Legacy Document for the CORE Group Partners Project (CGPP)

Contributors

Avishek Hazra
Cheshta Gulati
Raj Kumar Verma
Shruthi S
Ananya Saha
Amna Meraj
Goutam Kumar Burman
Arup Kumar Das
Manoj Kumar Choudhary
Roma Solomon
Jitendra Awale
Vivekananda Biswas
Himangshu Bailung
Shilpi Das
Imran Majid

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Abbreviations

ADRA	Adventist Development Relief Agency
AEFI	Adverse effects following immunization
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BMC	Block Mobilization Coordinator
CAG	Community Action Group
CGPP	CORE Group Partners Project
CHC	Community Health Center
CMC	Community Mobilization Coordinator
COVID-19	Coronavirus disease 2019
CRS	Catholic Relief Services
DMC	District Mobilization Coordinator
FGD	Focus Group Discussion
FLW	Frontline Workers
GEAG	Gorakhpur Environmental Action Group
IDI	In-depth Interview
IPC	Interpersonal communication
JKS	Jan Kalyan Samiti
KII	Key Informant Interview
MM	Mobilization Mitra
MSS	Meerut Seva Samaj
NGO	Non-governmental organization
PANI	People's Action for National Integration
PCC	PopulationCouncil Consulting Pvt. Ltd
PCI	Project Concern International
PEI	Polio Eradication Initiative
PHC	Primary Health Center
PVO	Private Voluntary Organization
SARD	Society For All Round Development
SC	Scheduled Caste
SDF	Sarathi Development Foundation
SHG	Self-Help Group
SMC	Social Mobilization Coordinator
SMNet	Social Mobilization Network
SRC	Sub Regional Coordinator
ST	Scheduled Tribe
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHSNC	Village Health Sanitation and Nutrition Committee
WHO	World Health Organization

Executive Summary

Context: For over two decades, the CORE Group Partners Project (CGPP), previously known as the CORE Group Polio Project, has played a pivotal role in addressing public health challenges in India, with a primary focus on polio eradication, routine immunization, and recently COVID-19 response. To tackle the challenges faced in the polio eradication program in India, CGPP adopted a multi-pronged and community-based approach to improve the uptake of vaccination. The approach was rooted in the identification, training, and engagement of community leaders, known as 'community influencers,' who harnessed behavioral interventions to counter misinformation and misconceptions associated with vaccination. These influencers played a crucial role in supporting vaccination campaigns and building trust within resistant communities, thus serving as a bridge between the community and the public health system. The motivation, commitment and consistency displayed by the local cadre and development partners supported the government in India's attainment of the polio free status in March 2014.

Emergence of Community Action Groups (CAGs): With the onset of the COVID-19 pandemic, issues such as fear, stigma, misinformation, myths, and misconceptions resurfaced. Recognizing the urgency of these challenges in hindering the adoption of COVID-19 appropriate behaviors and vaccine uptake, CGPP was called upon to support the pandemic response. As a strategic response, existing and new community influencers were organized into CAGs, with capacities reinforced for sustained functioning. The CAGs emerged as essential entities in curbing the spread of COVID-19 and addressing issues related to stigma and misinformation. These groups offered direct support in the form of food, medicine, counseling, and information to families facing quarantine, infection, or ostracism. Additionally, CAGs played a pivotal role in aiding frontline workers (FLWs) in identifying families for surveys and contact tracing. During the pandemic, approximately 450 CAGs, each comprising 6-8 members, catered to the needs of the most vulnerable populations, including migrants, economically disadvantaged individuals, and those facing social isolation. Furthermore, CAGs have continued to play a significant role in mobilizing for COVID-19 vaccination, measles rounds, and routine immunization.

Objectives and methodology: Despite the recognized success of this approach within the health system, valuable insights from the CAG intervention have not been comprehensively documented or shared with relevant stakeholders. To address this gap, PCC conducted a study to develop a legacy document for CGPP outlining the formation, process and functioning of CAGs. The specific aims of the study were to:

1. Document the profile of CAG members and their motivations for such volunteer work
2. Capture stakeholders' perspectives about the CAG intervention and their functioning
3. Explore the scalability and replicability of the CAG intervention in other geographic locations and contexts

The study employed a cross-sectional, mixed-methods approach, incorporating rapid literature review, secondary data analysis, and qualitative data collection through focused group discussions (FGDs), post-FGD surveys, in-depth interviews (IDIs), and key informant interviews (KIIs) for stakeholder interactions. The findings and recommendations were also shared with the study participants in a one-day co-learning workshop to incorporate participants' reflections on the findings and add contextual nuances into the study report. The study was conducted during Aug-Oct 2023 in all the three states, namely Uttar Pradesh, Assam, and Haryana, where CGPP is supporting the CAG intervention.

Key findings

The fight against the COVID-19 pandemic gave birth to CAGs: The study found that the CAGs surfaced in response to the vacuum created because of the withdrawal of Community Mobilization Coordinators (CMCs) in 2020 and to address the emerging concerns such as the proliferation of myths and misinformation, stigma towards returning migrants and coronavirus-infected families, and vaccine hesitancy and resistance among others during the COVID-19 pandemic. The rationale of forming CAGs was premised on multiple factors, such as group ownership, shared responsibility and accountability towards community's needs, and linkages with diverse government departments which would further ensure CAG's sustainability.

CAG structure was uniform across states, but contextualized approaches were followed for CAG formation: The study revealed that CAGs comprised of proactive influencers who held membership in other groups or were elected members and residing near each other. They were selected based on diverse criteria such as political or religious authority, economic influence, departmental linkages, or intimate knowledge of the community. In COVID-19 programming areas, contextualized approaches were employed to form CAGs. These groups served as an amalgamation of diverse skill sets and networks, comprising individuals with traits such as selflessness, a commitment to social welfare, effective communication skills, time availability, patience, and a profound understanding of the community.

Three-fourths of CAGs formed in the last 2 years, most members are male, 30-49 years old, and 70% have completed high school of above: Further, 90% are also members of other platforms. CAG members have diverse occupations, including farmers, ration dealers, ASHA workers, local doctors, teachers, and *pradhans*/village heads. Many members were religious leaders.

High motivation among CAG members, driven by social commitment, humanity, recognition, and can be strengthened by government felicitation of CAGs: The study used a scale to assess motivation of CAG members and found high motivation levels overall but low commitment to CAG in nearly two-thirds of members. Internal factors like community engagement and skill use, along with external factors such as learning opportunities and peer support, were key motivating factors. While most members didn't report personal issues or burnout, 38% noted an impact on family responsibilities.

CAG members are trained on health system's needs by the BMC/MM: The study revealed that the support extended to CAGs centered on capacity building, focused on health-related issues driven by the health system's needs. The orientation process, conducted digitally and telephonically during the COVID-19 pandemic, evolved through monthly meetings, where BMCs played a key role in providing guidance. The study also noted variations in BMC's support and facilitation of CAGs. CAG members expressed the need for expanded training scope beyond health, covering issues like domestic violence, education and child marriage.

CAGs bring additional value to the health system and community's trust in CAG is high: The study found varying levels of awareness about CAGs among the interviewed stakeholders. Before the CAG formation, FLWs sought support from community influencers. The collaboration between CAGs and community stakeholders proved mutually beneficial. The stakeholders highlighted that composition and group structure, influential position of the members and their knowledge about the community, and departmental linkages as key strengths, leading to quicker and more effective results, often in comparison to FLWs. Despite community members' limited awareness about CAGs, the community's trust in them was rooted in their socially relevant profiles, perceived dedication to community welfare, and timely support provision during COVID-19.

The sustainability of CAGs is based on inherent structure and linkage with the Health Department, but the challenge lies in ensuring motivation: The study revealed mixed perceptions on the sustainability of CAGs, with concerns raised about potential challenges after

the withdrawal of CGPP. Government officials highlighted the importance of DMCs and BMCs as intermediaries between CAGs and the health department, fearing a loss of communication channels without them. Limited handholding by BMCs and DMCs was a strategic move to foster self-sufficiency and group ownership for long-term sustainability. Key concern was on maintaining motivation among CAG members, which was viewed as essential for sustainability of the model in the absence of financial incentives. Stakeholders emphasized the need for continuous motivation, skill-building, and acknowledgment of CAG members by government officials. The plans to link CAGs directly with the health system is underway. The inclusion of CAGs in various health department meetings and linking CAGs with departments other than health were recommended to ensure sustainability.

Replication and scalability of CAGs: The study identified three key components for scalability which included: a) careful selection of community influencers in collaboration with multiple stakeholders, b) ensuring motivation among CAG members, and c) strong collaborations with local committees, organizations, and health department. Stakeholders emphasized the importance of an inclusive CAG with diverse representation, i.e., involving position holders from different government departments. Challenges in replicating and scaling CAGs into new geographies were acknowledged, with a focus on building community ownership and motivation through learning environments, orientations, and recognition. The findings focused on contextualizing intervention strategies based on evidence for effectiveness. The acceptability of leveraging community influencers in health interventions was recognized, and both the program team and government officials have called for government orders to institutionalize the engagement of community influencers in the health system. Monitoring mechanisms were considered potentially disabling to motivation. Stakeholders suggested the need for support structures at the district and block levels to guide CAG setup and initial functioning in new geographies.

The study provides five key takeaways and implications for sustainability and scalability:

1. The CAGs comprise of influencers who are already linked with various government departments. It is thus a window of opportunity to leverage the CAG model as a community-based support group that can work beyond health-specific issues. Advocacy is required so that multiple government departments can tap the potential of such groups that can play catalytic role in bridging the gap between the government's programs and the community.
2. Develop clear guidelines for the set-up of CAGs with scope for contextualization at district-level. This should be shared with district/block level program implementers (DMCs, BMCs) and government officials. Advocacy is required with relevant departments to release government orders to streamline the set-up and implementation of the CAG model as a supplementary support group that can be leveraged by the respective departments.
3. Advocacy with relevant departments can be done for felicitation of CAG members that can boost their motivation in engaging in various community level activities. Recognizing that departments may have budget constraints, the acknowledgement of CAGs can take the form of invitations to the monthly meetings at the Community Health Centre (CHC) or Primary Health Centre (PHC), appreciation of CAGs on special days, recognition of best working CAGs in meetings that CAG members would already be a part of due to their portfolios.
4. Provision of identity cards can be made available to CAG members for easy access and in-roads into government departments to address administrative barriers in problem solving. This can further provide recognition to CAG members and serve as a mechanism for prioritizing their needs.
5. Advocacy is needed with government using advocacy/pitch notes for early and contextualized identification of government functionaries who will take up the role of DMCs and BMCs after program withdrawal to ensure ease of role transfer. BMCs, with support from CAGs could develop a micro-level transition plan for the slow transition of CGPP.

Introduction

In India, the polio virus posed a grave challenge to the public health system. It undermined India's efforts in achieving full immunization coverage and endangered the lives of millions of children. The resistance to the polio vaccine was unprecedented yet scattered, making the battle against polio a difficult feat to accomplish. As recently as 2009, India was contributing to almost fifty percent (741 of 1,604) of the polio cases worldwide[1]. Despite concerted efforts by the Government of India, with support from international and national development partners, polio eradication has remained one of the most stubborn public health crises that the country has witnessed.

The journey to eradicate polio began with the National Immunization Days in 1995[2]. However, the initial successes in vaccine uptake soon saw a downward trend due to fears, misconceptions, myths and misinformation alongside service related barriers. Addressing these challenges to improve demand generation required a multifaceted approach, involving partnerships with various stakeholders and implementing diverse strategies such as religious sermons, announcements at religious sites, engagement of school children through *bulawwa tollies*, use of invitation slips, involvement of community influencers, and informal discussions at common sites like tea stalls and barber shops.[3]

CGPP's journey at a glance

- In 1995, India introduced National Immunization Days to eradicate polio
- In 1999, USAID-funded CGPP was launched in India
- CGPP is a coalition comprising of ADRA, PCI, CRS
- The objective of CGPP's launch was to eradicate and maintain population immunity against polio
- CGPP has a presence in Uttar Pradesh, Assam and Haryana
- CGPP and UNICEF introduced SMNet in Uttar Pradesh to tackle resistance against polio vaccine
- CGPP identified community influencers and engaged them in community mobilization
- India was accorded polio-free status on March 27, 2014

In 1999, the USAID-funded Polio Eradication Initiative through CGPP was launched in 6 high-risk countries, including India. Since 2001, the India coalition comprises of ADRA, CRS and PCI. The primary objective of CGPP's efforts centred on eliminating polio and, subsequently, sustaining population immunity against the virus (CGPP India Transition Plan). Initially, CGPP worked only in 58 blocks across 12 districts of Uttar Pradesh. However, in 2018 and 2021, CGPP also initiated programming in 2 districts each in Assam and Haryana, respectively. While ADRA works through direct programming, CRS and PCI work through local non-governmental organizations (NGOs), including Gorakhpur Environmental Action Group (GEAG), Meerut Seva Samaj (MSS), Sarathi Development Foundation (SDF), Society for All Round Development (SARD), People's Action for National Integration (PANI) and Jan Kalyan Samiti (JKS).

The resistance to the polio eradication campaign was the highest in the Indian state of Uttar Pradesh. Leveraging the power of collaborative partnerships, United Nations Children's Fund (UNICEF) and CGPP came together to institutionalise a multi-tiered structure, known as the social mobilization network (SMNet)[4]. The structure of the SMNet comprised of CMCs at the community level, BMCs, Liasioning Officers or district underserved coordinators, Social Mobilization Coordinators (SMCs) and Sub-Regional Coordinators (SRCs). The CMCs were

[1] From 200,000 to Zero, The journey to a polio-free India, UNICEF, 2012

[2] https://www.cdc.gov/mmwr/preview/mmwrhtml/00041414.htm#:~:text=On%20December%209%2C%201995%2C%20the,or%20equal%20to%203%20years.

[3] Solomon R. Involvement of Civil Society in India's Polio Eradication Program: Lessons Learned. Am J Trop Med Hyg. 2019 Oct;101(4_Suppl):15-20. doi: 10.4269/ajtmh.18-0931. PMID: 31760980; PMCID: PMC6776100.

[4] Solomon R. Involvement of Civil Society in India's Polio Eradication Program: Lessons Learned. Am J Trop Med Hyg. 2019 Oct;101(4_Suppl):15-20. doi: 10.4269/ajtmh.18-0931. PMID: 31760980; PMCID: PMC6776100.

recruited locally from resistant pockets and trained on interpersonal communication (IPC), social mobilization and given polio-specific information to allay people's fears, misconceptions and misinformation. Their responsibilities encompassed household visits, identifying and marking households with children, and assisting FLWs in mobilizing resistant families to accept the oral polio vaccine. The CMCs were withdrawn in 2020, just before the outbreak of the COVID-19 pandemic.

Overall, CGPP adopted a community-based approach, focusing on building and strengthening local capacities aimed at improving the health and well-being of women and children globally[5]. This approach aligned with the Alma Ata Declaration of 1978 which signaled community participation as one of the important components of primary health care[6]. This approach involved a comprehensive and iterative influencer mapping exercise, often targeting individual families, to identify community leaders such as religious leaders, shopkeepers, school teachers, employers, trade associations, health workers, local doctors and quacks, based on their social portfolios and influence over resistant families. Referred as 'community influencers', they were oriented on polio and social mobilization, and engaged to mobilize resistant families using behavioural interventions to tackle misinformation and misconceptions guided by social norms.

The community influencers, who acted as links between the health system and the community, actively collaborated with and supported CMCs to build the community's trust in the public healthcare system. The CMCs and community influencers became the polio eradication campaign's eyes and ears on the ground, providing valuable insights into the community's needs and aspirations, and guiding the actions of government and development partners. Through their close ties and rapport-building with the community, they made inroads into the homes of resistant families. This cadre gradually earned the trust of underserved communities, and this trust continued to have a lasting impact even after the polio virus was eradicated.

The core essence of India's achievement in the battle against polio lies in community ownership of and involvement in the polio eradication campaign. Through the efforts of the Government of India, CGPP partners and other development partners, India was accorded polio-free status on March 27, 2014[7]. Since achieving the polio-free status, the focus of CGPP has been on maintaining population immunity against polio, improving demand generation for child immunization and response to disease-outbreaks.

[5] Core wealth_coverpages2.p65 (coregroup.org)
[6] Javanparast S, Windle A, Freeman T, Baum F. Community health worker programs to improve healthcare access and equity: are they only relevant to low-and middle-income countries? Int J Health Policy Manag. 2018 Oct 1;7(10):943. https://doi.org/10.15171/ijhpm. 2018.53
[7] https://www.gavi.org/vaccineswork/india-draws-lessons-polio-eradication-initiative

Intervention Context

The COVID-19 pandemic affected billions of lives worldwide. In India, the multiple waves of COVID-19 placed an overwhelming burden on health systems and authorities to respond with effective and appropriate interventions, policies and messages. As the severity of the pandemic evolved, so did the needs of the community, especially considering multiple disruptions that affected food systems, supply chains, service delivery and institutional safety nets. Furthermore, the outbreak of COVID-19 in India led to the resurgence of some of the existing concerns associated with disease outbreaks such as stigma, misinformation, myths, and misconceptions.

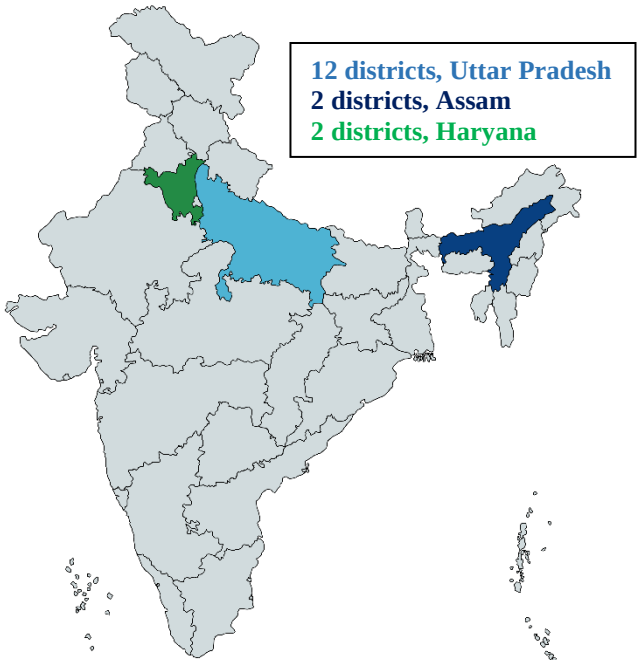

Figure 1: Geographic spread of CGPP through its partner organizations

Recognizing the criticality of these factors in hindering the adoption of COVID-19 appropriate behaviours and vaccine uptake, the CGPP were called upon to support the pandemic response[8]. As a strategy, existing and some new community influencers were formed into social groups, called 'Community Action Groups' and their capacities were built for sustained functioning. The program documents shared by CGPP indicate that during the pandemic, about 450 CAGs of 6-8 members each served the most vulnerable population, e.g., migrants, economically disadvantaged, and those facing social isolation. The CAG was envisioned as a community-focused model that would work on integrating social, cultural, and educative approaches to combat fear and stigma related to COVID-19, and other issues like vaccine hesitancy resulting in low immunization coverage in Uttar Pradesh, Haryana Assam.

Snapshot of CAG

- During the COVID-19 pandemic, community influencers were organized into CAGs by CGPP and its partners in India
- 450 CAGs of 6-8 members each were formed across Uttar Pradesh, Assam, and Haryana
- CAGs addressed myths, misinformation, and stigma associated with COVID-19 infection and vaccine
- CAGs also distributed essentials to COVID-19-infected families
- CAGs also support in routine immunization program

The group was essential in decreasing the spread of COVID-19 and addressing stigma and misinformation about the virus. The CAGs provided direct essential support such as food, medicine, counselling, and information to quarantined, infected, ostracized families, thereby encouraging communities to offer support to affected families. The CAGs also supported FLWs in identifying families for survey and contact tracing. Subsequently, the CAGs have extended support in COVID-19 vaccination campaigns, measles rounds, and routine immunization efforts.

[8] Bologna L, Stamidis KV, Paige S, Solomon R, Bisrat F, Kisanga A, Usman S, Arale A. Why Communities Should Be the Focus to Reduce Stigma Attached to COVID-19. Am J Trop Med Hyg. 2021 Jan;104(1):39-44. doi: 10.4269/ajtmh.20-1329. PMID: 33258438; PMCID: PMC7790080.

Scope and Objectives of the Study

The success achieved by the innovative CAGs has been recognised within the local health system and community. However, there is a notable absence of documented insights and knowledge sharing with relevant stakeholders. This study sought to address this gap by developing a comprehensive legacy document for CGPP. This document serves as a detailed account of the inception, operational processes, and functioning of CAGs, particularly during their formation and activities amid the COVID-19 pandemic. The study further explored determinants of motivation, mechanisms for supportive supervision, linkages with other stakeholders (FLWs, Self-help Groups (SHGs), Village Health Sanitation and Nutrition Committees (VHSNCs), ward members etc.) community trust and acceptance, challenges and limitations of the approach, and overall sustainability of the CAG model. Additionally, the aim of this project was to also assess the replicability and scalability of CAGs in other geographies and contexts.

The specific aims of the study were to:

1. Document the profile of CAG members and their motivations for such volunteer work
2. Capture stakeholders' perspectives about the CAG intervention and their functioning, and
3. Assess the scalability and replicability of the CAG intervention in other geographic locations and contexts

Methodology

CGPP's programming was initiated in Uttar Pradesh, and further replicated and scaled up to Assam and Haryana over the years. The study was conducted in all three states of CGPP's presence. Insights from the three states have provided critical information on the conceptualization, implementation and the scaling up of the program in different geographical contexts. Given the scope and objectives of the study, a descriptive study design was adopted to achieve the research objectives. The study used a cross-sectional, mixed-methods research design involving literature review, secondary data analysis and qualitative data collection with a component of quantitative data collection. The use of mixed-methods research enabled the study team to comprehensively understand and document the journey of the CAGs, and the learnings, thereof, for replication and scalability to other geographies and contexts.

The study used the following methods to achieve the research objectives:

1. **Rapid literature review:** This included a quick review of relevant literature emphasizing voluntary social groups with altruistic objectives, prioritizing non-materialistic incentives. This review was restricted to India and/or South Asia, considering their socio-cultural similarities. We also reviewed the program documents and data available with CGPP partners to substantiate our observations. For the literature review we considered qualitative and quantitative studies published in the English language between 2013 and 2023 that explore the factors influencing motivation, for community-based work in any of the South Asian countries. This included peer reviewed journal articles and reports from grey literature. We excluded publications not based on research such as blogs, interviews and opinion pieces as well as studies conducted outside of South Asia. Additionally, any research unrelated to motivation and voluntary work or published in languages other than English or, outside the specified timeframe were also excluded.

2. **Secondary data analysis:** Existing MIS and administrative data collected by CGPP partners were used to analyse CAG members' profile, including their age, occupation, and working duration as a CAG member among other things. This aided in contextualizing the

findings and explaining the sustainability of such models. The profiling of CAG members was conducted for CAG members in all 16 districts of Uttar Pradesh, Assam and Haryana.

3. **Qualitative data collection with a quantitative component of a post-FGD survey:** The study adopted a qualitative method for an in-depth exploration of components such as group formation, determinants of motivation, existing mechanisms for support, relevance of CAGs, linkages with other stakeholders, community acceptance, sustainability and potential scalability among others. A consultative approach was adopted to capture insights from Uttar Pradesh, Assam and Haryana.

   Following are the methods that were used for the study:

   a. FGD and a post-FGD survey with CAG members:

   i. **FGD with CAG members:** We conducted 14 FGDs with 90 CAG members in Uttar Pradesh, Assam and Haryana. This included 10 FGDs in five districts of Uttar Pradesh and 2 FGDs each in two districts of Assam and one district of Haryana. FGDs with CAG gathered information around CAG members' motivations, training and orientations, group functioning, challenges/limitations and successes from their point of view among others.

   ii. **Post-FGD survey with CAG members:** A self-administered post-FGD survey was conducted with the 90 CAG members following FGDs to understand factors influencing motivation. While the FGDs provided insights into the motivations of CAG members, the post-FGD survey offered quantitative data regarding specific factors and their relative significance and level of influence on CAG members' motivation. The survey covered seven domains including organizational commitment, extrinsic and intrinsic job satisfaction, community commitment, work consciousness, burnout and personal issues. The seven domains had 23 constructs cumulatively. Each construct was scored between 1 and 5, where 1 denoted 'strongly disagree' and 5 denoted 'strongly agree.' In the same manner, the scale for negatively worded constructs were scored in reverse. The motivation scale was adapted from two existing scales namely, the CTC Provider Motivational Indicator Scale, which was implemented in six countries, including Bangladesh, Ethiopia, Indonesia, Kenya, Malawi and Mozambique[9] and a motivation scale used to assess levels of motivation of community health workers in Haryana, India[10].

   b. FGD with community members: We conducted 9 FGDs with 50 community members in Uttar Pradesh, Assam and Haryana. This included 6 FGDs in five districts of Uttar Pradesh, 2 FGDs in two districts of Assam and 1 FGD in one district of Haryana. The scope of these discussions explored community members' perceptions on the relevance of CAGs. It also delved into the social capital provided by the CAGs to the community, focusing on aspects such as trust and acceptability.

   c. IDI with community stakeholders: We conducted 20 IDIs in Uttar Pradesh, Assam and Haryana with community stakeholders, such as Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), office bearers of SHG platforms, VHSNC, ward members, and tea estate managers among others. This included 15 IDIs in five districts of Uttar Pradesh, 2 IDIs in two districts of Assam and 3 IDIs in

[9] Vallières, F., Kok, M., Mahmud, I. et al. Measuring motivation among close-to-community health workers: developing the CTC Provider Motivational Indicator Scale across six countries. Hum Resource Health 18, 54 (2020). https://doi.org/10.1186/s12960-020- 00495-7

[10] Tripathy JP, Goel S, Kumar AM. Measuring and understanding motivation among community health workers in rural health facilities in India-a mixed method study. BMC Health Serv Res. 2016 Aug 9;16(a):366. doi: 10.1186/s12913-016-1614-0. PMID: 27507034; PMCID: PMC4977615

one district of Haryana. These IDIs helped understand CAG's complementary role in disaster management (e.g. COVID-19 disease prevention and vaccination, Measles outbreak, Polio/zero dose etc.), perceived utility and value add and potential of CAGs over other forms of mechanisms that exist in the eco-system.

d. **Stakeholders' interactions:** We conducted 20 KIIs in Uttar Pradesh, Assam and Haryana with selected program implementers from Private Voluntary Organizations (PVOs) and the CGPP secretariat who engaged in strengthening CAG. These interactions helped document system players' perspective and explain the potential of CAGs for their replicability and/or sustainability.
e. **KIIs with government officials:** We conducted 4 KIIs in Uttar Pradesh with health officials, including the District Immunization Officer (DIO), Medical Officer In-charge (MOIC) and Block Medical Officers (BMOs). These interactions provided insights on CAG's linkages with the health department, their relevance and sustainability.
f. **CAG members co-learning workshop:** We had a one-day co-learning workshop with 12 best-performing CAG members and 10 program implementers and managers. The key purpose of this activity was to discuss and validate the learnings and recommendation from the qualitative assessment, and capture any contextual variations in CAG functioning. The comprehensive insights from this co-learning workshop helped generalize the key lessons.

Sampling

For the qualitative component of the study, the sample respondents and the size were decided purposively in consultation with CGPP partners, considering the time and resource constraints. The selection of sample respondents was determined through a careful review of available documents and comprehensive discussions with the program managers at CGPP. The diversity in the selection of the respondents was based on the criticality and positioning of each stakeholder in the overall functioning of CAG. Furthermore, this also ensured the richness of the study findings by contributing multiple perspectives to holistically understand the CAG model. To achieve the objectives of the study, we conducted FGDs with 90 CAG members, FGDs with 50 community members, IDIs with 20 community stakeholders (ASHAs, Anganwadi Workers (AWWs), ANMs, office bearers of SHGs, VHSNCs etc.), KIIs with 4 government officials and 20 program managers in Uttar Pradesh, Assam and Haryana and the CGPP secretariat. The rationale for conducting the study in the selected states was based on the presence of the CAG model in the 3 states. In Uttar Pradesh, CGPP has been working for a longer duration, in comparison to Assam and Haryana. The inclusion of Assam and Haryana as study states informed the replicability and scalability of the model in different geographies and contexts, which contributed to the study's objectives.

Brief about this study

- The study was conducted in 5 out of 12 purposively selected districts in Uttar Pradesh, 1 district in Haryana and 2 districts in Assam
- In Uttar Pradesh, districts were selected based on a composite score and representation from each PVO was ensured
- Selection of blocks and villages was based on the principle of effective and efficient implementation
- The study respondents included CAG members, community members and stakeholders, government officials, and program managers and implementers

District and Block selection

CGPP has a presence of CAGs in 58 blocks spread across 12 districts of Uttar Pradesh, 4 blocks across 2 districts of Assam and 2 districts in Haryana through PVOs. As per the guidance provided by CGPP, the study was conducted in 5 out of 12 districts purposively selected from Uttar Pradesh, both the districts in Assam and one district purposively selected in Haryana. The selected districts in Uttar Pradesh encompassed both CGPP programming and COVID-19 response districts. The CGPP programming districts refer to those districts which have been engaged in both polio programming and COVID-19 response. Whereas the COVID-19 response districts are those districts where efforts have been concentrated on COVID-19 response. The use of purposive sampling for the selection of districts and blocks aligned with the study's aim of elucidating the underlying constituents and conditions that were essential to the success of CAGs. Therefore, it was crucial to consult CGPP in the selection of geographies where the implementation had been effective and efficient.

An additional criterion was employed in the selection of districts for the study. A composite score was computed, considering various indicators, including the percentage of rural population, scheduled caste (SC) and scheduled tribe (ST) population, female literacy rates, and full immunization coverage, for each district with CGPP presence in Uttar Pradesh. Based on the composite scores, districts were categorised into three distinct groups, namely those falling within the 0-50% range, the 51-70% range, and the 71-100% range. Notably, districts with higher percentile scores demonstrated better performance across the selected development indicators. Two districts were selected from the first (0-50%) and the third (71-100%) categories, while one district was chosen from the second category (51-70%). Furthermore, district selection was evenly distributed among the three PVOs. Specifically, two districts each were selected from ADRA and PCI. In the case of CRS, one district was selected, as this organization also operates programming in the neighbouring state of Haryana. At the local level, the program teams identified one block in each selected district, taking into consideration the effectiveness and efficiency of program implementation. The study encompassed the examination of two villages within each identified block.

Recruitment of respondents/participants

The approach followed for recruitment varied based on the participant group. Based on the inclusion and exclusion criteria for each stakeholder category, PCC sought coordination support from CGPP to facilitate interactions. The study defined community members as individual members of a family who had benefited from CAG's support during COVID-19. On the other hand, community stakeholders, such as FLWs, health supervisors, local doctors, members of SHGs and VHSNCs, religious leaders, local political leaders, ward members, school teachers, and tea estate managers among others were defined as position-holders who were not members of CAG but had collaborated with them during the pandemic. Community members and stakeholders were recruited from the catchment areas of the CAG members who had been included in the FGDs. The field team identified program implementers such as BMCs, DMCs and MMs for interviews and recruited them for the study. For program managers, recommendations were sought from the CGPP team, and included members from PVOs and the CGPP secretariat. The research assistants involved in the study introduced the study participants to the study objectives and took informed consent before initiating data collection.

Data collection

PCC hired and trained research assistants to conduct qualitative data collection in Uttar Pradesh, Haryana and Assam as per the field movement plan. All interviews were facilitated by PCC research assistants. Data was collected by 2 research assistants, including 1 male and 1 female research assistant in Uttar Pradesh and Haryana. The research assistants were supervised by members of the study team at PCC. The research assistants had a Master's degree in social sciences and were well-versed in Hindi. In Assam, data collection was conducted by the PCC study team with support from local translators. After receiving informed consent for interview and audio recording, the research team conducted the discussion/interview using an audio recorder to facilitate writing notes from the discussion. The interviews and discussions took approximately 45-60 minutes.

Research ethics

The study team underwent a day long in-person training by PCC on the background and scope of the study, methodology, study tools, research ethics and a discussion on how to troubleshoot issues that may arise during data collection. Pre-testing of tools were conducted prior to their finalization.

The study took verbal consent from all participants before initiating data collection. Separate informed consent forms in local language – Hindi (for Uttar Pradesh and Haryana) and Assamese (for Assam) were developed for each respondent category. The consent form included components such as purpose of the study, voluntary participation and rights of the study participants, consent for audio recording and note-taking, risks and benefits of participating, compensation, confidentiality, data protection measures, results of the research, rights to ask questions and contact information.

The study team took multiple steps to protect confidentiality of study participants. Only participant IDs were assigned to the audio recordings and no identifiable information such as the name, address and contact numbers of the participants were recorded. Consent forms were stored in a locked cabinet at the PCC office in Noida.

The study protocol was approved by Sigma Institutional Review Board in India.

Key Findings

Profile of CAG members

The study analyzed the profiles of CAG members to assess their certain characteristics such as usual occupation, age, sex, education, religion, duration of CAG membership etc. The profile data from each geography was provided by the respective program partners. The profile data included information of 10,573 CAG members from 15 districts of 3 states, namely Uttar Pradesh, Assam, and Haryana covering 1,228 villages (Table 1).

Table 1: Program coverage in terms of total CAG members, and villages/districts covered

State	Partner organization			Total
	ADRA	CRS	PCI	
Uttar Pradesh	**3,249** (Dist: 3, Vill: 403)	**1,814** (Dist: 3, Vill: 250)	**4,126** (Dist: 6, Vill: 429)	**9,189**
Assam	**894** (Dist: 2, Vill: 60)			**894**
Haryana		**490** (Dist: 1, Vill: 86)		**490**
Total CAG members	**4,143**	**2,304**	**4,126**	**10,573**

The program data revealed that three-fourths of the members had joined CAG in the last two years. Additionally, two-thirds of the CAG members were male and fell within the age group of 30-49 years. More than 70% had completed high school and above, and 90% held membership in other platforms, such as VHSNCs, Nigrani Samitis, and SHGs, among others.

The data further unveiled a varied occupational composition among CAG members, with a predominant representation from diverse backgrounds such as farmers, ration dealers, ASHA workers, local doctors, teachers, and pradhans/village heads, among others. Many CAG members were also religious leaders in the community.

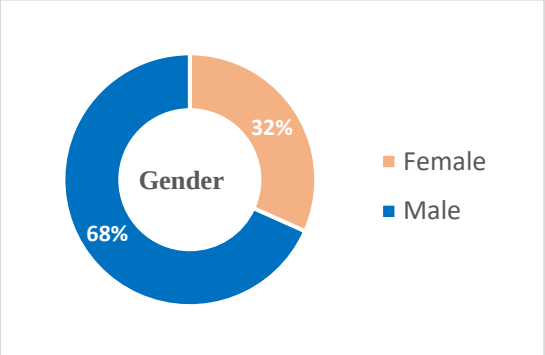

Figure 2: Gender distribution of CAG members

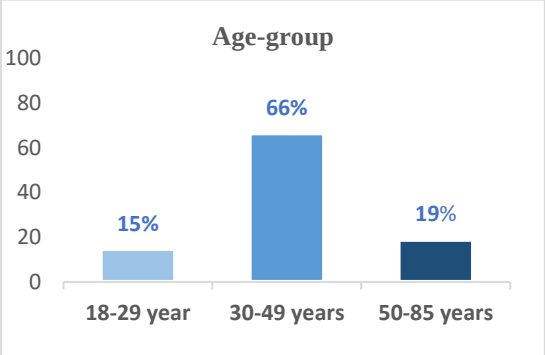

Figure 3 Age distribution of CAG members

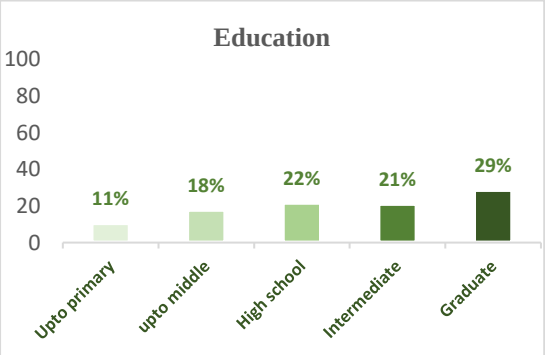

Figure 4: Highest educational qualifications of CAG members

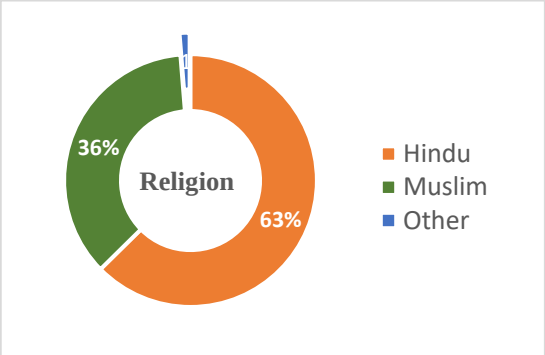

Figure 5: Religious representation of CAG members

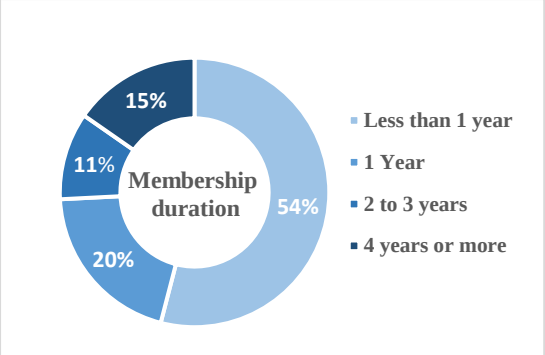

Figure 6: Membership duration in CAG

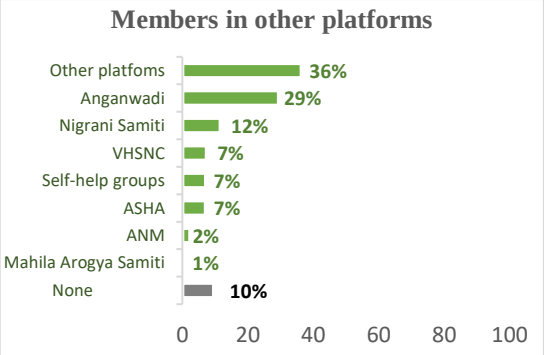

Figure 7: CAG members' membership in other platforms

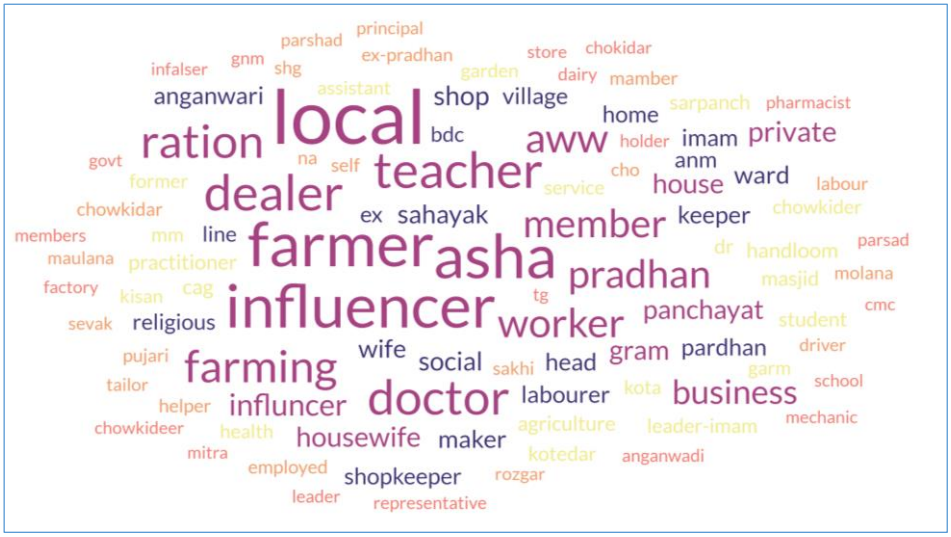

Figure 8: Occupational status of CAG members

Context for the emergence of CAG and vision

The outbreak of the COVID-19 pandemic was a turning point for the global community, ushering in a 'new normal' that posed significant challenges. The COVID-19 pandemic particularly affected marginalised communities, as government services and development programming came to a standstill. The community members, stakeholders and CAGs informed that the public health crisis was compounded by other factors including rising unemployment, closure of health and education services, mass migration into rural areas, discrimination against and stigma towards returning migrants, lack of access to food and other resources, information overload, and proliferation of myths and rumours among others. To add to that, the monumental task of vaccinating the entire population faced hurdles from hesitancy and resistance fuelled by misinformation and rumours.

Interactions with program managers revealed that they were made aware of these challenges by BMCs, DMCs, and in some instances, even CMCs who despite being withdrawn in March 2020 were actively engaged with the community in their personal capacities. The withdrawal of CMCs created a vacuum, as described by the program team, which had to be filled by other community-level volunteers to address concerns emerging during the COVID-19 pandemic. The study found that this served as the impetus for organizing community influencers into groups, known as CAGs who were oriented digitally and telephonically on COVID-19 and vaccination. Recognizing that many community influencers did not possess smartphones, the formation of groups, as suggested by the program team, eased the process of orienting the CAG members.

The study revealed that the underlying rationale for forming CAGs was based on the principle of group ownership. This was rooted in the idea that when community influencers collectively own and participate in decision-making concerning their community's needs, it promotes a sense of responsibility and accountability towards the community. Additionally, the concept of belonging is closely intertwined with sustainability, which was a key consideration in the formation of CAGs as indicated by the program team. Until the CAG formation, community influencers were scattered and did not have shared responsibility. The program team suggested that groups such as CAGs would enable members to tap into and seek support from diverse departments to address the community's concerns as CAG members as a whole would have linkages with diverse departments.

- Challenges such as closure of government services, mass migration, stigma towards returning migrants, lack of food supplies, myths, rumors and misinformation required urgent solution
- The vacuum created by the withdrawal of CMCs in 2020 gave impetus to CAG formation
- Group formation eased the orientation process for CAG members
- Group ownership, collective decision-making, shared accountability and potential for sustainability were the key reasons for CAG formation
- Group formation would enable linkages with diverse departments
- CAGs were envisioned as community assets that could be leveraged and activated by the government

"If I am not there and some work needs to be done back here, it will be done, because we are a group now."

- CAG member

Whereas CAGs engaged in multiple activities during and after the COVID-19 pandemic, such as rumor tracking, distribution of essential supplies, tackling stigma and misinformation in the community, facilitating people's access to government schemes, supporting FLWs in mobilizing resistant and hesitant families during vaccination campaigns, for COVID-19 and child immunization, the overarching vision, as revealed by the program team was to create and capacitate community groups to support and strengthen the work of health functionaries in improving their community's uptake of health services, primarily child immunization by bridging the gap between the health system and the community at large, as well as during emergencies. In other words, the CAG was envisioned as a group of trained community influencers who could be leveraged and activated by the health system when required. To this end, as CGPP undergoes a transition, efforts are underway to institutionalize this group by linking them with the health department in select geographies.

The program team's vision for CAG was shared by health department officials such as the MOIC and BMO. Interactions with government officials revealed that the purpose of CAGs was to bridge gaps between the health system and the community by reaching the last mile. Recognizing their critical role in ensuring community acceptance of public health programs, the study found that CAGs and community influencers were considered local assets, trusted by the community that the government could leverage to support its programs and campaigns.

Formation process and composition of CAG

Interactions with the program team further suggested that a deliberate and strategic approach was adopted for the formation of CAGs. In essence, community influencers who were proactive, held membership in other groups or were elected members, and lived in close geographical proximity to one another formed the CAG. It was reported by the program team that the identification and selection of CAG members was facilitated by BMCs and DMCs, who had close linkages and ties with the community. In areas of COVID-19 programming, where there weren't pre-identified

community influencers, BMCs and DMCs reported organizing meetings with community members to on-board community influencers to form the CAG. This was validated by community members, stakeholders and CAG members. In some instances, BMCs and DMCs sought support from FLWs and village heads for the identification of potential CAG members. Furthermore, a unique approach was followed in the case of Assam where the program was implemented in tea estates, which were contextually different from other geographies. A strategy reported by the program team was to secure approval from the tea estate management, and consult the Tea Estate Welfare Officer to identify community influencers. To get easy inroads into tea estates, the program team indicated the inclusion of members of the management in the CAG.

"BMC and ASHA organised a meeting in our village to provide information on coronavirus. We were then asked if we wanted to join the group and those of us who agreed were informed about the meetings."

- CAG member

The study found CAGs to be mixed-groups, with representation from diverse gender and religious identities. As noted by the program team, this was a crucial consideration made at the time of the formation of CAGs. This decision was informed by a valuable lesson learnt from the polio eradication campaign, where the involvement of both men and women proved crucial in engaging resistant and hesitant families. As observed by the program team during the polio eradication campaign, female CAG members had easier access into the homes of community members, and were therefore successful in communicating with women. Conversely, since decisions, including healthcare decisions often rest with men, it was vital to engage with them to dispel myths and misconceptions. Similarly, religious representation in groups was incorporated for the same reason. The program team also shed light on intentionally keeping the group size small (7-8 members) to prevent group dynamics from breaking the solidarity of the group.

It is crucial to delve deeper into the definition of a 'community influencer,' a key constituent of CAG formation. The study discovered that while community influencers were generally individuals respected and listened to by the community, CAG members embodied more than just influence. They typically represented individuals with political authority (such as village heads or Pradhans), religious authority (like local priests or imams), economic influence (contractors), departmental linkages (ASHA, AWW), individuals with intimate knowledge of the community, and those recognized and accepted by the community (e.g., postmen or line in-charges within tea estates). The interactions with program teams illustrated that the CAG is an amalgamation of diverse skills and networks which can be harnessed to address challenges faced by the community.

- Influencers who were proactive, held membership in other groups, elected members, and in close proximity to each other formed the CAG
- Influencers with political or religious authority, economic influence, departmental linkages, or with intimate knowledge of the community formed the CAG
- In COVID-19 programming areas, contextualized approaches were followed to identify and select CAG members
- CAGs are mixed groups of maximum 7-8 members only
- CAG is an amalgamation of diverse skill sets and networks
- Traits of CAG members includes selflessness, a desire to contribute to social welfare, communication skills, availability of time, patience, and an in-depth understanding of the community, among other qualities.

Importantly, the narratives of the CAG members, program teams, and government officials portrayed that not all CAG members were required to work collectively on every issue. Depending on the specific challenge at hand, relevant CAG members were activated. For instance, in the context of COVID-19

vaccination, ration dealers played a pivotal role in motivating resistant families. The study found that in many rural areas where food chains were disrupted and people's access to food was impacted, ration dealers emerged as essential sources of uninterrupted food access. Leveraging the tactic of withholding food supply, CAG members informed that ration dealers in various regions succeeded in converting vaccine resistors into acceptors.

"When people would collect in large numbers to collect ration, I would first urge them to take the vaccine by giving them information about it. Sometimes I even threatened people that I would withhold their ration until they get vaccinated. This made a lot of people take the COVID-19 vaccine."

- CAG member

As articulated by CAG members themselves, some common traits among CAG members included selflessness, a desire to contribute to social welfare, commitment to the community, effective communication skills, availability of time, patience, and an in-depth understanding of the community, among other qualities.

Enablers of motivation among CAG members

The study thoroughly investigated various motivational factors spanning organizational commitment, extrinsic and intrinsic job satisfaction, community commitment, work consciousness, burnout, and personal issues. Across all seven domains, a notable prevalence of high motivation was seen among members of the CAG (refer Table 3 in Annexure).

"Self-satisfaction is there when other people of the community give us respect for the work we do." ***- CAG member***

Regarding organizational commitment, the study discovered that CAG members generally experienced a sense of pride and inspiration due to their affiliation with the group. However, it was noteworthy that almost two-thirds of CAG members reported a relatively lower level of commitment to the CAG.

An important finding of the study was the identification of both internal and external factors positively correlating with heightened motivation levels. Interactions with CAG members shed light on the sources of internal satisfaction, including engagement in community work, the utilization of their skills and influence to enhance community health, and the positive impact of their contributions. External factors, such as opportunities for learning, support and guidance from fellow CAG members, BMCs and MMs, as well as recognition and appreciation from their families and community, were also identified as influential contributors to overall motivation.

Positive work consciousness and community commitment emerged as additional noteworthy

- High motivation among CAG members across domains such as organizational commitment, intrinsic and extrinsic job satisfaction, community commitment, work consciousness, burnout and personal issues
- Sense of pride and inspiration associated with CAG membership
- Two-third CAG members reported low commitment to the CAG
- Internal satisfaction was derived from community work and use of skills for positive impact
- External satisfaction was derived from learning opportunities, program support and community recognition
- Membership in CAG was driven by community commitment
- 38% CAG members reported CAG's work impacting their family responsibility
- Enhancers of motivation include felicitation by health officials, and regular orientations and meetings with program staff

contributors to motivation. Community commitment was also invoked as a primary reason for joining the CAG and initiating voluntary work. For instance, a sense of belonging and responsibility towards the community coupled with the desire to improve community health were the driving factors for the majority members to join the CAG.

Interestingly, the study revealed that a majority of CAG members did not report experiencing personal issues or burnout as a consequence of their engagement with the group. While emotional or physical fatigue was not a prevalent outcome, it was noteworthy that 38% of respondents acknowledged that CAG's work had an impact on their responsibilities toward their families.

The investigation also delved into determinants capable of augmenting the motivation of CAG members with respect to their sustained engagement in voluntary work. The insights gathered from interactions indicated that routine acknowledgment and felicitation of CAG members by government officials, coupled with capacity-building and skill enhancement sessions, in addition to recurrent engagements through meetings with BMCs and MMs could contribute to amplifying their motivational disposition towards continued voluntary service.

Support and monitoring mechanisms

Both CAG members and the program team indicated that the support received by CAG primarily centred on orientation and capacity building. It was found that many CAG members had prior experience in community mobilization, either in their personal capacities or from their involvement in previous initiatives like the polio eradication campaign. In the early days of the COVID-19 pandemic, the CAG members reported receiving digital and telephonic orientations about the disease, its symptoms, prevention measures, and vaccination. Subsequent meetings with BMCs also helped address their questions about the disease. The program team conveyed that the capacity building of CAG members was not carried out through a pre-defined structure but was instead context-driven. For example, in regions where malaria and measles-rubella were prevalent, such as Uttar Pradesh, BMCs oriented CAG members on the same. However, it's important to note that these orientation efforts were primarily health-focused and informed by the health system's needs. Many CAGs reported the need for increasing the scope of training to include issues other than health, such as domestic violence, education, and child marriage among others. Both CAG members and BMCs talked about emerging issues pertaining to areas beyond health. In such situations, some BMCs reported making attempts to connect CAG members with relevant departments, as their expertise was limited to health.

- CAGs primarily received capacity building support from the program
- Digital and telephonic sessions were organized for CAGs to disseminate information on COVID-19 and vaccination
- Capacity building was informed by the health system's needs and was health-specific
- Orientation sessions were conducted during monthly CAG meetings.
- Orientation support beyond health is needed. At this point, some BMCs support by linking CAGs with relevant departments.
- Variation exists in support extended by BMCs
- Notable difference in CAGs' capacity to function independently across districts
- Monthly meetings strengthened CAGs motivation and relationship with program staff
- Monitoring mechanism in place for BMCs and DMC, not for CAGs

The orientation of CAG members was an ongoing process, with monthly meetings serving as a platform for these orientation sessions. For instance, in majority districts, CAG members reported receiving guidance from BMCs during these meetings. However, the study discovered variations in the support extended by BMCs and a notable difference was also observed in CAGs' capacity to function independently across districts. In some geographies, CAG meetings were sometimes organised by CAG members themselves without facilitation support from the BMC, other CAG

members reported attending meetings only when they were organised by BMCs. Yet, other CAGs talked about receiving orientation support from Medical Officers or other health officials. Furthermore, some CAGs indicated receiving IEC material to assist in mobilization, whereas others did not receive any support of this nature.

"Sometimes when there are issues that need attention, we meet amongst ourselves to discuss the same"

- CAG member

As reported by the program team, the overall training approach followed a cascading pattern, where DMCs and BMCs received training from CGPP. They then disseminated this knowledge to CAG members during monthly meetings. Interactions with the program team indicated that BMCs were tasked with conducting four monthly meetings. However, majority CAGs reported attending only one meeting per month. While the meeting agendas were guided by the BMC, but in some cases, as was reported by a few CAGs, many issues concerning the community were also taken up in these meetings. Additionally, the study discovered that these meetings served to strengthen the relationship and trust between CAG members and program staff. CAG members indicated feeling motivated by regular meetings, which were sometimes also attended by government officials.

In terms of monitoring, the program team illustrated not following any standardized monitoring mechanism for CAG members. However, BMCs were expected to report on the total number of meetings conducted and the number of participating CAG members. Although some BMCs indicated seeking updates on topics discussed in previous meetings and inquired about any challenges faced by the CAG members, they too did not monitor any activities of CAGs.

Relevance and collaboration of CAGs with Government and community stakeholders

The study found that while only some community members recognised CAG, majority community and all government stakeholders were aware of the existence of CAG. The knowledge about CAG and their role in supporting community stakeholders varied based on the profile of the stakeholders. As the core focus of the CAG is on health, community and government health functionaries not only had more knowledge about the CAG but also had stronger collaboration with the CAG during and after COVID-19. For instance, the health functionaries displayed an understanding of the overall structure of CAG, their composition and could make a distinction between CAG as a group and its individual members, which was not common among other stakeholders. The latter identified CAGs work more with individual members, in most cases the village head or *Pradhan,* which blurred the CAGs role and capacities with that of the scope of work of the individual member.

"Last year when dengue had increased a lot, I contacted with pradhanji and asked him to call the team to increase awareness in the community members."

- Head Teacher

Furthermore, in many instances it was noted that even before the formation of CAGs, FLWs sought support from community influencers in mobilizing refusal and hesitant families for the uptake of routine immunization.

"The CAG basically became active in 2020, although the individual members used to support us even before, Core group asked us to give them a name, so we gave them the name 'samarthak group'"

- Anganwadi Worker

Based on the narratives of CAG members and community and government stakeholders, the study found that the collaboration between CAGs and community stakeholders was a mutually beneficial arrangement. The community stakeholders received information, communications, and mobilization support from CAG members. For instance, SHG members talked about receiving information about COVID-19 appropriate behaviours and the COVID-19 vaccine at a time when misinformation and rumours were spreading in the community.

"CAG members had come during COVID to give awareness regarding COVID vaccination and they convinced us to take the vaccine."

- SHG President

Additionally, there are multiple accounts of support received from CAGs to mobilise resistant and hesitant families by FLWs. On the other hand, the community stakeholders reported providing support to CAGs in conducting several activities. For example, CAG members have sought support from school teachers in conducting awareness drives related to breastfeeding, good touch and bad touch and on the use of sanitary pads among others. The work done by CAGs in their respective communities has not only got them recognition among the community and government officials, but has also promoted their work and interests. The stakeholders highlighted the need for CAGs to expand their scope of work beyond health.

All stakeholders interviewed for the study spoke of the relevance and value addition brought about by CAG in bridging the gap between the health system and the community. Furthermore, CAGs were acknowledged as the missing link in the health system to ensure last mile delivery of health programs and campaigns. The underlying principle for value addition was characterised by the composition and group structure of the CAG.

"Value addition of CAG is in it being a group. A group archives result faster than an individual." ***- SHG President***

The study found that the CAG comprised of influential members with knowledge about their communities, diverse skills and departmental linkages, making it a key strength of the CAG. To add to that, the community and government stakeholders recognised that group functioning yielded quicker and more effective results. For instance, because of their shared goals, a few CAG members worked on any specific issue, especially mobilization, tapping into their skills and networks, which gave quicker results. Additionally, given that different families came under the influence of different stakeholders, it became easier for community stakeholders to leverage support from individual CAG members. This was also validated by government officials who said that the reiteration of information by different community influencers who already possessed influence over communities was more effective than efforts by individual ASHA workers.

As indicated by government officials, not only were CAG members considered highly skilled in communications and mobilization, often in comparison to ASHAs, the insights from ASHAs also revealed that in some instances CAG members assumed their role in their absence. Both community members and health department officials conveyed that CAG members were highly trusted and accepted because they held important profiles in their respective domains and influence over their communities. The belief that CAG members are only driven by community welfare, as opposed to frontline workers, was common among community members.

"Since CAG is not on government's payroll unlike the FLWs, a section of the community had greater belief on what they say, in comparison to FLWs. They think that CAG is not motivated due to any personal gains and are genuinely working for the welfare of the society hence they are more believable." ***- Anganwadi Worker***

- Community member's recognition of CAG is limited
- Knowledge about CAG varied based on the community stakeholders' profiles
- Strong collaboration observed between CAGs and health functionaries
- FLW sought support from community influencers even before CAG formation
- Mutually beneficial arrangement observed between CAGs and community stakeholders
- CAG acknowledged as missing link to ensure last mile delivery of health programs
- Relevance and value of CAGs work lay in its group composition and structure, diverse skills, departmental linkages, more effective results, communication skills, and community trust in CAGs
- Community's trust of CAGs was based on their individual profiles, work during COVID-19, ease of access, timely support provision, and community commitment in comparison to FLWs

The idea that CAG members go beyond their scope of work, to talk about health issues without any monetary benefits contributed to the community's trust in CAG. However, the perception of CAG members as selfless individuals was questioned by some health department officials who viewed them as also being motivated by personal and professional gains.

"During COVID-19 if in some household someone had cough and cold and people started to say that they might have corona virus, the CAG group would come to us and give us emotional support and tell us that they are there for us and would try to provide whatever might be required."

- Community Member

As reported by community members, the work done by CAGs during COVID-19, the ease of contacting CAG members and the timely support provided by them contributed to community's trust in CAGs. Furthermore, the study discovered that the prevailing gender norms gave CAG, which has majority representation from men, an upper hand in communicating and mobilizing male members of the community, the key decision makers in their respective households.

"Men believe less on women, especially of their own village. Men believe men. They do not trust the women (FLWs) on what vaccines they'd give. So CAG members (all males) play an important role in convincing the men of the village."

- SHG President

The CAGs proved to be a pivotal asset, distinguished by their deep community roots and knowledge, influence over their communities, diverse skills, and extensive departmental connections. With robust communication and mobilization abilities, the study found that CAG members were trusted influencers, playing a crucial role in bridging gaps between the community and the health system. Recognizing their effectiveness in reaching the last mile, the health department reported viewing CAGs as invaluable assets to leverage in future health programs and campaigns.

Sustainability of the CAG model

The study uncovered insights on the sustainability of the CAG model through interactions with CAG members, community and government stakeholders and the program team. While majority of the respondents considered the model sustainable, others indicated their doubts regarding the sustainability of CAGs after the withdrawal of CGPP. The government officials regarded the CGPP structure at the district and block level as the key intermediary between CAGs and the health department. Without DMCs and BMCs, the government officials feared losing the communication channel with CAGs. Other reasons for doubts regarding the sustainability of the model centered on ensuring motivation among CAGs, which is an important substitute for financial incentives. All stakeholders talked about motivation as a pre-requisite for sustainability.

They commented on the critical role played by MMs, BMCs and DMCs in ensuring motivation among CAG members. In fact, through interactions with BMCs, MMs and CAGs, the study found that in some geographies, the CAGs were activated only when required by the MMs and BMCs, and many were also of the opinion that the CAGs weren't self-sufficient yet to function independently.

Interactions with the program team revealed that the limited handholding of CAGs by BMCs and DMCs was a strategic approach to make the groups self-sufficient, a pre-requisite for sustainability. As reported by the program team, handholding support entailed orientation sessions to disseminate information about key health issues and regular meetings to strengthen the group's ownership. The study showed that while majority CAG meetings were guided by the BMCs, the CAG members in a few geographies reported taking initiative to organize meetings to address community concerns even without the BMC's presence or guidance.

"The idea was to provide limited handholding support to CAG members to enable them to become self-sufficient, and to build a sense of ownership towards their work, which would ensure sustainability in the long run."

- Program Implementer

For the sustainability of CAGs, two critical needs were raised by all stakeholders. These included ensuring motivation among CAG members and regular information dissemination on health-specific and other issues and skill building on communication and mobilization for effective work. In fact, the two needs were found to be interrelated as the skill of CAG members positively influenced motivation among them, as reported by CAG members. With CGPP's transition, capacity building of CAGs also emerged as a requirement to strengthen CAGs for independent functioning in the absence of DMCs, BMCs and MMs. The other factor influencing motivation, and therefore sustainability, suggested by all stakeholders was felicitation of CAG members by government officials.

"Learning something new motivates me to be associated with and continue working as a CAG member."

- CAG Member

According to the program team, the very composition of the CAG including members representing different government departments, was a built-in factor ensuring the sustainability of CAGs. Furthermore, this would directly contribute to the need for information and skilling. The program team indicated that the inclusion of different profiles, particularly FLWs, would enable CAG to fulfill its requirement for additional information and skilling through the FLWs' dissemination of information within the group.

Commenting on barriers in their work, the CAG members conveyed the need for identity cards to address administrative challenges and get easy inroads into different government departments. Though the inclusion of the village head was premised on this factor, as suggested by the program team, the CAG members in some geographies talked about the inactive role of the village head due to their busy schedules.

The program team revealed its plan of linking CAGs directly with the health system, which is already at varying levels of action in different geographies. The BMCs and DMCs reported having meetings with block and district health officials, including names of CAG members in the micro plans of ANMs, and preparing and sharing lists of CAG members with the health department to

strengthen collaboration between the health department and CAGs. The rationale behind this initiative was to inform the health department of the existence of CAGs which can be leveraged and activated whenever required. Additionally, the study also discovered that banners with CAG members' names were put up in some villages. As revealed by the program team, this strategy had a twin objective of informing the community about CAG's presence and instilling ownership and accountability on CAGs.

Government officials recommended enhancing the focus of CAG from health to the social determinants of health, such as sanitation, education, environment, and nutrition among others. As suggested by them, this would enable convergent programming and support from different departments, thereby making CAGs more sustainable. It was also reported that direct linkage and improved communication between CAGs and the health department could be strengthened by involving CAGs in FLW and VHSNC meetings which would keep CAGs updated with developments in the health sector. Further, inclusion of CAGs in VHSNC meetings would enable their contribution to the Village Health Plans. A similar proposal was put forth by the BMCs and DMCs who suggested the need for CAGs to be involved in CHC and PHC planning meetings.

- Majority of the stakeholders considered CAG as a sustainable model
- Limited handholding of CAGs by program staff, inclusion of FLWs who can pass on information to CAGs, membership of CAG members representing different departments were built-in features for sustainability
- Factors contributing to sustainability include regular orientation sessions, felicitation of CAG members for motivation, provision of identity cards, and strengthening collaboration with government departments
- Capacity building of CAGs for independent functioning emerged as a requirement
- Interlinkages with government departments is being secured through meetings with district and block health officials, inclusion of CAG members' names in micro plans, sharing names of CAG members with the health department and putting banners with CAG members' names at common sites
- Recommendations for sustainability include convergent programming which would enable collaboration with diverse departments, inclusion of CAGs in government meetings
- Reasons the model might collapse after CGPP's transition included the absence of a communication channel, lack of motivation in the absence of program staff, CAG's inability to function independently
- ASHAs, ASHA supervisors and BMOs have been proposed to replace BMCs and DMCs

"CAG members should be involved in AAA and VHSNC meetings so that they can stay up to date with discussions and plans of the health department."

- Government Official

While some stakeholders suggested ASHA workers or ASHA supervisors to take up the convening role in the absence of BMCs and DMCs, others proposed BMOs take up this role.

Replication and scalability of CAGs

Interactions with diverse stakeholders including CAG members, community stakeholders, government officials and the program team revealed insights on the replicability and scalability of the CAG model. As defined by all stakeholders, three components are critical to the successful scalability of the model, namely the identification and selection of the right community influencers in collaboration with multiple stakeholders, including the community, and those in authority, ensuring motivation among CAG members and, developing and cementing collaborations with local level committees and organizations, as well as the health department to strengthen CAG's role in addressing the community's needs.

Both CAG members and the program team revealed that an ideal CAG must have both male and female influencers and also be representative of the area's religious composition. Additionally, they also focused on the need to include position holders, linked with different government departments and members with in-depth knowledge about their communities.

"If CAGs are to be formed in new geographies, it should be ensured that they are inclusive and represent the composition of the area."

- Program Implementer

- Key considerations for scalability include the identification and selection of the right community influencers in collaboration with multiple stakeholders, ensuring motivation among CAG members, and strengthening linkages with local committees and health department
- Building community ownership and motivation among CAG members may be a challenge during scalability
- Need for clear guidelines informing CAG set-up
- Intervention strategies in the new geographies must be evidence-backed
- There is acceptance and recognition of the community influencer approach within the health department
- A government order to institutionalize CAGs will enable scalability
- The CAG's activities should not be monitored as that is a disabling factor
- CAG's motivation can be ensured through their felicitation, regular orientation sessions and administrative support
- DMCs and BMCs to guide the set-up and functioning of CAG in the initial years

The replication and scalability of CAGs into new geographies and contexts, as suggested by the program team may face the challenge of building community ownership and motivation among CAG members. The program team resolved these issues by creating a learning environment through orientations, providing guidance, and garnering recognition of CAGs by the community and government officials. Another challenge that was shared by the DMCs was the absence of clear guidelines, detailing the process of CAG formation, their role, scope of work and the mechanism for government linkages.

Furthermore, the study discovered that a key consideration for replicability is that the intervention strategies should be informed by evidence to make it more effective. The program team indicated the need for contextualizing the intervention based on evidence, as was also done in the current phase of implementation. For instance, a rapid survey was conducted in June 2023 which found that only 8% of community members were aware about the existence of CAG in their communities. This nudged the program team to incorporate interface meetings between CAGs and community members. The survey was repeated in August 2023 and found that community's awareness about CAG had increased to 32%.

From interactions with health officials, the study discovered that the approach of leveraging community influencers was well-recognized and used by the Health Department even in areas without CAG's presence. The study found that acceptability of the approach was already in place. Both the program team and government officials indicated the need for a government order to institutionalize the process of engaging community influencers or CAGs in the health system.

In terms of setting up a monitoring mechanism for accountability, the program team believed that it would act as a disabling factor to motivation as CAGs work on a voluntary basis. The CAG members conveyed that ensuring motivation through felicitation of CAG members, regular orientation sessions and administrative support to address the community's needs will enable motivation among CAG members in new geographies. Their narratives also suggested the need for a structure at the district (DMC) and block (BMC) level to guide the set-up and initial functioning of CAG.

Discussion and Way Forward

The study aimed at developing a legacy document for CGPP, with emphasis on the CAG model. We explored the overarching context within which the CAGs emerged and flourished, the vision behind organizing CAGs, their formation and relevance to the health system, factors enabling motivation among CAG members, and finally their sustainability and scalability into new geographies and contexts. The study had several limitations. Firstly, its scope was confined to describing the process of CAG formation and functioning, without delving into an exploration of the intervention's effectiveness in achieving its vision and goals. Secondly, when examining motivation, socially desirable answers from participants may have constrained the study's ability to gain unfiltered insights into motivating factors. Lastly, the distinction between CAG members and their official roles, such as Pradhan, ASHA, and AWW became increasingly blurred. Moreover, there was a tendency to acknowledge individual influencers rather than recognizing them as integral parts of the broader CAGs. This blurred distinction made it challenging to investigate the group's functionality, as community perception often centred on these individual influencers.

During the polio eradication campaign, CGPP's programming was guided by a community-based approach of identifying and orienting community influencers who supported CMCs and FLWs in mobilizing and converting vaccine resistors into acceptors. This approach, which was rooted in the principle of community participation helped close the gap between the health system and the community. A rapid review of literature conducted by the study team also revealed the value of involving the community in health planning and implementation. Health programs which invoke community participation have the capacity to adapt to local needs, close the gaps between community needs and program objectives, neutralize community distrust of the public healthcare system, tackle hesitancy and/or resistance by collaborating with community influencers, leaders, and gatekeepers, earn credibility through community trust and acceptance of community influencers and address the challenges posed by vacancies in the healthcare system among others[11].

During the COVID-19 pandemic, this approach took a new turn by organizing community influencers into CAGs. The withdrawal of CMCs in March 2020 and the emergence of new challenges during the pandemic, served as an impetus for the formation of CAGs. The CAGs engaged in rumor tracking, distributing essential supplies to COVID-19-infected families, addressing stigma, myths and misinformation through IPC and mobilizing families for the uptake of the COVID-19 vaccine among others. Since then, the CAGs have also responded to dengue, malaria and measles outbreaks in the community, and supported FLWs in enhancing immunization coverage through IPC and community meetings, thereby strengthening the outreach of health programs and campaigns to the last mile.

The study also revealed high motivation among CAG members, driven by a sense of belonging and responsibility towards their community, personal satisfaction and happiness in improving community health, prevalence of learning opportunities, support and guidance from peers and program staff, and recognition and appreciation from community and health officials among others. Some of the reasons for motivation such as a sense of social responsibility and altruism, opportunity to enhance knowledge and skills on community health through training, peer support

[11] Deutsch N, Singh P, Singh V, Curtis R, Siddique AR. Legacy of Polio-Use of India's Social Mobilization Network for Strengthening of the Universal Immunization Program in India. J Infect Dis. 2017 Jul 1;216(suppl_1):S260-S266. doi: 10.1093/infdis/jix068. PMID: 28838190; PMCID: PMC5854010.

and cross-learning were also found among ASHA workers in a mixed-methods study conducted in Odisha by Gopalan et al[12].

The CAGs emerged as a transformative force, bridging the critical gap between the health system and the community, as affirmed by all stakeholders in the study. Recognized as the missing link in ensuring the last-mile delivery of health programs and campaigns, CAGs demonstrated unparalleled value addition. Their composition, comprising influential members with in-depth community knowledge, diverse skills, and robust departmental linkages, stood out as a key strength. The collaborative nature of the group facilitated swift and effective results, with members leveraging their skills and networks for efficient issue resolution, particularly in mobilization efforts. Trusted by both the community and government stakeholders, CAGs are perceived to have commitment to community welfare. Their impact during the COVID-19 pandemic further solidified community trust, emphasizing the indispensability of CAGs in enhancing communication, mobilization, and overall community health.

Now with the transition and withdrawal of CGPP, sustainability considerations have taken center stage. The study discovered that the conceptualization of the CAG model rested on the principle of sustainability. In terms of sustainability, group functioning was described to have advantages over individual-level action. The program team informed that the underlying factors of sustainability, which can be found in groups include shared responsibility, accountability and ownership. Unlike in the case of individual community influencers, the community's problems and needs become a shared responsibility of the group. Individual members of the group are tasked with certain actions which are interlinked, making the group members inter-dependent. Although there is no formal accountability mechanism, the very functioning of a group ensures accountability to one another.

The study also delved into other factors influencing sustainability which are found in group functioning. Firstly, the study found that groups tend to fulfill emerging needs of the group and ensure motivation among group members. Let us explore this further by looking at the composition of CAGs. CAGs comprise of members who hold important positions in the community, display political, cultural, religious and economic authority and have linkages with different government departments, among others. Therefore, any needs that emerge within the group for problem solving can be fulfilled by CAG members themselves. Take for example, the need for skill-building and health-specific information seeking. The very inclusion of FLWs in CAGs can fulfill these needs by sharing information and skills that the FLWs have gathered from their respective trainings held by different departments. This not only enhances the capacities of CAGs, but also contributes to their motivation, which as we saw, was directly associated with the opportunity to learn. The study also discovered that CAGs achieve quicker and effective results due to the members' positioning in the community and their close association with different government departments. The successful resolution of issues, which wins them the community's trust, acceptance and recognition in turn motivates the group members to address new problems in the future. The benefits of recognition of one's work came repeatedly as a pre-requisite for continued and sustained functioning in the future.

Another factor for sustainability, on which the work has already been initiated, is the linking of CAGs to the public health system, so they may receive support from the health officials which they previously received from the CGPP structure at the district (DMC) and block (BMC) level.

[12] Gopalan SS, Mohanty S, Das A. Assessing community health workers' performance motivation: a mixed-methods approach on India's Accredited Social Health Activists (ASHA) programme. BMJ Open. 2012 Sep 27;2(5):e001557. doi: 10.1136/bmjopen-2012-001557. PMID: 23019208; PMCID: PMC3488714.

This support entails orientations, health-specific information, and felicitation by government officials which enables motivation. The collaboration with the health department will further give recognition to the CAG through their inclusion in various meetings, and remove any administrative challenges that they face, enabling better results, which as we saw above, is yet another motivating factor for CAGs. This collaboration between the health department and CAGs is mutually beneficial. While it offers non-material entitlements to the CAG due to their association with government departments, such as, but not limited to their improved positioning within their community, the public health system has much to benefit from the CAGs. The CAGs are trusted, often more so, in comparison to the FLWs in some geographies. They have reach among community members, who are unreached by the public health system. The CAGs offer untapped opportunities to bridge the gap between the health system and the community.

To conclude, while the community influencer approach is a well-recognized strategy, implemented by the health department even in areas without CGPP's presence, the sustainability and scalability of the CAG model will require advocacy with relevant government departments. Further, the successful replication of the CAG model is based on three factors, namely, the identification of the right influencers, using contextualized approaches, ensuring their motivation for continued work and the linkage of CAGs with relevant departments to ensure its sustainability in the long run. The study also found that the successful replication of this model is hinged on the existence of the CGPP structure at the district (DMC) and block (BMC) level as the findings have shown that they support fulfilling all three requirements.

Findings from the study have five **implications for the sustainability and scalability of the CAG model**. These include:

1. The CAGs comprise of influencers who are already linked with various government departments. It is thus a window of opportunity to leverage the CAG model as a community-based support group that can work beyond health-specific issues. Advocacy is required so that multiple government departments can tap the potential of such groups that can play catalytic role in bridging the gap between the government's programs and the community.
2. Develop clear guidelines for the set-up of CAGs with scope for contextualization at district-level. This should be shared with district/block level program implementers (DMCs, BMCs) and government officials. Advocacy is required with relevant departments to release government orders to streamline the set-up and implementation of the CAG model as a supplementary support group that can be leveraged by the respective departments.
3. Advocacy with relevant departments can be done for felicitation of CAG members that can boost their motivation in engaging in various community level activities. Recognizing that departments may have budget constraints, the acknowledgement of CAGs can take the form of invitations to the monthly meetings at the CHC or PHC, appreciation of CAGs on special days, recognition of best working CAGs in meetings that CAG members would already be a part of due to their portfolios.
4. Provision of identity cards can be made available to CAG members for easy access and in-roads into government departments to address administrative barriers in problem solving. This can further provide recognition to CAG members and serve as a mechanism for prioritizing their needs.
5. Advocacy is needed with government using advocacy/pitch notes for early and contextualized identification of government functionaries who will take up the role of DMCs and BMCs after program withdrawal to ensure ease of role transfer. BMCs, with support from CAGs could develop a micro-level transition plan for the slow transition of CGPP.

ANNEXURE

IRB approval

The study team submitted the study protocol, tools and consent forms for the study titled 'Development of Legacy Documentation for CORE Group Partners Project (CGPP)' to Sigma Institutional Review Board. Further, the technical content and ethical principles mentioned in the study protocol was presented to the IRB members in a virtual meeting held on September 09, 2023. Based on reviewer's feedback the revised protocol was submitted and approval was obtained on October 07, 2023. The IRB Number is 10049/IRB/23-24 and IRB REG No is IORG0008260.

Sample size for study respondents

Table 2: Sample size covered under different methods/approaches

Methods	**Respondents**	**Sample size**
Qualitative data		
Focus Group Discussion (23)	CAG members	90
	Community members	50
In-depth interviews (20)	Community stakeholder (ASHAs, Anganwadi Workers, ANMs, office bearers of SHGs, VHSNCs etc.)	20
Key Informant interviews (24)	Program managers	20
	Government officials	4
Co-learning workshop (1)	CAG members and program implementers/managers	22
Secondary data		
Post-FGD survey on CAG members' motivation		77
MIS/program data to study CAG members' profiles (as per list obtained from ADRA; from 1,228 village of 15 districts of 3 states namely Uttar Pradesh, Assam, and Haryana)		10,573

Findings from post-FGD survey of CAG members

Table 3: CAG members' motivation scales across different domains

Motivation factors	CAG members (in %)				
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I am proud to be working as a member of the community action group				26.3	73.7
I feel very little commitment to the community action group	16.2	19.1	1.5	48.5	14.7
My membership to the CAG really inspires me to do the very best in my work as a CAG member	1.4			28.4	70.3
I am satisfied with the support I receive from other CAG members	1.4	1.4	4.1	27.0	66.2
I am satisfied with the opportunity to enhance my skills and knowledge through meetings that I attend as a CAG member				29.0	71.1
I am satisfied with the community recognition I receive for my work as a CAG member	1.3			37.3	61.3
I am satisfied with the support I receive from CGPP functionaries	1.4	1.4	2.7	27.4	67.1
I am proud to be working for my community as a CAG member				25.0	75.0
Overall, I am very satisfied with my work as a CAG member				26.7	73.3
I am satisfied with the opportunities I have to use my abilities in my work as a CAG member				32.5	67.5
I feel that my work as a CAG member is relevant for improving the health of my community		1.3		31.2	67.5
I am satisfied that I accomplish something worthwhile as a member of the CAG	1.3	2.6		31.6	64.5
I think my work as a CAG member will not be valuable these days	23.6	61.1	2.8	11.1	1.4
I am satisfied by the positive impact of my work during COVID-19			1.3	28.0	70.7
I can be relied upon as a CAG member	1.3		1.3	26.7	70.7
I have always completed my tasks efficiently and correctly as a CAG member				27.3	72.7
As a CAG member, I have taken initiative to do things without being asked or told during COVID-19	6.8	8.1	4.1	32.4	48.7
I feel I am the right person to be a member of the CAG				42.9	57.1
I feel emotionally tired after engaging in a day of CAG activities	24.7	55.8	6.5	6.5	6.5
I feel physically tired after engaging in a day of CAG activities	29.9	49.4	9.1	7.8	3.9
I feel overburdened because of my engagements as a CAG member	27.6	56.6	6.6	6.6	2.6
I don't find time for my personal engagements when I am called upon to engage in CAG activities	31.2	48.1	3.9	10.4	6.5
My work as a CAG member affects my duties towards my family	26.0	31.2	5.2	20.8	16.9

Note: Green cells represent positive motivations while brown cells indicate negative motivation

Study tools and guidelines for data collection

Study to develop a legacy document for the CORE Group Partners Project
कोर ग्रुप पार्टनर्स प्रोजेक्ट के लिए एक विरासत दस्तावेज़ विकसित करने के लिए अध्ययन

Focus Group Discussion guidelines for members of Community Action Groups (CAG)
सामुदायिक कार्रवाई समूहों (सीएजी) के सदस्यों के लिए फोकस समूह चर्चा दिशानिर्देश

[EACH FGD SHOULD BE CONDUCTED BY TWO PEOPLE – ONE FACILITATOR AND ONE NOTE-TAKER]
[प्रत्येक एफजीडी का संचालन दो लोगों द्वारा किया जाना चाहिए - एक सुविधाकर्ता और एक नोट लेने वाला]

Facilitator and note-taker's welcome, introduction and instructions to participants. Welcome and thank you for volunteering to take part in this focus group. Mention that "you have been asked to participate as your point of view is important. We appreciate you for participating and giving your time."

Introduction: This FGD is designed to assess your throughs and perspectives about your role in community engagement during the COVID-19 pandemic. We want to understand your motivations for joining the CAG and continuing your work with the community. We would also like to learn about your journey as a CAG member, including the functioning of CAG, the activities you engage in, your perception of the value of CAG and community's acceptance and trust in the same. The focus group discussion will take no more than one hour.

Consent for recording of the discussion: We would like to audio record the discussion that will help us writing detailed notes. We would like to assure you that the discussion will be anonymous. The audio recording will be kept confidential. You should try to answer and comment as accurately and truthfully as possible. We would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so; however please try to provide your views and be as involved as possible.

सुविधा प्रदाता और नोट लेने वाले का स्वागत, परिचय और प्रतिभागियों को निर्देश। इस फोकस समूह में स्वेच्छा से भाग लेने के लिए आपका स्वागत है और धन्यवाद। उल्लेख करें कि "आपको भाग लेने के लिए कहा गया है क्योंकि आपका दृष्टिकोण महत्वपूर्ण है। हम भाग लेने और अपना समय देने के लिए आपकी सराहना करते हैं।

परिचय: यह FGD COVID-19 महामारी के दौरान सामुदायिक सहभागिता में आपकी भूमिका के बारे में आपके विचारों और दृष्टिकोणों का आकलन करने के लिए डिज़ाइन किया गया है। हम सीएजी में शामिल होने और समुदाय के साथ अपना काम जारी रखने के लिए आपकी प्रेरणा को समझना चाहते हैं। हम सीएजी सदस्य के रूप में आपकी यात्रा के बारे में भी जानना चाहेंगे, जिसमें सीएजी की कार्यप्रणाली, आप जिन गतिविधियों में शामिल हैं, सीएजी के मूल्य के बारे में आपकी धारणा और समुदाय की स्वीकृति और उस पर विश्वास शामिल है। फोकस समूह चर्चा में एक घंटे से अधिक समय नहीं लगेगा।

चर्चा की रिकॉर्डिंग के लिए सहमति: हम चर्चा को ऑडियो रिकॉर्ड करना चाहेंगे जिससे हमें विस्तृत नोट्स लिखने में मदद मिलेगी। हम आपको आश्वस्त करना चाहेंगे कि चर्चा गुमनाम रहेगी। ऑडियो रिकॉर्डिंग को गोपनीय रखा जाएगा. आपको यथासंभव सटीक और सच्चाई से उत्तर देने और टिप्पणी करने का प्रयास करना चाहिए। यदि आप फोकस समूह के बाहर समूह के अन्य सदस्यों की टिप्पणियों पर चर्चा करने से परहेज करेंगे तो हम इसकी सराहना करेंगे। यदि कोई प्रश्न या चर्चा है जिसका आप उत्तर नहीं देना चाहते या उसमें भाग नहीं लेना चाहते, तो आपको ऐसा करने की आवश्यकता नहीं है; हालाँकि कृपया अपने विचार प्रदान करने का प्रयास करें और यथासंभव शामिल हों।

Ground rules

- The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking, but please wait until they have finished.
- There are no right or wrong answers
- You do not have to speak in any particular order
- When you do have something to say, please do so. There are many of you in the group and it is important that we obtain the views of each of you
- You do not have to agree with the views of other people in the group, please provide your individual perspective
- Does anyone have any questions? (Answer them)
- OK, let's begin

नियम

• सबसे महत्वपूर्ण नियम यह है कि एक समय में केवल एक ही व्यक्ति बोलता है। जब कोई बात कर रहा हो तो बीच में कूदने का प्रलोभन हो सकता है, लेकिन कृपया उनके समाप्त होने तक प्रतीक्षा करें।

•कोई भी सवाल सही या गलत नहीं है

• आपको किसी विशेष क्रम में बोलने की ज़रूरत नहीं है

• जब आपके पास कहने के लिए कुछ हो, तो कृपया ऐसा करें। समूह में आप में से कई लोग हैं और यह महत्वपूर्ण है कि हम आप में से प्रत्येक के विचार प्राप्त करें

• आपको समूह में अन्य लोगों के विचारों से सहमत होने की आवश्यकता नहीं है, कृपया अपना व्यक्तिगत दृष्टिकोण प्रदान करें

• क्या किसी के पास कोई प्रश्न है? (उन्हें जवाब)

• ठीक है, चलिए शुरू करते हैं

Community engagements | सामुदायिक व्यस्तताएँ

1. You all have been working for the community in many capacities, Can you briefly talk about the ways in which you have worked to improve community welfare, both before CAG and through CAG?
   आप सभी कई क्षमताओं में समुदाय के लिए काम कर रहे हैं, क्या आप संक्षेप में उन तरीकों के बारे में बता सकते हैं जिनसे आपने सीएजी से पहले और सीएजी के माध्यम से सामुदायिक कल्याण में सुधार के लिए काम किया है?
2. How did you come to know about CAG? What made you want to be a part of CAG?

   आपको CAG के बारे में कैसे पता चला? आप सीएजी का हिस्सा क्यों बनना चाहते थे?

3. In your opinion, what are some of the traits or qualities that a person should have to effectively become a member of the CAG?

   आपकी राय में, सीएजी का सदस्य बनने के लिए एक व्यक्ति में कौन से गुण होने चाहिए?

Knowledge about CAG | सीएजी के बारे में जानकारी:

4. What is the role of the CAG at the community level?

   सामुदायिक स्तर पर CAG की क्या भूमिका है?

5. How does the CAG function? -
   Probes:
   - **a.** How frequently does the CAG meet?
   - **b.** How is it decided that the CAG should meet?
   - **c.** What is discussed during these meetings?
   - **d.** Who facilitates these discussions?
   - **e.** How do you plan for community outreach? How is your work monitored?
   - **f.** What is the structure of the CAG?
   - **g.** How do CAG members communicate amongst themselves?

   CAG कैसे कार्य करता है? -

   जांच:

   a. CAG की बैठक कितनी बार होती है?
   b. यह कैसे निर्णय लिया जाता है कि CAG की बैठक होनी चाहिए?
   c. इन बैठकों के दौरान क्या चर्चा होती है?
   d. इन चर्चाओं को कौन सुगम बनाता है?
   e. आप सामुदायिक आउटरीच की योजना कैसे बनाते हैं? आपके काम की निगरानी कैसे की जाती है?
   f. CAG की संरचना क्या है?
   g. CAG सदस्य आपस में कैसे संवाद करते हैं?

Perception about their own work | अपने स्वयं के कार्य के बारे में धारणा

6. In your community, who is a trusted source of information and is able to dispel myths around health practices to the community members?

   आपके समुदाय में, जानकारी का विश्वसनीय स्रोत कौन है और समुदाय के सदस्यों के लिए स्वास्थ्य प्रथाओं के बारे में मिथकों को दूर करने में सक्षम है?

7. What do you think is the role of CAG members in providing accurate health information and dispelling myths related to health practices?

   आपके अनुसार सटीक स्वास्थ्य जानकारी प्रदान करने और स्वास्थ्य प्रथाओं से संबंधित मिथकों को दूर करने में सीएजी सदस्यों की क्या भूमिका है?

8. What has changed in how you conduct your activities with community since you became part of CAG?
   Probe A: community engagement, information sharing, mobilisation, meetings, etc
   Probe B- to gauge their opinion on the changes: any added burden to work, easier processes to mobilise, better access to resources, etc)
   सीएजी का हिस्सा बनने के बाद से आप समुदाय के साथ अपनी गतिविधियों का संचालन कैसे करते हैं, इसमें क्या बदलाव आया है?
   जांच ए: सामुदायिक सहभागिता, सूचना साझा करना, जुटाना, बैठकें आदि
   जांच बी- परिवर्तनों पर उनकी राय जानने के लिए: काम पर कोई अतिरिक्त बोझ, जुटाने के लिए आसान प्रक्रियाएं, संसाधनों तक बेहतर पहुंच, आदि)
9. Have there been any changes in how the community approaches you since you became a CAG member? (Probe: changes in the issues they bring to you, changes in how they reach out, changes in number of people seeking your support, etc)

   क्या आपके सीएजी सदस्य बनने के बाद समुदाय आपके साथ कैसे व्यवहार करता है, इसमें कोई बदलाव आया है? (जांच: आपके द्वारा लाए गए मुद्दों में परिवर्तन, उनके पहुंचने के तरीके में परिवर्तन, आपका समर्थन चाहने वाले लोगों की संख्या में परिवर्तन, आदि)

Perception of the community about CAG | CAG के बारे में समुदाय की धारणा

10. How do you think the community perceives the work/contributions/activities of CAG? – (Probe: community acknowledgement, appreciation, ease of reach out)

    आपके अनुसार समुदाय सीएजी के कार्य/योगदान/गतिविधियों को किस प्रकार देखता है? - (जांच: सामुदायिक स्वीकृति, सराहना, पहुंच में आसानी)

11. Let us think back to the COVID lockdown time, what were some of the specific services or help for which the community reached out to you? (Probe: any services like distribution of ration/health kits, any information sharing or campaigning, any queries on where to seek help, linkage with community health workers etc)
    आइए हम कोविड लॉकडाउन के समय के बारे में सोचें, ऐसी कौन सी विशिष्ट सेवाएँ या सहायता थीं जिनके लिए समुदाय आपके पास पहुंचा? (जांच: कोई भी सेवा जैसे राशन/स्वास्थ्य

किट का वितरण, कोई सूचना साझा करना या अभियान चलाना, सहायता कहां लेनी है, इस पर कोई प्रश्न, सामुदायिक स्वास्थ्य कार्यकर्ताओं के साथ जुड़ाव आदि)

12. During COVID-19, were there any cases of stigma or discrimination against COVID-19 infected families in your village? If yes, can you tell us more about such cases? Probe: How did you respond to these cases?

    Probe:Were you able to resolve these cases? If yes, how?

    क्या कोविड-19 के दौरान आपके गांव में कोविड-19 संक्रमित परिवारों के खिलाफ कलंक या भेदभाव का कोई मामला सामने आया था? यदि हाँ, तो क्या आप हमें ऐसे मामलों के बारे में और बता सकते हैं?

    जांच: आपने इन मामलों पर क्या प्रतिक्रिया दी?

    जांच: क्या आप इन मामलों को सुलझाने में सक्षम थे? यदि हां तो कैसे?

13. Can you now tell us what were some of the services for which the community was dependent on other stakeholders like VHSNCs, SHGs, Nigrani Samiti, etc? (Probe: What were some of the differences in the services they sought from you versus other stakeholders, eg. Medical services)

    क्या अब आप हमें बता सकते हैं कि ऐसी कौन सी सेवाएँ थीं जिनके लिए समुदाय अन्य हितधारकों जैसे वीएचएसएनसी, एसएचजी, निगरानी समिति आदि पर निर्भर था? (जांच: अन्य हितधारकों की तुलना में उन्होंने आपसे जो सेवाएं मांगी थीं, उनमें कुछ अंतर क्या थे, उदाहरण के लिए चिकित्सा सेवाएं)

14. Can you cite some instances where you worked in collaboration with these other stakeholders for the community?

    क्या आप ऐसे कुछ उदाहरण बता सकते हैं जहां आपने समुदाय के लिए इन अन्य हितधारकों के साथ मिलकर काम किया है?

15. You have told us about your activities during COVID-19. Let us now talk about the present time. What are the changes in the services and engagement activities that you are now conducting as a CAG member since the threat of COVID-19 has diminished?

    a. Do the community approach you for any support now?
    b. What are some of these support requirements?

    आपने हमें COVID-19 के दौरान अपनी गतिविधियों के बारे में बताया है। आइये अब बात करते हैं वर्तमान समय की। चूंकि अब COVID-19 का खतरा कम हो गया है, इसलिए CAG सदस्य के रूप में आप जिन सेवाओं और सहभागिता गतिविधियों का संचालन कर रहे हैं, उनमें क्या बदलाव आए हैं?

    a. क्या समुदाय अब किसी सहायता के लिए आपसे संपर्क करता है?
    b. इनमें से कुछ समर्थन आवश्यकताएँ क्या हैं?

Motivation (Enabling and disabling factors) | प्रेरणा (सक्षम और अक्षम करने वाले कारक)

15. What motivates you to be a part of the community action groups?

    सामुदायिक कार्रवाई समूहों का हिस्सा बनने के लिए आपको क्या प्रेरित करता है?

16. How do you perceive your role in the welfare of your community?
    Probe: How do you perceive your role in future emergencies?

    आप अपने समुदाय के कल्याण में अपनी भूमिका को किस प्रकार समझते हैं?
    जांच: आप भविष्य की आपात स्थितियों में अपनी भूमिका कैसे समझते हैं?

17. What are some of the challenges or difficulties of being a CAG member?

    CAG सदस्य होने की कुछ चुनौतियाँ या कठिनाइयाँ क्या हैं?

Journey of CAG members – capacity building sessions/orientations and activities conducted | सीएजी सदस्यों की यात्रा - क्षमता निर्माण सत्र/अभिविन्यास और गतिविधियाँ आयोजित

18. What capacity building sessions and orientations have you received as a CAG member? (Before and after joining the CAG) - Probe about the duration, mode of delivery, refresher sessions
    सीएजी सदस्य के रूप में आपको कौन से क्षमता निर्माण सत्र और अभिविन्यास प्राप्त हुए हैं? (सीएजी में शामिल होने से पहले और बाद में) - अवधि, वितरण का तरीका, पुनश्चर्या सत्र के बारे में जांच

19. What are the various activities you have conducted in your community? - Probe about awareness raising, knowledge sharing, dispelling myths, mobilisation, community meetings, connecting to stakeholder?

    आपने अपने समुदाय में कौन सी विभिन्न गतिविधियाँ संचालित की हैं? - जागरूकता बढ़ाने, ज्ञान साझा करने, मिथकों को दूर करने, लामबंदी, सामुदायिक बैठकें, हितधारकों से जुड़ने के बारे में जांच?

20. What are some of the challenges you face in conducting your activities?
    अपनी गतिविधियाँ संचालित करने में आपको किन चुनौतियों का सामना करना पड़ता है?

21. What support mechanism exists to facilitate your work? - Probe: from CGPP, health system and govt. Bodies
    आपके काम को सुविधाजनक बनाने के लिए कौन सा समर्थन तंत्र मौजूद है? - जांच: सीजीपीपी, स्वास्थ्य प्रणाली और सरकार से। निकायों

22. What additional support do you expect in carrying out your work and addressing challenges? - Probe: support expected from CGPP, health system and govt. Bodies
    अपना काम पूरा करने और चुनौतियों का समाधान करने में आप किस अतिरिक्त सहायता की अपेक्षा करते हैं? - जांच: सीजीपीपी, स्वास्थ्य प्रणाली और निकायों से समर्थन की उम्मीद।

Sustainability | वहनीयता

23. What are the reasons for CAG members to discontinue engaging in CAG activities?
CAG सदस्यों द्वारा CAG गतिविधियों में भाग लेना बंद करने के क्या कारण हैं?

24. Do you think CAG can continue without external support? - Probe: If yes, how? What preconditions will have to be met (structure, human resource, capacity building)? | If no, why not? What are some of the challenges in continuing work without external support?
24. क्या आपको लगता है कि सीएजी बाहरी समर्थन के बिना जारी रह सकता है? - जांच: यदि हां, तो कैसे? क्या पूर्व शर्तें पूरी करनी होंगी (संरचना, मानव संसाधन, क्षमता निर्माण)? | यदि नहीं, तो क्यों नहीं? बाहरी समर्थन के बिना काम जारी रखने में कुछ चुनौतियाँ क्या हैं?

Study to develop a legacy document for the CORE Group Partners Project
कोर ग्रुप पार्टनर्स प्रोजेक्ट के लिए एक विरासत दस्तावेज़ विकसित करने के लिए अध्ययन

Focus Group Discussion guidelines for community members (households in the catchment area of CAG)
समुदाय के सदस्यों के लिए फोकस समूह चर्चा दिशानिर्देश (सीएजी के जलग्रहण क्षेत्र में घर)

[EACH FGD SHOULD BE CONDUCTED BY TWO PEOPLE – ONE FACILITATOR AND ONE NOTE-TAKER]
[प्रत्येक एफजीडी का संचालन दो लोगों द्वारा किया जाना चाहिए - एक सुविधाकर्ता और एक नोट लेने वाला]

Facilitator and note-taker's welcome, introduction and instructions to participants. Welcome and thank you for volunteering to take part in this focus group. Mention that "you have been asked to participate as your point of view is important. We appreciate you for participating and giving your time."

Introduction: This FGD is designed to assess your throughs and perspectives about the role of community action groups/community influencers in engaging with and supporting you and your community during the COVID-19 pandemic. We would like to learn about the activities they conducted at the community-level and how you and your community benefited from the same. The focus group discussion will take no more than 45 minutes.

Consent for recording of the discussion: We would like to audio record the discussion that will help us writing detailed notes. We would like to assure you that the discussion will be anonymous. The audio recording will be kept confidential. You should try to answer and comment as accurately and truthfully as possible. We would appreciate it if you would refrain from discussing the comments of other group members outside the focus group. If there are any questions or discussions that you do not wish to answer or participate in, you do not have to do so; however please try to provide your views and be as involved as possible.

सुविधा प्रदाता और नोट लेने वाले का स्वागत, परिचय और प्रतिभागियों को निर्देश। इस फोकस समूह में स्वेच्छा से भाग लेने के लिए आपका स्वागत है और धन्यवाद। उल्लेख करें कि "आपको भाग लेने के लिए कहा गया है क्योंकि आपका दृष्टिकोण महत्वपूर्ण है। हम भाग लेने और अपना समय देने के लिए आपकी सराहना करते हैं।

परिचय: यह FGD COVID-19 महामारी के दौरान आपके और आपके समुदाय के साथ जुड़ने और समर्थन करने में सामुदायिक कार्रवाई समूहों/सामुदायिक प्रभावकों की भूमिका के बारे में आपके विचारों और दृष्टिकोणों का आकलन करने के लिए डिज़ाइन किया गया है। हम यह जानना चाहेंगे कि उन्होंने समुदाय-स्तर पर क्या-क्या गतिविधियाँ संचालित कीं और उनसे आपको और आपके समुदाय को क्या लाभ हुआ। फोकस समूह चर्चा में 45 मिनट से अधिक समय नहीं लगेगा।

चर्चा की रिकॉर्डिंग के लिए सहमति: हम चर्चा को ऑडियो रिकॉर्ड करना चाहेंगे जिससे हमें विस्तृत नोट्स लिखने में मदद मिलेगी। हम आपको आश्वस्त करना चाहेंगे कि चर्चा गुमनाम

रहेगी। ऑडियो रिकॉर्डिंग को गोपनीय रखा जाएगा. आपको यथासंभव सटीक और सच्चाई से उत्तर देने और टिप्पणी करने का प्रयास करना चाहिए। यदि आप फोकस समूह के बाहर समूह के अन्य सदस्यों की टिप्पणियों पर चर्चा करने से परहेज करेंगे तो हम इसकी सराहना करेंगे। यदि कोई प्रश्न या चर्चा है जिसका आप उत्तर नहीं देना चाहते या उसमें भाग नहीं लेना चाहते, तो आपको ऐसा करने की आवश्यकता नहीं है; हालाँकि कृपया अपने विचार प्रदान करने का प्रयास करें और यथासंभव शामिल हों।

Ground rules

- The most important rule is that only one person speaks at a time. There may be a temptation to jump in when someone is talking, but please wait until they have finished.
- There are no right or wrong answers
- You do not have to speak in any particular order
- When you do have something to say, please do so. There are many of you in the group and it is important that we obtain the views of each of you
- You do not have to agree with the views of other people in the group, please provide your individual perspective
- Does anyone have any questions? (Answer them)
- OK, let's begin

नियम

• सबसे महत्वपूर्ण नियम यह है कि एक समय में केवल एक ही व्यक्ति बोलता है। जब कोई बात कर रहा हो तो बीच में कूदने का प्रलोभन हो सकता है, लेकिन कृपया उनके समाप्त होने तक प्रतीक्षा करें।

•कोई भी सवाल सही या गलत नहीं है

• आपको किसी विशेष क्रम में बोलने की ज़रूरत नहीं है

• जब आपके पास कहने के लिए कुछ हो, तो कृपया ऐसा करें। समूह में आप में से कई लोग हैं और यह महत्वपूर्ण है कि हम आप में से प्रत्येक के विचार प्राप्त करें

• आपको समूह में अन्य लोगों के विचारों से सहमत होने की आवश्यकता नहीं है, कृपया अपना व्यक्तिगत दृष्टिकोण प्रदान करें

• क्या किसी के पास कोई प्रश्न है? (उन्हें जवाब)

• ठीक है, चलिए शुरू करते हैं

1. Can you please share some of the challenges/difficulties you and your community members experienced during COVID-19?
   We want to understand from you how you and your community was supported during an emergency, such as COVID-19?

1. क्या आप कृपया उन कुछ चुनौतियों/कठिनाइयों को साझा कर सकते हैं जिन्हें आपने और आपके समुदाय के सदस्यों ने COVID-19 के दौरान अनुभव किया है?
हम आपसे यह समझना चाहते हैं कि COVID-19 जैसी आपात स्थिति के दौरान आपको और आपके समुदाय को किस प्रकार सहायता प्रदान की गई?

2. Where do you think most people obtained information about COVID-19? Why?

Probe: What were the most trusted sources of information about COVID-19 in your community?

2. आपको क्या लगता है कि अधिकांश लोगों को COVID-19 के बारे में जानकारी कहाँ से प्राप्त हुई? क्यों?
जांच: आपके समुदाय में COVID-19 के बारे में जानकारी के सबसे भरोसेमंद स्रोत क्या थे?

Information for the data collector: In case community members don't know what the CAG is, please explain the following: "The community action group was formed during the COVID-19 pandemic and includes members such as the Village Pradhan, ASHA worker, ration dealer, school teacher, religious leader etc."

डेटा संग्राहक के लिए जानकारी: यदि समुदाय के सदस्यों को पता नहीं है कि सीएजी क्या है, तो कृपया निम्नलिखित बताएं: "सामुदायिक कार्रवाई समूह का गठन सीओवीआईडी -19 महामारी के दौरान किया गया था और इसमें ग्राम प्रधान, आशा कार्यकर्ता, राशन जैसे सदस्य शामिल हैं डीलर, स्कूल शिक्षक, धार्मिक नेता आदि।

3. Who in your community contacted you for COVID-19 related information? Probe: religious leader, schoolteacher, ration dealer, shopkeeper, volunteer, ASHA worker
3. आपके समुदाय में किसने आपसे COVID-19 संबंधित जानकारी के लिए संपर्क किया? जांच: धार्मिक नेता, स्कूल शिक्षक, राशन डीलर, दुकानदार, स्वयंसेवक, आशा कार्यकर्ता

   a. **[if CAG not mentioned]:** Did any CAG member such as {insert relevant CAG members known} reach out to you?
      i. Probe: How did they reach out to you and your community members?
      ii. Probe: How frequently did they reach out to you and your community members?

   [यदि सीएजी का उल्लेख नहीं किया गया है]: क्या कोई सीएजी सदस्य जैसे कि {सम्मिलित प्रासंगिक सीएजी सदस्यों को ज्ञात} आप तक पहुंचा है?

   जांच: वे आप और आपके समुदाय के सदस्यों तक कैसे पहुंचे?

   जांच: वे आपसे और आपके समुदाय के सदस्यों तक कितनी बार पहुंचे?

4. Do you remember any instances or incidents where the CAGs supported you or your community? How did they reach out and engage with you or your community?
   a. How was CAG's engagement beneficial to you and your community?

b. What were some of the challenges you faced with CAG?
Probes: challenges in contacting them, challenges in receiving timely support, challenges in addressing your demands, areas they couldn't support/help with

4. क्या आपको ऐसे कोई उदाहरण या घटनाएं याद हैं जहां सीएजी ने आपका या आपके समुदाय का समर्थन किया हो? वे आप तक या आपके समुदाय तक कैसे पहुंचे और उनसे कैसे जुड़े?
   a. CAG की भागीदारी आपके और आपके समुदाय के लिए किस प्रकार लाभदायक थी?
   b. CAG के साथ आपको किन चुनौतियों का सामना करना पड़ा?

   जांच: उनसे संपर्क करने में चुनौतियाँ, समय पर समर्थन प्राप्त करने में चुनौतियाँ, आपकी माँगों को संबोधित करने में चुनौतियाँ, वे क्षेत्र जिनमें वे समर्थन/मदद नहीं कर सके

5. There are many stakeholders (ASHAS, AWWs, ANMs) and committees/bodies (VHSNCs, SHGs) working in your village. In your opinion, what is the need for CAG in your community?
   a. How is the support provided by CAGs different from that given from the other stakeholders and committees/bodies working in your village? (Probe areas: issues that received attention from CAG versus other stakeholders, timeliness of support, activities conducted by CAG versus other stakeholders)
   b. Can you tell us if you noticed any differences in the community's response to the support provided by CAG as compared to other stakeholders (Probe: different areas that they trusted the CAG with, comfort level with CAG, timely response to the support provided by CAG)?

5. आपके गांव में कई हितधारक (आशा, आंगनवाड़ी कार्यकर्ता, एएनएम) और समितियां/निकाय (वीएचएसएनसी, एसएचजी) काम कर रहे हैं। आपकी राय में, आपके समुदाय में CAG की क्या आवश्यकता है?

   a) सीएजी द्वारा प्रदान किया गया समर्थन आपके गांव में काम कर रहे अन्य हितधारकों और समितियों/निकायों द्वारा दिए गए समर्थन से किस प्रकार भिन्न है? (जांच क्षेत्र: मुद्दे जिन पर सीएजी बनाम अन्य हितधारकों का ध्यान गया, समर्थन की समयबद्धता, सीएजी बनाम अन्य हितधारकों द्वारा संचालित गतिविधियां)
   b) क्या आप हमें बता सकते हैं कि क्या आपने अन्य हितधारकों की तुलना में सीएजी द्वारा प्रदान किए गए समर्थन के प्रति समुदाय की प्रतिक्रिया में कोई अंतर देखा है (जांच: विभिन्न क्षेत्र जिन पर उन्होंने सीएजी पर भरोसा किया, सीएजी के साथ सहज स्तर, सीएजी द्वारा प्रदान किए गए समर्थन के लिए समय पर प्रतिक्रिया) ?

6. In relation to other stakeholders present in your village, what do you think are the strengths of CAG?
   Probe: easier to contact, timely support, trust in CAG, strong influence/network within village and with government officials

6. आपके गांव में मौजूद अन्य हितधारकों के संबंध में, आप क्या सोचते हैं कि सीएजी की ताकतें क्या हैं?

जांच: संपर्क करना आसान, समय पर सहायता, सीएजी पर भरोसा, गांव के भीतर और सरकारी अधिकारियों के साथ मजबूत प्रभाव/नेटवर्क

7. In relation to other stakeholders present in your village, what do you think are some of the weaknesses of CAG?

7. आपके गांव में मौजूद अन्य हितधारकों के संबंध में, आपके अनुसार सीएजी की कुछ कमजोरियां क्या हैं?

8. Would it be beneficial to your community to have CAGs continue to provide support?
    a. What types of support are most beneficial to your community?

8. क्या सीएजी का समर्थन जारी रखना आपके समुदाय के लिए फायदेमंद होगा?
    a. आपके समुदाय के लिए किस प्रकार का समर्थन सबसे अधिक लाभदायक है?

Study to develop a legacy document for the CORE Group Partners Project

In-depth Interview (IDI) guide for block and district level health officials

Identification	
State Name	
District Name	
Block Name	
Type of respondent	
Interviewer Name	
Date of Interview	Day Month Year

Introduction

1. Can you briefly tell us about your scope of work?
    a. In your block/district, what are some common health-specific issues?
    b. In your block/district, what are some barriers to achieving improvements in health/positive health outcomes?

Knowledge about CAG

2. Have you heard about the community action groups?
    a. How did you get to know about CAG?
    b. What do you know about them?
    c. **Probes**:
        a. What is the purpose of CAGs?
        b. Who are the members of CAG?
        c. Since how long have CAGs been functioning in your block/district
        d. What are the activities/functions of the CAG?

Relevance of CAG

3. In the past or present, have you/your office collaborated with CAGs in any way?
    a. If yes, can you tell us more about it? | If no, why not?
4. In your opinion, what is the relevance of CAGs in managing health emergencies/emergency preparedness (covid-19 vaccination, routine immunization, disease outbreak)?

Complementary

5. In your opinion, how has CAG contributed to the health system in your block/district?
    a. In what ways has it strengthened/supported the health system?
    b. What are the specific areas that it has contributed to?
6. How can CAGs complement the work of Mahila Arogya Samitis in urban areas and Rogi Kalyan Samitis in rural areas?

Strengths and weaknesses

7. In comparison to other committees/groups, what are the core strengths of the CAG?

8. In comparison to other committees/groups, what are the primary weaknesses of the CAG?

Sustainability

9. Moving forward, in your opinion, what should be the primary focus/function of the CAG in the overall health system?
10. Moving forward, what are some ways in which the CAGs can be integrated into the health system?
11. What are some of your suggestions to ensure the continuity of CAGs in your block/district?
    a. In what capacity can the government engage CAGs to ensure their sustainability?

Study to develop a legacy document for the CORE Group Partners Project
कोर ग्रुप पार्टनर्स प्रोजेक्ट के लिए एक विरासत दस्तावेज़ विकसित करने के लिए अध्ययन

In-depth Interview (IDI) guide for community stakeholders (ASHA, ANM, AWW, office bearers of SHGs, VHSNCs)
सामुदायिक हितधारकों (आशा, एएनएम, आंगनवाड़ी कार्यकर्ता, एसएचजी के पदाधिकारी, वीएचएसएनसी) के लिए गहन साक्षात्कार (आईडीआई) गाइड

Identification | पहचान	
State Name | राज्य का नाम	
District Name | जिले का नाम	
Block Name | ब्लॉक का नाम	
Type of respondent | उत्तरदाता का प्रकार	ASHA worker.....1 ANM.....2 Anganwadi worker.....3 Office bearer of self-help group.....4 VHSNC member.....5 Any other, please specify
Interviewer Name | साक्षात्कारकर्ता का नाम	Interviewer Id | साक्षात्कारकर्ता आईडी
Date of Interview | साक्षात्कार की तिथि	☐☐ ☐☐ ☐☐☐☐ Day Month Year

1. Please tell us about your role in the community?
    a. Probe: What are some of the best parts about working with communities? What are the most difficult parts?

कृपया हमें समुदाय में अपनी भूमिका के बारे में बताएं?

a. **जांच:** समुदायों के साथ काम करने के कुछ सबसे अच्छे हिस्से क्या हैं? सबसे कठिन भाग कौन से हैं?

Knowledge about CAG | सीएजी के बारे में जानकारी

1. What do you know about the community action groups?
   Probe: Who are the members of CAG, since how long have CAGs been functioning in your community, what are the activities of the CAG?
   आप सामुदायिक कार्रवाई समूहों के बारे में क्या जानते हैं?
   जाँच: CAG के सदस्य कौन हैं, CAG आपके समुदाय में कितने समय से कार्य कर रहे हैं, CAG की गतिविधियाँ क्या हैं?

2. What are the differences and commonalities between the work done by the CAG and your platform?
   सीएजी और आपके मंच द्वारा किए गए कार्यों के बीच क्या अंतर और समानताएं हैं?

Perception of CAG | सीएजी की धारणा

3. In your opinion, what is the relevance of CAGs in managing health emergencies/ emergency preparedness (covid-19 vaccination, routine immunization, disease outbreak)

आपकी राय में, स्वास्थ्य आपात स्थितियों/आपातकालीन तैयारियों (कोविड-19 टीकाकरण, नियमित टीकाकरण, बीमारी का प्रकोप) के प्रबंधन में सीएजी की क्या प्रासंगिकता है?

4. How has the CAG worked in collaboration with you/your platform?
   Probe: Can you share some specific experience of working with CAG members?
   सीएजी ने आपके/आपके प्लेटफॉर्म के साथ मिलकर कैसे काम किया है?
   जांच: क्या आप सीएजी सदस्यों के साथ काम करने का कुछ विशिष्ट अनुभव साझा कर सकते हैं?

5. What opinions about CAGs have you heard from the community members you work with?
   जिन समुदाय के सदस्यों के साथ आप काम करते हैं, उनसे आपने सीएजी के बारे में क्या राय सुनी है?

Complementary| पूरक

6. To what extent has CAGs complemented your work? - Probe: how has CAG supported your work? What are the specific areas that the CAG has contributed to?

   6.1 What changes should be made to the activities of the CAG to avoid duplication and provide further support to your work?

   सीएजी ने आपके काम को किस हद तक पूरक बनाया है? - जांच: सीएजी ने आपके काम का किस प्रकार समर्थन किया है? वे कौन से विशिष्ट क्षेत्र हैं जिनमें CAG ने योगदान दिया है?

   6.1 नकल से बचने और आपके काम को और अधिक सहायता प्रदान करने के लिए सीएजी की गतिविधियों में क्या बदलाव किए जाने चाहिए?

7. What have been the challenges of working alongside and with CAGs?
   a. Probe on role definition, coordination, community understanding of roles.

   सीएजी के साथ और उनके साथ काम करने में क्या चुनौतियाँ रही हैं?
   a. भूमिका की परिभाषा, समन्वय, भूमिकाओं की सामुदायिक समझ पर जांच।

Value addition | मूल्य संवर्धन

8. In your opinion, what additional value does the CAG bring vis-a-vis your group/platform (VHSNCs, Nigrani Samitis etc)? - Probe: community's trust and acceptance, IPC skills, social influence etc
   आपकी राय में, CAG आपके समूह/प्लेटफ़ॉर्म (VHSNCs, निगरानी समितियाँ आदि) के लिए क्या अतिरिक्त मूल्य लाता है? - जांच: समुदाय का विश्वास और स्वीकृति, आईपीसी कौशल, सामाजिक प्रभाव आदि

Study to develop a legacy document for the CORE Group Partners Project
कोर ग्रुप पार्टनर्स प्रोजेक्ट के लिए एक विरासत दस्तावेज़ विकसित करने के लिए अध्ययन

Key Informant Interview (KII) guide for programme managers from CGPP
सीजीपीपी के कार्यक्रम प्रबंधकों के लिए मुख्य मुखबिर साक्षात्कार (केआईआई) मार्गदर्शिका

Identification | पहचान	
State Name | राज्य का नाम	
District Name | जिले का नाम	
Block Name | ब्लॉक का नाम	
Designation | पद का नाम	
Interviewer Name | साक्षात्कारकर्ता का नाम	
Date of Interview | साक्षात्कार की तिथि	☐☐ ☐☐ ☐☐☐☐ Day Month Year

Vision and conceptualisation | दृष्टि और संकल्पना

1. How was the CAG model conceptualised? Probe: what was the vision for CAG?
   CAG मॉडल की संकल्पना कैसे की गई? जांच: CAG के लिए क्या दृष्टिकोण था?
2. Tell me about the CAG model.
   a. What is a CAG's main functions?

   CAG मॉडल के बारे में बताएं?
   a. CAG के मुख्य कार्य क्या हैं?
3. Tell me about the process of designing the CAG model?
   a. Probe: What was the impetus for this model of community engagement and support?
   b. What was the purpose of their formation?

   CAG मॉडल को डिज़ाइन करने की प्रक्रिया के बारे में बताएं?
   a. जांच: सामुदायिक सहभागिता और समर्थन के इस मॉडल के लिए प्रेरणा क्या थी?
   b. उनके गठन का उद्देश्य क्या था?

Identification process | पहचान प्रक्रिया

4. What was the process followed for identification of community influencers and formation of CAG?

   4.1 What was the criteria used for the selection of community influencers?
   4.2 How has the process of identification of Community Influencers changed/evolved over time?
   4.3 How often does CGPP update/revise the list/pool of community influencers? What is the basis of this revision?

   सामुदायिक प्रभावकों की पहचान और सीएजी के गठन के लिए क्या प्रक्रिया अपनाई गई?
   4.1 सामुदायिक प्रभावशाली व्यक्तियों के चयन के लिए क्या मानदंड अपनाए गए थे?

4.2 समय के साथ सामुदायिक प्रभावकों की पहचान की प्रक्रिया कैसे बदली/विकसित हुई है?

4.3 सीजीपीपी सामुदायिक प्रभावकों की सूची/पूल को कितनी बार अद्यतन/संशोधित करता है? इस संशोधन का आधार क्या है?

5. Tell me about the process and steps of forming a CAG?
    a. What key considerations are important when forming at CAG?

CAG बनाने की प्रक्रिया और चरणों के बारे में बताएं?

a. CAG का गठन करते समय कौन सी मुख्य बातें महत्वपूर्ण हैं?

Capacity building/knowledge sharing for action/sensitization | कार्रवाई/संवेदीकरण के लिए क्षमता निर्माण/ज्ञान साझा करना

6. What were the capacity building activities (workshops, meetings, orientations) executed with CAG members?

Probes

a. Do you have periodic (refresher) capacity building meetings/sessions?
b. What is the duration?
c. What components (skills, knowledge-based) are covered in the capacity building sessions/meetings?
d. Do you engage with other stakeholders to conduct these sessions/meetings?
e. Capacity building agenda, modules, structure that was followed

6.1 How has the approach towards capacity building changed over time?
6.2 What are some of the challenges you faced in conducting capacity building sessions? How did you address these challenges?

सीएजी सदस्यों के साथ क्षमता निर्माण गतिविधियाँ (कार्यशालाएँ, बैठकें, अभिविन्यास) क्या निष्पादित की गईं?

जांच

a. क्या आपके पास समय-समय पर (पुनश्चर्या) क्षमता निर्माण बैठकें/सत्र होते हैं?
b. अवधि क्या है?
c. क्षमता निर्माण सत्रों/बैठकों में कौन से घटक (कौशल, ज्ञान-आधारित) शामिल किए जाते हैं?
d. क्या आप इन सत्रों/बैठकों के संचालन के लिए अन्य हितधारकों के साथ जुड़ते हैं?
e. क्षमता निर्माण एजेंडा, मॉड्यूल, संरचना जिसका पालन किया गया

6.1 समय के साथ क्षमता निर्माण के प्रति दृष्टिकोण कैसे बदल गया है?
6.2 क्षमता निर्माण सत्र आयोजित करने में आपको किन चुनौतियों का सामना करना पड़ा? आपने इन चुनौतियों का समाधान कैसे किया?

Activities/Engagement of CAG| सीएजी की गतिविधियां/संगठन

7. What activities are CAGs expected to implement?

Probes:

a) what is the frequency and their level of engagement
b) How do they decide what activities to take on? Is there any guidance from CGPP or are these choices made within the CAG?

सीएजी से किन गतिविधियों को लागू करने की अपेक्षा की जाती है?

जांच:

a. आवृत्ति और उनके जुड़ाव का स्तर क्या है
b. वे कैसे तय करते हैं कि कौन सी गतिविधियाँ शुरू करनी हैं? क्या सीजीपीपी से कोई मार्गदर्शन है या ये विकल्प सीएजी के भीतर चुने गए हैं?

8. How has the engagement of CAGs evolved throughout the COVID-19 pandemic? **Probe:** what are the activities expected from the CAGs now versus during the pandemic
पूरे सीओवीआईडी-19 महामारी के दौरान सीएजी की भागीदारी कैसे विकसित हुई है? **जांच:** महामारी के दौरान अब बनाम सीएजी से क्या गतिविधियां अपेक्षित हैं
9. Are the CAGs expected to follow any work plans? Probe: who makes these work plans, is there a template?
क्या सीएजी से किसी कार्य योजना का पालन करने की अपेक्षा की जाती है? जांच: ये कार्य योजनाएं कौन बनाता है, क्या कोई खाका है?

Monitoring and review| निगरानी एवं समीक्षा

10. What is the monitoring mechanism used for CAG's activities? -**Probe**: how often is the work monitored? Who monitors the work? How are the updates shared, and with whom?
CAG की गतिविधियों के लिए उपयोग किया जाने वाला निगरानी तंत्र क्या है? -जांच: कार्य की कितनी बार निगरानी की जाती है? कार्य की निगरानी कौन करता है? अपडेट कैसे साझा किए जाते हैं और किसके साथ?
11. What is the mechanism for support established for CAG members? **Probe:** what is the nature of support provided to CAG? How do the CAG members reach out for support?
सीएजी सदस्यों के लिए स्थापित समर्थन तंत्र क्या है? जांच: सीएजी को प्रदान किए गए समर्थन की प्रकृति क्या है? सीएजी सदस्य समर्थन के लिए कैसे पहुंचते हैं?
12. Can you tell us about some of the review/update meetings that CAG members take part in? **Probe:** who are these meetings held with, how often are these meetings conducted
क्या आप हमें कुछ समीक्षा/अद्यतन बैठकों के बारे में बता सकते हैं जिनमें सीएजी सदस्य भाग लेते हैं? जांच: ये बैठकें किसके साथ होती हैं, ये बैठकें कितनी बार आयोजित की जाती हैं
13. After CGPP's withdrawal, what monitoring mechanisms do you think should be put in place for the CAG?
सीजीपीपी की वापसी के बाद, आपके अनुसार सीएजी के लिए कौन से निगरानी तंत्र स्थापित किए जाने चाहिए?

Challenges| चुनौतियां

14. What are some of the challenges in using a voluntary approach in an emergency context? **Probe:** What are the reasons for CIs to discontinue their engagement with CAG?
आपातकालीन संदर्भ में स्वैच्छिक दृष्टिकोण का उपयोग करने में कुछ चुनौतियाँ क्या हैं? जांच: सीआई द्वारा सीएजी के साथ अपना जुड़ाव बंद करने के क्या कारण हैं?

Replication of learnings| सीखों की प्रतिकृति

15. What are the key learnings that these voluntary platforms offer?
ये स्वैच्छिक मंच क्या प्रमुख सीख देते हैं?
16. What components of the CAG model can be integrated in the existing government platforms?
CAG मॉडल के किन घटकों को मौजूदा सरकारी प्लेटफार्मों में एकीकृत किया जा सकता है?

Sustainability| वहनीयता

17. What are some of the factors that motivate CIs to engage in CAG?
    ऐसे कौन से कारक हैं जो सीआई को सीएजी में शामिल होने के लिए प्रेरित करते हैं?
18. At present, how sustainable is the CAG model? **Probe**: why?

    18.1. What modifications do you suggest to make this a sustainable model?
    18. वर्तमान में CAG मॉडल कितना टिकाऊ है? जांच: क्यों?
    18.1. इसे एक टिकाऊ मॉडल बनाने के लिए आप क्या संशोधन सुझाते हैं?

Study to develop a legacy document for the CORE Group Partners Project

Post-FGD Survey for members of the Community Action Group

सामुदायिक कार्रवाई समूह के सदस्यों के लिए पोस्ट-एफजीडी सर्वेक्षण

We want to thank you for agreeing to participate in the survey. The objective of the survey is to understand the factors that influence your motivation as a member of the community action group. The survey has 23 statements. You are expected to indicate your level of agreement with the statement by selecting the appropriate response that best reflects your feelings about your association with CAG. You must select only one option out of five options – strongly agree, agree, neutral, disagree, strongly disagree. Please ensure that you complete the survey independently, and not in consultation with other members. There is no right or wrong answer. The survey will take 15 minutes to complete.

While we encourage you to respond to all the questions, you have the option to skip any if you feel uncomfortable answering it. Your responses will be kept confidential. The survey results will be used for research and program purposes only.

If you have any questions before starting the survey, please feel free to ask any one of the coordinators present in the room.

सर्वेक्षण में भाग लेने के लिए सहमत होने के लिए हम आपको धन्यवाद देना चाहते हैं। सर्वेक्षण का उद्देश्य उन कारकों को समझना है जो सामुदायिक कार्रवाई समूह के सदस्य के रूप में आपकी प्रेरणा को प्रभावित करते हैं। सर्वेक्षण में 23 कथन हैं। आपसे अपेक्षा की जाती है कि आप उचित प्रतिक्रिया का चयन करके कथन के साथ अपनी सहमति के स्तर को इंगित करें जो सीएजी के साथ आपके जुड़ाव के बारे में आपकी भावनाओं को सबसे अच्छी तरह से दर्शाता हो। आपको पांच विकल्पों में से केवल एक विकल्प चुनना होगा - दृढ़ता से सहमत, सहमत, तटस्थ, असहमत, दृढ़ता से असहमत। कृपया सुनिश्चित करें कि आप सर्वेक्षण स्वतंत्र रूप से पूरा करें, न कि अन्य सदस्यों के परामर्श से। कोई सही या गलत जवाब नहीं है। सर्वेक्षण पूरा होने में 15 मिनट लगेंगे।

हालाँकि हम आपको सभी प्रश्नों का उत्तर देने के लिए प्रोत्साहित करते हैं, लेकिन यदि आप उत्तर देने में असहज महसूस करते हैं तो आपके पास किसी भी प्रश्न को छोड़ने का विकल्प है। आपकी प्रतिक्रियाएँ गोपनीय रखी जाएंगी. सर्वेक्षण परिणामों का उपयोग केवल अनुसंधान और कार्यक्रम उद्देश्यों के लिए किया जाएगा।

यदि सर्वेक्षण शुरू करने से पहले आपके कोई प्रश्न हैं, तो कृपया बेझिझक कमरे में मौजूद किसी भी समन्वयक से पूछ सकते हैं।

Sr. No.	Statement	Strongly Agree दृढ़तापूर्वक सहमत	Agree सहमत	Neutral तटस्थ	Disagree असहमत	Strongly Disagree दृढ़तापूर्वक असहमत
1	I am proud to be working as a member of the community action group मुझे सामुदायिक कार्रवाई समूह (CAG) के सदस्य के रूप में काम करने पर गर्व है					

Sr. No.	Statement	Strongly Agree दृढ़तापूर्वक सहमत	Agree सहमत	Neutral तटस्थ	Disagree असहमत	Strongly Disagree दृढ़तापूर्वक असहमत
2	I feel very little commitment to the community action group मैं सामुदायिक कार्य समूह के प्रति बहुत कम प्रतिबद्धता महसूस करता हूँ					
3	My membership to the CAG really inspires me to do the very best in my work as a CAG member सीएजी में मेरी सदस्यता वास्तव में मुझे CAG सदस्य के रूप में अपने काम में सर्वश्रेष्ठ प्रदर्शन करने के लिए प्रेरित करती है					
4	I am satisfied with the support I receive from other CAG members मैं अन्य CAG सदस्यों से मिले समर्थन से संतुष्ट हूं					
5	I am satisfied with the opportunity to enhance my skills and knowledge through meetings that I attend as a CAG member मैं CAG सदस्य के रूप में जिन बैठकों में भाग लेता हूं, उनके माध्यम से अपने कौशल और ज्ञान को बढ़ाने के अवसर से संतुष्ट हूं					
6	I am satisfied with the community recognition I receive for my work as a CAG member मैं CAG सदस्य के रूप में अपने काम के लिए मिली सामुदायिक मान्यता से संतुष्ट हूं					
7	I am satisfied with the support I receive from CGPP functionaries मैं सीजीपीपी पदाधिकारियों से मिले समर्थन से संतुष्ट हूं					
8	I am proud to be working for my community as a CAG member मुझे सीएजी सदस्य के रूप में अपने समुदाय के लिए काम करने पर गर्व है					

Sr. No.	Statement	Strongly Agree दृढ़तापूर्वक सहमत	Agree सहमत	Neutral तटस्थ	Disagree असहमत	Strongly Disagree दृढ़तापूर्वक असहमत
9	Overall, I am very satisfied with my work as a CAG member कुल मिलाकर, मैं CAG सदस्य के रूप में अपने काम से बहुत संतुष्ट हूं					
10	I am satisfied with the opportunities I have to use my abilities in my work as a CAG member मैं CAG सदस्य के रूप में अपने काम में अपनी क्षमताओं का उपयोग करने के अवसरों से संतुष्ट हूं					
11	I feel that my work as a CAG member is relevant for improving the health of my community मुझे लगता है कि CAG सदस्य के रूप में मेरा काम मेरे समुदाय के स्वास्थ्य में सुधार के लिए प्रासंगिक है					
12	I am satisfied that I accomplish something worthwhile as a member of the CAG मैं संतुष्ट हूं कि CAG के सदस्य के रूप में मैंने कुछ सार्थक हासिल किया है					
13	I think my work as a CAG member will not be valuable these days मुझे लगता है कि CAG सदस्य के रूप में मेरा काम इन दिनों मूल्यवान नहीं रहेगा					
14	I am satisfied by the positive impact of my work during COVID-19 मैं कोविड-19 के दौरान अपने काम के सकारात्मक प्रभाव से संतुष्ट हूं					
15	I can be relied upon as a CAG member CAG सदस्य के रूप में मुझ पर भरोसा किया जा सकता है					
16	I have always completed my tasks efficiently and correctly as a CAG member CAG सदस्य के रूप में मैंने हमेशा अपने कार्यों को कुशलतापूर्वक और सही ढंग से पूरा किया है					

Sr. No.	Statement	Strongly Agree दृढ़तापूर्वक सहमत	Agree सहमत	Neutral तटस्थ	Disagree असहमत	Strongly Disagree दृढ़तापूर्वक असहमत
17	As a CAG member, I have taken initiative to do things without being asked or told during COVID-19 CAG सदस्य के रूप में, मैंने COVID-19 के दौरान बिना पूछे या बताए काम करने की पहल की है					
18	I feel I am the right person to be a member of the CAG मुझे लगता है कि मैं CAG का सदस्य बनने के लिए सही व्यक्ति हूं					
19	I feel emotionally tired after engaging in a day of CAG activities दिनभर CAG की गतिविधियों में शामिल होने के बाद मैं भावनात्मक रूप से थका हुआ महसूस करता हूं					
20	I feel physically tired after engaging in a day of CAG activities दिनभर CAG गतिविधियों में शामिल होने के बाद मैं शारीरिक रूप से थका हुआ महसूस करता हूं					
21	I feel overburdened because of my engagements as a CAG member CAG सदस्य के रूप में अपनी व्यस्तताओं के कारण मैं अत्यधिक बोझ महसूस करता हूं					
22	I don't find time for my personal engagements when I am called upon to engage in CAG activities जब मुझे CAG गतिविधियों में शामिल होने के लिए बुलाया जाता है तो मुझे अपनी व्यक्तिगत व्यस्तताओं के लिए समय नहीं मिल पाता है					
23	My work as a CAG member affects my duties towards my family CAG सदस्य के रूप में मेरा काम मेरे परिवार के प्रति मेरे कर्तव्यों को प्रभावित करता है					