
	Girls 0-2	32		103		102		113	
	Girls 0-2 not vaccinated	22	68.75%	34	33.01 %	38	37.25%	23	20.35 %
	Boys 0-2	26		113		137		153	
	Boys 0-2 not vaccinated	18	69.23%	50	44.25 %	40	29.20%	23	15.03 %

One trend that is immediately evident is more reporting occurred from April to July in all 18 villages and in all categories. But, as the total number reported increased, the trend from June to July in both percentage of boys and girls not linked to Anganwadi and percentage of boys and girls not vaccinated decreased.

Total number of girls 0-5 increased from 312 to 327 from June to July, but the percentage of those girls not linked to Anganwadi during the same time period decreased from 37% to 30%. For boys 0-5, the total number of boys increased from 395 to 406. The percentage drop in those linked was 40% to 30%. When we look at vaccinations for boys and girls between the ages of 0-2, we see similar results. From June to July, total girls increased from 102 to 113 and boys from 137 to 153. Percentages of girls and boys not vaccinated also dropped from 37% to 20% for girls and 29% to 15% for boys.

These results are due to either of the following either individually or

combined:

- As more villages came on line with reporting, those villages already had boys and girls that were linked and vaccinated.
- As more villages came on line, those villages already enrolled and participating began linking and vaccinating more of their children.

It is difficult to determine which of these was the case in Balatora because many of the villagers in this block participate in almost all of the governmental programs. However, in other blocks surveyed, I would hazard to guess that it would be due to the latter reason. When I visited the villages in the case study, the villagers themselves were anxious for guidance and were eager to be involved in the improvement of their lives.

Similarly, the number of Anganwadis being open increased each month from 1 to 7 to 11 to 12. These results could be due to increased participation and reporting as new villages came on line with the CBM program or as monitoring continued in villages, providers began providing the required services.

The next area of concentration I examined was Primary health, specifically as it relates to the location of health care facilities and care during childbirth. Similar to the Anganwadi issues above, we felt that these issues should be tracked on a monthly basis until an appropriate standard could be demonstrated for healthcare for pregnant women. In rural areas, there are three types of healthcare facilities available to the citizens: the sub-center which is located either within or close to each village; the primary health center which services several villages and is between 5-15 km away; and the central health center which is supposed to house surgeons, a full hospital staff, has more beds available, and is to be located between 15-25km away from the villages. In the Balatora block, the sub-center is an average of 1.87km away from each village; the PHC is an average of 14.66km away from each village; and the CHC is an average of 20.69km away from each village.

The monthly data collected is summarized in the table below.

Table 2-Primary Health

Monthly Questions	April		May		June		July	
Pregnant women	24		68		70		59	
Pregnant women registered with ANM	16	66.67 %	53	77.94 %	52	74.29 %	43	72.88%
Deliveries last month	0	0.00%	6	8.82%	12	17.14 %	16	27.12%
Institutional deliveries	0	0.00%	3	50.00 %	4	33.33 %	11	68.75%
Cases of maternal death	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Cases of infant death	0	0.00%	1	1.47%	0	0.00%	1	1.69%

These results are a little more dispersed and no trends are immediately evident. There may be a degree of reporting error due to women not feeling comfortable speaking about health issues. As the CBM program continues and familiarity is developed between the collectives and the facilitators, if any reporting bias exists, it may decrease. The number of pregnant women increases from April to May to June and then decreases in July. This may be due to increased reporting or more women coming to term and delivering. The number of women registered with the ANM worker similarly increased and then decreased in July. Institutional deliveries, that is those deliveries taking place within a sub-center, PHC, or CHC steadily increased. Similarly, this may be due to a combination of things, namely increased reporting/monitoring or increased services, as providers are held accountable to the citizens.

May and July both had one infant mortality reported in each month. Using these deaths as a learning tool, we were able to draft specific action items for the facilitators to convey to the village collectives for extreme cases such as this. These items primarily concerned reporting the deaths immediately, not waiting till the end of the month when the facilitator claimed and also filing with the Panchayat to ensure that if not ANM was present or if the delivery was not conducted in an institution, an investigation into why was conducted.

Chapter VI

Conclusion

Increased monitoring/reporting of vaccinations and institutional deliveries or increased vaccinations and institutional deliveries, which is it? And which would be considered a success? I would argue that not only are both occurring, but also both should be considered successes. As the number of institutional deliveries increases, more of them will be reported. But, more importantly, more mothers and infants will be given basic healthcare. As they become educated, they will educate their fellow villagers as to their experiences through the village collectives. As more villagers are educated, more will begin demanding the services that they are entitled to. In turn, this will lead to improved health outcomes, which will hopefully better the lives of the villagers.

The Community Based Monitoring program started by Unnati can already claim a certain level of success on the advocacy level as well. Before leaving Rajasthan, we were able to contact the state government and provide them some data on Social Security that they were interested in collecting. Besides advocacy, success can be counted on several levels:

- Villagers are participating in their own governance and affecting changes that will benefit them.
- More villagers are reporting, thereby giving researchers an accurate base line to compare to in the coming years.
- As more reporting occurs, best practices are being developed and identified. Through the facilitators, these best practices are being shared between villagers.
- Facilitators are improving in their interactions with villagers and trust is being developed which will aid in any future projects or programs.

Moving forward, Unnati should continue to work with the facilitators to ensure that they are enlightening the village collectives. The facilitators hold the key to the entire program. By establishing their training and monitoring their interactions among the village collectives, best practices will be allowed to develop and grow at the village level. As the facilitators conference with Unnati staff to review results on a monthly basis, these best practices and advocacy successes can be spread to other

village collectives. Then, as the CBM program is spread to more villages, block then district then state then national advocacy efforts to eradicate the SES divide and reduce corruption and discrimination can be undertaken.

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