PRESENTATIONS FOR
ORIENTATION MODULE FOR PLANNERS, IMPLEMENTERS AND PARTNERS

MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA
INTRODUCTION

CONTENTS

1. Introduction to NUHM
2. Overview of Orientation Module
3. Objectives of the Orientation program
4. Topics covered under training
5. Modes of teaching
NATIONAL URBAN HEALTH MISSION

Launched on 1st May 2013 under NHM

**Aim:** To address unique and diverse needs of urban poor and vulnerable population

**Mission:** To provide **essential primary health services** to the entire urban population, while urban poor and vulnerable sections remaining its prime concern

**Urban issues: Are different from** Rural, and their solutions involve:
- Inter-sectoral coordination
- Equity
- Community involvement
- Sustainability

OBJECTIVES OF ORIENTATION PROGRAM

- Provide overview of NUHM program components
- Sensitization and perspective building on vulnerability and urban health issues
- Give guidance on effective implementation (planning, convergence, HR management, financial management)
### TOPICS COVERED UNDER ORIENTATION PROGRAM

#### 1. Perspective building on urban health
   1. Urbanization, migration and marginalization of urban poor
   2. Understanding and responding to urban health needs

#### 2. National Urban Health Mission
   1. Introduction to NUHM
   2. Key Components of NUHM

#### 3. Implementing NUHM
   1. Establishing institutional mechanism
   2. City Mapping and Vulnerability assessment
   3. Urban Health Planning
   4. Operationalizing UPHCs and UCHCs
   5. Linking Disease Control Programs to NUHM
   6. Organizing outreach services
   7. Organizing referral services
   8. Reporting Mechanisms
   9. Intersectoral convergence for urban health

#### 4. Essential Processes and Programs under NUHM for Urban people
   1. Community Processes
   2. Population based NCD Screening
   3. Quality assurance in Urban Health
   4. Managing disease outbreaks in Urban health
   5. Public Private partnership for urban health
   6. Monitoring and Evaluation

#### 5. Administrative issues in NUHM
   1. Financial management and budgeting for NUHM
   2. Human Resource management under NUHM
   3. Communication Strategy for NUHM
MODE OF TEACHING UNDER TRAINING PROGRAM

- Presentations
- Lectures
- Discussions
- Questions and Answers
- Case studies
- Interactive teaching and experience sharing to ensure interest of the participants

THANK YOU
PERSPECTIVE BUILDING ON URBAN HEALTH

CONTENTS

1. Urbanization and effects
2. Migration: Reasons and consequences
3. Marginalization
4. Barriers to Health care in Urban settings
5. Determinants of Health
6. Urban morbidities & its causes
7. Sustainable development for Urban Health
Presentations for Orientation Module for Planners, Implementers and Partners

URBANIZATION

- Urbanization is one of the most significant trends of 21st century
- Proportion of Urban population increased from 10.8% in 1901 to 31.2% in 2011 and is expected to increase to 50% in next few decades
- Urban population grew from 91 million to 377 million between 2001 to 2011
- By 2030 it is estimated to increase by more than 200 million
- 3 main factors contributing to this escalating growth rate are:
  - Natural population growth rate (Highest)
  - Net migration
  - Transformation and re-classification of cities and peri-urban areas

URBANIZATION LEADING TO VULNERABILITY

NUHM lays special emphasis on improving the reach of healthcare services to vulnerable groups among the urban poor

The three main vulnerable categories as identified by Hashim Committee are:

1. Residential or habitat-based vulnerability
2. Social vulnerability
3. Occupational vulnerability

Definition of vulnerability should accommodate following variable experiences and requirements: All people facing disproportionate burden of ill-health often seen co-terminous with low-incomes, social exclusions, poor housing, risky occupational settings, gender, disability, singleness, age, debilitating ailments and others constitute vulnerability
MARGINALIZATION

Various circumstances of the urban life marginalize the urban poor in such a way that they cannot access services, and can also not demand their entitlements:

- Inadequacy of resources for all (hence lack of basic services like water, electricity)
- Hazardous living environment (exposure to extreme weather, poor hygiene)
- Exposure to Violence and Crime
- Fear of Eviction from their ‘illegal housing’
- Unsafe work environment – in terms of physical safety
- Monetization of Basic needs (in urban areas, every little necessity needs to be purchased, unlike in rural)
- Limited access to social security schemes (mostly they are unable to establish their entitlement and eligibility)
- Lack of Social Networks (hence poor social and emotional support)
BASIC PRINCIPLE

All persons, whether residing in rural or urban areas, are entitled to basic primary healthcare. It is the responsibility of the public health system to ensure that affordable primary healthcare services of acceptable quality are available to all – irrespective of their type of housing (whether they live in slums or are homeless), place of residence (urban or rural), social status or economic productivity.

Population health cannot be ensured by leaving out large numbers of population out of the fold of the public healthcare system.
**DETERMINANTS OF URBAN HEALTH**

- Cities offer the best and worst environments for health and well being. However, there are large disparities between health or the poor and the wealthy.
- For certain indicators, health outcomes of urban poor are worse than those of rural residents.

**URBAN MORBIDITIES**

**Major Causes of Death in Rural and Urban Areas, 2007-2013, NSSO**

- While NCDs are the largest cause of mortality in both urban and rural, in urban areas, they are more common cause of death (56%)
HEALTHCARE SEEKING IN URBAN AREAS

Outpatient Care seeking in Rural and Urban Areas (2014, NSSO)
- In both urban and rural areas, people primarily seek private care. Proportion of people visiting a public hospital is similar in urban and rural.

In-patient Care seeking in Rural and Urban Areas (1995-2014, NSSO)
- Hospitalizations are higher in urban than in rural areas.
- However, 82% of urban population is not covered by any insurance.

RISK FACTORS FOR URBAN MORBITIES

<table>
<thead>
<tr>
<th>Rank</th>
<th>Causes of death &amp; disability</th>
<th>Risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ischemic heart disease</td>
<td>Poor diet, high blood pressure, high body mass index (overweight), high blood sugar, tobacco smoke.</td>
</tr>
<tr>
<td>2</td>
<td>Neonatal preterm birth</td>
<td>Child and maternal malnutrition, Unsafe water, maternal disorders</td>
</tr>
<tr>
<td>3</td>
<td>Neonatal encephalopathy</td>
<td>Child and maternal malnutrition, Unsafe water, maternal disorders</td>
</tr>
<tr>
<td>4</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Air pollution, tobacco use</td>
</tr>
<tr>
<td>5</td>
<td>Lower respiratory infections</td>
<td>Air pollution</td>
</tr>
<tr>
<td>6</td>
<td>Diarrhoeal diseases</td>
<td>Unsafe water</td>
</tr>
<tr>
<td>7</td>
<td>Cerebrovascular disease (stroke)</td>
<td>Poor diet, high blood pressure, high body mass index (overweight), high blood sugar, tobacco smoke.</td>
</tr>
<tr>
<td>8</td>
<td>Tuberculosis</td>
<td>Pollution, exposure to infection, malnutrition</td>
</tr>
<tr>
<td>9</td>
<td>Iron deficiency (anemia)</td>
<td>Poor diet, Unsafe water</td>
</tr>
<tr>
<td>10</td>
<td>Lower back &amp; neck pain</td>
<td>Poor posture, excessive physical work, lack of exercise</td>
</tr>
</tbody>
</table>

Government needs to invest in: walkways, parks, occupational safety mechanisms, cycling tracks, safe urban transport, clean fuel, pollution reduction and create HEALTHY CITIES.
**SUSTAINABLE DEVELOPMENT FOR URBAN HEALTH**

- With the SDGs for the first time ‘Sustainable Cities and Communities’ has been declared as an international goal.
- There are 17 SDGs with 169 targets that all 191 UN Member States have agreed to work towards by the year 2030.
- All the SDGs have a direct and indirect impact on health.
- Health in all policies will lead to achieve SDG.
- With increasing global urbanization, achievement of SDGs will not be possible without working towards especially urban health.

**HEALTHY CITIES**

- A clean, safe physical environment of high quality (including housing quality);
- An ecosystem that is stable now and sustainable in the long term;
- A strong, mutually supportive and non-exploitative community;
- A high degree of participation in and control by the citizens over the decisions affecting their lives, health and well-being;
- Meeting of basic needs (food, water, shelter, income, safety and work) for all the city’s people;
- Access by the people to a wide variety of experiences and resources, with the chance for a wide variety of contact, interaction and communication;
- A diverse, vital and innovative economy;
- Connectedness with the past, with protected historical and cultural heritage;
- An optimum level of appropriate public health and sickness care services, accessible to all; and
- High health status (high levels of positive health and low levels of disease).
KEY LEARNINGS

- With poor access to basic amenities, employment, health, social security and high incidence of crime, cities are harsh living environments for the urban poor. These and many other social determinants of health render them vulnerable and susceptible to ill-health.

- Urban vulnerable groups face multiple barriers to seeking health care. Although medical facilities are available, expenditure on medical care is high often pushing them further down in poverty.

- Urban residents face triple burden of ill-health i.e., communicable, non-communicable diseases and injuries. However, NCDs are responsible for 56% deaths in urban areas.

- City administrations can develop ‘Sustainable cities and communities’, one of the 17 Sustainable Development Goals.

- Cities must encourage healthy behaviours and lifestyles by ensuring basic sanitation and hygiene, solid waste management, water management, proper transport and recreational spaces.

THANK YOU
CONTENTS

- History of Urban Health Services & Genesis of NUHM
- Comprehensive Primary Healthcare Approach to NUHM
- Introduction to NUHM Components
  - UPHC
  - UCHC
  - Urban ASHA
  - MAS
INTRODUCTION TO NUHM

- **Approved on** May 1, 2013 as a sub-mission of the National Health Mission (NHM) to strengthen the primary health care system in cities & towns
- **Target Population:** 29.95 Crore urban population (Census 2011)
  - 942 cities/towns with population above 50,000 (29.69 Crore)
  - 64 District Headquarter towns with population between 30,000 – 50,000 (0.26 Crore)
- **Special focus on:**
  - People living in listed, unlisted slums and other low income neighborhoods
  - All other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, and other temporary migrants
- **Implemented by:** Joint implementation by State Health Department and ULBs (either may take the lead, depending upon city population)

HISTORY OF URBAN HEALTH SERVICES

- Though many steps were taken at state & central levels, to improve service delivery in urban areas, they were scattered and sporadic
- **National Health Policy of 2002** identified the need to organize public health services in urban areas
- MoHFW recommended establishment of ‘Urban Health Posts’ for 50,000 population, to be located in and around urban slums, with strong linkages with secondary and tertiary level facilities
- World Bank supported India Population Projects (IPPs) Urban Health Posts Maternity Homes and 244 sub-centres were created in Mumbai & Chennai as part of IPP VIII
- Similar health facilities were also established in Delhi, Bengaluru, Hyderabad and Kolkata as part of IPP VIII
- Under various schemes and projects, there was establishment of UHPs, Urban Maternity Centres, Urban Dispensaries, Urban Health and Family Welfare Centres
Under the Comprehensive Primary Healthcare Service Package, following services are essential:

- Care in pregnancy and child-birth.
- Neonatal and infant health care services
- Childhood and adolescent health care services including immunization.
- Family planning, Contraceptive services and Other Reproductive Health Care services
- Management of Common Communicable Diseases and General Out-patient care for acute simple illnesses and minor ailments
- Management of Communicable diseases: National Health Programmes
- Prevention, Screening and Management of Non-Communicable diseases
- Screening and Basic management of Mental health ailments
- Care for Common Ophthalmic and ENT problems
- Basic oral health care
- Geriatric and palliative health care services
- Trauma Care (that can be managed at this level) and Emergency Medical services
Presentations for Orientation Module for Planners, Implementers and Partners

**SERVICE DELIVERY STRUCTURE OF NUHM**

<table>
<thead>
<tr>
<th>Population Served</th>
<th>Health Facility/Worker</th>
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</thead>
<tbody>
<tr>
<td>2.5 lakh population (5 lakh for metros)</td>
<td>1 UCHC (30-50 bedded in-patient facility, 100 bedded in Metros for 5 lakh population)</td>
</tr>
<tr>
<td>50,000 population</td>
<td>1 UPHC (OPD facility)</td>
</tr>
<tr>
<td>10,000 population</td>
<td>1 ANM</td>
</tr>
<tr>
<td>1000-2500 population (200-500 households)</td>
<td>Community Health Volunteer (ASHA)</td>
</tr>
<tr>
<td>250-500 Population (50-100 households)</td>
<td>Mahila Aarogya Samiti</td>
</tr>
</tbody>
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**UPHC: EPICENTER OF COMPREHENSIVE PRIMARY HEALTHCARE**

- Effective and Regular Outreach Services
- Convergence with Urban Development, Swachh Bharat, Urban Local Body (ULB) at ward level
- In-facility services, Drugs & Diagnostics under all National Health Programs
- Community Processes (Community Based interventions & Home visits by ASHAs, ANMs and MAS)
- Population Based Screening of NCDs
- Multi-directional and Assured Referral

The Urban Primary Health Center
URBAN PRIMARY HEALTHCARE CENTER

- UPHC is the Epicenter of public healthcare provision in urban areas
- One for every 50,000 population, as close to the slums or vulnerable areas as possible
- Registered with a Rogi Kalyan Samiti (RKS)
- OPD hours: To be open for 8 hours a day, dual shifts

<table>
<thead>
<tr>
<th>Cadre</th>
<th>Number at UPHC</th>
</tr>
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<tbody>
<tr>
<td>MO I/C</td>
<td>1</td>
</tr>
<tr>
<td>2nd MO (part time)</td>
<td>1</td>
</tr>
<tr>
<td>LHV</td>
<td>1</td>
</tr>
<tr>
<td>Nurse</td>
<td>1</td>
</tr>
<tr>
<td>Lab Technician</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1</td>
</tr>
<tr>
<td>ANMs</td>
<td>3-5</td>
</tr>
<tr>
<td>Public Health Manager/ Mobilization Officer</td>
<td>1</td>
</tr>
<tr>
<td>Support Staff</td>
<td>3</td>
</tr>
<tr>
<td>M and E Unit</td>
<td>1</td>
</tr>
</tbody>
</table>

URBAN COMMUNITY HEALTHCARE CENTER (UCHC)

- Similar to the rural Community Health Centre in its basic operationalization and functions
- One UCHC envisaged for a population of 2.5 lakhs
- 30-50 bedded (100 in Metro cities)
- It acts as the first referral unit for 4-5 UPHCs in its catchment area
URBAN ASHA

- Each Urban ASHA for 1000-2500 population. Resident of the “slum clusters” and belong to a vulnerable group. Formal education of at least Tenth class.

Her Role:
- Undertake a vulnerability assessment of the households in her area
- Create awareness on social determinants and entitlements for health and other public services
- Counsel women, families & adolescents on reproductive, maternal & child health, prevention of common infections, substance abuse, prevention of domestic and sexual violence.
- Curative care for common ailments, first aid, other communicable diseases like malaria, Japanese encephalitis, chikungunya, leprosy, etc.
- Attend UHND and outreach activities, make home visits.
- Coordinate MAS formation and their functioning

MAHILA AAROGYA SAMITI (MAS)

- Local collective or Group of 10-15 community women
- One MAS per 50-100 households
- Formed in slum and slum-like areas
- Coordinated by Urban ASHA
- Groups will conduct monthly meetings to discuss issues faced by the community
- Mobilize action for resolving them
- Untied Funds of Rs. 5000 per year transferred to their accounts
ANM UNDER NUHM

Functions and Duties of ANM under NUHM are wider and expanded under NUHM, as compared to her traditional RCH centric role:

- Not just RCH services provision, but also services for communicable and non-communicable diseases
- Vulnerability assessment and mapping of UPHC catchment area
- Understand non-health issues of community (water, sanitation, garbage disposal) and communicate to MO or PHM
- Plan and organize Urban Health Nutrition Days in her areas
- Support organization of Special Outreach Camps and NCD Screening
- Supervisions of urban ASHAs for urban slums
- Make home visits for high risk pregnancies and those requiring special services

HEALTH KIOSKS

- NUHM has no sub-centers, so some states have felt the need for an additional level of facility such as Health Kiosks
- It is a prefabricated structure that can facilitate ANM/MPWs (F) in conducting outreach services
- Location: Where slums under a UPHC are distant
- Good for unauthorized slums and/or in areas inhabited by communities at high risk of adverse health outcomes, e.g. commercial sex workers, street children, rag pickers, nomads etc.
- Health kiosks will act as the first point of contact between the community and the health system
KEY LEARNINGS

- NUHM adheres to principles of comprehensive primary health care, and aims to provide a defined package of services as close to home as possible for vulnerable population
- There are multiple service platforms of NUHM – UPHC, UCHC, home and community (outreach)
- UPHCs aim to effectively gate keep and reduce the burden at secondary and tertiary health services
- ASHAs and Mahila Aarogya Samitis are important components to enhance community participation

THANK YOU
IMPLEMENTING NUHM

CONTENTS

- Establishing Institutional mechanism

- Urban Health Mapping (City Mapping & Vulnerability Assessment)
  - Types of Mapping,
  - Methodology of Mapping

- Urban Health Planning and its processes
**PROCESS OF IMPLEMENTING NUHM**

1. Establish Institutional Mechanism
2. Urban Health Planning
3. Urban Mapping
4. Operationalize UPHC, UCHC
5. Intersectoral convergence

These 2 topics will be covered in the next PPT.

**NUHM IMPLEMENTATION**

3 models identified by TRG* based on the roles played by State & ULBs in providing urban health services:

- **Model 1**
  - State: 100%
  - ULBs: Minimal
  - Municipal Health Officer in charge of non-medical services
  - Examples: HP, Bihar, Small towns (< 2 lakh population)

- **Model 2**
  - State: Major
  - ULBs: Minor
  - State: District hospital, Medical colleges
  - Examples: Bhubaneshwar
  - ULBs: Urban Health Dispensaries, Health Posts, Health Volunteers

- **Model 3**
  - State: Minimal
  - ULBs: Major
  - State: Municipal corporations
  - ULBs: Metropolitan
  - Example: Mumbai, Calcutta, Chennai, Bangalore, Ahmedabad, Delhi Non-Metro: Madurai, Pimpri

*TRG: Technical Resource Group on NUHM in 2013, a committee formed by MoHFW to give recommendations on NUHM strategies.*
CORE PRINCIPLES

To be exercised while deciding lead implementer of NUHM

- There should be no withdrawal of reduction in the current services being offered
- Convergence with non medical services should be strengthened
- For large cities (e.g., Metros and Million Plus Cities), Health → ULBs
- For smaller cities (where ULBs are not strong): Health → State
- If State Health Department is leading NUHM implementation, MUST coordinate with ULBs

ESTABLISHING INSTITUTIONAL MECHANISM: KEY STEPS

1. Appointing Additional Mission Director, NUHM
2. Expansion of SHS (State Health Society)
3. Expansion of DHS (District Health Society)
4. Establishing CHS (City Health Society)
5. Establishing Urban Health Cell/Unit within State Program Management Unit (SPMU) & District PMU and setting up City Program Management Units
6. Convergence with ULBs & Urban stakeholders

Expansion: Means Inclusion of members from other urban stakeholders such as Municipal Administration, Water, Sanitation, Social Welfare etc.
## Legacy Management

Legacies of health services (previously hired health workforce, health facilities, health programs and projects need to be properly managed while rolling out NUHM

<table>
<thead>
<tr>
<th>State Governments</th>
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<tbody>
<tr>
<td>Must devise a plan for legacy management</td>
</tr>
<tr>
<td>Proper absorption of existing workforce, dispensaries, secondary hospitals, health posts, link workers, MMUs into formal NUHM framework</td>
</tr>
<tr>
<td>Minimization of redundancy, duplication or loss of role clarity</td>
</tr>
<tr>
<td>Clear re-allocation of job descriptions with training &amp; supervisory changes</td>
</tr>
<tr>
<td>Legacy management is an important exercise for externally funded projects particularly those yielding good results</td>
</tr>
</tbody>
</table>

## Urban Health Mapping
OBJECTIVES OF URBAN HEALTH MAPPING

- Identify & map vulnerable groups (slums, mobile population), infrastructure, environmental features
- Understand health issues, needs and coping mechanisms
- Barriers faced by poor and marginalized in accessing health services
- Locate health care services, their accessibility and responsiveness

CITY MAPPING

Mapping is geo-spatial distribution of vulnerable populations, physical structures, social relationships and issues of access to health care.

It helps to understand the availability & distribution of:
- Resources
- Services (and gaps therein)
- Health Needs
- Vulnerable groups and their needs

Mapping makes urban poor and vulnerable visible to the health system!
**TYPES OF MAPPING**

<table>
<thead>
<tr>
<th>City Mapping</th>
<th>UPHC Catchment area Mapping</th>
<th>Vulnerability Assessment Mapping</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health facilities</td>
<td>• To be done by ANM, ASHA, PHM, supervised by MO</td>
<td>Done at 2 levels:</td>
</tr>
<tr>
<td>• Notified/un-notified slums</td>
<td>• Covers area catered by the UPHC</td>
<td>• Slum level assessment (team of Urban ASHA, ANM, PHM, RKS, ULB members)</td>
</tr>
<tr>
<td>• Anganwadi Centers</td>
<td>• Shows locations of slum and vulnerable pockets</td>
<td>• Household level assessment (ASHA, ANM) [Registration of families at UPHC may also be done during this process]</td>
</tr>
<tr>
<td>• Educational institute (Public and private)</td>
<td>• Areas under each ANM</td>
<td></td>
</tr>
<tr>
<td>• Major landmarks</td>
<td>• Major landmarks</td>
<td></td>
</tr>
<tr>
<td>• Agricultural land</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Water bodies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rationalize the location of Health Facilities, MMUs, outreach

Ensure adequate service delivery to vulnerable poor

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**FLOW CHART OF CITY MAPPING & VULNERABILITY ASSESSMENT**
OBJECTIVES OF URBAN HEALTH PLANNING

- Prevention of ill-health
- Strengthening of primary health facilities
- Ensure access to primary health service through outreach, awareness and efficient Asha and ANMs
- Identification and strengthening of multi-directional referral linkages
- Address specific urban health issues of the city like malaria, heat stroke, road safety, pollution and water quality
Utilizing Mapping for Planning Process

The Mapping Process, as explained before, is the foundation of good planning. Mapping data can be used for the following:

- **Identifying site** for UPHC, Health Kiosk, MMUs, and their catchment areas
- **Organizing Outreach** UHND and Special Outreach sessions
- **Planning for Community processes** (population allocation to ASHAs, helping ASHA understand needs of her population, formation of MAS groups)
- **Public private partnerships** (understanding the need for a PPP, which private/NGO partners are available through stakeholder analysis)
- **Convergence** (Mapping process brings together multiple stakeholders)
- **Disease Surveillance** (understand which areas to focus on for which outbreaks)
- **Planning for Referral transport**
**OUTCOMES OF PLANNING PROCESS**

- The entire urban population (covered under NUHM) is included under UPHC catchment areas.
- All identified slum, slum-like areas and vulnerable pockets have an urban ASHA assigned. ASHAs and ANMs are aware of their assigned households.
- Health services are delivered as per population needs through appropriate platforms.
- The administrative divisions of the city (wards, zone, cluster) coincide with the UPHC catchment area boundaries as much as possible.
- The patient load at the secondary and tertiary health facilities is effectively reduced by strengthening primary health care facilities.
- Coordination committees are constituted at the state level, city level and sub-city level and UPHC level.
- Measures are implemented to create healthy cities i.e., cities which encourage healthy behaviours such as walking, cycling, effectively process waste, reduce pollution and have open spaces for outdoor activities with safe environment.

**KEY LEARNINGS**

- Vulnerability Mapping and Assessment in urban health means understanding the locations of various vulnerable communities as well as their health needs and health seeking behaviour.
- While spatial mapping may be done through GIS or a manual process, vulnerability assessment should be done by community health workers, using specially designed formats at the household or at the slum level.
- In addition, each UPHC should map out their catchment area and clearly define the households of each ANM and ASHA.
- In order to plan urban health services, we need to first conduct a comprehensive situational assessment - for health services and for various determinants of health.
- For such a cross cutting assessment and planning exercise, various stakeholders need to be involved.
- The assessment should be followed by identification of areas of focus for the planning period. Accordingly, key activities need to be decided, with consensus of all stakeholders.
- The focus must be on appropriate health service delivery, and creation of a healthy and safe city for all.
THANK YOU
OPERATIONALIZING HEALTH FACILITIES, OUTREACH SERVICES & REFERRAL SERVICES UNDER NUHM

CONTENTS

- Operationalizing UPHCs and UCHCs
  - Minimum Services to be provided at UPHC
  - Diagnostic Services at UPHCs
  - Identification of UPHC Catchment Area
  - Registration of Households
- Linking Disease Control Programs to NUHM
- Outreach services under NUHM
  - Urban health nutrition day: UHND
  - Special outreach sessions
- Referral services
OPERATIONALIZING UPHCs AND UCHCs

- **Location**
  - As close to the slum area as possible, and preferably will be inside the slum or slum-like habitation
  - When one UPHC serves multiple slums, be so located that maximum beneficiaries can access it conveniently.
  - ULBs should facilitate land procurement, identifying premises

- **Timings**
  - The UPHC must be operational for 8 hours every day.
  - Each UPHC must have morning and evening OPD.
  - The laboratory timings must match the OPD timings.

- **Constitution of Rogi Kalyan Samitis**
  - All facilities should have a Registered Patient Welfare Committee or Rogi Kalyan Samiti
  - Guidelines for constitution of RKS defining the constitution, functioning, roles and responsibilities have been formulated and released by the Ministry of Health.
  - The Samiti is responsible for expenditure of the untied funds received by the facilities.

IDENTIFICATION OF UPHC CATCHMENT AREA

- The MOIC should obtain a broad written mandate from the Nodal Officer in the Municipal Corporation / Chief Medical and Health Officer (CMHO) of the district, regarding the area to be covered.

- The catchment area of the UPHC should be depicted on a physical map (details in UPHC Mapping)

- The population should be divided equally between all ANMs such that an ANM gets allocated roughly 10,000 population.

- All slum and slum-like habitations must be covered by an Urban ASHA, under the supervision of an ANM.

- The Non-slum areas shall be covered by the respective ANM of the area.
REGISTRATION OF HOUSEHOLDS

- **House-to-house visit** by ASHA/ANM to register households to the UPHC, starting from slum and covering entire population under UPHC.
- Each family member should be given a health card, placed in a Family Folder for future reference and follow ups.
- The information to be collected: name of each member, age, sex, relationship with head of household, occupation and current need and access to primary healthcare services, number of under-five children, immunisation status, pregnant women with ANC history, eligible couples, risk factors and chronic illnesses.
- Create lists of: vulnerable population (based on the Vulnerability Assessment Guidelines) eligible couples, pregnant women, infants, children aged one to four, elderly, and those with different specific chronic illness
- In a paper format or electronic. To be updated periodically as per requirement.

MINIMUM SERVICES TO BE PROVIDED

<table>
<thead>
<tr>
<th>Clinical Services</th>
<th>Diagnostic Services</th>
<th>Support Services</th>
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<tbody>
<tr>
<td>• Maternal &amp; Child health</td>
<td>• Clinical pathology</td>
<td>• Health promotion through IEC</td>
</tr>
<tr>
<td>• Family Planning</td>
<td>• Biochemistry</td>
<td>• Behaviour Change Counseling (BCC)</td>
</tr>
<tr>
<td>• RTI/STI (HIV/AIDS)</td>
<td>• Microbiology</td>
<td>• Counselling</td>
</tr>
<tr>
<td>• Nutrition</td>
<td>• Urine analysis</td>
<td>• Advocacy</td>
</tr>
<tr>
<td>• Vector born diseases</td>
<td>• Stool examination</td>
<td></td>
</tr>
<tr>
<td>• Mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chest infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NCDs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Communicable diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Surgical → Referral</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### LINKING DISEASE CONTROL PROGRAMS TO NUHM

<table>
<thead>
<tr>
<th>Services Areas</th>
<th>Services to be provided</th>
<th>Programme Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternal Health</strong></td>
<td>ANC, PNC, initial management of complicated delivery cases and referral, management of regular maternal health conditions, referral of complicated cases</td>
<td>Revised National Tuberculosis Control Programme</td>
</tr>
<tr>
<td><strong>Child health and Nutrition</strong></td>
<td>Diagnosis and treatment of childhood illnesses, referral of acute cases/chronic illness identification and referral of neonatal sickness</td>
<td>Reproductive Child Health Programme</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td>Distribution of OCP/CC, IUD insertion, referral for sterilization, management of contraceptive related complications</td>
<td></td>
</tr>
<tr>
<td><strong>RTI/STI (including HIV/AIDS)</strong></td>
<td>Symptomatic Diagnosis and primary treatment and referral of complicated cases</td>
<td></td>
</tr>
<tr>
<td><strong>Nutrition Deficiency disorders</strong></td>
<td>Height/weight measurement, Hb testing, distribution of therapeutic doses of IFA, promotion of iodized salt, nutrition supplements to identified children and pregnant/lactating women.</td>
<td>National Programme for Prevention and Control of Diabetes, Cancer, Cardiovascular diseases and Stroke.</td>
</tr>
<tr>
<td><strong>Vector-borne Diseases</strong></td>
<td>Slide collection, testing using RDKs, DDT Counselling for practices for vector control and protection, Diagnosis and treatment, referral of terminally ill cases</td>
<td>National Vector Borne Diseases Control Program</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Initial screening and referral</td>
<td>National Mental Health Programme</td>
</tr>
<tr>
<td><strong>Oral Health</strong></td>
<td>Initial screening, Diagnosis and referral</td>
<td>National Oral Health Programme</td>
</tr>
<tr>
<td><strong>Chest infections (TB/Asthma)</strong></td>
<td>Symptomatic search and referral, ensuring adherence to DOTS, other treatment, Diagnosis and treatment, referral of complicated cases</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular Diseases</strong></td>
<td>BP measurement, symptomatic search and referral, follow-up of under treatment patients, Diagnosis and treatment and referral during specialist visits,</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>Blood/urine sugar test (using disposable kit), Diagnosis and treatment, referral of complicated cases</td>
<td>National Programme</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>Identification and referral, follow-up of under-treatment patients</td>
<td></td>
</tr>
<tr>
<td><strong>Trauma care (burns &amp; injuries)</strong></td>
<td>First aid, emergency resuscitation, documentation for MLC (if applicable) and referral</td>
<td></td>
</tr>
<tr>
<td><strong>Other Surgical Interventions</strong></td>
<td>Identification and referral</td>
<td></td>
</tr>
<tr>
<td><strong>IEC/BCC</strong></td>
<td>Distribution of health education material</td>
<td>All Programmes</td>
</tr>
<tr>
<td><strong>Counseling</strong></td>
<td>Patient/attendant counseling</td>
<td>All Programmes</td>
</tr>
</tbody>
</table>
### Diagnostic Services at UPHC

<table>
<thead>
<tr>
<th>Name of Diagnostic Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Pathology</strong></td>
</tr>
<tr>
<td>- Haemoglobin Estimation (Hb)</td>
</tr>
<tr>
<td>- Total Leukocyte Count (TLC)</td>
</tr>
<tr>
<td>- Differential Leukocyte Count (DLC)</td>
</tr>
<tr>
<td>- Platelet count</td>
</tr>
<tr>
<td>- MP (Slide Method)</td>
</tr>
<tr>
<td>- ESR</td>
</tr>
<tr>
<td>- Clotting Time (CT)/Bleeding Time</td>
</tr>
<tr>
<td>- Blood Group (ABO-RH typing)</td>
</tr>
<tr>
<td><strong>Biochemistry</strong></td>
</tr>
<tr>
<td>- Blood sugar</td>
</tr>
<tr>
<td>- Serum Bilirubin</td>
</tr>
<tr>
<td>- Lipid Profile (Blood Cholesterol)</td>
</tr>
<tr>
<td><strong>Microbiology</strong></td>
</tr>
<tr>
<td>- Rapid Plasma Reagin (RPR) Kit Test</td>
</tr>
<tr>
<td>- HIV Test (ELISA Kit)</td>
</tr>
<tr>
<td>- Sputum for AFB</td>
</tr>
<tr>
<td>- Dengue (Rapid test)</td>
</tr>
<tr>
<td>- Malaria (Rapid test)</td>
</tr>
<tr>
<td>- Typhoid (Widal Test/Typhi dot test)</td>
</tr>
<tr>
<td>- Hepatitis (HBsAg Test)</td>
</tr>
<tr>
<td><strong>Urine Analysis</strong></td>
</tr>
<tr>
<td>- Urine Sugar / Albumin/Leucocyte Esterase</td>
</tr>
<tr>
<td>- Stool for OVA and cyst</td>
</tr>
<tr>
<td>- Water Quality Testing-H2S Strip test for</td>
</tr>
<tr>
<td>Faecal Contamination</td>
</tr>
<tr>
<td>- Urine Pregnancy test (UPT)</td>
</tr>
<tr>
<td>- Estimation of chlorine level of water</td>
</tr>
<tr>
<td>using ortho-toludine reagent.</td>
</tr>
</tbody>
</table>

**Outreach Services Under NUHM**
OUTREACH UNDER NUHM

- Critical component of primary health care.
- Expands the reach and coverage of health services to the urban poor population
- First step in the continuum of care linking primary to secondary and tertiary care services.
- As per the guidelines, two types of Outreach services are envisaged under the NUHM:
  1. Urban Health and Nutrition Day (UHND or Routine Outreach)
  2. Special Outreach Sessions

1. URBAN HEALTH AND NUTRITION DAY (UHND)

<table>
<thead>
<tr>
<th>Location</th>
<th>AWC, community center, any appropriate community space (fixed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>Weekly per ANM (monthly for every 2500 population)</td>
</tr>
<tr>
<td>Services</td>
<td>Preventive, promotive &amp; basic curative (immunization, ANC, screening of oral, breast cancer, hypertension, diabetes, counseling on nutrition, hygiene etc)</td>
</tr>
<tr>
<td>Conducted by</td>
<td>ANM</td>
</tr>
<tr>
<td>Community Mobilization by</td>
<td>ASHA and MAS, with help from ANM, AWW</td>
</tr>
</tbody>
</table>

Responsibilities of MO/IC:
- Development of annual Calendar for UHND
- Review coverage & Quality of UHND services
- Submission of monthly/quarterly reports

Responsibilities of ASHA/ MAS:
- Prepare a list of vulnerable people requiring services
- Inform community and MAS members about date, time and location

Responsibilities of ANM:
- Conduct the UHND - provide services to UHND clients
- Appropriate referral where needed
## 2. SPECIAL OUTREACH SESSIONS

- Organized to provide specialist services to marginalized communities
- State may source specialists may be sourced from private practitioners
- Planning for type of specialty required to be based on vulnerability assessment
- Services will differ from one area to another as per need of population

<table>
<thead>
<tr>
<th>Designed for</th>
<th>Hard to reach Communities, communities with specific special needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>To be decided as per need of the population (Eg: Monthly, fortnightly)</td>
</tr>
<tr>
<td>Services</td>
<td>Health check-up, Specific set of services for endemic diseases or population specific problems</td>
</tr>
<tr>
<td></td>
<td>Screening and treatment of NCDs</td>
</tr>
<tr>
<td></td>
<td>Basic lab investigations (using portable /disposable kits), and drug dispensing</td>
</tr>
<tr>
<td></td>
<td>Geriatric care, Dental Care, Specialist RCH services</td>
</tr>
<tr>
<td>Service provision by</td>
<td>Specialist doctors (Gynecologists, Orthopedics, Dentists, Dermatologists etc.), Nurses, Lab technicians, Clinical psychologist, Medical social workers, Pharmacists</td>
</tr>
<tr>
<td>Need Assessment</td>
<td>By ASHAs, ANMs, MAS by MO based on type of OPD cases observed</td>
</tr>
</tbody>
</table>
MULTI-DIRECTIONAL REFERRAL LINKAGES REQUIRED FOR UPHC

- UPHCs should identify multiple referral sites for various special needs (Multi-directional referral)
- Identify focal persons at each referral center to communicate with directly
- Follow up treatment and compliance by ASHA and ANM for all referred cases

ORGANIZING REFERRAL SERVICES

- Identify the referral centers for each service required
- Identify the focal contact person/desk in each referral center
- Referral should be in writing on Referral Slip
- Referral register to be maintained at facility
- Patients should be informed about reasons for referrals and risk of non-compliance to referral
- Results of diagnostics tests should accompany the Patient Referral forms
- Transport should be made available for emergency referrals
- Patient should be advised for follow-up visits
- ANM or ASHA should follow up referred cases for treatment compliance
THANK YOU
Reporting Mechanisms under NUHM

CONTENTS

- Significance of Reporting
- Types of reporting mechanisms
  - Service delivery reporting
  - Patient data reporting
  - Staff performance reporting
Significance of Reporting Mechanisms

Effective and efficient reporting mechanism is crucial component to need based successful health care delivery &

It is essential to:
- Understand program implementation process
- Track performance and progress of programs
- Identify bottlenecks and reorganizing strategies
- Generate early warning for diseases affecting communities at large

Types of Reporting Mechanisms

- Service Delivery Reporting
- Program Specific Reporting Systems
- Patient Data Reporting
- Staff Performance Reporting
1. SERVICE DELIVERY REPORTING

**Reporting of service delivery data** under NUHM is done through:
- A. Health Management Information System (HMIS)
- B. NHM-MIS Quarterly Progress Reports (QPRs)

**A. Health Management Information System (HMIS)**
- Web-based monitoring system put in place by MoHFW to monitor its health programmes and provide key inputs for policy formulation and interventions
- Launched during October, 2008 for uploading district consolidated figures
- Initiated “facility based reporting” in April, 2011 to facilitate local level monitoring
- HMIS for UPHC has same format as PHCs
- Few data elements have been added to capture NUHM components
- Changes incorporate data reporting for and from Municipal corporations Data is made available to different stakeholders in various standard and customized reports, factsheets, scorecards

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HMIS DATA COLLECTION

HMIS Data is collected in monthly formats from each facility under following heads:

- Ante Natal Care Services
- Deliveries
- C-Section deliveries
- Pregnancy outcome & weight of newborn
- Complicated pregnancies
- Post natal care
- Medical Termination of Pregnancy
- RTI/STI Cases
- Communicable Diseases
- Family Planning
- Child Immunization / Vitamin A doses
- Childhood Diseases
- Blindness Control Programme
- Patient Services
- Laboratory Testing
- Monthly Inventory Status
- Mortality Details
- Non-Communicable Diseases
B. NHM-MIS QUARTERLY PROGRESS REPORTS (QPR)

Data is collected from state level on a quarterly basis, under following 13 heads:

1. City Planning & Mapping,
2. Institutional framework,
3. Appointment of ASHA including MAS information,
4. Training for community Action,
5. Orientation training under NUHM
6. Health Kiosks,
7. 24x7 services
8. Operationalization of U-PHCs/U-CHCs/ Maternity Homes
9. HR for health facilities
10. Progress of Infrastructure
11. Mobile Medical Units
12. Innovations & PPP
13. Quality Assurance
2. PATIENT DATA REPORTING

- **Patient Information**: Name, age, sex, ailment, service sought and other Characteristics
- **Data Reported by**: Service Provider at UPHC/UCHC
- **Records/Registers at facility**: Specific registers are maintained at UPHC for patient data such as: Eligible couple Register, Family Planning Register, ANC Register, Laboratory Register, NCD Register and other program specific registers
- **Patient data reporting helps in**:
  - Keep track of service delivery
  - Follow up of patients undergoing prolonged treatment like TB and chronic diseases
  - Monitor patient Recovery
  - Identify drop outs
3. STAFF PERFORMANCE REPORTING

- Each facility should have a well-defined reporting line of reporting for each staff.
- There should be clear understanding of responsibilities & deliverables of staff.
- Performance of staff should be regularly recorded [Eg: ANM performance assessment for ANMs have been designed and provided in guidelines for ANMs].
- Systematic and fair annual appraisal of all staff performance should be undertaken.
- Well performing staff: Rewarded with incentives.
- Un-satisfactory performance: should be given inputs for improvement.
- Supervisors should be able to identify strengths and weaknesses of each staff.

THANK YOU
# Intersectoral Convergence for Urban Health

## Contents

- Concept, need and challenges for inter-sectoral action for health (IAH)
- Ways of establishing collaboration mechanisms and the roles of various stakeholders
- Engaging with different sectors: Action Points
**WHY CONVERGENCE?**

- Health problems are Multi-casual in nature with factors outside the control of health sector
- Health Sector alone cannot ensure good health outcomes
- Urgent need to systematically aligning of all sectors together with health sector
- Highlighted as an urgent need by World Health Organization, and at Alma Ata Declaration, as a pre-requisite for Primary Healthcare Approach

We need to build partnership with institutions and actors both in the health and across other related areas, to tackle various determinants of health, in a holistic and integrated manner.

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**TYPES OF CONVERGENCE**

<table>
<thead>
<tr>
<th><strong>Intersectoral Convergence</strong></th>
<th><strong>Inter-departmental Convergence</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bringing together different sectors</td>
<td>Bringing together departments/divisions within health</td>
</tr>
<tr>
<td>- Water</td>
<td>- TB</td>
</tr>
<tr>
<td>- Sanitation</td>
<td>- Vector Borne Diseases</td>
</tr>
<tr>
<td>- Waste management</td>
<td>- Non-Communicable Diseases</td>
</tr>
<tr>
<td>- Nutrition</td>
<td>- HIV/AIDS</td>
</tr>
<tr>
<td>- Education</td>
<td>- Maternal and Child Health</td>
</tr>
<tr>
<td>- Housing</td>
<td>- Family Planning etc.</td>
</tr>
<tr>
<td>- Roads and Transport</td>
<td>- Communicable Diseases</td>
</tr>
</tbody>
</table>
INTERSECTORAL CONVERGENCE

Multi-sectoral collaborations depend on shared understanding & interests, driven by supportive and joint accountability.

CHALLENGES IN INTERSECTORAL CONVERGENCE

- Lack of perceived significance of other stakeholder’s role in one’s areas of work
- Lack of understanding about systems and processes of other sectors
- Sense of loss of control over processes and procedures during collaborative processes
- Unpredictable delays as a result of following a collaborative process
- Official hurdles in involving multiple stakeholders from the government
- Hierarchical and isolated work environments, with non-participatory processes even within a particular sector
- Discomfort with others entering one’s ‘turf’ or domain which is looked upon as interference
- Difficulty in involving stakeholders at senior levels
3 BROAD TYPES OF MULTI-SECTORAL ACTIONS

1. Supporting actions within single sectors that form their core business and have positive or negative implications for health

2. Health sector supports cross sectoral policies to address issues that drive disparities

3. Identifying, promoting, and co-financing actions that require collaboration between two or more sectors (inter-sectoral work) to produce joint or “co-benefits”

4. Joint ownership of convergent actions

ESTABLISHING INTERSECTORAL CONVERGENCE

Ways of overcoming challenges & establishing sustainable convergence mechanism

- Designing systematic process of collaboration
- Forming multi-stakeholder teams and committees at various levels
- Participatory planning involving all stakeholders
- Conducting joint workshops
- Advocacy
- Mutually benefitting process
- Shared goal setting
- Trust building
- Cross cutting information sharing & evaluation systems
- Integrated workforce development
Presentations for Orientation Module for Planners, Implementers and Partners

ENGAGING WITH VARIOUS PARTNERS: ACTION POINTS

SANITATION AND SOLID WASTE MANAGEMENT

- Communicate list of sites of accumulated garbage that may cause health hazards to the sanitation department
- Coordination for channelization of stagnant water for prevention of vector breeding, use of disinfectants at unsanitary sites
- Advocacy for occupational health, safety and hazard prevention program for sanitation workers and rag-pickers
- Advocacy measures and feedback loops for setting up and monitoring biomedical waste management systems
AIR POLLUTION

Air Pollution has become a serious issue impacting health of urban residents. Some of the action points in this regard are:

- Analysis of rising levels of air pollution
- Collection of data on incidence of respiratory disease from public and private sectors
- Conduct studies to understand causes and impact of rising air pollution in your state/city
- Advocacy with respective stakeholders to address causes of increasing pollution
ROAD SAFETY

Road traffic accidents are recorded by the Police department. Some steps which may be taken in this regard are:

- Collection of data on road traffic accidents
- Advocacy with concerned department on measures to reduce road injuries
- Creation of joint task force for reduction of road injuries involving health department, traffic police, department of transport, ULBs, research institutions
- Traffic police to ensure compliance to road safety rules and regulations by all
- ULBs to ensure designated parking spots, elimination of encroachment on roads
- Develop data analytics based public health feedback loops
- Creation of public feedback mechanism regarding accident prone areas, report issues/individuals making roads unsafe
- Awareness generation on safe driving, drunken driving

FOOD & NUTRITION SECURITY

- Data on location and functioning of ICDS centers for coordinated action and effective implementation of ICDS
- Food security programs need to be under the purview of both the MAS and the Ward Health Committee
- Develop tools for Health Impact Assessment of projects on urban populations
- Identify specific causes of malnutrition in your area through ICDS data, research studies and national/state level surveys
- Establish joint task force to identify, address and combat malnutrition in your state involving health, ICDS, research centers and national/state level institutions on nutrition
- Identify needs for nutritional rehabilitation centers, and facilitate their establishment if needed
**CONVERGENCE WITH ULBs**

- NUHM facilitates convergent planning & implementation with ULBs and other stakeholders
- Coordination is delivered through platform of DHS
- Municipal Commissioner may coordinate convergence effort, with support from Municipal Health Officer & City Nodal Officer/ District Medical and Health Officer coordinating in implementation

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**MAJOR CONVERGENCE PLATFORM**

Collaborative implementation of:
- National Urban Health Mission (NUHM)
- National Urban Livelihoods Mission (NULM)
- Swachh Bharat Mission (SBM)
- At National, State, City & Ward Levels

- Ultimate objective of all three Missions is same: well-being of urban population in a prosperous, healthy and hygienic environment
KEY LEARNINGS

- Intersectoral and interdepartmental convergence is essential for urban health.
- Implementing convergent actions require advocacy, planning, transparency, mutual trust, goal setting, consensus building and following a participatory approach.
- For urban health, water, sanitation, nutrition, road safety, pollution and housing are important aspects, which must be involved for health planning.
- There are several examples of best practices of convergent actions. Urban Local Bodies are ideal grounds for convergent action, as has been demonstrated in many states.

### VARIOUS CONVERGENCE STRUCTURES (EXAMPLES)

<table>
<thead>
<tr>
<th>S.No</th>
<th>Partner 1</th>
<th>Partner 2</th>
<th>Type</th>
<th>Coordinated Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>West Bengal UHC wards and higher level</td>
<td>Formal Smooth Health service delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mysuru Health Department ULB</td>
<td>Informal Coordination City urban health planning by forming City Urban Health Committees</td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Chhattisgarh Health &amp; ICDS ULBs, Schools, elected officials</td>
<td>Formal coordination Promoting health seeking behavior, infrastructure &amp; monitoring of developmental inputs (including WASH)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Pune Health Department UCD-Pune, ICDS, JNNURM and PMC Eng. Deptt.</td>
<td>Formal Addressing issues both health &amp; beyond like: stray dogs, traffic jams and electricity connections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Nutrition committee Madhya Pradesh Neighborhood committees under SJSRY and ward committees under JNNURM</td>
<td>Informal coordination Potential for being leveraged for health purposes as well</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
THANK YOU
COMMUNITY PROCESSES

Community Processes
Urban ASHA and Mahila Arogya Samitis

CONTENTS

Part A: will focus on:
(i) Selection of the ASHA: Criteria and Process
(ii) Roles and Responsibilities of the ASHA
(iii) Key Tasks of the ASHA
(iv) Institutional Support

Part B: will focus on:
(i) Objectives of the Mahila Arogya Samities (MAS)
(ii) Formation of MAS
(iii) Activities of MAS and use of Untied Funds
(iv) Monitoring of MAS
CRITERIA FOR URBAN ASHA SELECTION

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Desirables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only A woman</td>
<td>Married/Widow/divorced/Separated</td>
</tr>
<tr>
<td>Age group</td>
<td>25 to 45 years</td>
</tr>
<tr>
<td>Residence</td>
<td>Local to slum/vulnerable cluster</td>
</tr>
<tr>
<td>Educational Qualification</td>
<td>Class X pass: Mandatory</td>
</tr>
<tr>
<td></td>
<td>(Class XII pass should be given preference)</td>
</tr>
<tr>
<td>Skills Required</td>
<td>Effective communication; leadership qualities and reach out to the community</td>
</tr>
<tr>
<td>Convergence with:</td>
<td>Existing community workers such as Link workers in RCH programs, or in</td>
</tr>
<tr>
<td></td>
<td>schemes such as JnNURM, SJSRY, etc. may be given preference</td>
</tr>
<tr>
<td>Urban ASHA Selection Committee</td>
<td>CMHO/CDMQ, DPO-ICDS, representative of Urban Local Body, and PO of JnNURM,</td>
</tr>
<tr>
<td></td>
<td>DUDA, SJSRY as appropriate</td>
</tr>
</tbody>
</table>
ASHA’S ROLE

- Facilitating access to health care services
- Building awareness about health care entitlements especially amongst the poor and marginalized
- Promoting healthy behaviours
- Mobilizing for collective action for better health outcomes
- Meeting curative care needs as appropriate to the organization of service delivery in that area and compatible with her training and skills

FIVE ACTIVITIES OF ASHA

1. Home Visits
2. Supporting UHND & Outreach Sessions
3. Visiting Health facility
4. Supporting MAS
5. Maintaining Records and registers
Roles and responsibilities for urban ASHA:

1. Vulnerability assessment of the households
2. Create awareness on social determinants & health promotion
3. Counsel and facilitate awareness among women, families and adolescents for a range of functions related to RMNCH, Communicable and non communicable diseases, gender based violence,
4. Serve as a depot holder for essential health products like ORS-Zinc, Iron and Folic Acid Tablet (IFA), Chloroquine, Sanitary napkins, Oral contraceptives, Condoms etc.
5. Provide community level curative care for ailments such as diarrhoea, fevers, care for the normal and sick newborn, childhood illnesses, nutrition counselling, and first aid.
6. Measure blood pressure and blood glucose for those on treatment and support ANM with screening for common NCDs

Conti....

- Facilitate access to health services available at the Anganwadi/U-PHC/Urban secondary and tertiary health centres
- Promote convergent action by MAS on social determinants of health and take action to increase access of vulnerable groups for various public services.
- Work on issues of water & sanitation in coordination with MAS and enable construction and use of household/community toilets and promote sanitation and hygiene in the community.
- Maintain information and records about births & deaths, and other services
**MONTHLY REVIEW MEETINGS & WORK SCHEDULE**

- **ASHA Monthly review meetings at Urban PHC**
- Convened by Medical Officer, Community Mobilizer (Public Health Manager of U-PHC), ASHA Facilitator/community organizer and ANMs working in the U-PHC
- Serve as a forum for planning, performance review; trouble shooting, problem solving, sharing and validating information related to payments, replenishment of drug kits and refresher trainings
- Flexible work schedule: Workload to be limited to 3-5 hours per day on about 4 days per week
PRESENTATIONS FOR ORIENTATION MODULE FOR PLANNERS, IMPLEMENTERS AND PARTNERS

COMPENSATION TO THE ASHA

ASHA is compensated for the following:

- Rs. 1000 for routine & recurrent tasks
- UHND (200)
- MAS (150)
- Monthly UPHC review meeting (Rs. 150)
- Maintaining health registers and records/update biannually (Rs. 500)
- For the duration of her training, both TA and DA, to partly compensate loss of livelihood
- For other specific measurable tasks

Non Monetary Benefits:

- Social Recognition
- Group recognition/ awards
- Non-monetary incentive e.g. exposure visits, annual conventions etc.
- Sarees, Id cards etc.
- Supporting further education
- Career progression by making provision for admission to ANM/GNM training schools
- Social Security

ASHA HELP DESK & GRIEVANCE REDRESSAL

- **Navigation**: An ASHA Help desk to ensure facilitation of proper service availability, to navigate the patients and support for referrals

- **Grievance Redressal**: Five member committee notified by the District Health Society (DHS) (under the leadership of the Chief Medical Officer (CMO) and District Collector) in NRHM to be expanded to seven members to address grievances of urban ASHAs and the composition of the Committee will need to have representation from members of ULBs.
**FUNCTIONALITY OF ASHAs**

- Undertaking vulnerability assessment in coordination with MAS
- Preparing health resource map for her designated cluster with MAS
- Ensuring home visits to the marginalized and vulnerable households including low birth newborns and malnourished children.
- Organizing monthly meetings of MAS and undertaking locale specific action.

**FUND FLOW MECHANISM**

- Funds for ASHA and MAS are specifically earmarked as part of NUHM Flexipoool
- Covers cost heads related to training, Supervision and Support mechanism for ASHAs
- Current ceiling amount of Rs.16000
- ASHA are entitled:
  - For TA/DA for attending training programmes to be given at the venue itself.
  - For compensation money under the various national programmes payments are made in accordance with the programme guidelines.
OBJECTIVES OF MAS

- To provide mechanism for the community to voice health needs, experiences and issues with access to health services
- To generate awareness on locally relevant health issues & to promote the acceptance of best practices in health by the community
- To direct focus on preventive and promotive health care activities and management of untied funds
- Support and facilitate ASHA and other frontline workers
- Provide an institutional mechanism in community to act as nodal health centres
- Organize or facilitate community level services and referral linkages for health services.
**COMPOSITION AND FORMATION OF MAS**

- Each MAS to cover 50-100 HHs, & have 10-12 members, depending on the size of the slum/cluster
- Not less than 5 or more than 20 members
- Members to be drawn from a neighbourhood cluster, one member from each cluster of 10 to 20 houses
- Every ASHA would be linked to between Two to Five such groups
- A MAS with different social groups in its coverage area, all groups and pockets should have representation
- In small slums of less than 50 HHs or presence of disparate groups within each slum, the coverage of MAS should be aligned with the coverage area of Anganwadi Centre and has to cover all pockets of the slum

**PROCESS OF MAS FORMATION**

**Step I: Constitution of a team at the slum level**
- Team will include
  - ASHA, AWW, and ANM
  - ASHA facilitator/Community organizer,
  - NGO field functionary (if any, or any other development programme worker)
- Each ASHA will supervise the formation of two to five MAS.

**Step II: Initial meetings at the slum level**

**Step III: Identification of Active and Committed Women**

**Step IV: Formation of MAS & Selection of Office Bearers**
PRESENTATIONS FOR ORIENTATION MODULE FOR PLANNERS, IMPLEMENTERS AND PARTNERS

COMPOSITION OF MAS: SUGGESTED MEMBERS

<table>
<thead>
<tr>
<th>Opinion Leaders</th>
<th>ASHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members of local CBOs</td>
<td></td>
</tr>
<tr>
<td>ICDS frontline staff</td>
<td></td>
</tr>
<tr>
<td>Local Women</td>
<td></td>
</tr>
<tr>
<td>SHG Members</td>
<td>Service Users</td>
</tr>
</tbody>
</table>

MAS FUNCTIONING

<table>
<thead>
<tr>
<th>Role of Chairperson</th>
<th>Role of Member Secretary</th>
</tr>
</thead>
</table>
| MAS Monthly meetings:  
  • Be responsible for ensuring regular, meetings  
  • Lead meetings & ensure smooth coordination | Organize MAS Monthly Meetings  
  • Fix the schedule & venue  
  • Ensure meetings are conducted regularly with all members |
| Health Plan: Develop community health plan for the area in consultation with all MAS members | Health Plan: Draw attention of MAS on specific constraints and achievements related to community’s health status and enable appropriate planning |
| Record Keeping: Ensure all the records and registers of MAS are adequately maintained. | Manage Untied Funds:  
  • Open & operate joint Bank A/C  
  • Ensure proper utilization of untied funds, disbursement of funds  
  • Provide information fund utilization to MAS |
| Represent MAS and voice concerns during interface with providers and Govt. reps | Health and Nutrition Days  
  Make arrangements for the Urban Health and Nutrition Days |
| Support the member secretary in her functions |  
  • Presentation of MAS activities & expenditures in ULB meetings  
  • Preparation of annual statement of expenditure & Utilization certificate. |
MAS ACCOUNT & UNTIED FUNDS

- A saving bank account will be opened in any nationalized bank/ scheduled bank/ post offices in Zero balance
- Every MAS is entitled to Rs.5,000 annually
- The joint signatories of the MAS account would be the Chairperson of the MAS and the Member Secretary (ASHA)
- All withdrawal must be done by signature of all signatories
- The withdrawal will only be done through a written approved proposal of the MAS with signatures of its members.
- The Member Secretary may be authorized expenditure of up to Rs 500/- for emergencies

MONITORING OF MAS

ASHA Facilitator would assist city/district PMU in maintaining a detailed database on MAS with following information:

- No. of slums under each U-PHC
- No of MAS formed → composition of samiti → Monthly meetings held
- No. of MAS with Bank accounts opened
- Dates of release of the un-tied fund to each
- Total Fund spent by each MAS – as per UCs received.
- All supervisory staff must make a sample visit to MAS meetings and ANMs and ASHA facilitator/community organizers must try and end MAS meetings, at least once in 2 months.

Indicators of functionality:

- % of MAS having regular monthly meeting
- % of UHND held as compared to UHNDs planned
- % of MAS who have submitted UCs with over 90% of their funds spent
- % of MAS who have submitted UCs
CAPACITY BUILDING: QUARTERLY WORKSHOPS

Build capacities in the following aspects:

- Community participation and need for MAS
- Objectives of NUHM
- Health and its determinants viz nutrition, safe drinking water, sanitation and hygiene
- Concept of inequity, vulnerability, socio-economic marginalization and its impact on health
- Objectives, roles and activities of MAS
- Identification and mapping of vulnerable groups
- Community mobilization, management of untied funds, monitoring of public services and undertaking local level planning for improving access of the community to health and other services like safe water and improved sanitation facilities.

MAJOR ACTIVITIES OF MAS

1. Identify Vulnerable Groups
2. Mapping and listing slums
3. Organize Preventive & Promotive Health Activities
4. Service delivery in Community
5. Managing untied funds & Records
SPECIAL FOCAL POINTS OF MAS

- Homeless,
- Rag-pickers,
- Street children,
- Rickshaw pullers,
- Construction and brick and lime klin workers,
- Sex workers,
- Other temporary migrants.
- The other focus of work of MAS will be on social determinants - sanitation, clean drinking water, vector control, etc.

MONTHLY MEETING OF MAS

- Once a month for MAS group on a fixed date / day
- Discuss the local level issues and plan for local solutions
- Develops an action plan for addressing health and related issues.
- Venue: Public facility like AWC, Office of any Community based organization/ NGO, House of any of the members, Community Centre or School.
- Should be attended by at least 50% of the members for a minimum quorum
- Objective of monthly meeting: Work done, plan future activities, and decide on use of untied funds.
- Records: Meeting minutes (with attendance signatures), record of financial approvals, cash book, public service monitoring register, Birth register, Death register
COMMUNITY MONITORING OF HEALTH CARE FACILITIES

1. Filling scorecards for health facilities
2. Organizing Jan Samvads—Various MAS groups of an area would come together to organize Jan Sanwads which act as a forum for dialogue between the community and the authorities and also help in grievance redressal.
3. In the Jan Sanwad, the U-PHCs doing well as per the scorecards will be felicitated and those faring poorly in the scoring would be singled out for appropriate action.
4. Monitoring schemes such as Rashtriya Swasthya Bima Yojana (RSBY) and private sector partnerships and highlighting their problems.

LOCAL COLLECTIVE ACTION FOR HEALTH PROMOTION BY MAS

- Organizing cleanliness drives especially for decaying solid waste and pools of stagnant water
- Building teams for source reduction for prevention of vector borne diseases
- Undertaking “Sanitation Mapping” for identifying slum pockets/areas prone to open defecation and improving sanitation status of the slum
- Undertaking sanitary survey of public drinking water sources for assessing the potential contamination of drinking water.
- Promoting convergent action in partnership with all other urban area initiatives for environmental health, water, sanitation and housing.
Presentations for Orientation Module for Planners, Implementers and Partners

ACCOUNTING FOR THE MAS UNTIED FUND

- MAS should present an account of its activities and expenditures in the bi-annual meetings.
- The annual Statement of Expenditure (SOE) and Utilization Certificates (UCs) to be submitted to ASHA facilitator/ANM/ the U-PHC to City/District PMU.
- All vouchers related to expenditures will be maintained for up to three years, by the MAS. After that the SOE should be maintained for 10 years.
- At the state level, disbursal done by district/city PMU will be treated as advance.
- City/DHS will conduct financial audit of MAS account. However, state should progress towards social audit.
- In case of delayed receipt of untied fund, MAS needs to be given a six month period to spend funds beyond the end of the financial year.

FACILITATING SERVICE DELIVERY & SERVICE PROVIDERS IN THE COMMUNITY

The MAS serves as an important platform for facilitating access to services in the following ways:

<table>
<thead>
<tr>
<th>Service Provision</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting Organization of Urban Health and Nutrition Day</td>
<td>Mobilizing pregnant women &amp; children particularly from marginalized families and Supporting ANM, AWW and ASHA in organizing UHND.</td>
</tr>
<tr>
<td>Support in organizing Outreach Sessions (both routine &amp; special)</td>
<td>Mobilizing pregnant women &amp; children particularly from marginalized families and Coordination with ASHA and ANM.</td>
</tr>
<tr>
<td>Supporting community service providers</td>
<td>Allowing community service providers to share their problems in MAS meetings and to reach the vulnerable and “hard to reach” populations.</td>
</tr>
<tr>
<td>Facilitating Referral Transport</td>
<td>Generating awareness on referral transport and 108 services. Organizing local tie-ups with private vehicle owners to transport patient.</td>
</tr>
<tr>
<td>Support in Strengthening AWC</td>
<td>Providing important amenities missing in AWC improving their functioning.</td>
</tr>
<tr>
<td>Births &amp; death Registration</td>
<td>Maintaining records of all births and deaths in the slum cluster.</td>
</tr>
<tr>
<td>Maternal &amp; child deaths</td>
<td>Providing immediate info on maternal/child death to the ASHA/ANM/MO.</td>
</tr>
<tr>
<td>Information on disease outbreaks</td>
<td>Providing immediate information on any disease outbreak to the ASHA/ANM/U-PHC Medical officer.</td>
</tr>
</tbody>
</table>
MAINTENANCE OF RECORDS

The records to be maintained by the MAS can be classified into the following two categories:

<table>
<thead>
<tr>
<th>Activity Records</th>
<th>Financial Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Record of Meetings</td>
<td>1. Cash Book</td>
</tr>
<tr>
<td>2. Public Services Monitoring Tool and</td>
<td>2. Bank Pass Book</td>
</tr>
<tr>
<td>Register</td>
<td>3. Statement of Expenditure (SOE)</td>
</tr>
<tr>
<td>4. Death Register</td>
<td></td>
</tr>
</tbody>
</table>
### Key learnings

- Community Processes are an essential component of NUHM which connect the UPHC with the community it serves, as well as with other community-based stakeholders.
- Urban ASHAs have defined roles and responsibilities to identify and address health care needs at her level, for approx. 2000 population allocated to her through home visits and community-based activities.
- Mahila Arogya Samitis, i.e., groups of community women should meet every month to discuss community health issues, mobilize community for healthy behavior and develop linkages with ULB members.
- ASHAs and MAS along with the Anganwadi worker should work as a team to identify and address health needs of the community.

### THANK YOU
PREVENTION, SCREENING & CONTROL OF NON-COMMUNICABLE DISEASES

Prevention, Screening & Control of Non-Communicable Diseases

CONTENTS

- Rationale for Population based Screening of Non-Communicable Diseases
- Population Enumeration
- Service delivery framework
- Principles of screening at community level
- Key tasks on screening day
- Health promotion
- Referral and treatment
- Drugs and diagnostics
**RATIONALE**

Four major NCDs:
- Cardiovascular Diseases
- Diabetes
- Chronic Respiratory Diseases
- Cancer

Account for over 60% of mortality - placing them ahead of injuries, communicable diseases, Maternal, Prenatal and Nutritional conditions.

**KEY PROCESS OF NCD PROGRAM**

- Screening and diagnosing common NCDs
- Identifying and addressing modifiable risk factors
- Referral of precancerous conditions, hypertension and diabetes (according to protocols)
- Community level follow-up
**SERVICE DELIVERY FRAMEWORK**

- **Population Enumeration**: Registration of families through individual health cards in a family folder. ASHAs/ANMs to complete health cards, giving each a unique health ID.

- **Completion of Community Based Assessment Checklist (CBAC) [given in Module Annexure C]** ASHA/ANM to screen the target population using the CBAC (to identify risk factors):
  - All men and women over 30 years for Hypertension, Diabetes Mellitus, and oral cancer
  - All women over 30 years for Cervical and Breast cancer

- **Screening day to be organized at a fixed location with a fixed day approach**
  - No individual should need to travel more than half an hour to be screened
  - Privacy to be assured at screening site
  - Standard protocols to be followed

---

**SCREENING AT COMMUNITY LEVEL**

<table>
<thead>
<tr>
<th>NCD</th>
<th>Frequency of Screening</th>
<th>Method</th>
<th>Screening Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>Annual</td>
<td>BP Check</td>
<td>Outreach</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Annual</td>
<td>Blood Test</td>
<td>Outreach</td>
</tr>
<tr>
<td>Oral Cancer</td>
<td>Once in 5 years</td>
<td>Oral Visual Examination (OVE)</td>
<td>Outreach</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Once in 5 years</td>
<td>Clinical Breast Examination (CBE)</td>
<td>Outreach with adequate privacy</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>Once in 5 years</td>
<td>Visual Inspection with Acetic Acid (VIA)</td>
<td>UPHC/UCHC</td>
</tr>
</tbody>
</table>

- Cervical cancer screening using VIA to be conducted at health centres
  - With provision for sterilization of equipment
  - 2 ANMs (or 1 ANM, 1 MPW)
  - Supervision trained LHV, SN, MO
**PLANNING AT STATE/DISTRICT LEVEL**

- **Rollout** of screening for all 5 conditions in Year 1 for selected health centers & UPHCs and expand to all facilities
- **Prioritization of screening** in health facilities with 2 ANMs (or 1 ANM & 1 MPW) & requisite ASHAs
- **Staff Training** to be undertaken for ANMs, LHV, SNs for:
  - Oral visual examination (OVE)
  - Clinical Breast Examination (CBE)
  - Visual Inspection using Acetic Acid (VIA)
- **Additional Staff**: State may engage:
  - One addition SN, Lady AYUSH provider to manage Screening program for UPHC area.
  - One District Programme Officer & one MIS officer to oversee the planning and implementation of NPCDCS. Existing Human Resources in NPCDCS to be involved at various levels as appropriate
  - LHV and SNs to serve as mentors and trainers to the health centre staff
- State may **pilot different modalities** for different contexts to find out the best way to scale the program up

**KEY TASKS ON SCREENING DAY**

- Community awareness & active mobilization
- Organizing the venue
- History taking
- Patient flow management
- Recording results
- Feedback to patients
- Monitoring of already diagnosed cases
- Referral advice

- **Coordinated effort** of ANM, ASHA, ASHA facilitator, AWW, Volunteers required
- **Community mobilization** may be done by MAS members, adolescent groups and local organizations
- **Monitoring & Supervision**: Overall responsibility for monitoring & supervision of field activities is with the UPHC Medical officer.
- **Program review** should be an integral part of monthly review meetings, field supervision, and data monitoring.
- Recording and reporting at all levels would be aligned with NPCDCS guidelines.
### HEALTH PROMOTION

- **Healthy behaviours** critical for prevention and control of NCDs
- **IEC and behaviour change communication (BCC)** is integral component of NCD program.
- States to develop **context specific strategy** for lifestyle modification
- **Integrated health promotion strategy** to be targeted at individuals, families, communities, facilities and the system.

<table>
<thead>
<tr>
<th>Individual &amp; Family</th>
<th>Community</th>
<th>Facility</th>
<th>Systems Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• IEC Material,</td>
<td>• Through MAS</td>
<td>• Patient support groups</td>
<td></td>
</tr>
<tr>
<td>• Dietary advice</td>
<td>• Use of traditional media</td>
<td>• RKS level of interventions</td>
<td></td>
</tr>
<tr>
<td>• Yoga</td>
<td>• Local gathering, melas, festivals</td>
<td>• IEC- BCC Displays at facility</td>
<td></td>
</tr>
<tr>
<td>• Counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Social Medial</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### REFERRAL & TREATMENT

- In case of Cancer, positive cases will be referred to appropriate UPHC/UCHC for confirmation and treatment as per the Operational Framework developed for Cancer screening and management
- **After Diagnosis of Hypertension /Diabetes Mellitus (HT/DM)**
  - First follow up visit to UPHC at the end of 3 months
  - An annual specialist consultation at UCHC - NCD clinic should be facilitated
- **HT/Diabetes** – once diagnosed, patient must receive at least a month’s supply of drugs from the UPHC. Once stable, 3 months supply can be provided.
- Regular visits of ANM/ASHA to ensure adherence to treatment plan
- **Drug supplies as per state Essential Drug list : leverage Free Drugs and Free Diagnostics Services Initiative**
### Key Learnings

- NCDs such as Diabetes, Cardiovascular diseases and cancers (oral, breast, cervical) have become the major cause of death in urban areas.
- NCD screening and treatment is an important component of Comprehensive Primary Health Care. Under CPHC provision, registration of families will be done to provide each member a health card.
- Population based NCD screening shall be done on fixed days in outreach mode by ANMs and ASHAs.
- Screening, referral and treatment shall be done as per protocol, with ensured continuity of care.
- States need to formulate a strategy for scale up including trainings, additional staff required, monitoring, referral and follow-up of identified cases.

### Capacity Building

<table>
<thead>
<tr>
<th>Cadre</th>
<th>Training Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANMs or MPWs</td>
<td>Three-day module on hypertension, diabetes and screening of oral and breast cancers</td>
</tr>
<tr>
<td>ASHA</td>
<td>Five-day module on hypertension, diabetes and screening of oral and breast cancers</td>
</tr>
<tr>
<td></td>
<td>One day of overlap for integrated training with ANMs/MPW, so that they are able to better function as a team.</td>
</tr>
<tr>
<td>ANMs, Staff Nurses &amp; LHVs</td>
<td>Two weeks training at a DH/ tertiary care institution for training in VIA</td>
</tr>
<tr>
<td>MOs</td>
<td>Five days training in a tertiary care setting</td>
</tr>
</tbody>
</table>
THANK YOU
INTRODUCTION TO QUALITY & OVERVIEW OF NQAP & QA STANDARDS FOR UPHCS

Introduction to Quality & Overview of NQAP & QA Standards for UPHCs

CONTENTS

- Quality defined
- Dimensions of quality
- NQAP: National Quality Assurance Program
- NQAP for public health facilities
- Requirement for pro public health quality model
- Key features of program
- Quality Assurance commitments under ADB
- QA institutional structure
- Budgetary proposals in PIP for QA
- Implementation of QA at facility level
QUALITY DEFINED

Quality is Meeting and Surpassing the Customer Expectation

Who are our customers?

- External
  - Patients
  - Target Population/Beneficiaries
  - Community
- Internal
  - Employees
  - Health departments

QUALITY IS ABOUT:

Quality is Minimizing Variations
Quality is Standardization

QUALITY IS DOING RIGHT THINGS
IN RIGHT WAY
FIRST TIME &
EVERY TIME
**DIMENSIONS OF QUALITY**

**Structure**

**Process**

**Outcomes**

Focus shifting from Structure to Processes

---

**DR. AVEDIS DONABEDIAN (1919-2000)**

---

**WHY QUALITY IN URBAN HEALTH**

- All-India population growing at 2 per cent, urban population at 2.75 per cent, large cities at 4 per cent and slums at 5-6 per cent
- Social exclusion
- Lack of information and assistance
- Expensive private healthcare facilities
- Perceived unfriendly treatment at government hospitals
- Emotionally secure environment at home
- Non-availability of caretakers for other siblings in the event of hospitalization
Because POOR QUALITY ruins image of Public Health System.

INTRODUCING NATIONAL QUALITY ASSURANCE PROGRAM (NQAS)
**EVOLUTION OF NQAS FOR PUBLIC HEALTH FACILITIES**

**2012**
1. Assessment of Pre-Existing Models of Quality Assurance and Accreditation for Public Health Facilities by Deloitte
2. Mandate given to NHSRC to Develop the Quality Assurance Model and Standards

**2013**
2. Assessors Guidebook for District Hospitals

**2014**
1. QA becomes Key Priority Area for NHM
2. Release of QA Standards and Assessors Guidebooks for PHCs & CHCs

**2015**
1. Launch of Kayakalp Award Scheme for Public Hospitals
2. Development of QA Standards for Urban PHCs

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**REQUIREMENTS FOR PRO PUBLIC HEALTH QUALITY MODEL**

- Internal Quality Culture
- Evidence Based
- Structure Processes & Outcome
- Flexibility for States to Customize
- Explicit, Measurable & Transparent
- Sustainable & Scalable
- Inbuilt Accreditation/Certification
- Low Cost of Implementation
KEY FEATURES OF PROGRAM

1. Unified Organizational Framework
2. Explicit Measurement System
3. Flexibility of adopting as per state’s need
4. Training & Capacity Building
5. Continuous Assessment and scoring
6. Inbuilt Quality Improvement Model
7. Certification at State & National Level
8. Incentives on Achievement & Sustenance

RELATIONSHIP BETWEEN DIFFERENT COMPONENTS

- Departmental Checklists:
  - Checkpoint
  - Checkpoint
  - Checkpoint

- Score Card:
  - Departmental & Hospital

Area of Concern
- Standard
- Measurable Elements

Score against checkpoints: 0, 1, 2

8 35 198
SAMPLE CHECKLIST

CHECKLIST FOR GENERAL CLINIC

<table>
<thead>
<tr>
<th>Reference No.</th>
<th>Measurable Element</th>
<th>Checkpoint</th>
<th>Compliance</th>
<th>Assessment Method</th>
<th>Means of Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mal A1.1</td>
<td>Facility provides promotion, preventive and curative services</td>
<td>The facility provides treatment of common ailments</td>
<td>Availability of consultation services for common illnesses</td>
<td>RR/SL</td>
<td>Common cold, fever, diarrhoea, respiratory tract infections, bronchial asthma, conjunctivitis, foreign body in conjunctival sac, etc.</td>
</tr>
</tbody>
</table>

- a: Name of the checklist
- b: Area of concern
- c: Statement of standard
- d: Reference no.
- e: Measurable element
- f: Checkpoint
- g: Compliance score
- h: Assessment Method
- i: Means of verification

CHECKLISTS

- General clinic
- Maternal Health
- Child Health
- Immunization
- Family Planning
- Communicable
- NCD
- Dressing Room
- Pharmacy
- Laboratory
- Outreach
- Laboratory
QA COMMITMENTS UNDER ADB ARRANGEMENTS DLI

DLI: Deliverable Linked Incentives

<table>
<thead>
<tr>
<th>March 2016</th>
<th>March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 15 States/UTs/Large ULBs have set-up Organisational Arrangements for QA of Health Facilities (U-PHC &amp; U-CHC)</td>
<td>1. 20 cumulative States/UTs/ Large ULBs have set-up Organisational Arrangements for QA of Health Facilities (U-PHC &amp; U-CHC)</td>
</tr>
<tr>
<td>2. 50% of U-PHCs &amp; U-CHCs are assessing Quality of Services</td>
<td>2. 80% of U-PHCs &amp; U-CHCs are assessing Quality of Services</td>
</tr>
<tr>
<td>3. System of collection of Patients’ Satisfaction is in place at facilities as mentioned at Serial no. 2</td>
<td>3. System of collection of Patients’ Satisfaction is in place at facilities as mentioned at Serial no. 2</td>
</tr>
</tbody>
</table>

QUALITY ASSURANCE INSTITUTIONAL STRUCTURE

- **National Level**
  - Central Quality Supervisory Committee

- **State Level**
  - State Quality Assurance Committee
  - State Quality Assurance Unit

- **District / City Level**
  - District Quality Assurance Committee (DQAC)
  - District / City Quality Assurance Unit (DQAU/CQAU)

- **Facility Level**
  - Quality Team
**IN VOLVING ULBS IN QA PROGRAM (MONITORING)**

**WHAT**
Regular Meeting with Corporations and ULBs.

**WHO**
Nodal officer for Urban Health/QA

**WHEN**
First meeting within a Month and after that at least quarterly.

---

**BUDGETARY PROPOSALS IN PIP FOR QA**

**WHAT**
Budget proposals for QA Consultant for large cities (Class A/X), Trainings, Assessment and Monitoring visits, Meetings and QA activities

**WHO**
SPM, DPM, Nodal officer for Urban Health/QA

**WHEN**
At the earliest. Before submission of PIP.
IMPLEMENTATION OF QUALITY ASSURANCE AT FACILITY LEVEL

1. Sensitization of Service Providers on QOC
2. Setting up Quality Team
3. Baseline Assessment
4. Action planning & prioritization
5. Measuring Key Performance Indicators

6. Patient satisfaction Survey
7. Setting Quality Policy & Quality Objectives
8. Implementation of Standard Operating Procedures
9. Periodic Assessments & Improvement
10. Certification
KEY LEARNINGS

- An overview on Quality and its definition
- Dimensions of quality
- NQAP: national quality assurance program
- NQAP for public health facilities
- Requirement for pro public health quality model
- Key features of program
- Quality assurance commitments under ADB
- QA institutional structure
- Budgetary proposals in PIP for QA
- Implementation of QA at facility level
MANAGING DISEASE OUTBREAKS IN URBAN AREAS

Managing Disease Outbreaks in Urban Areas

CONTENTS

1. Disease outbreaks
2. Disease surveillance
3. Types of surveillance
4. Integrated disease surveillance project: IDSP
5. Data collection in IDSP
6. Administration level IDSP
7. Outbreak management
8. Flow of information under IDSP
9. Diseases under IDSP cover
10. IDSP and NUHM
DISEASE OUTBREAK

**Disease Outbreak:** Occurrence of a disease or syndrome clearly in excess of the norm in a given area over a particular period of time, or among a specific group of people.

**Disease Surveillance:** The systematic ongoing collection, collation and analysis of data for public health purposes and the timely dissemination of public health information for assessment and public health response as necessary (WHO)

**Objective of Surveillance**
- To keep a close watch on health events occurring in the community
- Immediately understanding any abnormal pattern or reporting of illness
- Analysis at higher level indicates geographical coverage and decision making on the type of out-break
- Rapid Response to epidemic prone diseases

TYPES OF SURVEILLANCE

**Active Surveillance:**
When a health worker goes into the area or house to house and collects information

**Passive Surveillance:**
When people come to the health center and information is collected through different registers
THE INTEGRATED DISEASE SURVEILLANCE PROGRAMME

The Integrated Disease Surveillance Program (IDSP) was launched in November 2004 to:

- Strengthen and maintain decentralized laboratory based, IT enabled disease surveillance for epidemic prone diseases
- Monitor disease trends
- Detect and respond to outbreaks in early rising phase through rapid response teams (RRTs)

Central Surveillance Unit (Delhi)
State Surveillance Unit (All states & UTs)
District Surveillance Unit (All districts)

Administrative levels in IDSP set-up

DATA COLLECTION IN IDSP

- Data collected on weekly basis from different reporting units in three forms (S, P, L)
- Event based surveillance is conducted through scanning media
- These alerts are shared with the concerned states and districts for verification and response Whenever there is a rising trend of illnesses, it is investigated by the Rapid Response Teams (RRT) to diagnose and control the outbreak.

<table>
<thead>
<tr>
<th>Types of incident reported</th>
<th>Syndromic</th>
<th>Presumptive</th>
<th>Lab confirmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Diagnosis made on the basis of signs and symptoms</td>
<td>Diagnosis made on typical history and clinical examination</td>
<td>Clinical diagnosis confirmed by an appropriate laboratory test</td>
</tr>
<tr>
<td>Form type</td>
<td>Form S</td>
<td>Form P</td>
<td>Form L</td>
</tr>
<tr>
<td>Form filled by</td>
<td>Health Workers</td>
<td>Medical Officers</td>
<td>Lab technician</td>
</tr>
</tbody>
</table>
DISEASES MONITORED UNDER THE IDSP

- Acute Diarrhoeal Disease
- Acute Encephalitis Syndrome
- Acute Flaccid Paralysis
- Acute Respiratory Infection (ARI)
- Bacillary Dysentery
- Chicken Pox
- Chikungunya
- Dengue
- Diphtheria
- Dog Bite
- Enteric Fever
- Fever of Unknown Origin
- Leptospirosis
- Malaria
- Measles
- Meningitis
- Pertussis
- Pneumonia
- Snake Bite
- Viral Hepatitis

- On an average, 30-40 outbreaks are reported every week by the states.
- Compiled in the form of a “Weekly Outbreak Report” and is available on the IDSP website (http://www.idsp.nic.in)
- A unique code (outbreak ID) is assigned to each outbreak in the Weekly Outbreak Report for easy data storage and retrieval.

INFORMATION FLOW UNDER IDSP

Sub Centers ➔ Primary Health Centers ➔ District Surveillance Unit ➔ State Surveillance Unit ➔ Central Surveillance Unit ➔ Program officers

CHCs, District Hospitals, Medical College Hospitals, Private Hospitals, Labs ➔ District Surveillance Unit

On an average, 30-40 outbreaks are reported every week by the states.
IDSP & NUHM

- Disease surveillance will be key to strengthening NUHM
- UPHCs and UCHCs will be the key reporting units at the city level – and they will submit the “P” form
- Essential to get disease data from private facilities & labs as well
- For NUHM, IDSP is establishing city level mechanisms. IDSP is being implemented in three metro cities; Mumbai, Kolkata, and Chennai.
- On population criteria, the following cities have been selected for the first stage of implementation: Mumbai, Bangalore, Hyderabad, Ahmedabad, Chennai, Kolkata, Surat, Pune, Jaipur, Lucknow, Kanpur, and Nagpur

ROLES OF VARIOUS STAKEHOLDERS

Specific roles have been outlined for Epidemiologists, Data Managers, Public Health Managers, Community Health Workers, ULBs & other Departments

Public Health Manager
- Ensure timely IDSP reporting from UPHC
- Ensure disease notification from private providers
- Advocacy for water, sanitation, waste disposal to various departments
- During outbreak, assist in identifying cause & initiate remedial measures

Community Health Workers (ANM/ASHA/MAS)
- Collection, collation & preliminary analysis of weekly surveillance data
- Reporting: Fill ‘Form S’ from data in Syndromic Surveillance Register & send it to MO every Monday
- Public Health Action: Inform MO of any clustering of cases/unusual events in their area. Carry out syndromic surveillance routinely to prevent, detect & respond to outbreaks
**ROLE OF ULBs & OTHER DEPARTMENTS**

- As most outbreaks are Water borne or Vector borne, close cooperation of ULBs, especially Water, Sanitation, Waste Disposal necessary to tackle outbreaks
- Health workers working under ULBs fill ‘S’ form for syndromic surveillance
- Ward members to respond to issues of water logging, open drains, mosquito breeding
- Employ innovative information channels to generate awareness among community on preventive measures for diseases

**THANK YOU**
PPPs FOR URBAN HEALTH

CONTENTS

- What is PPP
- Why and When to enter into PPPs
- Challenges in Urban Health
- Steps of PPPs
- Different model in PPP in urban health
- How to make PPPs successful
PUBLIC PRIVATE PARTNERSHIP (PPP)

PPP is a contract between a government and a private entity, wherein these two bodies jointly provide public services in line with the pre-defined terms of contract.

WHY PPPs
Governments need to balance rising healthcare costs and escalating demands for healthcare services. Key factors that push governments to PPP are:

- To improve operation of public health services and to expand access to quality services
- It is an opportunity to leverage private investment for the benefit of public
- Involve the non-profit partners in formal management of owing to their important contribution in delivering public services
- Government can have a greater pool of potential partners with the maturing private healthcare sector
- To use PPP as flexible opportunity for casting the activities to suit the needs of the population

KEY CHALLENGES FOR PPPs IN PRIMARY HEALTHCARE

- Limited presence of established private providers in primary care
- Payment mechanisms do not incentivize better performance
- Delays in payment to the private service provider
- Lack of specific and measurable performance parameters
- Lack of robust monitoring mechanism
- Inadequate capacity of the public officials managing the PPP contract
- Lack of motivation from private players due to low profit margins in Public Health
**Presentations for Orientation Module for Planners, Implementers and Partners**

**AREAS OF PPPs UNDER NUHM**

Services under NUHM which can be delivered through PPPs:

- Clinical services provided at Urban Primary Health Centres
- Specialist outreach services
- Community outreach services (awareness programs, screening etc.)
- Laboratory and Radiology Diagnostic services
- Services provided through Mobile Health Units

**STEPS FOR ESTABLISHING PPP**

1. Situation analysis: To identify gap in service delivery
2. Identify private partner availability: to bridge gap
3. Work out scope & type of PPP model
4. Develop & design transparent process of tendering (with help from state/ MoHFW)
5. Prepare RFP and SLAs with KPI
6. Develop mechanism to Monitor performance and service delivery standards
### SUCCESS FACTORS FOR PPP

<table>
<thead>
<tr>
<th>Critical success factors for private sector participation in primary care</th>
<th>Effective governance structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing of responsibilities based on capabilities</td>
<td>Incentivizing performance</td>
</tr>
<tr>
<td>Effective monitoring</td>
<td>Minimal bureaucracy and delay in payment</td>
</tr>
<tr>
<td>Standardizing practices for PPPs in similar services/activities of value chain</td>
<td>Government commitment for investment and infrastructure</td>
</tr>
</tbody>
</table>

### DIFFERENT MODELS OF PPP IN URBAN HEALTH

<table>
<thead>
<tr>
<th>PPP model of Urban PHC Management</th>
<th>With private service providers for Special Outreach camps</th>
<th>Capitation model for engaging private service provider in slum areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cluster/single PHC given to private</td>
<td>• Giving Primary healthcare to vulnerable through outreach services</td>
<td>• Engaging for-profit/ not-for-profit private service provider in Urban areas</td>
</tr>
<tr>
<td>• State may provide space</td>
<td>• Involve private specialists &amp; necessary diagnostics through competitive bidding</td>
<td>• Involvement through tenders invited by SHS, DHS or ULB</td>
</tr>
<tr>
<td>• Private partner pay for utilities</td>
<td>• DHS/ ULB invite tender for involving private partners</td>
<td>• Partner will identify &amp; register beneficiaries</td>
</tr>
<tr>
<td>• Set of KPIs with Quantitative &amp; Qualitative indicators given to private partner</td>
<td>• State shall provide the drugs or funds for drugs procurement</td>
<td>• Fee paid based on number of beneficiaries identified</td>
</tr>
<tr>
<td>• Performance based incentives/penalty present</td>
<td>• ASHA/MAS ➔ community mobilization</td>
<td>• KPI with qualitative and quantitative indicators given by govt.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Performance based incentive/penalty present</td>
</tr>
</tbody>
</table>
**PRINCIPLES FOR SUCCESSFUL PPP PROJECTS**

**Pillars of successful PPP**

- Access to Healthcare services
- Quality of care to Beneficiaries
- Feasible to private partner within budgetary constraint of Government
- Efficient delivery system & scalable
- Robust Monitoring framework and clearly specified and measurable performance indicators

**KEY LEARNINGS**

- PPP is an important strategy to reach the poor and underserved, which the public sector by itself is unable to reach
- Urban health is challenging hence PPP could be experimented upon
- Different models of PPP in urban health exists, the most appropriate one must be selected as per need of the population
- Steps for implementing a successful PPP
- Effective monitoring mechanisms are a must for ensuring success of a PPP
THANK YOU
MONITORING AND EVALUATION IN NUHM

Monitoring and Evaluation in NUHM

CONTENTS

- Program Cycle
- Results Chain
- Monitoring
- Evaluation
- Evaluation and its phases
- Difference between supervision, monitoring and evaluation
- M&E in NUHM
- Data quality, its elements and issues
- Indicators for monitoring
**PROGRAM CYCLE**

Program Cycle involves following main 4 steps:

1. Problem Identification
2. Planning
3. Implementation
4. Evaluation

Evaluation is one of the four main steps of program cycle while Monitoring keep occurring very frequently at several places.

**RESULTS CHAIN**

<table>
<thead>
<tr>
<th>Input</th>
<th>Process</th>
<th>Output</th>
<th>Outcome</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources committed for program activities:</td>
<td>Utilization of services to generate products &amp; services:</td>
<td>Products and services generated through processes:</td>
<td>Effects or behaviour changes resulting from outputs (short-medium term):</td>
<td>Long term, widespread change in society:</td>
</tr>
<tr>
<td>• Human Resources</td>
<td>• Staff recruitment and training</td>
<td>• Children fully immunized Pregnant women given full ANC</td>
<td>• Improved health seeking behaviour</td>
<td>• Reduction in IMR, MMR, TFR etc in urban population</td>
</tr>
<tr>
<td>• Financial Resources</td>
<td>• Administrative processes</td>
<td>• 30+ individuals screened</td>
<td>• Improved birth weight</td>
<td>• Financial protection from OOPE</td>
</tr>
<tr>
<td>• Infrastructure</td>
<td>• Community mobilization</td>
<td></td>
<td>• Reduced anemia</td>
<td></td>
</tr>
<tr>
<td>• Drugs and consumables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diagnostic Equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Monitoring Evaluation
Monitoring is a routine process used to determine the extent to which a programme has been effectively implemented at different levels, in time and at what cost.

- It is part of the management information system (MIS).
- Basically an internal activity.
- Conducted by those responsible for project implementation at every level.
- It should be carried out regularly, for example, monthly, quarterly, half-yearly or annually.
- Primary purpose is to achieve the best possible project performance by providing feedback to project management at all levels.
EVALUATION

- Evaluation may be defined as "a collection of activities designed to determine the value or worth of a specific programme or project"
- It links a result directly to the design of the particular intervention.
- Three sequential levels or phases of evaluation are:
  - Process evaluation
  - Outcome evaluation
  - Impact evaluation

PHASES/TYPES OF EVALUATION

<table>
<thead>
<tr>
<th>Process Evaluation</th>
<th>Outcome/Effect Evaluation</th>
<th>Impact Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aims to assess:</td>
<td>Describes changes in effects and cannot alone produce evidence that a specific programme caused the change</td>
<td>Long term effects of project against its ultimate purpose</td>
</tr>
<tr>
<td>- Project content</td>
<td>- Eg: Contraceptive use in a family planning program</td>
<td>- Eg: Reduction in unintended pregnancies as an appropriate measure of impact</td>
</tr>
<tr>
<td>- Scope &amp; coverage</td>
<td>- Eg: Percentage of births attended by a trained staff in a safe motherhood program</td>
<td>- Ultimate impact should be defined in terms of reductions in the proportions of pregnancies that result in severe complication or the mother’s death</td>
</tr>
<tr>
<td>- Quality &amp; integrity of implementation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Eg: Contraceptive use in a family planning program
- Eg: Percentage of births attended by a trained staff in a safe motherhood program
- Long term effects of project against its ultimate purpose
- Eg: Reduction in unintended pregnancies as an appropriate measure of impact
- Ultimate impact should be defined in terms of reductions in the proportions of pregnancies that result in severe complication or the mother’s death
MONITORING & EVALUATION OF NUHM

**DIFFERENCE BETWEEN SUPERVISION, MONITORING & EVALUATION**

<table>
<thead>
<tr>
<th></th>
<th>Supervision</th>
<th>Monitoring</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responds to</td>
<td>Are we doing the thing right? How can I help you?</td>
<td>Are we doing the thing right?</td>
<td>Are we doing the right thing?</td>
</tr>
<tr>
<td>Measurement</td>
<td>Through on the job interaction</td>
<td>Describe change over a shorter period</td>
<td>Analyses causality/attrition over a longer period</td>
</tr>
<tr>
<td>System (main) focus</td>
<td>Process</td>
<td>Input, process, output</td>
<td>Outcome, impact</td>
</tr>
<tr>
<td>Timing</td>
<td>Continuous</td>
<td>Regular</td>
<td>Episodic</td>
</tr>
</tbody>
</table>

**HMIS**
- Web-based monitoring system put in place by MoHFW to monitor its health programmes and provide key inputs for policy formulation and interventions
- Details in ‘Reporting Mechanisms’ (3.8)

**QPRs**
- Quarterly Progress Reports (QPRs) reflect implementation progress at the state level, submitted by States on a quarterly basis. Cover progress on 13 NUHM elements
- Details in ‘Reporting Mechanisms’ (3.8)

**Monitoring Visits**
- Made periodically from centre, state, district officials to review field implementation
- Aims to understand challenges in implementation
- Findings should be followed up at all levels to ensure corrective actions are taken

**Periodic Evaluations**
- May be done for entire program or components of a program
- Not done yet for NUHM program as a whole, being recent in implementation
**QUALITY OF DATA**

- Data quality is essential for its effective use in decision making
- Managers require accurate, complete, and timely data in order to accurately target resources for effective management of the health system
- Data generated to be reviewed at every level
- Quality involves a complex mosaic of issues relating to organizational procedures, processes, and institutional capacity, and cannot be assessed just by looking at one factor in isolation

**Essential Elements of Data Quality**

<table>
<thead>
<tr>
<th>Accuracy</th>
<th>Completeness</th>
<th>Timeliness</th>
<th>Consistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refers to the correctness of data collected in terms of actual number of services provided or health events organized</td>
<td>Refers to the number of facilities reporting and the number of data elements that they collected</td>
<td>Making data available ‘in time’ as planned in order</td>
<td>Reliability of comparing data</td>
</tr>
</tbody>
</table>

**ISSUES OF DATA QUALITY IN HMIS**

- Completeness of data reporting
- Adequacy of reporting (or completeness of reporting-2nd dimension)
- Timeliness of reporting
- Errors due to poorly designed primary registers
- Data definitions and misinterpretation, consistency of terms used
- Data aggregation problems - both random and systemic
- Data entry errors and Logistical problems
- Confirmation and error management procedures and guidelines
- Data duplication and the issue of area reporting
- The zero problem – what does zero denote? non-utilisation, non-availability or non-reporting v/s service delivery reporting
- Death reporting issues - line listing and formats
- Wrong denominators and Poor indicators
- False reporting and falsification
## SELECTED INDICATORS FOR MONITORING NUHM

### PROCESS INDICATORS:
- Number cities/population where Mission has been initiated
- Number of City specific urban health plans developed and operationalized
- Number of U-PHCs with outreach made operational
- Number of Cities/population with all slums and facilities mapped
- Number of Slum/ Cluster level Health and Sanitation Day
- Number of MAS formed
- Number of U-PHCs with Programme Managers
- Number of ASHAs trained and functioning

### OUTPUT LEVEL INDICATORS:
- Increase in BPL referrals from U-PHCs/ referral availed
- Increase in complete immunization among children < 12 months
- Increase in case detection for malaria through blood examination
- Increase in case detection of TB through identification of chest symptoms
- Increase in referral for sputum microscopy examination for TB
- Increase in number of cases screened and treated for dental ailments
- Increased Tetanus toxoid (2nd dose) coverage among pregnant women
- Strengthened civil registration system to achieve 100% registration of births and deaths

### OUTCOME LEVEL INDICATORS:
- Increase in OPD attendance
- Increase in ANC check-up of pregnant women/ 100% ANC coverage (in urban areas)
- Increase in institutional deliveries as percentage of total deliveries/ Achieve universal access to reproductive health including 100% institutional delivery

### IMPACT LEVEL FOCUS ON URBAN POOR:
- Reduce IMR by 40 % (in urban areas) – National Urban IMR down to 20 per 1000 live births by 2017
- 40% reduction in USMR and IMR
- Reduce MMR by 50 %
- 50% reduction in MMR (among urban population of the state/country)
- Achieve replacement level fertility (TFR 2.1)
- Achieve all targets of Disease Control Programmes
KEY LEARNING

- Monitoring is a routine, continuous inbuilt mechanism to keep track of different activities in the organization or under various National Health Programmes.
- Monitoring helps in detecting any deviations from the planned activities in the program and helps in taking remedial action at the earliest.
- Supervision is as an art or a process by which designated individuals or group of individuals oversee the work of others and establish controls to improve the work and the worker. Components include training, guidance, demonstration, individual counselling & checking.
- For monitoring we need to develop indicators. An indicator has a numerator, a denominator and is multiplied by a constant.
- As a manager try to be certain that the gap in performance is true. Causes for spurious discrepancies may be due to faulty data collection, due to faulty data handling or compilation and due to faulty data processing.

THANK YOU
HUMAN RESOURCE MANAGEMENT UNDER NUHM

CONTENTS

- Human resources
- Staff at facilities
- Human resource management
  - Selection of staff
  - Training and capacity building
  - Employee Management
  - Compensation and benefits
  - Coordination
**HUMAN RESOURCES**

Human Resource is a critical component for efficient & effective service delivery

**NUHM** emphasizes that States first need to fill their regular and sanctioned post. Thereafter, **NUHM** supports states/UT in engaging HR under following heads on contractual basis:

- Program management staff
- Clinical service providers
- Para-medical staff workers
- Community level workers

---

**CATEGORIES OF STAFF UNDER NUHM**

**HEALTH FACILITY STAFF**

**At UPHC**

- Clinical staff: Doctors (2) one regular and one part time
- Paramedical staff: Staff nurses (3), Pharmacist (1), Lab technician (1), ANMs (4-5) (depending upon the population covered)
- Clerical and support staff
- Managerial: Public Health Manager (1)
- Community Level Workers (ASHA, Link Workers)

**At UCHC**

- Specialists: Medicine, Pediatrics, Gynecology, Surgery, Eye etc.
- Medical Officers
- Paramedical Staff
- Finance & Account Staff
- Support Staff

**PROGRAM STAFF**

**At State, City and District Levels**

- Program Managers
- Urban Health Consultants
- Urban Health Coordinators
- Component Specific Personnel (Community Processes, Monitoring & Evaluation, Epidemiology) Accounts Personnel
- Finance Personnel
CHALLENGES & ISSUES IN HUMAN RESOURCES

- **Inequitable distribution of health workers**
  - Concentration of health professionals in cities
  - Shift from public to private leads to inequitable distribution
  - Large number of positions in different categories of staff are vacant

- **High Attrition**
  - Low salaries, contractual appointments without benefits
  - Complexities & delays in recruitment leads to numerous vacant vacancies

- **Delays in Recruitment**
  - Complex administrative procedures and approvals
  - Large scale of recruitments not manageable without external support

- **Capacity Building**
  - Shift in roles of existing cadres (ANM) & introduction of new cadres (public health manager)
  - Large scale of trainings to be undertaken from state level to community level

- **HR Conflicts**
  - Between State & ULB (recruited by one & managed by another)
  - Pre-existing cadres from previous programs resist new recruitments
  - Resistance from staff regarding evening shifts, transfers, addition of duties

HUMAN RESOURCE MANAGEMENT

1. Recruitment Process under NUHM:
   - Any additional hiring to be planned only Gap Assessment & Performance Assessment of existing staff
   - All approved and vacant positions to be filled on priority basis though competence assessment
   - State to play active role in HR selection even where NUHM implementation is by ULB & vice versa
   - State level agencies like SHSRCs & SIHFWs may be involved in selection process
   - MoHFW has empanelled 10 HR Recruitment Agencies for States/UTs to be utilized for large scale recruitments, including for NUHM
   - Medical Colleges may be approached for providing Specialist services for outreach & fixed day Specialist care
   - Competitive salaries, incentives, housing, grace marks for PG admissions to reduce attrition
2. Training & capacity building:

- **Training Needs Assessment** and identifying nodal institutions for capacity building of UH staff
- **Induction training** on NUHM for all new medical, paramedical, program management staff and ULBs at State, District, City level
- **Skill up-gradation** and refresher/ Multi-skilling of HR to be undertaken
- NUHM staff to develop **soft skills** in liaising with ULBs for effective inter-sectoral coordination
- **Monitoring** of trainings and follow up plan
- Plan for **professional development** for staff through performance appraisals

3. Monitoring & Supervision:

- **Monitoring & reporting lines** should be well defined and shared with the employees
- Robust mechanism of **performance appraisal** including both team and individual based performance incentives should be in place
- This should be linked to **incentives** and contract renewal
4. Professional Support:
- Staff should be provided with professional support & personal development opportunities
- All staff should have access to skill building and skill enhancement opportunities
- Staff must be given adequate benefits as affordable by the state
- Innovative mechanisms to keep staff motivated must be taken up by the state: peer support programs, employee awards etc.
- Informal & formal appraisal awards for good performances
- Task shifting to be encouraged (Eg shifting cervical cancer screening from MO to Nurse after proper training)

5. Co-ordination:
- State NHM review meetings with ULBs to review progress of HR every quarter
- While proposing new HR for ULB run health facilities, ULBs also should be consulted for better planning
- There needs to be coordination among ULBs & State for proper HR Management
<table>
<thead>
<tr>
<th>Staff</th>
<th>UPHC</th>
<th>UCHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>M.O</td>
<td>75 OPD cases [@4 min/patient and 5 working hrs]</td>
<td>60 OPD [@5 min/patient]</td>
</tr>
<tr>
<td>Specialists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANMs</td>
<td>Given in detail ‘Guidebook for ANMs under NUHM’</td>
<td></td>
</tr>
<tr>
<td>LTs</td>
<td>100 Lab Tests</td>
<td>100 Lab Tests</td>
</tr>
<tr>
<td>Counselors</td>
<td>Group Counseling: 4 group counseling of 1hr each</td>
<td>Same as UPHC</td>
</tr>
<tr>
<td></td>
<td>InterPersonal Counseling: ~8 persons in 2 hours</td>
<td></td>
</tr>
<tr>
<td>Dentist</td>
<td>30 [20 consultations/day &amp; 10 procedures]</td>
<td></td>
</tr>
<tr>
<td>Dental Technician</td>
<td>50 cases</td>
<td></td>
</tr>
<tr>
<td>X-ray technician</td>
<td>35 cases [@8 min for each patient X 5hrs]</td>
<td>35 cases [@8 min for each patient X 5hrs]</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>120 Prescriptions [@2min for dispensing drugs to each patient for 4 hours rest time for store work]</td>
<td>120 Prescriptions [@2min for dispensing drugs/patient for 4 hours + store work]</td>
</tr>
<tr>
<td>Data Entry Operator</td>
<td>75 OPD registrations and 75 other data elements</td>
<td>60 OPD registrations &amp; 75 other entries</td>
</tr>
</tbody>
</table>

*As given for PHC & CHC in DH Strengthening Guidelines. May vary by context for UPHC & UCHC.
FINANCIAL MANAGEMENT & BUDGETING FOR NUHM

CONTENTS

- PIP planning & its key considerations
- Fund Mechanism
- Banking arrangements
- Monitoring and Reporting
- Audits
FUNDING FOR NUHM

- The Centre State funding pattern is 60:40 for all the states
- North-Eastern states including Sikkim and other special category states of J&K, Himachal Pradesh and Uttarakhand, centre-state funding pattern is 90:10
- All the Union Territories with or without legislature are 100% centrally funded
- As in case of NRHM, funds under NUHM do not lapse at the end of financial year and are carried forward to next year

The Department of Expenditure, Ministry of Finance has laid down certain conditionality for release of funds under NHM. These conditionality needs to be fulfilled as under:

<table>
<thead>
<tr>
<th>Conditionality for release of 1st tranche of funds i.e. 75% of BE</th>
<th>Conditionality for release of 2nd tranche of funds i.e. 25% of BE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clearing of the matching State share contribution against releases by GoI.</td>
<td>1. Clearing of the matching State share contribution against releases by GoI</td>
</tr>
<tr>
<td>2. Submission of Provisional Utilization Certificates of the preceding financial year</td>
<td>2. Submission of Annual Audited Accounts along with UCs for the preceding Financial Year</td>
</tr>
</tbody>
</table>
FUND REVIEWS IN PIP PLANNING

Funds under NUHM do not lapse. They are carried on to the next Financial Year in the form of committed and uncommitted unspent balances

- **Committed unspent balance**: These include activities for which implementation has already started or is underway but full payment has not been made which may shift to next year
- **Uncommitted unspent funds**: Includes the activities approved in the PIP and proposed to be taken up during the current financial year, but could not be taken up may be shifted to the next financial year

**Resource Envelop**: Resources allocated to a particular state for any given financial year.

**It consists of:**
- Uncommitted unspent balance
- GoI allocation (BE) proposed for the year
- State share contribution due for the year

PROGRAM ASSESSMENT FOR PIP PREPARATION

PIP preparation and planning needs to be done based on program performance

- **Assessment of the program**
  - Whether program is able to meet its objectives or not
  - What are the process gaps
  - Trained HR/service people
- **Breaking the programs into activities and action plans**
- **Identifying the gaps in the implementation of program**
- **Linking the gaps with the PIP proposed budget**
**KEY CONSIDERATION IN PIP PLANNING**

- Committed unspent balance should be kept for the activities which have been initiated either partially/ completely and the remaining of the unspent balance should be as uncommitted balances for fresh approvals in PIP
- The State does not need to carry over the activities older than a year old in committed balances
- The State is required to share the activity wise breakup of the committed balances with the PIP submitted
- The proposals should be prepared strictly as per the prescribed FMR format. Any additional activity can only be added under existing sub heads
- The budget requirement of the Municipal Corporations needs to be budgeted as per the PIP guidelines

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**FUND FLOW MECHANISM**

- Fund Flow in States where NUHM is implemented through Urban Local Bodies
BANKING ARRANGEMENTS

- All bank accounts of UPHCs should be operated under the joint signatures (preferably both or at least 1 belonging from the Regular Government Service)
- All the urban health facilities where the funds under NUHM have been transferred should keep a separate bank account for NUHM funds operated under joint signatures
- All the Corporations (including seven metro cities) must have their Delegation of Financial Powers for NUHM funds

FUND FLOW MECHANISM

Fund Flow in States where NUHM is implemented by State Health Violence
MONITORING & REPORTING

- All Urban units should report the expenditure strictly in the FMR format
- Expenditure of all the reporting units needs to be clubbed before submission of FMR to the supervisory units
- In case of changes in expenditure figures, the adjustment entry needs to be done in the next quarter. Figures once reported to GoI need not be changed
- The state officials should carry out the following activities:
  - Budget Vs. Expenditure Analysis
  - Physical Vs. Financial Performance

FINANCIAL MONITORING ACTIVITIES UNDER NUHM

- Field visits by various Supervisory units to the units under their jurisdiction
- Periodical Financial Analysis by GoI and States
- Periodical meetings at supervisory level
- Common/ Joint Review Missions/ Midterm review
- External Reviews
Audit is an independent examination of the financial information of the entity. The process of audit includes vouching, ticking, ledger scrutiny, balance confirmations, verification of financial statements, etc.

Objectives of audit

- To assess and provide an opinion on whether the Financial Statements present a “True and Fair” view of
  - Financial position (Balance Sheet) at the end of the period; and
  - Financial performance (Income and Expenditure account) during the period
- To test whether requisite internal controls are in place, commensurate to the size and volume of operations of the entity
1. Statutory Audit

- The Statutory Audit shows that whether the financial statements represent a “True and Fair” view of the financial position as at end of the financial year or not.
- The Statutory Auditor is appointed at the State level and it covers all the programmes under NHM including NUHM.
- Separate guidelines/ instructions are issued by NHM-Finance every year regarding the terms and conditions for appointment of Statutory Auditor.
- It should be ensured that the Statutory Audit should cover the NUHM programme.
- The Statutory Audit Report should be submitted to the Ministry by 31st July every year unless stated otherwise.
- The compliance report on the observations of the Statutory Audit relating to the NUHM programme should be sent to the Ministry.

**Types of Audits**

**Statutory Audit**

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**Circulation of ToRs / RFP**

- By 31st Jan

**Submission of report to MoHFW**

- By 31st July

**Completion of SHS audit**

- By 30th June

**Consolidation of DHS and SHS accounts**

- By 15th June

**Completion of DHS audit**

- By 31st May

**Circulation of ToRs / RFP**

- By 31st Jan

**Last date to accept tech bids**

- By 28-29th Feb

**Date for opening technical bids**

- By 7th March

**Date for intimating the selected firm**

- By 15th March

**Last date of appointing auditor**

- By 31st March

**Completion & finalization of DHS accounts**

- By 30th April

**Completion & finalization of DHS accounts**

- By 30th April

**Statutory Audit Cycle**

- By 31st Jan
- By 31st July
- By 30th June
- By 15th June
- By 31st May
- By 30th April
- By 31st March
- By 15th March
- By 7th March
- By 28-29th Feb
- By 31st July
**CONCURRENT AUDIT**

- To be conducted on a monthly basis by all the State/ Districts /Municipal Corporations. Reporting on a quarterly basis.
- Concurrent audit is a systematic and timely examination of financial transactions on a regular basis to ensure accuracy, authenticity, compliance with procedures and guidelines. The emphasis under concurrent audit is not on test checking but on substantial checking of transactions.
- It is an ongoing appraisal of the financial health of an entity to determine whether the financial management arrangements (including internal control mechanisms) are effectively working and identify areas of improvement to enhance efficiency.
- It must be ensured that the Concurrent Audit Report should cover and list the observations on the NUHM programme.
- The observations of the Concurrent Auditor on the NUHM programme should be timely settled.

**KEY LEARNINGS**

- Financial considerations while PIP planning
- Fund flow when NUHM implemented through ULB
- Fund flow when NUHM implemented directly through state
- Monitoring of fund flows
- Reporting of funds
- What is Audit
- Understanding statutory and concurrent audits
THANK YOU
CONTENTS

- Develop communication strategy and plan for NUHM
- Understand measures to enhance understanding of NUHM among all stakeholders
- Institutional branding for NUHM
- Ways of effective communication for desired change among various groups
States & ULBs should prepare a Communication Strategy & Plan to:

- Generate awareness on NUHM program and its services
- Advocate for urban health issues among stakeholders to facilitate collaboration and convergence
- Improve health seeking behavior of urban vulnerable around UPHCs
- Encourage preventive health behaviour, knowledge on health issues among beneficiaries
- Sensitize service providers on the needs of poor and vulnerable

Properties of IEC Messages

- Messages should be short and clear
- Should connect with the audience
- Should be effective and influential
- Should be supported by evidence, real time data and examples
- Should be customized differently for different stakeholders as per their orientation, level of education & expected action
1. INSTITUTIONAL BRANDING

- Standard signage and symbols for NUHM to be used on all communication materials and institutions
- Uniform hoardings & banners for all facilities with standardized size, colour, font and content
- All facilities to be painted in same colour
- All facilities must have standardized essential displays such as: list of services available, facility timings, entitlements under various schemes, essential drug list, citizens charter, composition of RKS.
- Mobile Medical Units to also have uniform branding with IEC corner at MMU station sites.
2. NUHM AWARENESS: FOR BENEFICIARIES

Awareness generation on:

- NUHM components, availability of health services at UPHC & UCHC
- Timings, location of health facility, free of cost
- Outreach and special outreach locations and timings
- Special days observed by the health department
- Endemic diseases and preventive measures for them eg Dengue, Chikungunya, Filariasis
- Healthy practices and behaviours
- Any other issue identified by state/ULB

Ways of Awareness Generation

- Through community health workers
- Health facility bases IEC tools
- Effective use of media
  - Hoardings at strategic locations
  - Radio and TV spots, newspaper ads
  - Wall paintings & folk art, Exhibitions
  - Street plays by community volunteers
  - Public announcements
  - Pamphlets & handbills
- Innovative mechanisms
  - Involving school children
  - Local competitions
  - Health walks, cleanliness drives

States may develop own standard and design, which should be uniform throughout the State
2. AWARENESS GENERATION: FOR PARTNERS

For generating interest and awareness among partners, follows methods may be used:

- Policy briefs and brochures
- Advocacy meetings
- Participation in state level conferences and seminars
- Targeted communication for specific stakeholder groups such as medical colleges, professional bodies and organizations, other government departments, private sector collaborators, development partners etc.
3. SENSITIZATION OF SERVICE PROVIDERS

While service providers may have adequate knowledge on NUHM, they need to be sensitized for providing services. They should be sensitized on:

- Issues, challenges and special needs of the urban poor population
- Ways of providing supportive and empathetic care
- Special needs of urban vulnerable population
- Understanding underlying cause of illness and addressing it
- Providing appropriate advice and referrals (e.g., domestic violence help center, de-addiction center etc)
- Providing practical solutions to their problems

THANK YOU