National Consultation
on
Community Action for Health

January 24, 2018

New Delhi, India

Organised by

Advisory Group on Community Action

On behalf of

Ministry of Health and Family Welfare

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Acronyms

AGCA	Advisory Group on Community Action	NHM	National Health Mission
MoHFW	Ministry of Health and Family Welfare	VHSNCs	Village Health, Sanitation and Nutrition Committees
CAH	Community Action for Health	PIP	Programme Implementation Plan
ANM	Auxiliary Nurse Midwife	MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
SIRD	State Institute of Rural Development	NGO	Non-Government Organisation
AWWs	Anganwadi Workers	NUHM	National Urban Health Mission
ASHA	Accredited Social Health Activist	MSSAT	Meghalaya Society for Social Audit and Transparency
MAS	Mahila Arogya Samiti	MGCA	Mentoring Group for Community Action
NRHM	National Rural Health Mission	CSO	Civil Society Organisation
IVRS	Interactive Voice Response System	JSY	Janani Suraksha Yojana
SSAAT	Society for Social Audit Accountability and Transparency	PRIs	Panchayati Raj Institutions
CBM	Community Based Monitoring	RKS	Rogi Kalyan Samiti
NHSRC	National Health Systems Resource Centre	MDM	Mid-Day Meal
PHC	Primary Health Centre	VHCs	Village Health Committees
FP	Family Planning	MEPMA	Mission for Elimination of Poverty in Municipal Areas
GoI	Government of India	VHSND	Village Health, Sanitation and Nutrition Day
MHIS	Megha Health Insurance Scheme	PDS	Public Distribution System
ICDS	Integrated Child Development Scheme	RRC-NE	Regional Resource Centre for North East
DHP	Decentralised Health Planning	UPHSSP	Uttar Pradesh Health Systems Strengthening Project

ATRs	Action Taken Reports	UHC	Universal Health Coverage
MCH & RH	Maternal and Child Health & Reproductive Health	NIOS	National Institute of Open Schooling
CMO	Chief Medical Officer	PUHCs	Primary Urban Health Centres
IMR	Infant Mortality Rate	PSG	Patient Support Group
MMR	Maternal Mortality Rate	e-UPHCs	Electronic Urban Primary Health Centres
VHN	Village Health Nurse	PGIMER	Postgraduate Institute of Medical Education and Research
LSGD	Local Self-Governance Department	VHWSNC	Village Health Water and Sanitation and Nutrition Committee
FHWs	Frontline Health Workers	WHSNC	Ward Health Sanitation and Nutrition Committee
MPHWs	Multi-Purpose Health Workers	RTI	Right to Information

Foreword

This report captures the discussions and recommendations of the National Consultation on Community Action for Health organised by the Advisory Group on Community Action (AGCA) on behalf of the Ministry of Health and Family Welfare (MoHFW) on January 24, 2018 in New Delhi.

The consultation brought together 101 participants from over 23 states, which included senior government officials from National and State Health Missions, development partners, civil society organisations, media and the AGCA members. The overall objective of the day-long workshop was to share progress made by individual states as well as promising practices and innovations on community action and accountability. The meeting also sought to identify key challenges, explore probable solutions and make recommendations for the effective scaling up of community action for health (CAH) under the National Health Mission (NHM).

The National Health Mission provides a mandate to the community to undertake inclusive need-based planning and monitoring of health services for ensuring accountability through an intensive, three-pronged accountability framework, namely, routine internal monitoring, external surveys and community based monitoring.

The AGCA, comprising eminent public health experts, was constituted in 2005 under the former National Rural Health Mission (NRHM) by the Ministry of Health and Family Welfare (MoHFW) to provide guidance and technical support to states for initiatives promoting community action for health. The Population Foundation of India (PFI) hosts the Secretariat for the AGCA. At the consultation, the sessions were structured around themes related to scaling up of implementation, promising initiatives, state progress and challenges faced. The final session was devoted to identifying priorities and the support required for scaling up implementation of CAH at the state level.

On behalf of the AGCA, we would like to thank the Ministry of Health and Family Welfare for their guidance, support and commitment to scaling up community action for health. Their insights in preparing for the national consultation were invaluable. Our sincere thanks to Mr Manoj Jhalani, Additional Secretary and Mission Director, National Health Mission (NHM), Dr Manoj Agnani, Joint Secretary, Policy, MoHFW, Ms Preeti Pant, Joint Secretary, National Urban Health Mission, MoHFW, and Ms Limatula Yaden, Director, NHM, MoHFW.

A special thanks to the State Mission Directors and State Nodal Officers who spared their valuable time to contribute their rich experiences. We would like to thank the development partners, public health experts and practitioners, national and state level organisations for sharing their perspectives and making important contributions.

We are confident that with the support and engagement of all stakeholders, the AGCA will be able to take forward the key recommendations that emerged from the national consultation and more importantly, empowering communities to play a pivotal role in the implementation of the National Health Mission and bringing public into public health.

Poonam Muttreja
(On behalf of the AGCA)

National Consultation on Community Action for Health
Deliberating Pathways for Scaling Up
India International Centre, New Delhi, January 24, 2018

Introduction and background

The Ministry of Health and Family Welfare (MoHFW) constituted the Advisory Group on Community Action (AGCA) in 2005, to provide guidance on the design, implementation and strengthening of the community processes component under the National Rural Health Mission (NRHM). The Secretariat of the AGCA, which comprises distinguished public health experts, is housed at the Population Foundation of India (PFI). With support from the MoHFW, the AGCA is currently providing technical support to 22 state governments[1] to strengthen and scale up the implementation of the Community Action for Health (CAH) under the National Health Mission (NHM).

On 24 January 2018, the AGCA, on behalf of the MoHFW, organised a National Consultation on Community Action for Health (CAH) at the India International Centre Annexe, New Delhi. Led by the MoHFW, the participants included State NHM Mission Directors, State Nodal Officers and Civil Society Organisations from across the country.

The key objectives of the Consultation were to:

i. Share promising practices on community action and accountability;
ii. Share innovations and progress in the implementation of Community Action for Health (CAH) processes in the states;
iii. Identify key challenges/solutions; and
iv. Provide recommendations and strategies for the effective scaling up of CAH under the National Health Mission.

Summaries of Inaugural and Keynote Address

In his keynote address, **Dr Manohar Agnani, Joint Secretary, Policy, MoHFW,** reiterated the Ministry's commitment towards community processes with focus on CAH. Touching upon his experiences, he emphasised the need for planning for a horizontal cut in all vertical programmes. Along with an increase in budgetary allocations, he underlined the importance of having a more comprehensive healthcare system with a community-centric approach.

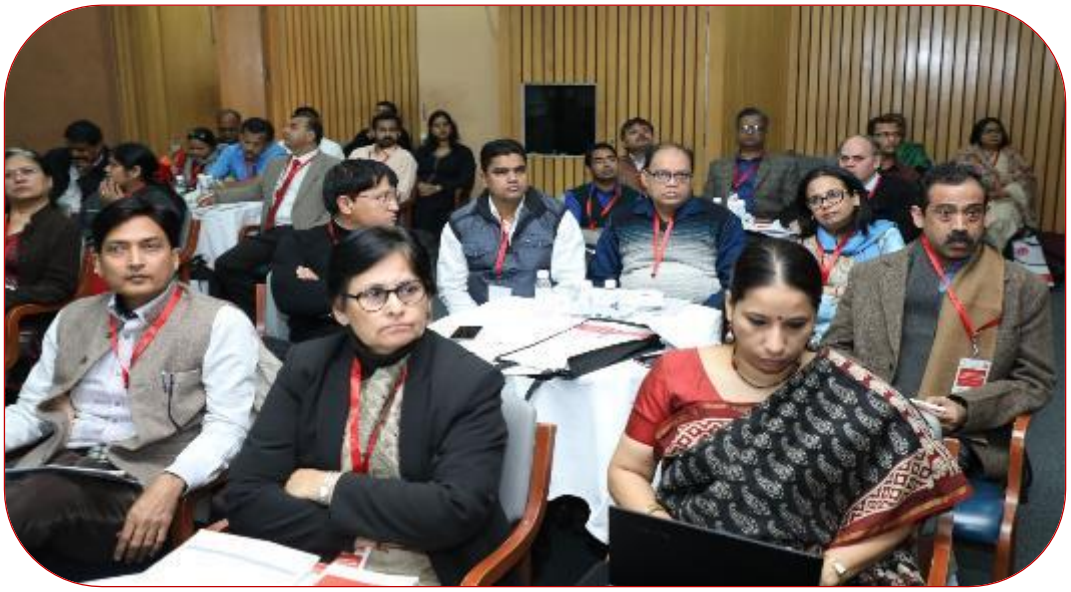
Acknowledging the support of the Ministry of Health and Family Welfare, partner agencies, the field staff, members of the AGCA and practitioners in scaling up CAH from 9 states to 22, in her presentation, **Ms. Poonam Muttreja**, highlighted the assistance provided by the AGCA Secretariat. She stressed upon the need for inclusion of information technology (IT), real time data collection and the use of IVR systems for scaling up of CAH.

[1]Andhra Pradesh, Assam, Bihar, Chhattisgarh, Delhi, Gujarat, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Punjab, Sikkim, Telangana, Tripura, Uttarakhand, and Uttar Pradesh.

Key Recommendations

The key recommendations that emerged from the consultation are as follows:

1. States should allocate adequate funds for CAH processes and ensure timely disbursement after the Programme Implementation Plan (PIP) approval.
2. Capacitate ASHAs as a lead facilitator for the Village Health Sanitation and Nutrition Committees (VHSNCs).
3. States should provide an enabling environment for the active involvement of the community platforms with service providers in rolling out of comprehensive healthcare, as envisioned under the Ayushman Bharat.



National Consultation in Progress

4. VHSNCs should be capacitated to monitor mortality and morbidity at the village and Panchayat levels.
5. As in Mahatma Gandhi National Rural Employment Guarantee Scheme (MG-NREGA) earmark a certain portion of the NHM budget for accountability processes.
6. States should explore the possibility of creating an autonomous state institution for facilitating social audits of key government schemes.
7. States should develop specific strategies – create a dedicated trainers' pool, estimate a training load and allocate funds for the training roll out for VHSNC and Rogi Kalyan Samitis (RKSs)/ Patient Welfare Committee members.
8. States should ensure the availability of essential support structures for the scaling up of CAH, making sure that the core principles of community engagement and accountability are maintained.
9. Innovations that have the potential to be scaled up:
    a. Male VHSNC mentors for family planning in Uttar Pradesh
    b. Allocation of dedicated responsibilities among the VHSNC members for monitoring specific schemes in Chhattisgarh.

Inaugural Session

On behalf of the AGCA Secretariat, **Ms Sona Sharma, Director, Programmes at PFI,** welcomed the participants to the national consultation.

- She thanked Dr Manohar Agnani, Joint Secretary, Policy, MoHFW for his active support of AGCA and CAH, and welcomed Mr P Sampat Kumar, Commissioner and Secretary, Department of Community and Rural Development, Government of Meghalaya and all the State Mission Directors and officials from 23 states.
- She extended her appreciation to the state participants, practitioners and experts from the field for giving the consultation a priority and coming to share their experiences and challenges from the field.
- The expectation was that the meeting would lead to a systematic scale up within the 23 states as well as an expansion of the implementation of CAH processes in more states, in addition to contributing to a better understanding of the potential and value of bringing '*Public into Public Health*'.

Ms Poonam Muttreja, Member, AGCA presented the journey of AGCA and AGCA members as well as people working in the field.

- She welcomed and thanked Dr Rajani Ved and highlighted her contributions to the evaluation of the pilot phase of Community Based Planning and Monitoring (CBPM).
- She informed the house about Mr Jhalani and Dr Agnani's continued commitment to community action for health (CAH) and their assured support.
- She applauded PFI partners and the staff of the AGCA Secretariat, led by Mr Bijit Roy, for their excellent work and introduced them.

Outlining the decade-long journey of CAH, Ms. Muttreja made the following points, ensuring that it reflected voices from the field:

- Community Action for Health (CAH) is one of the key pillars of the National Health Mission.
- The AGCA Secretariat is providing the required technical support to strengthen and scale up implementation of CAH in the states.
- The technical support consists of capacitating the state institutions and the local community to monitor and support NHM interventions and scale up best practices under CAH.
- The AGCA provides feedback on ground realities through fact-finding missions.
- Development of communication and resource material with NHSRC, which were further adopted by seven states.
- Current priorities include: developing modules for decentralised participatory health planning and detailed tools for the inclusion of specific local issues in the district and state PIPs; initiating CAH in urban areas through MASs and ward coordination committees; strengthening of RKSs and using RKS funds for local planning based on priorities.
- Some pilots to substantiate innovations on CAH are being supported by The David and Lucile Packard Foundation (IVRS on mobile-based technology in two districts of Bihar) and The John D. and Catherine T. MacArthur Foundation (strengthening the RKSs in UP).

- Two documentary films have been developed to substantiate the CAH processes, viz., *Bringing Public into Public Health (Jan Swasthya Ke Bhadtey Kadam)* and *We Must Change this Story – Yah Kahani Hamien Badalni Hi Hogi* to encourage maternal death reviews (with support from the Madhya Pradesh State Government).
- Initiate use of mobile technology, like IVRS, which is described as the 'Facebook' of the poor to obtain real time data, which can enable prompt and corrective action.

A short film clip, capturing voices from the field was screened.

Key Note Address by Dr Manohar Agnani, Joint Secretary, Policy, MoHFW

"*Comprehensive healthcare is not possible minus active community involvement….the Government is very keen on establishing a "Jan Andolan," where people feel the need to participate in the entire processes of continuum of care and have their grievances heard."*

Dr Agnani drew on his key learnings' from his past experience as Mission Director of the Rajiv Gandhi Mission for Community Health and the NHM in Madhya Pradesh, namely:

- In a resource crunch situation, decentralised planning with the community and a convergence of resources at the district level to bridge the gap can deliver positive results.

Dr Agnani shared some priorities of the Government of India for the near future:

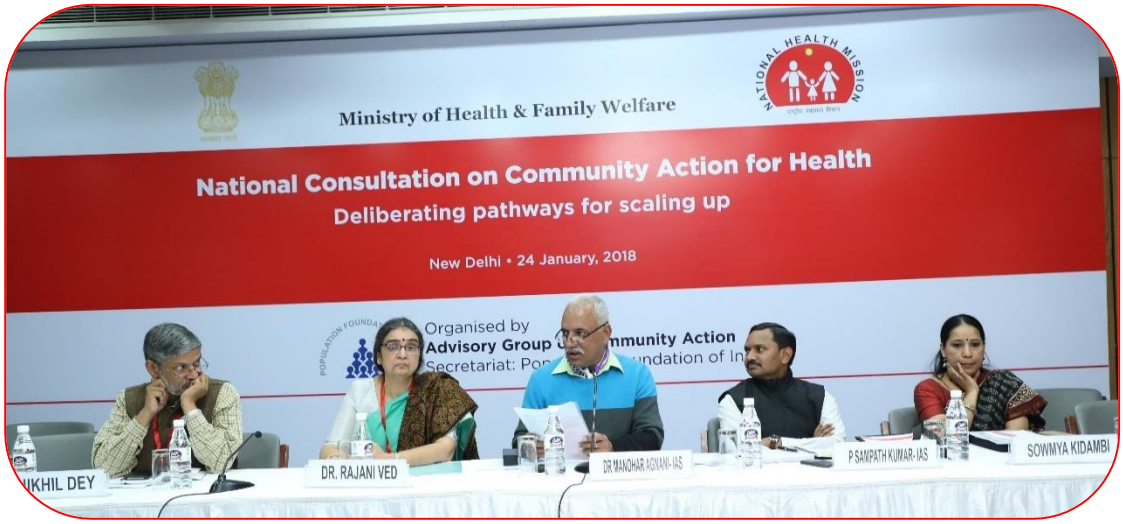
- There will be an increase in the allocation for health – from 1.15 per cent of the GDP to 2.5 per cent by 2025.
- The focus will move from fragmented care to comprehensive healthcare, which will include NCDs, lifestyle diseases, mental health, ophthalmic care, screening and treatment of various cancers, issues of old age care and trauma and burn care.
- Requested development partners to formulate standard operating procedures (SOPs) for screening, treatment and referral protocols, to operationalise the increased package of services at different levels.
- Inputs were sought on the setting up of an IT system to enable management of a comprehensive inventory for drug, diagnostic services, database of family records and a referral system.
- The Government is committed to converting the Sub-Centre or the Primary Health Centre into a Health and Wellness Centre, providing a gamut of services.
- Asked states to allocate adequate funds in their PIPs, unlike FY year 2017-2018 when Rs. 32.72 crore had been allocated for CAH which was only 0.015% of the total annual NHM allocation.
- States to make funds available for CAH processes at the beginning of the financial year.
- Assured states that activities proposed for CAH in the PIPs would get funded and that they could count on his support.

Session Details

Session 1 - Promising initiatives on Community Action and Accountability, chaired by Dr Manohar Agnani, Joint Secretary, Policy, MoHFW

The session objectives were to:

- Learn about recent innovations and emerging good practices on community action and accountability;
- Understand the aspects of adaptability and scalability of these innovations under the National Health Mission; and
- Identify the key facilitating factors to enhance the effectiveness, scaling up and sustainability of these innovative approaches.



Dr Manohar Agnani Chairing the Session on Community Action and Accountability

Dr Rajani Ved, Executive Director, National Health Systems Resource Centre (NHSRC)

"North Eastern states and high focus states have performed better for the entire community processes intervention than progress made in non-high focus states. The programme officers in non-high focus states think that health system strengthening is equivalent to service delivery and therefore feel that if good indicators are achieved in health service delivery then community participation is no longer important."

"As a country, we should be very proud that we have been able to cover one third of the country's villages under the accountability initiative through the active participation of civil society, community efforts and the state…..the people who designed CAH, had studied the health system since independence."

Dr Rajani Ved, Executive Director, NHSRC, made the following key points:

- The principle of health sector strengthening is based on the edifice of strong community participation with a community-based approach being an integral component, going beyond just hardware and financing. The clients, beneficiaries, users and the community are also an active part of the entire health system.
- In primary healthcare, community engagement is a prerequisite to achieve preventive and promotive health.

- The ASHA programme has overtaken other components of the community processes because of a systematic support system in place and a clear plan for skill building and training. The ASHA programme evolved because it imbibed learnings from the field, established a grievance redressal mechanism and was open to programmatic modification, providing career opportunities to ASHAs - "*Once an ASHA not always an ASHA*." This did not happen in the case of the VHSNC and RKS members.
- The ASHA, in her role as a community level service provider has improved her credibility not just in the eyes of the community but also in the eyes of the health system. Now the health system relies even more on the ASHAs to carry out many other functions, such as being a facilitator and a community mobiliser activist.
- The support structure meant for ASHAs is also intended to support other community structures like the VHSNCs and CAH, which has not happened as envisaged. **This needs to be introspected upon.** Evidence shows that wherever the ASHA plays a strong role in the VHSNC, the better it performs, as also, does CAH. Progress made in the ASHA programme will be limited if there isn't commensurate support for her in the community through community structures, like the VHSNCs and RKSs.
- In addition to participation of civil society, CAH needs active engagement with Panchayats in playing a strong role in the management of the VHSNCs, as for example, in: the Swasthya Panchayat Yojana in Chhattisgarh, the Odisha Gram Kalyan Yojana and the Kerala Ward Panchayat Samiti, which takes up issues of palliative care and gender-based violence.
- In the move towards Comprehensive Primary Healthcare, the VHSNCs should be strengthened to move beyond death analysis to morbidity and mortality analysis at the community level, giving a strong impetus to a concurrent monitoring system at the Panchayat level.

"As a country, we should be very proud that we have been able to cover one third of the country's villages under the accountability initiative through the active participation of civil society, community efforts and the state…..the people who designed CAH, had studied the health system since independence." Dr Rajani Ved

- Some challenges: slow progress in strengthening the VHSNCs and RKSs and in monitoring the use of untied funds; a lack of understanding of guidelines for the composition of the committees; very few women members in the committee and low participation from the SC and ST categories; no defined role of the ASHA with the VHSNC – "*is she a leader, a member or a bystander?*" The relationship between the VHSNC and the Gram Panchayat needs to be elucidated.
- In urban areas, where there are MASs, these community bodies could be made more inclusive by involving men and consider calling them 'Jan Aroghya Samitis', which is more contextual to urban areas.
- Need for some parity to retain trainers for the ASHA programme and VHSNCs, where there is a huge attrition due to significant payment disparities between trainers for community processes in general (Rs 350 a day) and trainers for other programmes (Rs 2000 a day).
- Need to explore the role of IT in the scaling up of training and data management.
- It is a challenge to maintain the community embedded-ness of the ASHA because of the pulls towards service delivery by the health system. A balance between the two (community

embedded-ness and service delivery) needs to be found as both the roles of the ASHA are important.

Dr Ved offered the following suggestions for going forward:

- Under the new initiative called VISHWAS, which is a part of the Swachh Bharat Mission, introduces topic-based training (e.g. hand washing, vector borne diseases) of VHSNC members to revitalise the committees.
- Continuity of funding for community processes and advocacy for additional funds are required.
- Promote use of community platforms like the VHSNCs, MASs, RKSs and Swasth Nagrik Abhiyan for a social movement on health, as recommended in the National Health Policy (NHP) 2017.

Mr P Sampath Kumar, Commissioner and Secretary, Department of Community and Rural Development, State Government of Meghalaya shared his experience of institutionalisation of a social audit mechanism in the state. According to him:

- The inhibiting factors in the delivery of social services are mostly issues related to demand, for example, illiteracy, prevailing feudal, social and hierarchical structures. Even though the government has the intent and mandate to deliver services, there is always a disconnect between the supply and demand because of implementation bottlenecks.
- The Meghalaya Community Participation and Public Services Social Audit Act 2017 can be termed as a Right to Information (RTI) Act as it covers all the government line departments.
- The Act ensures both information and entitlement by mandating the state government to inform every village and urban locality and conduct a social audit every two years. This empowers the public as they know where to get the information and what their entitlements are.

"It's giving us a great scope for taking course corrective measures as it is not a post audit, where only action on someone who failed to perform can be initiated." Mr P Sampath Kumar

The Institutional Mechanism

- This Act was designed after a pilot process in a participative manner where the government, civil society organisations and experts came together to contribute. During the process, the facilitator actually educated the community to access their entitlements helping them in the application processes.
- To implement this Act, the state created an independent institutional society, the Meghalaya Society for Social Audit Accountability and Transparency (MSSAAT) under MGNREGA.
- Along with the Society, a Social Audit Council has been constituted headed by a person with rich developmental experience as a chairperson, with the Principal Secretaries of all the departments covered under the Social Audit Act, as members.
- The District Collector is the district social audit coordinator and at the village level there are social audit facilitators who have been appointed to conduct the social audit by involving the village level social audit committee members.

The Processes and Outcome

- The cluster level social audit facilitators conducted an elaborate process in every village, which included at least a seven-day stay, conducting door-to-door visits, visiting institutions and carrying out a social audit of a total of 26 schemes covering 11 departments.
- Led to the emergence of ten policy decisions beneficial for the people, such as bringing about parity in the payment of pension by instituting a uniform scale.
- Ensured regularity in Janani Suraksha Yojana (JSY) payments.

"The social audit act is a powerful instrument and has actually disrupted the hierarchy….an egalitarian society needs such interventions to bring in a sense of accountability among all service providers." Mr P Sampath Kumar

Ms Sowmya Kidambi, Director, Society for Social Audit, Accountability and Transparency (SSAAT), Department of Rural Development, Government of Telangana

"There are plethora of schemes and various mechanisms to provide social safety nets to the poor but the manner in which both funds, policies and guideline are interpreted decide the direction of the spending at the lowest level. By the time the funds reach the block level it's up to anyone to decide to what can be done and what cannot be done….'kya ho sakta kya kaya nahai ho sakta hai'."

"Social audit mechanism needs institutionalisation within the Government system and should also maintain the overall sanctity of the processes." Ms Sowmya Kidambi

- In Telangana, the social audit process has got embedded in the government system which has given standardisation and a scale to the whole process, which would have been very difficult for any CSO to achieve.
- Social audit mechanism followed in Andhra Pradesh, Telangana and Meghalaya could catalyse cross-learning among states and sectors to widely benefit everyone as social audit processes keep alive participatory democracy and decision-making processes.
- The institution of the Social Audit Unit in Telangana can be attributed to the efforts of a single senior bureaucrat who garnered all administrative and political support to make it functional as an independent society.
- Because of its independency, other programmes are also being socially audited through this set up, which is helping in building up a trained cadre of auditors from the marginalised community, giving them an opportunity, not just to work, but also to raise questions as an auditor.

Impact of creating an independent social audit body

- Rather than spending crores on mass media advertisement and even then not earning peoples' trust, it is beneficial to spend on social audits as they foster a personal connection between the service provider and the public. For example, when people see somebody from the government coming once every six months, asking them how satisfied they are on different parameters, this reflects good governance - and which is what people want at the end of the day. Social audit gives an opportunity to train in community participation, which ensures public participation, breaks hierarchies, benefits disadvantaged groups, curbs corruption and challenges nepotism – and most importantly develops human resource in social capital at the village level, which has a huge impact on the implementation of any scheme.

"As 80 per cent of the issues are related to grievances, taking governance to the door-step and sorting them out turns around the interface between the public and the service provider. If we can ensure spending of 0.5 per cent on social audit then we do not need anything more for 100 per cent fund utilisation in the entire welfare scheme." Ms Sowmya Kidambi

Mr Nikhil Dey, Founder Member, Mazdoor Kisan Shakti Sangathan (MKSS) delved into his own journeys on demanding accountability and transparency through peoples' participation to share his learnings' and insights.

"Moving beyond transparency towards accountability, which is where we need to focus, as the system is getting used to providing information but also ensuring that the work is not done." Mr Nikhil Dey

He made the following key points:

- The Right to Information (RTI) has become one of the most powerful people's movements in the country and perhaps in the world as any such movement is well beyond anyone's control as it acquires a life of its own. This fundamentally changes the relationship between the citizen and the state.
- The RTI campaign did not restrict itself to only looking at accounts but to the larger issue of accountability.
- Community mobilisation and community action cannot only be restricted to places where CSOs are facilitating the processes. In a democratic set up every citizen has the right to participate. Therefore it is a combined responsibility to create the enabling conditions to promote community participation and independent facilitation up to the grassroots level on a regular basis.
- These accountability processes should spread into other areas like health where citizens can get access to those kinds of platforms to exercise their rights as citizens and demand accountability from the system.
- He opposed privatisation of education and health because of a lack of accountability and said that PPP should stand for people-public partnership rather than public-private partnership.
- The role of civil society should be that of a facilitator enabling the formulation of a structure within a government system, which functions on the basis of equality rather than creating a separate structure, which cannot be scaled up.

"Unless and until people start putting pressure on the system, the system does not react and facilitate a solution…this is relevant for health, education and all relevant departments." Mr Nikhil Dey

- The Jawabdehi Yatra of the *Shiksha ka Sawal hai – Jawab Do* campaign, backed up by strong media support and generated issues beyond those related to accountability on education and helped thousands of people lodge complaints with the state government against the non-delivery of services, firming up the group's demand for an accountability law for public servants.
- There is a difference between speech, thought and action. He gave the example of grievance redressal through the SMS mechanism, which does not work as people get an SMS of a grievance redressed when actually it is not; half of the population cannot read the SMS; and there are others still who do not receive the SMS – which means that the process has not delivered and one has to then begin again from scratch. **Therefore a grievance redress mechanism through a face-to-face interaction is vital for accountability processes.**

- He advocated for the building up of a 'Janta Information System', which is more accessible to the general public and can be used to develop a more preventive and holistic public healthcare system.

Going forward, Mr Dey made the following points:

- The facilitation of the social audit should be by an independent body having presence across the state, rather than a civil society organisation or a department; it should be concerned with all sectors, like the Meghalaya model which takes up all issues on governance and delivery mechanisms.
- Like the Meghalaya model, which focuses on issues of governance and delivery, similarly, social audits should not confine themselves to just audits or grievance redressal but also look into the larger issue of fulfilling entitlements.
- There should be a mechanism to establish association between the government official and the responsibility to be discharged within a given timeframe.
- Proposed to pilot a social audit for community health using the social audit society in the state, constituted under MGNREGA, and in line with Supreme Court orders to extend the social audit to issues beyond MGNREGA.

"The 'Right to Hearing Act' in Rajasthan changed the entire dynamic by providing people with the opportunity, not only to file their grievances but also to interact face-to-face with the appropriate official authorities, to follow up and seeks answers in a time-bound manner."
Mr Nikhil Dey

- The use of one per cent of every social sector programme to: establish a mechanism of a weekly right to hearing; set up a six-month social audit mechanism; and create an independent forum at the block level to facilitate the resolution of grievances and denial of any entitlements would lead to more benefits.

In conclusion, Mr Dey observed that NGOs should be involved only in the designing of the institutional system and not in the delivery mechanisms.

Discussion on Rights versus Responsibility

- While participation of the people is required, there is a need to ensure that the social audit platform doesn't become a forum for complaints and gaps are resolved in a systematic and time bound manner.
- CAH should not be considered simply as social accountability but also encompass the various roles and responsibilities that go with it. This includes empowering the community to plan for their own village, take positive action on cleanliness and other health determinants.
- There is a need to build indicators for community action for health which gives people an idea on bringing about a tangible change.
- There needs to be a mechanism which gives a space to capture the concerns of people with a physical disadvantage and mental health issues.

Dr Agnani summed up the session by noting that social audit is of the greatest importance as it has policy implications. The issues of grievance redress, Janata Information System and the various issues raised during the session were extremely important and that people who work on these issues should be encouraged.

Updates from states on implementation of Community Action for Health

Session 2: Experiences, challenges and commitments from states to scale up implementation of CAH

Session objectives

- To learn about recent innovations and emerging good practices on community action.
- To understand the aspects of adaptability and scalability of these innovations under the NHM.
- To explore the key facilitating factors to enhance the effectiveness of these innovative approaches.

State Mission Director/Nodal Officer - Assam, Bihar, Chhattisgarh, Jharkhand, Maharashtra, Madhya Pradesh and Uttarakhand

Moderators: Dr M Prakasamma and Dr Thelma Narayan, Members AGCA

Dr M Prakasamma and Dr Thelma Narayan, Members-AGCA Chairing the Session (Middle)

Dr Thelma Narayan asked the participants to present their experiences, challenges and commitments from the state to scale up implementation highlighting the state specific strategies and innovations as well as the challenges faced so far.

Dr Partha Saikia, Assam: CAH has been scaled up in three phases to 4200 VHNSCs leading to an increased fund utilisation for VHNSCs. VHNSC members were trained by NGOs.

Benefits from CAH processes

- The Anganwadi Centre in a place called Amerigog was renovated by the VHSNC which shows convergence between the village Panchayat and the ICDS departments.
- The Kandupur VHSNC put in place a functional water supply system for Uparhali Block PHC.
- Identity cards were issued to VHSNC members for easy identification.

Challenges

- Working with NGOs for establishing accountability sometimes creates a parallel system, which can lead to a vacuum when the contract with the NGO ends. Therefore, the state has decided to scale up the CAH utilising its own system.

Moving Forward

- VHSNC members will be trained on monitoring tools to assess the functioning of services such as maternal health, family planning and general health in 2017-18.
- Focus group discussions will be held with active VHSNC members, culminating into a Village Health Report Card.
- The state will establish a sub-health monitoring system through VHSNC members to increase accountability.

Mr Pranay Kumar, State Health Society, Bihar: The state is currently implementing the CAH in two districts of Darbhanga and Nawada, though earlier it was being implemented in five districts.

Benefits from CAH processes

- Improvements have been noticed in both the quality and quantity of service delivery.
- Following orientation, VHSNC members are being supported in opening bank accounts.
- There has been a reduction in out-of-pocket expenditure.
- Community enquiry through "m-Shakti", which is an IVRS, has been conducted and the report card generated.
- Public grievances have been addressed through a Jan Samwad.

Challenges

- Frequent transfer of staff and the election of new PRI members every five years creates hindrances for VHSNC functioning.
- A reduction in the allocation of untied funds for each VHSNC – down from Rs 10,000 to Rs 4,400.
- The RKS needs to be strengthened.

Moving Forward

- There are plans to scale up in three more districts in addition to the existing two.

Mr Prabodh Nanda, State Health Resource Centre, Chhattisgarh: The CAH processes, facilitated by SHRC are being implemented throughout the entire state.

Benefits from CAH processes

- Unresolved issues raised in monthly VHSNC meetings are getting resolved at VHSNC cluster meetings.
- Elected members and state government officials are attending the Jan Samwads organised annually.
- A new feature, the use of a skit presentation on burning issues to sensitize both the departments and the public, has been introduced in the Jan Samwad.

- The state has introduced the concept of 'Nigrani Sadasaya' (Monitoring Member), a VHSNC member who is entrusted with the responsibility to monitor a scheme, such as the MDM, PDS, VHSND and others, every month. The observations are shared in subsequent VHSNC meetings and get addressed immediately.
- The Jan Samwad has become much more effective as this platform is used for sharing success stories, organising issue-based rallies and reviewing action taken reports on issues identified in previous Jan Samwads. It has now become a forum for people to demand their rights, which is different from the Samashya Nivaran Shivirs (Grievance Redressal Camps), organised by the district officials for requesting services.

Challenges

- Inadequate funds allocated for CAH activities make it difficult to sustain the interventions.

Moving Forward

- In 2018-19, the state is planning to organise district level Jan Samwads.

Dr Pradeep Baskey, Deputy Director, State Saahiya Cell, NHM, Jharkhand: The Participatory Learning Approach has been rolled out for the training of VHSNC members and the ASHAs are now moving forward in their careers as they are being selected as PRI representatives, AFs, AWWs, Siksha Mitras and ANMs.

Benefits from CAH processes

- VHSNC members are more aware about their entitlements and utilising untied funds.
- RKSs and PRI members are conducting community enquiries and Jan Samwads.
- The state level ASHA Mentoring Group, which consists of top officials and NGOs, suggested the transfer of benefits directly to VHSNCs, Saahiyas (ASHAs) and RKSs to strengthen them.
- The State Saahiya Resource Centre has revised the guidelines as suggested by different stakeholders.
- The toolkit has been revised to capture details on the community perspective in accordance with the national guideline.

Challenges

- The inclusion of PRIs and ICDS in CAH requires deeper engagement with multiple stakeholders to enable convergence.
- The grievances redressal unit (currently in 16 districts) needs to be strengthened.

Dr Shailesh Sakalle, NHM, Madhya Pradesh: The state has merged the ASHA Mentoring Group and the Advisory Group for Community Action, renaming it as the Mentoring Group for Community Action (MGCA) to avoid duplication of members and objectives. Intensive work on community action is being conducted in seven districts.

Benefits from CAH processes

- Feedback provided to health officials at the state, districts and blocks levels by the Mentoring Group for Community Action (MGCA).
- There is an increase in the involvement of various voluntary health organisations in the programme for coordination with ASHAs and VHSNCs.

- The process has facilitated the ownership and involvement of PRIs in the Community Based Monitoring (CBM) processes.
- The grievance redressal mechanism is in place and Jan Samwads are providing the platform for interaction.
- There is more sensitivity and transparency in the Health Department.

Challenges

- Issues related to human resources, capacity building, coordination with other departments and the scaling up of CBM in districts where there is no active involvement of NGOs or MGCA members.

Moving Forward

- The state will be using NGOs to train VHSNC members of 17 high priority districts, using the Participatory Learning Approach (PLA).

Ms Mukta Gadgil, State Health Systems Resource Centre (SHSRC), Maharashtra: The state has initiated the process in 21 districts and 51 blocks, where SHRC is playing a central role.

Benefits from CAH processes

- Decentralised Health Planning (DHP), which reflects community needs is slowly finding a place in budget proposals. NGOs are facilitating the process and converging with other line departments based on village level gap identification.
- The administration department and PRI members along with CSOs are actively supporting the effort.
- The CBM processes are being integrated with the existing platforms, such as the VHSNC and Gram Sabha.
- A mentoring group of NGOs has been formed at the block level to institutionalise the CBM process.
- Issues identified through the DHP process are getting resolved at the local level.

Challenges:

- Strengthening and activating RKS and VHSNC committees.
- Poor ownership and coordination of urban local bodies in NUHM.
- Ensuring efficacy of community based monitoring activities in raising and meeting demands for health services.
- Timely resolution of community demands to ensure sustainable participation and ownership of the processes.

Moving Forward

- The state is making an effort to institutionalise the Community Based Monitoring (CBM) process as a sustainable model on a pilot basis in 5 districts.

Dr Pankaj Kumar Singh, State Nodal Officer, NHM, Uttarakhand: The processes are being implemented in all 13 districts through the ASHA support structure.

Benefits from CAH processes

- Jan Samwads are being organised on a regular basis at the block and district levels.
- The state has adapted the community enquiry toolkit as per the national guidelines, to identify the gaps.
- The VHSNC members have been capacitated and Action Taken Reports are being prepared.
- VHSNC meetings are taking place regularly and the utilisation of the untied funds has increased from the past few years.
- Since the ASHAs play a very active role, the VHSNCs have gradually gained a clear understanding about their roles and responsibilities.

Moving Ahead

- The focus is on strengthening CAH activities in other revenue villages through village level monitoring by involving the SHGs, who are currently engaged in community accountability processes and social audit of the MGNREGA and the Mid-day Meal programmes.
- VHSNCs are involved in the VISHWAS campaign.
- The state is adapting the CAH Guidelines and Managers' Manual to its context and plans to share the toolkit of community monitoring with other departments to include important pointers for field level facts.

Summing up by the moderators

- In addition to capturing evidences on quantitative aspects, it is also important to capture the qualitative aspects.
- A doubt was raised on how civil society-led CAH processes could be transitioned to system supported CAH processes and whether there would be dilution because of this transition.
- Need to explore avenues to capture the accountability of private providers.
- Though states are at different levels of progress, some states are still struggling with the basics.
- We need to move ahead from the ASHA-based community action to holistic community action.

Session 2 (continued):
Experiences, challenges and commitments from states scale up implementation of CAH

State Mission Director/Nodal Officer- Delhi, Gujarat, Meghalaya, Nagaland, Rajasthan, Sikkim, Tripura and Uttar Pradesh

Moderators: Dr Abhijit Das and Dr H Sudarshan, Members AGCA

Dr H Sudarshan and Dr Abhijit Das, Members-AGCA Chairing the Session (Middle)

Dr Monika Rana, Delhi State Health Mission: In Delhi, the CAH has not been implemented in the way it was envisaged as Delhi is predominantly an urban area while most of the CAH processes have been designed for a rural context. 98 Mahila Arogya Samitis (MASs) have been formed under the pilot phase, bank accounts have been opened and members of MASs have been trained.

Benefits from CAH processes

- ASHAs who are skilled are now been certified with the National Institute of Open Schooling (NIOS).
- In order to expedite fund utilisation and draw benefit of having a RKS at each facility level, the Delhi Government is shifting the district level RKS at the Assembly level to support the Jan Swasthya Samiti at the Primary Urban Health Centres (PUHCs).
- MAS members have been capacitated to conduct an analysis of the area through resource mapping, and initiating efforts to discourage open defecation, reporting drug abuse, helping in establishing a mechanism for garbage collection and identifying and screening the visually impaired for further treatment. MASs used simple community tools to assess the water and sanitation conditions in their localities.
- MAS members have been able to get the local authorities to deliver services.

Challenges

- Urban areas are very different to the rural and lack a PRI like structure at the grassroots level, which would have facilitated CAH.
- While it is difficult to form MAS, it is even more difficult to sustain and keep them motivated.
- The opening of bank accounts for MAS.

- Unionization of ASHAs in Delhi and demands for higher incentives.
- All institutions have RKSs in place barring a few.
- The primary health care level facilities are yet to benefit from the untied funds of RKS even though they have cabinet approval.

Dr Rakesh Vaidya, Deputy Director -MCH & RH, Gujarat: Currently, CAH activities are being implemented in 22 districts and 70 talukas.

Benefits from CAH processes

- Community participation is being used to achieve the Sustainable Development Goals.
- Staff and community level functionaries in high priority districts have been capacitated on CAH processes using the VHSNC training module developed in the local language.

Challenges

- Mentoring of village health and sanitation committees and NGO involvement.

Moving Ahead

- The focus now is on consolidating and scaling up CAH activities to all 33 districts in a phased manner.
- Efforts to institutionalise capacity building on CAH for ASHAs, FHWs, MPHWs, ASHA Facilitators, PHCs and Taluka's staff are to be initiated through existing structures and institutions.

Dr Joy Lyngwa, Meghalaya: The programme is being implemented in five districts, nine blocks, 27 PHCs, 61 sub-centres and 189 VHSNCs through the state NHM staff.

Benefits from CAH processes

- A sub-centre in West Jaintia Hills, which used to provide services from a rented house has been operating from a building of its own since 2016.
- Through joint efforts of the VHSNC members and funds of the RKS and the Megha Health Insurance Scheme (MHIS), the PHC in East Jaintia Hills, now has safe drinking water available and institutional deliveries have begun taking place since April 2017.
- A documentary film on CAH, focusing on the villages that have performed well on VHSNCs and a video documentary depicting the roles and responsibilities of the ASHA are being used as an IEC tool and have even been telecast in the local news channels.

Challenges

- Due to paucity of funds, the state could no longer engage with NGOs, leading to the adoption of a new strategy of implementation.

Moving Ahead

- To scale up the CAH processes, the state is in a process of consultation with the Meghalaya Society for Social Audit Accountability & Transparency (MSSAAT) for potential collaboration.

Ms Chubala Pongen, Community Action for Health, NHM, Nagaland: The community participation is happening at all levels and there are village health committees (VHCs) in all villages, reconstituted as per state notification.

Benefits from CAH processes

- The VHC members are clear about their roles and responsibilities.
- Untied funds are being used for community behaviour change communication activities.
- Communities have begun sharing their feedback on health issues with service providers.

Challenges

- A lack of resource persons, scattered population and delays in the release of funds.
- A hilly terrain makes it difficult to provide regular handholding support.

Moving Ahead

- The state has initiated the training of members of the VHSNCs and RKSs, who will be implementing CAH in 2 districts.

Dr Vishal Singh, Associate Professor, SIHFW, Rajasthan: The SHRC and NGOs are playing a vital role in initiating and sustaining the community participation. The VHSNC has been reconstituted as per the revised guidelines of 2013. In the last year, activities for CAH were budgeted and subsequently a TOT was organised with support of the AGCA Secretariat.

Benefits from CAH processes

- During the pilot process with PRAYAS, the result obtained through community monitoring was very encouraging.
- For Universal Health Coverage (UHC), the state is capacitating the VHSNC to play a preparatory role.

Challenge

- The biggest challenge is that the PRIs are not aware of their roles and responsibilities to be discharged through the RKSs.

Moving Ahead

- Members from the reconstituted VHSNC are to be oriented.
- The training budget provisioned under last years' PIP (FY 2017-2018) will be used to roll out activities in 6 more districts.

Dr M L Lepcha, Sikkim: The existing ASHA Mentoring Group has been reconstituted as the Community Process Mentoring Group to encompass all four components of community processes. Sikkim has a grievance redressal mechanism in place in all the facilities.

Benefits from CAH processes

- The state acknowledged that it has achieved many of the health indicators due to active community participation.
- The state has identified the gaps as per the rapid review of the RKSs and VHSNCs by the Regional Resource Centre for North East States (RRC-NE) and is working with them to strengthen these community platforms.

Challenges

- There is a lack of dedicated trained personnel and infrastructure for community processes.

Moving Ahead

- Key members of the RKSs from 31 facilities and VHSNCs will be trained after taking charge of the newly elected PRI members. They are expected to undertake the monitoring of their respective facilities and services, followed by a Jan Samwad in four district hospitals.
- In the coming PIP the state has proposed to take up more districts under CAH and community monitoring.

Mr Rajib Ghosh, State ASHA Manager, NHM, Tripura: CAH is implemented in two blocks of Gomati district where the VHSNCs have been made into a community level body by replacing Multipurpose Workers with ASHAs as the member secretary. VHSNCs are in place and have a bank account.

Distinctive Features and Benefits of CAH

- There are regular meetings of the Rogi Kalyan Samitis and the expenditure of untied funds is above 76 per cent.
- CAH processes in the state have three distinguishing features within them: active participation of PRIs, ASHA selection and accountability to the villagers, and ASHAs as an active member of the VHSNC committee.
- The programme provides an upward career growth for the ASHAS: 112 were selected as PRI members and 19 as Pradhans (Village Heads).
- The 'ASHA VAROSHA Divas' is a single window mechanism for the ASHA, which was established to strengthen the ASHA programme.
- There is a mentoring process at the district and block levels for the ASHAs and VHSNC members.

Moving Ahead

- A one-day district level workshop will be organised for the key district health officials, PRI members and CBOs in the pilot districts.

Dr Rajesh Jha, General Manager-Community Processes, Uttar Pradesh: The social accountability process is currently operational in 12 districts under the Uttar Pradesh Health Systems Strengthening Project (UPHSSP), which is funded by the World Bank. This is why no activities have been proposed under NHM. The UPHSSP has an independent monitoring unit, which is conducting concurrent monitoring.

Distinctive Features and Benefits of CAH

- The processes consist of activation of the VHSNCs, regularisation of Jan Samwads, automated generation of reports, including ATR compliance reports for feedback to the VHSNCs and the health system.
- In some pilot facilities, the RKSs are being strengthened with PFI support.
- In seven districts with high TFR, a male member of the VHSNC acts as a mentor to increase male participation.
- These members have been trained on specific topics and this potential can be replicated to cover other health determinants, thereby facilitating increased participation on their part.

Moving Ahead

- Automated generation of reports for feedback to the VHSNCs and health system.
- Regularisation of Jan Samwad at the block level.
- Monitoring and supportive supervision of VHSNDs by the VHSNC members and the community.
- Assessment of health services by the community through Community Score Card mappings.

Summing up by the moderators

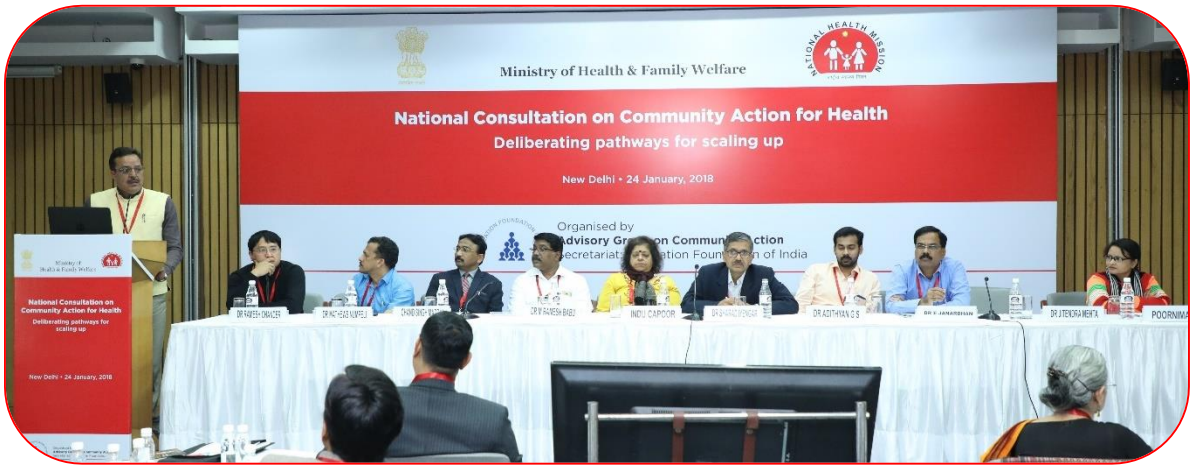
- Implementers need to be thoroughly convinced that empowering communities will add value to the existing health system while implementing the CAH processes.
- Need to focus on some key innovations, which could be scaled up and contributed to achieving the objectives set in the SDGs.

Session 2 (continued)

Experiences, challenges and commitments from states to scale up implementation of CAH processes

State Nodal Officer: Himachal Pradesh, Jammu and Kashmir, Karnataka, Kerala, Andhra Pradesh, Telangana and Tamil Nadu

Moderators: Ms Indu Capoor and Dr Sharad Iyengar, Members AGCA



Ms Indu Capoor and Dr Sharad Iyengar, Members-AGCA Chairing the Session (Middle)

Dr Ramesh Chander, Nodal Officer, Himachal Pradesh: It is a recent state to initiate CAH under NHM and the ASHA recruitment is still under process. VHSNCs have been formed at the ASHA village levels and funding initiated.

Progress made so far:

- Dedicated HR in place for community processes.
- Cluster meetings of VHSNCs are being conducted.
- The training of other community participation programmes is clubbed with the VHSNC training in order to optimise the paucity of funds and human resources.
- The ASHAs are using the state's community based monitoring tool.

Challenges

- The funding of VHSNCs through the Department of Rural Development is problematic as the ASHA recruitment process is still in progress.
- The hilly terrain, poor motivation of ASHAs in difficult areas due to inadequate incentives, the scarcity of credible NGOs in the state and the free diagnostic policy, which may shrink resource generation by RKS at the facility level, are some key challenges.

Moving Ahead

- There is a plan to scale up Jan Samwads.

Dr Mathews Numpeli, Kerala: The health system is under a three tier system, which is facilitated by a strong NGO presence.

Benefits of CAH

- There is a powerful Hospital Management Committee with strong support from the local self-governance department (LSGD) and the Kudumbashree initiative (women's empowerment).
- LSGDs prepare decentralised health plans with active involvement of the community, based on the health status reports, considering epidemiological profiles and causes of mortality.
- Most health related issues taken up by LSGDs are related to NCD, palliative care, infrastructure modification and medicine purchase.
- The state practices a strong mandatory palliative care project from village to the district level through one lakh volunteers.
- Moving from a primary health centre approach to a family health centre concept, named "Aardram". There is provisions for a family doctor and one health volunteer (Arogyasena) to provide primary health services to 25 - 50 houses under the leadership of the Ward Health Sanitation and Nutrition Committee (WHSNC) co-ordinated by the ASHA.

Moving Forward

- Undertake an Arogya Jagratha (Health Awareness/Mobilisation Campaign), which is a year-long campaign to promote positive health habits.

Dr Adithyan G S, Tamil Nadu: CAH was piloted from 2007 to 2009 as a part of the national process. Since then, 446 Panchayats in 14 development blocks of six districts in the state have been covered. Universal Health Coverage (UHC) is being piloted in 3 districts by provisioning a second Village Health Nurse (VHN) only for community level activities. A population based NCD screening pilot is currently underway in the same 3 districts.

Benefits of CAH during the pilot project

- Expansion of VHSNCs to Village Health Water and Sanitation and Nutrition Committees (VHWSNCs).
- In open meetings at every village, community chooses one or two interested members from each village.
- Health centres have been graded through community level monitoring and open meetings.
- Community conducted grading of health centres through opinion poll.
- ASHAs are designated as Village Health Volunteers (VHV) by the state government.
- 2650 VHVs/ASHAs have been provisioned for tribal and remote hamlets, covering 26 districts.
- ASHAs are trained to operate BP apparatus and Blood Glucose Meter at the house hold level.

Challenges

- A model of an ideal and fully fledged CAH is yet to be instituted.
- Huge gap in institutionalising community participation.
- Community led monitoring and audits are yet to be established in their fullest form in the system.

Moving Ahead

- In the current PIP the state proposes to revamp the CAH processes. The UHC with second ANM to be scaled up to 918 sub health centres.
- Provision of community palliative care staff nurses in 130 blocks

Dr M Ramesh Babu, Andhra Pradesh: The departments of Health, Medical and Family Welfare, Women and Child Welfare, the Mission for Elimination of Poverty in Municipal Areas (MEPMA), Municipal Administration and Urban Development are working in tandem for wide publicity on health care services in urban areas. They are working in convergence to improve the nutritional and health status of women and children and reduce the IMR and MMR in urban areas. The state has initiated Electronic Urban Primary Health Centres (e-UPHCs) to offer speciality care services for the urban population.

Benefits of CAH and Convergence with other departments in urban area

- Awareness on e-UPHCs has been created and they have been popularised through information displayed on health entitlements and the services offered under various schemes.
- Improved coverage of immunisation and antenatal checkups through preparation of the area specific action plan and schedule for coverage of services meant for the target group.
- All the national programmes are being implemented in the e-UPHCs.
- The third part knowledge partner, the Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh inspects 10 per cent of the facilities every six months and submits a report on their performance.
- The performance of e-UPHCs is available on a real time basis in the public domain.
- Each e-UPHC is equipped with a software, which tracks patients' records electronically.
- The departments of Health and Family Welfare and Women and Child Welfare have collaborated to reach unserved areas through Anganwadi workers.
- The NUHM has collaborated with the Mission for Elimination of Poverty in Municipal Areas (MEPMA) for the implementation of CAH processes.

Challenges

- Migrating population in the urban area.
- Convergence with line departments.

Moving Ahead

- Community mobilisation strategy to build and strengthen convergence with e-UPHCs and CAH agencies.
- Empowerment of community through awareness generation for demanding health services.
- Special focus and tracking of migrating and un-reached communities.
- Training of frontline workers for interpersonal communication.

Ms Purnima B. S, Consultant, Community Processes, Karnataka: Community processes approved in the PIP will now be implemented through a specialised agency called the Karnataka State Health Resource Centre. There are plans to organise a state level training of VHSNCs in the coming months.

Dr Jitender Mehta, NHM, Jammu and Kashmir: The state has a mechanism in place to monitor activities of ASHAs against 10 parameters as well as an ASHA grievance redressal mechanism. It has a fixed date for VHNSC meetings, which is followed by cluster, block and state level meetings. The ANMs play the role of ASHA facilitators and the Deputy CMO supervises the community processes at the district level.

Challenges

- The training of community and ground staff on various health and health related indicators is a very capital intensive exercise for which the state needs adequate funding.

Dr E Janardhan, Telangana: The state is paying a performance based incentive of Rs. 6,000 per month per ASHA and she is required to perform all outreach activities. All VHSNCs are in place with bank accounts.

Benefits of CAH

- The ASHA facilitates the preparation of the village health plan with members of the VHSNCs, which are submitted to the state for implementation within a given timeframe.
- The state facilitates the formation of a patient support group (PSG) at the village level.
- Telangana has piloted health and wellness centres at the sub-health centre level (50 in urban and 50 in rural areas) to provide comprehensive care.
- ASHA facilitators (the male multipurpose health workers from the system) facilitate the VHSNCs.
- The Telangana government increased performance under the VISHWAS programme.

Mr Chand Singh, State NGO Coordinator, NHM, Haryana: The state has empowered ASHAs by connecting them through mobile technology.

Benefits of CAH and Mobile Technology

- The state has given a mobile connection to all the ASHAs and passes down information to them through a call centre at the state level. The ASHAs are required to inform on any malpractices encountered at the health facilities to ensure quick action against the culprits.
- With the help of mobile technology, the ASHAs contributed in the "Beti Bachao Beti Padhao" campaign by mapping illegal ultra-sonography centres conducting prenatal sex determination or sex selective abortions. For these services, a few ASHAs have been given a cash award.

Summing up by the moderators

Quality assurance checklists and quality improvement process frameworks emphasise more on equipment, supplies and clinical processes, to assess the quality and functioning of services, neglecting user experiences on services received. Medical professionals hide behind the issues making everything technical, claiming that the people would not be able to understand. There is a need to find a practical way, such as a social audit, to increase accountability for healthcare and improve quality, building bridges between the providers and users in practical ways. "We cannot have high quality health services without accountability." Dr Sharad Iyengar

Session 3:

Panel discussion: Priorities and support required by the states for scaling up implementation of CAH

Moderator: Ms Mirai Chatterjee, Member AGCA

Session 3 in Progress

Ms Preeti Pant, Joint Secretary, National Urban Health Mission, MoHFW highlighted the importance of sustaining MASs by enabling convergence with other departments. She made the following points:

- There is a need to develop training strategies and modules to build the capacity of the MASs to formulate an effective meeting agenda, document minutes of the meeting, effectively manage untied funds and associate with other livelihood activities (Livelihood Mission).
- She mentioned the importance of capacitating MAS members to become agents of change for NCDs and a forum for propagating preventive and promotive aspects of health.
- The AGCA members and Secretariat should provide handholding support to the states where strengthening of MASs and urban ASHAs is required.

Dr Yugal Kishore Pant, Mission Director, NHM, Uttarakhand highlighted the importance of convergence with other departments for the provision of universal health coverage. He made the following key points:

- A prerequisite for effective community action for health is to have the knowledge of the services and entitlements of the target group, the perception of the service providers and the trust that people have in the service provider.
- Universal health services can be effectively delivered using the three-tier governance system under the 73rd and 74th Constitutional Amendment Acts; though the delivery of health functions was entrusted to local self-governance through these Acts, this is yet to happen in many states.

- In his experience, platforms of public interactions (Jan Samwad) with departments increased positive perceptions among the public; this needs to be scaled up.
- Adequate funding is required to capacitate urban local bodies and PRIs to achieve the objective of universal health coverage.
- He proposed social audits on health in pilot blocks to ascertain the output of the process before scaling up.
- He will be initiating a training of newly elected PRI representatives on NHM to capacitate them on demanding services as well as assessing the quality.

Dr Rajani Ved, Executive Director, NHSRC spoke of the importance of committed financing for being able to carry out high quality training for process intensive activities, such as CAH. She made the following points:

- Though funds are available for building capacity of local governance under the 14th Finance Commission, there is a need to customise the content of the training so that topics related to health and health related issues can be adequately covered.
- VHSNCs should not limit themselves to only social audits but also conduct participatory planning, and support frontline workers in the implementation of universal health coverage.
- There is a need for quality studies on the functioning of VHSNCs, which could provide enough evidences and advocacy material to strengthen them.
- In order to utilise ASHAs and the VHSNCs for community based monitoring, the states should seek funds through their PIPs and effectively engage AGCA members and the Secretariat.

Mr Anand Sinha, Country Advisor, the David and Lucile Packard Foundation highlighted the need for evidences to showcase the efficacy of CAH and its impact on overall health services, be it provision or quality, so that donors would be interested in coming on board.

- CAH is different for everybody reflecting diverse dimensions such as awareness about entitlements, training, monitoring, providing feedback about accountability, NGO empowerment, or community empowerment – these offer unique starting points for various stake holders.
- There are options of starting with capacitating the frontline workers or the NGOs, or working with the political system to create enablers within the system.
- CAH activities are expected to raise the quality of interaction between the service providers and the community and overall improve the quality of services.
- The implementers should focus on how the CAH activities contribute to the overall outcome, documenting those in order to have a clear understanding of what worked and what did not.

"We need to create a clear understanding of the field of work and what exactly we want as an outcome." Mr Anand Sinha

Summing up by moderator

- Community processes require investment of funds and quality time to show the desired results.
- The civil society can play a larger role by partnering with the government and in bringing feedback from the field in a constructive manner.
- Need to invest in the local people, particularly for the position of a frontline worker, by bringing them in as a second ASHA as the existing one currently seems to be overburdened.
- Need to invest in technology.

"As we are talking about changing perceptions, structure and the system for those who have had no voice and visibility ever in this system, especially woman and young people, I think we need to invest time for them and be patient." Ms Mirai Chatterjee

Discussions

- The state needs to negotiate with the banks which are currently custodians of large amounts of NHM funds and work out means which would enable them to open up a zero balance account for MAS.
- Communities should be allowed to develop their own plans as they are aware of their own priorities and issues of concern. States need to facilitate uniformity in service provisions, irrespective of conditions, failing which the next best available local alternative should be promoted and nurtured.
- The role of an ASHA should be more of a facilitator-cum-activist than the role as a health care provider. As a former, she is supposed to educate the community on various diseases and entitlements whereas as in the latter case, she needs to develop her technical skills. For an ASHA to be more effective, more incentive should be given to her when she plays the role of facilitator-cum-activist.

CONCLUDING SESSION AND KEY TAKEAWAYS

Summing up the discussion, **Ms Muttreja, Member AGCA** suggested the development of a cadre of resource persons to support and mentor VHSNCs, RKSs and MASs to deepen effectiveness. She made the following points for moving forward:

- Need for a larger role for the state institutes of rural development (SIRDs) and greater synergy in a more formal manner to take the strengthening of community platforms forward.
- NGOs should play an advisory role in bringing in the rights-based perspective.
- MAS is a fantastic women's empowerment approach, which should have a comprehensive and flexible strategy that strengthens them.

- Need to have a technology-based grievance redressal which has the potential to be scaled up – for example: the CM online in Madhya Pradesh and the block grievance redressal committee in Maharashtra.

In his concluding remarks based on the day-long consultation, **Mr Bijit Roy, Team Leader, AGCA Secretariat** presented the following takeaways:

1. States should allocate sufficient funds and make prompt disbursement of funds for CAH based on PIP approvals
2. Focus on building capacities of the ASHAs to lead VHSNC- organizing meetings and planning local action
3. VHSNCs should be capacitated to undertake monitoring of mortality and morbidities, especially cause of death
4. Orientation of health managers and government officials on CAH processes is essential to facilitate their involvement and ownership
5. Certain proportion of the NHM budget should be earmarked for accountability processes , as in MGNREGs -0.5%
6. Need to have an autonomous state institution for facilitating social audits of key governments schemes
7. Many states are focusing on online complaint registration and redressal. This should not replace face – face dialogue of the community with officials, which is a very vital and empowering process
8. Social audits 'disrupt the power hierarchy 'and are an important accountability seeking platform
9. There is a need to develop a Janata Information Systems for easy access of information to the community
10. VHSNC and RKS strengthening processes are complex. States should develop specific strategies – trainers pool, training load, allocation of funds and monitoring training roll out
11. While management of implementation of CAH through the NHM Community Processes structures is essential for scale up, there is a need to retain the essence of accountability aspects -community monitoring and Jan Samwads
12. Following innovations have potential for scaling up
    - Male VHSNC Family Planning Mentors (Uttar Pradesh)
    - Monitoring the SDG indicators (Gujarat)
    - Monitoring Comprehensive Primary Health Care (Uttarakhand)
    - Allocation of responsibilities among VHSNC members for monitoring specific schemes (Chhattisgarh)

In her concluding remarks, **Ms Muttreja** said that she realised that such a meeting should have at least two days as the states do not get ample time to present their work and do justice to the work undertaken for CAH. She thanked the representatives of the states for coming and sharing their work. She especially thanked Mr Jhalani who has been a huge pillar of strength and champion of the CAH programme and Dr Manohar Agnani, who as his successor, is equally supportive and committed. Ms. Muttreja thanked Ms. Limatula Yaden and Ms Amita Chauhan, members of the AGCA, Dr Rajani Ved, Ms Preeti Pant and Mr Anand Sinha for giving their valuable inputs and time.

Please log on to www.nrhmcommunityaction.org for the presentations made at the consultation.

National Consultation on Community Action for Health
Deliberating Pathways for Scaling Up
India International Centre, New Delhi, 24 January 2018 (9.00 am to 5.00 pm)

Consultation objectives:

i. Share promising practices on community action and accountability;
ii. Share innovations and progress in the implementation of Community Action for Health (CAH) processes in the states;
iii. Identify key challenges/solutions; and
iv. Provide recommendations and strategies for effective scaling up of CAH under the National Health Mission.

Agenda

Time	Session Plan
9.00 AM- 9.30 AM	Tea and Registrations
9.30 AM - 10. 00 AM	**Inaugural Session** • Welcome and objective setting - Ms Sona Sharma, Director Programmes, Population Foundation of India • Scaling Up Implementation of Community Action for Health (CAH): The Journey over the Decade - Ms Poonam Muttreja, Member AGCA • Key Note Address: Vision and priorities for CAH under the National Health Mission (NHM) - Dr Manohar Agnani, Joint Secretary -Policy, MoHFW
10.00 AM - 11.10 AM	**Session 1:** *Panel discussion: Promising initiatives on Community Action and Accountability (10 minutes for each speaker)* • Strengthening Community Processes under the NHM - Dr Rajani Ved, Executive Director, National Health Systems Resource Centre (NHSRC) • Meghalaya Social Audit Act - Mr P Sampath Kumar, Commissioner and Secretary, Department of Community and Rural Development, Government of Meghalaya • Demanding Accountability through People's Campaigns - Mr Nikhil Dey, Founder Member, Mazdoor Kisan Shakti Sangathan (MKSS) • Enhancing Accountability in Delivery of Public Service through Social Audits - Ms Sowmya Kidambi, Director, Society for Social Audit, Accountability and Transparency (SSAAT), Department of Rural Development, Government of Telangana Chair - Dr Manohar Agnani, Joint Secretary –Policy, MoHFW Followed by discussions
11.10 AM - 12.30 PM	**Session 2:** *Experiences, challenges and commitments from states to scale up implementation of CAH (5 minutes for each state)*

Time	Session Plan
	- State Mission Director/Nodal Officer- Assam, Bihar, Chhattisgarh, Jharkhand, Maharashtra, Madhya Pradesh and Uttarakhand - Moderators: Dr M. Prakasamma and Dr Thelma Narayan, AGCA Members Followed by discussions
12.30 PM - 1.30 PM	**Session 2** (contd): *Experiences, challenges and commitments from states scale up implementation of CAH (5 minutes for each state)* - State Mission Director/Nodal Officer- Delhi, Gujarat, Meghalaya, Nagaland, Rajasthan, Sikkim, Tripura and Uttar Pradesh Moderators: Dr Abhijit Das and Dr H. Sudarshan, AGCA Members Followed by discussions
1.30 PM - 2.00 PM	**Lunch**
2.00 PM - 3.00 PM	**Session 2 contd:** *Experiences, challenges and commitments from states to scale up implementation of CAH processes (5 minutes for each state)* - State Nodal Officer: Himachal Pradesh, Jammu and Kashmir, Karnataka, Kerala, Andhra Pradesh, Telangana and Tamil Nadu Moderators: Ms Indu Capoor and Dr Sharad Iyengar, AGCA Members Followed by discussions
3.00 PM - 3.15PM	**Tea/ Coffee Break**
3.15 PM - 4.45 PM	**Session 3:** *Panel discussion: Priorities and support required by the states for scaling up implementation of CAH* - Ms Preeti Pant (Joint Secretary, National Urban Health Mission, MoHFW) – Community processes and accountability initiatives under the NUHM - State Mission Directors: i. Dr Gaurav Dahiya (Mission Director, NHM – Gujarat) ii. Mr Yugal Kishore Pant (Mission Director, NHM – Uttarakhand) - Dr Rajani Ved (Executive Director-NHSRC) - Mr Anand Sinha (Country Advisor, the David and Lucile Packard Foundation)- Donor perspectives on Community Action and Accountability - Ms Mirai Chatterjee, AGCA Member Moderator: Dr Manohar Agnani, Joint Secretary- Policy, MoHFW Followed by discussions
4.45 PM- 5.00 PM	Concluding Remarks and Vote of Thanks - Ms Poonam Muttreja, Member AGCA

National Consultation on Community Action for Health: Deliberating Pathways to Scaling-up

January 24, 2018, India International Centre, New Delhi

List of Participants

Sl. No.	Name	Organisation	Designation
Speakers			
1.	Mr P Sampath Kumar	Department of Community and Rural Development, Government of Meghalaya	Commissioner and Secretary
2.	Mr Nikhil Dey	Mazdoor Kisan Shakti Sangathan	Founder Member
3.	Ms Sowmya Kidambi	Society for Social Audit, Accountability and Transparency	Director
4.	Mr Anand Sinha	The David and Lucile Packard Foundation	Country Advisor
Ministry of Health and Family Welfare			
5.	Dr Manohar Agnani	Ministry of Health and Family Welfare	Joint Secretary - Policy
6.	Ms Preeti Pant	Ministry of Health and Family Welfare	Joint Secretary - NUHM
7.	Ms Amita Chauhan	Ministry of Health and Family Welfare	Senior Consultant- Public Health Policy & Planning
State Mission Directors			
8.	Dr Gaurav Dahiya	National Health Mission, Gujarat	Mission Director
9.	Dr Satish Pawar	National Health Mission, Maharashtra	Additional Mission Director
10.	Mr Yugal Kishore Pant	National Health Mission, Uttarakhand	Mission Director
National Health Systems Resource Centre			
11.	Dr Rajani Ved	NHSRC	Executive Director
12.	Dr Nobhojit Roy	NHSRC	Senior Advisor, PHP Division
13.	Mr Arun Srivastava	NHSRC	Consultant

Sl. No.	Name	Organisation	Designation
14.	Dr Manoj Kumar Singh	NHSRC	Consultant
State Representatives			
Jammu & Kashmir			
15.	Dr Jitender Mehta	State Health Society	State Nodal Officer/PM
Himachal Pradesh			
16.	Dr Ramesh Chander	National Health Mission	
Maharashtra			
17.	Ms Swati Patil	State Health Society	Programme Officer (CBM)
18.	Ms Mukta Gadgil	State Health Systems Resource Centre	Senior Consultant
Chhattisgarh			
19.	Dr Kaushal Prasad	National Health Mission	State Nodal Officer for Mitanin Programme/VHSNC
20.	Mr Prabodh Nanda	State Health Resource Centre	Programme Coordinator
Rajasthan			
21.	Dr Vishal Singh	State Institute of Health and Family Welfare	
22.	Dr Amita Kashyap	State Institute of Health and Family Welfare	
Gujarat			
23.	Mr Randhir Patel	National Health Mission	Programme Officer – Rural Health
24.	Dr Mrunal Mehta	National Health Mission	Programme Officer (ARS)
25.	Dr Rakesh Vaidhya	National Health Mission	-
26.	Dr Hardik Nakshiwala	National Health Mission	

Sl. No.	Name	Organisation	Designation
Kerala			
27.	Dr Mathews Numpeli	National Health Mission	
Tamil Nadu			
28.	Dr Adithyan G S	National Health Mission	State Consultant
Uttar Pradesh			
29.	Dr Rajesh Jha	State Programme Management Unit	General Manager – Community Processes
30.	Mr Dhanunjaya Rao	Uttar Pradesh – TSU	Deputy Director
Uttarakhand			
31.	Dr Pankaj Kumar Singh	National Health Mission	Assistant Director
32.	Mr Surat Singh Tomar	National Health Mission	Programme Management Coordinator – ASHA/VHSNC
Madhya Pradesh			
33.	Dr Shailesh Sakalle	National Health Mission	
Bihar			
34.	Mr Pranay Kumar	National Health Mission	
Jharkhand			
35.	Dr Manir Ahmed	National Health Mission	Training Coordinator – Community Processes
36.	Dr Pradeep Baskey	National Health Mission	Deputy Director
Karnataka			
37.	Ms Poornima B S	National Health Mission	
Andhra Pradesh			
38.	Dr M Ramesh Babu	National Health Mission	Programme Officer – NUHM

Sl. No.	Name	Organisation	Designation
Telangana			
39.	Dr E Janardhan Reddy	National Health Mission	Senior Programme Officer
40.	Dr P Vikram	National Health Mission	Joint Director
41.	Mr T V S Ranjit Babu	National Urban Health Mission	Programme Officer
New Delhi			
42.	Dr Monika Rana	DSHM	State Programme Officer
43.	Mr Arvind Mishra	DSHM	Consultant, Community Processes
Haryana			
44.	Mr Chand Singh Maddan	National Health Mission	State NGO Coordinator
Regional Resource Centre – North East			
45.	Dr Biraj Kanti Shome	RRC – NE	
Assam			
46.	Ms Partha Saikia	National Health Mission	
Sikkim			
47.	Dr Melozina Leezum Lepcha	National Health Mission	ADHS cum Nodal Officer
48.	Dr Namita Hangma Subba	National Health Mission	State Programme Manager
Meghalaya			
49.	Dr Joy Lyngwa	National Health Mission	Deputy Director, Health Services and Nodal Officer
50.	Ms Dakaru Passah	National Health Mission	

Sl. No.	Name	Organisation	Designation
Nagaland			
51.	Dr Vizolie Suokhrie	Directorate of Health and Family Welfare	Project Director (NHP)
52.	Dr Leamnyei Konyak	National Health Mission	Director
53.	Ms N Chubala Pongen	National Health Mission	Senior Programme Manager
Tripura			
54.	Mr Rajib Ghosh	National Health Mission	State ASHA Manager
State Non-Governmental Organisations			
Gujarat			
55.	Ms Pallavi Patel	CHETNA, Ahmedabad	Director
Maharashtra			
56.	Dr Nitin Jadhav	SATHI-CEHAT	Associate Coordinator
57.	Ms Trupti Joshi	SATHI-CEHAT	Project Officer
58.	Ms Neena Shah More	SNEHA	Programme Director (MAS Programme)
Bihar			
59.	Mr Arvind Kumar	Gram Nirman Mandal	General Secretary
60.	Mr Basudev Mandal	GPSVS	Secretary
61.	Ms Priyadarshini Trivedi	PFI, Bihar	State Programme Manager
62.	Mr Sheikh Nausad Akhtar	PFI, Bihar	State Programme Officer
Madhya Pradesh			
63.	Dr S R Azad	MGCA	State level Member
64.	Mr Amulya Nidhi	MGCA	State level Member
Uttar Pradesh			
65.	Mr Niraj Kumar	PFI, Lucknow	Programme Coordinator

Sl. No.	Name	Organisation	Designation
Meghalaya			
66.	Ms Mayfereen Ryntathiang	Voluntary Health Association	State Coordinator
Development Partners			
67.	Ms Mini Varghese	Nutrition International	National Programme Manager
68.	Mr Alok Pattanaik	Care India	
69.	Ms Shanti Mahendra	Options	
70.	Ms Dipa Nag Chowdhury	MacArthur Foundation	Deputy Director
Indian NGOs			
71.	Ms Rakshita Swamy	Centre for Budget and Governance	Fellow
72.	Ms Richa Chintan	Centre for Budget and Governance	Research Consultant
73.	Dr Aparajita Gogoi	Centre for Catalysing Change	Executive Director
74.	Ms Sanjeeta Gawri	Centre for Catalysing Change	Programme Officer
75.	Ms Ranu Bhogal	OXFAM	Director – Policy Research and Campaigns
76.	Ms Shamaila Khalil	OXFAM	Programme Coordinator - Health
Media			
77.	Ms Salapa Deb	NDTV	
78.	Mr V P Chopra	Delhi Shopping	Editor
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79.	Dr Abhijit Das	CHSJ	Director
80.	Dr H Sudarshan	Karuna Trust	Honorary Secretary
81.	Dr M Prakasamma	Academy of Nursing Studies	Honorary Director

Sl. No.	Name	Organisation	Designation
82.	Dr Thelma Narayan	Community Health Cell/SOCHARA	Director
83.	Ms Indu Capoor	CHETNA	Founder Director CHETNA and Director CHETNA Outreach
84.	Ms Mirai Chatterjee	SEWA Social Security	Director
85.	Dr Sharad Iyengar	ARTH	Chief Executive
86.	Ms Poonam Muttreja	Population Foundation of India	Executive Director
AGCA Secretariat			
87.	Mr Bijit Roy	AGCA Secretariat	Team Leader
88.	Mr Daman Ahuja	AGCA Secretariat	Programme Manager – CAH
89.	Ms Seema Upadhyay	AGCA Secretariat	Programme Manager – CAH
90.	Mr Sanjoy Samaddar	AGCA Secretariat	Programme Manager – CAH
91.	Mr Saurabh Raj	AGCA Secretariat	Programme Manager – CAH
92.	Ms Jolamma Jose	AGCA Secretariat	Programme Associate
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97.	Ms Gita Gupta	Population Foundation of India	Consultant
98.	Mr Ravindra N. Singh	Population Foundation of India	Programme Coordinator - ACA
99.	Mr Gagan Singhal	Population Foundation of India	Manager Administration
100.	Mr Abhijit Mali	Population Foundation of India	Manager Digital Communication
101.	Ms Urvashi Mitra	Population Foundation of India	Communication Officer