

Minutes of Meeting of 13th AGCA – NRHM
Population Foundation of India
23 January 2009

Advisory Group Members present

Ms Mirai Chatterjee - Chair
Dr H Sudarshan
Dr Abhay Shukla
Dr Abhijit Das
Dr Narendra Gupta
Dr Shanti Ghosh
Ms Indu Capoor
Dr Sharad Iyengar
Dr Alok Mukopadhyay
Dr Thelma Narayan

Representatives from GOI

Mr G C Chaturvedi, MD, NRHM
Dr Tarun Seem, Dir NRHM

Other invitees

Mr Manoj Kumar Singh, NHSRC Delhi
Ms Sunita Singh
Dr Kumudha Aruldas
Mr S Ramaseshan
Ms Sona Sharma
Ms Sudipta Mukhopadhyay

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

Prof Ranjit Roy Chaudhury
Dr M Prakasamma
Dr Vijay Aruldas
Mr A R Nanda
Dr Dilip Mavalankar
Sh. Gopi Gopalakrishnan
Sh. Harsh Mander
Dr R S Arole
Dr Saraswati Swain

Agenda Item 1: Confirmation of minutes of 12th AGCA

Ms Sudipta highlighted the 12th AGCA actionable points. Members had no suggestions/comments on the minutes of the 12th AGCA and the minutes were finalized.

Agenda Item 2: NRHM Common Review Mission – response from review team members

Following are the key highlights from state reviews as mentioned by the members:

Kerala: Dr Narendra Gupta

- The state has already achieved NHRM goals much before the programme. Therefore the review focused on quality and private sector participation.
- 80% of institutional deliveries were in the private sector.
- Gross underutilisation of public health services especially super specialty facilities leading to imbalance in utilization of these facilities.
- PHC level utilisation very low since access was high to taluka level facilities.
- Equity – out of pocket expense high, high borrowings, heavy debts.
- Contribution of panchayat funds very high (40% of district development funds is routed through panchayats in maintaining and developing health facilities e.g. wisdom ward for elderly people, construction of hospitals).
- Kutumbshree an excellent model for learning.
- Occupational and environmental health problems are serious in the state. Mental health programme has been introduced which will include psychiatrist at district and taluka hospitals.
- Is Kerala moving towards over medicalisation of the system, which is leading to erosion of community-based approaches?
- Formation of Kerala Medical Supplies organization has led to streamlining of drug supplies and which is need based.
- Empowered ASHAs who are mostly literate and have completed school education. Since institutional delivery is already very high (e.g. 99% institutional delivery in tribal district of Waynad) ASHA are focusing on conveying key messages – e.g. breast feeding, motivating people for accessing government facilities.
- The only state where payment made to ASHA through debit cards (tie up with ICICI). This has ensured that the expenditure is online which has increased transparency in the process.

Mizoram: Dr Sharad Iyengar

- The state has a homogenous tribal population.
- Completely Christian population.
- High positive influence of the Church.
- Benefits of heavy GoI investment (e.g. government employment), literate population. Consciousness of accessing health services was very high. High utilization of health facilities.

- Shortage of specialists.
- ANM, LHV underutilized.
- RCH outcomes good (high use of oral pill) but badly managed by government.
- Abortion need very high and is conducted in health centres.
- No contraceptives available for adolescents.
- Dental care sought after.
- High levels of drug addiction.
- Roles of ASHAs need to be revisited.
- Proactive VHSCs
- Role of other pan state community based organisations in mainstream governance e.g. Young Mizo Association, Mizo Womens association, Elders association. Representatives of these organisations are members of VHSC.
- Worth studying the reasons for no malnutrition and high birth rate of healthy babies.

Orissa: Dr H Sudarshan

- State doing fairly well in Orissa particularly in the districts visited for review i.e. Dhenkalal, Subhranpur and Ganjam.
- ASHA programme doing very well with 48% trained on module 4.
- Drug kits available
- VHSC formed late due to confusion on registration but as of date 36% VHSCs formed.
- Sub centres have received funds.
- RKS needs to be empowered.
- Mobile medical units running well including Janani Express.
- New PHCs have no lab technician post. They are only in namesake.
- Sub centres do not report to new PHC.
- CHC fairly good.
- FRUs low with no FRUs below district hospital.
- EMoC available only at district level.
- Under funding of PHCs (Rs 16000/- annual budget for PHC) and CHCs (1 lakh for CHC for drug supply).
- 70% of children anaemic. The state has procured pediatric iron syrup.
- HR challenges very high. Training centres not cleared for nursing and ANM training. Need more medical colleges.
- Need for training of MO in ObGyn.
- Proactive leadership of Mission Director.
- Good financial management.
- HMIS by passing sub centre. No feedback to sub centre.
- DPM and BPM very proactive. They are the strength of the Mission.
- MNGO programme the best in the country. Good NGO coordinator.
- Community monitoring pilot programme has led to good impact. Government wants a low cost replicable programme.
- ICDS – AWW participation good.
- Convergence with PRI.

- IDSP programme in Dhenkanal district was good.
- Planned and non-planned expenditure has reduced.
- Public health cadre lacking. The state can adopt Tamil Nadu model.
- Ayush doctors in place at new PHC.
- Duplication in external funding. State has been asked to dovetail external funding into PIP plan.
- JSY mismanagement in Ganjam district, under spending. In Dhenkanal mothers received money.
- State mission feels that there should be only one review of NHRM instead of JRM and CRM.
- Vaccine supply has been a disaster leading to lack of vaccines for six months in the state.
- Backlog in blindness control.
- IMR figures in Orissa - NFHS is quoted but SRS figures are different and more reliable.
- Malaria: Impact of lack of timely insecticide supply from centre. Malaria kits available.
- Peripheral staff not available in naxal affected areas.
- Need for tripling drug supply.

Agenda Item 3: Presentation of findings from review of Community Monitoring Programme

Mr S Ramanathan presented the findings of the review of the programme on community monitoring on behalf of the review team. Detailed presentation attached as annexure A.

Following are the suggestions/comments from the members.

- Designing needs revision.
- Should have kept state in mind and locating pilot within state needs.
- Lessons learnt should be included in the scaling up and replication phase.
- Need to relook and reflect on the paradigm of community monitoring.
- Need to address problem of setting parallel structures. Need to strengthen panchayat system.
- Need more state buy in from beginning e.g. where state governments have been especially resistant such as in Madhya Pradesh.
- Need for convergence among various community level health workers ASHA and link worker for HIV/AIDS.
- Need to explore to what extent ASHA Resource Centre can address community monitoring.
- Red districts – whether NGOs can play role in these districts – CM, ASHA, PPP, service delivery.
- Whether community monitoring process can lead to triangulation. Can learn from Rajasthan where process of triangulation has begun and cross validation of data at village level has begun.

- Community monitoring data yet to be accepted as 'valid' data by PRI members and block health officials.
- Triangulation can also be limited to local level through community monitoring rather than at the higher level (block/district level). This will lead to more action at the local level.
- PRI involvement varied across state.
- Karnataka has undertaken second cycle of monitoring. State government includes planning and monitoring. Taluka level separate committee but at district level monitoring part of district health mission.
- PRI involved in Karnataka.
- Triangulation has been accepted in Karnataka
- Revised tools and manuals developed in the state.
- Independent study shows quality of fixed health day services improving. Neo natal and postnatal counseling improved in camps and in villages with and without VHCS.
- Need to adopt incremental approach in implementation of community based planning and monitoring.
- State resource organizations need to be involved in revision of manuals.
- Need support for two more rounds of community monitoring.
- Programme review was comprehensive. Such reviews should be conducted as per requirement.
- Programme experience should be widely disseminated at national and regional level.
- Monitoring should look into mortality rather than on processes.
- Good ownership at state level.
- Paucity of ownership at district and block level.
- Monitoring and planning process should lead to better planning and utilisation of untied funds as per community need.
- ASHA programme needs separate review.
- Need to define role of AGCA in next phase.
- Need for continued support and incentive from GoI in community monitoring.
- Need for exposure visit to state where process as been robust.
- Community based monitoring should be part of communitisation package.
- Need to award best PHC award on lines of Nirmal Gram award.
- Panchayat involved in Rajasthan has been good both at VHSC and block level
- PRI cannot monitor below GP level.
- In Karnataka it is too premature to hand over to panchayat department.
- Need for continued role of civil society both in handholding and in playing the role of a watch dog.
- States should evolve their independent model of community based planning and monitoring.
- The current secretariat established for community monitoring may be revised as per future need and may also raise funds from GoI and other sources.

Response of Mission Director

- Almost two year programme, which made the need for scaling up imperative.
- For a state like Madhya Pradesh there is need for change in process of dialogue. Non-threatening and supportive posture required.
- Need simple flexible tool of monitoring.
- Process should be inclusive.
- Rajasthan has developed 7 parameters for village plan development. 45000 village plans formed and is part of PIP.
- GoI in the process of convergence of NGO activity – MNGO, ASHA, Community monitoring.
- Need for clarity on process of data collection ANM data
- The process can also limit itself to local level i.e. upto community health functionaries in order to improve service output.
- NRHM open to PRI involvement to whatever extent is it possible at the state level.

Mission Director approved extension of the phase I programme till 31 March 2009 with no additional cost.

Actionable points

1. Letter to GoI giving reference to 13th AGCA meeting and decision on no cost extension till 31 March 2009.
2. Letter to state nodal NGOs informing approval of no cost extension till 31 March 2009.
3. Revision of community monitoring tool with feedback from TAG members.

Agenda Item 4 and 5: Community action on social determinants of health and nutrition

Dr Thelma Narayan presented on community action on nutrition. The note and the presentation attached as Annexure B and C respectively.

Social determinants of health

Ms Mirai Chatterjee shared the key recommendations from the WHO report on social determinants in health. One of the key recommendations was formation of a task force. She suggested that the AGCA could debate on the possibility of the group's role in the task force.

Following are suggestions/comments of members for social determinants and nutrition:

- AGCA could help in developing an equity measure (health equity tool) taking examples from South Africa experience.
- Expand community planning and action to include nutrition.
- Undertake reviews as per need.

- Develop guidelines
- Implement pilot on similar lines like community monitoring
- Undertake studies on impact of action on nutrition and other social determinants.
- Engage Ministry of health and family welfare to provide inputs and action on nutrition through a national stakeholders workshop.
- Nutrition should be located within NHRM and not limited to RCH
- Need for separate bodies to oversee various ministries since nutrition as an issue is located within various ministries.
- Need for strategic input by AGCA in nutrition e.g. alliance on nutrition for dialogue with multiple actors and ministries. Also link up with ASHA mentoring group.
- Equity issues within NRHM as one step getting involved in nutrition.
- Develop fact sheet on nutrition.
- Add nutrition and equity agency in the 9 pilot states and link with community monitoring implementation groups.