

## Analysing local actors & processes

### OP-22 PARTICIPATORY AUDIT AND PLANNING OF FLEXIBLE FUNDS UNDER NATIONAL HEALTH MISSION IN MAHARASHTRA, INDIA

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**Background** Community empowerment is being increasingly recognised as a critical component towards enhancing accountability of and equitable access to health care. In India, a participatory process termed ‘Social audit’ has emerged as an effective model for ensuring accountability and equity in the Employment Guarantee scheme. In Maharashtra, a group of Civil Society Organizations (CSOs), implementing Community-Based Monitoring and Planning (CBMP) of health services under the National Rural Health Mission (NRHM) since 2007, considered *Rogi Kalyan Samities* (RKS, Patient Welfare Committees) as an important gateway to ensure effective and equitable utilisation of flexible funds under what is now the Nation Health Mission (NHM), and initiated a Participatory Audit and Planning (PAP) process.

**Methods** Retaining the core of social audit with appropriate modifications in the context of RKS funds, a PAP was conducted in 9 health facilities from three tribal districts of Maharashtra between December 2014 and March 2015. In a preparatory phase, RKS expenditure data of the year 2013–2014 were analysed and public report cards were prepared. The PAP then involved examination of financial documents, physical verification of purchases and report cards. Multiple stakeholders (RKS members, elected representatives, health providers and CSO actors) were involved in the process. Eventually, in a dialogue among key stakeholders, identified issues would be discussed, decisions taken and future planning done accordingly.

**Findings** Implementation of the PAP process yielded positive impact on accountability and effective utilisation of RKS funds based on peoples’ needs. The process enabled a better understanding of the functioning of RKS by making its expenditure public to all stakeholders in the form of report cards.

According to our findings, RKS functioning however had a series of issues: committee members and coordinators appointed by NHM did not have clarity about their roles and responsibilities; most of the expenditures were done without prior sanctions from RKS; and decisions were in most instances autonomously taken by the medical officer. As revealed by the report cards, funds were predominantly spent on stationary, internet and telephone bills, purchase of equipment and medicines.

During the stakeholder dialogue, findings and issue were discussed and decisions were taken. Up to 45% of the issues were resolved locally with follow-up by CSOs. These were mainly contributions to improved service delivery – like provision of curtains for women’s ward, of sitting arrangements for patients, of drinking water and food for patients and relatives, or corrections. An example of the latter is given by a stakeholder: “A fridge and cooler were purchased for health institution however kept in staff quarters. During the process concerned officer was asked to bring it back to the institute and this was done on the very same day”. Dissemination of the PAP process also had positive impact at state level, where two decisions were taken. One was to conduct a state-level workshop for RKS coordinators and accountants regarding their role and responsibilities. Second was to upscale the PAP process to a total of 140 health facilities across Maharashtra. So far, the PAP process was conducted in 65 health facilities in the year 2015–2016.

**Discussion & recommendations** Before the PAP process was installed, RKS flexible funding only underwent a ‘technical’ financial audit by state government, without a mechanism in place for feedback of beneficiaries and with very limited community involvement. In comparison, the PAP process presents an effective pathway towards accountability with involvement of various RKS stakeholders, including active community members. As expected, the PAP process has contributed in increasing empowerment of RKS members and responsiveness of healthcare providers. Presenting report cards with expenditure patterns in a multi-stakeholder dialogue also helped in bringing transparency, thereby creating awareness among key stakeholders. The PAP process provided a foundation for community-based monitoring of actual utilisation of RKS flexible funds, for planning of expenditure taking into account peoples’ needs, and for dialogue among all key stakeholders. As such, the PAP process has the potential to contribute to improved service quality, to bring a sense of ownership amongst community and elected members, and eventually to increase accountability and equity of public service delivery.

Based on our study findings, for a PAP process to become effective a series of conditions have to be in place: (1) bringing together a multiple-stakeholder group, including CSOs, health providers and elected members, and that is given authority to take decisions and actions; (2) a critical mass of active community members who can raise the issues; (3) a basic mandate at least in the form of orders from high-level officials to field-level staff, to ensure engagement of healthcare providers; and (4) sufficient and active response of the healthcare authorities, so as to maintain the motivation of community and other stakeholders.

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