Implementing NRHM
Source book for District Officers
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Chapter 1

National Rural Health Mission: A brief overview

The Goals:

The goal of the National Rural Health Mission “universal access to equitable, affordable and quality health care which is accountable and at the same time responsive to the needs of the people, along with effective inter-sectoral convergent action to address the wider social determinants of health”.

Another simple way of stating this is that people must become more healthy, they must receive the health care services they need, and the cost of getting these services must not lead to financial hardship.

The Twelfth Five Year Plan has laid down a clear set of measurable objectives for NRHM:

1. Reduce MMR to 1/1000 live births (or 100 per 1 lakh)
2. Reduce IMR to 25/1000 live births
3. Reduce TFR to 2.1
4. Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases.
5. Reduce household out-of-pocket expenditure on total health care expenditure.

The National Rural Health Mission recognised that this could only be built around a robust public health systems- and for strengthening public health systems other than increased investment one also need what is called ‘an architectural correction’ of the health systems. The main directions of such sector reform are as follows:

a. Decentralise public health management to the district- and build the institutional capacity of districts and states to manage the available funds efficiently and effectively. The district health plan is the core of such decentralization.

b. Give a much larger role for community participation – for better prevention and promotion, for more community level care and for increased accountability and responsiveness of public health systems.
c. Create standards- the Indian Public Health Standards- to define the norms for quality service delivery and finance and monitor so as to reach these standards.

d. Increase the human resource deployed with innovative strategies to retain them in rural areas and improve their performance.

e. Flexible financing to districts for financing districts programme implementation plans. Untied funds to facilities to meet local expenses needed to provide quality services in a flexible manner.

NRHM was launched in 2005, but its framework was approved in July 2006 and its major roll out started only in 2007 – in parallel with the 11th Five Year Plan.

There are number of evaluations which are now available of the NRHM and each of its components. All of them show considerable strides forward in strengthening health care systems- and an acceleration of child and maternal survival- but they also show that the growth was uneven across states and districts and even within districts. Those states which had good baselines and better human resource availability made much better use of the money available than the high focus states. Though high focus states were far from achieving targets, the rate of change was much better than ever before, and even significantly better than the average national rate of change.

Given this varied rate of growth, NRHM in the 12th Plan, has decided to identify districts which are more challenged and invest more in both financial resources and technical support to enable them to catch up with the rest. This is the context in which this hand-book is being prepared for District Magistrates, and indeed for all members of the district health society. We recognise that internal capacity in some of these districts is weak, and challenges are many and therefore there is a much greater urgency for the district administration to provide a leadership to this effort.
Chapter 2

The District Plan: identifying priorities for action

There are two reasons why district plans are made. One reason is as a request for financial resources from the district to the state. And the other is to use the resources made available by the state and center to achieve the goals of NRHM and health for all. In principle the resources allocated should match the plans made. In practice, what is sanctioned and how much is sanctioned is affected by a wide number of factors.

The best way to manage this is to have at all times a three-year strategic district health plan in place. When the time comes for submitting the next year’s district plan, use the strategic district plan as the basis. Post sanction, re-align the annual goals and activities to the money available- while keeping the option open to explore other sources for more resources where there are gaps.

What do we mean by a district plan?

A district health plan is a document, which records

1. The current health status- and the measurable improvement that is aimed for.
2. What public health services are currently available ( by facility) and what is the planned increase in availability of services in the coming year.
3. Who are most in need of these services and why many are unable to access these services and what we intend to do about it.
4. What is quality of care- in terms of whether it is effective as also with respect to service users safety, comfort, and dignity- and how quality of care would be improved upon.
5. States which part of the disease burden could be prevented through action at the level of public policy, through collective action and through health education that addresses individual behavior and the plans to act at each of these three levels.
6. States the current out of pocket expenditure on health care and what actions are planned to reduce this. (This particular component is not in place in any district).
7. How the organisations proposes to manage all these tasks- and who has the accountability for the various processes and what are the timelines to achieve each of these.

A district plan helps the district health society-
a) To make a rational allocation of human and financial resources between facilities – creating new facilities where required.

b) To monitor progress on both prevention of illness and in expansion of health care services.

c) To identify gaps in service delivery, and mobilize more resources to close these gaps.

A district health plan helps the state health society

1. To make a rational allocation of technical and financial resources between districts

2. To monitor progress of a district and hold the district officers accountable for a failure to deliver assured services.

3. To generate more resources as required to meet the service delivery goals.

Since a plan is based on measurable outcomes- the most important tool for a district plan – is INDICATORS. Indicators are a relationship between one data element that records a particular activity- the numerator- and another data element that places this number on context- the denominator.

Some important indicators one could start with are the following:

a. Infant mortality rate- the number of infants below the age of 1 who died in the previous year, for every 1000 live births. We also have related indicators- neo-natal mortality where the numerator is the number of infants below the age of 28 days, and under-five mortality where the numerator is the number below the age of 5 years.

b. Maternal mortality ratio- the number of women who died due to pregnancy related causes in the previous year, as a proportion of 1 lakh live births.

c. Crude birth rate: The number of live births in the previous year in every 1000 population. This is a good indicator of population stabilization efforts. Though the more reliable and often used figure is total fertility rate, the computation of the latter figure is complicated and a demographers privilege. The numerators for both figures are the same. The aim is a CBR less than 21 per 1000.

d. Crude death rate- the number of deaths in the previous year in every 1000 population.

Problems with health outcome indicators- are that they are difficult to measure at the district level. Often due to problems of reporting and weak civil registration system for recording of births and
deaths, a large number of births and deaths are missed. A good starting point for all district officers is to review the civil registration system and ensure complete reporting of births and deaths. There are also many disease specific indicators of health outcomes which we would detail in the chapter on disease control.

Other than outcome indicators we also look at output indicators which are mainly measures of service delivery. If any output indicator shows that a programme is doing poorly, one must look at process indicators and input indicators to understand why. These too would be explained in subsequent chapters.

It would help if the district plan is printed and is a public document that is readily available at every level.

What to look for?

1. The district health action plan document that was submitted.
2. The district health plan or work plan document as made after sanction of the funds for the year.
3. If both are not available still ask for the preparation of a document that lists the 7 aspects of district health action indicated above, as well as the sanctioned budget for that year and the money released so far.
A. Health Programs
Chapter 3

Maternal and Child Survival

One of the most important goals of the health system is to reduce maternal mortality and child mortality. Pregnancy and child development are natural events - not a disease. However even in the best of situations about 15% of pregnant women will develop complications, many of which would be life threatening. A large number of these complications and deaths can be averted by birth preparedness, timely preventive action such as treatment of anaemia, vaccination, identification and referral of high risk pregnancies, a good quality of care at the time of delivery including access to emergency obstetric services where required. Almost all deaths related to pregnancy and child birth are preventable, and it's a national health priority and social commitment to do so.

Similarly newborns and children have a high vulnerability – for their immune systems are much less developed and they are solely dependent on the care provided by the elders. Younger the child, the higher is his vulnerability. Research suggests that the highest probability of a person dying is on the first day of his/her life. Nearly x% of all infant deaths (deaths in children <1yr of age) occur during the first week and x% during the first month of life (neonatal deaths). Again- almost all neonatal, infant and child deaths are preventable by well-established appropriate simple interventions.

The Medical Causes of Maternal and Child Mortality.

The medical causes of maternal mortality are haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour.

![Figure 1: Causes of maternal deaths in India](image)

About one thirds of deaths of children under five, and two thirds of deaths of children under one occur in the first month of life. (figure)

Deaths in the first month of life are mostly due to infections, birth asphyxia, and prematurity or hypothermia. (figure)

The medical causes of infant and child deaths are acute respiratory infections, diarrhoea, and malaria as well as deaths from vaccine preventable diseases of measles, diphtheria, whooping cough and tetanus.
Relationship of Medical causes with Social determinants:

The major social determinants of maternal and child mortality are – poverty, literacy and education, nutrition, access to clean drinking water, hygiene and sanitation and access to health care. The relationship between the medical cause and the social determinants is not always obvious- but needs to be understood. For example poor women are more likely to be anemic and more likely to have eclampsia. Poverty acts through lower nutrition (both macro and micro\(^1\)), higher susceptibility to water and vector borne infectious disease, lesser educational and awareness levels, greater social exclusion from health care services and so on. Thus though almost any pregnant woman can develop post partum bleeding- it is the anemic woman who is much more likely to die of it, and generally it is the poor woman who would be anemic and having her delivery at a site which is least equipped to manage such a complication. Still nearly 50% women deliver at home in absence of skilled provider and medical equipment. The famous ‘3 delays’ also further contribute maternal mortality; the delay in identification of problem and decision to seek care, the delay in reaching the health facility, and delay in provision of effective medical care at the health facility.

There is little we could do to address social determinants at an individual level, especially determinants such as poverty and illiteracy. However, at the societal level health, hygiene and nutrition promotion, as well as awareness about availability of effective health and referral transport services can improve health seeking behavior and minimize the ‘delays’. It is also important that when user comes into contact with the health system- an affirmative, timely and appropriate action must be taken. Greater attention and focus has to be on those women who are most at risk. This would mean women and children from the poorer and marginalised sections of society.

Public health strategies for ensuring maternal survival are:

Broadly there are four pillars of maternal health:

1. Antenatal Care
2. Skilled Birth Attendance, including provision of Emergency Obstetric Care
3. Post natal Care
4. Access to modern family planning methods and safe abortion care
   1. Good ante-natal care (ANC): This requires early identification and registration of pregnant women by the ANM. Besides facility based services, good outreach visits and close coordination with ASHA and ICDS workers in each of the village falling under the ANM are

\(^1\) Macro nutrients include fats, carbohydrates and proteins while micro nutrients include vitamins, minerals and trace elements
needed. Such care facilitates early detection and treatment of anemia and hypertension in pregnancy – two major contributors of maternal deaths. Besides this, vaccination against Tetanus, birth preparedness, counseling for family planning and breastfeeding, and identification of high risk pregnancies is undertaken during the ANCs.

2. **Provisions for a safe delivery:** When there is a skilled birth attendant available to assist in the delivery, she prevents or effectively manages many complications of the delivery and reduces maternal and neonatal mortality considerably. Any midwife, nurse or doctor who has been formally trained and qualified is a skilled birth attendant\(^2\). Developing countries such as Thailand, Sri Lanka and Malaysia have successfully reduced maternal mortality to acceptable levels through scaling up skilled birth attendance and shifting to births in hospitals (institutional deliveries).

a) Access to emergency obstetric care service- there must be a hospital within one hour travel time of every health facility providing safe delivery services and equipped to manage all complications of delivery. Most causes of death are due to bleeding or prolonged and obstructed labour- which requires C-sections and blood transfusions. Since even a normal pregnancy can suddenly get complicated- there is a need to have universal access to such emergency obstetric care service.

b) There are two levels of emergency obstetric care. In the basic level- all complications except those requiring C-section or blood transfusion can be managed. In the comprehensive level even surgery is available. The latter needs a gynecologist or anesthetist, or at least a medical officer who has been trained through short term course on these skills. A facility where comprehensive emergency obstetric and neonatal care is available is also called a First Referral Unit (FRU) or a Level 3 facility.

c) To enable assured access to skilled birth attendants and at least basic emergency care, in all areas, at all times, the NRHM strategy has been to focus on developing select health facilities as sites of institutional delivery or “delivery points”. In these facilities additional midwives, and supporting staff are provided- and these are better equipped and supervised- so as to ensure quality of care. Even other facilities are allowed to provide institutional delivery if need arises- but the effort is to stream the pregnant women preferably to these facilities. Thus a delivery point would be doing about 30 deliveries per month. This is also referred to as a level 2 facility- while other skilled birth attendant facilities are called level 1 facility.

\(^2\) **WHO Definition:** “an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns”
d) Good referral transport services – to be able to pick up any pregnant woman with a complication and reach her to a center providing surgical services and blood transfusion within the hour. Also an ambulance service that picks up a pregnant woman from her home once labour starts and brings her to the appropriate facility- is an essential component of the system.

3. Access to Modern family planning methods and safe abortion services- As already discussed, pregnancy poses a risk to woman’s life. While majority maternal deaths are at the time of (or immediately following) delivery, as many as one tenth of maternal deaths are due to unsafe abortions. These deaths could easily be averted if women are empowered to prevent the unwanted pregnancies through use of limiting or spacing family planning methods. Similarly access to safe abortion services is pertinent to minimize the incidence of self induced or ‘backstreet abortions’ which could be life threatening. Ideally every facility which is level 2 or 3 should be providing these services- but ensure that at least level 2 facilities provide first trimester abortion services and post abortion care.

e) Post Natal Care (PNC): The first week and the month post delivery is most crucial for mothers and their newborns. Ideally, women delivering normally should be kept in the hospital for atleast 48hrs and C-Section deliveries for one week. Those delivering at homes should be visited by ASHA and ANM at home. Newborns and their mothers should be examined for danger signs. Families should be counselled on identification of danger signs and the need for prompt care seeking if one or more of them are present. Basic care for all newborns should include promoting and supporting early and exclusive breastfeeding, keeping the baby warm, increasing hand washing and providing hygienic umbilical cord and skin care, identifying conditions requiring additional care and counselling on when to take a newborn to a health facility. Newborns with who have preterm birth or low birth weight or who are sick need special care.

**Public health strategies to ensure child survival are:**

Immunisation against specific childhood diseases. This is delivered through the same facility based and outreach sessions where antenatal care is also delivered. Vaccines are administered to all children below the age of one to protect against tuberculosis, Polio, diphtheria, whooping cough, tetanus and measles. Except polio (given orally), all other vaccines are administered
through injections. In most states vaccine against hepatitis B is also part of the package. In some endemic states vaccine against Japanese encaphalitis has also been introduced.

Optimum infant and young child feeding practices are very important for a child’s physical and cognitive development. Early initiation of breast feeding and exclusive breastfeeding for 6 months followed by introduction of complementary food at 6 months while breastfeeding continues for upto 2 yrs.

Access to supplementary nutrition services and preventing and addressing child malnutrition through the anganwadi centers including community based care for the children with severe acute malnutrition. Nutrition Rehabilitation Centers or NRCs have also been established at selected health facilities to provide treatment and therapeutic nutritional rehabilitation for the children suffering from Severe Acute Malnutrition. promoted by health workers and ASHAs.

Community Level Care: Home based care and counselling that improves newborn and child care practices, provides essential newborn care, identifies and refers the sick child early providing such first contact care as specified in appropriate protocols.

Facility Based Care for the Low birth weight baby, the sick newborn and the sick child. There are three levels of this- the Special Newborn Care Unit (SNCU) synonymous with Newborn ICU – to be located at least in each district hospital, the newborn stabilisation unit (NBSU) to be available in all CHCs and the Newborn care corner (NBCC) to be available at every site of delivery. The last is rudimentary- just a clear corner or space, with a newborn table or bed, a radiant warmer, and a ready availability of equipment to manage birth asphyxia.

Good referral transport services.

**Adjunct Strategies:**

Village Health and Nutrition Day.

Mother and Child Tracking Systems


Differential Strategy to reach remote areas.

The Janani Suraksha Yojana.

The Janani Shishu Suraksha Karyakram

The Rashtriya Bal Suraksha Yojana

Maternal and Infant Deaths- Systematic Reviews:
A. Facility Based Care in Pregnancy and Childhood:

The district plan must clearly list all facilities and state what services would be available at what level. It would state how facilities are to be prioritised, developed and networked so that between them they can provide universal access to institutional care needed for a safe delivery, including for the management of complications any time during the pregnancy or post partum period and for care of the normal and the sick newborn. Along with referral and transport links- one must establish a continuum of care from home to facility, to referral site and back again to home.

In such a plan, the focus is on identifying the delivery points. Most sub-centers perform only the outreach functions, but some are needed for providing institutional delivery at a very basic level, since there is no other facility which is accessible. On an average this is about 10% of sub-centers, but in some districts it could be as high as 50% or even more. Such sub-centers must have two ANMs in place- and if the case-loads are high even a third is permissible. The necessary equipment support should be in place.

The plan should also clearly note the areas where skilled birth assistance for home delivery remains a necessity, because the change in health seeking behaviour takes time.

All PHCs and CHCs should be able to provide not only skilled assistance at birth, but some of them should also be prioritised to manage most complications- except those that require surgery. This has also been called the level 2 of care. This requires three nurses so that one is available at any time and two doctors, all of whom are trained and supported to have skills at this level. This requires facility development and human resources development and deployment as discussed in the earlier two chapters. PHCs with less staff, and amenities- but at least having a skilled birth attendant in place, would be part of level 1 care.

The district hospital and a selection of sub-divisional or civil hospitals and CHCs should be upgraded to the level where they are able to manage all complications of childbirth- both for the mother and the newborn. This is also known as the first referral unit level of care or level 3 of care and includes the capacity to do C-sections and give blood transfusions to save maternal lives. This implies the availability of medical officers or specialists with gynaecological surgery and anaesthesia skills- with specialists in that domain or those who have undergone special short term courses for the same. The
importance is to have one such level 3 facility within one hour travel time of any level 1 or level 2 facility.

<table>
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<th>Level of Care</th>
<th>Synonyms</th>
<th>Services provided</th>
<th>Norm</th>
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<td>Comprehensive Emergency Obstetric and Neonatal Care</td>
<td>First Referral Unit</td>
<td>Management of all complications in delivery including those requiring C-sections and blood. Safe abortion services- even for second trimester All family planning procedures at least once a week. A sick newborn care unit.</td>
<td>All DHs and as many CHCs as possible. Aim for at least one FRU per 5 lakh population.</td>
</tr>
<tr>
<td>Level- 3</td>
<td>PHS level CHC or DH</td>
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</tr>
<tr>
<td>Basic Emergency Obstetric and Neonatal care</td>
<td>24*7 PHC</td>
<td>All complications in delivery except those requiring surgery. Safe abortion services- for first trimester. All family planning services. Stabilisation and basic care for sick newborn.</td>
<td>All CHCs and as many PHCs as possible- Aim for at least two or three per block. 1 doctors and 3 nurses at least.</td>
</tr>
<tr>
<td>-Level 2</td>
<td></td>
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<tr>
<td>Skilled Birth attendance and the newborn corner.</td>
<td>Other PHCs- plus sub-centers providing midwifery services where SBA is available, but not a health team</td>
<td>Normal delivery. All spacing methods of family planning.</td>
<td>Where ever there is no level 2 or 3 facility which is not accessible within an hour. One SBA at least should be available.</td>
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<tr>
<td>Level- 1</td>
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Please note standards for quality of care for each of these levels of care have also been specified (detailed in the MCH operational guidelines, and Maternal and Newborn health toolkit).

**Indicators to look for:**

- Institutional Delivery Rate
- Percentage of FRUs (Level 3) facilities – which are performing caesarian sections
- Percentage of 24X7 facilities conducting over 30 institutional deliveries per month.
- Percentage of pregnant women who have three ANCs.
- Caesarian Section Rate (C – section)
- Number of maternal deaths reported as compared to number of deliveries expected (based on birth rates and based on immunized children)
- Rate of abortion
- Percentage of pregnant women with anaemia

The HMIS operational in the states captures data for the key indicators mentioned above.
B. Community Level Care: The importance of community level care is that almost all preventive and promotive health action happens here. Changes in health practices and health behaviours are one of the most cost effective ways to improve health status. Secondly there are a lot of common illness that could be addressed at very little costs at the community level. Attending to such illness also allows the community level care giver to detect dangerous and life threatening illness early and refer them for care in time. For these reasons, it is important to have a functional and effective ASHA programme.

Much of this is discussed in the section on ASHAs and VHSNCs. Here we discuss one key strategy; the village health and nutrition day.

1. The Village Health and Nutrition Day:

Most ANMs cover a population of more than 5000- usually it is about 8000. Also because of high fertility rates, there are far more pregnant women and young children she has to reach.

Most ANMs have to conduct two immunisation sessions per week. Also if the nearest cold chain point is only the block headquarters, she has to travel all the way to get the vaccines from there and then return the leftover vaccine the same day- to prevent spoilage. The immunisation sessions are now expanded into the concept of a village health and nutrition day. This means that the immunisation session has been transformed into a platform for providing all the services to be delivered by her and the anganwadi worker in a convergent manner. Other than antenatal and postnatal services contraceptive services, and counselling for adolescent health etc would also be provided. For children below two, take home rations could also be distributed to their mothers.

The Village health and sanitation committee plays a lead role in making this village health and nutrition day work.

ASHAs play an immense role by informing all the families about VHND so that pregnant women and young children can come on time to get these services. Ensuring that the ASHA is well motivated and supported to reach out to every single house is one of the most important steps. She must understand the importance of reaching out to the most marginalised sections and bring them in for the VHND. For .this she needs to be sensitised and supervised. Paying the ASHA promptly for attending the VHND would also add to her motivation.
The other major innovation is to get the vaccines delivered by a vehicle rented at the block level to the venue of the immunisation session. If the ANM is coming from the block headquarters or has to travel some distance to the venue this vehicle also transports her. This saves the ANM the task of going all the way to the block hospital to get the vaccines and all the way back to return the unused vials.

Despite all this, it is still difficult to get all the children fully immunised because of the low density of ANMs. Wherever there is less than one ANM per 5000 population and there is less than one ILR point per 1lakh population, immunisation coverage would fail to pick up with just demand side measures.

The other major concern about VHNDs is the quality of antenatal and post natal care provided. It is not enough that the pregnant women get registered and are given iron and folic acid tablets and TT injections. It is also important that at every visit their weight is taken, BP is measured, abdomen is examined and blood and urine samples are tested. Such quality of care must be achieved. Indicators in the HMIS would be a reliable source to identify the gaps necessitating direct supportive supervision to close these gaps.

2. **Mother and Child tracking**: Tracking is a term used in two contexts:

   - Ensuring that every pregnant woman and child is contacted for service
   - Once contacted every pregnant woman is followed up till the complete set of services is delivered.

The latter is best done by the ANM in the sub-center with good quality of help from the supervisor. The main tool of doing this is that her register must be properly designed so that she can record the care given to each pregnant woman and child and easily see when the next service is due.

Computerizing this entire information is useful if the computer can generate a feedback to each sub-center every month, reminding the ANM of the services that are due in the coming month. Ensuring such a level of feedback requires focussed efforts. Identifying that services have reached all women and no one is missed is a more difficult goal and the register is not of much help. What helps is to assess the gap between reported pregnancies or children and the expected numbers of children using standard demographic computations. If the gap is high then the likelihood that many women and children are not being reached becomes very high. We therefore identify the blocks where there is a large gap between reported and expected pregnancies, and then identify which facility contributes to a major part of this gap. Field level discussions with communities and mapping of service delivery by hamlets would also be needed to track down these “missing” pregnant women and children.
The mismatch in numbers reported between some of the data elements would also help track the areas where some part of the potential users are being missed out. For example- the number of children coming for immunisation, the number of live births reported and the number of pregnant women identified should be the same- with some adjustments- but often these figures reported from the districts do not match.

3. Referral Transport Systems:

It is essential for a State to have an assured referral transport system that can link the various facilities with each other and the peripheral facilities with the village.
The aim is to have a patient transport system that the time from calling the ambulance by a mobile to the arrival of ambulance, picking up the patient and dropping them at an appropriate facility is never more than two hours- preferably well within one hour’s time.
States have one or more of the following three approaches. The effort should be to integrate these approaches so that the time standards for such services are achieved.
A fleet of vehicles for emergency services through partnership with emergency transport provider which provides vehicles prepared for providing basic and advanced life saving services en route to referred facility. A model of this type would be the EMRI service in Andhra Pradesh.
The second system is the use of the basic facility level government owned ambulances available at the facility level for providing inter facility transfers and drop back home as stipulated under JSSK scheme.
The third option is to have a tie up for each facility and for each village with local transport service – to provide a pool of vehicles such that the provider gives cashless service against a voucher, and is later reimbursed on presentation of that voucher. This is something that the RKS funds and the VHSC funds can be used for.
Another option is to have a call centre run by the department through a suitable agency which is linked to a number of private providers who provide the services. The providers could be commercial vehicle operators or NGOs.

In terms of priority- every state could start immediately with assured patient transport systems linked to facility based emergency care- firstly for pregnancy and children below one, then expanding to a larger category of emergencies through an emergency response system and finally include patient transport for certain other categories of vulnerability as well. Local tie-ups can start
up immediately in tribal and dispersed population areas as a supplement and may again be needed when an expanded role of patient transport for vulnerability is considered.

4. Differential strategies for inaccessible/remote hilly and tribal areas

States should clearly map out remote and inaccessible areas located within the tribal areas and pockets, and closely monitor progress (physical, financial) on all health activities in these areas. Most states have categorized difficult areas in the district including the facilities located in these areas and use this as a basis to incentivize health service providers and ensure their availability in these areas.

Under NRHM, there is a provision to formulate specific plans and allocate additional resources to tribal areas of the country, which includes relaxed norms for development of health infrastructure, medical mobile unit services, and performance-based incentives to doctors and staff posted in such selected and notified tribal areas.

**Birth waiting homes:** In remote and tribal areas, with poor road connectivity and access to health facilities, pregnant women often have to be carried by palkis/carts/cots to the nearest road head. To improve access to health facilities, 'birth waiting homes' can be constructed in such areas within the compound of the health facility or in close proximity. Pregnant women can come and stay in these homes well before their expected date of delivery (EDD) and transferred to the facility once they go into labour. The pregnant woman may be provided all support and incentivized to move into these facilities at least a week before the EDD. Special and innovative transportation: In remote and inaccessible areas where there is no motorable road, special schemes and incentives need to be instituted for bringing pregnant women and sick neonates (by palkis, carts, etc) to the nearest road head that serves as a pickup point for referral transport.

**Suitable incentives to ANMs (SBAs):** ANMs trained in SBA can be incentivized for attending home deliveries in pre-identified and notified villages in remote and inaccessible areas where it is difficult to bring a woman to the institution for delivery on account of geographical/climatic exigencies. Local tie-ups with private transport providers in the Janani Express model would help close gaps and ensure pregnant women can reach facilities in time. One could also use this to reach ANMs to homes where this is required. In some of these areas training local dais would still have relevance.
**Mobile Medical Units:** In tribal and remote areas, where availability of health infrastructure is not available on regular basis, MMUs are to provide a range of RCH services and also act as a referral link from the outreach services. Basic diagnostic services for basic laboratory tests are available in the MMUs which are led by a team of Medical officers, Nurse, laboratory technician and pharmacists. The number of MMUs could range from one per district to a maximum of 5 per district, based on the size of the district.

5. **Janani Suraksha Yojana:**

Janani Suraksha Yojana (JSY) is a central scheme that provides cash to pregnant woman, many of whom are from poor and marginalised families, to encourage and empower her to be able to give to birth to her child in the comfort and safe environment of an institution. There are costs involved in transport, diet and medical care that poor families have to meet in order to deliver at a health facility. The JSY provides for these costs in the form of cash transfer to such families. The scheme also provides incentives for ASHA to promote institutional delivery and guide and support the pregnant women to seek appropriate care. The scheme has provision for contracting in specialist services in the facilities @Rs 1500 per case.

The JSY also provides a smaller sum as support for those poor women who opt for home delivery for reasons ranging from lack of access or confidence in institutional delivery services to their own cultural beliefs.

<table>
<thead>
<tr>
<th>Place of Delivery</th>
<th>Rural</th>
<th>Urban</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Package for mothers</td>
<td>ASHA Package</td>
</tr>
<tr>
<td>Low performing states</td>
<td>1400</td>
<td>600</td>
</tr>
<tr>
<td>High performing states</td>
<td>700</td>
<td>200</td>
</tr>
<tr>
<td>Home Deliveries</td>
<td>500</td>
<td>NIL</td>
</tr>
</tbody>
</table>

Table: JSY benefit package at a glance

*For the detailed information regarding JSY Financial Package, refer to page 40 – 41 of the Operational Guidelines on Maternal and Newborn Health; 2010.*
6. Janani Shishu Suraksha Karyakram:

Janani Shishu Suraksha Karyakram (JSSK) was launched on 1st June 2011 to assure free services to all pregnant women and sick neonates accessing public health institutions. This initiative supplements the cash assistance given to pregnant women under JSY and is aimed at mitigating the burden of out-of-pocket expenses incurred by pregnant women and sick newborns including cost of caesarean sections. Recently (Jan 2013), the scheme has been expanded to include all infants (aged <1yr)

The entitlements include free drugs and consumables, diagnostics, blood and diet for the entire duration of the pregnant woman’s stay in the facility expected to be three days in case of normal delivery and seven days in case of a caesarean section.

Similar entitlements have been put in place for all the sick newborns accessing public health institutions for healthcare till the age of one year. They would also be entitled to free treatment besides free transport, both ways (to and from home) and between facilities.

The scheme also mandates setting up of a grievance redressal system for addressing patient complaints with regard to the free entitlement.

**Actions at District Level**

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Nominate a District Nodal Officer</td>
</tr>
<tr>
<td>2.</td>
<td>Circulate the G.O on free entitlements widely in the public domain</td>
</tr>
<tr>
<td>3.</td>
<td>Institute a grievance redressal mechanism for ensuring that commitments are fulfilled in letter and spirit.</td>
</tr>
<tr>
<td>4.</td>
<td>Regular review the stocks of drugs &amp; consumables for ensuring availability at the public health institutions.</td>
</tr>
<tr>
<td>5.</td>
<td>Ensure laboratory facilities and diagnostic services are functional at all designated facilities, particularly at DH, SDH, FRU, CHC and 24X7 PHCs.</td>
</tr>
<tr>
<td>6.</td>
<td>Prepare time-bound action plans for establishing and operationalizing Blood Bank at district level and Blood Storage Centres at identified FRUs.</td>
</tr>
<tr>
<td>7.</td>
<td>Review referral linkages and their utilization by beneficiaries.</td>
</tr>
<tr>
<td>8.</td>
<td>Provide required finances/ empowerments for utilization of funds to the Block MOs and facility in-charges for the above activities, particularly in emergency situations / stock – outs.</td>
</tr>
<tr>
<td>10.</td>
<td>Review the implementation status during Block MOs/ MOs meetings.</td>
</tr>
</tbody>
</table>

**Guidelines for Janani – Shishu Suraksha Karyakram (JSSK); 2011; page 9**

**Dissemination of entitlements in the public domain**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Widely publicize these entitlements through print and electronic media.</td>
</tr>
<tr>
<td>2.</td>
<td>Display them prominently on adequate size hoardings &amp; boards, which is clearly visible from a distance in all Government health facilities e.g SCs, PHCs, CHCs, SDHs and DHs/ FRUs (main...</td>
</tr>
</tbody>
</table>
entrance, labour room, female and neonatal wards and outside outpatient areas). Refer Annexure 1 of guideline.

3. IEC budget sanctioned in the Project Implementation Plan (PIP) under RCH / NRHM can be utilized for this.

Guidelines for Janani – Shishu Suraksha Karyakram (JSSK); 2011; page 9

For detailed information on JSSK initiative refer to NRHM Guidelines for Janani – Shishu Suraksha Karyakram (JSSK); Materna l Health Division; Ministry of Health & Family Welfare; Government of India; Nirman Bhawan, New Delhi

7. Rashtriya Bal Swasthya Karyakram:
The Rashtriya Bal Swasthya Karyakram (RBSK) is a new initiative that has been launched in Feb 2013. It is aimed at Screening, early detection and provision of Early Intervention Services to over 27 crore children between the age of 0 to 18 years. The RBSK would focus on identification of 4 Ds - Defects at birth, Diseases, Deficiencies and Development Delays including Disabilities. Children diagnosed with illnesses shall receive follow up including surgeries at tertiary level, free of cost under NRHM. The ‘Child Health Screening and Early Intervention Services’ will also translate into economic benefits in the long run. Timely intervention would not only prevent the condition from deteriorating but would also reduce the out-of-pocket (OOP) expenditure of the poor and the marginalised population in the country.

Roll-Out Steps for Child Health Screening and Early Intervention Services

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Identification of State Nodal Persons for the Child Health Screening and Early Intervention Services.</td>
</tr>
<tr>
<td>2.</td>
<td>Dissemination of ‘Operational Guidelines’ to all Districts.</td>
</tr>
<tr>
<td>3.</td>
<td>Estimation of the State/ District magnitude of various diseases, defects, deficiencies, disabilities as per available national estimates.</td>
</tr>
<tr>
<td>4.</td>
<td>State level orientation meeting.</td>
</tr>
<tr>
<td>5.</td>
<td>Recruitment of District Nodal Persons.</td>
</tr>
<tr>
<td>6.</td>
<td>Estimation of the total requirement of dedicated Mobile Health Teams &amp; recruitment of the Mobile Health Teams.</td>
</tr>
<tr>
<td>7.</td>
<td>Mapping of facilities/institutions (public and private for treatment of specific health conditions).</td>
</tr>
<tr>
<td>8.</td>
<td>Establishment of DEIC at the District Hospital.</td>
</tr>
<tr>
<td>9.</td>
<td>Procurement of equipment for the Block Mobile Team and District Hospital (as per the list provided in the ‘Operational Guidelines’).</td>
</tr>
<tr>
<td>10.</td>
<td>Translation of tools, training packages, printing of formats, training material.</td>
</tr>
<tr>
<td>11.</td>
<td>Training of Master Trainers.</td>
</tr>
</tbody>
</table>
12. Block micro-plan for school and community visits monthly outreach plan based on the mapping of educational institutions and Anganwadis and enrolment in them.

13. The schedule of visits of the Block Mobile Teams should be communicated to the school, Anganwadi Centers, ASHAs, relevant authorities, students, parents and Local Government well in advance so that required preparations can be made.

14. Anganwadi Centers and school authorities should arrange for prior communication with parents and motivate them to participate in the process.

Operational Guidelines - Rashtriya Bal Swasthya Karyakram (RBSK) Child Health Screening and Early Intervention Services under NRHM; page 17

For detailed information on RBSK initiative refer to Operational Guidelines - Rashtriya Bal Swasthya Karyakram (RBSK) Child Health Screening and Early Intervention Services under NRHM; Ministry of Health & Family Welfare; Government of India; FEBRUARY, 2013.

What to look for? How to act?

Monitoring and evaluation of programmes is pertinent for mid course corrective actions and for policy matters, where required. Following indicators can help the programme managers to keep track of the MCH programmes.

Please bear in mind, in order to draw valid inferences and take appropriate actions, the data must be timely, accurate and complete. Adequate mechanisms must be in place to check the validity and reliability of data.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Interpretation &amp; Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Health- Ante-natal Care</td>
<td></td>
</tr>
<tr>
<td>Percentage of Pregnant Women received three ANC Care</td>
<td>This is one of the most reliable indicators in HMIS. If first ANC is high, the low coverage could be due to poor quality of follow up of ANC. The mother and child tracking system is meant to overcome this. It could also be due to lack of mobilization at community level. Where even first ANC is low then it could be areas which have no access, or that many women are going to un-accredited private sector units.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Percentage of Pregnant Women Moderately anemic (Hb 11gm %)</td>
<td>We know that mild or moderate anemia in pregnant women is almost universal. Look for facilities which report 0 or very low figures. This may be low due to lack of Hb testing services at the facility level. The importance is that without testing we do not detect severe anemia in time. <strong>Actions</strong>- Identify facilities which are not conducting Hb testing and ensure Hb estimation kit is available in the facilities and ANMs are trained to conduct Hb test.</td>
</tr>
<tr>
<td>Percentage of Pregnant Women with Hypertension.</td>
<td>We expect all facilities to report that about 5% of pregnant women in antenatal care have this complication. But if no cases are being reported – there is a problem with quality of antenatal care. Blood Pressure measurement of pregnant women may not be done due to either lack of non-functional BP instruments or lack of skill of ANMs to measure blood pressure. <strong>Action</strong>- Identify which facilities are not measuring blood pressure. Ensure availability of BP instrument in all facilities. Replace old/non-functional equipments. Give periodic trainings to the ANMs for BP measurement.</td>
</tr>
<tr>
<td>Institutional Delivery Rate- against estimated number of pregnancies</td>
<td>This indicator should be estimated using two denominators-estimated deliveries and reported deliveries. The former will help identify <em>Unreported Deliveries</em> – which is an indicator of lack of access to these services. These unreported deliveries can correlate with high and usually unreported home deliveries and even maternal deaths. Sometimes unreported deliveries are because the mothers have gone to non-accredited private sector units. This can be made out by discussions on the local context. This too is cause for concern as they would not get JSSK benefits. <strong>Action</strong>- On supply side SBA trained staff with adequate medicine and equipment should be placed in all facilities, especially in the facilities of blocks which are reporting low institutional deliveries. Use of emergency transport system in the area by pregnant women would be a good indicator to assess access and reach to health facilities. Ensure IEC about JSSK entitlements, Display of emergency transport service number etc.</td>
</tr>
<tr>
<td>Obstetric Complications Management Rate</td>
<td>Low rate could be due to the lack of reporting data from the labour room registers into HMIS. It could also be low due to lack of trained staff in the facilities to manage complications. <strong>Action</strong>- Identify availability of gynecologist or EmOC trained doctors in Level III &amp; Level II facilities. Identify how many of them are actually managing emergency complications and how many are only conducting elective C-Sections.</td>
</tr>
<tr>
<td>Percentage of pregnancies terminated in abortion.</td>
<td>As many as 10% of pregnancies end up as either spontaneous or induced abortions (the latter is also called MTP medical termination of pregnancy). The first concern is to note which delivery points (level 2 or 3) are not reporting any MTPs. Most often it would mean that the services are not been provided there - and this is a cause of concern. <strong>Action</strong> - Availability of safe abortion services in the facilities needs to be identified. Where Medical Officers are not trained they need to be trained for provision of safe abortion services.</td>
</tr>
<tr>
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</tr>
<tr>
<td>Percentage of pregnancies who got all JSSK benefits.</td>
<td>This is not available on HMIS. This is best seen from exit interviews of women from delivery points. Or on a visit - just ask women who have delivered - how much they had to pay for what. Ideally they should not have had to pay anything at all. The diet should have been organised by the hospital. All drugs and diagnostics are to have been free - and no prescription that patient had to go out and buy should have been there. Even blood transfusions and surgery are free. Coming to the hospital should also not have costed - if it is through a local travel tie-up or using 108 or 102 services. Important to check whether the entitlements are publicised adequately both in the facility and in the general public through mass media. One important role for the district administration is to supervise and guide flow of JSSK funds - so that the facilities get it in proportion to their usage.</td>
</tr>
<tr>
<td>Percentage of pregnancies who got JSY benefits. (home and institutional)</td>
<td>Both of these needs to be supervised - both for home deliveries and for institutional deliveries. Timely and hassle-free payment is also essential both for mother and for ASHA. Generally if there is a large backlog of payments – it is more difficult to prevent irregularities in payment. Insisting on prompt payment is one of the best ways of preventing irregularity - but that requires proper flow of funds.</td>
</tr>
<tr>
<td>Time between delivery and receipt of JSY benefits.</td>
<td>Percentage of ASHAs who got JSY benefits</td>
</tr>
</tbody>
</table>
Mortality Reporting and Maternal and Infant Death Reviews

Maternal Deaths with causes

Still birth rate

Maternal & Infant deaths with causes will help to identify issues with access and the health systems ability to manage complications. The number of apprehended deaths can be estimated from the most recent maternal and infant mortality rates available- and where the number of deaths reported- are much less- these events should be enquired for. Though no disciplinary action is desirable for deaths- failing to report should be actionable. Low reporting should be overcome by motivating service providers and other community members to report more cases. Every single maternal death is a tragic event- and there is a clear protocol laid down for a maternal death review to identify both medical and systemic gaps. The district leadership should examine these reviews- if possible conduct a few- with assistance from a technical team- to identify gaps. Still births are also tragedies for the family. Categorise into still births before labour pains began- which has a set of causes- and those after labour pains have begun- which has another set of causes. Each type of still birth – but especially the latter- indicates the need for immediate action in quality and timeliness of care. Often early newborn deaths due to birth asphyxia are confused with still births- another reason for action.

Child Health

Reported live births against estimate births

High percentage could be due to the double counting of cases by ANMs as well as by the facilities. Low percentage could be due to non-reporting from the private sector hospitals. Compare with children immunised, especially for BCG and DPT1- where almost all children are picked up. Compare also with the data of registrar of births. 

**Actions**- Ensure reporting from all private hospitals and other public sector hospitals (corporation, township hospitals).

% newborns breastfed < 1 hour

**Action**- Ensure every pregnant woman is counseled during ANC visits for initiation of breast-feeding within one hour of birth. But most important, this is also the responsibility of the skilled birth attendant if the delivery happens at the institution and the ASHA if it happens at home.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNCU admission rate</td>
<td>This indicator should be calculated with Intra-mural and extramural disaggregation. Low Extramural indicates poor referral of sick neonates from lower facilities and from the ASHA and other front-line workers. It could also be poor availability of transport.</td>
</tr>
<tr>
<td>Low Birth Weight Rate</td>
<td>Low birth weight (&lt;2.5kg) would indicate poor health &amp; nutritional status of mother. If reporting of LBW is less than 20%, there is concern that weighing at birth and its subsequent reporting is not of sufficient quality. Check the equipment, and the alertness of the providers. The actions to prevent LBW are more complex- and need action at many levels. What is important is that children less than 1.6 kg would require care at the SNCU.</td>
</tr>
<tr>
<td>Percentage of Children received BCG dose under 1 year</td>
<td>If over 100%- this indicator can be high due to double counting of vaccines by ANM and by facilities. If Low coverage it would indicate vaccine unavailability, or difficulty in access to services.</td>
</tr>
<tr>
<td>BCG To Measles Drop-out rate</td>
<td>Child tracking is meant to keep this figure low. High drop-out could indicate poor outreach services and migratory population. Drop-out from BCG to DPT3 may be due to short supply of vaccine and insensitive behaviour of service providers. Action- VHNDs needs to be planned in the areas not covered in the current plan. Tracking of children needs to be strengthened to ensure complete immunisation.</td>
</tr>
<tr>
<td>Percentage of Children under 1 year received full immunisation</td>
<td>Low coverage would mean short supply of vaccine, poor planning of VHNDs – or just a failure to have a separate column in recording register for recording the achievement of the full immunization status.</td>
</tr>
</tbody>
</table>
Infant Mortality rate  
Under 5 child mortality rate.

Every infant death should be reported and reviewed.

Causes of newborn deaths –related both to care in pregnancy and to care for the newborn.

After the newborn period the most common causes are diarrhoea, ARIs and fevers like malaria and vaccine preventable diseases. Under 5 deaths call for community action on early detection and appropriate care including referral for diarrhoea, respiratory infection and fevers. Every secondary care facility should be showing admissions for pneumonia and diarrhoea with dehydration and fevers (usually malaria- but also meningitis etc) in children. If the public sector hospital has no such admissions need to dialogue both with the facilities and front line workers as to where the gaps are.

Indicator based reviews- is one approach. There is also a role for visits to facilities and attending meetings of VHSNCs, ASHAs or NGOs who are involved in the health sector, to get a feed-back on the functioning of facilities and the problems in access to services.

Periodic internal and external evaluations of programmes are also useful in gauging the progress of programmes against the objectives and identifying the bottlenecks.
Chapter 4

Achieving Population Stabilization

Why does population increase?

High rates of growth of population correlate with higher rates of poverty, high Infant mortality rates and gender inequity (with multiple reasons and consequences) acting through son preference, lower age at marriage for women and lack of decision making power of women with regard to contraception.

Repeated surveys have shown that when women are asked how many children they desire to have most report only two or three. The challenge is now not in promoting the small family norm but in enabling it.

Care also needs to be taken- that when families opt for a small family in a context where son preference still predominates, they do not discriminate against the girl child- before or after birth. The consequences of a declining sex ratio can be disastrous for any society. Societies with highly skewed sex ratios are known to be associated with high degrees of violence and insecurity and mental and social ill-health. Therefore in any population stabilisation programme, family planning should be positioned as one component of a programme of womens empowerment.

The major components of the district population stabilization plan would be:

1. Strategies for retaining girls in school (Universal Elementary Education and beyond ) i.e Increasing educational levels in women:
2. Strategies to delay age of marriage:
3. Strategies to address son preference and prevent sex selective abortions.
4. Improving child survival an care in Pregnancy.
5. An effective adolescent health care programme
6. Improving access to treatments for RTI/STI
7. Improving access to safe abortion services
8. Promoting behaviour change including a greater sense of male responsibility and participation.

______________________________
9. Planning for Efficient Provision of Contraceptive Services- which is largely equated with family planning services.

**Family Planning as a means to achieve population stabilization**

Having the number of children a couple want, when they want them, is called family planning. Many of the pregnancy related deaths occur because the pregnancies are either too early (less than 18), too late (more than 35), too close (gap between births less than 2 years) or too many (more number of children). Contraceptives provide a safe and effective way to regulate fertility and preserve health. When used properly and consistently, contraceptives can provide substantial protection against pregnancy. The methods can be permanent, or temporary.

The choice of method of contraception varies according to the context and circumstances. If the issue is delaying the first pregnancy, the first choice will be condoms and the second choice is pills. If spacing is the issue, then condoms, IUD and pills (in that order) can be considered.

Where the family is complete- most families opt for permanent methods. Among permanent methods though vasectomy or male sterilisation is safer and easier, to tubectomy gets preferred-and one of our goals remains to increase the levels of male sterilisation.

In the states with persistent high fertility states, access to even permanent methods remains a problem. The total demand for sterilization has improved, but there are problems of

   a) availability of surgeons or gynecologists trained in laproscopic surgery.
   b) Availability of laparoscopes (and in working condition)
   c) Availability of medical officers trained in mini laparotomy- conventional tubectomy.
   d) Legal issues arising out of deaths and failure of sterilisation.

While families await permanent methods of contraception they could have used condoms or pills or even IUD and this is becoming now the main context of usage of temporary methods. Temporary methods are the only methods for delaying the first child and for spacing. There are many problems we face with the promotion of temporary methods of contraception. We list some of these below:

   a. We need considerable counselling support for effective choice and use of temporary methods. Such counselling services remain a weak area.
b. Access to condoms and pills in rural areas – and even for the urban poor is a problem. There are problems of logistics and this is considerable embarrassment and hesitation for users in local communities to see these supplies openly.

c. A major effort has been made to promote access through social marketing of these by ASHAs as well as through other sources. But for this too logistics has to be very well maintained.

d. Access to IUCD services are limited due to both problems in skilled service providers and a low priority given to these services.

Thus due issues in access and use of both permanent and temporary methods – fertility rates continue to remain high. The states with high fertility- also have the highest unmet needs. Though there is some work still needed on generating demand for these services, the major focus of this relates to son preference- limiting family size even if there are only two daughters- a task that should be taken on with much care.

Planning for Family Planning: Community needs assessment

Community needs assessment is central to the departments’ effort to have an understanding of the people’s need. This can be a starting point for the districts’ population stabilization plan. This data generated sub center wise is then aggregated by block and then district. The basic question is what would be the fertility reduction approaches when contraceptive use by community needs assessment fall short of demographic requirements to stabilize population. The approach would be to focus on all the factors in addition to issues on access to contraception.

For contraception one needs to fulfil the following outputs:

a) Number of social marketing outlets- includes every ASHA as an outlet- and the approximate total volume of temporary contraception through this channel.

b) The total number of sites where IUCDs would be available as an assured services- and the number of persons who would need to be trained for this. The percentage of this which would be post- partum IUCD.

c) The number of sites for fixed day services of sterilisation – and for these the number of providers, the type of sterilisation surgery chosen (laproscopic, mini-lap, conventional) and the total case load they would be able to manage.

d) The number of providers of male sterilisation services- and a strategy to promote it.
e) Training of ASHAs, and other front line workers to provide counselling on family planning to all adolescents, all newlyweds, and in the post-partum period- with monitoring to ensure the same.

**Planning For Adolescent Health:**

Adolescents, aged between 10-19 years, account for 18 per cent of the world’s population and India has the world’s largest number of adolescents than any other country. A new generation of children who have survived the main killers of childhood face a different set of dangers as they enter adolescence. Risks to adolescent health stem from many causes such as accidents, HIV/AIDS, early pregnancy, unsafe abortions, anaemia among adolescent girls, risky behaviours like tobacco consumption and drug use, mental health issues and violence.

Additionally there are issues of early marriage and bearing children before the adolescent girls are ready, in turn cutting short their opportunities for education. The use of contraceptives is low among adolescents who are married or in union. In developing countries, only 22 per cent of adolescent girls (aged 15 to 19) who are married or in union use contraceptives. Nearly 24 per cent of the married adolescents show a high unmet need for contraceptives. The rate of contraceptive use is lowest in South Asia where the prevalence of child marriage as well as the number of girls out of school are the highest.

In the Indian context, although progress has been made and the percentage of women aged 20 to 24 who married before age 15 is 18 per cent, those who married before age 18 is still high at 47 per cent. Also, there are wide variances within the country with regards to the prevalence of child marriage. For e.g. states like Goa, Kerala have prevalence rates of 15 % or lesser, U.P and Bihar at the other extreme record 53 % and 60% prevalence.

Investments in girls through their adolescence period reduces the population momentum by delaying the age of marriage and childbearing, thereby increasing the space between generations; lowering the desired family size as well as decreasing the age and power differential between partners, thus positively affecting women’s ability to meet their fertility goals. The focus needs to be on:

- Helping girls stay in school through adolescence
- End child marriage and support married girls
- Focus on youngest first-time mothers
Public Health Strategies for providing Adolescent Friendly Health Services

1. Adolescent Reproductive and Sexual Health (ARSH) programme
   - WIFS - to address the high prevalence of anemia in adolescents, MoHFW launched the Weekly Iron and Folic Acid Supplementation (WIFS) programme for school going adolescent girls and boys and for out of school adolescent girls. The programme envisages administration of supervised weekly iron folic acid tablets and biannual deworming tablets to approximately 13 crore rural and urban adolescents through govt. and govt. aided schools as well as AWCs.

2. Menstrual Hygiene – to improve the menstrual hygiene among adolescent girls

3. School Health Programme and the Rashtriya Bal Swasthya Karyakram (RBSK)

There is a service delivery strategy through the existing public health system at the DH, CHC & PHC levels. Services are provided through stand alone as well as integrated clinics. In addition, there are fixed-day and weekly clinics with linkages established with the ICTCs and STI clinics to increase the demand of services. Outreach sessions are held with the VHNDs which is used as a platform to provide health services and education to the adolescents. The core package of services at an adolescent clinic includes:

- ARSH – Information, counseling and services related to sexual concerns, pregnancy, contraception, abortion, menstrual problems etc
- Nutrition counseling, prevention and management of anemia
- RTI/STI management
- Referral services for VCTC and PPTCT
- Outreach services – through School health and community camps
- Health check-ups, health education and awareness generation

The following table illustrates the different levels of care and the corresponding services provided at these:

<table>
<thead>
<tr>
<th>Level of care</th>
<th>Service provider</th>
<th>Target group</th>
<th>Flow of service delivery activities</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Centre</td>
<td>HW (F)</td>
<td>Unmarried F</td>
<td>During routine sub</td>
<td>Enrolment of newly married</td>
</tr>
<tr>
<td>Primary Health Centre/Community Health Centre/ District Hospital</td>
<td>Unmarried M Married F Married M</td>
<td>centre clinics</td>
<td>couples</td>
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<td>● Provision of spacing methods</td>
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<td>● Routine ANC care and institutional delivery</td>
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<td>● Referrals for early and safe abortion</td>
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<td>● RTI/STIs and HIV/AIDS preventive education</td>
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<td>● Nutrition Counseling including anemia prevention and menstrual hygiene</td>
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<td>● Immunization for pregnant adolescent mothers</td>
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<thead>
<tr>
<th>● Health assistant (F)/LHV ● Medical Officer</th>
<th>Unmarried male and female</th>
<th>Once a week: Teen clinic will be organised at PHC for 2 hrs</th>
<th>● Contraceptives, condom programming</th>
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</thead>
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<td></td>
<td>● Management of menstrual disorders, menstrual hygiene guidance</td>
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<td></td>
<td>● RTI/STI and HIV/AIDS preventive education and management</td>
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<td>● Counseling and services for pregnancy termination</td>
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<td>● Nutritional counseling</td>
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<td></td>
<td>● Counseling for sexual problems</td>
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<td></td>
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<td>● Immunization for pregnant adolescent mothers</td>
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</tbody>
</table>

**Source:** Implementation Guide on RCH II Adolescent Reproductive Sexual Health Strategy for State and District Programme Managers.

**Monitoring indicators:**

- Proportion of total population that are 10-19 years old
- No. of Adolescent Friendly Health Clinics (AFHCs) established
- No. of AFHCs functional
- No. of service providers (MOs/ANMs/LHVs/Counselors) trained in providing Adolescent Friendly Health Services
- Total number of clients who attended the facility – Boys and Girls
- Total no. of teenage pregnant mothers attending ANCs
- No. of new pregnancies below 20 years registered during a month
- No. of teenage PW delivering in the institutions
- No. of adolescent boys and girls that accessed contraceptives services by method (condoms/OCP/ECP/IUD)
- No. of adolescent boys and girls that availed RTI/STI treatment
Definitions

Crude Birth Rate: Number of Birth in an area in an year/ Midyear population of that area in that year X 1000

Eligible Couple: refers to a currently married couple wherein the wife is in the reproductive age, which is generally assumed to lie in between the ages of 15-45. There will be at least 150-180 such couple per 1000 population in India

Contraceptive prevalence rate (percentage): the percentage of women between 15-49 years who are practicing, or whose sexual partners are practicing, any form of contraception.

Couple Protection Rate (CPR): It is an indicator of the prevalence of contraceptive practice in the community. It is defined as the percent of eligible couples effectively protected against childbirth by one or the other approved method of family planning, viz. sterilization, IUD, Condom or oral pills.

Total fertility rate (TFR): the average number of children that would be born to a woman over her lifetime if she were to experience the exact current age-specific fertility rates (ASFRs) through her lifetime.

What to look for? What to act on?

<table>
<thead>
<tr>
<th>Family Planning</th>
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<tbody>
<tr>
<td><strong>Contraceptive prevalence rate</strong></td>
</tr>
<tr>
<td>OCP coverage rate</td>
</tr>
<tr>
<td>IUD coverage rate</td>
</tr>
<tr>
<td>Condom Coverage rate</td>
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<tr>
<td>Male Sterilisation Rate</td>
</tr>
</tbody>
</table>

- No. of adolescents referred to CHC, DH, tertiary facilities
- Percentage of adolescent girls who are anemic
Officer is in place to ensure service delivery. On demand side more IEC and counselling activities needs to be conducted at the community level through ASHAs during VHNDs.

| Female Sterilisation rate | **Action**: Address supply side hurdles- ensure trained doctor to conduct sterilisations and also ensure functional equipments availability in these facilities. The aim is to have a number of facilities which would provide assured services at least one fixed day per week. And that this is well publicised. Failing the above, at least the services should become available on a fixed day per month. A large number of women are unable to access services because the sterilisation camps occur only on two or three days of the year, and information of this is not known in advance, and if known-there are too many names listed for quality of care. There is a stipulation that only 20 cases should be performed in one day in one site- which really means a much larger number of assured days when these services are available. |

References:

2. Marrying too young, UNFPA, 2012
3. National Family Health Survey (NFHS) II and III
5. Implementation Guide on RCH II Adolescent Reproductive Sexual Health Strategy for State and District Programme Managers, MoHFW, May 2006s
Chapter 5

Disease Control Programmes

NRHM has envisaged an umbrella approach towards disease control programme by integrating all vertical programmes. Some of them are discussed below;

1. Integrated Disease Surveillance Project (IDSP)
2. Revised National Tuberculosis Control Programme (RNTCP),
3. National Vector Borne Disease Control Programme (NVBDCP),
4. National Leprosy Control Programme (NLEP)
5. National Programme for Control of Blindness (NPCB),

1. Integrated Disease Surveillance Project:

1.1 Introduction

Integrated Disease Surveillance Project (IDSP), a decentralized disease surveillance project in India was initiated by the Government of India in November 2004.. It is intended to generate and detect early warning signals of impending outbreaks and help initiate an effective response in a timely manner. Under the project, Surveillance Units under the project have been set up at Central, State and District level with the district being the hub of all information. Linkages have been established with Government Medical Colleges on a Satellite Broadband Hybrid Network for enhanced speedy data transfer and video conferencing facilities.

Objectives of IDSP

a. Establish a decentralized system of disease surveillance for timely and effective public health action.
b. Improve the efficiency of disease surveillance for use in health planning, management and evaluating control strategies

1.2 Disease Surveillance

What is an outbreak?

An outbreak is described as occurrence of cases in excess compared to the average or probable expected number of cases for the given time/period of the year. This is usually observed in endemic
areas or cases restricted to one focal point. In some cases a one or two cases of could also alert an epidemic outbreak, for eg: cases of Measles, JE and Dengue.

**What is Surveillance?**

Surveillance in its simplest form is collection of information on diseases for action. Disease surveillance is the ongoing systematic collection and analysis of data, converting into and the provision of information which leads to action being taken to prevent and control a disease. As the name suggests, surveillance means keeping a close watch on health events occurring in the community. By preventing outbreaks, the credibility of the health services is greatly improved. Hence it is important to have a good public health surveillance system, which is able to pick up any unusual events early enough and alert decision makers enabling them to act swiftly and effectively.

**The six main steps in surveillance are:**

1. Detection and reporting of health event
2. Collection of data
3. Investigation and confirmation
4. Analysis and interpretation of data
5. Response – a link to public health program specially actions for prevention and control
6. Feed back and dissemination of results.

**1.3 Information flow under IDSP**

Under IDSP disease surveillance data is collected on a weekly (Monday–Sunday) basis and immediate (SOS) on imminent outbreaks. The weekly data gives the time trends and silent outbreaks. The IDSP has a web portal through which information can be directly uploaded at district and is accessible at [www.idsp.nic.in](http://www.idsp.nic.in).

**Reporting formats under IDSP**

The information is collected on three specified reporting formats, namely “S” (suspected cases) reported by peripheral health workers- ANMs or MPWs “P” (presumptive cases) reported by clinicians and “L” (Laboratory confirmed cases) reported from Clinical Laboratory staff. Emphasis is being laid on reporting of surveillance data from major hospitals both in public and private sector and also Infectious Disease hospitals. Paramedical staff and pharmacists can be crucial links in collating the P form data from hospitals.
**Generating surveillance data for action**

The compilation and disease outbreak alerts has been started in 2008. On an average 10-15 outbreaks are reported every week to Central Surveillance Unit, IDSP. Data analysis and action are being undertaken by respective districts.

**IDSP Toll Free Number**

A 24X7 call center with toll free telephone no 1075 is accessible from BSNL/MTNL telephone from all districts and states of the country are in operation since February 2008. This receives disease alerts from anywhere in the country and diverges the information to the respective District Surveillance Units for verification and initiating appropriate actions wherever required. Private practitioners are particularly encouraged to use this toll free number and report if they are seeing an unusual increase in the number or presentation of cases.

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**Schematic Diagram Representing the Flow of Information**

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**1.4 Hospital Based Disease Surveillance Under IDSP**

A greater emphasis is being laid on reporting of surveillance data from major hospitals both in public and private sector and Infectious Disease hospitals under the Integrated Disease surveillance Project (IDSP).
Public Sector Hospitals cater to large populations especially lower and middle socio-economic groups and thus capture crucial data on many communicable diseases. Many of these diseases such as gastroenteritis, dengue and leptospirosis also have the potential of causing large outbreaks. If the hospital is able to timely notify and report a sudden increase in the number of cases of an infectious disease presenting to the hospital or clustering of cases in an area, to the district surveillance authorities, necessary corrective action can be taken to prevent spread of the outbreak and control it effectively. Experience also tells us that unless there is regular feedback to hospitals providing information the quality and regularity of information from them weakens.

### 1.5 Communicable Diseases under IDSP

For the purpose of surveillance under IDSP, the list of communicable diseases are given below:

1. Acute Diarrhoeal Disease (including acute gastroenteritis)
2. Bacillary Dysentery
3. Viral Hepatitis
4. Enteric Fever
5. Malaria
7. Chikungunya
8. Acute Encephalitis Syndrome( AES)
9. Meningitis
10. Measles
11. Diphtheria
12. Pertussis
13. Chicken Pox
14. Fever of unknown origin (PUO)
15. Acute Respiratory Infection (ARI)/Influenza Like illness (ILI)
16. Pneumonia
17. Leptospirosis
18. Acute Flaccid Paralysis < 15 years of age
19. Dog Bite
20. Snake Bite
21. Any other state specific disease (check with your district surveillance officer for any additional list of diseases)
22. Unusual syndrome (not being captured by any of the above)

Key points to be noted (as outlined in the diagram below)

1. IDSP surveillance reports are to be presented on monthly basis with explanations for increase in number of cases or any changes in pattern of occurrence. Review meetings should be held in presence of all directors of respective programmes.
2. Establish a Rapid Response Team within the given limited time frame which would come from the understanding of the resources in the district. The team should be given all necessary freedom to design preventive measures to confine the spread of disease. Other departments like water and sanitation, WCD, etc to be involved in the decision making on undertaking preventive measures.
3. Establish a continues hourly briefing by the Rapid Response Team and provide necessary support and decisions on preventive measures at the time of outbreak.
4. Establish a surveillance system to monitor further outbreaks and containment of spread of infection and implementation of case management system at district/sub-district hospitals.
2. Revised National Tuberculosis Programme (RNTCP):

2.1 Introduction
The National Tuberculosis Programme is operational since 1962. Following a comprehensive review in 1992, the Revised National TB Control Program was launched in a phased manner in 1993 incorporating the components of the internationally recommended DOTS strategy for the control of TB. RNTCP has now been implemented in the country for more than a decade, and has been expanded geographically to achieve nation-wide coverage in March 2006.

2.2 What is Tuberculosis?
Tuberculosis is an infectious disease caused predominantly by the organism Mycobacterium tuberculosis. Tuberculosis most commonly occurs in the lungs and is known as pulmonary TB. However, the disease can occur in any part of the body except the hair and nails. Patients suffering from smear positive pulmonary TB (PTB) constitutes the most important source of infection.
The infection occurs most commonly through droplet nuclei generated by coughing, sneezing etc., inhaled via the respiratory route. The chances of getting infected depend upon the duration, the frequency of exposure and the immune status of an individual. A smear positive pulmonary TB case in the general community may infect 10 – 15 other persons in a year, and remain infectious for 2 to 3 years if left untreated. All those who get infected do not necessarily develop TB disease. The life time risk of breaking down to disease among those infected with TB is 10–15%, which gets increased to 10% per year amongst those co-infected with HIV. Other determinants such as diabetes mellitus, smoking tobacco products, malnutrition and alcohol abuse also increase the risk of progression from infection to TB disease.

The programme gives priority in detecting and treating smear positive pulmonary tuberculosis (PTB), thereby aiming to cut the chain of transmission of infection. However, it needs to be remembered that under RNTCP all types of TB cases are treated.

**Goal and Objectives of RNTCP**

The goal of RNTCP is to decrease the mortality and morbidity due to tuberculosis and cut down the chain of transmission of infection until TB ceases to be a public health problem. The goal is achieved through the following objectives:

**To achieve and maintain:**
- cure rate of at least 85% among newly detected smear-positive (infectious) pulmonary tuberculosis cases; and
- case detection of at least 70% of the expected new smear positive PTB cases in a community.

However, the current focus is on ensuring universal access to quality assured TB diagnosis and treatment services under the programme.

**Directly Observed Treatment Short course (DOTS) strategy**

DOTS is a systematic strategy to control TB disease. This has the following 5 components:

- Political and administrative commitment
- Good quality diagnosis, primarily by sputum smear microscopy
- Uninterrupted supply of quality drugs
- Directly observed treatment (DOT)
- Systematic monitoring and accountability
**Political and administrative commitment:** The government’s commitment is measured in terms of continued financial assistance, human resources and administrative support. This priority must be reflected at the National, State, District and local levels. There must be an administrative unit for every 5 lakh population - this is called a TU- or tuberculosis unit. This does the listing of all facilities under it, and also the nodal center for supervision of the facilities and the 5 DMCs below it. It also lists all detected TB patients so that follow up is supervised and ensured.

**Quality assured diagnosis through sputum microscopy:** Under RNTCP, sputum microscopy is the primary tool for detection of infectious TB cases, facilitating categorization of treatment and an objective method for monitoring the response to treatment. Quality assured smear microscopy laboratories are established for this purpose. There should be at least one sputum microscopy center per 1 lakh population and one per 50,000 in hilly, tribal and other dispersed populations. Each PHC should be having about 2% of OPD patients as chest symptomatics-suspected TB to be referred for sputum examination. Each DMC should have examined at least 150 sputums of TB suspects in every lakh population in every quarter. About 75 new sputum positive cases are usually found in a lakh of population and if we count total TB cases it would be about 250 per lakh population.

**Uninterrupted supply of quality drugs:** The policy of procurement and distribution of drugs ensures sufficient quality assured anti-TB drugs available at all levels. The unique feature of RNTCP is the use of blister combipacks in patient wise drug boxes for adults and weight band wise drug boxes for pediatric cases which contain drugs for the entire course of treatment. Patient wise boxes have not only helped to improve patient care and treatment adherence but also to streamline drug supply and drug stock management. These boxes are available at the tuberculosis center and these are provided to the patient through DOTS providers.

**Directly Observed Treatment (DOT):** DOT is one of the key elements of the DOTS strategy. In DOT, an observer (health workers or trained community volunteer other than family member) watched and supports the patient in taking their drugs. This observer is called the DOTS provider. Direct observation ensures treatment adherence, with the right drugs in right doses and at the right intervals.

**Systematic monitoring and accountability:** A standardised recording and reporting structure which allows for rigorous monitoring and evaluation of the outcome of every patient put under treatment is essential. There is a district tuberculosis center which collates report and uploads it on the web/sends through e-mail. There are two supervisors under this programme - a senior laboratory supervisor and a senior treatment supervisor. It is their task
to ensure that the sputum testing is done adequately and with quality, and that those put on treatment complete it.

What to look for:
1. Whether there are enough functional designated microscopy centers- and whether they are achieving the minimum levels of functionality needed.
2. Whether the supervision mechanisms are fully staffed and functional?
3. Whether ASHAs or other front line workers have been engaged as DOTS providers and the community is sensitised through VHSNCs to support the programme.

3. National Vector Borne Disease Control Programme (NVBDCP):

The National Vector Borne Disease Control Programme (NVBDCP) is an excellent example of integration of all vector borne diseases. The diseases are grouped together as they have similar principle of transmission – the vector. The Vector borne disease include, 1. Malaria, 2. Filariasis, 3. Kala Azar, 4. Dengue, 5. Chikungunya and 6. Japanese Encephalitis. As policy of the government of India a commitment has been made to eliminate Filariasis and Kala-Azar by 2015. The NVBDCP is 100% centrally sponsored programme with pooled resources from World Bank and Intensified Malaria Control Programme (IMCP) funded by Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

a. Malaria: The strategy for prevention and control of malaria has changed rapidly with introduction of Rapid Diagnostic Tests (RDTs), Artesunate Combination Therapy (ACT), Insecticide Treated Bed nets, the deployment of ASHAs along with overall strengthening of the public health system. The specific objective of the malaria programme is to reduce Annual Parasitic Index (API) to 1.3 thereby reducing the number of malaria cases. Annual Parasite Index is the number of blood smear examination or RDK tests that tested positive for malaria per 1000 population. At least 10 cases per 1000 population should have been examined (the Annual Blood examination rate- ABER). There are also some criteria for how and when such slides should be taken- active surveillance- when we go house to house to detect fever and passive surveillance- when the test is done on those who come to the facility. In order to contain the spread of infection a surveillance mechanism has also been established which requires preparation of blood smear of all
cases of fever with clinical signs and symptoms of Malaria. By doing so an early diagnosis of the cases could be done and ensure complete treatment.

The district team should start by identifying the areas which are most affected. Mapping of hot spots areas which are endemic to malaria would be available with the district malaria office. This is based on API- and is available by every sub-center area and sometimes also by village.

In such hot spots- the main focus is Indoor Residual Spray (IRS) on a schedule that has to be outlined and also distribution and use of Insecticide Treated bed Nets (ITNs) / Long Lasting Insecticidal Nets (LLINs) (which is GoI supply to specific districts) to families. The mapping also would help in identification of the sources and in these areas Antilarval source reduction measures should be adopted.

Another major strategy is prompt presumptive treatment of those with malaria. This is now changing to treatment of confirmed cases as RDK can be used. For surveillance, ASHAs under NRHM are providing assistance in case detection with use of RDTs and provide Chloroquine (CQ) to suspected cases. This drug is available in ASHA drug kits. Some states have also provided incentives for ASHA in areas of high endemicity (more number of cases from a local area). All suspected cases of Malaria to be referred by ASHA/ANM to nearest public health facility (UPHCs) in cases where RDTs are not available. In places where this is not possible, they could be taught to make a blood smear on a glass slide for examination.

A 7 day laboratory facility needs to be made operational for providing the services and prompt referral of cases with symptoms that do not subside quickly on anti-malarial drugs or whose symptoms return within 14 days. The referrals are to be made to facilities where in-patient services are available.

The mapping should also highlight about the “Tribal” and “Vulnerable” groups with incidence (number of new cases) of malaria.

As part of surveillance the weekly and monthly data are reported to the division through respective formats and these data are incorporated into the IDSP reports. However this integration is limited in many districts.

b. Lymphatic filariasis:

Lymphatic filariasis (LF), at its worst leads to elephantiasis, which is a disfiguring, disabling disease, usually acquired in childhood. In the early stages there are either no symptoms or non-specific symptoms. Often there are fevers with chills and rigours. This
stage can last for several years. Infected persons sustain the transmission of the disease. Long standing disease with recurrent attacks often, but not necessarily precedes swelling of feet and even this takes considerable neglect before it becomes irreversible elephantiasis.

In India, more than 98% of the cases are caused by the species - *Wuchereria bancrofti* and is being reported from 250 districts. Eastern parts of Uttar Pradesh are identified as endemic areas. In areas notified to be endemic a Mass Drug Administration with Anti-filarial drug –diethylcarbamazine citrate (DEC) is given to all persons with respective dosages. The main vector for transmission of the infection is Mansonia mosquito which needs water plants for breeding. The best method would be to remove water plants and along with MDA.

One chronic condition due to this disease is Hydrocele, which is relatively common in these endemic areas. Only a simple surgery is required. Hydrocoelectomy ‘camps’ can be considered in selected CHCs in areas where the prevalence is high. Publicity should be given to these camps so as to encourage patients to avail the services.

c. Kala Azar:

Kala-Azar is endemic in Bihar, Jharkhand, and very few villages of Uttar Pradesh and West Bengal. The disease is caused by a protozoa named *Leishmania Donovani* and the vector for transmission of the protozoa is the “sand fly”. The sand fly only hops- it cannot fly well and hence the disease tends to be very localised. It breeds where there is plenty of moist organic matter- usually rotting like cow dung and piles of rotting leaves.

Clinically the person has chronic recurrent fever. The skin could become become dry, thin and scaly and hair may be lost. Light colored persons show grayish discolouration of the skin of hands, feet, abdomen and face which gives the Indian name Kala-azar meaning "Black fever". The patient becomes anemic with enlargement of liver and spleen which appears as a distension of the abdomen.

The programme to eliminate Kala-Azar was launched in endemic areas in 1990-91 as a centrally sponsored initiative. The programme has three strategy included:
i. Vector control through IRS with DDT spraying up to 6 feet height from the ground twice annually in dwellings of affected villages.

ii. Early diagnosis and complete treatment

iii. Information Education and Communication for protection and vector control.

iv. Capacity building for both prevention and management of the disease.

The key to the control is tracing which village every single detected case belongs to. Once the village is identified perform an intensive search for more cases in the village. This disease is so highly local and focal- that the cases will be highly clustered limited within the district to a few villages and within villages to a few households. Once all the cases are detected start them on treatment and simultaneously hold an awareness programme for villagers. Ask them to seal all low level cracks in houses with mud, and spray well with DDT and then clear away or cover all organic solid waste—especially cow dung. Then follow up on treatment till every case is certified cured.

This is one of the easiest diseases to cure- yet it has survived due to neglect and failure to understand the principles.

d. Japanese Encephalitis:

Japanese Encephalitis is primarily a zoonotic infection and man is an accidental host transmitted through female mosquitoes mainly belonging to Culex group. The virus is neurotropic and affects central nervous system. Clinically there are three stages abrupt (1-6 hours), acute (6-24 hrs) or more commonly subacute (2-5 days). Following an incubation period, in case of viral encephalitis including JE a prodrome of fever, headache, nausea, diarrhoea, vomiting, and myalgia occurs lasting for few days (1-5 days) followed by irritability, altered behaviour, convulsions and coma. The progression of disease is rapid. Signs of raised intra cranial tension are commonly present in acute stage of illness. The patient may develop difficulty of speech and other neurological deficits like ocular palsies, hemiplegia, quadriplegia and extra pyramidal signs in the form of dystonia, choreoathetosis and coarse tremors.

Laboratory investigations like ELISA, IgM (MAC) antibodies and Antigen detection tests RPHA, IFA and immunoperoxidase etc. These facilities are mainly available at the district hospitals. The patients are treated symptomatically for maintenance of airway, fluid and
electrolyte balance. In PHCs were JE is endemic PHCs in areas could be strengthened with trained manpower, equipments etc.

Personal protection against mosquito bites using insecticide treated mosquito nets are key to prevent from JE in the endemic areas. Secondly, source reduction mainly reduction in breeding of mosquitoes. JE vaccination campaign was launched during 2006 and currently 86 districts have been covered.

Overall Key Points for NVBDCP:

a. Identification of “hot spot” areas within the district using the district level maps with villages, forest areas, tribal population, vulnerable population, animal farming shelters.

b. Training of health personnel (including ASHA) at different capacities from those facilities on priority basis which come under the hot spot areas. Orientation of community leaders in prevention and control of spread of infection.

c. Ensure availability of RDTs and Drugs with ASHAs, ANMs and MPWs

d. Equitable distribution of ITNs and LLINs and promote IRS

e. Arrange Health Melas at district level with medical officers, ASHAs, PRIs, ANMs, AWWs, PWD workers etc.

f. Engage the District officers from respective programmes in meetings of IDSP monthly review so as to bring about integration within programme.

g. Monitor and manage the disease outbreak situation as outlined in the IDSP section.

h. NGOs are to be involved in distribution of IEC material and community mobilization.

i. Line listing of Lymphatic Filariasis cases can be easily done due to swelling of legs. Therefore ASHAs could be encouraged to be in high focused districts for identification of cases. The surveillance is done in endemic areas. However the blood sample has to be collected between 8:30 pm to 12:00 pm. This is because the worm would be in the peripheral system at this time. Therefore the community where the surveillance activity is being planned has to be informed before hand through the ASHA and ANMs. This should also be used as evidence for Mass Drug Administration.

j. Ensure availability of Dip Stick Rapid Test rk39 with ANMs and health facilities. As methods of source reduce, integrate with PWD department on IRS in houses upto 6 feet in the dwellings. The persons living should be informed about the importance and also not to paint the walls. Secondly to minimize accumulation of organic matter in the vicinity of the houses.
Ensure the availability of drugs Sodium Stibogluconate (SSG) and Amphotericin B at all facilities in the “hot spot” areas.

k. Community involvement in establishing Piggeries at 4-5 kms from human dwellings (as JE control measure).

**Summary table for NVBDCP**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Vector</th>
<th>Control strategies</th>
<th>Key points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria</td>
<td>Anopheles Mosquito</td>
<td>IRS, ITNs/LLINs, Larvivorous fish</td>
<td>Blood smear examination, ASHAs with RDTs</td>
</tr>
<tr>
<td>Lymphatic Filaria</td>
<td>Culex Quinquefasciatus/ Mansonia mosquito</td>
<td>MDA, Larvicidal measures (composite fish culture)</td>
<td>Hydrocelectomy camps at CHC level.</td>
</tr>
<tr>
<td>Kala Azar</td>
<td>Sand Fly</td>
<td>IRS, ITNs/LLINs</td>
<td>Dip stick Rapid test rk39, IRS in houses upto 6 feet</td>
</tr>
<tr>
<td>Japanese Encephalitis</td>
<td>Culex mosquito</td>
<td>IRS, ITNs/LLINs</td>
<td>Vaccination, symptomatic management at health facilities.</td>
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</table>
was utilized in the programme to measure achievements under NLEP. Further, special measures were taken every year on the basis of PR. Monthly availability of PR also helped in keeping active track on the disease epidemiologically.

The objectives of the programme are Provision of high quality leprosy services for all persons affected by leprosy, through General Health Care System including referral services for complications and chronic care, Enhanced Disability Prevention and Medical Rehabilitation (DPMR) services for deformity in leprosy affected persons, Enhanced advocacy in order to reduce stigma and stop discrimination against leprosy affected persons and their families, Capacity building among Health Service personal in integrated setting both for Rural and Urban areas, Strengthening the monitoring and supervision component of the surveillance system.

Key Points:

a. Ensure awareness campaign in the district
b. An official to be assigned for monitoring the progress of case detection and completion of treatment.
c. Ensure system strengthening for deformity treatment at district health facilities.
d. Incentivize ASHA involved in case detection of Leprosy and ensuring competition of treatment.
e. Monitor the activity plan and utilization of funds under the programme.

5. National Prevention and Control of Blindness:

National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100% centrally sponsored programme with the goal of achieving a prevalence rate of 0.3% of population. The decentralized mechanism of implementation was formulated through district health society during 1994-95. Currently the programme is integrated with National Rural Health Mission. The programme is implemented vertically through a four pronged strategy

a. Strengthening service delivery
b. Developing human resources for eye care
c. Promoting outreach activities and public awareness
d. Developing institutional capacity
Key Focus points:

a. Periodically assess the magnitude of the problem of blindness in the district through routine eye screening during the OPDs, EYE camps in the district with ophthalmologist and school eye screening camps with the help of optometricians.

b. Provide screening for detection and management of diabetic retinopathy and glaucoma at district and sub-district hospitals.

c. Involve NGOs in the local areas for conducting camps, and screening of EYE camps and also register volunteers for eye donation.

d. Engage NGOs in distribution of spectacles and post surgical follow-up of the cataract cases.

e. Distribution of spectacles could be integrated with the Sarva Siksha Abhyan (SSA).

f. From the system point of view, a register about village level blind register and other necessary information about voluntary eye donors to be maintained.

g. Eye ball collection and transformation is also a critical component where NGOs play a vital role for which Grant in Aid is provided under the programme.

h. The programme has been implemented through District Health Societies (NPCB).

i. Awareness generation though IEC and media, Panchayat Raj institutions, for identification of Eye infections and management and prompt referral to nearest health facility with an optometrician. Optometrician to be multiskilled in management of minor ailments and refer cases to Ophthalmologists at district hospitals.

j. Strengthen the facility based on the case load in the district and with trained manpower in place to operate the equipments, for eg. Laser Technique treatment of ailments. For these activities Grant-in-Aid is available from the department under NRHM funds.

National Polio Eradication Programme:

The Polio Eradication Programme is a global collaborative effort. The primary strategies are, attaining high routine immunization (immunize every child aged <1 year with at least 3 doses of oral poliovirus vaccine (OPV)), National Immunisation Days (Conduct Pulse Polio Immunization (PPI) programme by providing additional OPV doses to every child aged <5 years at intervals of 4-6 weeks), Surveillance of acute flaccid paralysis (to identify all reservoirs of wild poliovirus transmission which is done at specialized laboratories), “Mopping-up” immunization (when poliovirus transmission has been reduced to well-defined and focal geographic areas, intensive house-to-house, child-to-child immunization campaigns are conducted over a period of days to break the final chains of virus transmission.)
Poliovirus is highly communicable. The time between infection and onset of paralysis (incubation period) is 7-10 days (range 4 - 35 days). Transmission is primarily person-to-person via the faecal-oral route; i.e. the poliovirus multiplies in the intestines and is spread through the faeces. The virus is intermittently excreted for one month or more after infection. Communicability of infected children is highest just prior to the onset of paralysis and during the first two weeks after paralysis occurs.

Poliovirus infects only human beings and there is no animal reservoir. The virus does not survive long in the environment outside the human body. In tropical climates, the virus once excreted into the environment has a half-life of infectivity of 48 hours.

Most children infected with poliovirus do not show signs of disease since paralysis occurs only in 1 out of every 200 children infected with the virus. However, these children can pass on the virus to other susceptible children in the neighbourhood. Hence it is essential to reach every child under the age of five during every SIA round.

Key points:  

1. Mobilize community through BCC/IEC activities and encourage ASHAs, ANMs, Medical Officers and other programme officers to act as role models for immunizing children for polio. Popular personalities of the state and district could also act as role model for the programme.
2. Involve one-self in demystifying the myths about polio that circulate in the community and act as role model by administering polio vaccines to children in communities were the myths circulate. Also involve religious and community leaders.
3. Assure wide circulation of National Immunization Days (NIDs), sub national immunization days (SNIDs), Mop-up rounds in the district.
4. Ensure community health workers follow-up of the missed out children who are required to be immunized. These reports are provided by the polio surveillance units established at district level.
5. A district task force co-ordination committee should be formed with a role of supervise, support, monitor and ensure implementation of highest quality NIDs/SNIDs. These meetings are to be used for planning and implementation of the programme. These meetings are to be held at least 3 times before the round and every day during the activity.
6. A control room should be set up at the district level to monitor preparedness of blocks/PHCs/urban areas on a day to day basis and to monitor implementation of the programme.

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7. Ensure involvement and inter sectoral coordination of all other departments in the district for mobilization of manpower, transport and social mobilization.

8. Depute senior officials from the administration and other sectors to supervise preparations and implementation of the NIDs/SNIDs in various blocks and urban areas of the district. All senior officials are accountable for their areas.

9. Encourage involvement of voluntary organizations during the implementation of polio programme in the district.

10. Encourage Gram Panchayat Vikas Adhikari (Village development secretaries), Lekhpals, Village Pradhans and Panchayat members should accompany vaccination teams during house-to-house visits and mobilize community to accept OPV.
B. Health Systems
Chapter 6

Facility Development under NRHM

There are three aspects of this:

A. To ensure that adequate number of facilities are sanctioned where they are needed most.
B. That the facilities are housed in buildings adequate for the purpose.
C. That the facilities provide the services required of them – by IPHS as prioritised within the district health plan. This is essential for the success of all national health programmes as well.
D. That the facilities have the inputs and the process standards required to provide the quality of care required for services to lead to outcomes and to ensure patient safety, comfort and dignity.

A. Planning New Facilities:

The Indian Public Health Standards reiterates the Planning Commission norms for the creation of public health facilities:

- One Health Sub-center per 5000 population.
- One Primary Health Center per 30,000 population.
- One Community Health Center per 120,000 population.
- One district hospital or equivalent sub-divisional hospital with 100 beds for every 10 lakh population.

For tribal, hilly and desert areas the norms are relaxed as follows:

- One Health Sub-center per 3000 population.
- One Primary Health Center per 20,000 population.
- One Community Health Center per 80,000 population.

Another new standard added in by the 12th Plan is a target of 500 beds per 10, lakh population- and this is for secondary care- as distinct from PHC beds. If a district has 10 30 bedded CHCs and one 200 bedded DHs it would achieve this target. But where it does not have – then one has to add on more beds- both where there is overcrowding and where there is a lack of inpatient capacity.

Even on new facilities- the 12th Plan has brought in a new dimension- an access standard called time to care. Within half hour of any habitation there should be a primary health care site- at least a sub-
center. And within two hours of any primary health care site there should be a secondary facility that provides emergency care- FRU- first referral unit.

One of the first things- that the district administration needs to check out is what populations/habitations fall outside this time to care and or population criteria- and how best to close the gap. If time to gap criteria is satisfied, and there is no overcrowding in the nearest facility- there is no need to create an additional facility merely to meet the population criteria. However even if time to care is not achieved- even if population criteria are met- action either on improving transport and communications or by creating new facilities or upgrading existing ones would be required.

B. Closing Infrastructure gap:

a. The IPHS specifies the level of infrastructure each facility needs. These standards are available on the ministry website www.mohfw.nic.in/nrhm.htm and published as books by the government of India. These could be modified by the state and based on considerations of availability of space, pre-existing structures, local culture, at district level also. Make sure that you have the drawings and designs needed for the normative infrastructure of a sub-center, PHC or a CHC.

b. Make a civil works plan for complete infrastructure development. The plan should have a timeline linked to availability of funds and since funds granted may be less than what is asked for there should a clear list of priorities between the facilities asked for. Priorities could be divided into three phases. The first phase should be ensuring that all facilities prioritised for RCH services have an adequate building within the next one to three years. Also that those facilities which are already managing a high case load, whether of institutional deliveries or other conditions- have adequate beds and infrastructure- labour room, laboratories, store room, waiting space, ASHA waiting room etc. Usually these would be block PHCs, CHCs or larger hospitals. People have already chosen to use these sites. Respect that choice and ensure quality of care there.

c. Such a plan should also prioritize that piped water supply and electricity and toilets are adequate in all facilities already providing care.

d. Mobilise resources from as many sources as possible. The NRHM state PIP allots a budget for construction. The un-tied funds made available under NRHM could also be used- especially for renovations. 15 % of the untied funds could be pooled and given to priority facilities. Funds are also available in the state budget. District may have funds from other sources like the border districts development funds, or minimum needs programme or NREGA
programmes etc which could be used to close the gaps. Some of the Rogi Kalyan Samitis already have funds or can raise funds from donations to close smaller gaps. Usually funds for repair and renovation can be mobilised from available sources within the district - it is only for new constructions that we would need separate state level sanctions.

e. One has to check whether all the constructed buildings have been taken and put into use. There are huge time delays in handing over of buildings - most of which require active intervention by district administration to solve.

f. One has to check whether constructions have started on all buildings where it is sanctioned, and where civil works has started whether it proceeds on quality and on schedule. All this requires an engineer, either contractual or a regular employee assigned this task - who would have to submit a monthly report on progress - and each EC meeting should have a report on which constructions have fallen behind the agreed upon time-schedule. This nodal person also is accountable ensure careful selection of site - in consultation with the villages - but also with the health department.

g. Finally there must be a clear plan for maintenance of buildings – and standards and training for the same. Every facility has a nodal person in charge of infrastructure maintenance and every block and district too has a nodal person - who must be supported and trained and held accountable for the quality of maintenance.

C. Closing Service Delivery Gaps:

The Indian Public Health Standards lays down the services that each facility is expected to provide and the National Rural Health Mission funding was to help this level of service delivery to be achieved. We give below a brief summary of the expected service package at each level:

Health Sub-center (HSC)

Outreach services-

- immunisation services
- antenatal and post natal care for all pregnant women.
- Counselling for family planning, promoting access to permanent contraceptives and making temporary methods available. Temporary contraceptives includeIUD insertion, oral contraceptive pills, emergency contraceptive pills and condoms.
- Conducting the village health and nutrition day.
• Attending on home deliveries- if either due to circumstances or choice this becomes necessary.
• Care for minor illnesses, symptomatic care for illness, and stabilisation care if needed while referring sick persons.

Services at the facility:

• Midwifery services-
• Care for illnesses :
• Some services like IUCD insertion.

The ANM visits each anganwadi center (or any other place convenient to them like a primary school) in her area- on a fixed day of the month- and ASHAs and anganwadi workers bring the children and pregnant women to receive her services. Each ANM would have about 5 such anganwadi centers under her – as an anganwadi center caters to about 1000 population and thus on every Wednesday they would be visiting on such center. If the population they cover is large- then they visit on a Wednesday and on a Saturday.

Human Resources: The Sub-center should have one or two ANMs and one male worker.

Infrastructure: To enable its functioning, the sub-center is meant to have a building – which has a labour room with all necessary equipment for normal delivery, another room for outpatient care, a store room and a toilet, and a waiting space for patients. In addition integrated with the building is a two room plus toilet residential accommodation for the ANM. Now that two ANMs are planned, any new building should plan for two rooms. Wherever 2\textsuperscript{nd} ANMs are posted, clear job responsibilities of the 2\textsuperscript{nd} ANM have to be ensured.

Every sub-center is provided Rs 10,000 as annual maintenance grant and another Rs 10,000 as an untied fund. These are meant to maintain infrastructure and fill gaps in equipment and supplies and also use for contingency purposes.

Primary Health Centers:

The recommendation is that there is one for every 30,000 population( 20,000 in tribal areas)

It is meant to provide comprehensive primary outpatient care ( ambulatory care ) for a wide variety of illnesses.
It is also to provide institutional delivery facilities on a 24*7 hour basis. This requires a well equipped labour room and 4 to 6 beds- for women and their babies to be placed before and after delivery.

The PHC also supervises all the activities of the sub-center. Often there is a sub-center located in the same campus meant to provide outreach services to the nearest 5000 population. Sometimes there is no such designated sub-center but the ANM in the PHC is expected to provide this service.

Human Resources: The PHC should have two medical officers and one AYUSH doctors as well and five staff nurses. Of these, three staff nurses are provided under the NRHM programme- but this is only for those facilities which are providing 30 deliveries per month. There could be some relaxation of this for difficult areas and areas with dispersed populations. If case loads are high, even higher human resource deployment is justified.

Infrastructure: The PHC building provides space for provision of out patient care, 4 to 6 in patient beds- used both for care in pregnancy and as day care sites, and has a labour room, laboratory room and stores.

The Block PHC and/or the CHC:

Though the recommendation is that for every 1.2 lakh population, there should be a CHC, in practice the norm is that there should be at least one CHC in every block. And most blocks in high focus states are about 2.0 lakh in population.

A CHC is the most peripheral ‘hospital’ of the system. It therefore should have 30 beds and an operation theatre and enough nurses and doctors to manage such an in-patient load.

A CHC is the point of first referral to those working in primary level care- which is the community level ASHA, the sub-center and the primary health center. Since it is a first referral center, it should have the necessary laboratory and tests and the equipment to provide care to the most common reasons for referral. It also has to have a team of specialists to handle this level of referrals.

For maternal and newborn care, at this level the services of a gynaecologist, anaesthetist and paediatrician are needed- but if not available one should try to train medical officers in these skills through special courses. Ideally all CHCs should provide comprehensive emergency obstetric care- but this is difficult to achieve. On the other hand a sub-set of CHCs should be upgraded to provide comprehensive emergency obstetric care- such that the time standard for FRUs is met. Therefore choose one appropriately located CHC amongst four or five to upgrade first. All other CHCs should
function on a 24*7 basis and provide basic emergency obstetric care and newborn stabilisation care at least.

Display of the service guarantees by the BPHCs and CHCs and ensuring actual delivery of the same is important.

**District and Sub-divisional Hospitals:**

The district hospital norms are at least 100 beds for every 10 lakh population- this is over and above the beds in the CHC. But statewise variances are possible. In Uttar Pradesh, the district hospital is divided into a general hospital and a district women’s hospital. Together they may fulfil this bed strength. Often because of huge case loads, one would need to go upto 200 to 400 beds per district hospital, especially in large and highly populous districts. Larger hospitals are difficult to handle- and the better option would be to upgrade a sub-divisional hospital using the same district hospital norms.

**Closing Input Gaps:**

The Indian Public Health Standards also specifies the level of infrastructure, human resources, equipment, drugs and supplies each facility should provide as one measure of the quality of services to be provided. These standards are available on the ministry website [www.mohfw.nic.in/nrhm.htm](http://www.mohfw.nic.in/nrhm.htm) and published as books by the government of India.

We have discussed earlier the action taken to close the infrastructure gaps. The next chapter would deal with closing HR gaps- in terms of numbers, skills and performance. Closing gaps on equipment and supplies is through appropriate procurement and logistics organization and is discussed in the section on programme management.

The challenge before the district health society is to use the limited funds and human resources available to optimise the services that can be delivered. This is one reason for a planned development of services available within a district- so that the entire population could access all services – but at varying distances and time to care standards.

The phase that the district already understands is for Reproductive, Maternal and Child Health Care. Here the objective is to develop some facilities which could provide institutional delivery services such that entire population has easy access to them- and link these with a very few sites of comprehensive emergency care, where specialist care is available. Outreach services are however
available on a population basis. When prioritising which facilities will provide what level of care we are guided by a) distance from villages- and therefore time taken for reaching the facility and b) peoples existing healths seeking behaviour- which public hospital they prefer c) the need to prevent overcrowding in a few hospitals by ensuring that secondary and tertiary facilities are not unduly burdened with primary care obligations and d) making optimum use of the skills available within the district- whether in public or private and e) the funds available. This exercise is already done for RCH (though institutional memory of this may not have remained). It would now require to be done for emergency and trauma care and then for all communicable diseases and for all non communicable diseases. The implication is that every CHC or PHC may not reach the entire set of assured services expected of it – but the district health system as a whole can and must reach it.

C. Quality of Care:

This is also an important consideration- but that is not discussed further in this handbook. There are separate hand-books available for the same. There is mention of the quality assurance committees again in programme management. Any facility development plan should include quality as a dimension.

The principle is that even if all inputs are in place- quality of care may not be adequate- either for effectiveness or for patient comfort, safety and dignity. For the latter we need process standards, and organisation of work and capacity building and management to achieve this. These quality considerations can be measured and scored for each facility- and its improvement can then be tracked by the district health society.

In Summary:

What to look for?

a. Is the number of sanctioned facilities adequate-- as per norms and as per needs?

b. What is the infrastructure gap for sanctioned facilities? Is there are plan to close this gap?

    What is the current ongoing work to close it?

c. Is there clarity on what services are to be provided where. We give below how one can look at this for RCH services. Could we do the same by identifying level 1, 2, and 3 services for emergency care, CD care and NCDs as well.

d. What part of the lack of assured services in these facilities is due to input gaps-infrastructure, HR, drugs and supplies, equipment- and what is due to workforce performance and lack of supervision.
e. What is the quality of services provided? Have these been measured and scored? Is the quality scoring for all facilities available.

<table>
<thead>
<tr>
<th>Assessing to check whether assured RCH services are being delivered.</th>
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<tbody>
<tr>
<td>• % of Level III facilities not conducting C-Sections.</td>
</tr>
<tr>
<td>• % of Level II facilities not managing obstetric complications.</td>
</tr>
<tr>
<td>• % of Level II facilities conducting Sterilisations or MTPs.</td>
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<tr>
<td>• % of Level III Facilities with functional Blood Bank.</td>
</tr>
<tr>
<td>• % of facilities with functional New Born corner Stabilisation Unit, New born corner or SNCUs</td>
</tr>
<tr>
<td>• % of DH and CHCs which have no admissions of sick newborns</td>
</tr>
<tr>
<td>• Assured services should be available from each level of facility. If the facilities do not have assured services they need to plan for that.</td>
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<tr>
<td>• A similar plan is needed for</td>
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Chapter 7

Human Resources for Health (HRH)

No other single factor is as crucial to the success of the health systems as a good HRH policy that is well implemented. There is much that the district administration and health officers can do.

We discuss this as five key elements of human resource development

1. Numerical Adequacy - do we have enough staff in place.
2. Adequacy in Skills - do they have the right skills?
3. Adequacy in Performance? How do we measure, how do we support and supervise?
   i. Recruitments,
   ii. Postings and Transfers,
   iii. Promotions
   iv. Other Incentives and Rewards
   v. Disciplinary actions and proceedings.
   vi. Housekeeping in Workforce administration: ACRs, service books, pensions
5. Building Positive Practice Environments:

Numerical Adequacy:

The starting point is to know what are the numbers required as per IPHS and as per the local epidemiological profile. This is clarified in the discussion below. Then having determined this, one has to check how many posts are sanctioned in the district- and by facility. Then find out how many posts are vacant. Once this data is in place proceed to answer the following questions:

a) What are the posts that the district has the power to fill either with or without further approvals from state level. Initiate an appropriate and proactive process of filling this.
b) What are the posts requiring sanction to meet the assured services- has the district written asking for these posts.
c) Which are the vacant posts that require to be filled up by state action. What is the likely timeframe.
d) What staff positions can be filled within existing local resources- without substituting for regular positions on a long term basis.

The Indian Public Health Standards defines the minimum staff that is to be in place. The NRHM is committed to funding the difference between the existing sanctioned posts under the state
government and the required staff under IPHS- on a contractual basis- while expecting the state government to make some of these posts regular state cadre. We look at the provision for this in each facility.

**Health Sub-center:**

Before NRHM- one female multipurpose worker female- also referred to as the ANM, and one male multipurpose worker posted at the SC. The NRHM made it two ANMs per sub-center plus one male MPW with the stipulation that the Government of India would sanction only as many second ANMs as there are male MPWs in position.

*Action Points:* make sure your district has every first ANM in place – and then try to get every second ANM also in place. The already sanctioned and positioned second ANM must be deployed in the following order of priority

- In those few exceptional sub-centers which are doing over 5 to 10 deliveries per month- so that there is always someone at the sub-center to attend to the woman in labour, and the outreach work of immunisation does not get compromised. Please note that there is usually no more than five to six such sub-centers in a district.

- In those sub-centers which are handling far more than their norm of 5000 population. List and rank the sub-centers according to population served, and then start allocating the second ANM to those sub-center serving the maximum population and work your way down. These two ANMs can then increase the number of outreach and venues for immunisation session to as much as 8 and every week each of them can attend two such venues. Thus there would be one immunisation session venue for every 1000 population and by carefully scheduling of the sessions, we can ensure that there is one ANM at the sub-center on every day.

- In those sub-centers where the population is as per norms- there is a choice. If the area is very dispersed and/or the fertility rates are very high (appox over 100 newborns per year) the aim should be still to focus on RCH for both but monitoring a larger set of activities. This would include insisting on home visits for post-natal care, regular adolescent counselling and clinics including the adolescent anemia programme. These should anyway be part of her work even if there is one ANM- but it can be better accomplished and monitored now. In addition But then one can add on some aspects of non communicable disease- tobacco control, screening for hypertension, diabetes, cancers etc. However if the fertility rates are low- each ANM could have as few as 2 to 4 births per month and only
about 50 children to attend to and it would make sense for one ANM to specialise in RCH care and another in NCD care- or to divide both work geographically between both of them.

- The importance is not to let the second ANM become an assistant to the first ANM- which may well happen because there is such a huge pay difference between them. If that happens there would be no increased coverage despite the doubling of human resource at this level.
- Work allocation to the male worker should also ensure 6 to 8 hours of work per day. Where there is a high burden of TB, or malaria or kala-azar there is a considerable disease load. In other areas they must be used for effective programmes addressing NCDs.

**Primary Health Center:**

The IPHS recommends three medical officers and five nurses for every PHC. It also recommends an AYUSH medical officer, two pharmacists and two laboratory technicians. There is also a health supervisor for the male workers in the sub-center and a LHV to supervise the ANMs in the PHC as well as an ANM to handle the outreach functions of this PHC itself. This is for universal access to comprehensive primary care. To meet the immediate more pragmatic goals of universal access to RCH services, the operational guidelines for RCH calls for at least two medical officers and three to five nurses in place- and this is what the NRHM immediately addresses.

The NRHM goal is to make all our PHCs into 24*7 PHCs with such a staff strength of one or two medical officers and three to five nurses. Exact numbers will depend on case loads- but three is the bare minimum. As a start the NRHM has funded the appointment of three staff nurses for every PHC.

Most states have not chosen to make every PHC 24*7 and sought the three nurses only for select PHCs which are to be so upgraded.

**Action Points:** Ensure that all PHCs already providing, or designated to provide institutional delivery services, should have three nurses put in place. Ensure that at least one if not two medical officers, a pharmacist and a laboratory technician are in place as well as a male and female supervisor and an ANM.

**Community Health Centers and First Referral Units:**

The first question to ask is- are we planning to currently make this into an FRU or will it remain at the level of a 24*7 PHC? If it will remain at the level of a 24*7 PHC the earlier definition of human
resources is enough—though one may need more nurses and support staff and even medical officers if case loads are high.

If on the other hand we plan for a CHC of IPHS standards - the requirement is of 34 staff members—of which 5 are specialists, 6 are general duty medical officers, two is one AYUSH medical officers, there are 19 staff nurses and a public health nurse, an ANM for local outreach activities and 11 technicians. This again is for comprehensive health care services of the secondary level. If it is only for RCH emergency obstetric care then 3 specialists and as many medical officers and 9 nurses would be the minimum starting point. (Where we do not have specialists we can close the gaps with medical officers trained and certified in these skills and where we do not have nurses one could use ANMs).

This would be the same requirements for the maternity wing of the district hospital- except that depending on case load, we would need more specialists, medical officers and nurses. Thus a 100 bedded maternity ward or hospital doing over three to five CS per day and about 60 deliveries per day, may need as much as three or four gynaecologists, three paediatricians one or two anesthetists, and almost 50 nurses!!!

**Estimating the district numerical requirements:**

Based on these norms and prioritisation of RCH services, one can now estimate how many more ANMs, nurses, medical officers, specialists and lab techs we need to meet the requirements of the district- in terms of assured services promised in the district health plan. Even this number may be higher than the available staff or the numbers that have been sanctioned for recruitment. You will need to refer back to the facility development plan we made in the earlier chapter and go by the list of facilities prioritised. Start with the top of the list and move down, making sure that each facility has the critical numbers it needs.

**The Recruitment Plan:**

In most states powers of recruitment of contractual staff – especially ANMs, nurses, doctors and specialists have been devolved to the districts. (In some states, recruitment even against permanent posts have been so delegated.). Once the powers are in place- one needs a recruitment plan.

One of the best ways is to announce and advertise a specific dateand time for a walk-in interview-where one verifies certificates and interview all those who have minimum required qualifications. If the candidates are few, then almost everyone gets in- if there are more, it is based on the interview scores. Those selected should get the appointment, preferably within the same week and the list of
selected candidates should be put up by the end of the day. If there are still not enough candidates, consider a HR agency to help, or consider campus interviews in those nursing and medical schools where candidates are passing out. At all times specify to which facility they are being posted so that there is no delay or disappointment for either side later. A more friendly, persuasive and timely selection process would itself help close the gaps.

Examine whether there are service rules or other guidelines that come in the way of filling vacancies. If there are such issues take these up with the concerned state level officers.

**Workforce Management:**

*Postings and Transfers:* These are of greatest importance. The rule is to post contractual appointments to a specific facility not to the cadre as such. At the time of interview it helps to find out and tell where the candidate would join so as to save disappointment, time and effort in the event of failure to join. When vacancies are high, it is better to give the choice to a contractual staff amongst the existing vacancies.

For regular staff, adopting a transparent posting policy, where people who are in position are not disturbed unless they require it, is the best. The difficult postings should be allotted to those who volunteer for these postings. Those posts which do not get filled up by volunteers may be rotated amongst the rest. This is easier said then done and there would be a lot of pressures but it helps to keep a sound policy and exact list of postings in place one never knows when the window of opportunity to do good opens up.

*Promotions:* Find out which promotion powers are at the district and which are at state level. Those at district level should be completed on time. Most are at state level there should be a clear statement of who all are overdue for promotion and years of service put in and some efforts made to remind the state in this regard the least it will do is to get you local good will.

*Incentives and Rewards:* Many of these are part of state policy but there could be simpler district level recognition and awards that could be given to those performing well. Incentives may include sponsorship on educational tours, sponsorship for a workshop or professional conference, allocation of certain work responsibilities etc.
Disciplinary actions and proceedings need to be initiated as per rules, and promptly enquired into and concluded. Keeping track of it and administering it could be streamlined, so that too much time and energy is not lost on this work. Other than this there are a large number of other routine HR related tasks: releasing pension for those retiring and doing this on time and with dignity, ensuring work appraisals and ACRs are filled on time, updating service books and ensuring employees have a copy and so on. Alloting one day every month within the district and block offices to catch up with all the HR related paper work is done and inspection to ensure that every officer in charge of HR is managing this task is most important. For all contractual staff a HR manager needs to be in place, who would ensure payments on time, renewal of contracts on time or if the decision is not to renew, to give them one to three months notice, increments, performance appraisals etc in place.

Building Positive Practice Environments: One of the key problems for professionals to work in public health service is the professional and social isolation they face. It helps for the medical leadership in the district to provide an environment where the professionals find themselves encouraged and inspired to work. Organising continuing medical education (CME) programmes, providing telemedicine or referral linkages with arrangements for feedbacks or even telephonic consultations helps break professional isolation. Supportive supervision which also provides on the job training is another major strategy of addressing professional isolation. These could be linked to family get together and social activities that reduce social isolation. Conscious efforts from the community to reach out to professional providers coming in from outside also helps cement relationships. Unfortunately most young professionals working in rural areas, find their seniors within the department or in the community, very unsympathetic and unsupportive, if not actively rude and hostile. One of the functions of the leadership is to change this behaviours, attitudes and build up a positive practice environment towards a productive workforce

Adequacy in Skills:

One of the challenges of HRH policy is to ensure that the health workers in the system have the requisite skills they need to deliver their services and that these skills are upgraded and reinforced on a regular basis. One way to do it is through the training and supervision plans.

What to train for?

Given below are the skills that each service provider needs.

ANMs/staff nurses in sub-centers and PHCs: Skills to conduct deliveries safely, symptom based management of illness in the newborn and the young child, insertion of IUDs, counselling for care in pregnancy, family planning, infant and young child feeding and prevention of illness, and
immunisation. Ensure that the DHS selects ANMs who are residing at the facilities’ quarters and conducting deliveries (at HSC) to be sent for SBA and other relevant trainings on a priority basis.

Medical Officers posted in PHCs and CHCs: Ensure that these M.Os are selected for trainings on Basic emergency obstetric care, care of the sick newborn and young child with illness- at least to the level of stabilisation and all family planning procedures including non scalpel vasectomy and mini lap tubectomies. Trainings are also required on specific diseases control programmes such as RNTCP, NLEP, NVBDCP and other Non-communicable diseases control programmes where it is relevant.

Medical officers posted in FRUs: all of the above trainings plus the skills for providing comprehensive emergency obstetric care including surgical skills and safe blood transfusions, and/or giving anaesthesia for emergency obstetric care cases.

The standard training packages recommended are given below, but these can be modified to meet requirements and existing levels of knowledge.

- Skilled Birth Attendant (SBA) training package, A 21 day package – for conducting safe delivery.

- Intra Uterine Device (IUD) insertion: 6 days - spacing method of family planning.

- Integrated Management of Neonatal and Childhood Illness (IMNCI).- 8 days - symptomatic care for young child with illness

- Facility based IMNCI (F- IMNCI) – 11 days – facility based care for newborn and child

- Basic Emergency Obstetric Care (BEmOC) – 10 days

- Emergency Obstetric Care (EmOC) – 16 weeks

- Navjat Shishu Suraksha Karyakram (NSSK) – newborn care - 2 days

Whom to train?

Start with training those service provider who are already providing specific services. The primary purpose of these trainings, especially the SBA training, is to upgrade the skills of those who are currently provide service/care- not to motivate those who are not yet providing it. Start with those facilities that we had prioritised in the earlier chapter.

How to accelerate training?
The pace of training seriously lags behind our targets. Draw up a calendar back to back- so that every day the maximum persons who can be trained are undergoing training. The only limitation should be the criteria for the training venue which is defined by the clinical materials available. If you do not have the necessary number of trainers within the district, take the help of some technical assistance agency or development partner, or the state office to bring in trainers from elsewhere or hire some nurses & doctors on a contractual basis and get them trained as trainers and deploy them full time for this task. Or you could send your trainees to an accredited training center outside your district. The creation of a training center managed by a team of full time trainers is the most important long term measure to institutionalise training and ensure quality, competence and completeness. One could build capacity of existing institutions – like ANMTCs, or DTCs or RHFWTCs if they already exist, or one would have to build a new center for this purpose.

Action points – Check whether all the training centres have adequate teaching infrastructure, facilities and training aids including audiovisual aids, mannequins etc.). Also ensure 48 hours postpartum stay in the facilities, availability of women friendly services, warm clothes, diet for the inpatients etc.

**Quality of training.** This rests on three aspects; One, making sure that the master trainers are accredited and themselves adequately trained. Or else get them trained. Two, Making sure there is good printed training materials with evaluation methods built in which is available. This training material should be followed literally and every single trainee is to be evaluated. Group scores for each skills would also reflect on the trainer. Three, After the training programme, invest in on the job supervision and training follow up to ensure that the newly acquired skills are practiced in field conditions. Ensure providing enabling working environment to practice the skills in the facilities- esp. availability of drugs, supplies and other consumables.

**Adequacy in Performance:**

There are three mantras to achieve this:

- Ensure that the requisite skills are in place
- Measure the performance
- And support and supervise : what is called supportive supervision.
We suggest that suitable facility performance indicators be developed and used - not individual indicators. If a facility is performing poorly, then the responsibility is fixed using the data available in the facility that was used for making the indicators.

Here are some facility performance indicators that could be useful:

a. Number of out-patients seen per doctor
b. Bed occupancy rate- or midnight in-patient head counts per doctor
c. Number of operations done per surgeon available.
d. Number of Institutional deliveries per available nurse.
e. Number of complicated/obstetric cases managed/referred
f. Number of lab tests done per technician available.
g. Number of sick or low birth weight newborns admitted.

Measuring performance is helped by many applications that are now available for health human resources management, that can be customised and made available at low costs.

**Supportive Supervision**: There are two types of supervisory visits required. One is more administrative and relates to ensuring that infrastructure, equipments and supplies are in place. This supervisor also ensures that the supportive services - diet, laundry, security, etc- needed for quality care are all in place. The other sort of supervisory visit is clinical - this relates to ensuring that the protocols of care prescribed are followed and it provides on the job training to improve skills and build up the confidence in the providers. Both types of supervision can be done by the same person- but often it requires separate persons to do so.

A quality assurance committee that is functional may be one form of organising such supervision.

One important requirement for maintaining quality in any service is to provide a clear brief written protocol of the process each staff/employee is expected to follow, and then to ensure that there is a record generated which shows conformity with the protocol. Examples are: Outpatient register, tour diary of a supervisor, or the bed head ticket of the inpatient, or the diet register of the matron in charge of the ward and the kitchen and so on. If such a system is in place supervision becomes much more effective.
For effective supportive supervision always provide a facility specific check-list that the supervisors should use. Another important tool of supervision is the process of the supervisor documenting the findings at each visit, communicating the gaps to the service provider and noting the improvements on subsequent visits.

The task of the administration is to ensure that these processes are in place and that every single facility is visited with a minimum frequency. Also that every officer and supervisor knows clearly the schedule of supervisory visits expected of them. Every facility has a supervisor’s visit register and every supervisor has a tour diary and these documents are regularly inspected, referred and maintained by the district health administrator.

**What to look for :**

a. That the number of human resources needed to close the gaps are known and there is a plan of recruitment to close this gap.

b. That there is a clear workforce management plan which takes care of both routine HR tasks as well as building a positive practice environment proactively. This could include other measures to attract and retain skilled professionals in rural and under-serviced areas.

c. That there is a integrated district training plan in place which includes prioritisation of whom to train, and institutional arrangements to maximise the pace and quality of training with sound training follow up strategies in place.

d. A plan to improve workforce performance based on measuring facility performance and regular supportive supervision.

<table>
<thead>
<tr>
<th>Human Resources</th>
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<tbody>
<tr>
<td>Numerical Adequacy</td>
</tr>
<tr>
<td>% of vacancies for Medical officers, Staff Nurses, ANMs.</td>
</tr>
<tr>
<td>% of Level III facilities with 3 specialist in place (gynaecologist, anaesthetist, paediatrician)</td>
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<tr>
<td>% of 24*7 PHCs without 3 staff nurses.</td>
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<tr>
<td>% of Sub Center without ANMs.</td>
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<td>% of PHCs without Medical Officer.</td>
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<table>
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<tr>
<th>Performance Indicators.</th>
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<tr>
<td>OPD cases per PHC doctor</td>
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<tr>
<td>Delivery per Site of institutional delivery per month (</td>
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</table>

| These indicators will help ensure service guarantees as per norm. |
| could further look at per nurse posted there). |
| Bed occupancy rates in secondary care centers. |
| C-Sections per gynaecologist/ per multi-skilled MO per month. |
| Lab test per lab technician per month. |
| Sterilisation per surgeon (trained MO) per month. |
Chapter 8

Community Processes in the NRHM

Background: The architectural correction of the health system promised by the National Rural Health Mission (NRHM) included “communitization” as one of its key anchors. The process included several components whose collective vision was the active engagement of communities in the delivery of health care. The community process components were designed and implemented to synergize with improved access and use of services.

Key components are:

- The ASHA and her support network at village, block and district levels.
- The Village Health, Sanitation and Nutrition Committee (VHSNC)
- Untied funds to the Sub Centre and the VHSC to leverage their functions as avenues for public participation in monitoring and decision making
- Community Monitoring
- NGOs and other civil society organizations to support the implementation of these components

Seven years later, the ASHA programme continues to be the centrepiece of the community processes component. In 2005, when NRHM was launched, the ASHA programme was intended for implementation in the eight high focus EAG states, the North Eastern states and in the tribal areas in the other states. In 2008, based on popular support, and positive reports in the annual Common Review Missions (CRM) and individual state demands, the programme was scaled up to cover the entire country.5. The ASHA programme now has a force of 861548 women health volunteers working with communities and serving as a bridge between people and health facilities to ensure that the key goals of the NRHM are met.

Globally it is now acknowledged that community health workers serve to provide a critical and effective link with health systems and are a strong factor in promoting healthy behaviours. This is particularly true in several districts in the Indian context where health workforce is a constraint to improving health indicators.

1. The Role of the ASHA: There are three distinct yet related roles for the ASHA: that of a facilitator, an activist and a provider of services at the point of first contact. As a facilitator or

5 Himachal Pradesh does not have ASHA as they prefer to rely on the Anganwadi Worker.
link worker the ASHA enables people’s access to the health system, as an activist she is a social mobilizer, ensuring that the marginalized are reached and that people have access to health entitlements, and as a service provider, she delivers preventive, promotive and first contact curative care. The ASHA is trained in skills to provide a package of first contact care for mothers, newborns, and sick children. This is important for her credibility particularly in underserved areas where her services may be life saving. National and global experiences prove that provision of such care is well within the purview of a trained and skilled community health worker such as the ASHA. All three roles are important, and while contexts determine which role takes precedence over another, a well trained ASHA should be able to fulfil all three roles and it is the responsibility of the district health system to ensure that she does so.

2. **ASHA Profile:** The ASHA is a woman, preferably married, in the age group 25 to 45 years, and resident in the community. Local residence is a non negotiable factor. While the norm is of one ASHA per 1000 population, in geographically dispersed populations, or in areas where there are scattered hamlets, the norm can be relaxed to ensure that a hamlet or habitation is served by an ASHA. This flexibility allows the district to ensure that marginalized families are not excluded. The ASHA should be a literate woman with formal education up Class VIII. This may be relaxed only where it is not possible to get a local woman resident with such qualifications. Adequate representation from disadvantaged population groups should be ensured to serve such groups better. The ASHA is a part time voluntary worker paid upon a system of performance based incentives, and expected to work for no more than three to four hours a day for up to 15-18 hours a day.

3. **Selection Process:** The selection of ASHAs is expected to be overseen by the District Health Society. ASHA selection is initiated by conducting Focus Group Discussions (FGDs) at the village level, to enable community understanding of the roles and responsibilities of ASHA and result in short listing of at least three names from each village. A meeting of the Gram Sabha should be convened to select one out of the three shortlisted names, and the minutes of the approval process in Gram Sabha shall be recorded. State Governments may modify these guidelines to suit state contexts. At this stage of the programme, this process is to be followed in areas where new ASHA selection is required because of attrition.

4. **Activities of an ASHA:** The ASHA’s work in the field consists mainly of five activities:
• **Home Visits:** The ASHA is expected to spend about two to three hours every day, for at least four or five days a week, on visiting the families living in her allocated area. Each household is to be visited at least once a month, and are mainly intended for health promotion and preventive care. *Priority is to be given to households where there is a child below two years of age or any malnourished child or a pregnant woman, she should visit the families at home for counselling them. Also, if there is a newborn in the house, a series of seven visits or more becomes essential.*

• **Attending the Village Health and Nutrition Day (VHND):** The ASHA is expected to promote attendance of mothers and children at the VHND for services provided by the Anganwadi worker or the ANM.

• **Visits to the health facility:** This activity is expected to ensure that the ASHA forges a link with the health system. Escorting pregnant woman or sick newborn or child to the health facility, is a voluntary activity, but in practice it is seen that communities recognize that the ASHA supports them to negotiate the unfamiliar environment of health facilities. Other than escort visits, the ASHA is expected to attend a monthly meeting at the PHC or for training purposes.

• **Holding village level meeting:** The ASHA is a member convenor of the Village Health, Sanitation and Nutrition Committee (VHSNC), and responsible for convening a monthly meeting. She is also expected to conduct meetings of women’s groups and adolescent girls for health education on preventive and promotive health behaviours. These community partnerships play a mutually beneficial role with the ASHA serving as a community health resource and the VHSNC and community level collectives providing her with support in carrying out her activities.

• **Maintain records:** The ASHA is expected to maintain three basic records:

1. Village Register in which she records the names and details of all members of the households in her allotted area, and updates based on pregnancies, births and deaths.

2. A daily diary in which she records details of her day to day work, such households visited and persons met for services including counselling. This serves as a basis for verification of payments

3. Drug Kit stock register: which serves as an indent of the drugs received and those used.
It must be emphasized that these records are to enable her to plan her work better, and be more organized. While the registers are reviewed by the facilitator during the village visits and review meetings, they are not to be used as instruments to penalize the ASHA.

These five activities envisage that in a population of 1000 or less, the ASHA will need to spend about 15 to 18 hours in a week on this work. Adding on additional tasks by the health or any department that will require her to work about six to seven hours a day is the point at which she can consider herself to be a full time worker with the implications that this entails for the system. It would therefore be wrong to add on tasks at the district level – when there is no such clear policy in place.

**Box 1: Measurable Outcomes of the ASHA Programme:**

**Maternal Health**

1. Every pregnant woman and her family receive health information for promotion of appropriate healthcare practices – diet, rest and for increased use of services which would focus on care in pregnancy, delivery, postnatal care and family planning services.

2. Every pregnant woman avails of antenatal care and postnatal care at the monthly health worker clinic/VHND.

3. Every family with a pregnant woman has made a plan and is prepared for the event of childbirth.

4. Every couple that needs contraceptive services is counselled on where to avail of the service.

**Newborn and Child Health**

1. Every newborn is visited as per a fixed schedule, more often if there are problems and receives essential home-based care and appropriate referral for the sick newborn.

2. Every family receives the information and support required to access immunization.

3. Every family with children below the age of two years is counselled and supported for – prevention and management of malnutrition and anaemia and for prevention of illness such as malaria, recurrent diarrhoea and respiratory infection.

4. Every child below five years with diarrhoea, fever, Acute Respiratory Infection (ARI) and worms, is provided with first contact curative care with home remedies and drugs in the ASHA kit, or counselled when referral is immediately required.
Disease Control

1. Individuals identified during home visits as having chronic cough or blindness or a skin patch in a high leprosy block is referred to the appropriate centre for further check-up.

2. Individuals prescribed drug therapy for tuberculosis or leprosy or surgery for cataract are followed up and encouraged to take the drugs or go for surgery.

3. Individuals with fever which could be malaria (or kala azar) have their blood tested to detect the disease and provide appropriate care/referral.

4. Village and health authorities are alerted to any outbreak of disease the ASHA notes during her visits.

5. **Role of the District leadership:** Box 1 lists the measurable outcomes of the ASHA programme. However these outcomes can only be realized to the extent to which the ASHA is enabled to carry out these activities. She can fulfil her three roles but this depends upon an enabling policy framework, strong community partnerships, but above all, a committed district level leadership that ensures that the following are in place:

   (i) Support structure at district, block and sub block levels for onsite mentoring, support and supervision, which is trained to support the ASHA

   (ii) Training sites and ASHA trainers at sub district level to ensure that ASHA training and skill building is a continuous process

   (iii) A performance monitoring system that is used for monitoring, feedback and improvement.

   (iv) A drug kit that is replenished at periodic intervals, an equipment kit and a communication kit to facilitate the ASHA’s tasks.

   (v) Regular and timely disbursals of performance based monetary and non monetary incentives

   (vi) A grievance Redressal system that is prompt and responsive.

Evidence has shown that ensuring that these structures and mechanisms are in place and provided that ASHA selection is indeed community led, the promise of CHW serving as a valuable support to the health system can indeed be realized.
The ASHA guidelines were disseminated to the states to serve as a basis for implementation. The document provides guidance on a range of topics: roles and responsibilities, selection, institutional arrangements, convergence with the Anganwadi Centre and with the ANM, working arrangements, Training, compensation, monitoring and evaluation and financing of the programme. States were free to adapt the guidelines to their specific state context.

5.i Support Structures: At the national level, the management of the ASHA programme is located within the Training Division of the MOHFW, supervised by the Joint Secretary (Policy), with oversight and guidance from the National ASHA Mentoring group, and technical assistance to states from the National Health Systems Resource Centre (NHSRC) which also supports the Training Division at the MOHFW on policy and operational issues.

At the state level the programme is expected to be led by the Mission Director, supported by the state ASHA Resource Centre, with a team leader, supported by a deputy and consultants who are entrusted with the responsibility of training and monitoring support to a cluster of districts. This team should also include a communications and documentation specialist to undertake development of training material as required.

At the district level, a unit of a District Mobilizer/Coordinator supported by an Accounts/Data assistant is expected to manage day to day functioning at the district level and liaise with the state ASHA Resource Centre and the District Programme Management Unit. At the Block level, a Block Community Mobilizer with the aid of ASHA facilitators (appointed at a ratio of 1:20 ASHA) are expected to provide onsite support, mentoring, supervision and review of the programme at the ASHA level.

The ASHA facilitator is expected to visit the ASHA at least twice a month and provide on the job mentoring, supervision, and handholding and enable her to conduct village meetings or to reach marginalized or resistant households. The block community mobilizer serves as the supervisor at the level of the Block, and interacts with the ASHA facilitators, conducts village visits and ensures monthly meetings of ASHA and facilitators at the PHC which are attended by the Medical officer in charge. These meetings serve as the forum for on the job training, refresher courses, drug kit replenishment, verification of payments and general problem solving. The District mobilizer is the coordinator and supervisor of the programme at the district level, and in addition to ensuring

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periodic meetings with block mobilizers and facilitators for review and supervision, is expected to coordinate training programme, payments and the Grievance Redressal system.

This level of management support is considered to be critical to the processes of selection, training, support and monitoring of the ASHA and other community processes programmes. It is important to ensure that all support staff are well oriented to the ASHA programme and trained in facilitation skills for which an ASHA facilitator handbook is available. It is also the responsibility of the district leadership to ensure orientation of all staff at service facilities and outreach level to the guiding principles of the ASHA programme.

5.ii Training: Building skills and competencies of the ASHA is the key to an effective programme. The training is expected to be residential, and provided through about three to five training sites chosen and accredited for that purpose at the sub district level. ASHA training follows a cascade approach with state trainers and ASHA trainers. The ASHA trainers are drawn from the district and sub district levels and a team of three trainers are considered necessary to train a batch of 30 ASHAs. The team includes a mix of personnel with clinical and mobilizational skills and are trained and accredited at recognized state sites.

ASHA modules are designed for experiential learning. ASHAs are trained in an eight day induction module within the first two months of joining, followed by four rounds of training of five days each, in a set of skills designed to enable her to achieve the outcomes listed in Box 1. These are taught to her through Modules 6 and 7. These 28 days of training are to be completed in the first year. Annually thereafter in addition to the training days, the ASHA is also expected to mentored in the field by the ASHA facilitator and provided with about 12 days of refresher training or training in new topics that are locally relevant.

At the district level the trainers of ASHA and her facilitators are the ASHA trainers. The trainers at all levels should ideally be full time given the numbers to be trained. In addition to classroom training, trainers at each level are expected to support and supervise training held at the next level. The districts should ensure that at least 30% of block trainings are entrusted to NGOs of repute with experience in training health workers. This preserves the quality and fidelity of technical content, the spirit of mobilization and has the potential to serve as best practice area for the rest of the district. Adequate numbers of training modules for the use of the ASHA, trainer manuals and audio visual aids are expected to be in place at the sub district training sites. As part of building the training to enable career opportunities for the ASHA a certification programme is underway, this will be implemented at the district level.
5.iii Performance Monitoring of the ASHA programme:

ASHA performance is assessed on her functionality of the ASHA by the indicators in Box 2. Effectiveness of the ASHA is dependent on the quality of the training inputs, the support provided to her on a day to day basis, ensuring that she has the requisite supplies and equipment to undertake her activities, her motivation is kept high by timely and dignified payments, and finally by a functioning health system delivering accessible, affordable and quality services.

Box 2: Performance indicators of the ASHA programme

1. Newborn visit within first day in case of home deliveries
2. Set of home visits for new born care as specified in the HBNC guidelines
3. Attending VHNDs / Promoting immunization
4. Supporting institutional delivery
5. Management of childhood illness – especially diarrhea and pneumonia
6. Household visits with nutrition counseling
7. Fever cases seen/ malaria slides in malaria endemic area
8. ASHAs acting as DOTS provider
9. Holding village/ VHSNC meeting
10. Successful referral for IUD, female sterilization or male sterilization cases and/or providing OCPs/ Condoms

The process of data collection is as follows:

Step 1: ASHA facilitators will collect information from ASHAs during monthly meetings. ASHAs are not required to keep any additional records, but to use their register and diary to provide this information.

Step 2: The facilitator reports to the Block Coordinator on (i) total number of the ASHAs are functional on each task, and (ii) the total number of ASHA who are functional on at least six of the ten tasks.

Step 3: the Block Coordinators in turn consolidate the report from all facilitators of the block, on a monthly basis, and submits it to the district coordinators.
Step 4: Based on the data obtained in Step 3, the district coordinator will grade the blocks thus:

- **Grade A** – Blocks where of the total ASHAs >75% ASHAs are functional on each of the tasks 1-10 and the total of at least 6/10 tasks
- **Grade B** - Blocks where of the total ASHAs 50-75% ASHAs are functional on each of the tasks 1-10 and the total of at least 6/10 tasks
- **Grade C** - Blocks where of the total ASHAs 25-49% ASHAs are functional on each of the tasks 1-10 and the total of at least 6/10 tasks
- **Grade D** - Blocks where of the total ASHAs <25% ASHAs are functional on each of the tasks 1-10 and the total of at least 6/10 tasks

No numbers regarding functionality are to be reported by the district to the state.

At the block level a block level database is also maintained on the numbers of ASHA selected, population covered, numbers trained, individual payments made against various programmes, and recording drop outs. This is consolidated at the district and state levels.

5.iv **Drug Kit, Equipment Kit and Communication kit:** All ASHA are to be equipped with a drug kit and trained in the use of the contents therein, so as to able to treat minor ailments/problems. The drug kit contains: Paracetamol tablets, Albendazole tablets, Iron Folic Acid (IFA) tablets, Cotrimoxazole, Chloroquine tablets, Oral Rehydration Salts (ORS), and eye ointment, condoms and oral contraceptive pills, pregnancy testing kits, and malaria testing kits. The drug kit is to be refilled during the monthly meeting at the PHC. The ASHA is to keep a record of consumption of the drugs, for effective refilling and ensuring adequate/timely availability, in her drug kit stock card. In addition to the drug kit the ASHA also needs an equipment kit consisting of a weighing scale, watch, thermometer, and baby blankets to provide care of the newborn. Finally the ASHA also needs communication material to enable her to conduct interpersonal and group communication activities for behaviour change related to preventive and promotive health.

5.v **Payments:** ASHA payments are based on a system of performance based remuneration. She is incentivized for several tasks, and payments are expected to be made to her through bank accounts or other systems that ensure complete and timely transfers. The ASHA programme also supports other motivational instruments such as sarees, ID cards, Bicycles, ASHA help desks and rest rooms at health facilities, ASAH radio, newsletters, and events such as the ASHA diwas and ASHA sammelans. Monetary and non monetary payments are expected not just to compensate for her time, but to improve her social recognition in the community and strengthen her motivation.
5. vi  **Grievance Redressal System:** At the district level, a grievance Redressal mechanism for the ASHA is to be set up since the ASHA need a forum to be able to air their issues related to delayed payments and work situations. The district should ensure a separate space for the cell, set up a five member committee, provide a secretary, and equip the cell with a functioning phone line, and a fixed P.O number. The number of the cell should be displayed at all facilities and publicised so that ASHAs are aware of this. A record of complaints and Redressal needs to be available.

**Convergence between ASHA, ANM and AWW:** So far as the ANM and Anganwadi are concerned, the relationship at the community level is one of convergence for activities such as participation in the VHND and mobilizing for nutrition rattled interventions (growth monitoring, supplementary feeding, and take home rations). One source of conflict has been overlap in incentives (lack of specification on who the recipient is for incentives against family planning or JSY, for instance) but once this is taken care of working relationships tend to be smooth. Joint meetings of all three frontline workers and convergent monthly reviews at the block level facilitate team work between all three functionaries.

II. **The Village Health, Sanitation and Nutrition Committee**

The Village Health, Sanitation and Nutrition Committee (VHSNC) were defined as an integral part of the community processes intervention in the first phase of the NRHM, and were expected to serve as the community level of support to the ASHA. They were also the mechanism by which elected representatives were involved in community health and governance by enabling accountability of health care service providers in outreach and at facility levels. They are the key platform to address action on social determinants including age at marriage, literacy, water and sanitation, nutrition, substance abuse, ad for the development of village health plans. Given the focus of the districts and states to establishing and strengthening the ASHA programme, the progress on VHSNC in states is mixed.

A total of over 500,000 VHSNCs have been formed in the country. Although guidelines specify that the VHSNC is to be formed at the level of the revenue village, states such as Bihar, Uttar Pradesh, Haryana, Himachal Pradesh, Kerala and Tamil Nadu have formed the VHSNC at the level of the Gram Panchayat through engaging the Standing Committee on Health.

The ASHA is the member secretary of the VHSNC, and the PRI representative is expected to serve as the Chairperson. Other members include the AWW, frontline functionaries of other departments resident in the village, members of SHG, and representatives from marginalized communities. VHSNC are provided with an united fund of Rs.10,000 per year to address local health issues.
Experience with VHSCs is varied across states, and many states took three to four years to get them going. Training of VHSNC is underway in several states, but the pace is slow. Part of this is due to the paucity of support systems in most states. Most states have no mechanism to train the VHSNC members, ensure regular fund flow, and assess how funds are being spent.

VHSNC where even functional in a rudimentary way undertake such activities related to control of vector and water borne disease, village level sanitation, IEC and health promotion activities.

However there is sufficient experience emerging from selected states that well supported and trained VHSNCs can begin to play a role in addressing social determinants of health in a meaningful way, in the development of village health plans, and a strong VHSNC and a vibrant ASHA programme can play a mutually supportive role and enable positive outcomes. In the state of Chhattisgarh, the Mitanin plays an important role as convener of VHSNC, and there is also active inclusion of the PRI. In Orissa’s Gaon Kalyan Samithies also, PRI participation predications is strong, and the AWW also plays an important role.

VHSNC also need support, orientation and capacity building. VHSNC would need recurrent rounds of training- and just one round would not suffice. It would also require linkages with block level and district level committees. It is important that districts prioritize - proper constitution of VHSNCs, training of VHSNC members, regular fund flow and facilitate expenditure of untied funds to address local health needs of the community, rather than mandate expenditures by the block or district health society.

III. Community Monitoring: Community monitoring linked to the communization process is thus one of the key means of ensuring accountability in NRHM. The main strategy of community monitoring as developed under the National AGCA (Advisory Group on Community Action) is to mobilise VHSNCs to monitor and score health facilities in the form of colour coded report cards which display the level of performance of each and then conduct Jan Sunwais or Public Hearings to enable action on deficiencies. Planning and monitoring committees are also set up PHC, CHC and district levels. These bring pressure to improve public health care services. The programme is expanding in several states but is yet to be scaled up in the entire country. The effectiveness of community monitoring is reliant on intensive engagement by NGOs. The three major activities of community monitoring include:

1. Training and entitlement awareness:
   - Community awareness on health entitlements
- Training of village health committees (VHSNC) and RKS
- Display of Citizen’s charter and service guarantees

2. Monitoring and information sharing
- Collection of information and sharing of report cards, community experiences of health services
- Active multi stakeholder Monitoring and Planning Committees at PHC, Block and District levels

3. Public dialogue
- Periodic public dialogue (Jan Sunwais) - Engagement with providers based on community evidence, denial of services

What to look for:

<table>
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<tr>
<th>Indicator: Source and Periodicity</th>
<th>Interpretation and Action</th>
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<tr>
<td>% of ASHA functional on 6/10 tasks (tasks specified earlier)</td>
<td>Blocks graded B, C and D must be reviewed more frequently. The block coordinators of the respective blocks need to meet with the district coordinator and identify which clusters face these problems. The causes could be poor training, poor supplies, poor payment, and these must be investigated before labelling the ASHA as non-functional. Performance in terms of ASHA functionality as reported must be correlated with health system outputs. Where there are gaps - it is a complex of ASHAs skills and the supply side problems - and dialogue would help improve outcomes.</td>
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<tr>
<td>Source: Performance monitoring report with Block Grading on ASHA functionality indicators Monthly</td>
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<tr>
<td>% of ASHAs functional on home visits for newborn care as specified in HBNC guidelines</td>
<td>This indicator is one of the ten in the ASHA functionality indicators, and has a performance linked incentive of Rs. 250 per set of newborn visits. Newborn visits are expected to be made on specified days. Low figures on this could indicate non-payment to the ASHA, facilitators not visiting the ASHA to collect the information,</td>
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<tr>
<td>Source: Performance monitoring report, correlated with payment registers Monthly</td>
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<tr>
<td>% of VHSNC meeting held against expected (block wise)</td>
<td>Low reporting could include non-constitution of VHSNC, lack of cooperation by elected reps, and lack of initiative by the ASHA and need to be addressed through intensive engagement at the village by the facilitator supported by the block and district.</td>
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<tr>
<td>Source: HMIS</td>
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<tr>
<td>% of ASHAs attending VHSNCs meeting</td>
<td>This indicator is one of the ten in the ASHA functionality indicators, and has a performance linked incentive of Rs. 150 per</td>
</tr>
<tr>
<td>Source: Performance monitoring report, correlated with payment registers</td>
<td>monthly meeting held.</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
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</tr>
<tr>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Number of villages without an ASHA in the district</td>
<td>While at the facilitator level the focus should be on households not covered by ASHA, the block level data should identify villages without an ASHA and selection processes initiated.</td>
</tr>
<tr>
<td>ASHA database</td>
<td></td>
</tr>
<tr>
<td>Annual</td>
<td></td>
</tr>
</tbody>
</table>

| Number of ASHA who cover a population greater than 1500 in the district | This indicator provides information that when the population per ASHA exceeds 1500, the chances of households being dropped are high and could result in the marginalized being left out of the purview of the ASHA’s coverage, and hence other services as well. This data should alert district managers to the fact additional ASHAs should be selected. |
| ASHA database                                                 |                       |
| Annual                                                        |                       |

| Ratio of ASHA facilitator to ASHAs                             | This is a measure of supportive supervision. Block coordinators submit reports of the meeting with facilitators. The block coordinators are reviewed monthly or even twice a month at the district level. Facilitators may or may full time contractual staff or existing staff given additional work- but without the regular ASHA visits and ASHA meetings and the facilitators review meeting, the ASHA programme will not yield optimal results. |
| Proportion of ASHA facilitators who were reviewed and had made visits last month and completed their check lists. Source: District community mobiliser-minutes of review meetings of ASHA facilitators and block coordinators. |                       |

Other issues to look for include data on training status, quality of training, drug kit replenishment, regular payment to ASHA, functioning grievance Redressal systems, and that the marginalized households are not being left out.
Chapter 9:  

Programme Management at the district level

The institutional structures required at the district level could be listed as follows:

1. The District Health Society. (A district health mission of the leaders is also desirable)
2. The District Chief Medical and Health Office (CMHO).
   a. Establishment division.(HR management and infrastructure management)
   b. District procurement and stores unit.
   c. Nursing management division.
   d. Programme divisions including the national programme implementation bodies — Malaria control office, AIDS control office, leprosy control, blindness control, TB control, The district disease surveillance unit and the RCH programme office and sometimes a separate Immunisation officer. Financial division
3. The district(health) programme management support unit (DPMU). Under this we have the district programme manager (DPM), the district community mobiliser (DCM), the district HMIS coordinator or district data manager (DDM) and the district accounts officer (DAM). There may be contractual staff to support other programmes as well.
4. The district civil surgeon’s office—this refers to the officer in charge of the district hospital. In some states the same charge of other public hospitals in the district and either reports to the CMHO or directly to another director at the state level.
5. The district training unit/health resource center.

The District Health Mission:

It is meant as an apex institution of governance. It is often chaired by the cabinet minister in charge of the district. It could involve members of parliament, the legislative members and the elected district panchayat office bearers elected from that district. Its main function would be to endorse the annual work plan and review the progress on this plan. It has no executive powers by itself but since its members have their respective powers they could use it to assist or intervene in the programmes. Most states do not have a separate mission and the governing board of the district health society plays this role.

District Health Society:
All states have merged their various disease control societies into a single district health society. A district health society has a governing body and an executive committee. The governing body is usually chaired by the district collector or the district zilla parishad chief with the other being a co-chairperson. The chief medical officer is the member secretary.

In most states the district collector is the chairperson of the executive committee of the district health society though it could be the second IAS officer of the district too. The chief medical officer is its member secretary.

The members of the governing body include representatives of all key departments. It also includes representatives from civil society and from professional bodies usually by nomination. The executive members on the other hand are usually members of the different programmes including the HIV control programme, the RCH programme officer, the immunization officer, the malaria control officer, the tuberculosis control programme and the blindness control programme. There is no uniformity about this – but this is obviously desirable. Desirable too is the participation of the district programme officer that is contractually appointed under the RCH and NRHM programme.

Functions and powers: The district health society is the authority that approves and adopts the district health plan and that allocates work to the different individuals and institutional structures and reviews their performance. It is the main body empowered to implement all national health programmes. Most of the budget for the health programmes comes through the district health society. From here it is released to the blocks and to the different programmes. Hence it is one of the most important structures created.

The district health society acts through the office of the chief medical and health officer, the office of the civil surgeon, the district programme management unit, the district national programme management units, the district training center and the district planning/resource unit. In effect therefore it is the chief coordinator of these units. By virtue of the fact that the chief medical officer is the head of most of these units (except the civil surgeon’s office) coordination is achieved.

The district health society also, by its committee based functioning, allows for better distribution of work and more transparent and accountable distribution of resources for specific tasks.

The central role of the DM is to ensure good governance in the district health society. There are five such crucial aspects to monitor:
Periodic meetings of the district health society– at least a monthly executive committee meeting and a half yearly governing body meeting --for which detailed agenda papers are prepared and minutes are made and signed.

Ratification and approval of budgets and releases by executive committee, with clear delegation of financial powers – the higher amounts requiring approval by the full executive committee and chairperson of the governing body. This is essential for the transparency – accountability function.

Quality of public participation. Not just limited to a few persons close to those in power, but also some representatives of under-privileged sections be it elected representatives or NGOs or community based organisations.

Access and utilisation of good quality technical assistance and incorporating such inputs into the planning and management process.

Public scrutiny – Reports, especially annual report and plan available in the public domain and easily accessible to all.

A district magistrate is encouraged to undertake supportive supervisory visit to the health institutions in the district. This will help him in understand the actual delivery of services (preventive and curative) through the public health system. Annexure 1 details a supportive supervision checklist that would be handy.

The Chief Medical and Health Office:

This office is the central office that manages the district health programme.

It is usual to have four to six officers who function as deputy chief medical officers- who are usually known as programme officers – for each of them manages one or more national programmes. The usual posts are programme officer, immunization, tuberculosis control, malaria control, leprosy control, and RCH or family welfare. The situation differs from state to state and the exact number and designation of the posts varies. But in practice every chief medical officer would have three to five officers who assist him – not only in the programmes but in all planning, management and administrative functions. This structure along with its support staff at the clerical level is what would be the structure of the chief medical officers office which is the main institution of district health management.

Functions:
The most important of these is the section that manages workforce issues – appointments, transfers, service papers, promotions, disciplinary action, retirements, and pensions. Much of the time of the CHMO office is consumed in these functions.

The other most important function relates to financial arrangements – the payment of salaries and the payment for routine recurrent expenses and the expenditure of the amount budgeted and transferred to it – from the state treasury and from the district health society.

The third most important function usually relates to the creation and maintenance of infrastructure and the procurement of goods and supplies, their stocks in the stores and their distribution through the system. After these, the fourth in priority is the implementation of programmes- which translates to carrying out the activities that are of a recurrent pre-determined nature and which relate to the various health programmes. Conduct of the Maternal Death Review is one of the responsibilities of the CMHO.

Monitoring the implementation and the health status and planning for the next year is the next in order of priority. This is also known as the health management information system. And perhaps last and least in priorities is efforts in the form of field visits and meetings with the community --to understand health problems and their determinants. The above order of priority is not the desirable one nor what the authors recommend but what in practice is seen in most districts.

The District Programme Management Support Unit

This is usually made of contractual staff as different from the CHMO which has regular staff. The key persons under the NRHM are the

- District programme manager,
- The district accounts manager
- The district data analyst- for coordination of HMIS
- District community Mobiliser- for coordination of ASHA and VHSC programmes

Functions: The functions of each have been standardized at the national level and circulated.

The Civil Surgeon and the District Hospitals.

Typically the district hospital comes under an officer who does not report (only) to the CHMO, but directly to the state director. If there are any civil hospitals in the district this could also come under him. In many other states the civil surgeon reports to the CHMO. This district hospital administrator
may be assisted by a separate deputy medical superintendent and resident medical officers and other hospital administration staff.

**The Role of Supportive Supervision:**

There are many processes in programme management - planning, task allocation, resource allocations, supportive supervision, capacity building, monitoring and reviews, human resource management and so on. One of the weakest areas is supportive supervision. Supportive supervision is essential to ensure that the tasks are carried out as scheduled, and support the staff with help in capacity building and problems solving required to achieve objectives.

Effective Supportive supervision should mean that

a. Every facility is visited at least twice a month from the appropriate next higher level, and once a quarter at east from one more level higher.

b. There is a check-list for the above visits.

c. The facilities are clean and well maintained with accountability for this being shared with public health supervisor as well.

d. There is a periodic medical quality of care review done by the supportive supervision team which ensures that standard treatment guidelines and essential drug lists are in place and that these are followed.

e. That there is a quality assurance committee in place. Also that this QAC assesses and scores every facility for quality on a number of parameters-standards- and this is conveyed to them- as well as there are documented efforts to close the gaps and improve quality of care. This would include maintenance, bio waste management, infection control, patient amenities, etc etc.

f. There are no stock outs of drugs and supplies for CHC, PHC and sub-centers due to distribution gaps between district warehouse and the facilities.

g. The untied funds of each facility are properly spent and accounted for and that the RKS is functional.

h. Reporting on HMIS of public health facilities is regular, complete and true. There is a data quality assessment tool that is available for this purpose.

i. All private sector units in the block are registered, and so are their ultrasound machines and they are reporting regularly on HMIS and on form F.

j. There is a competent district health action plan which is revised into a district based work plan based on the final financial sanction made to the districts for that year.
The District Training/Resource Unit and the role of partnerships.

This is still only an idea in most states-- but slowly its necessity is being felt. NGOs could play this role but there is almost no instance of where such a role is being played by an NGO. It is a good idea to draw in five or six suitable, talented, individuals from within the department and from outside to form such a unit to help the district health society. The roles of such a unit could include:

- Making the district plan and supporting its implementation.
- Making the training plan and leading the training.
- Being a repository and channel of technical assistance to the district health system.
- Programme appraisal and evaluation.
- Epidemiological studies.
- Strategy development and projectisation.
- Acting as a think tank and change agent to support the district health planning and administration efforts.

More often than not the knowledge and skills needed to do all the above is not available within the district, nor are suitably qualified and experience resource persons available for employment. Even if they are available, they could hardly manage the whole task by themselves. The main strategy for knowledge resources is therefore through partnerships.

Every district health society and its key personnel should know which are its designated partnership organisations- and if there are none, they should strike up such partnerships.

The state and national health resource centers would also provide technical support or mobilise a technical support agency to assist the district.

The major challenge for administrators in this area is how to recognise the need for knowledge to inform the programme as different from more of active monitoring and enforcement of the rules. Administrators could be so full of answers that they do not see the question. A general principle that would help is that if over 50% of the units are not able to accomplish a particular activity or having problems with it- then there is a design issue requiring knowledge or the need for a careful re-examination of guidelines and rules to be able to solve this. And when problem-solving, one needs to go beyond the obvious. For after all earlier administrators must have grappled with the same problem- and one could learn from their experience instead of making the same mistakes all over again. This is what one means by not seeing the question. Faced with a problem one must be able to articulate it as a question which would help come up with a solution.
The other challenge is to respect and be guided by technical opinion, while at the same time being able to dialogue with it- and not accept it as a black box. This is particularly useful when technical opinion differs between experts-or between what the state guidelines are suggesting and what your local experts- government or non government sources are telling you. When the technical issue relates to a bio-medical detail- it is one type of challenge and resolving it involves looking for evidence in a set of sources- but eventually one would need some technical authority to sign off on the advice. When the technical issue relates to a health systems problem- then the challenge is to recognise it as a technical. Thus how to get doctors to stay in remote areas, or how to measure and motivate workforce performance, or how to get data of good quality on HMIS, or how to improve financial flows and improve absorption of funds, or how to select and build capacities in NGOs etc etc- are also technical domains where there is a fund of knowledge and experience that must be leveraged rather than de novo trying to re-discover the answers. Based on such knowledge, there is great potential for innovation. Without such knowledge it is costly process of trial and errors and whims of passing officers can do great damage to well laid out plans of their predecessors or to national and state guidelines.

**Health Management Information Systems:**

This is one of the most important tools that the district health administrator has to manage the health programmes in the district. HMIS provides

a. Monthly information on progress on the delivery of key health service – volume of services and quality of services as well.

b. Monthly information on births and deaths and some diseases.

c. Quarterly information on progress of training programmes and staff issues

d. Annual information on facility infrastructure and staff.

e. Quarterly financial management reports.

Of all these the most important from the viewpoint of health programme management are the first two. The quarterly and annual information is also important, but these are available as direct district officer’s reports also and a HMIS is not indispensable for getting these.

**Flow of Data:**
The service providers record the data as and when they provide services. Births and deaths are recorded by facilities and by ANMs from the sub-centers.

From the recording registers, the services providers or in large hospitals the data manager, transfers the data to reporting formats. They then send the reports to the block HMIS office.

At the block HMIS office the data of each facility is entered into a computer and a block aggregate data report is created by the computer. Sometimes this process is not computerised and the block aggregated report has to be generated manually.

The block aggregate reports are then sent to the district HMIS office. Here the district hospital data is added to all the block reports and the district HMIS report is generated.

Data from private sector facilities could be added into the block aggregated form using a CHC format or into the district HMIS report using a DH format. The latter is done, if the private hospital is catering to the entire district population or is located in the district headquarters town.

Once the district HMIS report is uploaded it has to be separately confirmed on the web-portal by a district officer assigned this task.

After the district HMIS report is uploaded, an analysis of the district data and block data should be done and the analysis report sent to the health programme managers and administrators at block and district level. This feedback form is the most important step. Without it the whole system is of little use. And if this is sent, it means the entire system is working well and any gaps found are likely to get corrected.

Analysis of the data is indicator based. This needs a good understanding of denominators. This in turn requires a good understanding of the population serviced by that facility.

The facility based uploading of data is now getting stabilized.

**Issues of Data Quality:**

The main causes of poor quality data are the following:

a. Non-reporting or delayed reporting of facilities: A facility may report so late that its data is not included. Then it may get added up altogether in the next month. Timeliness and completion of reporting therefore complement each other. The rules on delayed reporting should be clear.
b. Poor recording registers- either there are data elements which are missing, or the registers do not lend themselves to computing the monthly reporting figure and mistakes occur during computation.

c. Data duplication- the same event is recorded by two different persons and added up or by the same person twice. Example- 1. An institutional delivery in a PHC is reported from the PHC, but also reported by the ANM. This error is avoided if only those providing the services are allowed to report it. Example 2- A pregnant woman is registered in the sub-centre during her first ANC and then again registered from a PHC when she goes there for a check up. This error is avoided if the woman carries a maternal health card and the PHC records the visit as an ANC check up but not as a registration.

d. Data definition problems: The data definition has to be understood. This is a function of training. The service provider’s HMIS Manual prepared by M&E division of MOHFW and NHSRC should be the basis of the training service providers so that standard definitions are used.

e. Problems of aggregation: If done manually- high number of errors are likely to creep in. If data elements are disaggregated the errors could be even higher. There are also standard errors of which facilities are aggregated and what data elements contribute to an indicator etc. One would need a local software application for this purpose.

f. Data entry errors: The data manager should check these before confirming the data. There are also data validation checks that could be run to detect these errors in time.

g. Private sector data: Most private sector units would be willing to report, if we make the effort to contact them. Those accredited for JSY or part of a PPP would have to report as a condition of accreditation. Large gaps in private sector data is a problem today.

h. False reporting: This problem is overstated. Most data quality issues are due to the other reasons cited above- but there is some false reporting. Checking during supervision helps.

Use of Information:

The HMIS service provision data could be used to identify

1. which blocks/facilities are performing poorly or whose performance is declining and which facilities are performing well.
2. Which services are not reaching the entire population of potential beneficiaries ... for e.g. is immunisation reaching all children below 1 or are some children getting left out?

3. Whether the services provided are of adequate quality- thus if antenatal care was of good quality it would include checking for blood pressure and the number of pregnant women detected with hypertension would be at least 5% of all pregnancies if not more. If on the other hand the number of pregnant women picked up are very low, then the quality of services provided is likely to be deficient. There are many such useful “quality indicators” in the HMIS data set at each level.

Based on this information corrective or supportive action could taken. Such action could include investing more human and financial resources where the case loads are more, organising supervisory visits to places where the facilities are performing below expectations, organising BCC campaigns where beneficiaries are not utilising the services adequately and so on.

Analysis of HMIS data is the single most important source of information for district planning and for monitoring improvements in health service delivery.

What to look for?

a. Has governing board and executive committee of District Health Society met regularly. Are its minutes well maintained. The next time it meets, ensure that the annual work report and the annual work plan are placed before it before – if it has already not been done.

b. Is a district programme management unit in place. Are all the positions provided for under NRHM as approved for the state filled up. Is there a good integration and rational work allocation, between officers under the CHMO and the DPMU contractual team.

c. Is supportive supervision strategy and team is in place? Is every facility is visited once a month by immediate supervisor and once a quarter by the next higher level of supervisor. That supervisors have check list and when reviewed can clearly state progress against such check-lists.

d. Are all reporting units of HMIS (facilities) are filing complete reports in a timely manner.

e. Is there is monthly- at least quarterly - analysis of the HMIS data and a feedback sent to the blocks and facilities.

f. Is there clarity on who are the technical partners providing support for training; for planning? For other areas where progress is slow. How active are the links with state and national resource centers for technical support and with training centers?
Chapter 10:

Financial Management under NRHM

Introduction- The Macro-Picture:

The National Rural Health Mission (NRHM) not only initiated architectural corrections in the public healthcare delivery system, but also aimed at bringing the focus back to public health in terms of higher resource allocation to health, and to bring about financial protection for the poor and vulnerable sections of the society.

The funding under NRHM assumes an umbrella funding approach, i.e. it provides for all health programmes and activities. In this sense it is a departure from previous central financing which focussed on disease specific items: NRHM allocates resources for overall Health System Strengthening and not for any defined health condition or disease. This also makes NRHM planning and budgeting all the more challenging as strategies and activities for all levels need to be contextualised as per local needs, capacity and resources.

In order to increase the allocation of resources to public health system in real terms, NRHM envisaged a 10% increase in states’ health budget outlays every year accompanied by an increase in the central government’s share in the state health budget to 40% (from the current level of approximately 20%). These increases put together, are expected to take the share of public health expenditure in India to 2.5% of GDP (from the current level of approximately 1%). Within the NRHM financing pool, it is expected that at the state level, the share between the central and state governments would be in the ratio of 85%-15%. This 15% state contribution to NRHM has to be over and above its present commitments in the health sector spending. It is heartening to note that the eleventh did see a substantial increase in Plan allocation to the health sector- and the main instrument of this was the NRHM. It is also heartening to note that most states responded and made corresponding budgetary increases for health care. As a result the public share of total health expenditure expanded from a meagre 18% to almost 30%. However the actual sums released was about one-thirds of what was envisaged in the NRHM framework as required to reach NRHM service delivery targets (Rs 66,000 crores against Rs 175,000 crores ) and not surprisingly the achievements were also in the same range.

As we come into the 12th Plan- the situation changes. Though the Plan envisages the same expansion in public investment as in the 11th Plan, due to the necessities of fiscal consolidation- effected mainly through reduction of Plan expenditure in consumption areas, the first two years, especially the
budget for 2013-14 has seen very modest increases. Clearly the challenge is to use the money much more efficiently, so that we get more value for the money.

It would also mean that states would have to raise more resources- and fortunately many states are in a position to do so. Even at the district level, a competent and alert district administration could find many avenues for raising the resources required.

To summarise the challenges at the district level are:

a> to use funds more efficiently- and transparently!
b> To ensure social protection against the increasing costs of health care.
c> To raise additional resources needed.

A. Using Funds More Efficiently: (and transparently)

In order to ensure that the additional funds for the health sector are better and efficiently utilized for achieving the public health goals, NRHM adopts the following strategies:

Delegation of Powers:

a) utilizing the “society” route of financing in a decentralized structure through state and district health societies. The fund
b) Formation of RKS (Rogi Kalyan Samities) at health facility level.
c) moving much of the money in the form of untied funds- untied funds to the village committee, to the sub-center, to the PHC, to the CHC and to the District Hospital.

Improved Accounting:

d) electronic banking- with funds moving in the form of bank transfers as peripherally as possible.
e) paying for contractual supplementary accounting human resources to speed up accounting leading to submission of utilization certificates in time.
f) A system of concurrent audit- some audit agency that visits on a monthly or quarterly basis, and ensures that accounting procedures are efficiently followed.
g) Timely annual audits.

Differential Financing:
A more purposive resource allocation between facilities and providers so that those handling higher case loads have more resources to ensure quality of care.

**Funds Flow under NRHM- and the delegation of financial powers.**

- Financing to state and district health societies under NRHM is off-budget funding, i.e. over and above the budgetary provisions under regular health department budget lines. NRHM funds do not flow through DDOs (Drawing & Disbursing Officers), but through institutions in the form of Registered Societies. This also implies that the “doctrine of lapse” does not apply to NRHM funds. However as public funds, they are open to public scrutiny and public audits, and GFR (General Financial Rules) of the respective states apply to these funds. On the other hand, while Society route offers flexibility and continuity, it is also faced with some serious problems, especially in light of transparency and accountability. Potential problems are in the merger of Expenditure with Authorization & Payment, and for reducing this risk explicit transparency mechanisms are mandated.

- Explicit transparency mechanisms are built into the design: These include a more active participation of non-government members in the “Society”, concurrent audits and FMRs (financial management reports) in the public domain.

- The actual funds flow under NRHM from centre to state to district happens through cheque/bank transfers to respective bank accounts. Under NRHM, at the district level, one main account (bank account) needs to be maintained for the District Health Society (each for RCH and Mission flexipools transfers). This account may also have six separate sub accounts for the six national programmes. The scheme of funds transfer protocol is depicted in the figure below.
NRHM financing is bottom-up, in the sense that funds flow is according to need-based annual plans (PIP – Programme Implementation Plan) prepared at the district and state level, and discussed and ratified by the central government every year. The approved funds under NRHM flow through four major channels, which correspond to the four major parts under NRHM PIP, explained below.

NRHM financing channels:

A) Reproductive and Child Health-RCH

B) NRHM Health Systems Strengthening

C) Immunisation, including Pulse Polio (part of RCH Flexipool)

D) National Disease Control Programmes (as per existing programme formats)
1) NVBDCP (National Vector Borne Disease Control – Malaria, Filaria, Kalazar, Chikungunia)
2) RNTCP (Revised National Tuberculosis Control Programme)
3) NLEP (National Leprosy Eradication Programme)
4) NPCB (National Programme for Control of Blindness)
5) NIDDCP (National Iodine Deficiency Disorder Control Programme)
6) IDSP (Integrated Disease Surveillance Project)
7) Non communicable diseases

The main heads under RCH and Mission flexipools are as follows:

<table>
<thead>
<tr>
<th>RCH-II (Part A)</th>
<th>NRHM (Part B)</th>
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<td>1. Maternal Health</td>
<td>1. ASHA</td>
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<td>1.1. Operationalising facilities</td>
<td>2. Untied Funds</td>
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<td>1.2. Referral transport</td>
<td>3. Hospital Strengthening</td>
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<td>1.3. Integrated outreach services</td>
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<td>1.4. JSY</td>
<td>5. New Constructions, Renovations and setting-up</td>
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<td>1.5. 24-hour deliveries</td>
<td>6. RKS Corpus funds</td>
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<td>2. Child Health</td>
<td>7. Panchayati Raj initiatives</td>
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<td>3. Family Planning</td>
<td>8. IEC/BCC under NRHM</td>
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<td>3.2. Spacing methods</td>
<td>10. Additional Contractual Staff</td>
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<td>3.3. POL for Family Planning</td>
<td>11. PPP/NGOs</td>
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<td>3.4. Repairs of laparoscopes</td>
<td>12. Training (strengthening training institutions)</td>
</tr>
<tr>
<td>4. ARSH</td>
<td>13. Training &amp; Capacity Building under NRHM</td>
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<tr>
<td>6. Tribal RCH</td>
<td>15. Planning, Implementation &amp; Monitoring</td>
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<tr>
<td>7. Vulnerable groups</td>
<td>16. Community Monitoring</td>
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<td>8. Innovations/PPP/NGOs</td>
<td>17. Monitoring &amp; Evaluations</td>
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<td>9. Infrastructure &amp; HR</td>
<td>18. Procurement</td>
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<td>9.1. Contractual staff &amp; services</td>
<td>19. Support Services</td>
</tr>
<tr>
<td>9.2. Major civil works</td>
<td>20. NRHM Management Costs/Contingencies</td>
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<tr>
<td>9.3. Minor civil works</td>
<td></td>
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<tr>
<td>9.4. Operationalise infection (waste)</td>
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Facilitating Expenditure under NRHM: (Ensuring that the funds are spent on time)

One of the challenges a district administration faces is to ensure that the funds placed with the district health society are spent in time, properly accounted for so that the next instalment would be released. In times of fiscal consolidation when governments are pushed to keep fiscal defects low almost any problem in spending or accounting could lead to hold up of large sums of money. Without the active support and leadership of the district administration the technical officers would always find it difficult to make their way past the mire of rules and regulations honestly and get the money spent. This is particularly tragic because public facilities are so under-invested and one cannot fail to spent the modest sums provided.

We list below a few main areas of expenditure and identify specific actions by district administration that could help:

a. **Infrastructure**: Most unspent balances relate to construction of buildings. Sums of money allotted are large and progress is usually slow and quality of construction is very poor. Ensure that there is a cell in place dedicated to this task with at least one person regular employee or contractual preferably an engineer in charge on a full time basis. Ensure that there is a control sheet that shows what is the state of progress in this and what are the deadlines. The failure to meet any deadline must be brought to the notice of the district
administration- and the constraints solved. Critical in infrastructure management- is the issue of the contracting process and the contracted agency.

b. **Human Resources:** Unspent balances in this head are due to delayed or failed recruitments and poor workforce management leading to poor retention. One needs a clear person in charge for regular employees and their workforce management- and another person in charge for the workforce management of contractual employees. The latter person is important from the viewpoint of spending the district funds- since the NRHM funds are for contractual employees- but both are important for performance measurement. Much of the unspent money is due to delay in recruitments. Wherever appointment powers are at district level- one could ensure that within a month the process is completed. If there are no suitable or willing candidates - think out of the box- and/or contact your state health systems resource center and they would by themselves or with the support of the national resource center help you resolve the problems. Also ensure that contractual staff already on the job are well looked after, treated with dignity and renewed at least two to three months in advance.

c. **Untied Funds** : This is another area of delayed expenditure. In order to achieve greater responsiveness of the health facilities and decentralisation, there is provision of untied grants under NRHM for various levels at the following rates:

<table>
<thead>
<tr>
<th>Levels of facility</th>
<th>Annual Maintenance Grant (AMG)</th>
<th>Untied Funds (UF)</th>
<th>RKS Grants (RKS)</th>
<th>Total (annually)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub Centre</td>
<td>Rs. 10,000</td>
<td>Rs. 10,000</td>
<td>---</td>
<td>Rs. 20,000</td>
</tr>
<tr>
<td>PHC</td>
<td>Rs. 50,000</td>
<td>Rs. 25,000</td>
<td>Rs. 1,00,000</td>
<td>Rs. 1,75,000</td>
</tr>
<tr>
<td>CHC/SDH</td>
<td>Rs. 1,00,000</td>
<td>Rs. 50,000</td>
<td>Rs. 1,00,000</td>
<td>Rs. 2,50,000</td>
</tr>
<tr>
<td>District Hospital</td>
<td>---</td>
<td>---</td>
<td>Rs. 5,00,000</td>
<td>Rs. 5,00,000</td>
</tr>
<tr>
<td>VHSNC</td>
<td></td>
<td></td>
<td></td>
<td>Rs. 10,000</td>
</tr>
</tbody>
</table>

The main measures required to expedite expenditure are

a) clear guidelines which enable expenditures and local discretion with many positive examples of what it can be spent on. If one has to put it place negative guidelines-- what it cannot be spent on- keep that focussed.
b) Simple processes of accounting. The block accounts manager (BAM) should be responsible for visiting the facility and helping them complete the accounting process. The BAM is held accountable for this completion.

c) Release of funds in time- and only to those who have submitted their UC- so that poorly functional facilities not requiring these funds- are not flooded with it.

d) Ensuring that guidance and capacity building required for using this funds is part of the supportive supervisors responsibility- and he is accountable for this achievement as well as the facility manager. For the VHSNC expenditure- the block coordinator and ASHA/CP facilitators are accountable.

e) Making use of the guidelines that provides some room for differential financing- so that those facilities which require more untied funds are provided more.

**Procurement and Logistics:**

Ideally the state should have a centralised agency for procurement which provides supplies to each district warehouse so as to ensure that at all times at least a three months stock is available. There should be a similar arrangement between facility and the district warehouse so that no facility is without a three months stock on its essential drugs list. One important area of facilitation is intra-district transport- and the funds for the same. Fix a per km transport charge for hiring private vehicles where facility vehicles are unavailable- and it would become easier for all concerned. Situations where doctors or facility staff collect their stocks and lift and transport it personally are undignified and unsustainable- leading to frequent stock outs.

Where districts have to do procurement- establish a procurement committee, ensure clarity in rules- and set timelines- so that it is done on time. Review the process on a sample basis. Of course where the chairperson has to sign- the entire process is your responsibility.

**Payment to Beneficiaries and Payment of ASHA incentives:**

There are two issues here:

The first is the flow from state to the district. Make sure that the request for the next instalment is sent on time and followed up such that there is always a fund pool available at the district level for each of these heads. Delays from state to district leads to huge back-logs, and delays in payment and considerable mistrust and leakages.

The second is reaching it from the district to the beneficiary.
For JSY: Payment should be made on the date of delivery at the place of delivery. At best a 48 hour delay. Build a process that can enable this. Any system where beneficiary has to make another trip from village to the facility, or the town just for the payment is not desirable. Remember she is a lactating mother with a newborn to take care of. One could of course or a account payee cheque if she has a bank account or give a bearer cheque if she does not have it.

For sterilisation compensation: again best given at the same time- by account payee check, failing which by a bearer check or cash.

For ASHA incentives: Ideally done by bank transfers, failing which by account payee check.

It is important that ASHAs are not made to travel repeatedly to get the sum of money required. There are a variety of incentives. As and when she becomes eligible for each of these, she records it in the diary or pass-book she has for the purpose- and in the monthly visit to the block- all of these are examined and paid up at the same time. The paying officer can later debit to various incentive pools from which they are drawn. It is important for the district administrator to set time standards for making payment, and then examine the micro-details of the rules by which payment is made and issue such clear guidelines that there is no further delays and harrassment. Often administrators have their own strong perception about what works best. There should be local adaptation and innovation, but whatever is tried, it is important to check to see whether the time standards are being achieved for all ASHAs. And if one listens carefully to experiences of those who are already working on it- the learning time to reach a good solution is less.

**Expediting Training Programmes:** One of the major reasons for delay in training, is the great difficulty in organising the logistics of training- venue, accommodation, training materials, food, travel in particular. Very often trainers- especially for the ASHA programme have to struggle with getting each of these aspects organised through complicated and unclear problems of procuring service providers for food, venue, paper etc. - and that too before each training camp. This also diverts them from their core competency in skill building. Administration can help by issuing rate contracts at the local level for an year- or clear guidelines that ensure that no time is wasted on this task and the quality of food, venue etc is of good quality.

**Payment under PPP and NGO contracts:** It is important for the district administration to honour contractual obligations and to make contracts on time and with dignity. If we have fail to do so, honest and competent providers leave the scene and we are left with poor quality providers of doubtful integrity. Arrogant behaviour towards contracted agencies by officers is often a problem that deters many competent agencies/hospitals from applying. This is particularly a problem for
small nursing homes and NGOs who have no influence to appeal at the next level. A change of officer should not make a difference to this, and if the contract has to be terminated for whatsoever reason- the due process and terms as stated in the contract should be respected. There should be a time standards- that all payments should be made within one month of the first submission of the bills- and this cincluded minor procedural corrections, additional information, supporting documents and changes that may be required. All delays in payment over a month – should be informed to the district administration and action taken as appropriate.

It is also important to ensure that contracted agencies honour contractual obligations- and for that the most important aspect is clarity on the terms of the contract and then a regular system of monitoring PPPs and contracts to ensure observance of these terms.

In many districts the number of competent agencies would be limited- but internal capacity could also be limited. In some circumstances, it would be justified to invest in building capacity or handholding contracted in partners- especially NGOs – so as to ensure that they perform.

Delays in selecting partners are another major reason for non absorption of funds. Clear guidelines that ensure

**Reporting Requirements under NRHM Financing**

Every reporting unit under NRHM, i.e. State and District Health Societies, RKS/Hospital Management Committees at health facilities, etc., have the following financial reporting requirements:

1. **Financial Monitoring Report (FMR)** – Within a month after the close of quarter
2. **Statement of Fund Position (SFP)** – Within a month after the close of quarter and to be sent along with FMR
3. **Monthly Bank Balance Statement** – (within 10th of the following month)
4. **Audit Report**: annually by 31st July of the following year
   - A consolidated audit report for the integrated Society (including all programmes under NRHM) from 2006-07 onwards.
5. **Utilization Certificates**:
   - Final UCs along with Audit Report.
   - Provisional UCs along with March FMR

ENSURE that all of the above are submitted on time.

**Social Protection for Health:**
NRHM also aims to address the problem of high out-of-pocket (OOP) expenses by the people, especially the poor and the marginalized groups. Such out of pocket expenditure of health care is seen as a major contributor to poverty. The 12th Plan has made lowering the high out of pocket expenditure a central task of the government in the health sector. There are three central strategies of the same:

a. The first and most important is Strengthening the public health sector: To quote “There must be substantial expansion and strengthening of the public sector health care system if we are to meet the health needs of rural and even urban areas. The bulk of the population today relies upon private sector health providers, paying amounts, which they cannot afford, because of the inadequate reach of the public sector. While the private sector can continue to operate for those who can afford it, an expansion of good quality affordable public sector care is essential. As supply in the public sector increases, it will cause a shift towards public sector providers freeing the vulnerable population from dependence on high cost and often un-reachable private sector health care. “

b. Further to protect out of pocket expenditure in the public hospital- we need to ensure that there are no user fees, that there is no out of pocket expenditure on drugs, diagnostics and diet. We could limit it only for BPL- but the experience is that most persons do not come to the hospital with a BPL card and anyway BPL categorization has a lot of weaknesses. Thus any care seeking in public sector is taken as self selection for the poor- and free care is provided. We also know a) that the amount of finances raised by user fees is very limited- less than 10% cost recovery- and to the government therefore it makes little difference. B) that user fees exclude the poor- who hesitate not only because they have no money, but also because they are embarrassed at being asked to pay and treated differently when they cannot. And c) that the actual costs of providing free drugs and diagnostics is very affordable even in such times, provided we also promote rational use of drugs and diagnostics.

c. The second major route of social protection is through publicly financed Insurance Mechanisms. The most important of these is the RSBY- Rashtriya Swasthya Bima Yojana programme. To ensure social protection from this and other such insurance programmes ensure the following actions: a) insist on clearly informing every patient of the actual sum assured that is being deducted from the card, each time it is swiped. In the public hospital the help desk or some other mechanism should be held accountable. B) publicise the fact- that not only should treatment be free- but that there should be not asked to buy drugs or diagnostics. Periodically conduct exit interviews on sample basis and contact beneficiaries to verify this. C) publicise the
fact that the health care package for which the hospital is entitled is an entitlement and they cannot be refused the treatment. Hospitals often cherry-pick and provide treatment only for what they care. D) review the information of pattern of reimbursement by diagnosis and facility. This will help ensure that services are as per needs, hospitals are not driving the decision on which services are provided. E) ensure that those who have registered are provided cards at once. F) ensure that there is a well publicised grievance redressal system for the programmes. These measures taken together would prevent considerable needless expenditure for both patients and the government.

**Raising Resources:**

Even if we use resources efficiently- and maximise more value for the money- there is a limit to how far this would help. Eventually we need more money also. Largely this is a policy decision and a political decision.

We have already discussed why user fees and charging even for diagnostics is a bad idea. It excludes many sections and it does not lead to much resources. Of course a token fee for registration is often required- to prevent casual use and to give authenticity to OPD and in patient numbers- but even this should be exempted more or less on self declaration of poverty.

One form of raising resources is philanthrophy and funds from corporate social responsibility. This has been used successfully in the past for patient amenities and support services – and this should be encouraged. It could make a major contribition and should be routed through the RKS.

Another form of alternative financing- is public private partnerships. Clarity is needed on when to opt for public private partnerships. Given how scare public funds are, it is seldom a good idea to transfer public investment into private hands, or to substitute public care by private care. We need partnerships to close critical gaps where public is unable to provide, but there is a private sector which has invested its own funds- and from whom we can purchase the required care. For example a tie up with a mission hospital to provide C-sections for patients referred from a public hospital which lacks the necessary specialists skills. The other conditions of any public private partnership is that it should allow access to the poor, cost and quality should be regulated, and that payments should be made in a timely and dignified manner. Though the term partnerships implies a share of the investment, risks and objectives- in practice there are few successful models where such sharing is there. One example of tie-ups that has worked very well is for patient transport services. Other is in patient support services- like security, laundry, diet etc. A third is in specific procedures which require more specialists than available in the public sector- like cataract surgeries.
What to look for?

a) what are the funds allotted?

b) What is the pace of expenditure? If it is slow- which heads of expenditure are slow –moving and what could be done to facilitate this?

c) Have UCs been submitted in time- are any funds release held up for lack of UCs submission? If yes- what are the steps that are required to hasten the accounting process?

d) What is the out of pocket expenditure in the public hospitals- and how is this being contained?

e) What are the opportunities for raising supplementary resources?