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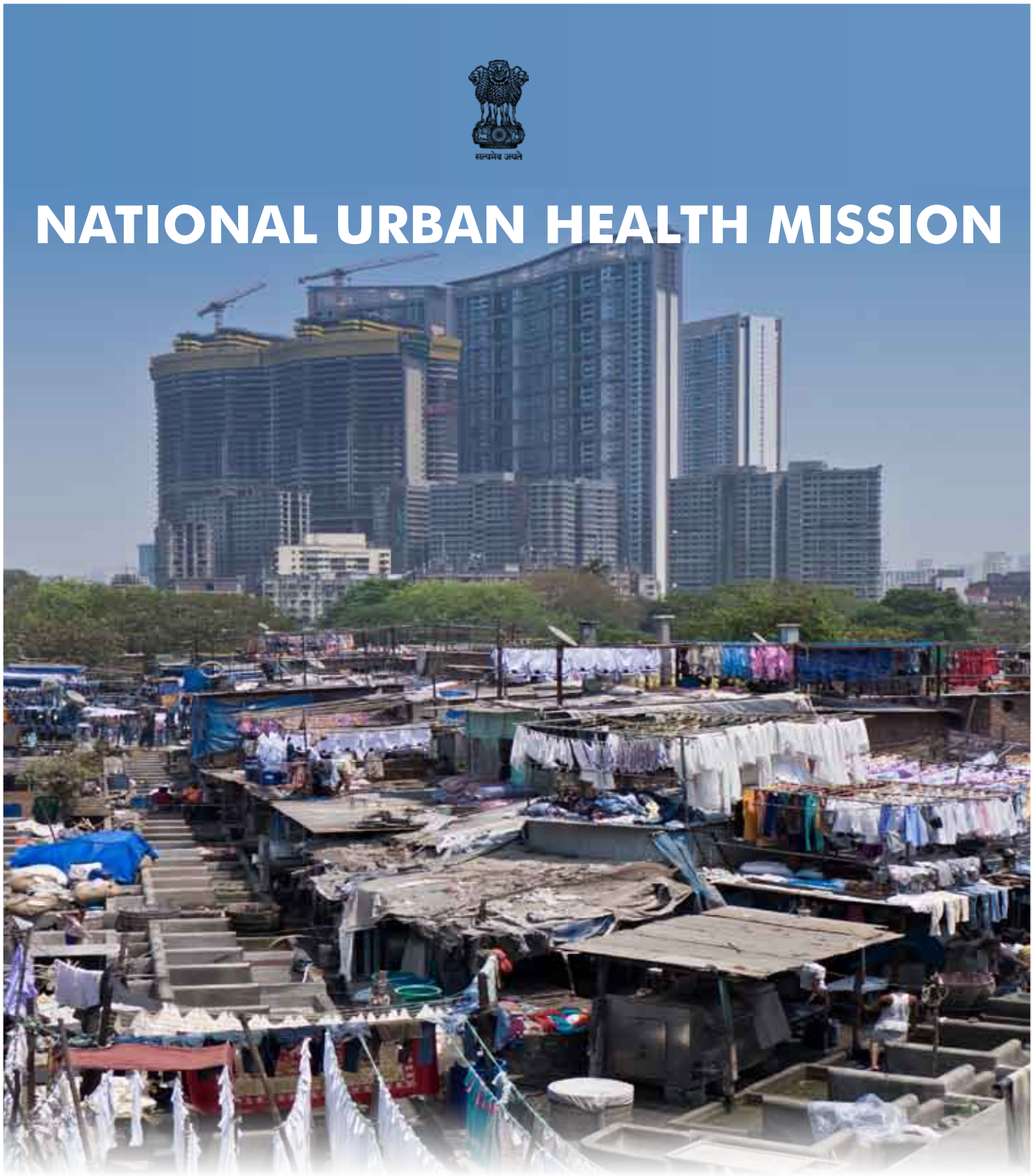
NATIONAL URBAN HEALTH MISSION



PRESENTATIONS FOR
ORIENTATION MODULE FOR PLANNERS, IMPLEMENTERS AND PARTNERS

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA

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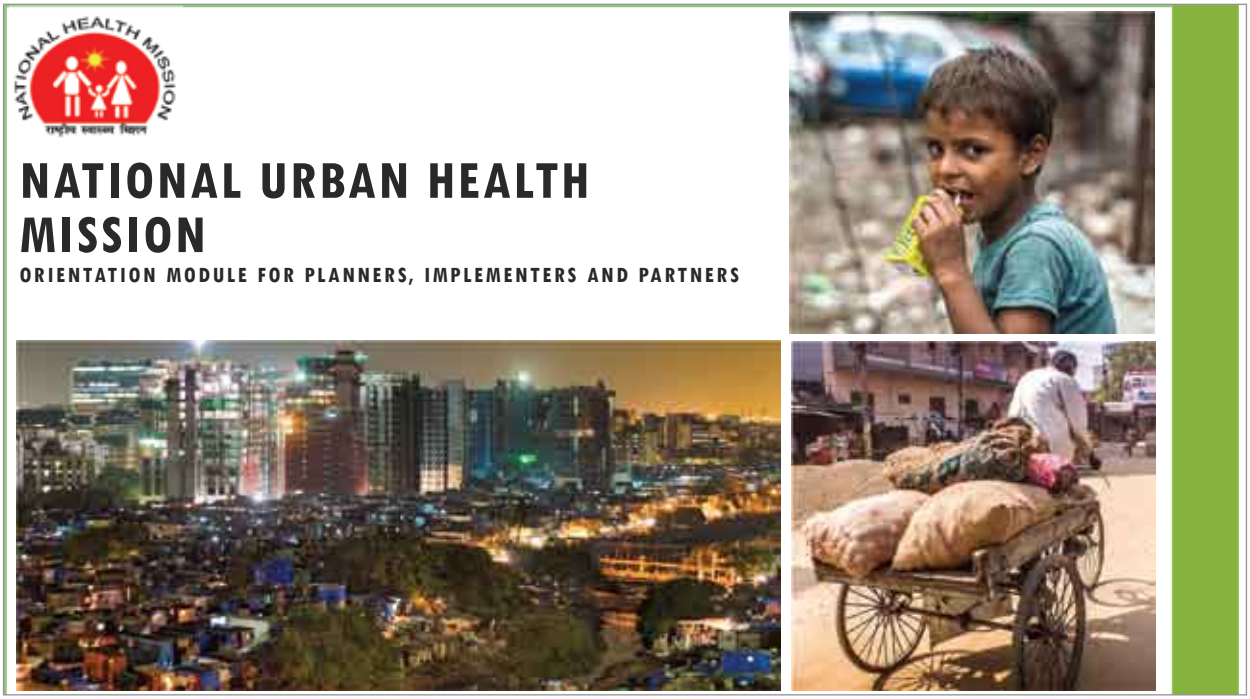
INTRODUCTION



CONTENTS

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

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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)

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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

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TOPICS COVERED UNDER ORIENTATION PROGRAM

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

6

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

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THANK YOU

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PERSPECTIVE BUILDING ON URBAN HEALTH

CONTENTS

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

3

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

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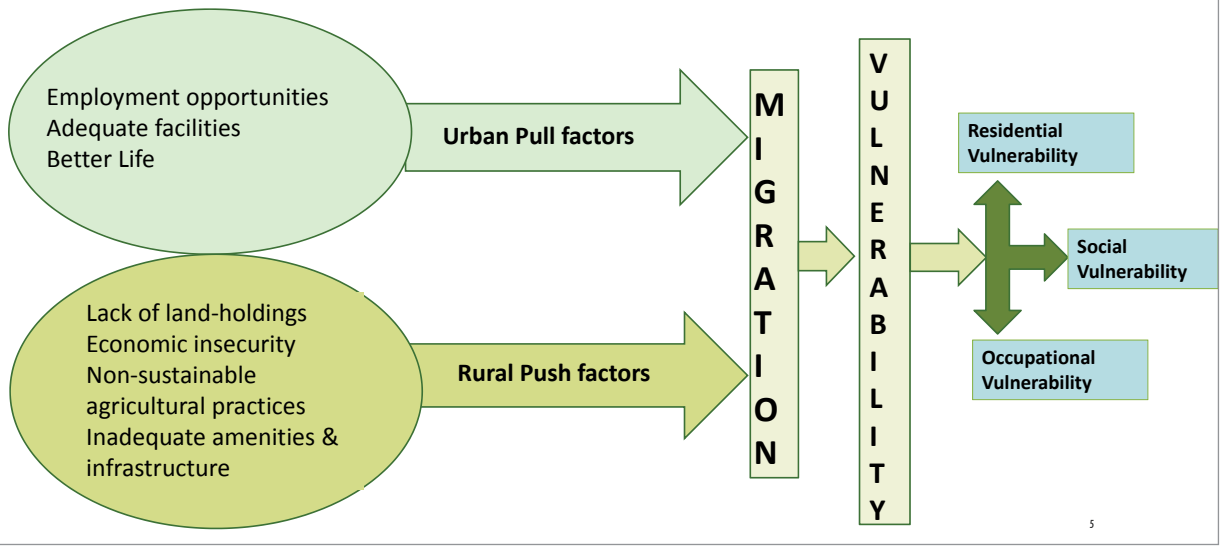
MIGRATION LEADING TO VULNERABILITY



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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)

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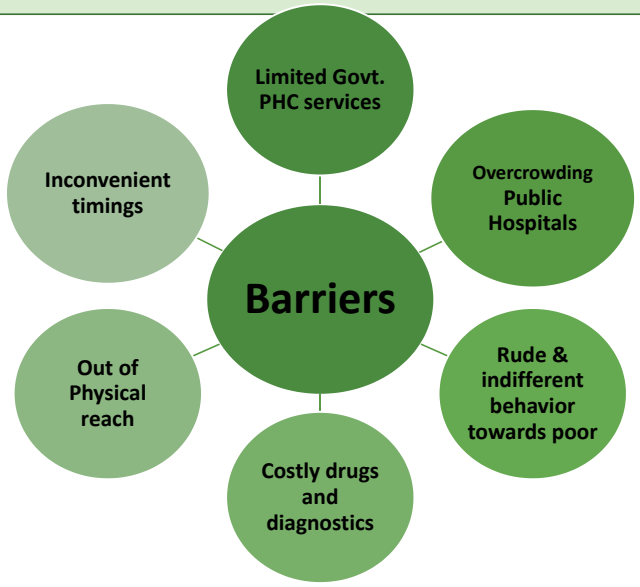
BARRIERS TO SEEKING HEALTHCARE SERVICES IN URBAN SETTINGS



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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.

8

DETERMINANTS OF URBAN HEALTH

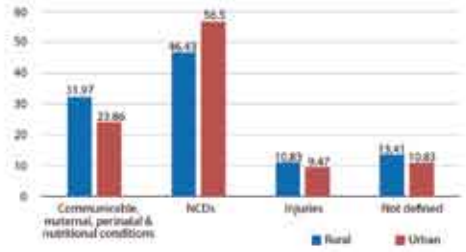
- Cities offer the best and worst environments for health and well being. However, there are large disparities between health or the poor and the wealthy.
- For certain indicators, health outcomes of urban poor are worse than those of rural residents.

9

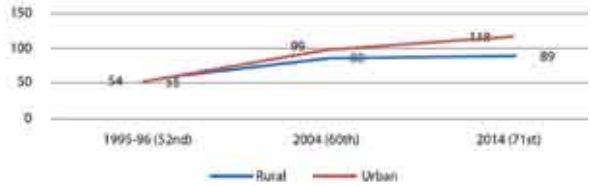
URBAN MORBIDITIES

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%)



Morbidity Rate in Rural and Urban Areas, 2007-2013, NSSO



- Reporting of illnesses is higher in urban than in rural – what do you think is the reason for this?

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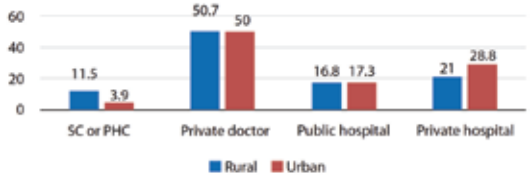
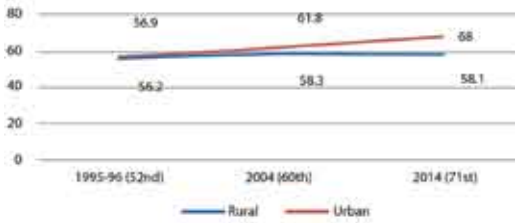
HEALTHCARE SEEKING IN URBAN AREAS

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.

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RISK FACTORS FOR URBAN MORBITIES

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

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

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).

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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

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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.

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THANK YOU

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NATIONAL URBAN HEALTH MISSION: OVERVIEW

NATIONAL URBAN HEALTH MISSION: OVERVIEW

CONTENTS

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

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

3

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)

4

COMPREHENSIVE PRIMARY HEALTHCARE APPROACH

- **Universal access:** No one shall be turned away or refused any health service.
- **Assured minimum package of services**: Delivered as close to home as possible to ensure universal access with quality.
- **Preventive and promotive care:** Enhanced focus on screening of NCDs, early identification of communicable diseases, early outbreak identification and management
- **Effective Gatekeeping:** Reduced patient load at higher facilities by strengthening primary health services
- **Outreach:** Special efforts to identify, reach out to and address health needs of marginalized
- **Reduction in out of pocket expenditure:** Provision of free drugs, diagnostics and consultation
- **Integration:** Collaboration with ULBs and other departments to tackle cross cutting issues
- **Continuity of Care: C**ontinued care through referral and follow ups

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PACKAGE OF PRIMARY HEALTHCARE SERVICES

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

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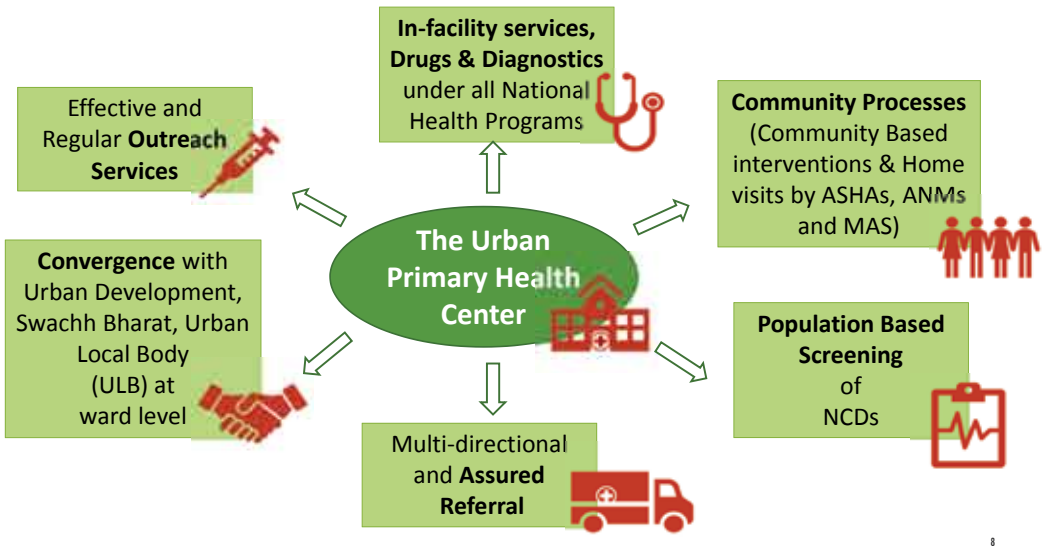
SERVICE DELIVERY STRUCTURE OF NUHM

Population Served	Health Facility/Worker
2.5 lakh population (5 lakh for metros)	1 UCHC (30-50 bedded in-patient facility, 100 bedded in Metros for 5 lakh population)
50,000 population	1 UPHC (OPD facility)
10,000 population	1 ANM
1000-2500 population (200-500 households)	Community Health Volunteer (ASHA)
250-500 Population (50-100 households)	Mahila Aarogya Samiti

UPHC: EPICENTER OF COMPREHENSIVE PRIMARY HEALTHCARE



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

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

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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

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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

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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

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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

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HEALTH KIOSKS

- NUHM has no sub-centers, so some states have felt the need for a 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

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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

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THANK YOU

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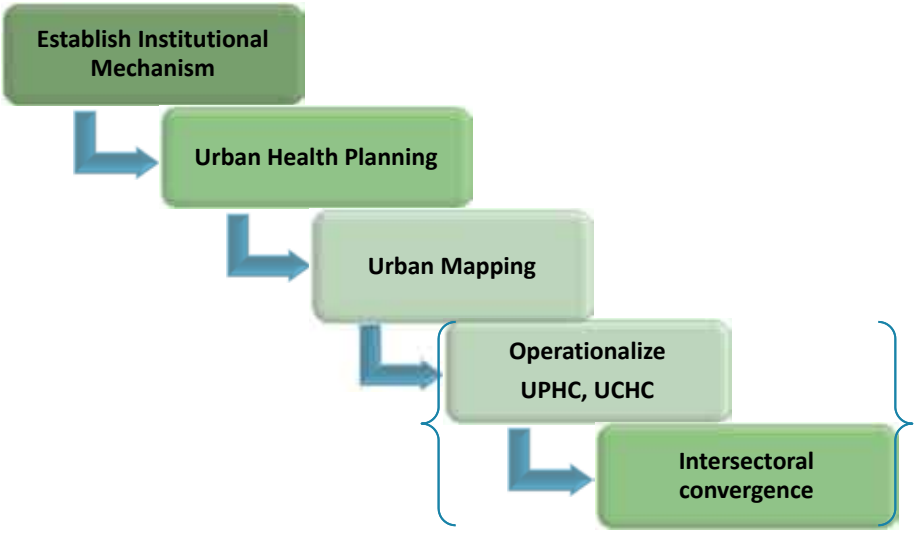
IMPLEMENTING NUHM

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



NUHM IMPLEMENTATION

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

Model 1	Model 2	Model 3
▪ State → 100% ▪ ULBs → Minimal ▪ Municipal Health Officer in charge of non-medical services ▪ Examples: HP, Bihar, Small towns (< 2 lakh population)	▪ State → Major ▪ ULBs → Minor ▪ State: District hospital, Medical colleges. Examples: Bhubaneshwar ▪ ULBs: Urban Health Dispensaries, Health Posts, Health Volunteers	▪ 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 (eg 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

5

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.

6

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

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

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URBAN HEALTH MAPPING

8

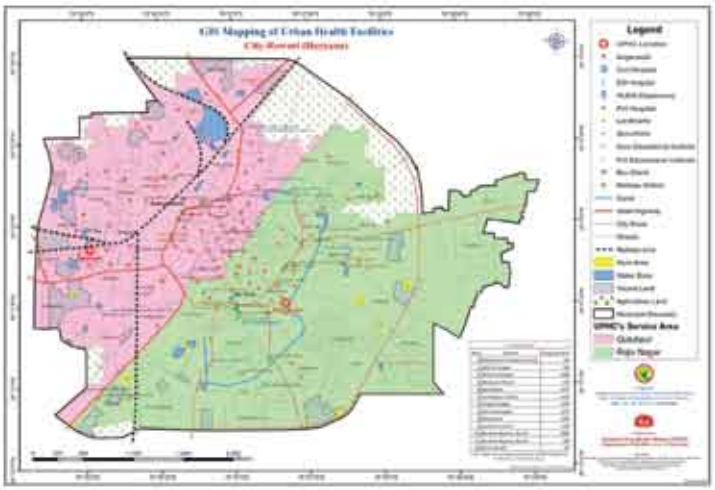
CITY MAPPING

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!



Sample GIS Map of Rewari city (Haryana)

9

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

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TYPES OF MAPPING

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

Rationalize the location of Health Facilities, MMUs, outreach

Ensure adequate service delivery to vulnerable poor

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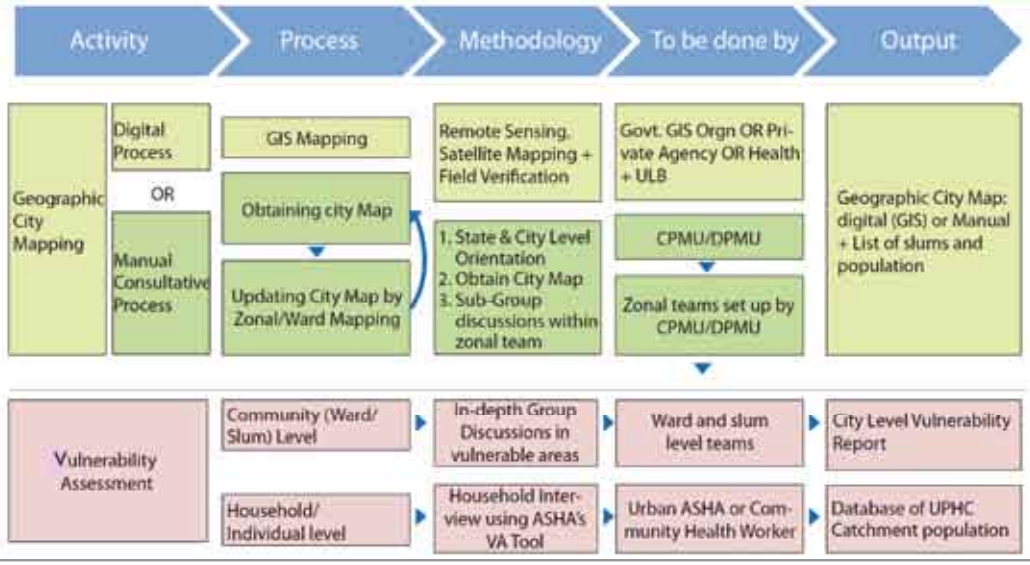
FLOW CHART OF CITY MAPPING & VULNERABILITY ASSESSMENT



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URBAN HEALTH PLANNING

A convergent action leading to holistic approach

13

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

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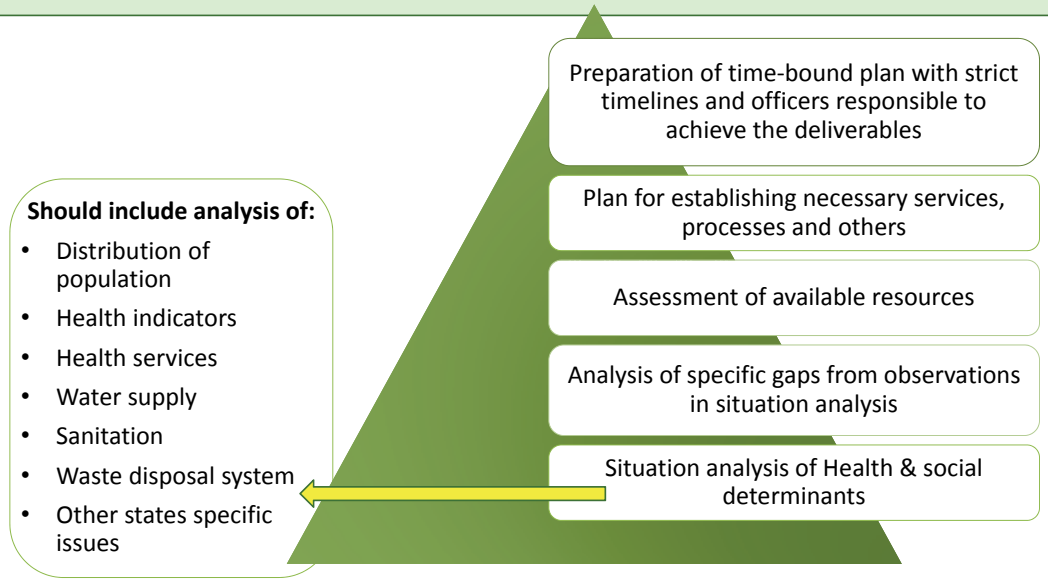
BOTTOM-UP APPROACH TO PLANNING



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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**

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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.

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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.

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THANK YOU

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OPERATIONALIZING HEALTH FACILITIES, OUTREACH SERVICES & REFERRAL SERVICES UNDER NUHM

CONTENTS

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.

3

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.

4

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.

5

MINIMUM SERVICES TO BE PROVIDED

Clinical Services	Diagnostic Services	Support Services
▪ Maternal & Child health ▪ Family Planning ▪ RTI/STI (HIV/AIDS) ▪ Nutrition ▪ Vector born diseases ▪ Mental health ▪ Oral health ▪ Chest infection ▪ NCDs ▪ Communicable diseases ▪ Trauma ▪ Surgical → Referral	▪ Clinical pathology ▪ Biochemistry ▪ Microbiology ▪ Urine analysis ▪ Stool examination	▪ Health promotion through IEC ▪ Behaviour Change Counseling (BCC) ▪ Counselling ▪ Advocacy

6

LINKING DISEASE CONTROL PROGRAMS TO NUHM

Services Areas	Services to be provided	Programme Covered
Maternal Health	ANC, PNC, initial management of complicated delivery cases and referral, management of regular maternal health conditions, referral of complicated cases	
Child health and Nutrition	Diagnosis and treatment of childhood illnesses, referral of acute cases/ chronic illness Identification and referral of neonatal sickness	
Family Planning	Distribution of OCP/CC, IUD insertion, referral for sterilization, management of contraceptive related complications	Reproductive Child Health Programme
RTI/STI (including HIV/ AIDS)	Symptomatic Diagnosis and primary treatment and referral of complicated cases	
Nutrition Deficiency disorders	Height/weight measurement, Hb testing, distribution of therapeutic doses of IFA, promotion of iodized salt, nutrition supplements to identified children and pregnant/ lactating women. Diagnosis and treatment of seriously deficient patients, referral of acute deficiency cases	
Vector-borne Diseases	Slide collection, testing using RDKs, DDT Counselling for practices for vector control and protection, Diagnosis and treatment, referral of terminally ill cases	National Vector Borne Diseases Control Prog.
Mental Health	Initial screening and referral	National Mental Health Programme
Oral Health	Initial screening, Diagnosis and referral	National Oral Health Programme

LINKING DISEASE CONTROL PROGRAMS TO NUHM

Services Areas	Services to be provided	Programme Covered
Chest infections (TB/ Asthma)	Symptomatic search and referral, ensuring adherence to DOTs, other treatment, Diagnosis and treatment, referral of complicated cases	Revised National Tuberculosis Control Programme
Cardiovascular Diseases	BP measurement, symptomatic search and referral, follow-up of under treatment patients, Diagnosis and treatment and referral during specialist visits,	
Diabetes	Blood/urine sugar test (using disposable kit), Diagnosis and treatment, referral of complicated cases	National Programme for Prevention and Control of Diabetes, Cancer, Cardiovascular diseases and Stroke.
Cancer	Identification and referral, follow-up of under-treatment patients	
Trauma care (burns & injuries)	First aid, emergency resuscitation, documentation for MLC (if applicable) and referral	
Other Surgical Interventions	Identification and referral	
IEC/BCC	Distribution of health education material	All Programmes
Counseling	Patient/attendant counseling	All Programmes

DIAGNOSTIC SERVICES AT UPHC

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

9

OUTREACH SERVICES UNDER NUHM

10

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

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1. URBAN HEALTH AND NUTRITION DAY (UHND)

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

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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

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

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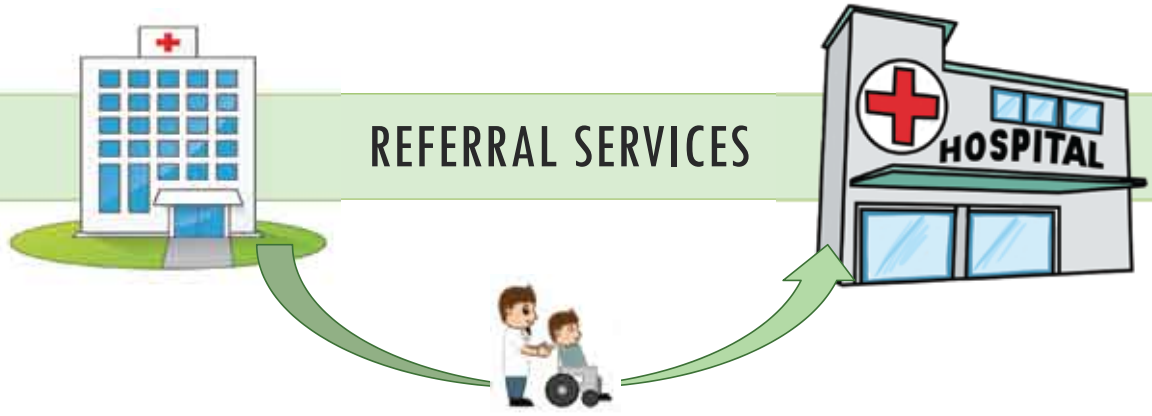
REFERRAL SERVICES



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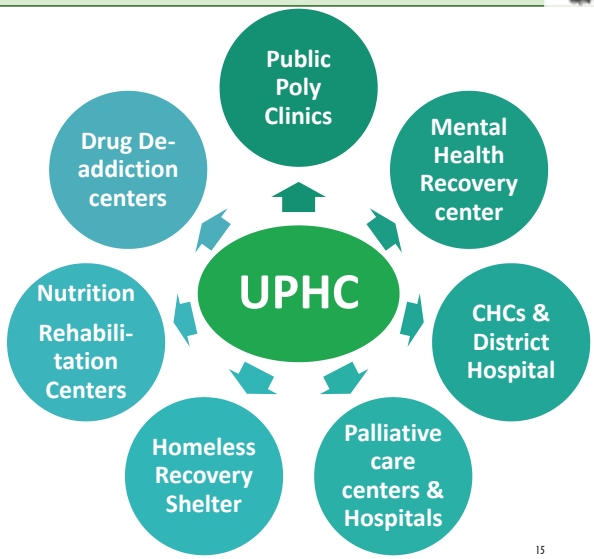
MULTI-DIRECTIONAL REFERRAL LINKAGES REQUIRED FOR UPHC

- 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



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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

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THANK YOU

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REPORTING MECHANISMS UNDER NUHM

Reporting Mechanisms under NUHM

CONTENTS

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

SIGNIFICANCE OF REPORTING MECHANIMS

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

3

Types of Reporting Mechanisms

- Service Delivery Reporting
- Program Specific Reporting Systems
- Patient Data Reporting
- Staff Performance Reporting

4

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 new-born
- 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

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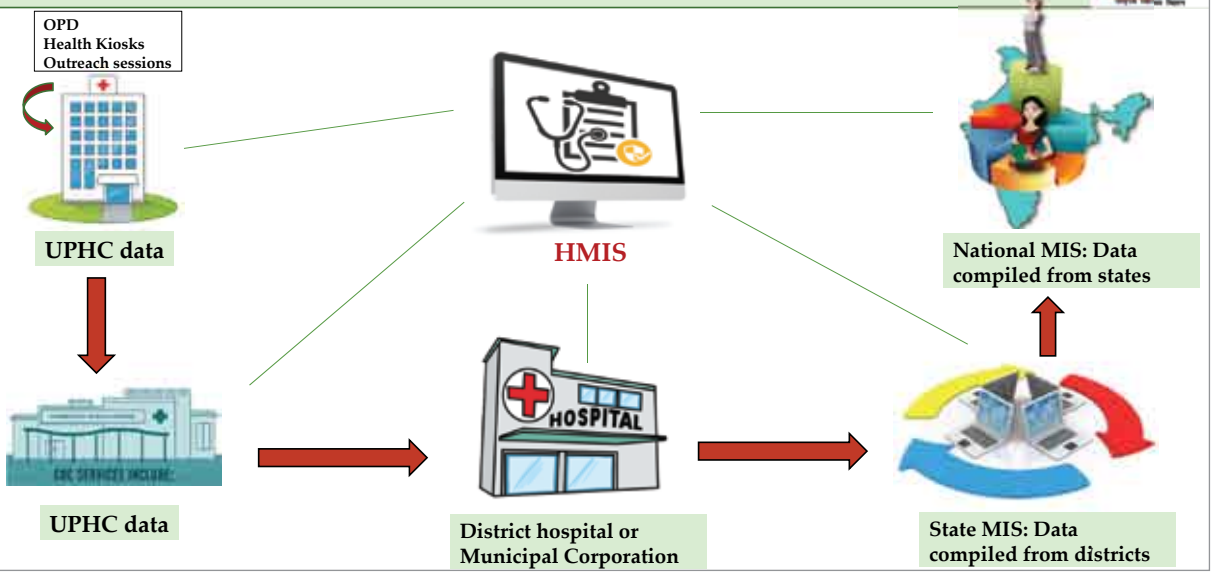
HMIS DATA FLOW



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

8

PROGRAM SPECIFIC REPORTING SYSTEMS

Certain disease control programs have set up their own data collection and analysis software like:

NIKSHYA: Revised National TB Control Program's Data portal

NAMMIS: National Anti-Malaria Management Information System

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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

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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

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THANK YOU

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INTERSECTORAL CONVERGENCE FOR URBAN HEALTH

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.

3

TYPES OF CONVERGENCE

Intersectoral Convergence

Bringing together different sectors

- Water
- Sanitation
- Waste management
- Nutrition
- Education
- Housing
- Roads and Transport

Inter-departmental Convergence

Bringing together departments/ divisions within health

- TB
- Vector Borne Diseases
- Non-Communicable Diseases
- HIV/AIDS
- Maternal and Child Health
- Family Planning etc.
- Communicable Diseases

4

INTERSECTORAL CONVERGENCE

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

5

CHALLENGES IN INTESECTORAL 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

6

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

7

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

8

ENGAGING WITH VARIOUS PARTNERS: ACTION POINTS

9

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 bio-medical waste management systems

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WATER SUPPLY AND SEWAGE MANAGEMENT

- Maintain a list of areas where safe drinking water is not available
- Epidemiological investigations of outbreaks and notified cases of water borne diseases in collaboration/coordination with Water Department officials
- Water quality surveillance and sharing the lists with the Water Department for remedial action
- Technical assistance to improve safe water supplies to vulnerable communities

11

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

12

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

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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

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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 frm Municipal Health Officer & City Nodal Officer/ District Medical and Health Officer coordinating in implementation

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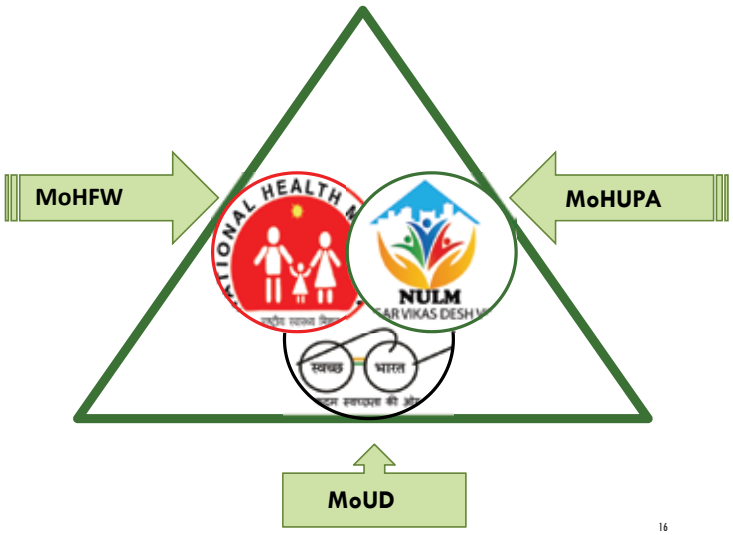
MAJOR CONVERGENCE PLATFORM

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



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VARIOUS CONVERGENCE STRUCTURES (EXAMPLES)

S.No	Partner 1	Partner2	Type	Coordinated Actions
1	West Bengal UHC	wards and higher level	Formal	Smooth Health service delivery
2	Mysuru Health Department	ULB	Informal Coordination	City urban health planning by forming City Urban Health Committees
3	Chhattisgarh Health & ICDS	ULBs, Schools, elected officials	Formal coordination	Promoting health seeking behavior, infrastructure & monitoring of developmental inputs (including WASH)
4	Pune Health Department	UCD-Pune, ICDS, JNNURM and PMC Eng. Deptt.	Formal	Addressing issues both health & beyond like: stray dogs, traffic jams and electricity connections
5	Nutrition committee Madhya Pradesh	Neighborhood committees under SJSRY and ward committees under JNNURM	Informal coordination	Potential for being leveraged for health purposes as well

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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.

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THANK YOU

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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

ASHA

ASHA: Accredited Social Health Activist

One ASHA for every 1000-2500 population, ie, about 200 - 500 households

3

CRITERIA FOR URBAN ASHA SELECTION

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

4

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

5

FIVE ACTIVITIES OF ASHA

1. Home Visits

2. Supporting UHND & Outreach Sessions

3.Visiting Health facility

4. Supporting MAS

5. Maintaining Records and registers

6

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

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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

8

SUPPORT MECHANISMS FOR ASHA PROGRAM

State	• MD, NHM • Community Processes Resource Centre (expansion of team for urban component) • State trainers team providing training support • State ASHA Mentoring group
District	• District ASHA Coordinator/ Mobilizer • DPMU/District Health Society • In contexts where required this existing support structure could be expanded if needed (For large cities a city Programme Management unit will be established)
Unit Level	• Community Organizer/ASHA Facilitator every 20 ASHAs and her MAS (ANM will play the role of the ASHA facilitator where there is no ASHA Facilitators).
Field support	• ANMs of the urban primary health centers and MAS

9

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

10

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

11

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.

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FUND FLOW MECHANISM

- Funds for ASHA and MAS are specifically earmarked as part of NUHM Flexipool
- 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.

13

MONITORING AND EVALUATION

Functionality of ASHAs is monitored on indicators, based on the key tasks undertaken by ASHA:

- 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.

14

MAHILA AROGYA SAMITI (MAS)

15

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.

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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

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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

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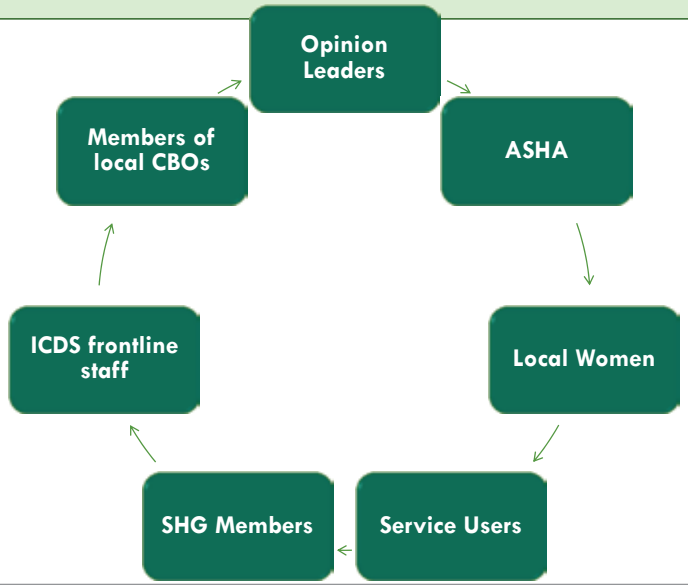
COMPOSITION OF MAS: SUGGESTED MEMBERS



MAS FUNCTIONING

Role of Chairperson	Role of Member Secretary
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

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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 an 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

22

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.

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MAJOR ACTIVITIES OF MAS

24

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.

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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

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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.

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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.

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FACILITATING SERVICE DELIVERY & SERVICE PROVIDERS IN THE COMMUNITY

The MAS serves as an important platform for facilitating access to services in the following ways:	
Supporting Organization of Urban Health and Nutrition Day	• Mobilizing pregnant women & children particularly from marginalized families and Supporting ANM, AWW and ASHA in organizing UHND
Support in organizing Outreach Sessions (both routine & special)	• Mobilizing pregnant women & children particularly from marginalized families and Coordination with ASHA and ANM
Supporting community service providers	• Allowing community service providers to share their problems in MAS meetings and to reach the vulnerable and "hard to reach" populations
Facilitating Referral Transport	• Generating awareness on referral transport and 108 services • Organizing local tie-ups with private vehicle owners to transport patient
Support in Strengthening AWC	• Providing important amenities missing in AWC improving their functioning
Births & death Registration	• Maintaining records of all births and deaths in the slum cluster
Maternal & child deaths	Providing immediate info on maternal/child death to the ASHA/ANM/MO
Information on disease outbreaks	Providing immediate information on any disease outbreak to the ASHA/ ANM/ U-PHC Medical officer

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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

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MANAGEMENT OF UNTIED FUND

- The management of untied fund is completely in the hands of the MAS.
- The utilization of the funds has to be transparent and should involve a participatory decision making process.
- Decisions taken on expenditure should be documented in the minutes of the monthly MAS meetings.
- The member secretary should be allowed to spend small amounts on necessary and urgent activities, of up to Rs. 500, for which details of activity and bills and vouchers should be submitted in the next MAS meeting and a post facto approval of the samiti taken.

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MAINTENANCE OF RECORDS

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

Activity Records	Financial Records
1. Record of Meetings	1. Cash Book
2. Public Services Monitoring Tool and Register	2. Bank Pass Book
3. Birth Register	3. Statement of Expenditure (SOE)
4. Death Register	4. Utilization Certificate (UC)

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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, ie, 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

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THANK YOU

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PREVENTION, SCREENING & CONTROL OF NON- COMMUNICABLE DISEASES

Prevention, Screening & Control of Non- Communicable Diseases

CONTENTS

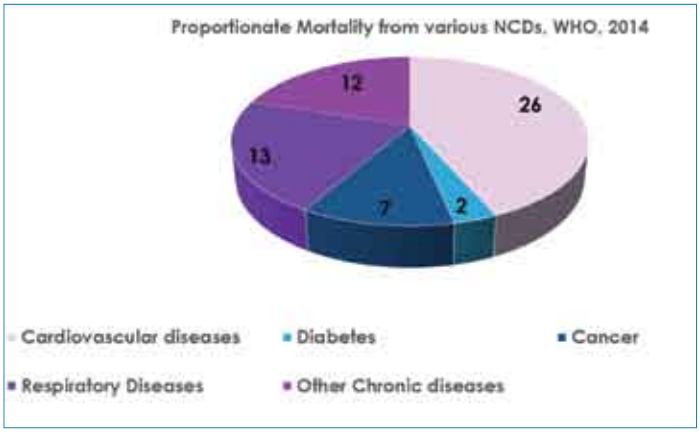
- Rationale for Population based Screening of Non-Communicable Diseases
- Population Enumeration
- Service delivery framework
- Principles of screening at community level
- Key tasks on screening day
- Health promotion
- Referral and treatment
- Drugs and diagnostics

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



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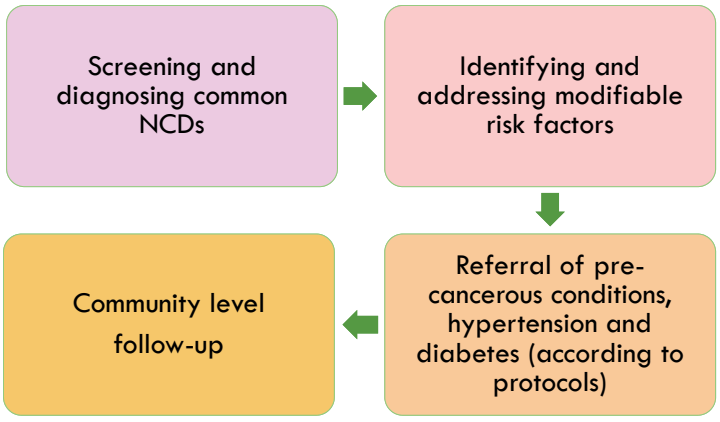
KEY PROCESS OF NCD PROGRAM



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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

5

SCREENING AT COMMUNITY LEVEL

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

- 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

6

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, LHVs, 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
  - LHVs 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

7

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 a 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.

Individual & Family	Community	Facility	Systems Level
• IEC Material, • Dietary advice • Yoga • Counseling • Social Medial	• Through MAS • Use of traditional media • Local gathering, melas, festivals	• Patient support groups • RKS level of interventions • IEC- BCC Displays at facility	• Linkage with existing programs (Tobacco control, AYUSH) • Audio visual messages through MMUs

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

10

CAPACITY BUILDING

Cadre	Training Required
ANMs or MPWs	• Three-day module on hypertension, diabetes and screening of oral and breast cancers
ASHA	• Five-day module on hypertension, diabetes and screening of oral and breast cancers • One day of overlap for integrated training with ANMs/MPW, so that they are able to better function as a team.
ANMs, Staff Nurses & LHVs	• Two weeks training at a DH/ tertiary care institution for training in VIA
MOs	• Five days training in a tertiary care setting

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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

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THANK YOU

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INTRODUCTION TO QUALITY & OVERVIEW OF NQAP & QA STANDARDS FOR UPHCS

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

CONTENTS

QUALITY DEFINED

Quality is Meeting and Surpassing the Customer Expectation

Who are our customers?

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

3

QUALITY IS ABOUT:

Quality is Minimizing Variations

Quality is Standardization

QUALITY IS DOING RIGHT THINGS

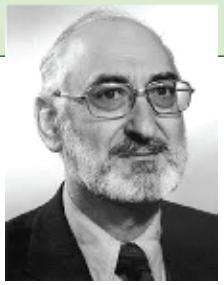
IN RIGHT WAY

FIRST TIME &

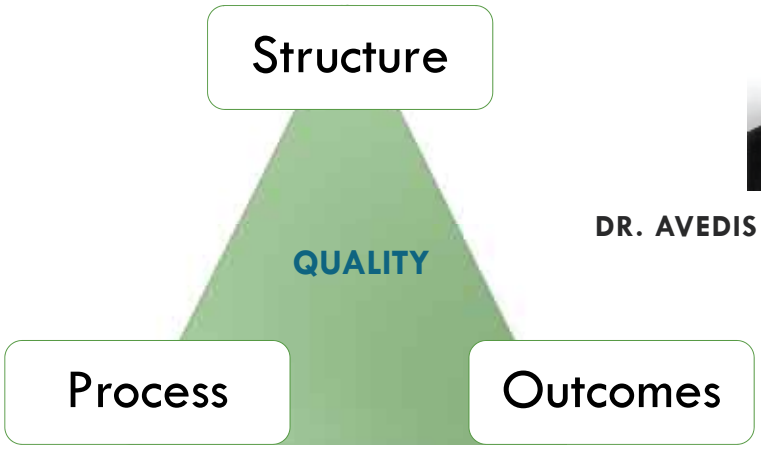
EVERY TIME

4

DIMENSIONS OF QUALITY



DR. AVEDIS DONABEDIAN (1919-2000)

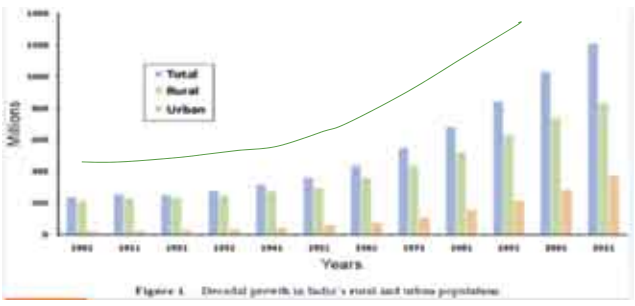


Focus shifting from Structure to Processes

5

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 securer environment at home
- Non-availability of caretakers for other siblings in the event of hospitalization



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Because POOR QUALITY ruins image of Public Health System.

7

INTRODUCING NATIONAL QUALITY ASSURANCE PROGRAM (NQAS)

8

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

1. Release of Operational Guidelines for Quality Assurance and National Quality Assurance Standards
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

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

10

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

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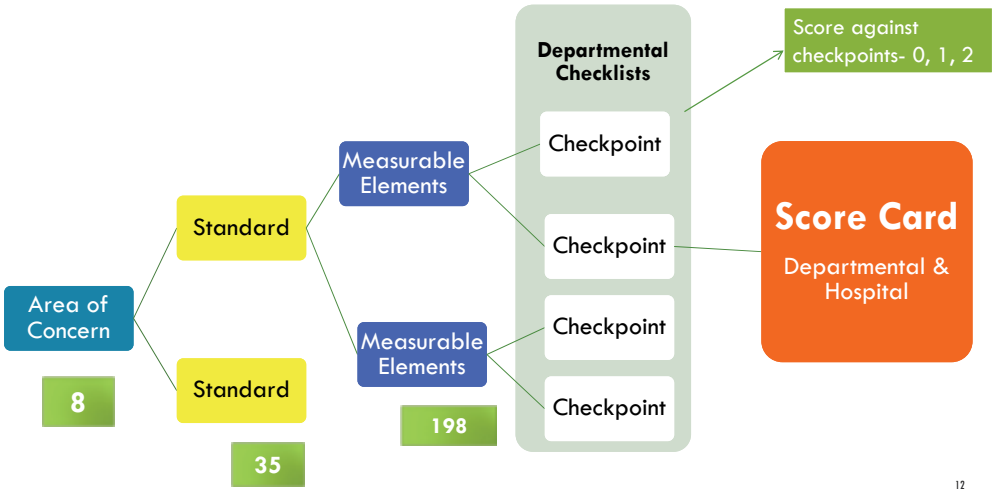
RELATIONSHIP BETWEEN DIFFERENT COMPONENTS



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SAMPLE CHECKLIST

CHECKLIST FOR GENERAL CLINIC → (a)

Reference No.	Measurable Element	Checkpoint	Compliance	Assessment Method	Means of Verification
Area of Concern – A: Service Provision → (b)					
Standard A1	Facility provides Promotive, preventive and curative services → (c)				
ME A1.1 (d)	The facility provides treatment of common ailments (e)	Availability of Consultation services for common illnesses (f)	(g)	RR/SI (h)	Common Cold, Fever, Diarrhoea, Respiratory tract infections, Bronchial Asthma, conjunctivitis, foreign body in conjunctival sac, etc. (i)

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

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

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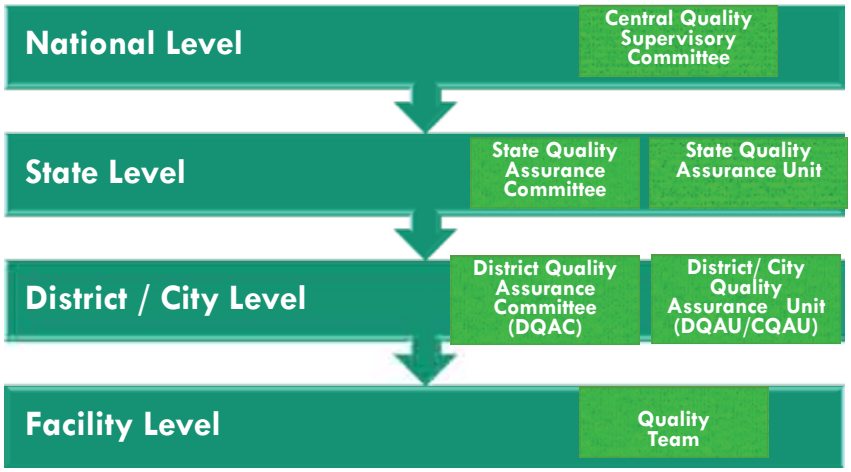
QUALITY ASSURANCE INSTITUTIONAL STRUCTURE



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INVOLVING 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.

17

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.

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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

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IMPLEMENTATION OF QUALITY ASSURANCE AT FACILITY LEVEL

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

20

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

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THANK YOU

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MANAGING DISEASE OUTBREAKS IN URBAN AREAS

Managing Disease Outbreaks in Urban Areas

CONTENTS

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

3

TYPES OF SURVEILLANCE

Active Surveillance:

When a health worker goes into the area or house to house and collects information

Passive Surveillance:

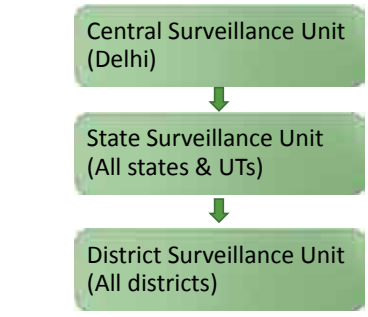
When people come to the health center and information is collected through different registers

4

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)



Administrative levels in IDSP set-up

5

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.

Types of incident reported	Syndromic	Presumptive	Lab confirmed
Definition	Diagnosis made on the basis of signs and symptoms	Diagnosis made on typical history and clinical examination	Clinical diagnosis confirmed by an appropriate laboratory test
Form type	Form S	Form P	Form L
Form filled by	Health Workers	Medical Officers	Lab technician

6

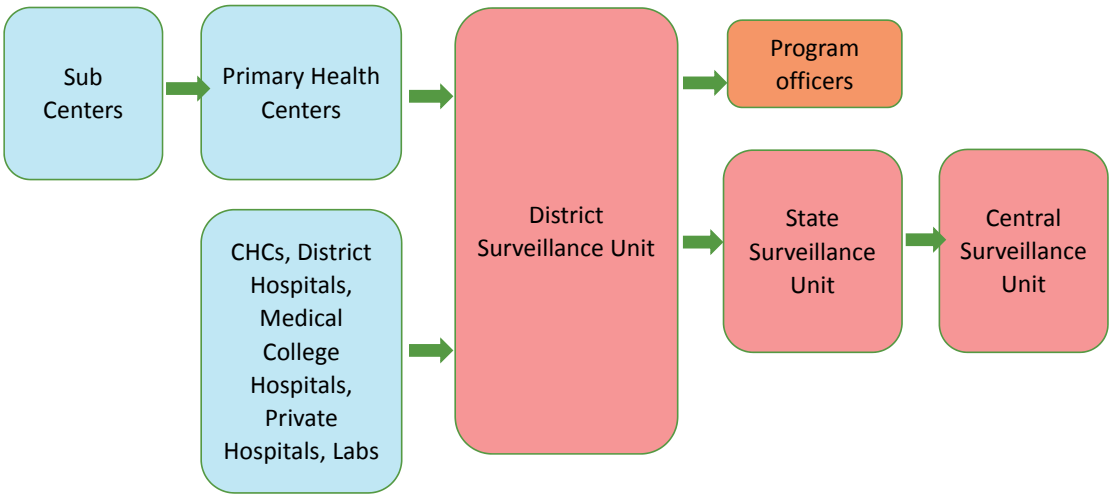
DISEASES MONITORED UNDER THE IDSP

- 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.

7

INFORMATION FLOW UNDER IDSP



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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**

9

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

10

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

11

THANK YOU

12

PPPS FOR URBAN HEALTH

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

3

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

4

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

5

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

6

DIFFERENT MODELS OF PPP IN URBAN HEALTH

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

7

SUCCESS FACTORS FOR PPP

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

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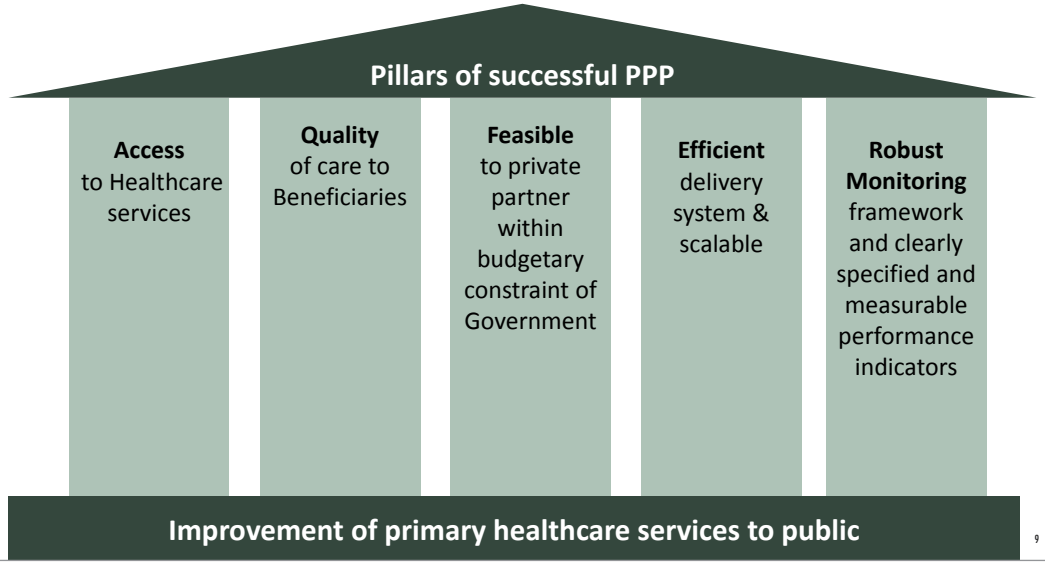
PRINCIPLES FOR SUCCESSFUL PPP PROJECTS



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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

10

THANK YOU

MONITORING AND EVALUATION IN NUHM

Monitoring and Evaluation in NUHM

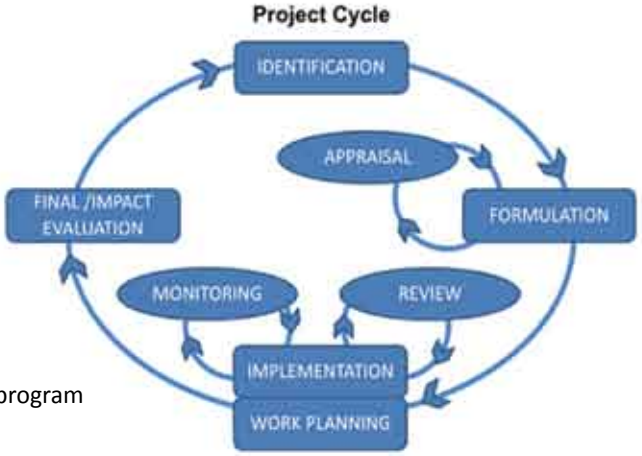
CONTENTS

- 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

3

RESULTS CHAIN

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

Monitoring

Evaluation

4

METHODS TO CHECK PROGRAM PROGRESS

Supervision — Carried out by designated individuals to oversee the productivity & progress of both the workers and the work

Monitoring — Routine/continuous measurement of progress while the project is running and taking the necessary actions for improvement in the project cycle

Evaluation — Measurement of progress, Result and impact when project is completed with relation to time, cost, quality and scope

5

MONITORING

- 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

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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**

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PHASES/TYPES OF EVALUATION

Process Evaluation	Outcome/Effect Evaluation	Impact Evaluation
Aims to assess: ▪ Project content ▪ Scope & coverage ▪ Quality & integrity of implementation	▪ Describes changes in effects and cannot alone produce evidence that a specific programme caused the change ▪ 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

8

DIFFERENCE BETWEEN SUPERVISION, MONITORING & EVALUATION

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

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MONITORING & EVALUATION OF NUHM

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 programs
- 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

Accuracy
- Refers to the correctness of data collected in terms of actual number of services provided or health events organized

Completeness
- Refers to the number of facilities reporting and the number of data elements that they collected

Timeliness
- Making data available 'in time' as planned in order

Consistency
- Reliability of comparing data

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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

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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

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SELECTED INDICATORS FOR MONITORING NUHM

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 U5MR 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

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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 due to faulty data collection, due to faulty data handling or compilation and due to faulty data processing.

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THANK YOU

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HUMAN RESOURCE MANAGEMENT UNDER NUHM

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

3

CATEGORIES OF STAFF UNDER NUHM

HEALTH FACILITY STAFF		PROGRAM STAFF
At UPHC	**At UCHC**	**At State, City and District Levels**
▪ 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)	▪ Specialists: Medicine, Pediatrics, Gynecology, Surgery, Eye etc. ▪ Medical Officers ▪ Paramedical Staff ▪ Finance & Account Staff ▪ Support Staff	▪ 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

Recruitment → **Training & Capacity building** → **Monitoring & Supervision** → **Professional Support** → **Co-ordination**

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**

6

HR MANAGEMENT

Recruitment | **Training & Capacity building** | Monitoring & Supervision | Professional Support | Co-ordination

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

7

HR MANAGEMENT

Recruitment | Training & Capacity building | **Monitoring & Supervision** | Professional Support | Co-ordination

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

8

HR MANAGEMENT

Recruitment | Training & Capacity building | Monitoring & Supervision | **Professional Support** | Co-ordination

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)

9

HR MANAGEMENT

Recruitment | Training & Capacity building | Monitoring & Supervision | Professional Support | **Co-ordination**

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

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MINIMUM STAFF PERFORMANCE NORMS (INDICATIVE)*

Staff	No. of service deliverables in 1 day	
	UPHC	UCHC
M.O	75 OPD cases [@4 min/patient and 5 working hrs]	60 OPD [@5 min/patient]
Specialists		50 OPD [@6min/patient]
ANMs	Given in detail 'Guidebook for ANMs under NUHM'	
LTs	100 Lab Tests	100 Lab Tests
Counselors	Group Counseling: 4 group counseling of 1hr each InterPersonal Counseling: ~8 persons in 2 hours	Same as UPHC
Dentist		30 [20 consultations/day & 10 procedures]
Dental Technician		50 cases
X-ray technician	35 cases [@8 min for each patient X 5hrs]	35 cases [@8 min for each patient X 5hrs]
Pharmacist	120 Prescriptions [@2min for dispensing drugs to each patient for 4 hours rest time for store work]	120 Prescriptions [@2min for dispensing drugs/patient for 4 hours + store work]
Data Entry Operator	75 OPD registrations and 75 other data elements	60 OPD registrations & 75 other entries

*As given for PHC & CHC in DH Strengthening Guidelines. May vary by context for UPHC & UCHC.

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THANK YOU

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FINANCIAL MANAGEMENT & BUDGETING FOR NUHM

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

3

FUNDING FOR NUHM

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:

Conditionality for release of 1st tranche of funds i.e. 75% of BE	Conditionality for release of 2nd tranche of funds i.e. 25% of BE
1.Clearing of the matching State share contribution against releases by GoI.	1.Clearing of the matching State share contribution against releases by GoI
2.Submission of Provisional Utilization Certificates of the preceding financial year	2.Submission of Annual Audited Accounts along with UCs for the preceding Financial Year
3.Submission of Financial Monitoring Reports and Statement of Fund Position for the last quarter	3.Submission of Financial monitoring reports statement of fund position for the last quarter of the preceding financial year

4

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

5

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

6

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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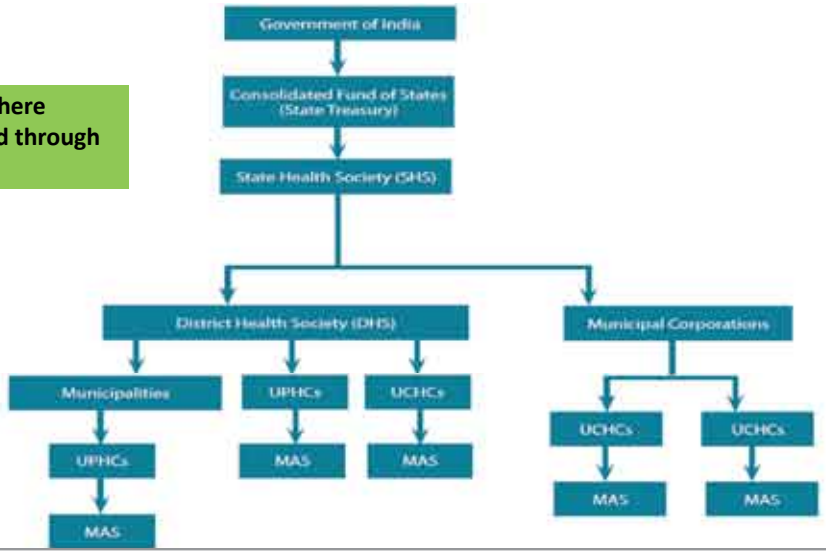
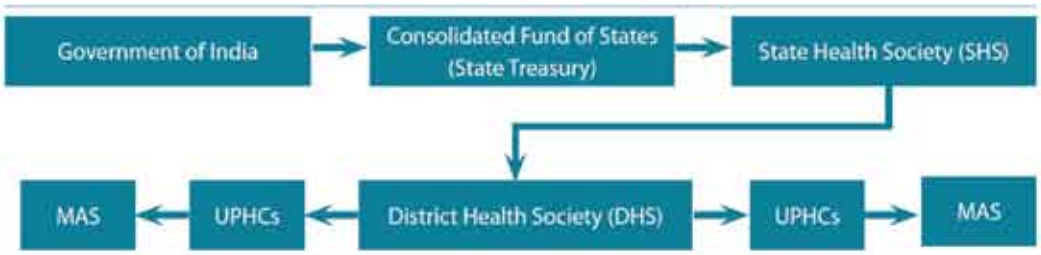
FUND FLOW MECHANISM

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



FUND FLOW MECHANISM

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



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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

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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**

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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

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FINANCIAL REPORTING UNDER NUHM

Unit/ Frequency	Financial Reports and their Timelines		
	Monthly	Quarterly	Annually
State to GoI	• FMR • SFP	• FMR • SFP	• UC (Audited) • Provisional UCs on demand
Municipal Corporations/ULBs to State	• FMR • SFP	• FMR • SFP	• UC (Audited) • Provisional UCs on demand
District to State	• FMR • SFP	• FMR • SFP	• UC (Audited)
UPHCs/UCHCs to their Supervisory Units (including RKS)	• FMR • SFP	• FMR • SFP	• RKS Audit Report

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AUDIT

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

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TYPES OF AUDITS

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.

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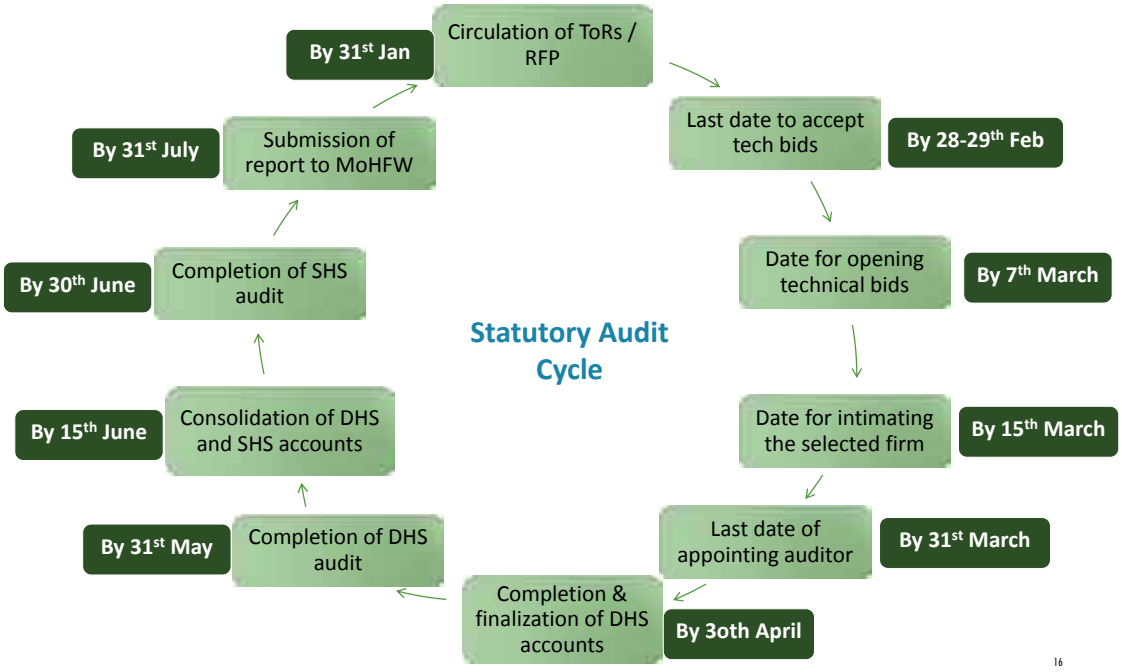

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CONCURRENT AUDIT

- 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

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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

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THANK YOU

INFORMATION & COMMUNICATION STRATEGY FOR NUHM

Information & Communication Strategy for NUHM

CONTENTS

STATE COMMUNICATION STRATEGY

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

3

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

4

ACTION POINTS FOR STATE & ULBS

To meet these objectives, States & ULBs should take the following actions:

- Institutional Branding
- Awareness generation on NUHM & UH Issues
  - Among Beneficiaries
  - Among partners & stakeholders
- Sensitization of service providers

5

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.

6

EXAMPLE OF STANDARD HOARDING (UPHC KERALA)

States may develop own standard and design, which should be uniform throughout the State

7

2. NUHM AWARENESS: FOR BENEFICARIES

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

8

CHANNELS TO REACH BENEFICIARIES

Community Health Workers

Facility Based IEC materials

Effective media Usage

9

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.

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3. SENSITIZATION OF SERVICE PROVIDERS

While service providers may have adequate knowledge on NUHM, they need to be sensitized for providing 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 (eg: domestic violence help center, de-addiction center etc)
- Providing practical solutions to their problems

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THANK YOU

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