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Minutes of the 24th Meeting of the Advisory Group on Community Action - NRHM
Nirman Bhawan, Ministry of Health and Family Welfare, New Delhi
May 28, 2012

Advisory Group Members present

1. Dr Abhay Shukla
2. Dr Alok Mukhopadhyay
3. Dr Abhijit Das
4. Dr H Sudarshan
5. Ms Indu Capoor
6. Dr Narendra Gupta
7. Dr Sharad Iyengar
8. Dr Thelma Narayan
9. Ms Poonam Muttreja

Representatives from GOI

1. Mr PK Pradhan, Secretary, Health and Family Welfare, MoHFW
2. Ms Anuradha Gupta, Additional Secretary and Mission Director-NRHM, MoHFW
3. Mr Manoj Jhalani, Joint Secretary-RCH, MoHFW
4. Ms Preeti Pant, Director-NRHM, MoHFW
5. Ms P Padmavathy, Deputy Director, NRHM, MoHFW

Special Invitees

1. Dr Rajani Ved, Acting Director and Advisor- Community Participation, NHSRC
2. Dr Rakhal Gaitonde, SOCHARA, Tamil Nadu
3. Mr Gurjeet Singh, VSRC /CINI , Jharkhand
4. Mr Girish Bhalerao, Joint Director, State Health Society, Maharashtra
5. Dr J Prebhu Clement Devadoss, Consultant, State Health Society, Tamil Nadu
6. Dr R Mohan Rao, State Health Society, Tamil Nadu

PFI Representatives

1. Mr Alok Vajpeyi
2. Ms Sona Sharma
3. Mr Bijit Roy

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

1. Ms Mirai Chatterjee
2. Dr Dileep Mavalankar
3. Mr Harsh Mander
4. Mr Gopi Gopalakrishnan
5. Dr Vijay Aruldas
6. Dr M Prakasamma

7. Prof Ranjit Roy Chaudhury
8. Mr A R Nanda
9. Dr Saraswati Swain
10. Dr Shanti Ghosh

Ms. Poonam Muttreja chaired the meeting at the request of the members present. She welcomed all the participants to the twenty-fourth meeting of the AGCA. She requested Ms Anuradha Gupta, Additional Secretary and Mission Director-NRHM, MoHFW to share her vision on Community Action under NRHM and the potential role of the AGCA. Ms Gupta shared the following points:

- NRHM pitches Community Action as one of its pillars with its strong rights based approach. Community Action centers around promoting the involvement of the community in planning, evolving a local health agenda, as well as monitoring the implementation of NRHM. Social audit helps in mobilizing and empowering communities to assess the delivery of health services. It provides them an opportunity to stand up and ask the service providers whether the promises made under NRHM are fulfilled in reality. However, the implementation of the community action component has been a little weak and there is urgent need to strengthen it.
- As NRHM planning and implementation processes have fairly stabilized now, it is the right time for community action to take off with momentum.
- NGOs have played an important role in initiating Community Based Monitoring (CBM) in the pilot phase. However, the area of intervention has been very small. A key constraint has been the fact that there are few committed NGOs to take forward the implementation of CM at scale. The implementation roadmap should emphasize that selected NGOs build the capacity of the community structures such as the VHSC and RKS of a set of villages/blocks to engage with the health system within a district and then moves on to the next set of villages/blocks. The focus should be on building the community's capacity to enable them to demand for their health entitlements.
- It is important to bring a systems approach to community action and in the process work across areas of maternal health, child survival, family planning etc. to ensure continuum of care.
- Most of the states have a limited understanding and capacity to implement the CBM. Even though states request for inclusion of CBM in State PIP, they lack the capacity to implement the component.
- CBM will now be an essential component of each State PIP. A portion of the state resource envelope can be retained by the Ministry for funding technical support.
- The Ministry is reworking the MNGO scheme, which will allow greater flexibility and space to NGOs to take forward the agenda of community action.
- The Ministry is open to discuss and provide additional funds to NGOs such as: supportive supervision, mobility support, IEC/BCC activities, and service delivery in remote / hard to reach areas.

- The RKS should be capacitated to question the funds allocated to the health facilities and its judicious utilization for patient welfare. They should also monitor if JSY benefits such as timely receipt of cash benefits, free transportation and medicines etc. are reaching women.
- There is an opportunity to leverage technology; the Ministry is insisting that all states/districts upload data related to mobile medical units (MMU), details on civil construction works, EMRI, facility wise deployment of HR, procurement of equipments, financial accounts. These should be displayed on the web page. The Ministry will share a copy of the appropriate documents with the AGCA members for inputs.
- There is a need to develop a code of conduct for NGOs as well as the Government. The government should trust NGOs, while on other hand the CSOs should not point fingers at the government over minor issues. It is important for both to work as partners rather than adversaries.

- *Family Planning*

Ms Gupta also emphasized that there is a need for a paradigm shift in the family planning programme to look at spacing, and guarantee universal access to contraceptives. Key reasons for this shift in focus are: 45% of the MMR is in the age group of 15-24 years, this age group contributes to 47% of the fertility. She further elaborated the initiatives taken by the Ministry to promote spacing methods and thereby strengthen the family planning programme.

- a) To improve access to contraceptive services, the Government is emphasizing on doorstep delivery of contraceptive services- condoms and OCP through the ASHA.
- b) Sub Health Centers are being provided with a 2nd ANM to strengthen delivery of services. This will enable delivery of health services on fixed days, including facilities for IUCD insertions, for 2 days a week. All states have included the training of ANM on IUCD insertion in their State PIP for FY 2012-13.
- c) In health facilities that have a high case load, post-partum IUCD is being promoted. The staff at these facilities will be trained on post-partum IUCD insertions in medical colleges and selected districts. Counsellors have also been appointed in these facilities to provide counselling on post-partum IUCD along with new born care.

Ms Muttreja requested Mr PK Pradhan, Secretary, Health and Family Welfare to share his vision of community action under NRHM. Mr Pradhan mentioned the following points:

- The Ministry is planning to develop a roadmap for the implementation of the Universal Health Coverage (UHC). It is also contemplating on the merging the urban and rural health under a larger umbrella of the National Health Mission.
- The Ministry firmly believes in strengthening community oversight in NRHM implementation. We need to develop strategies to intensify and expand CBM. The

AGCA should suggest what support it requires from the Ministry to take this forward beyond the nine states. States need to be allocated to one or more agencies to initiate CBM implementation at scale. Simultaneous efforts are required to groom other agencies in other states (and to other districts in the pilot states) to take CBM to scale.

- Community representation and oversight in the RKS committees is important to ensure that resources are being allocated on the basis of community needs.
- Resource Centres for Community Action will be essential to ensure scale up of CBM across a wider geographical area.
- Parameters and protocols for selection of NGOs to implement CBM will need to be developed. NGOs with experience in the health sector should be given a preference.
- The AGCA should set a reasonable target for 1st year for scaling up CBM, efforts could be intensified and expanded in the subsequent years.
- The AGCA should develop a terms of reference and seek approval from the Ministry to utilize the unspent balance from the pilot phase, for start up activities.
- The Ministry has initiated a TV and radio program on NRHM. The program could include the work on CBM through clippings or interviews of NGOs implementing CBM. AGCA members could also be invited to participate in the program.

The following points were shared by the AGCA members

- Partnerships with state governments are a challenge in taking forward CBM. There is a lack of conviction at the state level to implement and scale up CBM. Strong endorsement by the Ministry would be helpful in ensuring implementation of community action by the states. Grants for CBM must be made in a way that the implementation does not get stymied by state reluctance.
- In Karnataka, after the pilot phase, CBM has been scaled up to all districts. However, essential components of the CBM model have been dropped and it is now focusing only on training of VHSC members.
- Strong advocacy with the State Government is important. One of the reasons that the Regional Resource Centers (RCC) program never really took off was that states perceived this as a central funded program.
- CBM needs to address the key social determinants of health, especially nutrition, water and sanitation. There is also a need to focus on the mental health aspect in PHC.
- Membership of NRHM Committees at the state and district level should be drawn from NGOs involved in CBM activities. They could be included as Member Secretary in these committees. This will greatly help in ensuring the meetings are organized regularly and community issues needs and concerns are adequately represented in the planning and implementation cycle.
- VHSC and RKS are entry points for seeking /ensuring accountability for resources being spent in the NRHM. The financial transparency in the District Health Society (DHS) is missing. They do not share their accounts and financial details. NGOs need

to be included in these committees and regularly participate in the meetings to ensure greater transparency.

- The number of cash transfers through the ASHA and JSY schemes has increased drastically. This has resulted in the health staff being preoccupied with distribution of money rather than focusing on improving quality of services.
- The private sector is providing incentives to ASHAs for referring clients to their health facilities, this aspect needs to be carefully monitored.
- Radio and TV advertisement on the NRHM must include the component of CBM.
- In order to sustain the impact of CBM, it is essential to put in place and institutionalize a grievance collection and redressal mechanism in all public health facilities. PFI will send the information on Redressal Mechanism Committee which was announced and constituted. However, no meetings of this committee were held.
- The AGCA can support the Ministry in developing the guidelines and training modules for VHSC and RKS.

In response to the above, Ms. Anuradha Gupta suggested the following action points for AGCA:

- Facilitate a meeting of State Government NRHM officials to build their perspectives on operationalizing community action under NRHM. The meeting will be organized by the Ministry.
- Develop a road map to strengthen institutional capacity within the State Government on community action and assist them in implementation. Specific states could be allocated to AGCA members to support the implementation at state level.
- Develop guidelines and protocols for increasing the capacity of Rogi Kalyan Samitis, for effective decentralized planning and management of facilities to improve quality and accountability of services and service providers. They should be oriented to use simple score cards to assess the service standards and performance of health facilities.
- Develop and pilot the implementation of a set of monitorable indicators which can be used at different levels – community, district and state for managers to assess the level of community engagement and for communities to understand the performance of NRHM against its stipulated goals and outcomes.
- Support the development of an effective complaints/ grievance collection and redressal mechanism which enables active community engagement.
- Review the benefits of NRHM interventions, against established benchmarks, at the community level, especially among the most marginalized communities.
- The AGCA can identify potential institutions/ organizations at the state level, including Regional Resource Centers (RRC) and build their capacities to take forward community action- support district and block level NGOs to build capacity among VHSC, RKS and support implementation of other mechanisms.
- Support the development of a Advisory Group on Community Action at the state level

- Design a set of simple indicators for VHSC member to monitor outcomes like; sex ratio, low birth weight infants and children, severe anaemia, peri-natal and neonatal mortality, complete immunization, children with obvious disabilities etc.
- AGCA members and NGOs involved in implementation of CBM should be included in NRHM Committees at the state and district levels.

Ms Poonam Muttreja thanked Mr PK Pradhan, Ms Anuradha Gupta and other officials in the Ministry for sharing their vision and interest to work with the AGCA members to take forward and scale-up Community Action in India.

Post lunch discussions on the way forward

The following discussions were held in the post lunch session:

VHSC and RKS Guidelines

- NHSRC and AGCA can work collectively to develop the VHSC and RKS guidelines. NHSRC has begun work on developing the VHSC and the NGO guidelines. Members suggested that a joint committee can be constituted to further work on this.
- Members suggested that the VHSC and RKS manuals from different states can be pooled together to begin work on the national guidelines with NHSRC.
- Dr Rajani Ved shared that NHSRC is developing the RKS training manual. The manual currently focuses on aspects of facility management. Ms Ved will send a draft to the AGCA members for their inputs.

Reconstitution of AGCA:

- As discussed in earlier AGCA meetings, it was suggested that members who have not been able to commit time for the AGCA could be replaced with new members. A simple criteria suggested was – members who have not attended 3 consecutive meetings without notice and six with notice. Members reiterated the need for reconstituting the AGCA to allow greater representation from across states / regions. The north east and the EAG states need to have a better representation in the AGCA. The potential members will preferably have to be involved in health programming, however experts in disciplines like social justice, equity could also be included.

Review of CBM

- Members suggested that key learning on CBM from various states should be culled together rather than undertaking a detailed systematic review. Selected AGCA members can visit some of the states for a quick review. This can be followed by a national review.

Working groups:

- A two day, AGCA workshop could be organized in end of June or early July, 2012 to develop a detailed plan action and budget for submission to the Ministry. AGCA

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should subsequently request for a meeting with the Health Secretary and Additional Secretary and Mission Director to share the draft proposal and budget.

The AGCA members also volunteered to contribute to specific areas on which the Ministry has requested for support:

- a) Development of training curricula, operational guidelines, modules and materials for VHSC and RKS
Volunteers – Dr Abhijit Das , Ms Sunita Singh , Dr Rakhal Gaitonde , Dr Abhay Shukla, Dr Narendra Gupta, Ms Indu Capoor , Ms Renu Khanna,
 - b) Capacity building of professional managers and providers on accountability and transparency, quality, equity, integrity at the block, district and state level
Volunteers- Dr Thelma Narayan, Dr Narendra Gupta, Dr Abhijit Das, Dr Sharad Iyengar, Ms Sona Sharma
 - c) Community mobilization processes and mass accountability mechanisms
Volunteers – Dr Abhay Shukla, Mr Gurjeet Singh, Dr Rakhal Gaitonde
 - d) National review and lessons learned –
Volunteers – Dr Rajani Ved, Dr Abhay Shukla, Dr Thelma Narayan, Mr Bijit Roy.
- AGCA members also indicated the states they and other organizations could support for the scale up of Community Action;
 - a) Karuna Trust – Karnataka, Arunachal Pradesh, Meghalaya, Manipur
 - b) PFI – Bihar, Chhattisgarh, Delhi
 - c) CHETNA– Gujarat, Rajasthan
 - d) SEWA- Gujarat
 - e) VHAI- Assam, Jammu and Kashmir, Uttarakhand, Nagaland, Andhra Pradesh, Tripura
 - f) PRAYAS – Rajasthan
 - g) SATHI – Maharashtra
 - h) CHSJ – Punjab, Sikkim, Uttar Pradesh
 - i) CINI – Jharkhand, West Bengal
 - j) HDF – Orissa
 - k) SOCHARA-Tamil Nadu

The meeting ended with a vote of thanks from Ms Poonam Muttreja.