

**Minutes of Meeting of the 11<sup>th</sup> Advisory Group on Community Action – NRHM**

**June 13, 2008, PFI, New Delhi**

Advisory Group Members present

Dr H Sudarshan  
Prof Ranjit Roy Chaudhury - Chair  
Dr M Prakasamma  
Dr Abhay Shukla  
Dr Abhijit Das  
Dr Narendra Gupta  
Dr Shanti Ghosh  
Ms Indu Capoor  
Dr Sharad Iyengar  
Dr Alok Mukopadhyay  
Dr Vijay Aruldas  
Mr A R Nanda

Representatives from GOI

Mr Amarjit Sinha, Joint Secretary, MoHFW  
Dr Tarun Seem, Dir NRHM, MoHFW  
Dr Hamid Khan, Consultant, NRHM, MoHFW

Other invitees

Ms Seema Gupta  
Dr Ajay Khare  
Dr D N Sharma  
Dr Sudarsan Das  
Mr Kaushik Saikia  
Ms Sunita Singh  
Dr Ruth Vivek  
Dr Kumudha Aruldas  
Mr S Ramaseshan  
Dr Almas Ali  
Ms Sona Sharma  
Ms Sudipta Mukhopadhyay

AGCA Members who could not attend the meeting and given leave of absence

Dr Dilip Mavalankar  
Sh. Gopi Gopalakrishnan  
Sh. Harsh Mander

Ms Mirai Chatterjee  
Dr R S Arole  
Dr Thelma Narayan  
Dr Saraswati Swain

### **Agenda Item 1: Introduction**

Mr A R Nanda welcomed all and invited Dr Ranjit Roy Chaudhary to chair the meeting. He mentioned that today's agenda had two priorities, the first being the status of progress of the programme on community monitoring and the suggestions for the future role of AGCA.

Dr Roy Chaudhary welcomed all participants and mentioned that the members had asked for leave of absence. He also welcomed that representatives from the state nodal NGOs who were partners in the programme on community monitoring. This was followed by a self introduction by each participant.

### **Agenda Item 2: Finalization of minutes of the 10<sup>th</sup> AGCA meeting.**

Responding to this, Dr Sharad Iyengar mentioned that the following line be added to the minutes of the last meeting in page 3 in the paragraph related to the role of AGCA "Dr Sharad Iyengar requested that he be allowed to submit a dissent note which is to be kept on record". Members agreed that the note submitted by Dr Sharad Iyengar be included as an Annexure 1 to the minutes of the current AGCA meeting and approved the minutes of the last meeting.

### **Action taken on the last minutes:**

Ms Sudipta mentioned the followed action taken points on the last minutes.

<b>Sl. No.</b>	<b>Actionable Points</b>	<b>Action Taken</b>
1.	The current quarter should focus on the process of initiating the formation of the various structures for monitoring and planning at the state, district, block and PHC levels.	State-wise presentation including district, block and PHC will be made at the meeting
2.	PFI to conduct an in-house financial audit of the community monitoring programme.	It will be conducted after getting the audited UCs along with R/P A/cs from all the nine states.
3.	The state nodal NGO at Orissa may discuss the matter of registration of VHSCs with the Mission Director as the GoI has already clarified that registration is not necessary.	Response received by Dr Sudarsan Das is attached.

4.	The role of the AGCA should be discussed and TOR for the AGCA should be revisited.	Discussed at TAG meeting held at Pune on June 3-4, 2008. Notes of the following are attached: <ul style="list-style-type: none"> <li>• Dr Sharad Iyengar's note</li> <li>• Dr Hamid's field visit note</li> <li>• Dai note</li> </ul>
5.	Review of all reports of NRHM at the national level by the AGCA.	No reports have been received in the past quarter. All the reports of NRHM and state wise progress sheets are posted on the website of the MoHFW on the NRHM link and the members were advised to visit the same regularly. In case hard copies are required, the same shall be made available too.
6.	MoHFW to propose the dates for the national convention (comprising of Phase 1 states, Mission Directors and NGOs).	Yet to be decided by MOHFW
7.	National secretariat to circulate the date for meeting of TAG on community action	TAG meeting was held at Pune on June 3-4, 2008
8.	The revised name of the programme should be circulated to all the states.	It has been informed to all the states

Dr H Sudarshan observed that while the NGOs are required to submit audit utilization certificate, is there any need for PFI to verify their books and records. It was clarified by Mr S Ramaseshan, PFI that it is a procedural requirement of PFI and it is not a fault finding process and at the end in a way this process might assist the state nodal NGOs for maintaining appropriate financial records as per the project requirements.

Dr Sharad Iyengar mentioned that apart from email, PFI should send a letter to all state nodal NGOs regarding the approval for extension of the programme on community monitoring of health services under NRHM by GoI. He requested that state nodal NGOs communicate similarly to all districts and block nodal NGOs regarding the same.

Regarding submission of financial statements, Dr Sudarsan Das mentioned that they had submitted the audited Utilization Certificate and Receipts and Payments account upto 31<sup>st</sup> March, 2008 and under the payments the amounts paid to the district/block level NGOs have been shown as amount advanced to them and included in the audited accounts. Dr Abhay Shukla enquired whether the amount

paid as grants advance to district/block level NGOs be treated as amounts utilized by the state nodal NGOs. Mr S Ramaseshan, PFI clarified that for the purpose of submission of accounts this may be shown as grants advance and included as disbursements/outflow of funds by the state nodal NGOs, but only after receipt of the audited accounts from the district/block level NGOs, the state nodal NGOs can adjust the actual amount as expenditure and include it in their Utilization Certificate as amount utilised. Further it was clarified that the audited Utilization Certificate by all concerned has to clearly state that the amount received has been utilized for the purpose for which it has been received, namely, for implementing 'Pilot project on Community Monitoring of Health Services under NRHM'. Therefore no amount paid as advance can either be treated as expenditure or utilized as grants. Mr Amarjeet Sinha, Jt. Secretary, MoHFW agreed with the views of the PFI official and mentioned that the Government of India too expects the same type of Utilization Certificate duly signed by the auditors from all its grantees.

### **Agenda Item 3: Progress of the programme on community monitoring of health services under NRHM**

Responding to the question on the need for a NGOs facilitated programme on community monitoring of health services under NRHM Mr Amarjit Sinha mentioned the following reasons:

1. The government values the partnership with NGOs over and above its regular channels.
2. The government recognized that the process of community monitoring would require intensive handholding, which was therefore kick started through the current project funding mode through NGOs.
3. The AGCA was one among many other fora within the government to advise on key aspects of NRHM. The reason why the meetings of the AGCA and the ASHA Mentoring Group were kept separate was to ensure that each played an important but independent and focused role within the overall plurality and diversity of NRHM. The government is keen to learn from the experience of the first phase of the community monitoring programme and is open to suggestions and comments from the public. That is why all materials are made available on the NRHM website.
4. On the question of what happens to states which are not included in the current phase, Mr Sinha mentioned that Dr Seem recently shared the information of the first phase programme with all state mission directors. However realising that a mere discussion was not enough, GoI has asked state to set up grant in aid committees to take the process forward with facilitation by NGOs. For example the government was considering civil society involvement in rolling out the 5<sup>th</sup> ASHA training module which is a self actualization, empowerment module that does not lend itself to the standard cascade approach of training. Mr Sinha requested all AGCA members to take up the 5<sup>th</sup> ASHA module training in their states.

5. Realising the role of NGOs the government was committed to greater NGO support. In this regard the government was in the process of revising the MNGO programme to facilitate greater involvement of NGOs in areas where they have expertise. GoI expects state governments to actively partner with NGOs in future.
6. The concurrent evaluation of NRHM will be finalized for one third of all the districts in the country. The report will be available by September 2008. Also the DLHS – 3 report will be available by September 2008.

Mr Sinha emphasized that the AGCA is handholding and guiding. Through a process of recommending and not fault finding it is assisting in the process of making public system more accountable. He emphasized that it was equally important to document if an ANM or Doctor is doing good work and media should also highlight the positive work being done in a government programme.

Presentation on status of community monitoring programme:

On behalf of the national secretariat Ms Sudipta presented the physical status of the programme community monitoring and the observations from the field.

The following tables reflect the physical progress for the quarter April – June 2008.



State	Formation of Committees								Jan Samvad		
	VHSC	PH C	Block	Distri ct	VHSC	PHC	Block	Distri ct	Vill age Rep ort Car ds	PH C	Block
MP	225/225	45/7	Nil	Nil	225/84	Nil	Nil	Nil	Nil	Nil	Nil
MH	225/225	Nil	Nil	Nil	225/225	Nil	Nil	Nil	Nil	Nil	Nil
RJ	180/180	36/25	5	1	180/165	36/23	4	1	45	4	Nil
AS	135/120	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
OR	180/180	45/29	12/10	4/1	180/180	45/29	12/10	Nil	Nil	Nil	Nil
TN	225/225	45/38	Nil	Nil	225/225	45/15	Nil	Nil	Nil	Nil	Nil
CG	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
JH	135/135	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
KN	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
<b>Total</b>	1620/1290	324/99	108/10	36/0	1620/879	324/67	108/10	36/0	1620/0	324/0	108/0

It reflects that all the preparatory and capacity building work has been completed. All 9 states are currently in the process of formation and orientation of VHSCs and the planning and monitoring committees at all levels. It needs to be noted that the activities in Assam, Jharkhand and Chhattisgarh are progressing slowly as compared to the other states. This needs to be kept in mind while planning for the remaining months of the programme – i.e. July – September 2008.

Observations from the field: Ms Sudipta mentioned that the field visit was undertaken in Maharashtra, Madhya Pradesh, Assam, Tamil Nadu, Chattisgarh, Jharkhand, Rajasthan, Orissa visited with two districts in each state (2 blocks in 1 district., 1 village in each block). Activities undertaken were (a) interaction with State Coordinator District Coordinator Block Coordinator Block Facilitator VHSC members Community people MOs District collector BDO BMO, Mentoring group members District and state nodal agency (b) observation of IEC Material and documents prepared, filing and process documentation by nodal NGOs at all levels, identifying problems and challenges, discussion on relationship with government and different stakeholders, coordination between NGOs, communication, innovations, problem solving. The field visit team

comprised of Dr. Almas Ali, Ms. Sona Sharma, Ms. Sudipta Mukhopadhyay, Ms. Sunita Singh, Dr. Ruth Vivek from the national secretariat and Dr Hamid Khan from MoHFW. The visits were facilitated by state, district and block NGOs.

Following are the observations from the field:

- VHSC formation & Orientation
  - Completed in 5 states
  - AWWs & ASHAs are actively involved
  - VHSCs have gone into planning also but need hand-holding
  - Space for direct interaction between villagers and service providers and between health care providers and unions (e.g. TN)
  - Opportunity for involvement of dalit women, adolescent girls
  - Self-help groups are very helpful
  - Need to build in health workers perspective
- Role of PRI
  - At the village level the involvement is promising but at the higher level it is not good.
  - Recognition and involvement of PRI is important for effectiveness & sustainability of committees
- Relationship with Government
  - It has been proactive with participation in the workshops & trainings
  - Participation in mentoring group meetings is low
  - District governments apprehension in interference from block and district PRI members
- Innovations
  - Role play, PRA techniques, Pictorial tools & score card used in trainings
  - Training of VHSC members is being conducted in phases
  - Village health day used as a public platform to share results of survey
  - Media
    - States in the process of actively engaging with media & to identify Media fellows
    - State Media plan in the pipeline

Ms Sona Sharma added an observation from the field visits that more IEC materials needed to be distributed at the village level. Also the quality of VHSC orientation across states should be maintained.



The AGCA-TAG Meeting was held on 3-4 June 2008 in Pune. The main outcomes of the meeting were the following. Dr Abhijit Das presented the details of each in the next agenda item.

- Recommendations for future TOR for AGCA
- Role of AGCA-TAG beyond CM program
- Discussion over Innovations & documentation
- Setting up resource centre for CM
- Review & finalisation of Manuals, Posters & brochures
- TOR for External Review of CM program
- Website & Database discussed

Financial Status

**Amount of Grants Received from GOI-MOHFW, New Delhi**

Sl.No.	Date	Letter No.	Amount (Rs)
1	08.03.2007	No.Q11011/1/2007-NRHM-II	1,000,000.00
2	10.07.2007	No.Q11011/1/2007-NRHM-II	7,520,000.00
3	05.02.2008	No.Q11011/1/2007-NRHM-II	30,500,000.00
4	27.03.2008	No.Q11011/1/2007-NRHM-II	31,500,000.00
5	-	Savings Bank Interest	58,650.00
		<b>Total</b>	<b>70,578,650.00</b>
			<b>Amount (Rs)</b>
<b>Amount disbursed/ expenses incurred from March 8th 2007 to June 10th 2008 *</b>			<b>29,519,100.00</b>
<b>Balance of funds as on 10.06.2008</b>			<b>41,059,550.00</b>

\* Includes grant advances paid to state nodal NGOs

**Presentation by the states:**

**Orissa**

Dr Sudarshan Das, representative KCSD, state nodal NGO in Orissa presented the following as progress of the programme.

Dr Das also shared the detailed documentation undertaken by the state in the form of a state report. Dr Almas Ali mentioned that the district programme managers played a key role in the implementation of the programme. A lot also depended on the relationship between the NGO and the state government particularly the relationship with the Mission Director. Members appreciated and congratulated

KCSD on the effort taken and emphasised that a similar format of reporting be adopted by other states. Secretariat should share the reporting format with all states. Ms Indu Capoor mentioned that the state report should also mention whether the various committees formed are empowered to take action and the challenges related to the committees and difficulties in forming VHSCs. Dr Iyengar also added that state reports should highlight the process of VHSC mobilisation apart from the quantitative progress of the programme. Dr Prakasamma reiterated that service providers should be recognized in the programme. Dr Abhijit Das and Ms Sunita Singh also added that in Orissa the committees were empowered because as observed from interactions with the committees members the knowledge about NRHM and the role of members in the committee was very high. The committees also had very high participation of women.

Dr Tarun Seem mentioned that the progress in the state was very encouraging. He suggested the following:

1. Since the VHSCs have already developed the village profile, a plan should be developed for VHSCs to move towards community based planning.
2. There was positive media engagement in the state especially the local press. Therefore a media toolkit may be developed.
3. The fund utilisation was also good.

**Rajasthan:** Presentation made by Dr Narendra Gupta, representative Prayas, state nodal NGO of Rajasthan.

1. The main issue in Rajasthan is that there is no village level health and sanitation committees are formed. As per the present decision of the state government, only Panchayat level health and sanitation committees are being formed. This would require a discussion with all state NGO partners and the government. A meeting with the government is scheduled for June. Mr. Amarjeet Sinha said that the GOI has sent full amount of Rs. 10,000/- per revenue village for forming VHSC and village health plans to Rajasthan and we are hoping that these will be formed.
2. Dr Gupta also shared the newspaper reports related to the programme, a copy of which is attached in Annexure 2.
3. The RKS will become the PHC level planning and monitoring committee.
4. Four PHC level Jan Samvads were already held in Chittor district.
5. Letter head for VHSCs have been developed.
6. A fixed day meeting date was being decided for meeting of VHSCs.
7. Dr Sharad Iyengar added that the state had new Mission Director. The VHSC meetings were also not being held regularly. There was also a problem of capacity of the committees to undertake monitoring and planning. The committees were not ready. The issue of corruption in JSY is coming up in VHSCs.

Dr Hamid based on his field visit congratulated the NGOs doing good work under the program in Rajasthan. He mentioned that both men and women were participating in VHSC meetings as was evident in Jodhpur. He suggested the IEC materials in Marwari or any other local dialect could be developed for greater familiarity and use among villagers.

**Maharashtra:** Dr Abhay Shukla mentioned the following:

1. People's organisation have played an important role in the programme in the state and
2. Their involvement has been an innovative approach to implementing the programme and adding value beyond the regular framework (note on Thane process attached in Annexure 3).
3. The state level convention held earlier by the Mission Director was innovative in ensuring and building ownership of the state and district government and developing district level plans.
4. Innovative pictorial tools were also developed like the village health calendar and the report card.
5. There was good media coverage in the state (copy attached in Annexure 2).
6. Community monitoring has been included in the state PIP although the budget is yet to be allocated.
7. The main challenge is delay in issue of GR for formation of PHC and CHC level committee formation. A letter from GoI in this regard will be useful.

Maharashtra will share the case study protocol with other states.

**Madhya Pradesh:** Dr Abhay Shukla and Dr Ajay Khare presented the highlights of the programme.

1. Note on process of involvement of community in Bardwani district was circulated where community is already monitoring the PHC and CHC in Pati block of Bardwani district. This has led to non literate adivasis going to the CHC and PHC for health services.
2. Private doctors are also monitored in the process.
3. All VHSCs have been formed.
4. In 14 villages data gathering has started.
5. There was over reporting of institutional delivery in JSY whereas facility survey reveals under utilized facilities.
6. Man power shortage acute in MP. Most PHC's do not have doctors.
7. I-cards will be issued to VHSC members.
8. Script writing workshop was held as part of media involvement.
9. There is lack of response from the state government in including community monitoring in state PIP. GoI facilitation required for interaction with state government and including community monitoring in the state PIP.

Dr Sharad Iyengar, Dr Shanti Ghosh and Dr Prakasamma reflected that there was need for further probing into reuse of syringes, doctor client confidentiality issues

and privacy although experience from Andhra Pradesh reflects that women prefer someone to accompany them during delivery.

Dr Tarun Seem mentioned the following:

1. There was lot of innovation in the state.
2. Committees are yet to be oriented after GR is issued.
3. The pictorial report card was good and should be shared with the state government.
4. All pictorial tools of the state should be translated into English and shared with other states.
5. GoI has been regularly requesting the states to facilitate the community monitoring activities in phase 1 states. The need for proactive participation by the State Mission shall be reiterated.

**Chhattisgarh: Dr D N Sharma representative of state nodal NGO in the state presented the progress.**

- A workshop for District Managers was organized on January 20-21, 2008. A total of 32 participants including civil society members of State CBM mentoring group participated.
- District level orientation workshop was organized in the following districts:
  - Kawardha (Kabeerdham) on January 27, 2008
  - Koriya (Vaikunthpur) on March 12, 2008
  - Bastar (Jagdalpur) on March 17, 2008
- Government of Chhattisgarh, Department of Health and Family Welfare has proposed three districts (in addition to pilot districts) in its Project Implementation Plan (PIP) for the year 2008-09.
- Published a set each of guidelines (2), folders (3) and posters (2).
- District-wise activity plan for the period from May 2008 to August 2008 has been prepared.
- Till June 15, 2008, 135 VHSCs and 27 PHC Monitoring Committee and six out of nine block monitoring committees have been formed.
- First meeting was conducted with the following till June 15, 2008 –
  - VHSCs (135/102)
  - PHC Monitoring Committee (27/11)
  - Block monitoring committees (09/2)
  - ToT (03/0)

Members highlighted that the discrepancies of records between the state and national secretariat needs to be corrected. There was need for better communication between the two. Members also suggested that the secretariat needs to discuss the detailed work plan and realistic outcome expectation for the programme in the state.

**Jharkhand:** On behalf of state nodal NGO CINI, MR Kaushik Saikia, Coordinator PFI Jharkhand presented the status of the programme.

- District nodal agencies were identified in January 2008
  - State level workshop was organized in February 2008
  - State level training (ToT) was organized in March 2008
  - District level workshops and selection of block NGOs were done in May 2008
  - Training of block facilitators was organized in June 2008
  - The state does not have VHSC. The existing Village Health Committees (VHC) have been formed by the government through NGOs, mobilized through Kalajathas and strengthened by opening bank account and negotiated for Rs 1000 as grant.
  - Sub-centre level clusters are formed (5 pilot village per cluster – PHC only at block level)
  - Village Health Register prepared and introduced in VHCs
  - Government is supportive at all levels
  - PRI does not exist in Jharkhand. PRI members in various committees has to be worked out.
  - District mentoring groups are playing proactive role beyond community monitoring
  - State mentoring group playing important role in JSY implementation
  - Time line of activities has been prepared for June to August 2008. District working group meeting, identification of media fellow, formation of sub-centre and block planning and monitoring committee, state media workshop, gram swastha samvad and VHC orientation, block provider orientation will be held in June 2008.
1. Dr Tarun Seem responded by stating that the state government needs assistance in implementing this programme. The AGCA and TAG needs to articulate how this technical assistance can be provided.
  2. Dr Alok Mukhopadhyay mentioned that the state needs technical assistance in macro planning efforts.
  3. Other members also felt that the state would require more time to implement this programme. A revised workplan needs to be developed in view of district wise and block wise progress.
  4. Outcome indicator needs to be re-check and revised for the entire programme.

**Karnataka:** Dr H Sudarshan state nodal NGO representative presented the status of the programme.

1. Karnataka would require more time to implement the programme.
2. The block and district level NGOs have been selected.
3. State level ToT will be held soon.

**Assam:** Ms Sudipta presented that all the preparatory activities have been completed in Assam. However, keeping in mind the monsoon months, a revised workplan needs to be developed after discussion with the state nodal NGO.

**Tamilnadu:** Dr Ruth Vivek presented the broad status of the programme. She mentioned that the VHSC training is going on in full swing. The training is being held in phases. The Village Health Nurse (VHN) Association is proactive in the community monitoring process. Self Help Groups (SHGs) are proving to be useful in the formation of VHSCs. The untied fund is being used in various ways at the PHC and subcentre levels. The mechanism of utilization of untied funds is still centralized. The orders for expenditure come from the district authority and the Medical Officer (MO) just follows it.

**Agenda Item 4: Dr Abhijit Das presented the TAG recommendations on (1) Next phase community monitoring to community action and (2) evaluating the community monitoring programme.**

From Community Monitoring to Community Action

Completing the Current Phase

- Follow-up visits to every state
- Strengthen the documentation systems
- Assist in process documentation in all states
- Facilitate technical support for states where progress is slower
- Evaluate and finalise inputs – manuals, kits, brochures and posters
- Set up the evaluation process

Consolidating in the states where Community Monitoring was initiated this year

- Including in the state PIP is not adequate to nurture and scale up the process
- There must be a recommendation from AGCA for state level continued support for CM process where it has not been explicitly mentioned in PIP
- Some state's need to develop greater clarity about the purpose and modality of CM
- Introduce community planning and action – to be funded from the centre
- National/State Support Team – to continue to providing support; where financial support has not come from the state PIP the Central government to be requested to provide financial support

Initiating Community Monitoring in new States

- Sharing of the process has to happen with State Mission directors – when the first round of report cards are ready
- State level resource groups with Civil Society participation essential to initiate and nurture the process

Technical Advisory Group and National Secretariat / Resource Centre to provide need based support

**Evaluating Community Monitoring An Outline of the Process**

Key Principles

- Separate evaluation team for each state – briefed at a common workshop for finalising common methodology
- Participatory – Each state evaluation team to include three people – One member of State CMMGroup, one member from CMMGroup of a second team and an external resource person. One member could also be a AGCA member
- The evaluation should be a learning process and include documentation of innovations as case-studies / lessons
- There should also be standard guidelines for the evaluation process – allowing comparison across states
- We should invite NSHRC/PHFI to be part of the evaluation process so that there is mainstreaming of the learning into other mechanisms set up for strengthening the health systems

#### Elements for review- operational

- 1.Entitlement Awareness / Empowerment at the community level ( esp. VHSC)
- 2.Involvement of PRIs
- 3.Coordination between : Block providers – Community (VHSC) – NGO/CBO – Health administration ( CMO) and PRI.
- 4.Government Ownership - Influence on the government agenda/policies ; Orientation and involvement of government personnel
- 5.Improvement in services – accountability mechanism – equitable access ( look at issues of gender, caste, ethnicity, religion, migrant/displaced population)
- 6.Skills and Capacity building among facilitating organizations
- 7.Materials and their adaptations – distribution, and community perception

#### Elements for review – coordination/ administrative support

- 1.Financial mechanisms and reporting and actual fund flows, fund management, expenditure
- 2.Transparency – selection of partners, financial transparency
- 3.Role of Union and State Health Ministry
- 4.Role of the AGCA, TAG, National Secretariat and State Nodal Agencies
- 5.Partnership between GO and Voluntary Sector

#### Evaluation : Process

- Start the evaluation in a phased manner – five states first – Maharashtra, MP, Rajasthan, Orissa and TN in September
- Identify/form state level evaluation teams from a pool of resource persons
- Prepare – finalise terms of reference
- Evaluation to follow completion of process documentation
- Common methodology finalising workshop to be organised with all the state level teams
- State teams to conduct community level visits to interact with informants on a sample basis and also purposively to assess innovations/good practices

#### Evaluation: Issues for consideration

- Volunteers from AGCA members to participate in the evaluation process

- Volunteers for finalising Evaluation TOR
- Recommending and following up with potential resource persons – external members of the state evaluation teams
- Should we limit evaluation to the 5 states
- Current budget for evaluation – Rs. 60,000/state will be inadequate ( travel costs + resource persons honorarium)

Members appreciated the effort of the TAG in this regard. Following are the suggestions of the members:

1. Instead of an evaluation, a review of the programme should be undertaken which should reflect the government, community, NGO expectation. The review should focus on the good states and positive outcomes for highlighting the learning's for other states to replicate.
2. Next phase should focus on synergy with other efforts under NRHM such as ASHA mentoring and social determinants of health.
3. There needs to be good process documentation including measurable indicators and audio visual documentation.
4. Ensure dissemination of learning's and interchange of ideas at different fora.
5. Develop framework to suggest institutionalisation of community action.

Dr Seem also supported the above suggestion of a stronger documentation and review of the programme instead of an evaluation including PFI's expertise in upscaling programmes.

Ms. Indu Capoor said that documentation of poorly performing states also is essential. In the expansion phase other determinants of health need to be measured.

Mr. Alok said that we need to work towards the triangulation process.

Dr. Narendra Gupta also mentioned to the effect that we should get the status paper of NRHM in order to relate the progress of CM to the overall progress of NRHM.

The AGCA placed the recommendations for consideration and action by GoI.

### **Agenda Team 5: Role of AGCA**

Dr Abhijit Das presented the suggestions of the TAG on role of AGCA.

#### Unique features

- Membership is entire civil society
- All members have a base in community based activity
- Rich fund of experience in designing and managing and conducting experiments on community action



- Large number of members have public health expertise

### Roles of the AGCA

The AGCA agenda and roles should be based on NRHM goals “*The Mission seeks to provide **universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance.***”

- Provide inputs ( advice, models, feedback) on
  - increased access and utilization of quality health services by all.
  - Involvement of PRI and community in the management of primary health programmes and infrastructure. •
  - Promotion of equity and social justice. –promote local initiatives.
  - inter-sectoral convergence for promotive and preventive health care.
- AGCA roles and agenda should evolve with the progress of NRHM – preparatory input, new models, feedback, evaluation
- AGCA should strengthen the culture of evidence based policy making – especially in the context of community level action and experiences
- AGCA should also strengthen inputs on other aspects of community action eg. decentralised planning through the mechanism– concept note – experiment– recommendation
- AGCA should work as a feedback system
- AGCA should be able to commission studies cutting across different states
- There must a system of interface with NHSRC – Seen as a demand side – supply side interface
- The current CM project may require a separate resource centre – delinked from AGCA
- AGCA should continue to have a TAG and resource centre of to support its action

### Agenda of AGCA

- Look at convergence issues
- Look at the functioning of the systems
- Look at integration of ‘Determinants of Health’ into NRHM
- Assess functioning Rogi Kalyan Samiti – functioning; links with community etc.
- Status of Concrete Service Guarantees – review progress and status of guarantee and facilities compliance to IPHS etc.
- Review Mid-term indicators – request GoI to revise them if necessary
- Include inputs for setting up new /improving systems – eg. decentralised / community planning

### Members to set Agenda

- Members to collectively identify new agenda of concern at next AGCA meeting
- Members should be encouraged to set agenda for discussion – circulate write up on the issue for discussion/consultation

- Advisory agenda should be wide ranging
- Action agenda should be limited

Mechanisms to Support AGCA Functioning

- Continue with TAG – expand in view of other roles
- Expand National Secretariat to Resource Centre
- Regular interface with NSHRC
- Resource Centre should engage in evidence building for the AGCA discussion/consideration
- Resource Centre should conduct experiments and documentation for AGCA discussion/ consideration
- Continue with the autonomous website
- AGCA should be upwardly linked to the Mission Steering Group – common member participation should be specially ensured – coopt other MSG members as special invitees
- Community Monitoring may not excite all members of AGCA. We need to introduce other agenda which will enable other AGCA members to be involved. We should dedicate time in the next AGCA to set out an agenda of issues for engagement – build body of knowledge, enriched discussion.
- To advise on community action we will need to set the agenda – concept note – experiment
- We also need a TAG and Resource Centre to support initiatives in community action- invite for TAG as well

Role of AGCA	MECHANISMS	Support Structures
Advisory Roles Feedback	Meeting	Information Back up Secretarial Back up
Developing / Documenting new models of Community Action and recommend for further adoption/extension	Experiments and Documentation  Independent Member driven Consultations	Resource Centre Technical Advisory Group Community level partnerships

After discussion following were the various suggestions by the members:

1. Interface with RRC.
2. Integration in NRHM both at central and state government level.
3. AGCA should be independent. TAG should be an expanded group to be part of the resource centre as might be suitable.
4. Current AGCA agenda is wide, AGCA should have community based agenda with focus on denials, violations, positive aspects etc.
5. Exclusive civil society review of NRHM.
6. AGCA agenda should include presentation on overall status of NRHM.

7. Retain current AGCA ToR.

Mr. Alok Mukhopdhyay said that the best practices of community monitoring should be documented and circulated widely.

Dr. Abhay Shukla recommended that the phase I (a) of community monitoring should be followed by Phase I (b) which is less intensive and where the role of AGCA and TAG are well-defined.

Prof. Chaudhury reiterated that the TOR of AGCA is sacrosanct. There is a provision for additional clauses.

Members suggested that the AGCA's functioning has been limited to a narrow monitoring role. The programme on community monitoring and its detailed discussion should be held separate so that the AGCA can deliberate on other agenda's. If required the AGCA should meet over two days to deliberate on key issues of NRHM with prior preparation.

**Agenda Item 6: Recommendations of the Dai consultation**

The note on the recommendations was placed for information. Members added that the consultation highlighted the following.

1. Dai is still undertaking delivery at the institution.
2. Dai is the bridge or intermediary between the woman and the service provider and provides valuable psychosocial support..
3. If dai is well trained and supervised she can play a key role. There are many examples and community based evidences where trained dais' have helped reduce infant mortality.
4. In the consultation there was no dichotomy on home vs institutional delivery. The focus was on her role in taking care of the women's health as evident from various studies from Nepal, Pakistan and Gujarat.
5. Dai can be the birth companion and should be included in JSY.

It was decided that the group involved in the dai consultation will make a presentation and seek consultation from the government.

**Next meeting of AGCA : It was decided that the next AGCA meeting will be held for two days on 18-19 September 2008. VHAI will check and suggest the venue preferably outside of Delhi.**