

Minutes of the Meeting of the 8th Advisory Group on Community Action
14 September, 11.00 am – 2.00 pm, PFI, New Delhi

Advisory Group/Task Group/Co-opted Members Present

Advisory Group Members

Dr Shanti Ghosh
Dr Saraswati Swain
Dr Abhay Shukla
Dr Narendra Gupta
Dr Abhijit Das
Dr Alok Mukhopadhyay
Ms Indu Capoor

Task Group Members

Dr Ajay K Khare
Mr Tej Ram Jat
Dr Rakhai Gaitonde
Dr Dhananjay Kakde

Co-opted Member/Special Invitee

Dr Sylvia Selvaraj
Ms Sunita Singh

Ministry of Health and Family Welfare

Dr Tarun Seem
Dr Dinesh Baswal

Others in Attendance (invited)

Mr S Ramaseshan, PFI
Dr Almas Ali, PFI
Ms Sona Sharma, PFI
Ms Sudipta Mukhopadhyay, PFI
Dr Sanjit Nayak, PFI

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

Dr K Pappu
Prof Ranjit Roy Chaudhury
Dr Thelma Narayan

Dr Shyam Ashtekar
Dr Rama Baru
Ms Mirai Chatterjee
Dr Jaiprakash Narayan
Dr Vijay Aruldas
Mr A R Nanda
Dr R S Arole
Dr Sharad Iyengar
Dr H Sudarshan

Dr Almas Ali began the meeting by observing a moments silence in memory of Dr N H Antia, a member of the AGCA and who passed away on 26th June, 2007. Dr Ali informed all those present that Mr A R Nanda was unable to attend the meeting due to his illness. He wished a speedy recovery for Mr Nanda. He also informed that Dr Shyam Ashtekar has sent us a mail mentioning his resignation from the AGCA due to his personal reasons.

Dr Ali welcomed all the members including the task group members who met on 13 September 2007 at PFI to work on the detailed framework of the tools. He requested Dr Shanti Ghosh to chair the meeting.

Agenda Item 1: Approval of minutes of the 7th AGCA meeting

Ms Sudipta Mukhopadhyay of PFI presented the highlights of the decision taken on the last minutes.

1. Request for approval for one additional district of Maharashtra and Karnataka state sent to MoHFW by Secretariat. Approval due.
2. The task group meeting on the first phase programme on community monitoring of services under NRHM was held on 13 September 2007 to finalise the tools.
3. Revised budget was prepared by the Secretariat and discussed at the discussed at the budget committee meeting at MoHFW on 29 August 2007. The minutes of the budget committee meeting have been circulated. Revised budget to be submitted by the AGCA today.
4. Four documents mentioned in the minutes were to be made available to the AGCA. The Secretariat is yet to receive these documents.

Responding to the above report Dr Tarun Seem informed:

1. The approval letter for Maharashtra and Karnataka has been issued.
2. The immunization report is available on the website. He will also make available the working papers on maternal health.

Agenda Item 2: Progress of NRHM

Dr Seem presented the status of NRHM.

Following are the comments from members regarding the progress of NRHM.

Dr Alok Mukhopadhyay mentioned that the Independent Commission Report on NRHM would be shared shortly. Following are the highlights from the report.

- The communitisation process is lacking in NRHM. Need to understand how the community perceives ASHA.
- Those who are implementing the programme at the state and district level have not imbibed ideas, values and concepts of NRHM.
- There is need to reflect and ensure that those who are the implementers understand the value of NRHM, the role of PRIs and the follow-up of AHSA.
- Tremendous enthusiasm has been generated with the selection and training of ASHAs. But tragically follow-up is extremely poor. The training is not enough to empower AHSA to be able to conduct all the activities envisaged. There is need for handholding, strengthening her as part of a collective of new community based health worker.
- District officers are of the opinion that ASHA has been thrust upon them. There is disconnect between ASHA and district authorities. This needs to be changed and ASHA should be integrated into the system.
- The system of release of resources under NRHM stills follows the old pattern. As seen from grassroot implementation efforts in Arunachal Pradesh by VHAI and Karuna Trust the process of release of resources and funds is lengthy and the amount does not reach on time. Administrative processes continue to pose a hurdle. There is need to fast track the administrative processes. Mechanisms of administrative processes need to be looked into at the state level.
- NGO involvement in the entire program has been low. Integration of smaller NGOs remains elusive. There is need to build greater ownership among NGOs.
- There is no understanding at the Panchayat level of NRHM. There is no creativity in utilizing untied funds.
- There should be greater focus on states where the implementation of the programme has been difficult.
- Need to address the issue of corruption and political appointments.

Dr Mukhopadhyay further mentioned that states should claim greater stake in NRHM, states should be given more freedom to implement the programmes, ASHA's should not be over burdened and there should be greater transparency in NRHM.

Ms Indu Capoor responded that the process of community monitoring is difficult mainly because the community is not ready. This needs to be an intensive process e.g. Gujarat which took two years to ensure involvement of Panchayats in the process.

Dr Narendra Gupta raised the question on what is the current process adopted for PIP. Responding to the question Dr Tarun Seem mentioned that there has been a paradigm shift in the process of developing the state PIPs. Before April 2005 funds went vertically

from Government of India to the states. The implementation framework of NRHM provided the outline of the process of developing a state PIP based on local needs. In order to make the PIPs internally consistent, consultants provided technical assistance in developing the PIPs. The PIPs include a section on the background status in the state and specific destination sections such as RCH, NRHM, immunisation, infrastructure and intersectoral coordination. The PIPs are reviewed by Government of India based on which the PIPs are refined and even revamped.

Dr Abhay Shukla commented that many CBOs and NGOs were not aware of the process of PIP formation and that they can provide inputs at the district and block level in developing the PIP. He requested that at least for the 9 pilot states of community monitoring programme the state PIPs could be put in the public domain. He also recommended that the list of upgraded facilities – CHCs and PHCs should be available in the public domain. He asked about indicators being used to monitor the availability of essential drugs in PHCs and CHCs, since this was a matter of concern. He also queried about the status of fulfillment of guaranteed health services from PHCs and CHCs, and the time table regarding the same.

Dr Saraswati Swain mentioned that the main problem of NRHM was of execution of the programme. The district level officials did not promote the entitlements and key messages of the programme.

Dr Shanti Ghosh mentioned that it was a problem of the health system. There was a need to strengthen the system.

Dr Abhijit Das commented on three aspects. The first was that there were two websites on NRHM of the Government of India. Need to put both websites into the same address. The second was the problem of over reaching where benchmarking is based on indicators in NRHM. He expressed the need to revisit some of the interim indicators and include process indicators, which are realistic for NRHM. Thirdly he suggested the need to institute accountability and grievance redressal mechanism in NRHM in order to build accountability and subsequently increase the credibility of the health system.

Dr Ajay Khare expressed the need to orient health department officials on its role in ensuring efficient functioning by ASHA and involving PRIs.

Dr Shanti Ghosh concluded the session by mentioning that the ASHAs work needs to be simplified to that of an MCH worker who coordinates with the ANM, so that she is able to carry out the basic tasks.

Agenda Item 3: Update on First Phase of Community Monitoring

Ms Sunita Singh on behalf of the National Secretariat presented the detailed update on the progress of the programme in 9 states. Following activities have been undertaken by national secretariat:

1: Materials/posters/CDs:

- Six posters designed
- Four Posters designed in Maharashtra by SATHI- CEHAT
- Briefing kit on community entitlements, roles of providers and frameworks of accountability – English and Hindi – distributed to all states
- Community Monitoring Brochure – English and Hindi distributed
- Four pamphlets for community – designed in Hindi
- CD being prepared with soft copies of all materials

2) Model Curriculum for Trainings and Workshops:

- Manual draft designed and circulated
- Draft Workshop and Training Curricula designed and circulated
- Model presentations prepared and circulated
- TAG finalizing

3) Tools Development

- Draft Community Mobilization protocols being finalized by TAG
- Draft Community Monitoring protocols being finalized by TAG

4) National Workshop and Stakeholder Consultation

- Three day workshop was conducted between 19 and 21st July. Attended by over 50 participants (Resource Persons) for the 9 states. Programme details and State reports were shared, and discussion on protocols for community mobilization and monitoring took place.
- National Stakeholders Consultation on NRHM organised in collaboration with Centre for Health and Social Justice (August 8th 2007). Over 100 people participated (Attended by Mission director and other officials, officials from planning commission, AGCA members, international organizations, civil society organizations and experts)

Challenge(s): following are the challenges:

- The process of mutual communication is not yet been set-up
- Documentation part is not yet been regularized
- Technical support from TAG hasn't been properly institutionalized or regularized
- Functioning feedback mechanism has not been established with the state
- Difficulty to keep timeline in absence of timely financial disbursement

An update on State Level Processes of the Community Monitoring

1) Assam :

- AGCA member – Dr Narendra Gupta, State NGO representative Dr Sunil Kaul and National Secretariat PO met with Mission Director, Dr. J.B. Ekka.
- Mr. Muhammed Zaheer Abbas Majumder, State NGO Coordinator was appointed as the nodal officer.

- The state mentoring group has been constituted by the Mission Director on 20th August 2007.
- The pilot districts have been discussed, finalized and notified by the NRHM directorate are - Chirang, Dhemaji and Kamrup rural
- It was decided that the two-day state level workshop would be organized either in first or second week of July 2007 – but had to be postponed
- GO has been issued stating Voluntary Health Association of Assam (VHAA) as the state nodal organization. The MoU is being processed by PFI.

Chhattisgarh

- Early June National Secretariat PO met Health Secretary.
- On 6th July 2007, preparatory meeting was organized with civil society organization in the presence of a government observant.
- The mentoring team was formed in the meeting.
- Three districts were selected for community monitoring with the consultation of Secretary health. They are Baster, Kawardha, Koriya.
- A consortium has been formed to take forward the CM process (PFI, CGVHA and Sandhan). Sandhan is the lead NGO.
- The first mentoring group meeting took place on 25th July 2007
- The state level workshop took place on August 17th and 18th, attended by government officials, mentoring group members and NGOs
- Blocks were selected and a detailed plan of action was prepared
- Second mentoring group meeting took place on August 18th 2007
- Block level NGOs name has been recommended by district official Health Secretary along with mentoring team will finalized the name
- Village and Sub-centers have been selected

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Maharashtra

- State workshop level workshop was organized on 7-8th June 2007 in Pune. First state mentoring committee meeting held on 7th June 2007.
- Five districts selected for CM are; Nandurbar, Amravati, Osmanabad, Pune and Thane
- Nodal NGOs agreed upon and accepted by State health department
- Block nodal NGOs identified in all blocks
- TOT was organized August 7-11 2007 in Pune
- Second State mentoring committee meeting took place on 8th August
- First circular on community monitoring issued by State Health Ministry in August 2007.

Madhya Pradesh

- State level workshop was organized on 29th – 30th May 2007. The workshop was attended by Director, Health & Family Welfare, Commissioner, Panchayat & Rural Development, Govt. of M.P, CMO, Chairpersons Health Sub Committee, Zilla Panchayat, NGOs, AGCA members, State Mentoring team members & resource persons

- Blocks, PHC and villages finalized
- Coordination between PRI and Panchayat at district level worked out
- Letter for formation of Village health and Sanitation committee from Panchayat issued and committees are under formation.
- Five day State TOT held at Bhopal on 16th to 20th August 2007.

Orissa

- Four districts for community monitoring in first phase were selected representing 4 geographical zones of the state; Nawarangpur, Jharsuguda, Mayurbhanj, Kendrapada
- The process of selection of one NGO per block is over
- State level workshop on community monitoring was organized on July 24th
- The TOT will take place on 18th Sept
- The AGCM has decided not to choose any district level organization, as the coordination in the district and CM process is the responsibility of mentoring group members.

Karnataka

- On 25th July 2007, a civil society meeting was held at the Community Health Cell (CHC).
- In the meeting it was decided that the project in Karnataka will be called Community Planning and Monitoring of Health Services (CPMHS).
- The state mentoring group has been formed by the civil society side but the health department has yet to approve it.
- Karuna Trust has been selected as state nodal NGO
- The three pilot districts Chamarajnaragar- Yelandur, Kollegal and blocks have been finalized

Tamil Nadu

- Two days state level meeting was done in Chennai on 30th and 31st May. The civil society organisations from various backgrounds were participated.
- The state level nodal NGO has been identified. I.e. Tamilnadu Science forum (TNSF).
- State level Mentoring committee members were identified. In the mentoring committee representatives from academic, resource and human rights groups also included.
- The districts were finalized with their suggestion. Kanniyakumari, Perambalur, Dharmapuri, Vellore and Thiruvallur are the five districts chosen to carryout community monitoring project activities.
- Districts were identified along with the district nodal organisation. The districts were chosen on the basis of civil society organisation's strength in the particular district. Since this is pilot project the criteria was justified by the participant organisations

Rajasthan

- Dr. M.L. Jain, Director AIDS/Hospital Administration Rajasthan has been appointed as nodal officer.
- The three member committee consisting of Dr. M. L. Jain, Dr. Shiv Chandra Mathur, Director SIHFW and Dr. Narendra Gupta chose four pilot districts Chittorgarh, Udaipur, Jodhpur and Alwar.
- State Mentoring Group has been constituted.
- The state level workshop was held on the 27 and 28th of July 2007. The district level health department health officials and the CSO's had participated.

Jharkhand

- The Mission Director got who had been briefed about community monitoring has been transferred.
- The state health secretary, Mr. Siyaram Prasad Sinha, has made a query on the community monitoring plan so a decision is still pending on the file.
- GO has not been issued as yet.
- Dr. Suranjeen Prasad, Mr. Kaushik Saikia and Dr. Anant are keeping a track of the developments at the state level

Challenge(s)

- In few states processes at the state level have been slower than anticipated
- Frequent transfers of officials
- Health department politics
- Political and bureaucratic dynamics
- Government is still seeking clarification about the process of CM
- Delay in getting GO
- Due to late release in fund have delayed CM process in states

Following are the comments and suggestions on the progress of NRHM.

Dr Rakhil Gaitonde mentioned that the internal communication between the national secretariat, the state nodal NGOs and the state governments needs to be strengthened. This was also expressed by the Government of Tamilnadu. Copy of minutes of meeting of the AGCA should be send to the sate government.

Mr Tej Ram mentioned that in Rajasthan the following activities have been completed.

- a. Meeting held with Mr R.K. Meena (Principal Health Secretary) on 2nd April 2007 in Jaipur
- b. State nodal officer appointed. Dr. M.L Jain is the state nodal officer.
- c. Organised state level meeting on 8th May in Jaipur
- d. State level mentoring group has been formed.
- e. All the blocks in each of the 4 pilot districts have been finalised.
- f. Government order for state nodal NGO has been issued.

It is proposed that state ToT for Rajasthan will be held in October.

Ms Indu Capoor mentioned the dilemma in involving government in the selection process of district and block level NGO this leads to the government taking over the decision making process and often not involving the NGOs.

Dr Ajay Khare mentioned that following activities which have been completed in M.P.

- ✓ Five day State TOT held at Bhopal on 16th to 20th August 2007.
- ✓ Preparations underway for organising district level workshops.
- ✓ District level coordinators have been selected.
- ✓ Block level coordinators have been selected.

Dr Abhay Shukla mentioned that the uncertainty about the fund release was leading to slowing down the momentum gained in the programme and was hampering initiative by civil society organizations. In Maharashtra one NGO has already indicated that they may back out of the programme due to uncertainty in funding. He also mentioned that the process of MoU preparation took a long time.

Responding to the above Ms Sudipta Mukhopdhayay mentioned that the MoU process took longer since it was prepared after feedback and approval from the state nodal NGOs.

Dr Tarun Seem mentioned the following regarding progress of the programme.

- a. Regarding development of website for the programme, he suggested that a consultant be appointed for developing the website instead of an agency. The site can be hosted by NIC.
- b. The progress of the programme should be mentioned in the MoHFW website. The status of selection of state nodal NGOs with the names and details should be mentioned in the website.
- c. Dr Seem requested that his email id be included in the e-group on community monitoring.
- d. Members of the National ASHA mentoring team have been given responsibility for supporting the ASHA programme in specific states. They should link up with AGCA members related to the state and community monitoring mentoring teams at the state level to help the formation of State ASHA mentoring teams. GoI will provide government order mentioning the same.
- e. The ToR for the budget committee meeting also includes preparation for the sustainability of the project. PFI to create audit trail of learning and preparations for the second phase proposal to be undertaken at the earliest.
- f. All materials/tools to be shared with NHSRC, NIHFW, SIHFW in the pilot states and SHRC Raipur.

Dr Abhijit Das gave the following suggestions:

- a. There should be an institutional mechanism for AGCA members to be part of the Joint Review Mission (JRM) process. Responding to this Dr Seem mentioned that the JRM was for RCH II. NRHM would have a separate review process as part of which expressions of interest has been invited from all.

- b. He also asked what is the process of institutionalising people's feedback in the programme. He suggested that telephone helplines be set up at the state level as had been done in Bihar and Jharkhand and there should be provisions for receiving feedback through the website as well.
- c. The Ministry should recommend that state level AGCAs should be formed and these state level bodies could oversee the process of community feedback at the state level.
- d. When state level health department officials attend any meeting at the National Level there should be a short input on Community Monitoring in NRHM and AGCA National Secretariat could provide this input. This would facilitate the formation of state level AGCA.

Dr Seem also suggested that the AGCA could assist in preparing the state NRHM report. For this purpose the state mentoring group for community monitoring could be expanded to include individuals who would be useful in providing inputs in the state NRHM report.

Dr Dhananjay Kakade suggested that advertisements on NRHM could include advertisements on service guarantees. All members appreciated the suggestion.

Agenda item 4: Other

Dr Abhijit Das mentioned that the National Stakeholders Consultation on NRHM held on 8 August 2007 in Delhi was a useful process, which should be institutionalised. Copies of the consultation report were shared with the members. It was decided that the Recommendations emerging from the National Stakeholders Consultation should be forwarded to the Ministry by the AGCA for consideration and incorporation into the ongoing monitoring and review process.

Dr Shanti Ghosh concluded the meeting by thanking all members for their time and valuable inputs.

Annexure 1:

National Secretariat- Status Report

14th September 2007

<i>Tasks</i>	<i>Status</i>
Material for Awareness Generation	<ul style="list-style-type: none">• Six posters designed from Nat Sec• Four Posters designed in Maharashtra• Briefing kit on community entitlements, roles of providers and frameworks of accountability – E and H – distributed to all states in bulk• Com Monitoring Brochure – E and H distributed• Four pamphlets for community – designed in Hindi• CD being prepared with soft copies of all materials
Model Curriculum for Trainings and Workshops	<ul style="list-style-type: none">• Manual draft designed and circulated• Draft Workshop and Training Curricula designed and circulated• Model presentations prepared and circulated• TAG finalizing
Developing Tools	<ul style="list-style-type: none">• Draft Community Mobilisation protocols being finalized by TAG• Draft Community Monitoring protocols being finalized by TAG
Documentation Formats	Under preparation – not yet finalised
Assist AGCA members and State NRHM directorates for State NGO networks for State preparatory Phase	Regular contact maintained with concerned AGCA members and state contact persons. Multiple field visits made to each state
Develop a website on community based monitoring of processes and access to services under NRHM	In house meetings on website development, as well as discussion with consultant has taken place. Road map to be sent by consultant
National Workshop	This activity was not part of the initial plans. Three day workshop was conducted between 19

	and 21 st July. Attended by over 50 participants (Resource Persons) for the 9 states. Programme details and State reports were shared, and discussion on protocols for community mobilization and monitoring took place.
National Stakeholders Consultation on NRHM	Organised in collaboration with Centre for Health and Social Justice.
Process documentation	Ongoing. State level sharings took place at the National Workshop. State Nodal NGOs are taking responsibility. One state has set up a state level email group. National email group has been set up.
Setting up Budget Committee	Members for Budget Committee suggested and meeting held with MoHFW
Technical support to State Nodal Organisations	Being provided on a regular basis through visits, telephone and email- providing material, information.
Preparation of MoUs for the second installment	Finalised and being executed
Financial oversight, collation and finalisation of accounts of first installment	Done
Disbursal of grants	Ongoing
Quarterly reporting	Ongoing

Challenges:

- 1) The process of mutual communication is not yet been set-up
- 2) Documentation part is weak
- 3) Technical support from TAG hasn't been properly institutionalized or regularized
- 4) Functioning feedback mechanism has not been established with the state
- 5) Difficulty to keep timeline in absence of timely financial disbursement

Annexure 2:

An update on State Level Processes of the Community Monitoring of Health Services project under NRHM

14th September, 2007

Assam-

- AGCA member – Dr Narendra Gupta, State NGO representative Dr Sunil Kaul and National Secretariat PO met with Mission Director, Dr. J.B. Ekka.
- Mr. Muhammed Zaheer Abbas Majumder, State NGO Coordinator was appointed as the nodal officer.
- The mentoring group members have been finalized.
- The pilot districts have been discussed and finalized - Chirang, Dhemaji and Kamrup rural
- It was decided that the two-day state level workshop would be organized either in first or second week of July 2007 – but had to be postponed
- GO has been issued stating Voluntary Health Association of Assam (VHAA) as the state nodal organization. The MoU is being processed by PFI.

Challenge(s)

- Processes at the state level have been slower than anticipated

Jharkhand-

- The Mission director got who had been briefed about community monitoring has been transferred.
- The state health secretary, Mr. Siyaram Prasad Sinha, has made a query on the community monitoring plan so a decision is still pending on the file.
- GO has not been issued as yet.
- Dr. Suranjeen Prasad, Mr. Kaushik Saikia and Dr. Anant are keeping a track of the developments at the state level.

Challenge(s)

- Frequent transfers of officials
- Health department politics

Rajasthan-

- The three member committee consisting of Dr. M. L. Jain, Dr. Shiv Chandra Mathur and Dr. Narendra Gupta chose four pilot districts Chittor, Udaipur, Jodhpur and Alwar
- The state level workshop was held on the 27 and 28th of July 2007. The district level health department health officials and the CSO's had participated.

Challenge(s)

- Political and bureaucratic dynamics

Tamil Nadu-

- Initial discussion happened with the state health secretary and Director of Public health services.
- Draft GO has been sent from Health Secretary to the mission director
- Two days state level meeting was done in Chennai on 30th and 31st May. The civil society organisations from various backgrounds were participated.
- The state level nodal NGO has been identified. I.e. Tamilnadu Science forum (TNSF).
- State level Mentoring committee members were identified. In the mentoring committee representatives from academic, resource and human rights groups also included.
- The districts were finalized with their suggestion. Kanniyakumari, Perambalur, Dharmapuri, Vellore and Thiruvallur are the five districts choosen to carryout community monitoring project activities.
- Districts were identified along with the district nodal organisation. The districts were chosen on the basis of civil society organisation's strength in the particular district. Since this is pilot project the criteria was justified by the participant oranisations

Challenges:

- Government is still seeking clarification about the process of CM
- Delay in getting GO

Karnataka-

- On 25th July 2007, a civil society meeting was held at the Community Health Cell (CHC).
- In the meeting it was decided that the project in Karnataka will be called Community Planning and Monitoring of Health Services (CPMHS).
- The state mentoring group has been formed by the civil society side but the health department has yet to approve it.
- Karuna Trust has been selected as state nodal NGO
- The three pilot districts Chamarajnar- Yelandur, Kollegal and blocks have been finalized.

Challenge(s)

- Karnataka project funding yet to be sanctioned at the national level

Madhya Pradesh-

- 16th April 2007 in Bhopal state preparatory meeting was organized
- One state level resource group was formed comprising civil society and government officials for time to time technical support

- Five districts were chosen for the CM looking at the geographical diversity; Guna, Sidhi, Bhind, Badwani and Chindwada
- State level workshop was organized on 29th – 30th May 2007. The workshop was attended by Director, Health & Family Welfare, Commissioner, Panchayat & Rural Development, Govt. of M.P, CMO, Chairpersons Health Sub Committee, Zilla Panchayat, NGOs, AGCA members, State Mentoring team members & resource persons
- Blocks, PHC and villages finalized
- Coordination between PRI and Panchayat at district level worked out
- Letter for formation of Village health and Sanitation committee from Panchayat issued and committees are under formation.
- Five day State TOT held at Bhopal on 16th to 20th August 2007.

Challenge(s)

- Delay in getting GO

Maharashtra-

- State Mission Director and Director of Health services attended State Health Assembly organised by JSA – 22-23 Feb., preliminary discussion on CM pilot.
- State workshop level workshop was organized 7-8th June 2007 in Pune
- Five districts selected for CM are; Nandurbar, Amravati, Osmanabad, Pune and Thane
- Nodal NGOs agreed upon and accepted by State health department
- Block nodal NGOs identified in all blocks
- TOT was organized August 7-11 2007 in Pune
- Second State mentoring committee meeting took place on 8th August

Challenge(s)

- Government is still seeking clarification about the process of CM
- Involvement of Panchayats yet to get organised in significant manner, likely to develop with field level activities

Orissa-

- The State Advisory Group on Community Monitoring formed
- State secretariat for AGCM is in place
- Four districts for community monitoring in first phase were selected representing 4 geographical zones of the state; Nawarangpur, Jharsuguda, Mayurbhanj, Kendrapada
- The district officials were briefed about the community monitoring by AGCM members in two subcommittees.
- Blocks for community monitoring were selected as per the suggestion of the officials and other community leaders in the concerned districts.
- The process of selection of one NGO per block is already over.
- The letters about provisional selection of NGOs were also issued by the state secretariat.

- The one day orientation to selected NGOs on community monitoring is completed
- The consultation meeting on 11th April 07 built up a consensus among participant NGOs on having Kalinga Centre for Social Development KCSD as the State Nodal NGO for Community Monitoring.
- The proposal of selection of Nodal NGO finally approved by the Mission Director, NRHM, Orissa vide his letter no. OSH&FWS/4603(4)/101/07 dated 22nd May 2007.
- The formation of community monitoring group is formally approved by the Mission Director, NRHM vide his letter no. OSH&FWS/4645/101/07 dated 24th May 2007.
- A broad criteria was fixed by the AGCM
 - Presence of individual NGOs/CBOs in the area.
 - Geographical accessibility of the blocks.
 - Need of the community (served and underserved area)
- Two sub committees were formed
- The members of Sub committee visited two districts each
- State level workshop on community monitoring was organized on July 24th
- The TOT will take place on 18th Sept
- The AGCM has decided not to choose any district level organization, the coordination and CM process is the responsibility of mentoring group members.

Challenge(s)

- Due to timely release in fund is have delayed CM process in the state

Chattisgarh-

- Early June an AGCA representative met Health Secretary
- On 6 July 2007, preparatory meeting was organized with civil society organization in the presence of government observant
- The mentoring team was formed in the meeting
- Three districts selected for community monitoring are **Baster, Kawardha, Koriya**
- A consortium has been formed to take forward the CM process (PFI, CGVHA and Sandhan)
- The first mentoring group meeting took place on 25th July 2007
- The state level workshop took place on August 17th and 18th, attended by government officials, mentoring group members and NGOs
- Blocks were selected and a detailed plan of action was prepared
- Second mentoring group meeting took place on August 18th 2007
- Block level NGO selection is in process two districts (Baster and Koriya) have done the selection.

Challenge(s)

- District administration is still seeking clarification about the process of CM

Annexure 4:

National Stakeholders' Consultation

Two years of National Rural Health Mission

Organised by
Advisory Group on Community Action and Centre for Health and Social Justice

On
August 8, 2007

At
India International Centre, New Delhi

Context- The National Rural Health Mission was launched in April 2005 to provide a new and integrated direction to the implementation of health programmes in the country. The *Advisory Group on Community Action*, a standing committee under the NRHM in partnership with *Centre for Health and Social Justice*, organised a Stakeholders Consultation to share experiences of the implementation of NRHM across different states. Over one hundred participants attended the consultation. Representatives of civil society from 13 states across the country, public health experts, representatives from National NGOs and Networks, International organisations and Development Partners, INGOs shared their experiences and opinions. The consultation was attended by Member Planning Commission Dr Syeeda Hameed; Mission Director NRHM Mr G C Chaturvedi; Joint Secretary MoHFW Mr Amarjeet Sinha; Senior Advisor Health at Planning Commission Dr N K Sethi and Director NRHM Dr Tarun Seem from the Government of India.

Structure of Consultation – The Consultation was structured around thematic panel discussions. In each of the panel there were presentations on behalf of the Government, experiences from the community as well as opinions of public health experts. This was followed by discussion and questions from the floor. Some of the key issues that were discussed were as follows:

- Selection, Training and Functioning of ASHAs
- Implementation of RCH 2 in NRHM
- Integration of components (different National Health Programmes) and health determinants (nutrition, sanitation, water etc.) in NRHM
- Strengthening Services
- Decentralisation and Community Ownership

Concerns and Recommendations – The following recommendations emerged from the consultation

Public health infrastructure needs strengthening for effective service delivery:

- 1) Services must be based on the principle of continuum of care. The health centres must be easily accessible and equipped sufficiently to meet the local health requirements, more importantly with a *well-established referral system and emergency transport facilities*.
- 2) Doctors and other health providers should not only be knowledgeable about their subject, but should also be culturally competent and must have skills to deal with poor rural women and communities. *Doctors should be trained for community-health orientation, empathy and gender sensitivity*.
- 3) Many CHCs, PHCs and sub center still need structural and functional up-gradation. Lists of such upgraded PHCs and CHCs must be widely available, with the details of services available being displayed outside the centers.
- 4) The prescribed levels of health care must be provided at all centers and this must be regularly monitored through a *system of accreditation*.
- 5) *Essential drug lists* must be available in all the health facilities and accordingly the medicines must be made available. Medicine procurement and distribution mechanisms must be strengthened and *free medicines must be ensured to the poor*. Medicine kit must also be available with the ASHAs, which must also be refilled timely.
- 6) Special focus must be given to *developing systems and guidelines to provide special health care of the vulnerable and marginalised groups* including dalits, tribals and other forest dwellers, people affected with HIV, migrant groups and so on - based on their cultural practices and socio-economic situations they live in.
- 7) Similarly special and immediate attention is required to *develop systems for ensuring effective health care services during natural disasters, like droughts and floods*.
- 8) The roles and functioning of AYUSH department within NRHM must be properly defined. Functions of Ayush doctors, in relation to allopathic practitioners (which include the nursing staff) at the health centres must be clarified immediately.
- 9) Much resource goes into the pulse polio programme and it continues to affect regular service delivery at the periphery, still, polio has not yet been eliminated. *The pulse polio programme thus needs a serious and careful revision*.
- 10) *Vacancies, especially that of service providers must be filled up on a priority basis*. In some places it may even be necessary to revise the staffing pattern according to the levels of services that must be provided at various health facilities; accordingly posts must be quickly sanctioned or training provided to the existing staff. Fresh appointments have to be made and *contractual appointments must not be treated as a permanent staffing mechanism*.

- 11) *A transfer policy must be formulated to prevent frequent and irregular transfers of providers and other key functionaries.*
- 12) *Complete information about various NRHM programmes and schemes (eg RKS, IPHS) should be available with all the Medical Officers and ANMs.*
- 13) *To ensure a regular presence of health staff in peripheral /remote areas special steps need to be taken.* To provide an enabling environment for them following methods can thus be suggested here – providing incentives for serving in rural / difficult areas, develop a good system of referral and backup support (technical and functional) from higher institutions, continuing training module for ANM, revamping the cadre of male health worker.
- 14) *Urban Health section must be dealt in more detail in the PIP.* Urban health system is dominated by corporate players, and has been completely dissociated from the general healthcare system of the country. Integration between rural and urban health is important.
- 15) Partnership with the private sector must be a thoughtful process, with considerations made to *differentiate between engagement with for-profit and non-profit sector.* Contractual appointments do not assure long-term quality performance and system stability.
- 16) Costs in private sector are high but there are no regulatory mechanisms for quality assurance. *Regulation and standard setting for the private sector needs to be done on a priority basis.*

Strengthening RCH services under NRHM

- 17) Not all areas related to RCH services are addressed adequately in the PIPs; some of them that must be dealt in more detail are-
 - Adolescent reproductive and sexual health issues are addressed only superficially.
 - *Gender training for health care providers has to be introduced immediately.*
 - Equity and access issues for underserved population, including the urban poor has to be defined clearly. *The definition of vulnerable population in the PIP is adequate.*
- 18) Issues related to maternal health care that need reconsideration include the following
 - JSY is being seen as a scheme that covers out of pocket costs for safe delivery. It must be emphasized the JSY support is for nutritional and other support and not for service delivery costs
 - *Promoting institutional delivery without first addressing or improving the quality of care in these institutions is leading to serious cases of denial of care and the strategy needs to be revisited*
 - *JSY should be seen as a mechanism to strengthen safe delivery should be delinked from institutional delivery.*
 - Referral systems are very weak almost non-existent and women are ‘ping-ponged’ from one provider to the other.

- *Harmful practices like unsupervised use of oxytocin injections before delivery has to be addressed in the programme*
- *The role of Dais / TBA play a critical role in facilitating access to health services has to be acknowledged and suitable capacity building and empowerment of dais has to be encouraged in remote and underserved areas.*

Community mobilization and community participation

- 19) Expand IEC activities at the village and community levels to provide information about available health services, schemes (including JSY) and other entitlements under NRHM, including the roles of ASHA, for improving community health. *There must be wide publicity to the fact that all services mandated through the concrete service guarantees are free.*
- 20) ASHA selection and training has not taken place as envisaged in many places. *Ensure ASHA training as envisaged and perform regular evaluations of ASHA functioning*
- 21) Information about membership, roles and responsibility of *Rogi Kalyan Samiti*, Village Health and Sanitation Committees etc. must be provided to all stakeholders through a public notice.
- 22) District Action Plan is developed mechanically, without ensuring community participation for addressing the real needs of the community. *VHSC has to be activated and village level planning and inter-sectoral coordination must be initiated immediately PRI members must be provided with orientation / training on issues related to community health, village health planning & inter-sectoral coordination*

Regulatory systems - Governance and Monitoring mechanisms

- 23) Information on NRHM functioning has to be publicly available at the district and state levels
- 24) *Grievance redressal mechanisms and medical and social audits of adverse events and experiences must be instituted and publicized extensively.*
- 25) Corruption at all levels is a major problem. It is affecting the functioning of the system and implementation of several programmes. *Departmental monitoring, oversight and accountability mechanisms still needs to be developed further and strengthened for meticulous implementation.*
- 26) *Monitoring should include regulation and performance assessment of NGOs and private providers as well.*
- 27) *Availability of JSY incentives to women has to be monitored intensively to understand how much money is being received by women and at what time.*
- 28) Community monitoring and social audits should be introduced at the soonest for responsible functioning of the public systems.
- 29) The Right to Information must be recognized and used to strengthen governance and reduce corruption

30) Roles and potentials of civil society organizations as members of monitoring committees, institutions of capacity building and information gathering must be adequately explored and utilized.

Annexure 5:

Sl. No.	State Nodal NGOs	State	Total Sanctioned Amount	Ist Instalment Released	Government Order received
1.	Centre for Health and Social Justice	New Delhi	17,27,400	13,81,920 (released)	N.A.
2.	Anusandhan Trust	Maharashtra	7,08,800	5,67,040 (released Rs 5,59,144)	✓
3.	Madhya Pradesh Vigyan Sabha	Madhya Pradesh	6,44,600	5,15,680	✓
4.	Prayas	Rajasthan	6,87,680	5,50,144	✓
5.	Kalinga Centre for Social Development	Orissa	5,23,680	4,18,944	✓
6.	Sandhan	Chhattisgarh	6,15,760	4,92,608 (process)	✓
7.	CINI	Jharkhand	Due	Due	Due
8.	Voluntary Health Association of Assam	Assam	Due	Due	✓
9.	Tamil Nadu Science Forum	Tamil Nadu	Due	Due	Due
10.	To be decided	Karnataka - Formal approval from MoHFW is due	Due	Due	Due