Work Report 2009-11

National Health Systems Resource Centre

Work Report

2009-11

inclusive of the
North-East Regional Resource Centre Work Report

National Health Systems Resource Centre

Technical Support Institution with National Rural Health Mission
Ministry of Health & Family Welfare
Government of India

April 2011

National Health Systems Resource Centre
NIHFW Campus
Baba Gangnath Marg
Munirka, New Delhi – 110067
Tel: 011-26108982, 83, 84, 92, 93
Fax: 011-26108994
Website: www.nhsrcindia.org

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Vision

We are committed to facilitate the attainment of universal access to equitable, affordable and quality healthcare, which is accountable and responsive to the needs of the people.

Mission

Technical support and capacity building for strengthening public health systems.

Quality Policy

NHSRC is committed to lead as a professionally managed technical support organisation to strengthen public health system and facilitate creative and innovative solutions to address the challenges that this task faces.

In the above process, we shall build extensive partnerships and network with all those organisations and individuals to share the common values of health equity, decentralisation and quality of care to achieve its goals.

NHSRC is set to provide the knowledge-centred technical support by continually improving its processes, people and management practices.

K. Chandramouli
Secretary
Department of Health & FW
Tel.: 23061863 Fax: 23061252
e-mail: secyhfw@nic.in

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली – 110011
GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NIRMAN BHAVAN, NEW DELHI – 110011

Message

The National Rural Health Mission is an ambitious programme for strengthening public health systems and making them more efficient and effective. The NRHM Framework for Implementation envisages an increased public health expenditure rising to 3% of the GDP. But for States to absorb these funds and convert it into better services and better health outcomes, a massive effort at technical assistance and capacity building is essential, especially in the High Focus States. The NHSRC is a technical support institution that provides leadership to this effort.

In a short span of four years, the NHSRC has emerged as a policy and strategy think tank and knowledge management institution that could be benchmarked with the best nationally and even internationally. It is a good multi-disciplinary team that has emerged and I warmly appreciate their tremendous contributions.

I look forward to the growth and sustainability of this institution to support the MoHFW and the State health departments. There is much that needs to be done and NHSRC must not rest on its past achievements, but come up with innovative, creative and pragmatic approaches to address the challenges of the coming years.

(K. Chandramouli)
26/4/11

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

National Rural Health Mission

DR. R. K. SRIVASTAVA
M S (Ortho) D.N.B. (PMR)
DIRECTOR GENERAL

सत्यमेव जयते

भारत सरकार
स्वास्थ्य सेवा महानिदे ालय
निर्माण भवन, नई दिल्ली–110108
GOVERNMENT OF INDIA
DIRECTORATE GENERAL OF HEALTH SERVICES
NIRMAN BHAVAN, NEW DELHI - 110108
TEL No.: 91-11-23061438, 23061063
FAX: 91-11-23061924
E-mail: dghs@nic.in

Dated: ....27.04.2011.....

Message

The National Health Systems Resource Centre has played a major role in strengthening public health systems. The organisation is supported by a multi-disciplinary team of professionals including medical professionals with extensive public health experience.

The work report of the NHSRC provides an overview of the extensive work done by the organisation in the past three years. During this period, NHSRC has made significant contribution in strengthening the areas of community processes, health management information systems, healthcare financing, quality improvement of public health facilities and decentralised public health planning. The NHSRC has partnered with several leading national and international public health institutions to support the Ministry of Health and Family Welfare in policy and strategy development.

The NHSRC has made considerable progress in the past three years and should work towards consolidating the gains and continue to work with the Directorates at the State level. I wish the NHSRC all the best in their endeavour.

(DR. R. K. SRIVASTAVA)

P. K. PRADHAN, I.A.S.
Special Secretary &
Mission Director (NRHM)
Tele: 23061451 Fax: 23061975
E-mail: md-nrhm@nic.in

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली–110018
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110108

Message

I am happy to note that following the Work Report for 2007-09 published earlier, the NHSRC has now come up with the publication of the Work Report for 2009-11. This provides a useful documentation of the activities undertaken by the National Health Systems Resource Centre.

The NHSRC functions as a technical institution providing support to the Ministry in various policy issues and developmental strategy besides taking up capacity building of States. The NHSRC has made significant contribution in the areas of community processes, quality improvements, human resources for health, health management information system, public health planning and financing of healthcare. During the last year, NHSRC along with Regional Resource Centre for NE provided considerable support in formulating outcome based planning in 264 High Focus districts of the country.

A lot more work remains to be done in building of the health systems. The NHSRC should effectively function as a bridge between academic community and the public health practitioners. It should also build up the capacities of the States by strengthening their Resource Centres and building up equivalent institutions to support district planning process and effective use of information.

I am sure the entire team of NHSRC will strive to further improve the achievements in future. I wish the entire team success.

27th April, 2011

(P. K. Pradhan)

Preface

The National Health Systems Resource Centre was set up under the National Rural Health Mission and it started functioning from May 2007.

Its mandate is to assist in policy and strategy development, and in the provision and mobilisation of technical assistance to the states and in capacity building in the Ministry of Health and Family Welfare and in the states.

It has a 21 member governing board chaired by the Secretary, with the Mission Director, NRHM as the Vice Chairperson of the board and the Chairperson of its Executive Committee. Of the 21 members, 11 are ex-officio senior health administrators, four of whom are from the states and 10 are public health experts from academics and civil society. The Executive Director, NHSRC is the Member Secretary of both the board and the Executive Committee.

The NHSRC currently consists of seven divisions – community processes, public health planning, human resources for health, quality improvement in healthcare, financing of healthcare, health informatics and public health administration. Its annual governing board meet sanctions its work agenda and its budget, against which these work reports are submitted.

The NHSRC has a regional office in the north-east region. The NE Regional Resource Centre (NE RRC) has a considerable functional autonomy and a similar range of activities.

As of now in the three years of its existence, the board has met five times and this work report is against the work agenda as approved in its fifth governing board meeting held on April 5, 2010.

Though we have largely focused on work done in the period between 2010 and 2011, we include the events of the year 2009-10 as the annual report for that year was not published.

We note that most of the work reported here has been done with the corresponding divisions in the Ministry and even as we report our areas of contribution, we would gratefully acknowledge their participation in these outputs.

We present the work done by NHSRC as eight sections – one for each division and one on NE RRC. In each section, we first define the NRHM mandate for that area of work, followed by NHSRC areas of contribution, and then its work outputs, Challenges, partners and publications.

We look forward to your feedback and to your continued support.

Contents

Community Processes

"The community should emerge as active subjects rather than passive objects in the context of the public health system."

(Para 125 pg. 64, NRHM Framework for Implementation, MoHFW, GoI, 2005-2012)

NRHM and Community Processes

The National Rural Health Mission (NRHM) promised an architectural correction of the health system which included "communitisation" as one of its key anchors. Communitisation was envisaged as a process to "enable the community and community-based organisations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system.

Key components of NRHM that strengthen the community processes and promote public participation include:

- The Accredited Social Health Activist (ASHA) and her support network at village, block, district and state levels.
- The Village Health and Sanitation Committee (VHSC). Untied funds to the Sub Centre and the VHSC helped increase avenues for public participation in monitoring and decision making at this level.
- Public Participation in District Health Societies and the district planning process as well as in Rogi Kalyan Samitis (RKSs).
- Community Monitoring Programme.
- Programmes for involving NGOs in the NRHM.

In what is one of the world's largest community health worker programmes, 8,25,525 ASHAs have been selected, trained and deployed across the country[1], and 488,012 VHSCs have been set up. These two components account for an approximate expenditure of Rs. 2400 crore over the past five years, amounting to about 4% of the total NRHM budget released. One of NHSRC's major responsibilities is to provide technical assistance to the centre and states in the implementation of these two large programmes.

[1] Except in Goa, Himachal Pradesh, Puducherry, Daman and Diu and the non-tribal areas of Tamil Nadu.

Community Processes

NHSRC's areas of contribution

- Policy and strategy development support
- Capacity building in states–skill development and developing institutional capacity
- Conducting appraisals and evaluation studies
- Development of training modules and kits
- Ongoing monitoring of the ASHA programme
- Assistance to states in identifying constraints and seeking joint solutions
- Building partnerships with civil society

Work Outputs

Strengthening ASHA competencies

- Organised consultations with civil society, experts in community health and officials and National ASHA Mentoring Group. The key outcomes of these meetings were role clarity and list of competencies for ASHA.
- Development and printing of ASHA modules 6 and 7, Notes for trainers, Facilitators guide and training manual, and ASHA communication kit.
- Supporting the creation of three national training sites and teams of national and state level trainers.
- Development of Menstrual Hygiene modules for ASHA and trainers
- Technical support to states for ongoing Module 5 training.

Support to MoHFW and State Governments

- Developing guidelines for NGO schemes.
- Developing Operational Guidelines for the Menstrual Hygiene Scheme, Business Development Plan for the scheme through Self-Help Groups (SHGs) and conducting Orientation for state nodal officers of Health, Rural Development and Women's Development Programmes.
- Meeting of State ASHA nodal officers and training officers from 20 states on scaling up training of ASHA in Modules 6 and 7.
- Supporting the creation of state, district and block level support structures (including phased withdrawing of NHSRC direct assistance through state facilitators) in selected states.
- Orientation of newly recruited ASHA Resource Centre Staff/ASHA Resource teams in state Health Resource Centres.
- Training of District and Block community mobilisers.

Evaluations, studies and reports

- Conducting the ASHA evaluation in nine states – eight directly and one supported in Chhattisgarh.
- Publishing Bi-annual ASHA updates which reflect progress over the past six months. Each issue focuses on a specific theme. Thus, for instance, the last update included an analysis of expenditure pattern of ASHA payment.
- Analyse data, studies and other reports to respond to queries on ASHA and Community Processes for MoHFW/parliamentary committees. About 148 queries have been responded to in 2010-11 alone.

All of the above contributions were undertaken in collaboration with Training Division of MoHFW as well as with partners in civil society, academia, research agencies, network organisations, and technical agencies.

Key Contributions

Building ASHA competencies: Development of ASHA Modules 6 and 7 and a training strategy for the evolving role of the ASHA

NHSRC worked closely with the MoHFW to coordinate a consultation of civil society organisations and other experts in developing specific competencies and measurable outcomes for the ASHAs. NHSRC worked in consultation with a range of experts from the National ASHA Mentoring Group, SEARCH, Gadchiroli, Breastfeeding Promotion Network of India (BPNI), Public Health Resource Network (PHRN), and UNICEF in developing two new modules for the ASHA programme (Modules 6 and 7), which focus on skill building for ASHA in the areas of maternal, newborn, child health, nutrition, malaria and tuberculosis. Preliminary findings from ASHA evaluation also contributed to design. English and Hindi versions of the modules have been translated and sent to all the states. The modules have been translated into Hindi, Telugu, Kannada, Oriya, Bengali, Marathi, Gujarati, Urdu, and languages of the North-East (Bodo, Manipuri, Khasi, and Garo). NHSRC facilitated translations and printing for selected states. NHSRC also developed a Guide for trainers and provided technical support to the development of a companion Communication Kit for the ASHA.

NHSRC also developed a training strategy with clear Operational Guidelines to enable states to scale up of performance ASHAs based on Modules 6 and 7, to be undertaken over a 15 to 18 month period conducted in serial rounds. This includes the development of specific criteria for selection of trainers and training sites at all levels, timelines and evaluation formats. NHSRC worked with the MoHFW in developing budgetary guidelines and specifications for equipment. NHSRC assists states on an ongoing basis for rapid roll out of Modules 6 and 7.

Creating national training sites and training of national and state trainers

The training structure for ASHA includes national, state and district ASHA trainers. NHSRC created three national training sites in collaboration with SEARCH, Gadchiroli; FRCH; Parinche; and Karuna Trust, Mysore to enable training of state trainers. Twenty national trainers and 166 state trainers from Assam, Arunachal Pradesh, Tripura, Bihar, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttarakhand, Andhra Pradesh, Gujarat, Karnataka, Maharashtra and West Bengal). State trainers from Punjab and Haryana will be trained in April. Training of district ASHA trainers is complete in Manipur, Arunchal Pradesh, Uttarakhand, and selected districts of Karnataka. (The remaining states are expected to begin training of this cadre in mid to late May.) NHSRC continues to build training capacity in the states, by increasing the pool of available trainers through ongoing training programmes at the national sites. Skill based ASHA training has begun in Manipur, Arunachal Pradesh, Uttarakhand and Karnataka.

Support to States and Centre

In July, NHSRC presented the training strategy for skill development of ASHAs at a meeting of State Mission Directors. An orientation programme for nodal officers from 20 states was organised in August to sensitise them to the training strategy, training design and training modules, and to also understand varying state contexts. NHSRC also supported several states to select state trainers in order to ensure that the candidates met the selection criteria that were specified in the training strategy.

- NHSRC enabled training of state trainers in Rajasthan, Uttar Pradesh, Punjab and Kerala for Module 5.
- For the ASHA programme to achieve key outcomes, training as well as support and supervisory structures are required to be in place. NHSRC enabled the recruitment of staff in the State ASHA Resource Centres in Bihar, Orissa, Rajasthan, Uttarakhand, Delhi, West Bengal and Punjab. NHSRC enabled the recruitment of 572 district and block level staff in Bihar and district community mobilisers in Jharkhand to support the ASHA programme. With this, all the High Focus states (with the exception of Madhya Pradesh) and the NE states have either full or partial complement of support structures.
- As a member of the of the State ASHA Mentoring Groups in Bihar, Madhya Pradesh, West Bengal, Uttar Pradesh and Rajasthan, NHSRC has participated in ASHA mentoring group meeting in all these states.

- NHSRC has also been involved in sensitising newly recruited staff of State Health Resource Centres and the ASHA Resource Centres to the vision and principles of the community processes component of NRHM.
- NHSRC designed and supported an intensive training programme for the District Community Mobilisers, District Data Assistants and Block Community Mobilisers in Bihar.
- As part of ongoing support to these states, NHSRC's state facilitators and the Community Processes (CP) team conducted visits to the ASHA programme in the field and provided feedback to the states on improvements/correctives that need to be taken up. As a consequence, NHSRC also helped develop guidelines and in enabling issuance of orders by the states for strengthening the ASHA programme.
- NHSRC in partnership with PHRN, ICCHN, and SEARCH had appointed State Facilitators to assist programme management in the states of Madhya Pradesh, Uttarakhand, Bihar, Jharkhand, Orissa, Rajasthan, Uttar Pradesh and in the eight states of the North-East (NE). As states develop their State Health Resource Centres and ASHA Resource Centres, this provision is being gradually phased out so that NHSRC will not have a state presence after the end of this fiscal year.
- NHSRC provided support to community health fellowship programmes in a number of states– Bihar, Orissa, Madhya Pradesh, Rajasthan and Jharkhand.
- NHSRC has provided inputs to the Training Division of MoHFW on about 148 questions from Parliament on the ASHA and CP interventions in 2010, and provides ongoing support to monitor the ASHA programme in the states.

Evaluation of the ASHA programme in five EAG and three non High Focus states

NHSRC in collaboration with a National Advisory Team of public health experts including members of the ASHA mentoring group, has conducted a detailed evaluation of the ASHA programme in Assam, Bihar, Jharkhand, Rajasthan, Orissa, Andhra Pradesh, Kerala and West Bengal. The evaluation used the realist approach, with a combination of qualitative and quantitative methods. The first phase, using secondary data reviews and qualitative interviews, aimed at assessing the institutional and conceptual framework of the programme. In the second phase in 16 districts (two districts in each state), from each district a randomly selected set of 100 ASHAs, 600 service users belonging to two priority groups, and 100 Auxiliary Nurse Midwives (ANMs), Anganwadi Workers (AWWs) and Panchayati Raj Institution (PRI) members were administered a detailed questionnaire. Each state and within that, each district was analysed as an independent casestudy and the relationship between context, programme mechanisms and outcomes was mapped, to understand what is it about that programme that worked, to what extent, why and under what circumstances. The independent state findings will be used as a basis for dialogue with states to enable ownership and buy in, and form the basis of evolving joint recommendations for implementation over the next year. This is one of the largest evaluations of this kind. NHSRC acknowledges the contribution of eight organisations – FRCH, PHRN, ICCHN, CINI, SHRC–CG, OASIS, Social Medical Partnership, OASIS and APJVV–in data collection, and to members of the National Advisory Team, who participated in the Phase 1 study. NHSRC was responsible for training of investigators, quality control and report writing. The main report and a shorter summary report have been circulated to all key stakeholders. The report has been sent to over 15 international experts in this area who have commented favourably and made different suggestions for further improvement and follow up.

Serving as the key technical support agency to the MoHFW's Menstrual Hygiene scheme

As the key technical agency, NHSRC made significant contributions to the evolution of the "Menstrual Hygiene for Adolescent Girls" scheme, initiated by the MoHFW. This scheme was introduced in April last year and was not part of the work plan. NHSRC was actively involved in the scheme from its inception. NHSRC supported the development of the concept note, operational guidelines, training modules for ASHA and her trainers in raising awareness among adolescent girls and women on menstrual hygiene issues, including the use of sanitary napkins. NHSRC also conducted a national training workshop in collaboration with New concepts for state level trainers on the use of the modules. NHSRC developed

guidelines for involving and strengthening SHGs in the country to manufacture and supply sanitary napkins at the local level. NHSRC also enabled the development of a business development plan for SHGs with comparative cost effectiveness and break even costs of various models in operation in the state of Tamil Nadu, a pioneer on this front. NHSRC worked with the state government and NGOs from Tamil Nadu to conducted orientation-cum-exposure workshops in Chennai, for nodal officers from the states to sensitise them to the scheme and production processes.

Meeting of the National ASHA Mentoring Group

NHSRC serves as the secretariat for the National ASHA Mentoring Group. The 19 member group, constituted by the MoHFW, consists of eminent representatives from civil society. NHSRC has held two meetings of this group every year. Members are also supported to undertake visits for technical support to the states. In addition, the National ASHA Mentoring Group provides assistance to NHSRC and thereby the CP interventions of NRHM, in finalisation of evaluation design, critical reviews of evaluation findings, module development, advocacy support and facilitating networks with other agencies. Meetings of the group focus on progress over the last six months and issues of special interest, including identification of issues for advocacy and follow up at national and state levels. Meetings are attended by senior representation from the MoHFW. The April 2010 meeting focused on developing ASHA modules, strengthening of support structures and state level actions to speed up the pace of implementation of the ASHA programme. The ASHA evaluation advisory committee was set up by this group and it guided the evaluation of the programme. The group also recommended synchronisation of the ASHA, NGO programmes and the community monitoring interventions for better synergy to result in improved outcomes. Joint Secretary (Planning) participated on behalf of Government of India. The focus of the December 2010 meeting was on findings of the evaluation report and implications, and a review of the recommendations of the Parliament Sub-Committee report on Working Conditions of the ASHA. NHSRC keeps group members informed about the programme developments and regularly gets feedback from them.

Challenges

- Implementing recommendations of the ASHA Evaluation Report: This needs a substantial advocacy effort in building consensus among stakeholders at national and state levels on the role of the ASHA as envisaged in the ASHA guidelines. It also needs commitment from the states in setting up well resourced, dedicated full time support structures at state, district and block levels, for adequate mentoring and supervision of the ASHA and VHSC components.
- Limited role of NGOs in the NRHM: The lack of mechanisms to engage with NGOs to support the CP interventions has limited the potential of the programme to achieve even greater success particularly in the areas of strengthening the activist and rights based dimension of the ASHA programme, training, ongoing mentoring and fostering community mobilisation through active VHSC.
- Strengthening the VHSCs: Existing committees need to be strengthened through training and ongoing capacity building. The states have not yet put in the requisite effort into resource support, capacity building and monitoring for this programme. Nor is it possible to undertake this without involving NGOs.
- Expanding/Institutionalising Training and Resource Capacity for Community Processes. The key challenges facing the states in scaling up their training include the limited

Partners

- Cheema Foundation
- Communications Hub
- FRCH
- ICCHN
- Karuna Trust
- OASIS
- Public Health Resource Network
- SEARCH
- Social Medical Partnership
- APJVV

(The ASHA resource centres of the states and Training Division of MoHFW and the Members of the National ASHA Mentoring Group.)

availability of high quality full time trainers available for the programme, the lack of flexibility to enter into partnerships with NGOs and other agencies to support the training at state and district levels, and the limited capacity of support structures in the state and district to move the programme forward expeditiously.

Members of the National ASHA Mentoring Group

S.No.	Name and Organisation
1	Dr. Shyam Ashtekar, Nashik
2	Dr. Thelma Narayan, Centre for Health and Equity, Bangalore
3	Mrs. Neidonuo Angami, Oking Hospital, Kohima
4	Mrs. Indu Capoor, Centre for Health Education, Training and Nutrition Awareness (CHETNA), Ahmedabad
5	Dr. Sharad Iyenger, Action Research and Training for Health (ARTH), Udaipur
6	Dr. Nupur Basu, Child In Need Institute (CINI), South 24 Pargana
7	Dr. N. F. Mistry, Foundation for Research in Community Health (FRCH), Maharashtra
8	Dr. Rajani Ved, Advisor-Community Processes, NHSRC Delhi
9	Dr. Vandana Prasad, Public Health Resource Network (PHRN), New Delhi
10	Dr. Alok Mukhopadhyay, Voluntary Health Association of India (VHAI), New Delhi
11	Dr. Prakasamma, Academy of Nursing Studies (ANS), Hyderabad
12	Dr. H. Sudarshan, Karuna Trust, Bangalore
13	Dr. Abhay Bang, Society for Education, Action and Research in Community Health (SEARCH), Gadchiroli
14	Dr. Vijay Aruldas, Christian Medical Association of India (CMAI), New Delhi
15	Director, State Health Systems Resource Centre (SHSRC), Raipur
16	Mrs. Shilpa Deshpande, ICICI Centre for Child Health and Nutrition (ICCHN), Maharashtra
17	Dr. Prashant K. Tripathy, Ekjut, Jharkhand

Findings of the ASHA Evaluation

The findings from the quantitative phase of the ASHA Evaluation highlight that the vast majority of ASHAs are functional, (i.e. carry out a defined task) irrespective of context and other constraints. There is a wide variation in the range (exact set of tasks) of tasks that an ASHA carries out, coverage (the percentage of potential users of these services that she reaches), and the effectiveness (in terms of behaviour change or health outcomes).

The ASHA is in position in all states. The density of ASHA deployment varies, with over 50% of ASHAs in most states catering to a population of less than 1000. Most ASHAs are educated up to class VIII or above. In three states: 37% in Orissa, 27% in Jharkhand and 28% in AP, the ASHA had an educational qualification lower than Class VIII. There is no clear evidence that the selection process made much difference to outcomes as the contribution of other factors overshadows this dimension. Most ASHAs come from poor households, and the proportion of ASHAs who are SC or ST is equal to or more than the proportion of the SC/ST population in most districts studied. Across the states, most ASHAs are receiving Rs. 500 to Rs. 1000 per month.

The figures on utilisation of the ASHA vary widely. Kerala, Angul in Orissa, and Birbhum in West Bengal record over 80% utilisation. Assam and Rajasthan show utilisation of 75% and 77% for care in pregnancy but 67% for care of the sick child. Bihar shows utilisation for pregnancy care by 73%. The rest are at 60% or below. The lowest figure for care in pregnancy was 42.2% from East Godavari, but this district has 73% of beneficiaries reporting utilisation in sick child care. This pattern is also true for the districts of West Bengal, Kerala, Andhra Pradesh and Angul in Orissa. The lowest figures in the range of 45% for service utilisation in case of a child between six months and two years of age who was sick in last one month were from two districts of Bihar and two districts of Jharkhand.

A key finding that emerges is that even for care in pregnancy which is one of the most emphasised aspects of the whole programme, up to 11% of potential users are being missed by the ASHA.

ASHAs have been active and effective in immunisation promotion. Above 98% of mothers with children less than two years who had availed of ASHAs' services for sickness of the child also report full immunisation of the child.

Counselling women on all aspects of pregnancy and promotion and coordination for immunisation programmes were consistently reported by over 85% of ASHAs, with only Jharkhand having a 77% average for both and Bihar having 71% for counselling women.

Over 90% of ASHAs are functional on promotion of institutional delivery. In terms of coverage, four districts had over 80% (both districts of Kerala, Angul in Orissa, and Birbhum in West Bengal), another nine were in the 60% to 80% range, and the remaining three were in the 40 to 60% range.

For household visits, all but eight districts reported above 80% and another seven were in the 60 to 80% range while it was lowest in West Singhbum with 46%.

Nutrition counselling was reported as an activity by over 70% from all districts of Kerala, Andhra Pradesh and West Bengal, and from Nayagarh, and less than 50% in the remainder.

In the use of drug kit, only Kerala, Khammam and Nayagarh showed an adequate over 70% response. In Bihar, it was as low as 8.5% of ASHAs with 2% from Purnia.

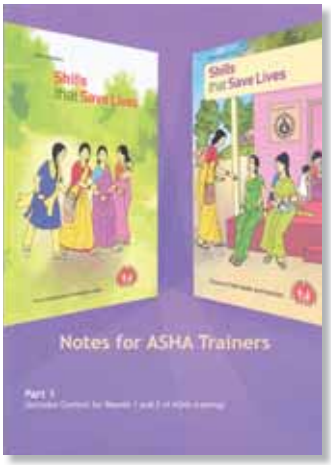
ASHAs also report action against alcoholism and domestic violence as forms of social mobilisation. 26% of ASHAs in AP report action against alcohol, and about 28% of ASHAs in Kerala and Rajasthan reported being active on issues of domestic violence; 62% of ASHAs in Jharkhand reported taking action on water and sanitation issues.

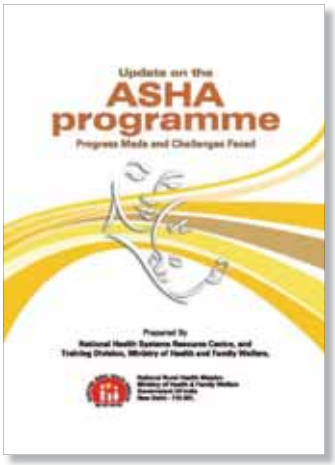
The variation in range, coverage and effectiveness occurs within and between districts and makes generalisation of any sort difficult. This wide variation is due to the fact that although the ASHA is tasked with many functions, in practice she is limited to the tasks for which she gets support, for which she has been trained, is monitored and the responsiveness of the health system. The lower functionality and effectiveness of the ASHA in a few states directly correlates with the perception among stakeholders of the role the ASHA is expected to serve. Such perceptions are in contravention of the original guidelines, have contributed to preventing the ASHA from being able to provide life saving skills and have diminished her potential to performing the functions of a commission agent.

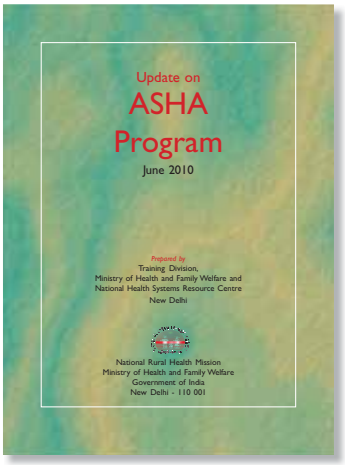
Publications

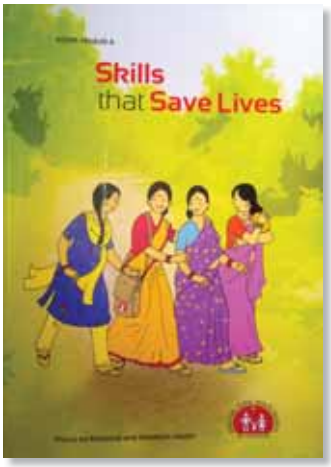
- Bi-annual updates of the ASHA programme: January 2011, June 2010, and January 2010
- Monthly reports for High Focus states; Quarterly reports for the non High Focus states
- ASHA Training Modules 6 & 7: In English and Hindi
- Trainer Notes for ASHA Training Module
- ASHA Communication kit
- ASHA Facilitator Handbook
- "ASHA: Which Way Forward:" An Evaluation of the ASHA programme in 8 states: Executive Summary, January 2011
- Mitanin Evaluation Report-2011
- Training Guide to NACO's "Shaping Our Lives"
- "Evaluation of ASHA Programme in 8 states of India" Paper accepted for presentation at ICCDRB's Annual Scientific Conference, 2011
- Evaluation of the ASHA programme: abstract accepted for presentation at the Evaluation Conclave, New Delhi, 2010
- The Mitanin and The ASHA programmes - The scaling up of Community Health Worker programmes in India: Divergent Programme Theories, Similar outcomes. Dr. T. Sundararaman, Dr Rajani Ved, Dr. Garima Gupta, Dr. B. Samatha (NHSRC) and the research team

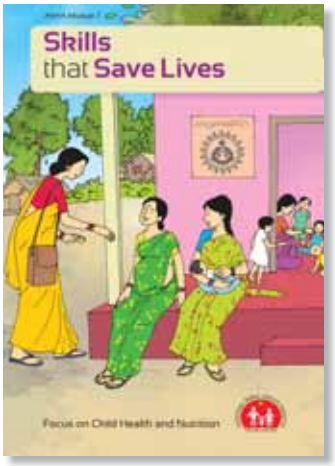
All the publications are available on NHSRC website: www.nhsrcindia.org

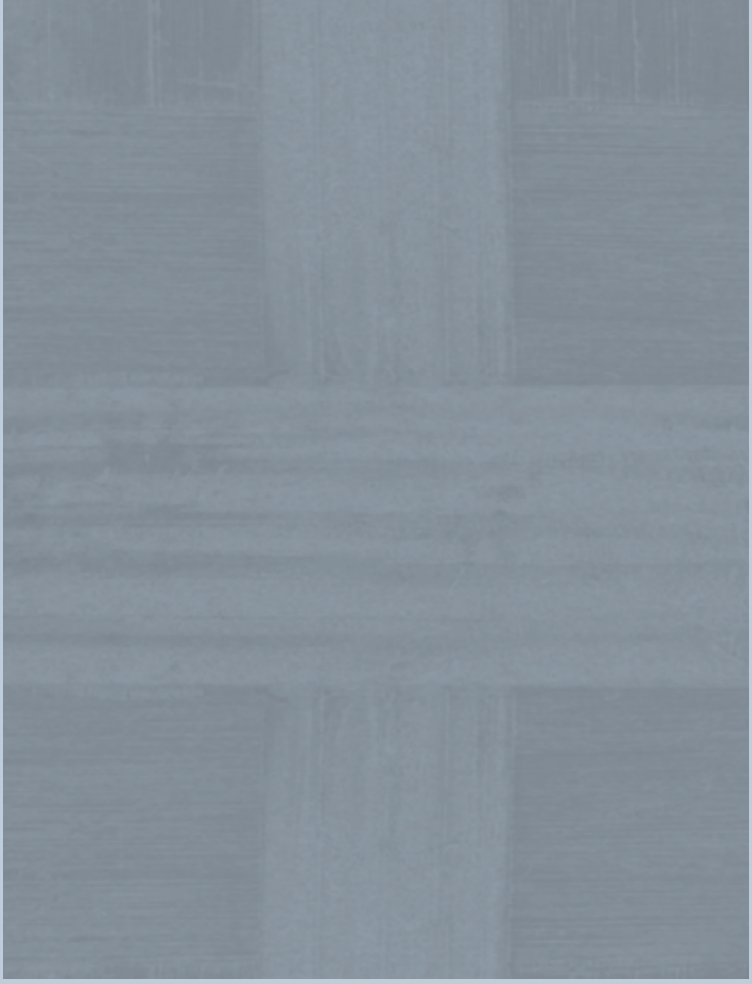












Public Health Planning

Service delivery reforms are meant to transform conventional healthcare delivery into primary care, optimising the contribution of health services – local health systems, healthcare networks, health districts – to health and equity while responding to the growing expectations for 'putting people at the centre of health care, harmonising mind and body, people and systems'.

- Primary Healthcare – Now More Than Ever
The World Health Report 2008

Planning under NRHM

One of the core strategies of NRHM as outlined in the Framework for Implementation document is preparation and implementation of integrated District Health Action Plans (DHAP) and village health action plans. District Planning has been conceived by NRHM as a tool of decentralisation. Further sanction of funds to states was to be made against State Implementation Plans. In 2009-10, 586 districts and in 2010-11, 540 districts had prepared district plans. However, review of the planning process during Common Review Mission shows that the district plans have not been adequately used as basis of resource allocation to districts by states. Use of available information on service delivery and disease profile is weak. Participatory processes and technical capacity to make comprehensive plans at district level need to be strengthened. Mechanism of review of district plans and their alignment to the approved state plans also need to be strengthened. A lot therefore remains to be achieved.

Much of the work of NHSRC has been geared towards making the planning process in districts and states more effective. At the national level, it is focused on gathering evidence that can support development of strategies and guidelines. The team also works on development of guidelines, tools and manuals that improve quality of planning. A continuous effort towards building institutional capacities at state level to provide technical assistance for ongoing planning process is one of NHSRC's primary roles. As states learn best practices from other states or come up with innovations, they integrate these into their state and district Programme Implementation Plans (PIPs). So, the planning process also becomes an idiom of strategy development and innovation.

Public Health Planning

NHSRC's areas of contribution

- Policy and strategy development
- Capacity building for district health planning
- Support to state and district plan implementation
- Evaluations, studies, programme reviews for evidence based decision making
- Support to MoHFW for state plan appraisals and monitoring
- Building up of State Health Systems Resource Centres (SHSRC) or equivalent bodies

Work Outputs

Capacity building

- Development of SHSRCs: Supported development of SHSRCs in Bihar, Chhattisgarh, Jharkhand, Kerala, Karnataka, Maharashtra, Punjab, Rajasthan, Uttarakhand, West Bengal and in process in Andhra Pradesh, Orissa and Himachal Pradesh.
- Capacity building for District Health Planning and Management: Over 1393 officers from 15 states, trained each for at least for six days in 2009-10. Other than this, one and two day trainings were conducted in a number of states.

Studies and reviews

- Common Review Mission III and IV – Report
- Complete database of accessibility and difficulty levels of all public health facilities, from PHC and above. Based on this database, list of difficult, most difficult and inaccessible health facilities prepared for all states.
- Mapping of reproductive and child health (RCH) facilities which taken together could ensure universal access to entire range of RCH services in High Focus districts. District level plans prepared for Facility development prepared for 251 High Focus districts.
- AYUSH in Public Health System- Study Report
- Janani Suraksha Yojana, Discussion Note, 24 districts comparative case studies.

Discussion notes as inputs to policy development

- Discussion notes towards a white paper on the health sector.
- Health and Nutrition – Discussion Note.
- Discussion note on Incentives for Health Professionals working in difficult and inaccessible health facilities

Support to MoHFW (NRHM and RCH divisions)

- Appraisal of State PIPs and contribution to drafting the administrative sections.
- Monitoring support visit to High Focus districts.
- Response to queries from constitutional bodies on programme and strategy.

Key Contributions

Building up of SHSRCs

As mandated by the MoHFW, it has been envisaged that SHSRCs for health systems strengthening would be set up in the large states. The small states would be provided with additional technical human resource in their programme management units.

In the national workshop on Human Resources and Public Health Management in Puducherry, the terms of reference (ToRs) for SHSRCs were developed and presented. Three institutional models of SHSRCs were proposed and guidelines on these were issued to the states. This was followed by several consultations, held with responsive states for rolling out the SHSRCs. NHSRC developed ToR for the SHSRC consultants and has undertaken recruitment for the SHSRCs in over 11 states. NHSRC continues to mentor the SHSRCs through capacity building training and workshops and assisting the state teams in developing their technical skills and capacities for strengthening the state health system. The seven divisions of NHSRC coordinate their support to the states through the respective SHSRC consultants.

The status of SHSRCs or equivalent bodies and the number of consultants in place is given in the table.

State	Institutional model	Status of Consultants
Bihar	Group of Consultants	2, recruitment underway
Chhattisgarh	Society	6
Himachal Pradesh	Group of Consultants	As a part of SIHFW
Jharkhand	Registered Society	Recruitment underway
Kerala	Registered Society	7
Karnataka	Registered Society	5
Maharashtra	Group of Consultants	15
Orissa	Group of Consultants	6
Punjab	Group of Consultants	7
Rajasthan	Group of Consultants	5
Uttarakhand	Group of Consultants	5
West Bengal	Registered Society (SPSRC)	Earlier with DFID

In Andhra Pradesh, NHSRC has conducted a study on existing institutions and located SHSRC in relation to them.

The district plan for facility development in high focus districts

- This task was done by a joint team of centre and states. Each team was led by a technical officer of the RCH division of the MoHFW, and NHSRC provided the coordination and support. Some of the development partners also assisted. The MoHFW had identified a set of 264 districts as High Focus based on RCH performance, socio-economic indicators, and those that were considered left wing extremism (LWE) affected.
- Capacity building: This was first undertaken for teams going to the districts and then for state and district teams. NHSRC directly participated in one round of training where up to 120 districts were reached. In the second round, this was extended to 264 districts.
- Mapping facilities for universal access: Then mapping was done through a consultative process with peripheral service providers and community representatives. People's preferences, transport links, case loads currently managed, human resource availability, inaccessibility of habitations and availability and willingness of private sector was also factored in. The choice and distribution of facilities was rationalised to guarantee universal access.
- Planning to close gaps for quality of care: Once facilities were shortlisted, plans were drawn up to close gaps in infrastructure, human resources and skills; gaps were calculated based on the standards and requirements as specified in Maternal and Newborn Health Guidelines.

Timelines and budgets were also specified. Plans for supportive supervision, developing quality improvement systems, were incorporated to ensure package of RCH services as envisaged. Budgets were not required, though many districts and states worked these out as well.

- An exercise of budgeting the gaps was also carried out by some of the districts. Based on the emerging pattern, NHSRC also worked out a proposal for resource allocation from state to districts and for resource allocation from district to facilities, which could be used to ensure that facilities and providers who provide a greater volume of services, a greater range of services and a greater quality of services get more of the financial resources.
- Compilation of the data and report dissemination: In order to support the final financing package and a discussion amongst the states, the data was consolidated state wise and a national summary was drawn out of that, which was later disseminated to stakeholders.

Incentivisation for skilled professionals working in difficult and inaccessible areas

- Subsequent to a policy decision to incentivise skilled professionals working in difficult, most difficult and inaccessible areas, NHSRC was asked to verify facilities identified as difficult by states, and this direction was modified to building up a database of all facilities and making an independent recommendation on accessibility of facilities which states could respond to. The reason for the change was the varying criteria used across states and the inconsistency of application of criteria, making it difficult for a central policy.
- NHSRC evolved a set of criteria, field tested it, and finalised this. The difficulty of health facilities was to be determined on the basis of an objective and verifiable database which measures difficulty in four dimensions: the difficulty posed by the remoteness of a rural area, the difficulty posed by natural and social environmental factors, the difficulty a family would have in terms of housing, water, electricity and schooling, and the record of success of the system in filling up the vacant posts of skill service providers in the facilities in the past. The database so collected was to be managed and stored in such a manner that it could be regularly updated.
- The survey was conducted in May, in 27 states, which included High Focus 8 Empowered Action Group (EAG) states, eight NE states and 11 non High Focus states. UTs were not covered under this survey. The data collection in the states was done by a total of seven external agencies. In three states, the database was provided by the state itself and verified by NHSRC. In two states, NHSRC conducted the survey in-house. The SHSRCs of Maharashtra and Punjab provided the data for their states. In few states like Kerala, Tamil Nadu, Haryana and Himachal Pradesh, the State Health Society had also taken the initiative to identify facilities in difficult areas. For NE region, the data was collected by North-East Regional Resource Centre (NE RRC), NHSRC's corresponding organisation in the NE region. With these inputs, NHSRC made a recommended list of difficult, most difficult and inaccessible areas, that was then circulated to the states. Many states have finalised this list with minor changes. In some, it is under discussion.
- Then based on studies carried out by NHSRC, on discussions with key stakeholders, and also on a reading of international experience, a set of financial and non-financial incentives to retain skilled professionals in such facilities was evolved. This is under consideration.

Capacity building for district health planning

Capacity building for district health planning continues to be a central theme of NHSRC's work. Now there are three packages on offer. The first is a five day basic package, and another is a distance education mode, mentored training programme with 18 days of contact programmes, that is conducted in collaboration with the PHRN, or other state level agencies. There is a sixteen module reading material available for this–modules 15 and 16 on tribal health and urban health having been released most recently. 1,314 programme managers have been trained in round I, 953 in round II and 630 in round III. Work on a module on non-communicable diseases and then on hospital management is also underway.

The entire 18 module course is available as an IGNOU course on District Health Management along with televised classes on key topics and contact programmes and about 275 students are enrolled, a large part of them coming from non-medical professionals working in the health department.

In addition, UP has trained for two days, five persons per district and NE states have round III of training where 407 were trained. One day sensitisation workshops on High Focus district plan have been held in many states.

Capacity building for district epidemiologists

NHSRC has provided the technical assistance to IDSP (Integrated Disease Surveillance Project) by selecting, placing induction training and mentoring district level epidemiologists, microbiologists at public health laboratories and entomologists at state level. With collaborating partners, NHSRC developed a distance education programme in epidemiology along with the course material. NHSRC then undertook the training of recruited epidemiologists. For training and mentoring of epidemiologists, NHSRC created a network of partner institutions.

In order to train these potential epidemiologists, 79 faculty members were selected from 53 medical colleges and public health institutions and trained at NCDC in a faculty development programme. So far, all the epidemiologists have completed their first contact programme of 14 days. A plan for taking this formally as a diploma in epidemiology was under discussion. In the last GB it was decided that the follow-up to this would be done by NCDC & IDSP.

The course material had been developed using the modules and interactive CDs of LSHTM (London School of Hygiene & Tropical Medicine) and further contextualised into the Indian scenario by PHFI and NHSRC. This resource material is now available to NCDC/IDSP.

Training on District Health Planning

States	1st Round	2nd Round
1. Regional ToT for all NE States	54	58
2. Assam	148	139
3. Arunachal Pradesh	37	21
4. Manipur	44	50
5. Meghalaya	30	26
6. Mizoram	40	36
7. Nagaland	44	65
8. Sikkim	22	26
9. Tripura	30	26
10. Jharkhand	140	124
11. Kerala	45	-
12. Orissa	35	-
13. Chhattisgarh	321	115
14. Haryana	77	77
15. Bihar	171	190
16. Uttarakhand	39	-
17. Punjab	82	-
19. West Bengal	45	-
Total	1404	953

Common Review Mission – III & IV

NHSRC has been facilitating the review mission for the last two years and had successfully continued to do so this year too. Over 84 members, which include national and state health administrators, public health experts, academicians, development partners and civil society members participated, and between them, visited 17 states. NHSRC consultants were part of 13 of these teams. The final compilation, and analysis and drafting of the final report was done by NHSRC team.

NHSRC participated in the seventh Joint Review Mission to Karnataka.

Study on "Status and Role of AYUSH & LHT under NRHM"

There was little literature available on AYUSH services in the public system prior to NRHM, and almost none after its implementation has begun. Hence, NHSRC undertook this study in the year 2008. Objectives of the study were to delineate

implications of NRHM's strategy of mainstreaming AYUSH and revitalising Local Health Traditions (LHIs) in terms of coverage and quality of services as assessed by public health management criteria, by AYUSH criteria, and by the demand for services.

The study, covering 18 states of India, the examined status of stand-alone AYUSH services existing in the public system prior to NRHM (initiated in 2005) and co-located services largely initiated under NRHM. Comparative analysis across states has revealed a wide variation of coverage and quality of services, and of factors that influenced the development of AYUSH services. Some parameters have also been compared between AYUSH and allopathic services. Demand for

Partners

NHSRC believes in building partnership with organisations:

Incentivisation for Skilled Professionals working in Difficult and Inaccessible areas – partner institutions:

- Medica Synergy
- AMS
- EPOS
- PHRN
- Vistaar
- ISOS Consultancy
- EMRI
- NE RRC
- SHSRC

Capacity Building

- PHRN
- SHSRC
- PGI, School of Public Health, Chandigarh
- Indian Institute of Health Management and Research, IIHMR Delhi
- Jawaharlal Nehru University (JNU), Delhi
- Indira Gandhi National Open University (IGNOU)

The District Plan for Facility Development in High Focus Districts

- PHRN
- SHSRC
- Development partners
- UNICEF
- NIPI
- UNFPA
- NE RRC
- IIM Ahmedabad

Study on Janani Suraksha Yojana

- SHSRC
- Saathi-Cehat
- Peoples Health Watch
- IIM Ahmedabad
- Foundation for Research in Community Health
- OASIS
- Social Medical Partnership
- Vistaar
- NIPI
- AMDD (Averting Maternal Death and Disability Program, Columbia University)
- CINI
- Peoples Health and Development Trust

Study on Status and Role of AYUSH & LHT under NRHM

- School of Oriental Medicine, Global Open University of Nagaland
- Dept. of CSMCH, Jawaharlal Nehru University

services was found to be high, assessed by data on utilisation of AYUSH services and perceptions of patients through exit interviews, community through household interviews, and of allopathic and AYUSH providers. A validation exercise using the principles and texts of AYUSH systems verified the scientific basis of community knowledge of LHT and AYUSH providers' prescriptions. The study raises a number of questions and makes recommendation for strengthening AYUSH systems.

The Janani Suraksha Yojana Studies

Janani Suraksha Yojana is one of the most visible components of NRHM, and one whose impact has been immediate and dramatic. The programme uptake has increased from 7 lakh in the first year to over one crore beneficiaries in the current year.

However, there were many questions as to its impact on maternal mortality, the extent of transfers received by the beneficiary and the desired behaviour change, and most important on how to improve the programme so that it has enhanced quality and outcomes. The framework of evaluation chosen drew upon a realist approach to programme evaluation and brings out how a centrally sponsored scheme plays out differently in different contexts. The programme was studied in three districts in each of the eight EAG states. The evaluation was in two phases.

Phase I – The Case Study phase focuses on mapping of contexts, mechanisms and various intermediate outputs based on evidences from secondary data. Data available in district and facility level records was followed up. Interviews with programme managers, service providers, ASHAs and beneficiaries were conducted. In each district, the sample included few public health institutions at primary and secondary levels of care – in three blocks and in the private sector. This was written up as a case study of each district. Case studies of all the 24 districts have been compared and compiled, and the reports are available and shared with the states.

Phase II – The quantitative phase focuses on how far JSY has succeeded in promoting institutional delivery, in the management of complications in pregnant women and the out-of-pocket expenses involved. Sample size is of 300 beneficiaries in each of the nine districts. In addition, all complications and maternal death cases are included. The data is tabulated and analysed. A report combining Phase I and Phase II is under preparation and could be released by May 2011.

Challenges

- The central challenge remains to make the district plans a much more effective and equity sensitive exercise. State plans must be based on the district plans, and resource allocation needs to have a correlation with district plans. The principle of resource allocation and the principles of participation need to be reconciled. The scientific basis of the plan, its use of information, its outcome basis and differential financing of facilities are all challenges. Inclusion of non-communicable and communicable diseases, other than the national disease control programmes, also remains a challenge. Building institutional mechanisms of planning at state and district levels is also a challenge.
- Many strengths and limitations of the NRHM flow from the design, and constraints faced during implementation. As the twelfth five year plan preparation begins, there is an urgent need to inform this process with relevant studies and documentation.

Creating District Health Planning Capacities

NHSRC partners with PHRN for capacity building of district health teams. For this purpose, a capacity building module composed of 16 volumes on various thematic areas of public health has been developed by NHSRC and PHRN jointly. These modules have been disseminated to various states to be used for capacity building and as reference and resource material to support planning. They have been widely used by the state and district health programme managers and government officers. Over 4000 sets or 40,000 copies of these modules have been sold.

Besides providing the resource materials for the specific volumes, NHSRC also provides resource persons from the various in-house divisions for the capacity building trainings and workshops. The capacity building module has been adopted by IGNOU for a Post Graduate Diploma on District Health Management. NHSRC contributes to this course by providing course materials, faculty for conducting the course and acts as one of the study centres for examination and contact classes. So far, 275 students have been enrolled in this course.

The list of the modules is provided below:

Modules	Thematic areas	Modules	Thematic areas
1	Introduction to Public Health System	9	Convergence
2	Reducing Maternal Mortality	10	District Health Planning
3	Accelerating Child Survival	11	District Health Management
4	Community Participation and Community Health Worker	12	Engaging the Private Sector
5	Behaviour Change Communication and Training for Health	13	Legal Obligation of District Health System
6	Mainstreaming Women's Health Concern	14	Issues of Convergence and Health Sector Reforms
7	Community Participation	15	Tribal Health
8	Disease Control Programmes	16	Issues in Urban Health

Publications

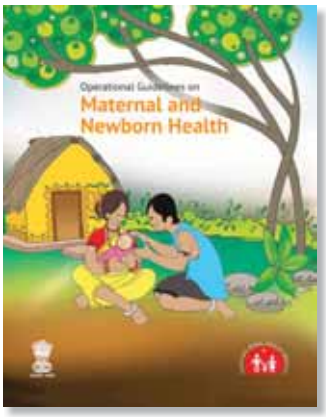
Publications

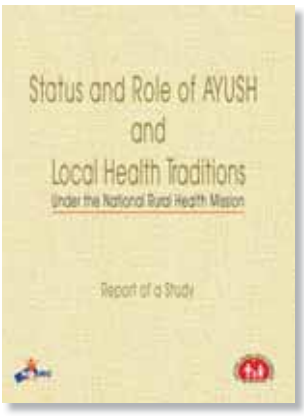
- Operational Guidelines for Maternal and Newborn Health
- Common Review Mission Report - Third Report, January 2010; Fourth Report, January 2011.
- Status and Role of AYUSH & Local Health Traditions under NRHM – Report of a Study
- Accelerating Maternal and Child Survival – The High Focus Districts Approach, for MoHFW, Government of India
- Public Health Resource Network Volumes - 1 to 16 (15 and 16 in current year) – lead contribution by PHRN
- Skilled Birth Attendant Guidelines – 1 to 3 (only publication, not authorship)

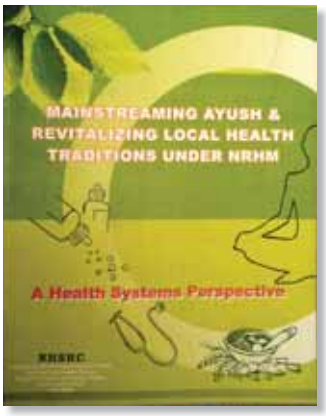
Discussion notes (provided as inputs for policy development)

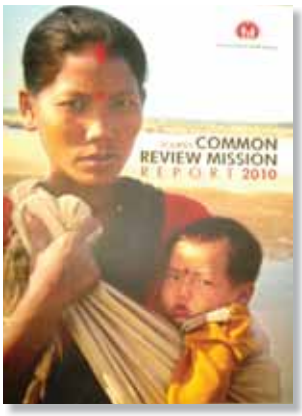
- Janani Suraksha Yojana: Issues and Challenges
- Janani Suraksha Yojana: 23 districts comparative case studies
- Health and Nutrition – Note
- Note on 'Incentives for health professionals working in difficult and inaccessible health facilities
- Annual Report to the People
- Standardising nomenclature of facilities
- Draft Standard Treatment Protocols for Newborn Health
- Medicine and Technology

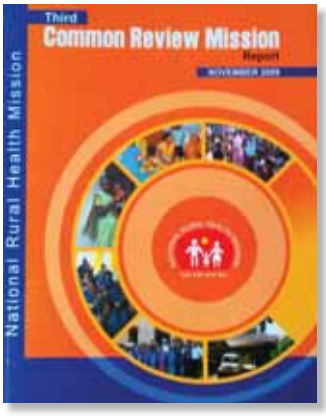
Copies of above are available on NHSRC's website: www.nhsrcindia.org

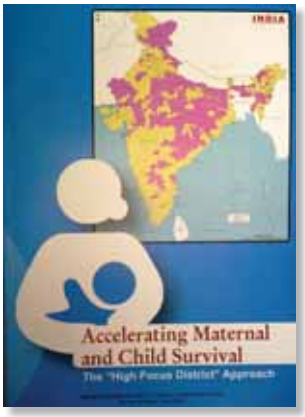


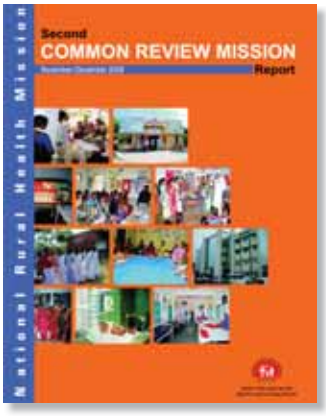


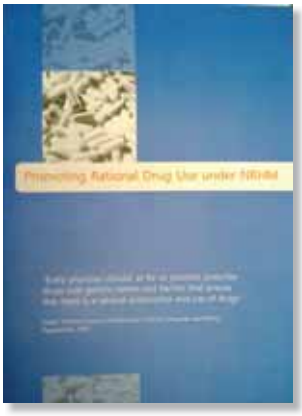












Quality Improvement

“Quality improvement is the primary source of cost reduction. Poor quality has a huge, documentable cost.”

- Tom Peters

NRHM and Quality Improvement

The NRHM has been launched with a view to bringing about “dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to equitable, affordable and quality healthcare which is accountable and responsive to the needs of the people.” (Pg. 10, NRHM Framework for Implementation, MoHFW, GoI. 2005-2012)

The NHSRC’s mandate is to make quality improvement an inherent part of public health facility management. The goal is that every single health facility would not only be certified by an external assessor for quality, but have in place a Quality Management System (QMS) that ensures that quality is continually improving. Given the nation’s vastness and diverse level of objective development and subjective readiness in each state, such a QMS should follow national and international norms of quality management but at the same time be flexible enough to accommodate different standards of quality certification, i.e. IPHS or ISO or NABH or NABL or any other state or central government defined standard.

The Indian Public Health Standards (IPHS) specifies the input standards for infrastructure, human resources, equipment and drugs. The QMS complements this by ensuring that for every first level of input, there is a maximisation of output, both in terms of quantity and quality of care.

Quality Improvement

NHSRC's areas of contribution

- Developing parameters, techniques and guidebooks for improving quality in public health facilities.
- Contributing towards policy and strategy development for quality in public health services, and for improving hospital management and RKS function.
- Support to states for quality improvements/certification of public hospitals and health facilities.

Work Outputs

Implementation of QMS in public hospitals

- Eight hospitals were selected by respective state governments in EAG states for piloting QMS, namely, Indira Gandhi District Hospital, Korba (Chhattisgarh), Dufferin Hospital, Allahabad (UP), Doon Hospital, Dehradun (Uttarakhand), Deoghar Hospital, Deoghar (Jharkhand), Karauli District Hospital, Karauli (Rajasthan), Puri District Hospital, Puri (Orissa), Ara District Hospital (Bihar) and Katni District Hospital, (Madhya Pradesh). All of these hospitals have been ISO 9001:2008 certified and succeeded in successful clearance of the Surveillance Audit. In the last two years, NHSRC support is to maintaining the certification.
- One hospital in each of the NE States was selected by state authorities in consultation with NE RRC – STNM Hospital, Gangtok, IGM Hospital, Agartala, Civil Hospital, Aizawl, Naga Hospital, Kohima, District Hospital, Churachandpur, M.M.C. Hospital, Guwahati, Ganesh Das Hospital, Shillong and Government Hospital, Pasighat. Out of these eight hospitals, seven have been cleared for certification. One

List of Facilities from different states under QMS

- Tamil Nadu – 48 certified and 42 committed, MoU to be signed
- Maharashtra – 342 committed, MoU to be signed
- Karnataka – 31 in self-implementation mode
- West Bengal – 12 (ongoing)
- Orissa – 1 certified, and 8 ongoing
- Andhra Pradesh – 2 ongoing
- Bihar – 1 certified and 46 – ongoing
- Jharkhand – 1 certified and 3 ongoing
- Chhattisgarh – 1 certified and 7 ongoing
- Punjab – 10 ongoing
- North-East – 7 certified and 1 on-going
- Haryana, Madhya Pradesh, Rajasthan, Uttar Pradesh, Uttarakhand – 1 certified in each

hospital Churachandpur District Hospital is still in the process of certification.

- Develop a programme of implementing QMS in government hospitals responsive to state requests. Currently, 568 facilities are under various stages of implementation/initiation.

Strategy development

- Developed the overall approach to building QMS in a government district hospital and then in a range of other government health facilities. Established the model and built up a resource team and guidelines to support replication.
- Developed three approaches to replication. One is a self-improvement model, where NHSRC trains a team from each facility, and state does the hand-holding. Another is a Technical and Supportive Supervision model where NHSRC does an annual rate contract for an agency which would provide initial training and the As-Is study followed by five days supportive supervision per month. It is suitable for smaller facilities. And third is a model where the technical support agency would provide on site support till certification is achieved. Handholding also allows for the same three options. The development of the tender documents and process itself can be used by states for independent replication of any of these three options.
- Developed a self-certification model which is in line with the QA schemes under NRHM and which requires only a five day hospital administrator's training and suitable checklist. This has been implemented in Orissa, HP and West Bengal.

Workshops

- A full day session in IIHMR Health Conclave was organised on comparative studies of different approaches to quality improvement in public hospitals. One plenary session was chaired by Mr. P. K. Pradhan, Mission Director and presided by Dr. V. K. Singh, AVSM. Different researchers presented studies of different approaches, including NABH experience in Gujarat, ISO 9001 experience in Orissa and Uttarakhand, and Quality Assurance Committee approach of RCH from Assam. Mr. Girdhar Gyani, Dr. B. K. Rana, Dr. T. Sundararaman, Dr. J. N. Sahay, Mr. J. P. Mishra and Ms. Ellora G. were amongst the resource persons.
- Workshops on revision of IPHS at Delhi and review workshop by Secretary, H&FW at Bhopal were conducted to give a final shape to IPHS before publication.
- NHSRC collaborated with Environment Protection Training and Research Institute (EPTRI), Hyderabad for training mentors from NE states to carry out further capacity building in the state. A plan for similar programmes for Bihar and MP is in pipeline.
- A one day workshop was organised in collaboration with SHS, Tamil Nadu to share the best practices and experience during quality improvement journey of 48 Primary Health Centre (PHCs) which have been certified to NHSRC model of ISO 9001:2008.

Key Contributions

Implementing QMS in a public hospital: getting public hospitals quality certified

This has been done in phases:

- **Pilot Phase** (April 2008 to March 2010) – 16 district hospitals, one in each High Focus state including NE ISO 9001-2008 certified as per NHSRC Protocols.
- **Scaling Up Phase** (October 2009 to Ongoing) – 508 in various stages of implementation.

Total no. of public hospitals certified as of date: 67

The distribution and type of these facilities are shown in the different table below. The key steps involved in implementation of QMS, the mandatory process that has to be certified in this NHSRC-ISO's approach and the parameters on which improvement is measured are given in the accompanying boxes.

Improving hospital management

NHSRC has been responding to requests from states for assistance in improving the management of public hospitals. One important support has been to help recruit qualified hospital managers. Another has been to train existing and freshly recruited hospital managers. NHSRC organised the recruitment of hospital managers in Jharkhand, Bihar and Chhattisgarh.

The training programmes on hospital management are seen in the table shown alongside. These programmes have also built up state capacity to take this forward. NHSRC organised training workshops as follows:

Location	Date	Partners in training
Shimla, HP	May 2010	PHFI IIHMR, Delhi GTZ M/S Octavo Solutions M/S ICRA Mgmt. Consultants M/s Perception Business Consulting CS Quality Services
Tanda, HP	July 2010	
Raipur	August 2010	
Patna	August 2010	
Bihar	September 2010	
Karnataka	September 2010	
Patna	December 2010	
Orissa	January 2011	

Status of ISO Certification of Public Health Facilities ISO Quality System under implementation

States	District Hospital	SDH/CHC + PHC
1. Andhra Pradesh	2	
2. Bihar	12 + 1*	5 + 29
3. Chhattisgarh	3 + 1*	4
4. Haryana		1*
5. Jharkhand	3 + 1*	
6. Karnataka	1	12 + 18
7. Madhya Pradesh	1*	
8. Maharashtra	27	85 + 230
9. Orissa	8 + 1*	
10. Punjab	5	5
11. Rajasthan	1*	
12. Tamil Nadu		42 + 48*
13. Uttar Pradesh	1*	
14. Uttarakhand	1*	
15. West Bengal	12	
16. Arunachal Pradesh	1*	
17. Assam	1*	
18. Manipur	1	
19. Meghalaya	1*	
20. Mizoram	1*	
21. Nagaland	1*	
22. Sikkim	1*	
23. Tripura	1*	
Total	89	112 + 319

*ISO certification achieved

The key steps involved in the implementation of QMS have been:

- Conducting a study of the selected healthcare facilities for the As-Is situation.
- After elucidating the gaps, action planning undertaken after categorising the gaps into three categories: those which could be addressed at the hospital level without much financial implications, about 70%; those needing the support of district administration about 15%; and those related to deployment of human resources, extension of infrastructure and policy of the state requiring state support or policy changes. This is also known as the To-Be document.
- To prepare documents for conformance.
- To provide basic orientation and training to hospital functionaries, PRI members
- Creating enabling environment to facilitate the change.
- Certification of Institution after external audit.
- Handholding for three years so that certification is maintained and process internalised.

Hospital Quality Improvement Parameters

	Clinical Procedures (General)		Hospital Administration Procedures
1	Out Patient (OPD) Management	13.	Patient Registration, Admission & Discharge Management
2.	In-Patient (IPD) Management (General/Critical/Intensive Care)	14.	Hospital Stores & Inventory Management
3.	Hospital Emergency & Disaster Management	15.	Procurement & Outsourcing Management
4.	Maternity & Child Health Management	16.	Hospital Transportation Management
5.	Operation Theatre and CSSD Management	17.	Hospital Security & Safety Management
6.	Hospital Diagnostic Management	18.	Hospital Finance & Accounting Management
7.	Blood Bank/Storage Management	19.	Hospital Infrastructure/Equipment Maintenance Management
8.	Hospital Infection Control Management	20.	Hospital Housekeeping & General Upkeep Management
9.	Data and Information Management	21.	Human Resource Development & Training Management
10.	Hospital Referral Management	22.	Dietary Management
11.	Pharmacy Management	23.	Laundry Management
12.	Management of Death	24.	Hospital Waste Management

Improvements were achieved in each hospital in terms of Implementation of ISO 9001:2008 Standards:

- Capturing patient satisfaction (both OPD & IPD).
- Developed performance indicators for different processes and services.
- Time-Motion Study for critical activities – Registration, Consultation, Investigations and Pharmacy: reduces patient waiting time.
- Calibration of measuring equipment.
- Validation of laboratory reports by external agencies.
- Compliance to regulatory requirements.
- Introduction of ABC/VED matrix system in stores for better Inventory management and detecting near expiry drugs.
- Measuring illumination level through 'Lux-Meters' and taking corrective action to comply with BIS Standards (IS: 10905).
- Improving the signage and establishing and strengthening of "May I Help You Desk"
- Improving the level of cleanliness.
- Monitoring access of the health facilities by BPL, marginalised and under-privileged population.

Challenges

- **Lack of enabling policy:** The need of have is to have a policy frame on credible system of mandatory accreditation/certification of health facilities, which could be followed by heath facilities, public & private both. Though, there are already many accreditation systems followed by countries globally, we require an accreditation system which meets the needs of health systems in India. In the priorities of the state level resource allocation, quality takes a back seat in their list of priorities. A clear policy frame on quality shall provide definite directions and accord higher priorities for quality initiative. This will also pave the way for flexible financing booty to public health facilities in the form of scheme of incentives that includes salary incentives for achievers and financial restrictions for non-achievers at personnel level and funding guided by the performance of the facility at institutional level. This will further help the evolution of most appropriate standard for public health facilities and the extensive database for health facility throughout the country will promote fact based decision making and planning.
- Development of infrastructure as per IPHS norms is resource intensive. Due to general crunch of human resources in the country, it is difficult to get critical manpower.
- Frequent transfers of civil surgeon/CMHO/ key functionaries of hospitals; shortage of key personnel – anaesthetist, gynaecologists, nursing staff, radiographers, technicians etc.
- Absence of state guidelines for procurement of drugs, equipment, consumables and outsourcing services like cleaning, security, laundry, kitchen, supplementary power supply, ambulance services, pest control etc. resulting in poor management of contracts.
- Lack of convergence amongst PHED, PWD, Electrical Department, Police & the Hospital.

Partners

- ACME Consulting
- Hosmac India Private Limited
- ICRA Management Consulting Limited
- Indian Register Quality System
- Medica Synergie Pvt. Limited
- Octavo Solutions Pvt. Limited
- Perception Business Consulting Solutions
- RITES Limited
- Transpacific Certification Limited
- TUV (SUD)

Publications

- RCH Checksheets for evaluation of level II and III facilities
- Evaluation Checksheet for District Hospitals/Sub-Divisional Hospitals
- Quality Management System – Traversing Gaps published
- 'As-Is' Study of all facilities taken up for QMS
- Proposal for PPP in sterilisation programme in states
- Gap analysis of Patna Medical College Hospital – 1800 bedded multi-speciality teaching hospital is under finalisation
- Self-Implementation Guidelines for quality improvement initiative leading to ISO 9001 certification as per NHSRC protocol

All the publications except 'As-Is' study available on NHSRC website, www.nhsrcindia.org

Before and after quality improvement

Health Informatics

“In God we trust, but for the rest we need data....”

Health Informatics

NRHM and the Health Management Information Systems

NRHM envisaged a fully functional health information system facilitating smooth flow of information for effective decision making. Lack of indicators and local health needs assessment have been identified as constraints for effective decentralisation. Almost 50% of the monitoring and evaluation cost was envisaged to be expended at the district level and below. All this requires a robust health management information system that can provide good quality information which would be essential for decentralised health planning.

Health Informatics

NHSRC's areas of contribution

- Rationalisation and choice of data elements and indicators.
- Building and maintaining systems of data collection, flow, management, processing and analysis to improve data quality.
- Use of information for planning and programme management.
- Assessing state preparedness and data quality and assisting states in improving data quality
- Building state capacity for HMIS management.
- Development of other areas of use of health information-GIS, Hospital Management Information Systems, Human Resources Information Systems, M-Health, and Name-based Tracking Systems.
- Website development to facilitate decentralised health planning.

Work Outputs

- Database of all district data in the form of ready to use indicators and displays of data: Disseminated 2009-10 data to all states and districts (also available on NHSRC website). Quarterly database for 2010-11 – first three quarters released. Last quarter report and annual report would be posted by Mid May. Dissemination service available on request.
- Printing and dissemination of HMIS training manuals – Volume I, II as printed manuals and Volume III as soft copy in CD format. Vol. IV is under preparation. (Vol. I for Service Providers, Vol. I and II for Health Programme Managers, Vol. I to III for HMIS Managers, and Vol. I to IV for HMIS Resource Persons)
- Development of Model Primary Registers and Guidelines.
- Capacity building for data collection, flow of data, and data uploading on National Web Portal.
- Capacity building for use of information and improvement of data quality.
- Monitoring progress on HMIS: Status report of HMIS implementation: functionality and readiness for each state.
- Customisation of DHIS-2 to facilitate offline data uploading (Uttarakhand, Sikkim), inclusion of data elements per States' need (Bihar, Orissa, Maharashtra, WB), generation of programme specific reports (Bihar, MP, Orissa), integration of other vertical health programmes (Bihar, Orissa, HP), and to incorporate data validation checks (Orissa).
- GIS attached to DHIS-2 and functional in Orissa, MP, Karnataka and Kerala.
- Completion report on pilot study on use of mobiles for HMIS data transmission (HP, Nagaland, Gujarat, Rajasthan, Kerala).
- Hospital Information Management Systems-preliminary installation in one HP hospital.
- HMIS division has initiated research work in the form of evaluation and triangulation studies.

Key Contributions

HMIS implementation

- **January 2007-November 2008:** HMIS team worked closely with national and state offices to identify and rationalise data elements and health indicators that contribute to evidence-based planning, policy making and advocacy. Theories and principles of HMIS and public health informatics are referred to during this decision making process. Simultaneously, efforts are being made to integrate health data/information collection through various vertical health programmes in one database. The National Web Portal started functioning in November 2008.
- **November 2008-March 2010:** The Web Portal was now working as data hub for the country. NHSRC used open source applications called DHIS-2 to gather all legacy data of 2007-08 and uploaded it on Web Portal – often having to enter data from paper records into the applications. Once this was completed, from March 2009, DHIS-2 was retained by all those states who chose to do so, and wanted to focus on intra-district data analysis and use. Meanwhile, all through the year (2009-10), the focus of NHSRC work was to build capacities to enter data into Web Portal either directly or via DHIS-2. By March 2010, 99% districts of our country had uploaded data on HMIS Web Portal. Quarterly reports were also generated.
- **April 2010-March 2011:** Uploading on Web Portal was now established and increasingly managed directly from the M&E Division with the assistance of consultants placed there. Annual Reports and Financial Management Reports were also being uploaded. NHSRC's role shifted to: a) data analysis and management at national and state levels; b) focus on improving data quality; and c) building capacities for 'intra-district data analysis' and 'use of data for decentralised health management and planning'. Assistance is provided to states through training programmes, through consultations provided to state officers in charge and visits to states. Another major mechanism of support is the recruitment, training and deployment of HMIS fellows who were handholding at district level.

HMIS training manuals

A set of four volumes was planned for building up an understanding of HMIS, for systematising the training and for dissemination of data standards by NHSRC, and after a detailed dialogue and discussions with M&E division of MoHFW was finalised and printed. The first manuals were released during 4th CRM dissemination workshop on 26 February 2011. Volume I is for the Service providers who are directly involved in collection and reporting of HMIS data. It builds knowledge of data definitions and formats. Volume II is for the health programme managers, who use HMIS data in programme planning and management. It provides skills to identify and manage data quality problems and to use information for district planning. Volume III is for HMIS Managers to understand the use of applications, the national web-portal and DHIS-2. Volume IV is for resource persons in HMIS design and leadership roles.

National workshop on Health Information Architecture

Design, Implementation & Evaluation' workshop was organised between 22-26 March, 2011. This workshop was meant exclusively for those who either lead state HMIS teams or who work as resource persons in the design of health information systems. Workshop was intended to develop advanced skills in policy and standards development, systems design, evolving the architecture of informatics as appropriate to state needs and evaluation methods. It also addressed frontline questions of addressing equity, and incorporating community concerns and methods of data triangulation. Related areas of information management – hospitals, human resources, geographic systems and case tracking were discussed and best practices in the use of mobiles for information transfer were presented. The papers presented and the discussions would feed into the development of Training Volume IV.

Data analysis and use of information

NHSRC's analysis of HMIS data at national, state and district levels is displayed on its website and disseminated widely to concerned officials at all levels. NHSRC receives almost daily requests for data pertaining to specific districts or states,

which it keeps responding to. Programme specific data analysis has also been done and disseminated.

NHSRC conducted a session called "Conversations over Data" in many states (Bihar, WB, Punjab, HP, Uttarakhand, J&K etc.) with Programme Managers/CMOs, where easily comprehensible, analysed data is projected and officers discuss the implications of the data and the action it calls for. This promotes use of data and improves quality of data.

Where facility or block level reporting is ongoing NHSRC builds capacity and provides support for districts to analyse and use district data regularly for programme management. DHIS-2, an open source application installed and supported by NHSRC, caters to this specific need and as of today, this provision is available in 15 states. The other advantage is that one could add-on, modify, or delete indicators and data elements at the state level to customise it for the special needs of that state. On this platform, facility-wise data entry (online and offline), feedback reports, customisation and modifications in database, integration with GIS, data analysis, report generation, and other resources useful for public health planning and management are available. Till date, 14 states and 1 UT (HP, J&K, Punjab, Chandigarh, Karnataka, Gujarat, Kerala, Manipur, Mizoram, Orissa, Nagaland, Uttarakhand, Chhattisgarh, MP & Bihar) have initiated facility-wise reporting and other states (Maharashtra, WB) have initiated block-wise reporting. These States have started intra-district analysis of data and feedback reporting, where district HMIS officers provide helpful information to planners and programme managers at district, block and facility levels.

NHSRC provides a HMIS Fellow or Intern, a trained fresh graduate, usually a graduate of Public Health Informatics or Public Health Management course, to assist the state in building district level capacity for this function and for improving data quality, but this is provided only in states which are keen to undertake this. In the year 2009-10, NHSRC recruited and deployed 12 Fellows and 6 Interns for HMIS.

Capacity building

For effective implementation and sustainability of HMIS, it is crucial to enhance capacities of health professionals. Data management, analysis, interpretation etc. are new concepts for many of them. During 2009-10, many training programmes were organised in states, districts, and blocks; during 103 training days, more than 20,000 health personnel were trained and approx. 800 Master trainers were identified. Depending on the skill to be imparted and HMIS competency of the health worker, some cadre of workers underwent multiple training programmes. MIS trainees were: ANMs, Data Entry Operators, Programme Managers, M&E Officers and Statistical Officers. HMIS personnel were also trained in facility-wise data entry and GIS (Kerala, Gujarat, Orissa and Karnataka). To develop skills in HMIS states using DHIS-2 to become more self-sufficient in their own ability to independently customise and use this applications, workshop on "Customisation and local use of DHIS-2" for two weeks during February was organised.

Sub-centre mobile-based reporting systems

Collection of data and reporting from ANMs has been made easy with the introduction of mobile [phone]-based data reporting and transmission. After the successful completion of pilot phase in five states (Himachal Pradesh, Rajasthan, Gujarat, Nagaland and Kerala) to test the efficacy of the application in circumstances that vary due to terrain, accessibility, infrastructure, human resources availability, integration with state HMIS, as well as level of skills in HMIS, this was implemented on a large scale in Punjab and Himachal Pradesh. ANMs are given a mobile which has SCDRT application installed for reporting via SMS. The aim of the project was that it would considerably decrease the burden of work of the ANM, as she would not have to report on paper and travel to HQ to report, and also it would improve data quality as the whole stage of data entry would be eliminated. Even as this was being done in April 2010, a decision was taken by state to increase the frequency of reporting from monthly to daily reporting, and to focus use on tracking the ANM's daily work. This was not a decision that NHSRC endorses, as in our view, the effort of such increased reporting was not commensurate

with its use, and a disciplinary approach to data collection and management compromises the use of data, other than the resentment it sets off in the service provider. While trying to keep the focus on the use of data, NHSRC would be observing and documenting the implications of converting the SCMBRS to AIMS (ANM Information Management Systems). The technology deployment is by the technical support partner-HISP, acting under the direct guidance of the state.

Hospital Information Systems (HIS)

NHSRC contributed to a pilot HIS in Doon Hospital, Uttarakhand and DDU Hospital, Himachal Pradesh. Detailed requirement study and situation analysis of all modules was carried out. The software was customised and field tested for some key modules prior to the initiation of implementation. Upon successful completion of the pilot, the initiative will be expanded and replicated. This is Health Information System Programme with NHSRC's collaborative effort where NHSRC is assisting in the clinical part.

Human Resources for Health Information Systems (iHRIS)

States are provided technical support for iHRIS- an open source solution acquired from USAID through Vistaar. In Tamil Nadu, one module of iHRIS has been developed and tested. At the same time in Bihar, Jharkhand, Gujarat, Karnataka, Meghalaya, and Jammu & Kashmir, HR informatics needs assessment is underway.

Name-based Information Tracking System (NBITS) for pregnancy and immunisation

NHSRC started pilot implementation in Ropar, Punjab. We were at the stage of developing an open source solution that could be used as much for pregnancy and immunisation as for tracking treatment in any other chronic ailment requiring long follow up. Since e-Mamata was launched as the main platform, the NBITS initiative, which at one stage was ready to go state-wide as in Madhya Pradesh, has been cut back to experimental and pilot scales. This could be used for tracking patients with SAM, leprosy, MDR TB etc.

Partners

- Health Information Systems Project-India
- Birla Institute of Technology & Sciences, Pilani
- Indian Institute of Health Management and Research, Jaipur
- Dept. of Public Health Informatics, Jamia Hamdard, New Delhi
- Department of Health Informatics, University of Oslo, Norway
- WHO
- Japanese International Co-operation Agency (JICA)
- Tata Institute of Social Sciences, Mumbai
- Dept. of Community Medicine, AIIMS, New Delhi
- Achuta Menon Centre for Health Sciences Studies (AMCHSS), Thiruvananthapuram
- Vistaar Project

HMIS division has initiated research work in the form of evaluation and triangulation studies.

Challenges

- Getting a consensus on the architecture needed for an integrated national system that provides enough decentralisation and autonomy to districts and states.
- Use of rationalised primary registers at all facilities across the country.
- Promoting use of information/HMIS data for decentralised planning across all districts.
- Building a National Data Policy and Standards – issues related to data quality standards, data definitions, data storage, accessibility, retrieval, intra-operability.
- Building multi-disciplinary teams that bring together statisticians, demographers and IT specialists under a public health leadership.

Data Quality in HMIS

The main causes of poor data quality relate to the following factors:

- Completeness of reporting
  - Non-reporting areas, e.g., corporations, company townships etc.
  - Non-reporting private sector facilities
  - Non-reporting public sector facilities
  - Non-reporting of some data elements from facilities that are reporting (usually due to lack of primary recording systems).

- Timeliness of reporting: excluding data from last one or two months to improve data quality.
- Accuracy and reliability of reporting.
  - Primary recording systems-inadequate (not having data elements, not amenable to easy computation).
  - Data duplication – same event reported from two centres.
  - Data definition problems – use of standard definitions and inherently weak definitions. (Training with good manuals helps.)
  - Problems in aggregation – exponentially increase if amount of disaggregation multiplies.
  - Data entry errors – relatively easily checked by validation checks-statistical outliers.
  - Lack of data entry staff and institutional structures for approving, checking data aggravates problems – especially the last two.

- Denominator issues: Wrong denominators in indicators can give a wrong interpretation, where denominators are not updated for population growth or the denominator does not reflect the actual catchment area that the facility serves, or that we are using a reported data element of poor quality as a denominator.
- Weak indicator choice – where indicators do not reflect accurately what is being measured or does so with low sensitivity or specificity could be the problem.

Most data quality issues have nothing to do with lack of training or false reporting. They are usually systemic problems. Only in data definition problems would training make a difference. Careless data entry errors could be a problem, but these are easily solved, by regular reviews of data and by validation checks. But for all the other causes of data quality improvement, NHSRC's role has been field visits for problem identification and then reports, and persuading states and districts to take necessary corrective actions.

In most of the states, 'data completeness status' ranges from 60-65% (all India average) with minimal data validation queries (all India average 20%). States such as HP, Kerala, MP, Manipur, Punjab and Uttarakhand have submitted reports that are more than 90% complete as of February 2010. HP, Orissa and Karnataka had only 10-15% validation queries as of August 2010. In 2010, trainings/workshops were organised where 2009-10 data were reviewed and additional skills in data analysis, report generation and use of data for public health planning were strengthened.

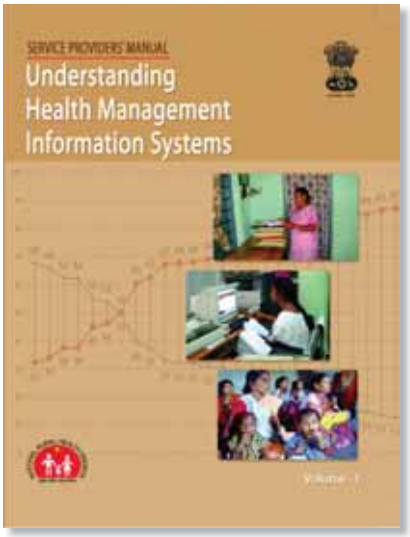
HMIS Training Sessions (2-5 days)

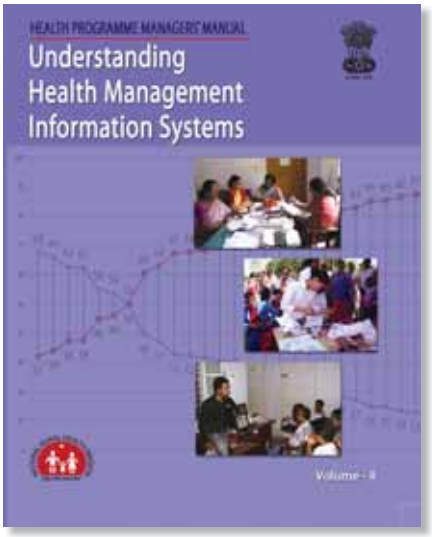
State	No. of Trainings
Assam	4
Bihar	4
Chandigarh	3
Chhattisgarh	4
Gujarat	10
Haryana	4
Himachal Pradesh	6
J&K	7
Karnataka	2
Kerala	7
Maharashtra	9
Manipur	7
Meghalaya	5
Mizoram	4
MP	4
Nagaland	5
Orissa	15
Punjab	8
Rajasthan	1
Sikkim	4
Tamil Nadu	7
UP	8
Uttarakhand	6
West Bengal	9
Total	143

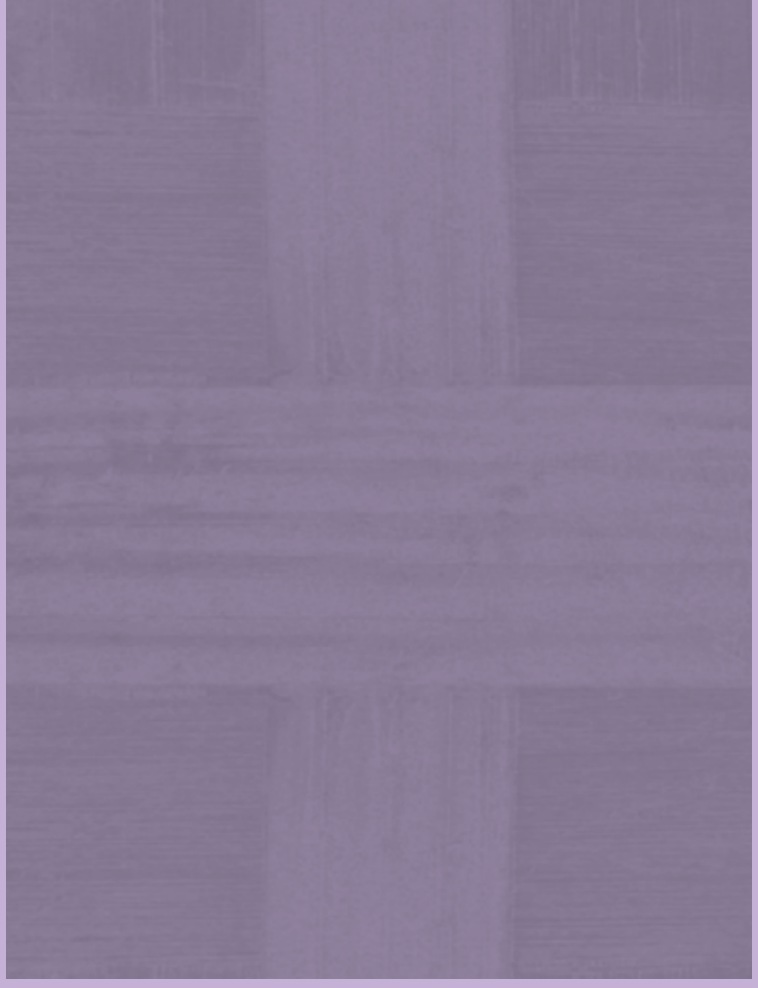
Publications

- HMIS Training Manuals
  - Service Providers' Manual
  - Health Managers' Manual
  - HMIS Managers' Manual
  - HMIS Resource Persons' Manual
- HMIS Annual (2009-10) Analysis: All States & Districts
- iHRIS Pilot-test Progress Report
- State Readiness Reports
- Reconfiguring HMIS: making them more "public health friendly"
- Report of implementation of Sub-Centre Mobile Based Reporting Systems
- Report of implementation of Hospital Management Information Systems
- Evaluation of HMIS (Research Proposal)

All the publications available on NHSRC website www.nhsrcindia.org







Human Resources for Health

Health service providers are the personification of a system's core values – they heal and care for people, ease pain and suffering, prevent disease and mitigate risk – the human link that connects knowledge to health action.

- Working together for health
the World Health Report 2006

NRHM and Human Resources for Health

One of the major areas of NRHM intervention has been in the development of human resources for health. Across the states, over 1,06,949 additional skilled personnel have been added to public health system by NRHM. It has also undertaken a number of programmes leading to skill upgradation of those already in service and innovations that lead to retention of skilled professionals in rural areas. This changing environment along with active government encouragement and reform has spurred a major increase in nursing and medical education across the country.

NHSRC has been contributing through sustained evidence based strategies for bridging the HR gaps between minimum human resources required as per national norms and the present availability. It is also documenting and sharing the interesting experiences from the states in regard to recruitments and retention of work force and performance improvements of the health workers. It is also contributing by assisting states for systematic studies and then in formulating state specific plans to address the human resource situation. On several occasions, it is called upon to respond to specific needs regarding existing situations or schemes.

Human Resources for Health

NHSRC's areas of contribution

- Studies and policy dialogues for assisting states and MoHFW in designing human resource (HR) strategies.
- Studies and policy dialogues on attraction and retention of skilled human resources for health in remote and rural areas.
- Support to development of curriculum/material/training strategies for HR development.

Work Outputs

- Male Multi-Purpose Worker: Development of proposal and training curriculum
- Nursing studies in six states and medical staff studies in five states have been finalised and shared with the states.
- Retention studies:
  - General strategies for retention of skilled health workers in rural and remote areas- the Indian Experiences
  - Why do some doctors choose to work in rural areas – an ethnographic study
  - The right doctor for the right place – a study of alternatives, non – MBBS clinical care providers from Chhattisgarh
  - Innovation in recruitment and incentivisation: The Haryana case study
  - The second ANM training and deployment programme of West Bengal
  - Three year course – political and contextual factors: Chhattisgarh and Assam
- Three year Rural Doctor Proposal – a Discussion Note.

Key Contributions

Studies of workforce management and HR development of nursing and medical staff

NHSRC facilitated studies for nursing and midwifery human resources in five states of Bihar, Chhattisgarh, Orissa, Rajasthan and Uttarakhand. All the five studies were assigned to the Academy of Nursing Studies & Women's Empowerment, Hyderabad. These studies were completed and dissemination workshops held in the state capitals in presence of the Principal Secretary (Health), Mission Directors, senior officials of Department of Health, members of State Nursing Council and principals of nursing and midwifery schools in the government and private sectors. NHSRC also facilitated the studies for the "determinants of availability and performance of specialists and general duty medical officers" in the states of Bihar, Gujarat, Jharkhand, Karnataka, Rajasthan and Uttarakhand. The preliminary reports for five states were furnished by the Indian Institute of Development and Management (Bhopal), Institute of Public Health (Bangalore) and Social Policy Research Institute (Jaipur). The reports have been forwarded to the respective states for further discussions and finalisation of the reports.

In terms of follow up, it has been most productive in Orissa. The Human Resources Action Plan for the Orissa state was prepared in consultation with the state officials and other stakeholders. The state government initiated several measures as per the recommendations leading, to starting of three medical colleges with doubling of MBBS seats from 364 to 750. The state has also proposed to start three new government medical colleges in the underserved districts. The nursing and midwifery education institutions recognised by Indian Nursing Council have substantially increased - ANM schools from 16 to 62, nursing schools from 10 to 45, B.Sc. nursing colleges from 4 to 13, post basic B.Sc. colleges from none to 2 and colleges conducting M.Sc. courses from none to 4. The state proposed to strengthen/ establish 11 male health worker training institutions. An exclusive HR division, headed by Joint Director, has been established for the implementation of HR strategies. The other initiatives include decentralised recruitments at the district level, upgradation of entry level posts, restructuring of cadres for increased promotional avenues, regularisation of contractual staff nurses on completion of six years, posting of public health nurses in the districts, financial incentives for service in 50 most difficult blocks, 47 difficult/LWE blocks as well as construction of cluster housing in LWE areas. The state introduced compulsory three years service in rural areas as well as reservation of 50% of PG medical seats for service candidates, sponsoring for diploma, degree and PG nursing courses on completion of six years rural service and earmarking of seats for underserved tribal districts. Bihar is also taking actions based on these reports. Follow up has been initiated in other states.

Partners

- Academy of Nursing Studies, Hyderabad
- Indian Institute of Development Management, Bhopal
- Indian Institute of Public Health, Delhi
- Institute of Public Health, Bangalore
- Social Policy Research Institute, Jaipur
- State Health Systems Resource Centre, Chhattisgarh
- Public Health Foundation of India, Delhi

Revitalising health worker (male) provision

As against 146,000 male workers required, the number of health workers (male) in the country declined to 57,439 by the year 2009 and their supervisors (health assistants - male) has also declined from 20,181 to 16,083. NHSRC helped develop a proposal to retrieve the situation. The approval of Mission Steering Group was accorded for the provision of 53,544 male health workers in 235 High Focus districts @ Rs. 867.40 crore during the next three years. The approval of Mission Steering Group was also accorded for the strengthening of health worker (male) training institutions @ Rs. 47.10 crore during the next three years. The curriculum for the new one year duration course of Diploma in Multi-Purpose Worker has been developed in association with the National Institute of Health and Family Welfare. The new curriculum and the Government of India assistance guidelines were communicated to the states.

Attraction and Retention of Health workforce

The NHSRC in collaboration with PHFI, and SHRC, Chhattisgarh has developed a research programme

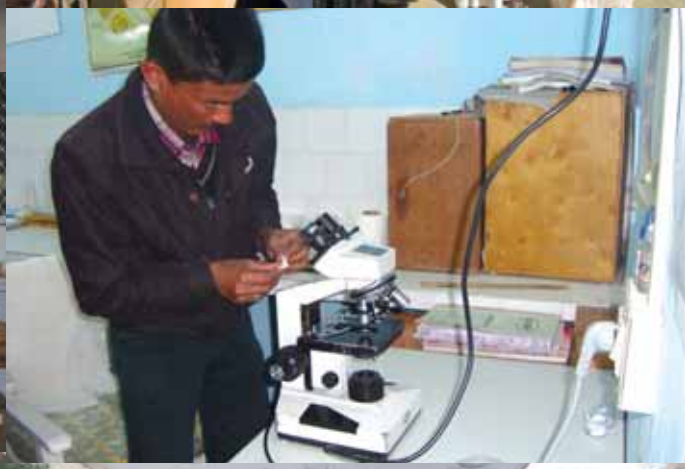
on this theme. As part of this programme, the following studies have been concluded:

- General strategies for retention of skilled health workers in rural and remote areas – the Indian Experiences
- Why do some doctors choose to work in rural areas- an ethnographic study
- Which doctor for the PHC? – a study of alternatives non-MBBS clinical care providers from Chhattisgarh
- Innovation in recruitment and incentivisation: The Haryana case study
- The second ANM training and deployment programme of West Bengal
- Three year course – political and contextual factors: Chhattisgarh and Assam

NHSRC is also an active part of the international expert group on retention of health workforce in rural and remote areas. It has been assisting on developing WHO's strategy and rolling this across the world.

Together these studies establish that though this problem is difficult, it admits of solutions given the political will and administrative competence.

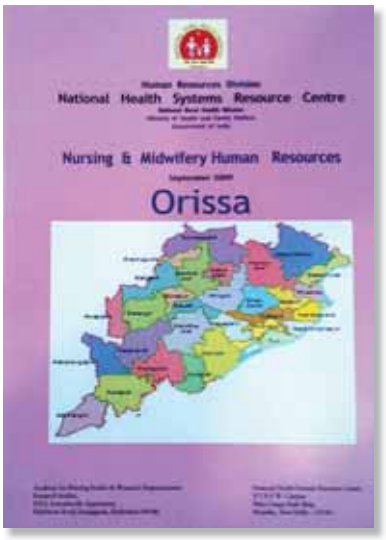


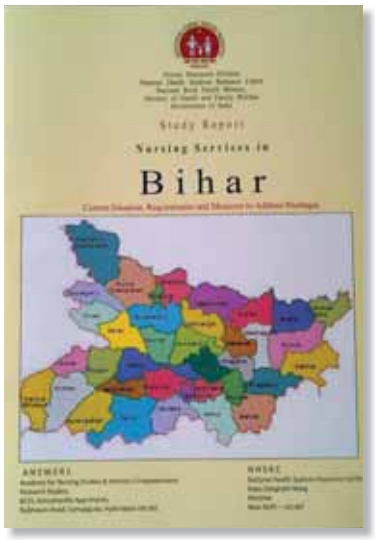



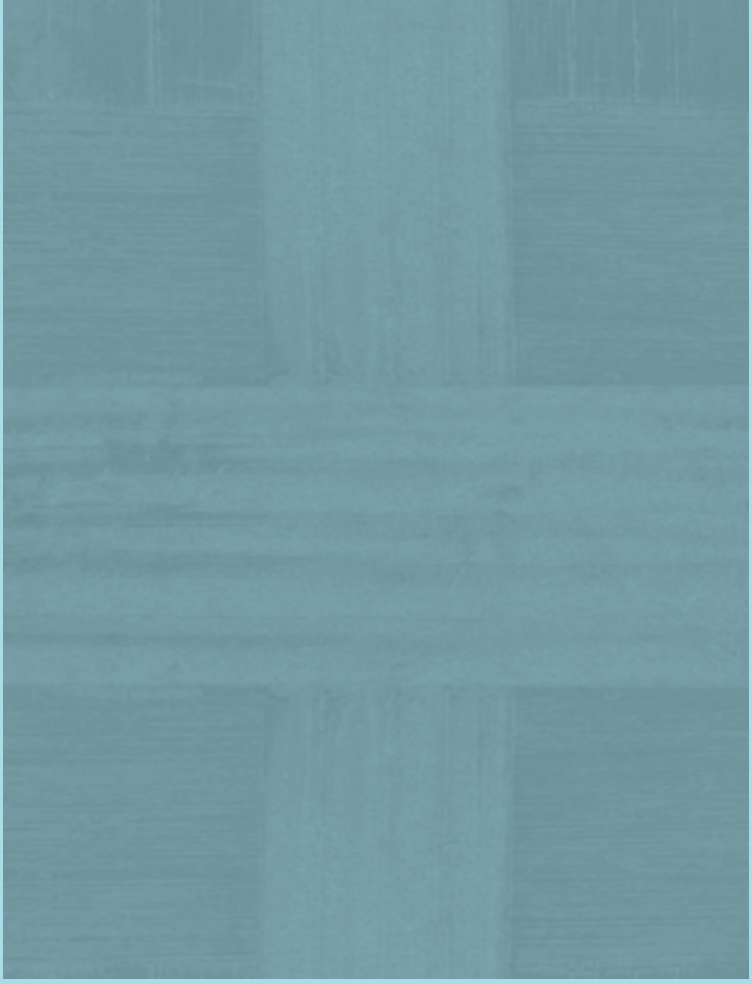
Publications

- Human Resources for Health: The Crisis, the NRHM Response and the Policy Options – Policy brief submitted to National Planning Commission
- Study report on Nursing Services – Current situation, requirements and measures to address shortages. NHSRC & ANSWERS. Five reports from:
  - Bihar
  - Chhattisgarh
  - Orissa
  - Rajasthan
  - Uttarakhand
- Human Resources for Health in India. Mohan Rao, Krishna D. Rao, A. K. Shivkumar, Mirai Chatterji. T. Sundararaman. Lancet, January 2011. (Pg. 80 to 91)
- Assessment of Primary healthcare providers in Chhattisgarh – NHSRC, PHFI & SHRC Chhattisgarh
- Why doctors serve in rural areas of Chhattisgarh – NHSRC, PHFI & SHRC: Chhattisgarh
- Strategies for increasing the availability of qualified health workers in underserved areas – NHSRC, PHFI & SHRC – Chhattisgarh
- Improving workforce management practices in haryana state to attract and retain medical professionals in public health service: A case study - NHSRC, PHFI & SHRC: Chhattisgarh
- Chhattisgarh's experience with three-year course for rural healthcare practitioners: A case study - NHSRC, PHFI & SHRC: Chhattisgarh
- Determinants of workforce availability and performance of doctors – Draft study reports:
  - Bihar
  - Gujarat
  - Jharkhand
  - Karnataka
  - Rajasthan
  - Uttarakhand
- Alternative service providers: Rationale and design of BRHC – Discussion Note:
- Case study - Second ANM training and deployment in West Bengal
- Strengthen for retention of skilled health worker in rural and remote areas – The India Experience Dr. T. Sundararaman, Dr. Garima Gupta, WHO Bulletin

All the publications are available on NHSRC website: www.nhsrcindia.org







Healthcare Financing

"...timely access to health services... cannot be achieved, except for a small minority of the population, without a well-functioning health financing system. It determines whether people can afford to use health services when they need them. It determines if the services exist."

– World Health Report, 2010

NRHM and Healthcare Financing

The key objectives of NRHM, with respect to allocation of financial resources to the health sector by government (centre and state) are as follows:

- Increase the public expenditure on health (centre and state combined) to 3% of the GDP, by the end of the XI Plan, i.e. 2012. NRHM funds at the state level to be shared between the central and state governments in the ratio of 85-15%. States to ensure a minimum of 10% increase in their own contribution to health budget every year, and that it does not substitute its contribution to the health sector with central government resources.

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

- Flexible Financing: Utilising the “society” route of financing in a decentralised structure through state, district and block health societies and RKS (Rogi Kalyan Samities) at health facility level. In order to meet demand for funds, health facilities are also provided untied grants.
- Public-Private Partnership (PPP): To engage the private sector in a transparent and efficient way with better regulation to expand service delivery capacity.
- Social Protection for Health: Demand side financing addresses the problem of high out-of-pocket (OOP) expenses by the people, especially the poor and the marginalised groups by its health facilities and through improving demand side financing/health insurance scheme.

Healthcare Financing

NHSRC's areas of contribution

- Policy and strategy Development.
- Expenditure Studies- budget tracking at national, state and district levels.
- Procurement and infrastructure audits.
- Studies of PPPs and alternative financing – including insurance schemes.
- Capacity building at the state and district levels on health financing, financial management, PPP, contracts management etc.

Work Outputs

Studies

- EMRI Evaluation report
- Case study on ERT (Emergency Referral Transportation) in Bihar
- Report on Janani Express
- Case study on ANM training through PPP model in West Bengal (also mentioned in the HRH division)
- Draft report on "HMRI Evaluation" – work in progress
- Draft proposal on "National EMS model"

Workshops

- Two-day national workshop on "Social Health Protection: Opportunities & Challenges"
- Two-day national workshop on "Performance Based Financing"

Papers and Discussion Notes

- Discussion note to 13th Finance Commission on Equalisation grants
- Policy note on differential financing to districts
- Policy note on RKSs, their functioning and financing
- Policy note on health financing- for report to the people
- Paper on "Budgets & Expenditure Tracking: 2001-08"
- District Expenditure tracking reports for the states of Bihar, Himachal Pradesh, Rajasthan and Karnataka
- Draft proposal on national EMS model were done jointly with officials in the MoHFW, GoI.

The first four policy notes and the last draft proposal on national EMS model were done jointly with officials in the MoHFW, GoI.

Key Contributions

Differential financing and the district health plan

The work of the Health Financing division of NHSRC, in the period from April to October 2010, had mostly centred around "Differential Financing". This involved developing a differential and results based financing approach for health facilities (with focus on comprehensive RCH services). This work had three roots. One was the district level public health expenditure (including NRHM) analysis undertaken in 2-3 districts in Bihar, Rajasthan, Himachal Pradesh and Kerala. Another was the study of the pattern of service delivery in the High Focus districts, which the planning team put together. The third was costing the service package as defined for three levels of service, and working out how the funds should flow to different facilities, so as to meet the costs of providing care of good quality, and also ensuring universal access.

At this stage, the output is in the form of three conceptual notes as well as assistance to drafting a proposal for moving untied funds to facilities in a more responsive manner than hitherto. This had been the thrust of the other note on revitalisation of RKS also.

Institutional and financing strategies for PPPs

In response to requests from states, NHSRC has been providing assistance in design of PPPs, in assessment of bids and in evaluation of ongoing PPPs. One major input was the EMRI study which has since been used extensively by state governments, courts and even the EMRI management to inform decision making. Also, there was a two-day workshop on "Social Health Protection: Opportunities & Challenges" based on a number of case studies that discussed the issues related to RSBY and Arogyasri. As a follow up, and as response to requests from states, evaluation study of RSBY was designed. Study has not yet begun. Janani Express in Madhya Pradesh and PPPs in ANM training in West Bengal were also studied and shared with the states. HMRI study is also ongoing.

Partners

- FHI-India
- DFID-India
- AIIMS (Community Medicine department)
- IIT-Madras (Department of Humanities)
- World Bank-India
- SHSRC-Rajasthan
- SHSRC-Kerala
- Grand Thronton
- Deloitte India
- ISEC, Bengaluru
- OASIS

Capacity building for budget tracking, financial management and contract management

NHSRC has in partnership with seven other institutions that work in healthcare financing standardised a simple tool of state budget analysis to help track state expenditures in healthcare. This is available as a guideline. Teams trained in this guideline have completed the study for 14 states.

The Health Financing division, in partnership with other divisions of NHSRC and other partner agencies, had engaged in capacity building at state and district levels through training workshops on Financial Management and Contracts Management in Himachal Pradesh (for hospital superintendents), Bihar, West Bengal and Orissa (for district planning teams). In all, 2 trainings in HP, 3 trainings in Bihar, 1 in West Bengal, and 1 in Orissa have been held. These are usually held as sessions in training of district planning programme or of hospital management training.

Challenges

Health financing reforms is dependent on higher level commitment as it involves thinking "outside the box" and moving beyond the GFR based norms and financial guidelines. This needs commitment and understanding of these issues at higher levels in the states, in the absence of which there is no "buy-in" of the state health system to try out reforms in financing (like differential financing, results-based financing etc.). This is also compounded by the lack of understanding of financing as a tool of undertaking health systems reforms.

Also, the innovations in PPP and Insurance are mostly looked at as stand-alone strategies and there seems to be a lack of strategic fit of these initiatives in the overall health sector reform strategy with respect to the unique situation and needs of respective states/ regions. Thus, the technical assistance needs are expressed more in terms of implementation issues rather than design issues.

Synopsis

Title: Patterns of Public Health Expenditure in India: Analysis of State and Central Health Budgets in pre and post NRHM period

Authors

Gautam Chakraborty, Advisor – Healthcare Financing, NHSRC

Arun B. Nair, Consultant – Health Economics & Financing, NHSRC

Looking at the significance of public health expenditure in achieving better health outcomes and reducing catastrophic health expenditure, it becomes important to examine the size, distribution, trends, composition and rate of growth of Union and State Health Expenditure during the period of 2001-02 to 2008-09.

The central government health budget increased by 21.5% per year (compounded annually) in the post NRHM phase (2004-06 to 2008-09) as compared to 10.8% per year in the pre-NRHM period (2001-02 to 2004-05). The overall growth rate of health expenditure (2001-02 to 2008-09) for all states was 12.8% per year, which in the pre-NRHM period was 5.7% per year; and in the post NRHM period, 18.4% per year. The overall growth rate for EAG states was 16.5%, while for NE states, it was 17.2% and for General Category states it was 10.8% per year. High Focus NE states show the maximum growth rate in the post NRHM period with 26.3%, while High Focus EAG states recorded 22.5% and General Category states recorded 17.1% growth (compounded annually).

Within NRHM financing, the utilisation rate of RCH flexi pool increased from 28.1% in 2005-06 to 95.5% in 2008-09, whereas NRHM flexi pool utilisation showed a humble beginning from 4.3% in 2005-06 but increased rapidly to 139.9% by 2008-09.

Thus, it seems that the post NRHM phase not only witnessed a positive shift in according greater priority to health sector in terms of increased financial commitments by both central and state governments, but also an increase in absorptive capacity of funds, which is an encouraging trend.

Title: Management Audit Approach to Evaluating Publicly Financed Schemes: Evaluation of Ambulance Services under the National Rural Health Mission (NRHM)

Authors

Gautam Chakraborty, Advisor – Healthcare Financing, NHSRC

Arun B. Nair, Consultant – Health Economics & Financing, NHSRC

Session/Thematic Area: Evaluation of and for health systems strengthening and improved public health

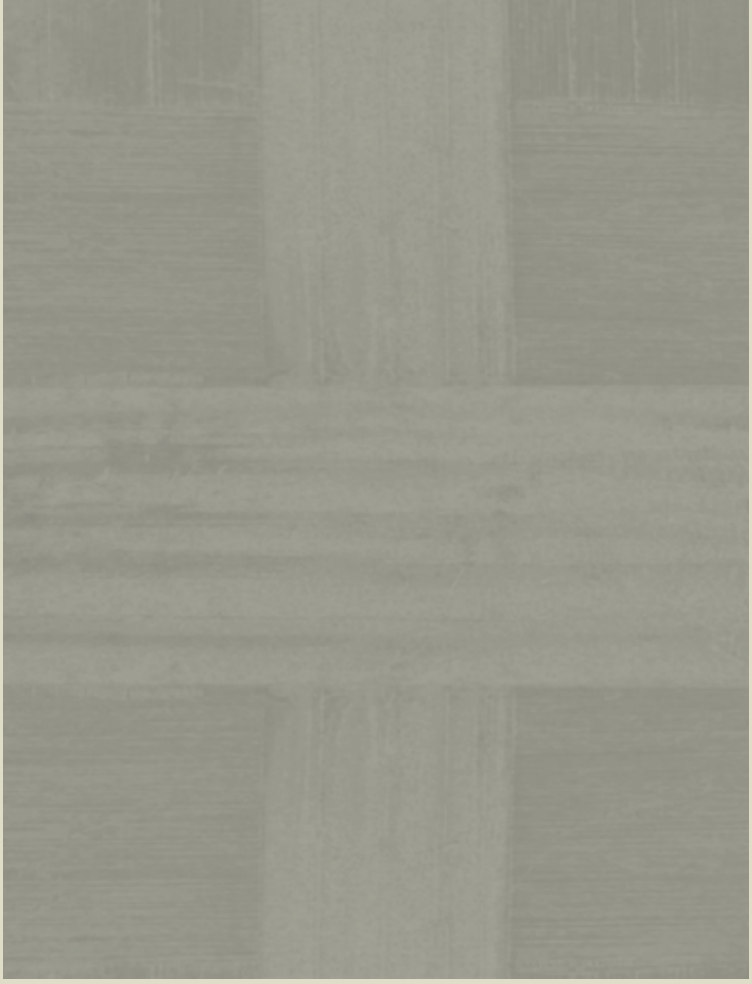
The National Health Systems Resource Centre, which is a national level technical support body under the National Rural Health Mission (NRHM), adopted the management audit approach to evaluate; (a) the design aspect and framework of the model in the context of overall health system goals; and (b) to evaluate the operational, financial and management efficiency of the EMRI model in the selected states. The framework used a comparative audit of the same ambulance scheme design (EMRI model) across three states, which were at different lifecycle stages (matured stage in Andhra Pradesh, growing stage in Gujarat and infancy stage in Rajasthan).

The detailed costing and other operational data revealed that the service is very effective in responding to medical emergencies, but the costs at optimum utilisation levels are substantially higher and disproportional to the public investments made in management of emergencies in the hospitals. It also brought the need for greater transparency in corporate governance and financial management. Subsequent to the study, many states had initiated substantial change, based on the evaluation report, in the contract documents, adopting greater transparency in the contracting process, and bringing in greater accountability regarding actual ambulance usage, linking funding to outputs, rather than inputs (as was previously done).

Publications

- Policy Note to 13th Finance Commission on Equalisation Grants
- Policy Note on Differential Financing to Districts
- Paper on “Budgets & Expenditure Tracking: 2001-08”
- District Expenditure Tracking reports for the states of Bihar, Himachal Pradesh and Rajasthan
- EMRI Evaluation report
- Report on Janani Express
- Review of HMRI-104 services in Andhra Pradesh
- Proposal on “National EMS model”
- Paper presented on “Management Audit Approach to Evaluating Publicly Financed Schemes: Evaluation of Ambulance Services under the National Rural Health Mission” in National Evaluation Conclave in New Delhi (October 25, 2010)

All the publications are available on NHSRC website www.nhsrcindia.org



Public Health Administration

“Efficiency is doing things right;
effectiveness is doing the right things.”

- Peter Drucker

Public Health Administration

The implementation framework and plan of action of NRHM stress on making the public health delivery system fully functional and accountable so that health indicators improve. The state capacity to plan, and implement the plan is limited, especially in the High Focus states of Bihar and UP, who are expected to benefit the most from NRHM. This division aims to support the High Focus states, especially Bihar and UP in planning and implementing what has been planned by the state, responsive to requests from the state or by the centre. It also helps to develop the plans.

This division also helps with development of guidelines, administrative orders to support implementation and is responsive to requests for assistance from the divisions of MoHFW, GoI.

Public Health Administration

NHSRC's areas of contribution

- Support to states of Bihar and Uttar Pradesh for implementing NRHM.
- Improving quality of monitoring and supervision.
- Assisting in the development of guidelines and orders for support to public health administration for appropriate orders, and orientation for implementation of key programmes.

Work Outputs

- **Technical assistance to Bihar**
  - Supported in preparation of district plans for last three years. Also provided technical support for planning and implementation of MCH facility mapping.
  - Developed 14 basic registers to be followed by institutions from APHC to DH.
  - Developing guidelines on ASHA payment system through banks.
  - Orientation of RKS members.
  - Orders/Guidelines for formation of VHSCs.
  - Payment of frontline workers of routine immunisation.
  - JSY study–data collection from three districts. (Nalanda, Samastipur and Madhepura)
  - Supported the State Health Society (SHS), Bihar in finalising clinical/preventive/ biomedical waste management protocols
  - Performance indicators for ranking districts by performance.
  - Reservation of post graduate seats for govt. doctors.
  - Performance assessment of contractual staff.
  - Concept note on gestational diabetes screening.
  - Advocacy to initiate non-surgical method for correcting Club-foot.
  - Preparation of the Guidebook on Nayee Pedi Swasthya Guarantee Programme.
- **Technical assistance to Uttar Pradesh**
  - District planning workshops were held at Lucknow in batches of three, covering all 71 districts in 2010-11.
  - Support to Jaccha Baccha Suraksha Abhiyan (JBSA) Programme.
  - Contributed to development of Maternal Death Review Guidebook and conduct of national workshop on the Maternal Death Review.
  - Developed concept note and a handbook for Family Friendly Hospital Scheme. State workshops conducted in Bihar, UP, Jharkhand and Chhattisgarh.
  - Instrumental in the publication of the monograph on Tamil Nadu "Making pregnancy safer in Tamil Nadu" by WHO SEARO, 2009.
  - Policy Research Working Paper – "How to improve Public Health system: Lessons from Tamil Nadu," October 2009. [Published in Economic & Political Weekly in 2010.
- Advocacy on management of severe anaemia in pregnant women by IV iron sucrose resulting in states and MoHFW accepting the same, incorporating the same in PIP and started the procurement process.
- LWE affected district planning – Plans for all the 33 districts were prepared by the division for additional financial support from Planning Commission.

Key Contributions

Family Medicine programme

Availability of a multi-skilled doctor who could independently deliver essential primary health services with view to support RCH programme in the CHCs was a necessity, especially in the High Focus states. Division worked for the development of Family Medicine programme for NRHM in consultation with CMC, Vellore. The programme is intended to develop a cadre of multi-skilled family medicine specialists who would "refer less and resolve more". The division and CMC, Vellore teamed up and made field visits in all High Focus states for selection of institutions for providing clinical experience for the FM candidates. In all the High Focus states, high volume institutions other than medical colleges were identified. The division also worked with High Focus states and facilitated selection of candidates (in-service doctors) for the CMC, Vellore run Family Medicine programme. Presently, the selection of second batch is under progress. The division developed the curriculum in partnership with CMC, Vellore and facilitated MGR University to start PG Diploma and MD in Family Medicine course. The MGR University received MCI approval for starting MD Family Medicine programme.

Maternal Death Review

MDR is an important strategy to improve the quality of obstetric care and reduce maternal mortality and morbidity. MDR involves analysis of causes and reasons that lead to the death of mother and is conducted by way of verbal autopsy in the community and facility based review of deaths that happen in the institutions. The importance of MDR lies in the fact that it provides detailed information on various factors at facility, district, community, regional and national levels that need to be addressed to reduce maternal deaths. Analysis of these deaths can identify the delays that contribute to maternal deaths at various levels and the information used to adopt measures to fill the gaps in service. MDR has been conducted as an established intervention for the last few years by some states like Tamil Nadu, Kerala and West Bengal. This activity has been undertaken by the division at the instance of MoHFW. The division participated in the conceptualisation and finalisation of the formats and guidebook. The division is part of the core group, implementing MDR at the national level. A national workshop on MDR was conducted in New Delhi in December 2010. The division has resource persons for the state level workshops on MDR as well. Recently, PHA resource persons conducted state workshops in Haryana and Puducherry.

Support to innovative schemes in Bihar

- Bihar has been using a set of indicators for ranking the districts. The indicators were mostly quantitative and did not reflect the actual scenario in the district. So a set of performance indicators was developed for district ranking, which was incorporated by the state. Further, the division successfully advocated for using these rankings to be used for mutual learning experience in the civil surgeons monthly meeting. The State Health Society released an office order revising the list of indicators for district ranking by incorporating some of the indicators submitted by the division. The SHS is currently revising the set of indicators for the year 2011-12. The civil surgeons' meetings have generated discussions based on the districts performance.
- The monitoring schedule (supportive supervision) for inspection of public health facilities was not effective. The frequencies of visits were less and mostly the institutions close to main roads were selected for visits. No structured formats were used and no feedbacks were given to the institutions. The division hence worked on the development of a structured format and a system of supportive supervision, which was used for 436 facilities in 2009-10. Subsequent to this, supportive supervision system for various levels of facilities was developed at the request of the Ministry. The formats are now being used in various states.

Support to Uttar Pradesh

The division participated in the conception and design of the programme aimed at strengthening the Routine Immunisation programme (Jaccha Baccha Suraksha Abhiyan [JBSA]). Field visits were made in selected districts of UP; some better

Key Partners

- PHRN (District Planning, Bihar)
- WHO (MDR, Iron Sucrose study)
- JICA (clinical protocols)
- Gates Foundation (FFHI)
- B-TAST (FFHI)

performing and some poor performing. The JBSA had features; like providing mobility support to ANMs, incentive scheme for ASHA and AWW and supervision of the sessions by AYUSH doctors.It also implemented Pregnancy and Infant Tracking system on a priority basis and provided resource persons for the divisional level workshops at Agra, Aligarh, Allahabad, Bareilly, Meerut, Moradabad, Mirzapur, Kanpur, Saharanpur and Varanasi. Subsequent to the launch of JBSA, the immunisation coverage has come up and polio cases reported so far, this year, is the lowest in the decade.

Iron Sucrose injection for the management of anaemia

The MoHFW, PHFI and PHA division are partnering to conduct a nationwide multi-centric study to evaluate the clinical outcomes among pregnant women.

Recruitments by NHSRC

As a part of its commitment to strengthening the public health systems under NRHM, one vital role NHSRC has played is, in the area of recruitment of public health professionals. NHSRC has recruited close to 3000 public health professionals for centre and the states. It has strictly followed a fair and transparent process of recruitment, involving all the stakeholders. As a result, there is a good diversity among the candidates selected and almost no legal contestation on the results. There has been emphasis on ensuring gender balance in recruitments along with constant efforts to learn and improve upon the recruitment techniques.

State Health Systems Resource Centre (SHSRC)

NHSRC has successfully recruited many public health professionals to build the SHSRCs'. It has successfully conducted recruitment in more than seven states. Given below is the list of skills based on which the recruitments were done.

Public Health Planning, Community Process, Health Human Resource, Healthcare Financing, Quality Improvement, Health Management Information systems etc.

Large recruitments

NHSRC has consistently delivered on large recruitments for states like Uttar Pradesh, Bihar and Jharkhand. It has conducted written test/ interviews of over 1200 candidates in one day, with an absolute fairness and efficiency. The interview panel has worked with very high level of transparency and with utmost fairness to meet the big challenge of recruiting large number of Consultants.

Campus recruitments

NHSRC has valued and given a high importance to the university graduates to help them in developing their careers in the field of public health within the government. It has hired and placed more than 30 consultants to work in the Ministry on various programmes under NRHM. NHSRC has tied up with premier institutes like the Symbiosis, Pune, IIHMR, Delhi & Tata Institute of Social Sciences, Mumbai, for recruiting at fresher level. It is currently in process of recruiting consultants for the Ministry from Symbiosis, IIHMR & TISS.

States/Programmes	Month/Year	Total No. of Positions	Total No. of Positions Closed
IDSP	September-08-09	731	600
UP NRHM	October-08-09	1193	1084
Chhattisgarh	January-09	12	10
Uttarakhand	September-09	10	10
NVBDCP Round-II	November-09	37	30
NHSRC	January-10	33	33
Rajasthan	February-10	8	5
Delhi	February-10	5	2
Punjab	February-10	7	7
Ministry	February-10	30	30
Karnataka	April-10	6	4
Jharkhand Round-I	April-10	247	216
Puducherry	August-10	1	1
Bihar	August-10	6	2
DCM & BCM & DDA	August-10	607	572
West Bengal	August-10	5	5
ANM Trainers	September-10	12	12
ARC Bihar	October-10	14	14
Jharkhand Round-II	October-10	184	42
Orissa	November-10	9	5
Jharkhand Round - III	December-10	188	In process
Total			**2684**

Regional Resource Centre for North-East States

Regional Resource Centre for North-East States

The NE RRC has the same objectives as NHSRC but with a focus on providing support to the eight states in the North-East. It had been set up under the earlier Sector Investment programme and absorbed into NHSRC administratively with the launch of NRHM. In practice, NE RRC functions with a considerable degree of administrative autonomy. NHSRC provides technical capacity building to NE RRC in key areas of district planning, HMIS, Community Processes and Quality Improvement. NE RRC also acts as a regional organiser of workshops and training programmes and monitoring arm for the NE division of MoHFW.

There is a multi-disciplinary team at the main office in Guwahati. To assist and facilitate at the state level, state facilitators and Consultants for Public Health and Community Mobilisation are in position. They also act as a link between the State and the RRC.

Much of the work of NE RRC has been geared towards making the planning process in districts and states more participatory, qualitative and more effective. Another role is in strengthening procurement and infrastructure development in the NE states.

Regional Resource Centre for North-East States

NHSRC's areas of contribution

- Public Health Planning
- Support to Finance, Accounting and Audit
- Support to Procurement and Logistics

Work Outputs

In Public Health Planning

- Capacity building of state and district health planners and managers of all eight NE states.
- Complete database of accessibility and difficulty levels of all public health facilities. Difficult, most difficult and inaccessible public health facilities in NE states were identified.
- Facilitating in formulation of RCH Sub-Plans of the High Focus districts of NE states which includes shortlisting of public health facilities to ensure universal access to entire range of RCH services.
- Induction training of newly inducted managers.
- Capacity building in financial management in NE states.

In Community Processes

- Training of trainers from NE states on ASHA Modules 6 & 7 was held at SEARCH, Gadchiroli, Maharashtra (national training site for ASHA Modules 6 & 7) in which 34 persons (NGO staff, RRC, NE staff and nurse tutors from States) were trained.
- ASHA Modules 6 & 7 were made available in local languages – Assamese, Bodo, Mizo, Manipuri, Khasi and Garo. Necessary modifications were done to fit it into state specific situations.
- Regional level orientation meeting was held of state ASHA nodal officers and training officers from all eight NE states for developing ASHA Modules 6 & 7 rollout plan and support to states in development of state specific rollout plan of ASHA Modules 6 & 7 training.
- Supported states in creation of seven different training sites in seven out of eight NE states. 262 ASHA/District trainers trained in six out of eight NE states on ASHA Modules 6 & 7. In remaining two states, training was held in December 2010/January 2011.
- Supported states in development of strategies for operationalisation of various support structures (ARC), in operationalisation of ASHA help desk/rest and house, in monitoring the programme.
- ASHA evaluation in Assam.

Health Management Information Systems

- Developed Maternal Health & Immunisation Register compatible to Mother & Child Tracking System; capacity building of the programme managers, health officials and data managers on Mother & Child Tracking system; and regional review meeting on Mother and Child Tracking System (MCTS) at Shillong for all eight NE states was conducted by NE RRC on 4-5 March, 2011.
- Capacity building of the different levels of data managers was done for data collection and facility wise data uploading in the NRHM HMIS Web Portal in Assam, Meghalaya and Tripura.
- State-wise comparative analysis of Key Indicators of 2008-09 & 2009-10 has been done so that the states can use the information available in the

report to take corrective measures and use the information in District Health Action Plan & State Programme Implementation Plan. State-wise fact sheets of NE states on Key Indicators of 2009 & 2010-11 (up to September) have been prepared and shared.

- Workshop on Data Quality and management at block level.

Procurement and Logistics

- Procurement guidelines prepared and circulated to the states.
- Tender documents for the following prepared and circulated to the states:
  - Drugs & Medicines
  - Surgical & Sutures
  - Mobile Medical Units
  - Medical Equipment.
- Assisted in preparation of tender documents for various specific items like emergency DG sets, critical care, ambulance and insecticide impregnated bed nets for DHS, Assam.
- Assisted in tender processing of NRHM, Assam, Mizoram, Sikkim & Tripura and AIDS Control Society, Assam and 108 Service (Mritunjoy), Assam.
- Assessment of procurement systems of Manipur, Mizoram and Nagaland done through external agency and reports sent to the states for taking necessary action.
- Coordination with NE states for conduct of ProMIS training programme by EPW, MoHFW which has been completed in five states.
- Capacity building on procurement as a part of workshop held centrally at Guwahati for the eight NE states.

Key Contributions

Capacity building of state and district health planners and managers of all eight NE states

In the earlier years, the capacity building workshops of state and district planners and managers of all the eight NE states were completed in collaboration with NHSRC and PHRN.

The process of preparation of the mapping of facilities for MCH centres and delivery points for the states was initiated in the NE states by NE RRC, with a capacity building workshop for the High Focus districts. During the workshop, the rationale behind the preparation of the Sub-Plan was explained in detail.

This was followed by group work during which the districts filled up the necessary templates including basic information, targets and identification of different levels of existing health facilities and their strengthening or upgradation. On the final day, the districts presented the draft Sub-Plans.

Workshops were conducted during 05-07 August, 2010 for High Focus districts of Arunachal Pradesh, Manipur and Meghalaya and during 12-13 August, 2010 for High Focus Districts of Assam. For Tripura, it was held during 25-27 August, 2010.

High Focus Districts – RCH Sub-Plans

Based on the overall assessment of health indicators, infrastructure development, manpower deployment & training, fund allocation and utilisation etc, a total of 28 High Focus districts in NE states have been identified by MoHFW, GoI. These High Focus districts account for around 50% of the total population of these five states. A majority of these facilities are not optimally functional in terms of providing assured services. This makes it even more important to have differential planning for the High Focus districts in the form of Sub-Plans with emphasis on RCH interventions, with proposals required for strengthening the health system apart from those already proposed in the District Health Action Plans.

The objective of NE RRC has been to provide support to the states and these High Focus districts, broadly in terms of capacity building, facilitation and supportive supervision for preparation of RCH Sub-Plans four Consultant-Public Health were recruited and stationed at NE RRC headquarter for continuous support and also monitoring the activities carried out in the High Focus districts. Outputs were gap analysis of all the High Focus districts in terms of infrastructure, manpower & training; service delivery and equipment; mapping of MCH centres for all these districts; and formulation of Sub-plans for all the 28 High Focus districts of NE including budget.

Hosting regional workshops for central programmes

Navjaat Shishu Suraksha Karyakram (NSSK) training was held during 13-14 June 2010. A two day training on NSSK was conducted by Indian Academy of Paediatrics (IAP), supported by Child Health division, MoHFW, GoI and organised by NE RRC at SIHFW, Guwahati for NE states, excluding Assam for In-service paediatricians.

Regional ToT for measles was conducted from 30-31 August, 2010 by NE RRC in collaboration with NIHFW & Child Health Division, MoHFW, GoI at SIHFW, Guwahati. District Immunisation Officers and Senior MOs of the piloted districts participated in the workshop. Orientation-cum-review meeting for measles was held on 8 October, 2010. One-day orientation-cum-review meeting for measles was conducted by NE RRC in collaboration with UNICEF and WHO at SIHFW, Guwahati. State and district level immunisation officers of piloted districts participated in the workshop.

Development seminar in Imphal East and Ukhrul, Manipur was held 18-20 October 2010, organised under the aegis of Ministry of Home Affairs, DoNER, NEC and Govt. of Manipur, wherein all the stakeholders in development sector participated.

Regional workshop was held on Maternal Death Review at Guwahati on 16 March, 2011 to orient participants from the state on MDR guidelines as well as take stock of implementation status.

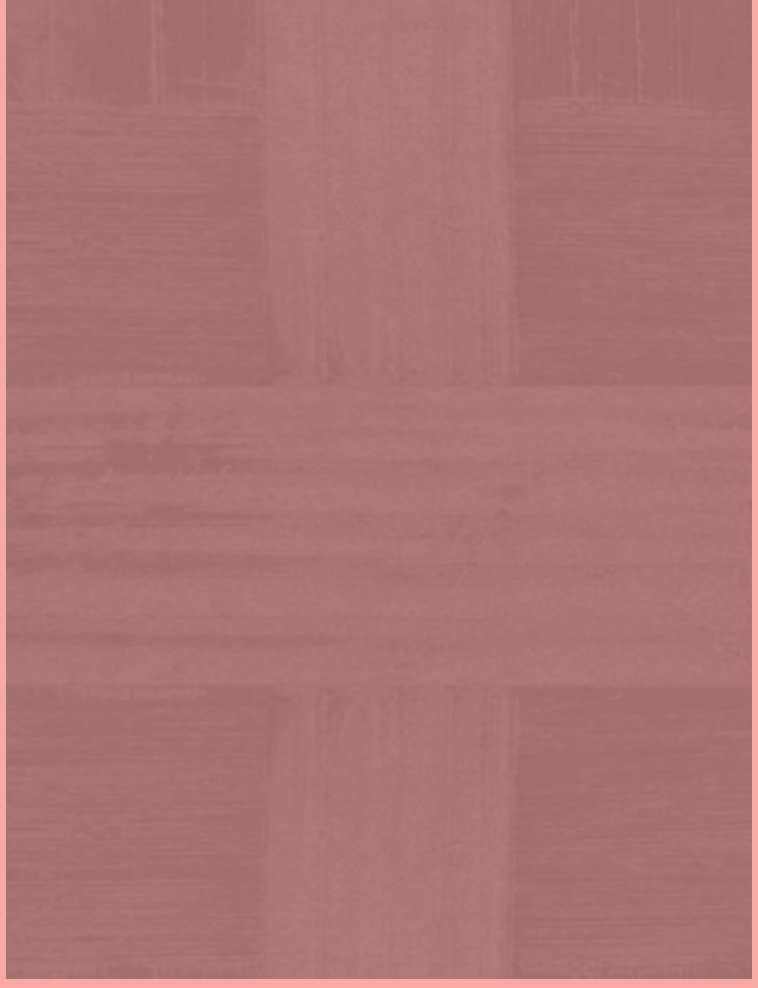
Training of national/state trainers and nurse tutors at national training site, and creating state training sites and training of district/ ASHA trainers on ASHA Modules 6 & 7

NE RRC along with NHSRC and the State Health Society of eight NE states, coordinated in training the national/state trainers and nurse tutors from NE states in SEARCH, Gadchiroli which acts as one of the national training sites for ASHA Modules 6 & 7.

NE RRC worked rigorously with all the NE states, and state specific rollout plan for ASHA modules 6 & 7 was developed. Training sites were developed in seven out of eight states, which are give below in the table.

In all the NE states, NE RRC, not only helped the states in developing the rollout plan of ASHA Modules 6 & 7 training for ASHA/District trainers and ASHAs, but also supported the states by providing trainers from NE RRC and its partner institutions/agencies who were trained in SEARCH, Gadchiroli. Till November 2010, in six out of eight NE states, 262 District/ASHA trainers having various background such as GNM, ANM, B.Sc. Nurse, LHV, AYUSH Doctors, MSW etc. had been trained on ASHA Modules 6 & 7.

Arunachal Pradesh	Administrative Training Institute (ATI), Naharlagun
Manipur	Nursing School, Lamphel, Imphal West
Meghalaya	Directorate of Health Services, Shillong
Mizoram	Health Workers Training Centre, Aizawl
Nagaland	Naga Hospital, Kohima
Tripura	Co-operative Management Institute, Agartala
Sikkim	Sir Tobgay Namgel Memorial Hospital (STNM) Hospital, Gangtok



Conferences & Workshops

Conferences & Workshops

National conferences and workshops organised by NHSRC

	Date/Venue	Partner Organisation
Quality Improvement Division		
"Equity, accountability and Quality Healthcare Services"	4-6 September, 2009 at Bhubaneswar, Orissa	IHMR, Delhi; GTZ and State Health Society, Orissa
Healthcare Finance Division		
"Publicly Funded Health Protection Schemes in India: Opportunities and Challenges"	30 April-1 May, 2010 at Hotel Claridges, New Delhi	FHI & DFID
Public Health Administration Division		
"National Maternal Death Review Workshop"	10-11 December, 2010 at New Delhi	organised by NIHFW, WHO, UNICEF
HMIS Division		
"Health Information Architecture: Design, Implementation & Evaluation"	22-25 March, 2011 Jamia Hamdard, New Delhi	Jamia Hamdard, HISP-India, BITS-Pilani
By NHSRC with IAPSM (special sessions)		
"Current Trends and Challenges in Health Systems Research" by Dr. T. Sundararaman "Building Quality Management Systems in District Hospitals" by Dr. J. N. Sahay "Quality issues in Bio-Medical Waste Management" by Dr. J. N. Srivastava 37th National Annual Conference of Indian Association of Preventive and Social Medicine (IAPSMCON-2010)	22-24 February, 2010 at Ranchi	IAPSM

International conferences and workshops participated/paper presented by NHSRC

"Health Financing in Low Income Settings (Social Protection and Purchasing/ Contracting)" organised by WHO–SEARO office	4-11 March, 2009 at Bali, Indonesia	Mr. Arun B. Nair
"Multi-skilling for Anaesthesia and Emergency Obstetric Care in South Asia", Human Resources for Maternal Survival: Task-Shifting to Non-Physician Clinicians Organised by UNFPA & AMDD	29 June-2 July, 2009 at Addis Ababa, Ethiopia	Dr. Geetha Rana Dr. P. Padmanaban Dr. Garima Gupta
"6th Bi-annual National Health Accounts symposium" "Public-Private Partnership for equitable and rationalised healthcare under National Rural Health Mission in India" "Efficiency Frontier Analysis of Indian States for Achievement of better Health Status" 7th International Health Economics Association World Congress: Exploration in Health	9-10 July, 2009 and 12-15 July, 2009 at Beijing, China	Gautam Chakraborty, Arun B. Nair & Riya Dhawan Health finance Division
"Innovations in financing healthcare: Analysis of demand side financing initiatives under National Rural Health Mission" in the Global Forum 2009	16-20 November, 2009 at Havana, Cuba	Mr. Gautam Chakraborty & Arun B. Nair
"Mainstreaming Traditional Medicines: Potential Role for Universal Health Coverage in the Indian Context" 13th ASCON ICCDR, Bangladesh	14-17 March, 2010 at Dhaka, Bangladesh	Dr. Ritu Priya and Dr. Shweta A. S.
"Human Resource for Health in India", International Conference on Health System Strengthening (ICONHSS) Organised by Tamil Nadu Health Systems Project	6-10 May, 2010 at Chennai, Tamil Nadu, India	Dr. T. Sundararaman
"Maternal Death Review in Cambodia", An address to Parliamentarians of Cambodia Ministry of Health, Cambodia.	July, 2010 at Phnom, Cambodia	Dr. P. Padmanaban
Study of Quality Status of midwifery Services	13-19 September, 2010 at Sweden	Dr. J. N. Sahay
"Retention Strategies for Human Resource - The Indian Experience", International Workshop on Rural and Community Primary Doctors Training, WHO	23 October, 2010 at Hunan, China	Dr. T. Sundararaman

"CHW Programmes under NRHM", Global Symposium on Health System Research organised by The World Health Organisation and partners	16-19 November, 2010 at Montreux, Geneva	Dr. T. Sundararaman
Workshop on 'Development of Maternal Health Indicators' organised by WHO	December, 2010 at Geneva	Dr. P. Padmanaban
1st Community Health Services Convention - organised by Ministry of Public Health & Sanitation, Kenya Status of Human Resources for Health in India	6-8 December 2010, Nairobi, Kenya	Dr. D. Thamma Rao
"Validation of the Prescriptions of Government Ayurveda Practitioners and Community Knowledge of LHT" 4th World Ayurveda Congress	9-13 December Bengaluru, India	Dr. Shweta A. S., and Dr. Ritu Priya
2nd Global Forum on Human Resources for Health PMA Conference 2011	25-29 January, Bangkok	Dr. D. Thamma Rao

Workshops to strengthen implementation of programmes

Workshop/Programme	Date/Venue	Organised by/Partners
NE RRC:		
Navjaat Shishu Suraksha Karyakram (NSSK) Training for In-service Paediatricians of all NE States except Assam	13-14 June, 2010 at SIHFW, Guwahati for NE States, excluding Assam	Conducted by Indian Academy of Paediatrics (IAP), supported by Child Health division, MoHFW, GoI and organised by RRC – NE.
"Workshop on Mother and Child Tracking System (MCTS) in Meghalaya" for District & Block officials and Data Managers of Meghalaya	24-25 June, 2010 at Shillong, Meghalaya	State in collaboration with NE RRC
"Induction Training of newly recruited District Data Managers of 3 districts" for District Data Managers of the districts	8 July, 2010) at Agartala, Tripura	NRHM – Tripura HMIS Cell in collaboration with NE RRC
"Regional Consultative Meeting for designing Training Roll Out plan for Module 6 & 7 for eight North Eastern States" for ASHA Nodal officers and Consultants (Community Mobilisation) from all NE states	23 July, 2010 at SIHFW, Guwahati	NE RRC & NHSRC
Workshop on "Data Quality & Facility Level Data uploading in the HMIS Web Portal for Baska Chirang & Dhubri districts of Assam" for District Data Managers and Block Programme Managers of the districts	4-5 August, 2010 at SIHFW, Guwahati	Assam NRHM HMIS Cell in Collaboration with NE RRC & MoHFW (Stats), GoI & Population Research Centre, Gauhati University, Guwahati

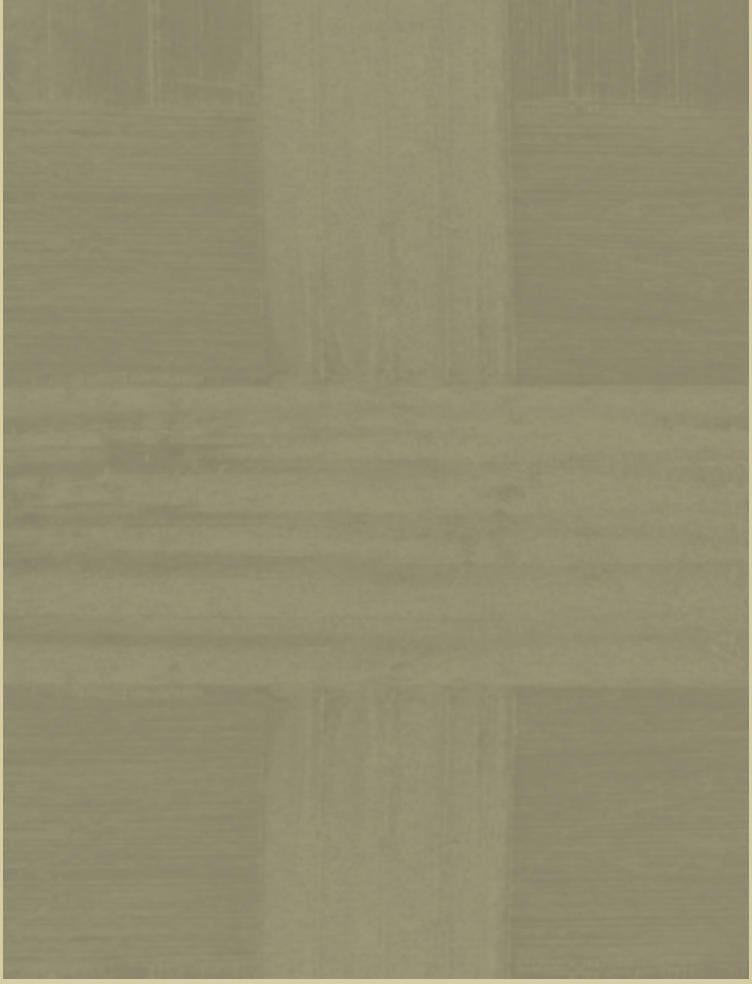
Workshop/Programme	Date/Venue	Organised by/Partners
Workshop on "Data Quality & Facility Level Data uploading in the HMIS Web Portal for Kamrup (Metro), Karbi Anglong & Nalbari districts of Assam" for District Data Managers and Block Programme Managers of the districts	6-7 August, 2010 at SIHFW, Guwahati	Assam NRHM HMIS Cell in Collaboration with NE RRC & MoHFW (Stats), GoI & Population Research Centre, Gauhati University, Guwahati
Workshop on "Data Quality & Facility Level Data uploading in the HMIS Web Portal for Bongaigaon, Darang, NC Hills and Udalguri districts of Assam" for District Data Managers and Block Programme Managers of the districts	9-10 August, 2010 at SIHFW, Guwahati	Assam NRHM HMIS Cell in Collaboration with NE RRC & MoHFW (Stats), GoI & Population Research Centre, Gauhati University, Guwahati
"Capacity Building Workshop for High Focus Districts of Arunachal Pradesh, Manipur and Meghalaya of North Eastern States" for State & District Officials of High Focus Districts of Arunachal Pradesh, Manipur and Meghalaya of North Eastern States	5-7 August, 2010 at SIHFW, Guwahati	NE RRC & PHRN
Workshop on "Data Quality & Facility Level Data uploading in the HMIS Web Portal for Barpeta Goalpara & Kokrajhar districts of Assam" for District Data Managers and Block Programme Managers of the districts	10-11 August, 2010 at SIHFW, Guwahati	Assam NRHM HMIS Cell in Collaboration with NE RRC & MoHFW (Stats), GoI & Population Research Centre, Gauhati University, Guwahati
"Capacity Building Workshop for High Focus Districts of Assam" for State & District Officials of High Focus Districts of Assam	12-13 August, 2010 at SIHFW, Guwahati	Conducted by NE RRC
Workshop on "Data Quality & Facility Level Data uploading in the HMIS Web Portal for Kamrup (Rural) & Morigaon districts of Assam" for District Data Managers and Block Programme Managers of the districts	23-24 August, 2010 at SIHFW, Guwahati	Assam NRHM HMIS Cell in Collaboration with NE RRC & MoHFW (Stats), GoI & Population Research Centre, Gauhati University, Guwahati
Workshop on "Mother and Child Tracking System (MCTS) in Assam" for State officials and District Data Managers of the districts	26-27 August, 2010 at SIHFW, Guwahati	Assam NRHM HMIS Cell in Collaboration with RRC–NE and Statistical division, MoHFW, GoI
Re-orientation on "Compiling of Financial & Accounting Reports of RKS & Other NRHM Funds for Medical Officers at Imphal, Manipur for Medical Superintendent/Officers I/Cs of District and sub-district hospitals, CHCs and PHCs of four hill districts	23-24 August, 2010 at Imphal, Manipur	Conducted by RRC–NE and organised by NRHM - Manipur
"Consultation on MCH Centres of High Focus Districts of Tripura" for State, District Officials and PMSUs of all the four districts of Tripura	25-26 August, 2010 at Agartala	NE RRC in collaboration with NRHM – Tripura
Zonal Workshop- FMG at SIHFW, Guwahati for State Finance Managers and State Accounts Managers of eight NE States	27 August, 2010	NE RRC in Collaboration with FMG – NRHM, MoHFW, GoI

Workshop/Programme	Date/Venue	Organised by/Partners
Regional ToT for Measles at SIHFW, Guwahati for DIOs and Sr. MOs of the piloted districts	30-31 August, 2010	NE RRC in collaboration with NIHFW & Child Health Division, MoHFW, GoI
"Training of District/ASHA trainers on Module 6 & 7" in Manipur for Nurse (ANM/GNM, PHN, LHV) and Block Programme Managers of five Valley districts of Manipur	1-8 September, 2010 at Imphal, Manipur	State Health Society in Collaboration with NE RRC
Training of District/ASHA trainers on Module 6 & 7 in Arunachal Pradesh in Naharlagun, Ar. Pr. for Nurse (ANM/GNM, PHN, LHV) and BPM	5-17 September, 2010	State Health Society in Collaboration with NE RRC
"Training of District/ASHA trainers on Module 6 & 7 in Manipur" for Nurse (ANM/GNM, PHN, LHV) and Block Programme Managers of four Hill districts of Manipur	16-23 September, 2010 Imphal, Manipur	State Health Society in Collaboration with NE RRC
Workshop on "Mother and Child Tracking System (MCTS), Arunachal Pradesh" for State and district officials and District Data Managers of the districts	13-15 September, 2010 at Naharlagun, Ar. Pr.	NE RRC & Statistics Division, MoHFW, Govt. of India
"Consultation of MCH Centres of High Focus Districts of Assam & Tripura for State & District Officials" of High Focus Districts of Assam and Tripura	4-5 October, 2010 at SIHFW, Guwahati, at Manipur and at Shillong (7-8 October, 2010)	NE RRC in collaboration with MoHFW, GoI and Govt. of Manipur and Meghalaya
"One-day Orientation-cum-Review Meeting for Measles S/A" for State and District level Immunisation Officers of piloted districts	8 October, 2010 at SIHFW, Guwahati	NE RRC in Collaboration with UNICEF & WHO
Training of District/ASHA trainers on Module 6 & 7 for four districts at Health Directorate, Shillong, Meghalaya for Nurse (ANM/GNM, PHN) and District Community Process Co-coordinators (DCPC) of four districts of Meghalaya	18-27 October, 2010	State Health Society in Collaboration with NE RRC
"Training of District/ASHA trainers on Module 6 & 7 in Nagaland" for Nurse (ANM/GNM, PHN, LHV) AND Block Coordinator-ASHA of six districts	20-29 October, 2010 at NHAK Hospital, Kohima	State Health Society in Collaboration with NE RRC
"Training of District/ASHA trainers on Module 6 & 7 in Nagaland" for Nurse (ANM/GNM, PHN, LHV) AND Block Coordinator-ASHA of five districts	30 Oct-8 Nov, 2010 at NHAK Hospital, Kohima	State Health Society in Collaboration with NE RRC
"Training of District/ASHA trainers on Module 6 & 7 in Sikkim" for Nurse (ANM/GNM, PHN, LHV) and DHE	25 Oct-3 Nov, 2010 at STRM Hospital, Gan gtok	State Health Society in Collaboration with NE RRC
"Induction Training of newly recruited Data Managers" for all seven districts for Block Data Managers of the districts	19 November, 2010 at Administrative Training Institute, Shillong, Meghalaya	NRHM - Meghalaya in collaboration with NE RRC

Workshop/Programme	Date/Venue	Organised by/Partners
"Training of District/ ASHA trainers on Module 6 & 7 in Tripura" for AYUSH Doctor and GNM	11-22 November, 2010 at Co-operative Management Institute, Agartala	State Health Society in Collaboration with NE RRC
"Review Meeting on HMIS & Mother and Child Tracking System (MCTS)" for all North Eastern States for State Official/State NRHM Nodal Officer/State Programme Officer/State Programme Manger, HMIS Consultant/State Data Manager, Nodal officer for MCTS and NIC Coordinators for MCTS	25-26 November, 2010 at Shillong and 4-5 March, 2011 at Guwahati	NE RRC in collaboration with Statistics Division, MoHFW, GoI
"Training of District/ASHA trainers on Module 6 & 7 in Mizoram" for DPM, GNM & MSWs	5-16 December, 2010 at Nurse Training Institute	State Health Society in Collaboration with NE RRC
"Training of District/ASHA trainers on Module 6 & 7 in Tripura" for AYUSH MO, GNM, NGO members	31 December, 2010 to 10 January, 2011 at Co-operative Management Institute, Agartala	State Health Society in Collaboration with NE RRC
"Maternal Death Review (MDR) Workshop for NE States" for State Level Officials and Planners	16 March, 2011 at SIHFW, Guwahati	NE RRC in collaboration with MoHFW, GoI
"Induction Training of newly recruited HMIS Assistant for PHC/CHC" for HMIS Assistant for PHC/CHC of West District, Tripura	8-10 March, 2011 at Agartala, Tripura	NRHM - Tripura
Public Health Administration:		
State workshop on District Planning in Uttar Pradesh	December, 2009 at Lucknow	
High Focus District Planning in Bihar	December, 2009 at Patna	
Maternal Death Review workshop for North Eastern States	16 March, 2010 at Guwahati	NE RRC
State workshop on Clinical & Preventive protocols in Bihar at Patna	March, 2010	
State workshop to finalise Basic Registers in Bihar	March, 2010 at Patna	
Jaccha Baccha Suraksha Abhiyan Workshop, UP Lucknow	June 2010	State Health Deptt., UP
FFHI State workshop in Uttar Pradesh	30 June, 2010 at Lucknow, UP	
Jaccha Baccha Suraksha Abhiyan Divisional Workshops	August to October, 2010 at all 9 divisional HQ, Uttar Pradesh	State Health Deptt., UP
Model District Plan for Karnataka Tumkur IPH, Bangalore	September, 2010	
Reproductive Child Health conference	October, 2010 at Nagpur	FOGSI

Workshop/Programme	Date/Venue	Organised by/Partners
High Level Expert Group meeting on Universal Health Coverage	February, 2011 at PHFI, New Delhi	PHFI
Reforms in Primary Healthcare	February, 2011 Jamia Millia University, New Delhi	
Round table meeting on Improving Healthcare Delivery system in West Bengal, Kolkata, Govt. of West Bengal	March, 2011 at Kolkata, West Bengal	Govt. of West Bengal
Gestational Diabetes Programme in Maharashtra	March, 2011	Mumbai Diabetic Association of India
State Consultation workshop on Clinical Establishments Act, 2010	11 April, 2011 MoHFW, New Delhi	
District Health Planning Workshop (3 rounds)	2009, 2010, 2011 at SIHFW, Patna, Bihar	PHRN
FFHI State workshop Jharkhand	30 November, 2010 at Ranchi, Jharkhand	
FFHI State workshop (Chhattisgarh)	4 December, 2010 at Raipur, C.G.	
Maternal Death Review workshop for the State of Chandigarh	at Chandigarh	
Maternal Death Review workshop for the State of Puducherry	at Puducherry	
HMIS Division:		
HMIS Fellows' Workshop	29-30 Oct, 2010 & 22-23 Jul, 2010 NHSRC, New Delhi 8-10 Apr, 2011 NHSRC, New Delhi	HMIS
Orientation workshop for HMIS Fellows	10-15 May 2010, NHSRC, New Delhi	HMIS
Community Health Fellows' Workshop	29-30 July, 2010 at Jamia Millia Islamia, New Delhi	PHRN
Capacity Building Program	13-15 Aug, 2010 at Ranchi, Jharkhand	PHRN PHP, NHSRC
District Health Planning Workshop	2-3 Sept, 2010 Patna, Bihar	PHRN & PHP, NHSRC
M&E Workshop for NIPI, LFA	11 Oct, 2010 NIPI, New Delhi	NIPI
Pre-planning meeting for the Round Table on PPP in Health Sector	16 Nov, 2010 Chennai, Tamil Nadu	APAC
PHP Division:		
District Health and Action Plan workshop, in West Bengal	13-18 August, 2010 Department of Health, 24 South Parganas	Govt. of West Bengal

Workshop/Programme	Date/Venue	Organised by/Partners
Training and Orientation of SHSRC Consultants	16-20 August, 2010 NHSRC, New Delhi	SHSRCs
District Health and Action Plan workshop, in Madhya Pradesh	2-4 Dec, 2010 Department of Health, Bhopal	Govt. of Madhya Pradesh
Development and Evaluation of Complex Healthcare Interventions	15-20 Dec, 2010 Goa	Sangath & NHSRC
Presentation of the study "status and role of AYUSH and Local Health Traditions under NRHM" to the secretary AYUSH and entire technical staff of Department of AYUSH.	19.01.2011 Department of AYUSH, Red Cross, New Delhi	Department of AYUSH
Capacity Building Workshop for AYUSH component in Planning Under NRHM with special Focus on inclusion of AYUSH in HMIS	19 February, 2011 at Ernakulam, Kerala	State Health Society and Directorate of AYUSH and SHSRC, Kerala
District Health and Action Plan workshop (2 days) followed by Model District Plan of Wayanad, Kerala	10-11 Dec, 2011 SHSRC, Thiruvananthapuram, Kerala	SHSRC, Kerala
Training and Orientation of MoHFW consultants	NHSRC, New Delhi	NRHM Division of MoHFW
Quality Improvement Division:		
IIHMR Health Conclave "Studies of different approaches to quality improvement in public hospitals"	18-19 November, 2009 at IHC, New Delhi	IIHMR, New Delhi
Workshops on revision of IPHS	Nirman Bhawan, New Delhi	MoHFW
Capacity building of NE States on Bio-Medical Waste Management	Hyderabad	EPTRI
Sharing the NHSRC's best practices and experiences on Quality Improvement of Public Health Facilities	29 March, 2010 Chennai, Tamil Nadu	ACME, State Health Society, Tamil Nadu
Implementation of Quality Management Systems in Public Health Facilities	18-22 May, 2010 at Shimla, HP	IIHMR, Delhi, GTZ, Perception
	26-30 July, 2010 at Tanda, HP	Octavo, CS Quality
	10 August, 2010 at Raipur	SHRC, Chhattisgarh, CS Quality
	30 August, September & December, 2010 at Patna, Bihar	Octavo, CS Quality, PHFI
	September, 2010 at Karnataka	
	January, 2010 at Orissa	Octavo, CS Quality



About the National Health Systems Resource Centre (NHSRC)

About the NHSRC

The Beginnings

The NHSRC was registered as a society in January 2007. A Governing Board was constituted with 21 members, 11 of whom were ex-officio government officials and 10 non-government public health experts. The Chairperson of the Governing Board is the Secretary, MoHFW and the Vice Chairperson was the Additional Secretary of the Ministry, and Mission Director of NRHM. The officials on the board were six senior officials from the central ministry and two secretaries and two mission directors from the High Focus states. The non-officials were selected from a list of public health experts forwarded by leading academic institutions which are active in public health systems development.

In the first governing board meeting, held in May 2007, the mandate of the NHSRC was explained and the Executive Director was directed to discuss with key stakeholders to suggest an organisational structure and an action plan that could fulfil such a mandate. This was done and approved by the second governing board meeting held in January 2008.

A partnership council consisting of representatives of all the development partners working in India, was constituted to provide a forum to share information and improve coordination on technical support being provided by development partners and by NHSRC. This council has met thrice so far.

The Mandate

Two key documents defined the mandate of the NHSRC

One such document is the Implementation Framework of the NRHM which describes the NHSRC thus:

"A National Health Systems Resource Centre (NHSRC) is being set up to serve as an Apex body for technical assistance, dissemination and for functioning as a Centre of Excellence for facilitating the Centre and the States in the Programme. The NHSRC would provide necessary technical assistance to the Mission Directorate." Pg 49. Implementation Framework of NRHM, MoHFW, GoI, July 2006

"Mandated as a single window for consultancy support, the NHSRC would quickly respond to the requests of the Centre/States/Districts for providing technical assistance for capacity building not only for NRHM but for improving service delivery in the health sector in general. It is proposed to have one NHSRC at the national level and another Regional Centre for the North-Eastern region. State level Resource Centres will be provided for EAG States on a priority to enable innovations and new technical skills to develop in the health system." ibid pg 23

Another document, which conceptualised the NHSRC, is the RCH-II National Programme Implementation Plan. This describes the NHSRC as follows:

"The National Health Systems Resource Centre (NHSRC) has been conceived primarily as an institution that is responsive to and is available for providing technical assistance to the centre/states for building their capacity for NRHM. The goal of this institution will be to improve health outcomes by facilitating governance reform, technical innovations and improved information sharing among all stake holders at the national, state, district and sub-district levels through specific capacity development and convergence models."

The Management of NHSRC

The Governing Board lays down the policies, frames the rules, and approves the annual plan and budget. In between Governing Board meetings, the Executive Committee which is chaired by the Mission Director NRHM and made up of 10 of the 21 Board members guides the organisation. The Executive Director reports to this committee and in between meetings

of the executive committee to the Mission Director, NRHM.

For the purposes of management, NHSRC has opted for a flat management structure. The 30 consultants at Delhi and another 20 fellows and facilitators spread over the states report to their division heads who may be advisors or senior consultants. These division heads in turn report to the Executive Director. All the administrative staff report to the Principal Administrative Officer who also reports to the Executive Director. To make the process of decision making more consultative and transparent, two management committees are functional. The first is the eight member secretariat which is part of the decision making process on all administrative issues and the second is 11 member programme committee which discusses, reviews and advises on all programme content and strategy areas. In addition the consultants' fortnightly meeting provides a platform for sharing the conceptual issues and work in progress of each division. This platform acts as a medium of internal capacity building and sharing of the work across divisions. The NHSRC is an ISO 9001:2008 certified organisation.

The Partnership and "Partnership Network" approach

Partnerships are the usual basis on which NHSRC is able to conduct its work. Contractual arrangements with financial support may or may not exist in such partnerships. Partners are purposefully selected for a stated intention, to work in a long term manner with NHSRC over a series of projects to develop capacities in the partners, so that as institutions they could continue to support the public health effort in a long term sustained manner. This thus becomes part of the mandate of the NHSRC to develop institutional capacities and eventually for the nation to be self-reliant in the area of technical assistance.

International partnerships for shared cross country learning are also emerging rapidly.

Building Positive Work Environment

NHSRC's constant endeavour is to ensure an appropriate work culture where efficiency, accountability and responsiveness are key to its services. As a part of this, there has been an effort to constantly improve management practices. In June 2009, NHSRC was certified to ISO 9001:2008, a certificate that we continue to retain through annual surveillance audits. This process enabled us to systematise our functioning and be more conscious of what needs to be done not only to increase effectiveness but also employee and partner satisfaction.

One important step is participatory decision making. The first Monday of every month, is fixed for a meeting of the secretariat or management leadership. This consists of Executive Director, Advisors, Direcotor NE RRC and the PAO. Followed by a meeting of the programme committee – which includes all secretariat members plus all senior consultants and the HR manager. The meeting reviews the previous month's work, and plans the next month's tasks while also sharing administrative or programmatic problems faced anywhere in the organisation. This work review is also against the approved annual plan and its results based framework which has in-built quarterly work targets. There is an effort to create a flat organisational structure and the workspace and processes are designed to encourage non-hierarchal and open relationships.

Employee satisfaction, well-being and motivation is monitored through annual Employee Satisfaction Survey. There is also a questionnaire sent to partners for understanding their satisfaction with NHSRC interaction. NHSRC is proud of its high retention rate of consultants, in a sector given to high turnovers. There is an exit interview for all those leaving employment to understand their views, when they feel most free to express them.

A monthly NHSRC internal communication bulletin keeps all NHSRC members and our Executive Committee and Governing Board members informed of what NHSRC is doing. An annual retreat looks at institutional strategy for one day, and then spends the next day as a family get-together, where all members meet over an informal setting.

NHSRC provides ample space for individual skill development. There is encouragement to be part of part-time distance education or doctoral programmes. There is active encouragement to present papers and attend national and international workshops. Though NHSRC does not pay for international visits, our papers not only get accepted, they usually attract the support needed for the travel and the stay. Over 30 international papers in three years at such terms is a significant achievement. NHSRC has attracted attention of a number of nations and international bodies as a significant innovation in technical assistance for health systems development.

Monthly internal workshops and guest lectures by external guest faculty also keep us growing in technical capacity. A small but carefully stocked in-house library and unlimited internet access makes for good resource support.

We have set ourselves a service guarantee cycle time for various bills to be handled by the Accounts Division and we try to achieve these standards. There are printed forms/formats and simple processes for all routine approvals which make administration less cumbersome and much more pleasant.

There is an effort to be gender-sensitive. Gender representation in employment has reached a ratio of 40% women in the organisation. Women have an extra six days leave which they can take for family reasons, and there is a one month paternity leave. Women are dropped back from office to their residence in cabs if they are required to stay beyond 6.30 pm on a working day.

It's a tough job…. to work at NHSRC, and the pay may be nothing to write home about, but we make it a lifetime experience that one can enjoy and treasure, and for young people it is a place to grow.

Governing Board (2011-2014)

- Shri. K. Chandramouli
  Secretary, MoHFW, GoI
  (Chairperson, Governing Board, NHSRC)
  Nirman Bhawan, New Delhi-110 011
- Dr. R. K. Srivastava
  Director General Health Services, MoHFW, GoI
  Nirman Bhawan, New Delhi- 110 011
- Mr. P. K. Pradhan
  Special Secy & Mission Director, NRHM
  MoHFW, (Chairperson Executive Committee, and
  Vice Chairperson, Governing Board of NHSRC)
  Nirman Bhawan, New Delhi – 110 011
- Shri Naved Masood
  Addl. Secy. & Financial Advisor, MoHFW, GoI
  Nirman Bhawan, New Delhi-110 011
- Ms. Anuradha Gupta
  Joint Secretary (RCH), MoHFW, GoI
  Nirman Bhavan, New Delhi – 110 011
- Shri Amit Mohan Prasad
  Joint Secretary, MoHFW, GoI
  Nirman Bhawan, New Delhi-110 011
- Dr. Deoki Nandan
  Director-NIHFW
  Munirka, New Delhi-110 067
- Principal Secretary
  Health & FW Department,
  Government of Uttar Pradesh
  Lucknow – 226 001
- Shri B. K. Mohanty
  Principal Secretary
  Public Health & FW Department
  Government of Madhya Pradesh
  Bhopal – 462 004
- Principal Secretary
  Government of Rajasthan
  Jaipur-302 005
- Principal Secretary
  Government of Bihar
  Patna-800 014
- Dr. Faujdar Ram
  Director, International Institute of Population
  Studies, Mumbai-400 088
- Dr. K. R. Thankappan
  Professor & Head, AMCHSS, SCTIMST
  Thiruvananthapuram, Kerala
- Prof. P. M. Kulkarni
  Centre for the Studies of Regional Development
  School of Social Sciences, JNU, New Delhi
- Dr. Dileep Mavalankar
  Professor, IIM, Ahmedabad
  Ahmedabad-380 015
- Dr. Prema Ramachandran
  Nutrition Foundation of India
  New Delhi - 110 016
- Dr. Yesudian
  Professor, School of Health System Studies
  TISS, Mumbai – 400 088
- Dr. A. K. Shiv Kumar
  Member, NAC and Adviser
  UNICEF, New Delhi – 110 003
- Dr. K. Srinath Reddy
  President, PHFI
  New Delhi – 110016
- Prof. Gita Sen
  Professor, IIM, Bangalore – 560 076
- Dr. T. Sundararaman
  Member Secretary, Governing Board &
  Executive Committee
  Executive Director, NHSRC
  NIHFW Campus, New Delhi-110067

We gratefully acknowledge the guidance and contributions of the three outgoing Governing Board Public Health experts – Dr. Chandrakant Pandav, Dr. Shalini Bharat and Dr. Thelma Narayan.

NHSRC Team

Executive Director		
1	Dr. T. Sundararaman	Executive Director
Administration		
A	Ms. Sushma Rath	Principal Administrative Officer
B	Mr. Vinit Goklani	HR Manager
C	Mr. Gambhir Jain	Accounts Officer
D	Mr. Ashok Pather	Account Assistant
Community Participation		
2	Dr. Rajani R. Ved	Advisor
3	Dr. Garima Gupta	Consultant
4	Dr. Manoj Kumar Singh	Consultant
5	Mr. Arun Srivastava	Consultant
Healthcare Financing		
6	Mr. Gautam Chakraborty	Advisor
7	Mr. Arun B. Nair	Consultant
8	Mr. Tushar C. Mokashi	Fellow
Health Human Resource		
9	Dr. Damisetti Thamma Rao	Advisor[#]
10	Mr. Prankul Goel	Consultant
HMIS		
11	Dr. Sandhya Ahuja	Sr. Consultant
12	Dr. Ekta Saroha	Sr. Consultant
13	Dr. Tanupriya Pal	Consultant
14	Ms. Alia Kauser	Consultant
15	Ms. Itisha Vasisht	Consultant
16	Dr. Amit Mishra	Consultant
Public Health Administration		
17	Dr. P. Padmanaban	Advisor
18	Mr. Prasanth K. S.	Consultant
Public Health Planning		
19	Mr. Padam Khanna	Sr. Consultant
20	Dr. Anuradha Jain	Sr. Consultant
21	Dr. Geetha Rana	Sr. Consultant[#]
22	Dr. Dinesh Kumar Jagtap	Consultant
23	Ms. Jhimly Baruah	Consultant
24	Dr. Prasad B. M.	Consultant

25	Dr. Shweta A. Saxena	Consultant
26	Dr. Abhilash Malik	Consultant
27	Ms. Saba Kaleem	Consultant
	Quality Improvement	
28	Dr. Jag Narayan Sahay	Advisor
29	Dr. J. N. Srivastava	Sr. Consultant
30	Dr. Parminder Gautam	Sr. Consultant
31	Ms. Nidhi Jain	Consultant
32	Dr. Nikhil Prakash Gupta	Research Assistant
33	Mr. Shubhendu Mandal	Fellow[#]
	Consultants placed at NHRM Division, Nirman Bhavan, MoHFW, GoI	
1	Dr. Hemant Kumar Sharma	Consultant
2	Dr. Sarita Sinha	Consultant
3	Ms. Neha Aggarwal	Consultant
4	Ms. Iti Kaushik	Consultant
5	Mr. Kunal Dhawan	Consultant
6	Ms. Shraddha Masih	Consultant
7	Ms. Asmita Jyoti Singh	Consultant
8	Dr. Prayas Joshi	Consultant
9	Ms. Shilpy Malra	Consultant
10	Ms. Namita Pandey	Consultant
11	Mr. Shahab Ali Siddiqui	Consultant
12	Dr. Abhishek Gupta	Consultant
13	Ms. Huma Siddiqui	Consultant[#]
14	Ms. P. Divyashree	Consultant
15	Dr. Rachna Parikh	Consultant
16	Dr. Sumegha Sharma	Consultant
17	Mr. Pradeep Tandon	Consultant
18	Dr. Salima Bhatia	Consultant
19	Mr. Vaibhao Ambhore	Consultant
20	Dr. Arpana Kullu	Consultant
21	Dr. jayant Kumar Singh	Consultant
22	Dr. Amar Ramdas Nawkar	Consultant
23	Mr. Rajiv Kumar	Consultant
24	Mr. Rakesh Hanuman Rajpurohit	Consultant
25	Ms. Heena Chakraborty	Consultant

[#] Have since moved to other institutions.

State Facilitators

Bihar		
1	Mr Ajit Kumar Singh	State Facilitator, Bihar
2	Ms Vasudha Gupta	State Facilitator, Bihar[#]
3	Suman Bely Lakra	Office Asst-cum-Data Entry Operator
Uttar Pradesh		
4	Dr. Sajid Ishtiaque	State Facilitator, SPMU NRHM-UP
5	Ms. Kanchan Srivastava	State Facilitator, SPMU NRHM-UP[#]
Jharkhand		
6	Mr. Randhir Kumar	State Facilitator, Jharkhand[#]
Rajasthan		
7	Mr. Vishal Pandit	State Facilitator, Rajasthan[#]
Orissa		
8	Mr. Susanta Kumar Nayak	State Facilitator, Orissa[#]
9	Mr. Perwaiz Alam	Research Assistant, HMIS
Himachal Pradesh		
10	Ms. Richa Saxena	Research Assistant
11	Ms. Marriyam	Fellow, HMIS
Jammu & Kashmir		
12	Mr. Mohd Kamil	Fellow
13	Mr. Mohd Abid	Fellow
Uttarakhand		
14	Mr. Deepak Chandra Bhat	Fellow, HMIS
Chhattisgarh		
15	Mr. Krishna Gopal	Fellow, HMIS
Punjab		
16	Dr. Menakshi Wasson	Fellow, HMIS

[#] Since absorbed in the state or completed contract.

Regional Resource Centre for NE States

S.No.	Name	Designation
1	Dr. A. C. Baishya	Director, NE RRC
2	Dr. M. Dilip Singh	Advisor, Public Health
3	Dr. Ashoke Roy	Advisor, Public Health
4	Mr. K. K. Kalita	Advisor- Proc & Log
5	Mr. Bhaswat Kr. Das	Regional Coordinator, HMIS
6	Mr. Biraj Kanti Shome	Regional Coordinator, Community Mobilisation
7	Mr. H. Nongyai	Regional Coordinator , Community Participation
8	Ms. Rita Devi Tamang	Coordinator, Training and Capacity Building
9	Mr. Devajit Bora	Consultant, Community Mobilisation
10	Ms. Sagarika Kalita	Consultant-HMIS
11	Mr. Jyotimani Das	IT Manager
12	Dr. Joydeep Das	State Facilitator, Assam
13	Dr. Pradip Jyoti Sarma	State Facilitator, Arunachal Pradesh
14	Dr. Latashori K.	State Facilitator, Manipur
15	Mr. Nabin Norbert Sharma	State Facilitator, Sikkim
16	Mr. Arindam Saha	State Facilitator, Tripura
17	Mr. Wahengbam Imo Singh	Consultant, Community Mobilisation, Mizoram
18	Mr. Sukamal Basumatary	Consultant-Public Health Planning, Meghalaya
19	Mr. Surajit Sen	Consultant-Public Health Planning, Sikkim
20	Ms. K. C. Lalparmawii	Consultant-CM, Mizoram
21	Mr. R. Lalmuankima	State Facilitator, Mizoram
22	Dr. Madhusudan Yadav	Consultant-Public Health (High Focus)
23	Dr. Manika Sharma	Consultant-Public Health (High Focus)
24	Ms. Shilpa John	Consultant-Public Health (High Focus)
25	Mr. A. Romendro Singh	Consultant-Public Health (High Focus)

The launch of NRHM has provided the Central and the State Governments with a unique opportunity for carrying out necessary reforms in the Health Sector. The reforms are necessary for restructuring the health delivery system as well as for developing better health financing mechanisms.

Natinal Rural Health Mission, Meeting people's health needs in rural areas, Framework for Implementation, 2005-2012, MOHFW, GOI, Section III.6, Pg 14

India has made much progress in the past few years, with several innovative pilot programmes and initiatives in the public and private sectors, and the establishment of the National Rural Health Mission in 2005 being the most noteworthy government-led initiative. This initiative has signalled the repositioning and rejuvenation of the public health system and in doing so has resulted in the inclusion of the health needs for the disadvantaged individuals, and health equity on the agenda.

Health Care and Equity in India, Lancet, January 2011. Pg. 75

NHSRC Website: www.nhsrcindia.org

The decentralised district-based planning envisaged in the NRHM needs to be rolled out throughout the country by 2012. The methods for situation analysis and planning need to be disseminated, and the capacity developed to use them. The National Health Systems Resource Centre has provided useful support to fill this gap. The time has come for development and implementation of one plan that encompasses the activities of both the NRHM and the Integrated Child Development Services to ensure convergence.

Vinod Kumar Paul, Harshpal Singh Sachdev, Dileep Mavalankar and Others
India towards Universal Health Coverage, The Lancet, January 2011, Pg. 48

India needs to adopt such an approch of rigorous assessment of the effect and implementation research, ideally with a specific organisation commissioned to coordinate and disseminate the knowledge that was developed through an active sharing of best practices between and within states, and internationally. The National Health Systems Resource Centre is well equipped to provide the necessary structure to support this approach, and help the continued development of the health management information systems.

Y. Balarajan, S. Selvaraj, S.V. Subramanian
India towards Universal Health Coverage, The Lancet, January 2011, Pg. 76

National Health Systems Resource Centre

Technical Support Institution with National Rural Health Mission
Ministry of Health & Family Welfare
Government of India