Minutes of the 40th Meeting of the Advisory Group on Community Action - National Health Mission
Population Foundation of India
August 21, 2019

Members of Advisory Group on Community Action (AGCA) present

1. Mr A R Nanda
2. Dr Abhay Shukla
3. Dr Abhijit Das
4. Mr Alok Mukhopadhyay
5. Dr H Sudarshan
6. Ms Indu Capoor
7. Ms Mirai Chatterjee
8. Dr M Prakasamma
9. Dr Narendra Gupta
10. Ms Poonam Muttreja
11. Dr Sharad Iyengar
12. Dr Vijay Aruldas

AGCA Secretariat and PFI staff present

1. Ms Sona Sharma
2. Mr Bijit Roy
3. Mr Daman Ahuja
4. Ms Seema Upadhyay
5. Mr Smarajit Chakraborty
6. Mr Saurabh Raj
7. Ms Jolly Jose

AGCA members who could not attend the meeting

1. Dr Thelma Narayan
2. Mr Gopi Gopalakrishnan
3. Dr Saraswati Swain

Permanent invitees who could not attend the meeting

1. Dr Rajani Ved, Executive Director, NHSRC

Ms Poonam Muttreja welcomed the AGCA members to the 40th meeting of the Advisory Group on Community Action (AGCA) and mentioned that Dr Manohar Agnani, Joint Secretary – Policy, MoHFW had committed to attend the AGCA meeting. However, he could not join due to extension of an out-station meeting.

The objectives of the meeting were to:

1. Share an update on the 'Strengthening Community Action for Health (CAH) under the National Health Mission' programme for the period: December 2018 to July 2019.
2. Share update on new initiatives from Jharkhand, Meghalaya, Uttarakhand and Assam.
3. Discuss priorities on community processes under the National Health Mission (NHM).
4. Finalise recommendations for submission to the MoHFW on: a) 'Social accountability processes and strengthening Rogi Kalyan Samities (RKSs) for HWCs'; b) 'Role of ASHAs in

ensuring continuum of care and empanelment of households for Health and Wellness Center (HWC) services'; and 'Processes for mapping HWCs to secondary and tertiary public health facilities.

5. Discuss on AGCA priorities for the FY 2019-20 and operational issues related to CAH implementation in the states.

Ms Poonam Muttreja, Member-AGCA chaired the pre-lunch session. Members confirmed the minutes of the 39th AGCA meeting held on November 28, 2018.

Compliance on Action Points from the 39th AGCA meeting

Bijit Roy shared an update on the action points identified at the 39th AGCA meeting.

Sl. No.	Action Points	Responsibility	Actions taken
1.	Share update with MoHFW and NHSRC on CAH implementation in states.	AGCA Secretariat	Update was shared with the MoHFW and NHSRC.
1.	Initiate integration of CAH in Health and Wellness Centers (HWCs).	AGCA Secretariat	• Pilot on community mobilisation and monitoring of HWC services initiated in 7 aspirational districts in Assam. • In addition, discussions in progress with Uttar Pradesh State Programme Management Unit to replicate the initiative. • Development of CAH manual for HWCs included in the FY 2019-20 proposal, which was approved by the MoHFW.
2.	• Share agenda of the National Consultation on CAH with AGCA members for inputs. • Finalise consultation date with Dr Manohar Agnani (Joint Secretary-Policy, MoHFW) scheduled in March 2019.	AGCA Secretariat	Consultation was organised on March 11 and 12, 2019. Report was shared with the AGCA members and the MoHFW in May 2019.

I. Updates on progress of CAH implementation in the states for the period: December 2018 to July 2019

Bijit Roy presented an update of the 'Strengthening Community Action for Health under the National Health Mission' programme for the period from December 2018 to July 2019. The presentation outlined the following: a) progress on CAH implementation in the states; b) the recent initiatives in Assam (community mobilization and monitoring of HWC services); Jharkhand, Meghalaya, Uttarakhand (facilitation of community monitoring through the state

audit units); and Maharashtra (Arogya Gram Sabhas); analysis of approvals for the CAH component in the state Project Implementation Plans (PIPs) for the FYs 2018-19 and 2019-20. A copy of the presentation is enclosed for reference as **Annexure -1.**

Bijit highlighted the following:

Updates on new initiatives

a. **Community mobilisation and monitoring of HWCs services in Assam**

The state has piloted the community mobilisation and monitoring of HWC services in 222 sub health centers across 7 aspirational districts: Baska, Barpeta, Darrang, Dhubri, Goalpara, Hailakandi and Udalguri. Support was provided to the state government in developing the implementation plan, guideline, monitoring tools and co-facilitating the training of trainers' (ToTs) for the district trainers. Subsequently, 3,200 VHSNC members were oriented between February and March 2019. The VHSNC members have completed the monitoring processes at 83 HWCs.

b. Institutionalizing community monitoring through state social audit units - Jharkhand, Meghalaya and Uttarakhand

Support was provided to the Social Audit Units (SAUs) and NHM teams in 3 states (Jharkhand, Meghalaya and Uttarakhand) to institutionalise community monitoring of health services as part of the mandate of the SAUs. Thereafter, the state ToTs for the SAU resource persons were facilitated.

- **Jharkhand**

The community monitoring was undertaken in 400 gram panchayats across 5 districts- Hazaribagh, Ranchi, Palamu, Deoghar and Chaibasa. Around 12,000 community members participated in 105 Jan Samwads organised at the block and district levels. The events were chaired by the Zilla Panchayat Adhyaksh and Block Pradhan. Key outcomes from this initiative were: (i) 90% JSBY and ASHA incentive payments were cleared, which were pending since 2017, and (ii) pregnancy test kits were sent to all districts.

- **Meghalaya**

The State NHM in partnership with the Meghalaya Society for Social Audit and Transparency (MSSAT) has scaled-up the social audit of health schemes in 11 districts across 2,161 villages from the pilot 6 districts across 18 villages. 323 resource persons were oriented and the audit processes were completed in 384 villages across 7 districts by the end of June 2019. Key findings from the social audit processes were: (i) Around 98% pregnant women were registered for ANC services across all districts, and (ii) pregnant women were charged for sonography services at the CHC Bhoirymbong Block, Ri Bhoi district, and informal payments for referral services in Laskien block, West Khasi Hills district. The Joint Director-Community Processes discussed the issue regarding charges for sonography services with the CHC In-Charge who agreed to waive off the sonography charges; and the issues on informal charges for referral services, Joint Director assured to the community that she would inform the concerned officials for action.

- **Uttarakhand**

The State NHM and the Uttarakhand Social Audit Accountability and Transparency Agency (USAATA) piloted community based auditing on availability of medicines and diagnostics in 6 blocks of Uttarakashi district in the 2018-19. This has been scaled up to 30 blocks across all 13 districts in the state in 2019-20. A pool of 60 district and block resource persons was developed to roll out the processes.

c. Arogya Gram Sabha in Maharashtra

To mobilize and seek community inputs to improve health service delivery, 102 Arogya Gram Sabhas (AGSs)[1] were organised in 4 districts: Raigad, Chandrapur, Amravati and Ahmednagar. Key highlights from the AGSs were: (i) gram panchayats decided to use 14th Finance Commission funds to improve infrastructure at the sub-health centre in Amravati district; (ii) PHC doctors provided information to the community on menstruation and reproductive health complications in Ahmednagar district; and (ii) piped water was brought to the village Ralegam Mhasod, Ahmednagar district with support from the community after a Gram Sabha meeting in the above village.

The group made the following suggestions:

- The AGCA Secretariat to regularly update the status of CAH implementation across all the states. The revised updates will include sections on scale of implementation over the years, status of funds approved and utilized and challenges, if any. The documents will be shared with the respective AGCA members within a month.
- Share the following documents with the AGCA members: (i) status of implementation of CAH in states submitted to the MoHFW in October 2018; (ii) HWC guidelines and community monitoring tools developed for Assam.
- There are often changes in the NHM Mission Directors. The new official should be oriented on the CAH processes in the state and role of the AGCA.
- Specific steps are to be taken for states which are not implementing CAH as per the Record of Proceedings (ROP) approvals, including engagements with the Mission Director and the MoHFW for necessary interventions.
- Develop a briefer on the Arogya Gram Sabha on the basis of Maharashtra experiences with support from SATHI.
- Adequate time should be allocated in the meeting agenda for presenting the progress update.

2. Social Accountability Processes and Strengthening Rogi Kalyan Samities for HWCs and Role of ASHAs

The session was chaired by Dr H Sudarshan.

The MoHFW constituted a committee under the chairmanship of Dr Manohar Agnani, Joint Secretary-Policy to strengthen the convergence between the Health and Wellness Centres (HWCs) and Pradhan Mantri Jan Arogya Yojana (PMJAY) components under the Ayushman Bharat Initiative on May 20, 2019. Three AGCA members: Dr H Sudarshan, Dr Abhay Shukla and Dr Narendra Gupta were nominated on the committee and led work on the following areas:

[1] Arogya Gram Sabha (AGS) is a state government initiative to ensure active engagement of the Panchayati Raj Institutions in monitoring and planning of health services, which was approved by the State Health Minister in June 2014.

i. Suggest mechanisms for community mobilisation and accountability, grievance redressal, and the role of VHSNCs and RKSs in such processes;
ii. Define role of the ASHAs in ensuring continuum of care;
iii. Empanelment of households for HWC services; and
iv. Processes for mapping HWCs to secondary and tertiary public health facilities (both in public and PMJAY empaneled private hospitals).

Dr Abhay Shukla made a presentation on the framework for community mobilisation and accountability, grievance redressal and the role of ASHAs in the context of Ayushman Bharat. The presentation included key components of CAH; key health system measures to support the CAH processes; community accountability and social audit in the context of HWCs; cycle of Jaankari-Sunwai-Karyavahi; inputs required for social audit, grievance redressal systems for HWCs and PMJAY, facilitation mechanism for CAH; ASHA's role in Ayushman Bharat, etc. A copy of the presentation is enclosed as **Annexure – 2.**

Speaking at the meeting Dr Shukla shared that the VHSNCs will have to be activated in about 6-7 lakhs villages. A dedicated and accountable facilitation mechanism should be there at every level like Chhattisgarh Swastha Panchayat Yojana or local active CSOs should be involved to activate, mentor and support the VHSNCs, which has been proposed in the framework.

Overall suggestions on the framework were:

- The presentation is too text-heavy which needs to include charts and diagrams with authentic data to demonstrate links and how community is engaged in feedback loops.
- The framework should have a vision and should be strategic, which can be later translated into implementation framework.
- The proposed framework represents only rural areas. The framework should address the rural and urban population equally. **Vulnerability assessment needs to be undertaken to reach the last mile first.**
- The framework of the Universal Health Coverage and the Sustainable Development Goals (SDGs) needs to be reviewed prior to framing the recommendations for Ayushman Bharat.
- The framework should be resilient in addressing the rapidly changing demography and epidemiology profile of the country.
- A mechanism has to be developed for states to report on the functionality of VHSNCs and RKS, which needs to be linked geographically from the community to HWCs.
- The word 'three monthly meetings/review' to be replaced with 'quarterly.'

2.a. Constitution and strengthening of RKSs at HWCs

Considering the current context of Ayushman Bharat, **the role of the RKS monitoring committee has become very important and there is a need to revise the RKS guidelines** for expanding its membership and defining their roles too. The AGCA Secretariat to develop draft guidelines for RKS Monitoring Committee members with support from the NHSRC and share with AGCA members for review.

2.b. Grievance redressal mechanisms under the PMJAY and HWCs

The PMJAY- health insurance scheme entitles the poor families to avail health care services in empanelled private hospitals, which may result in grievances against the services. This calls for a robust grievance redressal mechanism, which should be accessible to poor families to lodge their complaints. The group suggested the following:

- **The grievance redressal should not only be on ICT mechanisms (web or phone based) both under the NHM and PMJAY but should be on other modes of communications including complaint register, drop-boxes, in person, etc.**
- The effectiveness of the ICT mechanisms is mixed. Digital divide/gender digital divide is also an issue related to ICT based grievance redressal. It was suggested to look at the review done by Jonathan Fox on ICT based Grievance Redressal for reference.
- **Public disclosure of grievances are necessary for both feedback and time-bound official responses.**
- **The role of the District Quality Assurance Committees have to be extended to the PHCs and HWCs with one ombudsman at the district level for better patients' satisfaction and time-bound redressal of grievances.**
- **District level health officers' numbers could be displayed at the PHCs and HWCs for easy access to the general public.**

2.c. Capacity building and facilitation for implementation of social accountability processes

- The AGCA can support the state governments in developing a mechanism for community monitoring/social accountability of HWCs and PMJAY under the Ayushman Bharat.
- **As the Community Health Officers (CHO) are the key person in HWCs and are from different cadres, it is critical to orient them on CAH.**
- Performance related team incentives under the HWCs should be based on 'wellness aspects' rather than on 'clinical aspects including diagnostics, treatment and referrals '.
- 'Wellness concept' of HWCs is yet to take off under the Ayushman Bharat initiative, which needs attention. For example, in Assam, there is a lot of integration between the VHNSCs and the HWCs. However, their focus is on putting the infrastructure in place in HWCs.
- **A village level health index could be developed which can be monitored and tracked by the VHSNCs on regular basis. A healthy village (*nirmal gram*) tag could be provided to motivate them, which can also be linked to PHCs.**
- VHSNCs are not capacitated enough in the states to lead the social audit processes. People from the villages who are interested in raising village level issues need to get included in the VHSNCs and trained for its activation.
- A family in emergency should have a choice in which PMJAY accredited hospital they want to go for treatment. In order to avoid malpractices in referrals: (i) the audit of services at the hospital should be based on the feedback provided by the family, (ii) system will have to ensure that there is a criteria for referrals and its regular audits, (iii) and the patients treatment record from the referred institution needs to be fed in the system for future reference.
- Health Management Information System (HMIS) is not accountable to the public. Public disclosure of the information through a dash board on services rendered and availed will encourage the public for better utilisation of health services.

2.d. Engagement of civil society organisations

- Civil society organisations should be engaged for community mobilisation and facilitation in HWCs, which are not envisaged in the guidelines of HWCs.
- Local community based organisations should be part of the social audits.

3. Role of ASHAs in ensuring continuum of care

- **As ASHAs are overburdened with many things and incentivized for other work, her roles in the Ayushman Bharat initiative need to be redefined.** While ASHAs can mobilise the communities, the HWC team can undertake the health promotional activities collectively.
- VHSNCs could be made responsible for village level activities and support ASHAs.

4. Empanelment of households for HWC services and Process for mapping HWC to secondary and tertiary public health facilities

Discussing the Terms of Reference (TORs) for the empanelment of households and mapping of HWCs, Dr Narendra Gupta, Member –AGCA said that the overall objectives for developing these TORs are to improve and assure ease of access to medical care, facilitate continuum and quality of care services at different levels of facilities. The document detailed the geographical areas including rural and urban, to be covered under a HWC; identifying data base and processes for registering households; mapping HWCs with secondary and tertiary care facilities including PMJAY empanelled health facilities, etc. A copy of the document is attached as **Annexure – 3.**

The group made the following points:

- The document needs to include the broad principles and practical concrete options for its effective implementation – need to detail out the outreach services too. For example, a migrant family should be able to avail services at any locations across the country once being empanelled for HWC services.

- Family folder to be retained at the nearest HWCs (should be available within half an hour walking distance) with details of every family member. This folder would be one of the sources for providing preventive and curative health services and even for treatment.

- Individual wise electronic health card was proposed along with family records for easy access of health care services in case of migration or any other reasons.

- The Global Positioning System (GPS) can be used to identify whether the HWCs are open on a regular basis.

5. Discussion on Population Stabilization in India

In view of the increased discourse on population stabilization at the national level, the group discussed the potential role of AGCA in promoting family planning (FP) within a rights based approach. The following was suggested keeping in mind the mandate of AGCA:

- CAH plans developed at the state/district levels could include working within the communities to promote non-coercive approach for family planning, ensuring that communities are made aware of the benefits of birth spacing and use of family planning methods; adequate quality of care in FP services and informed choice.

- Inclusion of indicators around quality of care and provision of FP services for monitoring by communities could also be ensured within CAH processes.

6. Discussions on AGCA priorities for the FY 2019-20 and operational issues

Bijit Roy shared that the MoHFW has approved the AGCA proposal for the FY 2019-20 on August 13, 2019. Bijit sought suggestions from the group on two approved activities: (i) Development of HWC guidelines and community monitoring tool; and (ii) Development of innovation briefs on good practices in CAH. It was suggested that the AGCA Secretariat would develop the above documents (draft) by end of November 2019 and share with the AGCA members for review.

The meeting ended with a vote of thanks by Dr H Sudarshan.

Action Points

Sl. No.	Action Points	Responsibility
1.	Share the documents with the AGCA members - • Documents submitted to the MoHFW on Status of CAH implementation. • Guidelines on community monitoring and mobilisation of HWC services in Assam. • Updated document on CAH implementation in Karnataka since pilot with Dr H Sudarshan and Dr Thelma Narayan.	AGCA Secretariat
2.	Share updates on CAH implementation across states with AGCA members.	AGCA Secretariat
3.	Share analysis of CAH budgets as part of the Programme Implementation Plans (PIPs).	AGCA Secretariat
4.	Seek inputs from the AGCA members on outline for the guidelines on community monitoring and mobilisation of HWC services.	AGCA Secretariat
5.	Develop a briefer on Arogya Gram Sabha experiences in Maharashtra.	AGCA Secretariat and SATHI
6.	Develop a note on family planning for promotion of non-coercive approach through CAH.	AGCA Secretariat