National Rural Health Mission Documents

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National Rural Health Mission: Institutional Setup at State level

State Health Mission and State Health Society

At the National level, the NRHM has a Mission Steering Group (MSG) headed by the Union Minister for Health & Family Welfare and an Empowered Programme Committee (EPC) headed by the Union Secretary for Health & FW. The EPC will implement the Mission under the overall guidance of the MSG.

At the State level, the Mission would function under the overall guidance of the State Health Mission headed by the Chief Minister of the State. The functions under the Mission would be carried out through the State Health & Family Welfare Society. The structures of the Mission and Society and their linkages are mentioned in the following paragraphs.

State Health Mission

Composition

- Chairperson : Chief Minister
- Co-Chairperson : Minister of Health and Family Welfare, State Government
- Convener : Principal Secretary/Secretary (Family Welfare)
- Members :
    - • Ministers in charge of Departments relevant to NRHM such as AYUSH, Women and Child Development, Medical Education, Public Health Engineering, Water and Sanitation, Panchayati Raj, Rural Development, Social Welfare, Urban Development, Planning, Finance, etc.
    - • Nominated public representatives (5 to 10 members) such as MPs, MLAs, Chairmen, Zila Parishad, urban local bodies (women should be adequately represented)
    - • Official representatives: Chief Secretary/Development Commissioners and Principal Secretaries/Secretaries in-charge of relevant departments such as Women and Child Development, Public Health Engineering, Panchayati Raj, Rural Development, Tribal Welfare, Urban Development/Affairs, Finance, Planning and Representative, MoHFW, GoI, Director (Health Services)/Director (AYUSH).
    - • Nominated non-official members (5 to 8 members) such as health experts, representatives of medical associations, NGOs, etc
    - • Representatives of Development Partners

Frequency of meetings: At least once in every six months

Ordinary Business: Providing health system oversight, consideration of policy matters related with health sector (including determinants of good health), review of progress in implementation of NRHM; inter-sectoral coordination, advocacy measures required to promote NRHM visibility.

State Health Society

A. Governing Body

- Chairperson: Chief Secretary/Development Commissioner
- Co-Chair : Development Commissioner
- Vice-Chair : Principal/Secretary (Health & Family Welfare)
- Convener : Officer designated as Mission Director of State Health Mission
- Members:
  - Secretaries of the NRHM related Departments: Health & FW, Finance, AYUSH, Women and Child Development, Public Health Engineering, Water and Sanitation, Panchayati Raj, Rural Development, Tribal/SC Welfare, Urban Affairs and Planning and Programme Implementation.
  - DHS, Director AYUSH
  - GoI representative(s): MoHFW nominee.
  - Representatives of Development Partners supporting the NRHM in the State
  - Nominated non-official members: Four to six members (Public Health Professionals, MNGO representatives/ representatives of Medical Associations)
  - Regional Directors

Frequency of meetings: At least once in every six months

Ordinary Business of the Governing Body Meeting:

- Approval / endorsement of Annual State Action Plan for the NRHM.
- Consideration of proposals for institutional reforms in the H&FW sector.
- Review of implementation of the Annual Action Plan.
- Inter-sectoral co-ordination: all NRHM related sectors and beyond (e.g. administrative reforms across the State).
- Status of follow up action on decisions of the State Health Mission.
- Co-ordination with NGOs/Donors/other agencies/organisations.

B. Executive Committee

1. Chairperson : Principal Secretary/Secretary, FW
2. 2. Co-Chair (s) : Principal Secretary/Secretary, Health/FW (in case of separate secretaries in the State)
3. 3. Vice Chair: Director, Health & FW
4. Convener : Executive Director/Mission Director (To be an IAS Officer of JAG/Selection Grade)
4. Joint Secretaries: State Programme Managers/Project Directors of National Disease Control Programme

Members:

1. 1. Director, AYUSH
2. 2. Secretaries / technical officers from NRHM related sectors
3. 3. Executive Secretary, State AIDS Control Society [for the States which decide not to merge it with State Health & FW Society].
4. 4. MoHFW, GoI representative.
5. 5. Regional Directors

Frequency of meetings: At least once in every month

Ordinary Business:

- Detailed expenditure and implementation review.
- Approval of proposals from districts and other implementing agencies/District Action Plans.
- Execution of the approved State Action Plan, including release of funds for programmes at State level as per Annual Action Plan.
- Release of funds to the District Health Societies.
- Finalization of working arrangements for intra-sectoral and inter-sectoral co-ordination.
- Follow up action on decisions of the Governing Body.

C. Programme Committee for Health & FW Sector

The Executive Committee would ensure execution of integrated NRHM State Action Plan. However, for administrative convenience, the State may constitute Programme Committees for the National Programmes for a more focused planning and review of each activity. Suggested constitution of the Committee is as below:

Chairperson: Director
Member-Secretary: Concerned State Programme Manager
Members: Finance Manager (SPMSU), 2-3 related State Programme Managers and Consultants

D. State Programme Management Support Unit (SPMSU)

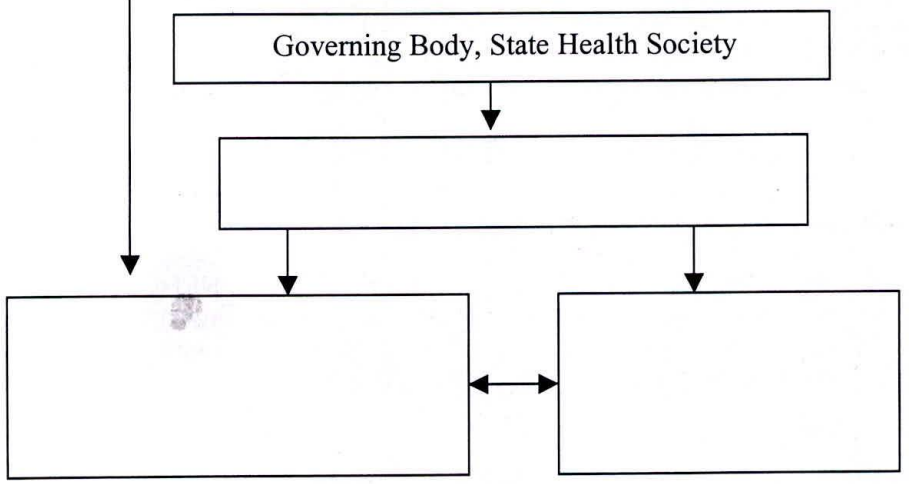
The SPMSU will act as the secretariat to the State Health Mission as well as the State Society. Headed by an Executive Director/Mission Director, the SPMSU will have experts in the areas of human resources, BCC, M&E and other technical areas, recruited from the open market. The SPMSU will provide the technical support to the State Health Mission through its pool of skilled professionals like MBA, CA, MIS Specialist and Consultants for RCH and other National Disease Control Programmes. This technical pool would be accessed by all programmes under NRHM for providing specific programme support related to logistics, financial management, MIS, tracking of funds etc.

After sanction of State Action Plan by the Governing Body of State Health Society and of District Plans by the Executive Committee, funds could be released through joint signatures of two authorized signatories (viz. State Program Manager/DHS and Secretary (HFW/Mission Director). The actual release of funds could either be made by the concerned Programme Management Unit with a copy of the sanction letter to the SPMSU, or vice-a-versa as per the decided State model. However, the responsibility of financial management, including tracking of funds, preparation of Utilization Certificates and audit of the Society, shall be overseen by the SPMSU.

E. Composite Organogram of the State Mission and the State Society

The State Mission and the State Society are inter-linked in terms of a common secretariat as depicted below:

State Health Mission



F. Process of merger of existing societies

After the State Society has been registered, a meeting of the Governing Body of existing State societies in the health and family welfare sector has to be convened to adopt the following resolution:

> " Resolved that the ..... (name of the society) be dissolved with immediate effect and that all assets and liabilities of the said society shall stand transferred to the ..... (name of the State Health Society)."

A signed copy of the above resolution has to be then filed with the Registrar of Societies to complete the process of merger.

Appendices to facilitate creation and functioning of State Society

- Model Memorandum of Association (**Appendix-I**)
- Model Rules and Regulations (**Appendix-II**)
- Generic Bye-laws (**Appendix-III**)

Appendix-I

(Model) MEMORANDUM OF ASSOCIATION OF (State name) HEALTH SOCIETY

1. Name of the Society	The Name of the Society shall be "State Health Society, (State name)" hereinafter referred to as the "Society".
2. Area of operation	The area of operation of the Society shall be whole of the State of .....
3. Location	The Society shall have its office at .....in the State of ..... with liberty for it to establish one or more subordinate offices or outlets elsewhere in the State, if so required.
4. Objectives	The Society shall serve in an additional managerial and technical capacity to the Department of Health & Family Welfare, Government of ..... for the implementation of National Rural Health Mission (NRHM) in the State.
5. Scope of functions	To achieve the above objectives, the Society shall direct its resources towards performance of the following key tasks: • • Receive, manage (including disbursement to implementing agencies e.g. Directorate, District Societies, NGOs etc.) and account for the funds received from the Ministry of Health & Family Welfare, Government of India. • • Manage the NGO / PPP (public–private partnership) components of the NRHM in the State, including execution of contracts, disbursement of funds and monitoring of performance. • • Function as a Resource Centre for the Department of Health & Family Welfare in policy/situational analysis and policy development (including development of operational guidelines and preparation of policy change proposals for the consideration of Government). • • Strengthen the technical / management capacity of the State Directorate as well as of the Districts Societies by various means including through recruitment of individual / institutional experts from the open market (with total programme management costs for the State as a whole not exceeding to 6% of the total programme costs). • • Mobilize financial / non-financial resources for complementing/supplementing the NRHM activities in the State. • • Organize training, meetings, conferences, policy review studies / surveys, workshops and inter-State exchange visits etc. for deriving inputs for improving the implementation of NRHM in the State. • • Undertake such other activities for strengthening NRHM in the State as may be identified from time to time, including mechanisms for intra and inter-sectoral convergence of inputs and structures.

For performing the above tasks, the Society shall:

- • Establish and carry out the administration and management of the Society's Secretariat, which will serve as the implementation arm of the Society.
- • Create administrative, technical and other posts in the Secretariat of the Society as deemed necessary.
- • Establish its own compensation package and employ, retain or dismiss personnel as required.
- • Establish its own procurement procedures and employ the same for procurement of goods and services.
- • Make rules and bye-laws for the conduct of the activities of the Society and its Secretariat and add, rescind or vary them from time to time, as deemed necessary.

6. First members of the Governing Body

The names, addresses, occupations and designations of the First Members of the Governing Body of the Society to whom by the rules and regulations of the Society, the management of the affairs of the Society is entrusted as required under section 2 of the Societies Registration Act, 1860 (No. XXI of 1860) are as follows:

Sl. No.	Name / Designation	Status in Governing Body
1.	Chief Secretary / Development Commissioner	Chairperson
2.	Development Commissioner	Co-Chair
3.	Principal /Secretary, Health & Family Welfare	Vice-Chair
4.	Mission Director of the State Health Mission	Convener
5-7	Principal Secretaries / Secretaries for NRHM related Departments: Finance, AYUSH, Women and Child Development, Nutrition, Water and Sanitation, Panchayati Raj, Rural Development, Social / Tribal Welfare and Urban Affairs /DHS	Members

A copy of the rules of the Society certified to be a correct copy by three members of the Governing Body is filed along with this Memorandum of Association.

7. Declaration

We, the several persons whose names and addresses are given below having associated ourselves for the purpose described in this Memorandum of Association do hereby subscribe our names to this Memorandum of Association and set our several and respective hands hereunto and form ourselves into a Society under the Societies Registration Act, 1860 (Act, No. XXI of 1860): this.....day of 2005

at.....

Sl.	Name	Occupation and address	Status in Society	Signature	Attested by
1					
2					
3					
4					
6					
7					

Dated: _____

Appendix-II

STATE HEALTH SOCIETY, ... (name of State)

THE RULES AND REGULATIONS

1. SHORT TITLE

1.1 These Rules and Regulations shall be called "The Rules and Regulations of the State Health Society (State name), 2005".

1.2 These Rules shall come into force with effect from the date of registration of the Society by the Registrar of Societies.

2. DEFINITIONS

2.1 In the interpretation of these Rules and Regulations, the following expressions shall have the following meaning unless inconsistent with subject or context:

"Act" means Societies Registration Act, 1860.
".....(abbreviation of State Society)" means the State Health Society, ... (State name)[1[1]].
"Central Government" means the Government of India.
"Chairperson" means the Chairperson of the Governing Body of the Society.
"Chief Executive Officer(CEO)" means the chairperson of the Executive Committee of the Society.
"Executive Committee" means the Executive Committee of the Society.
"Executive Secretary" means the Executive Secretary of the Society.
"Governing Body" means the Governing Body of the Society.
"Member" means the Member of the Society.
"Rules" means these Rules and Regulations registered alongwith the memorandum of Association & as may be amended by the Governing Body of the Society from time to time.
"Secretariat" means the Secretariat of the Society.
"State Government" means the Government of ..... (State name).
"Year" means the financial year of the State Government of .... (State name).

3 OFFICE

3.1 Registered office of the Society shall be situated in the premises of ..... located at ..... (address where Society secretariat will be located).

3.2 The Society may set up its branch offices in the State.

4 MEMBERSHIP

4.1 The following shall be the members of the Society:

- First members of the Governing Body.
- Additional ex-officio members of the Governing Body.
- Member Secretary of the Society, to be appointed under these Rules.

1[1] E.g. State Health Society, Haryana (SHSH), State Health Society, Bihar (SHSB) etc.

- Representative(s) of the Government of India.
- Representatives of Development Partners supporting the NRHM activities in the State.
- Representatives of NGOs and/or association of NGOs.
- Representatives of professionals' associations (e.g. IMA, FOGSI, IAP etc.).
- Representatives of other organisations as may be determined by the Governing Body from time to time.
- Individuals as may be nominated by the Governing Body from time to time.

4.2 The membership of an ex-officio member of the Society and of the Governing Body shall terminate when he/she ceases to hold the office by virtue of which he/she was member and his/her successor to the office shall become such member.

4.3 Non official members of the Society will be nominated by the Chairperson in consultation with other members of the Governing Body. Nominated members shall hold office for a period of three years from the date of their nomination by the Chairperson. Such members will be eligible for re-nomination for another period of 3 years.

4.4 The Society shall maintain a roll of members at its registered office and every member shall sign the roll and state therein his/her rank or occupation and address. No member shall be entitled to exercise rights and privileges of a member unless he/she has signed the roll as aforesaid.

4.5 All members of the Governing Body shall cease to be members if they resign, become of unsound mind, become insolvent or be convicted of a criminal offence involving moral turpitude or removal from the post by virtue of which s/he was holding the membership.

4.6 Resignation of membership shall be tendered to the Governing Body in person to its Executive Secretary and shall not take effect until it has been accepted on behalf of the Governing Body by the Chairperson.

4.7 If a member of the Society changes his/her address he/she shall notify his/her new address to the Executive Secretary who shall thereupon enter his/her new address in the roll of member. But if a member fails to notify his/her new address the address in the roll of members shall be deemed to be his/her address.

4.8 Any vacancy in the Society or in the Governing Body shall be filled by the authority entitled to make such appointment. No act or proceedings of the Society or of the Governing Body shall be invalid merely by reason of the existence of any vacancy therein or of any defect in appointment of any of its members.

4.9 No member of the Governing Body, except the Executive Secretary to be appointed as per these Rules, shall be entitled to any remuneration.

5 AUTHORITIES OF THE STATE HEALTH SOCIETY

5.1 The following shall be the bodies and authorities of the Society:

- Governing Body
- Executive Committee
- Programme Committees and such other bodies as may be prescribed by the Governing Body. (Optional)

5.2 GOVERNING BODY

5.2.1 All members of the Society as set out in para 4.1 shall constitute the Governing Body of the Society.

5.2.2 The first members of the Governing Body of the Society shall be those mentioned in Clause 6 of the Memorandum of Association. They shall hold office until a new Governing Body is appointed according to these Rules.

5.2.3 The management of the affairs of the Society shall be entrusted to Governing Body and the property of the Society shall be vested in the Governing Body.

5.2.4 The Society may sue or be sued in the name of the Executive Secretary of the Society or of such other members as shall, in reference to the matter concerned, be appointed by the Governing Body for the occasion.

5.3 PROCEEDINGS OF THE GOVERNING BODY

5.3.1 The meetings of the *Governing Body shall be held at least once in every six months* and at such time and place as the Chairperson shall decide. If the Chairperson receives a requisition for calling a meeting signed by one-third members of the Governing Body, the Chairperson shall call such a meeting as soon as may be reasonably possible and at such place as s/he may deem fit.

5.3.2 At the annual meeting of the Governing Body the following business shall be brought forward and disposed of:

- Income and expenditure account and the balance sheet for the past year.
- Annual report of the Society.
- Budget for the next year.
- Annual Action Plan and research work for the next year.
- Appointments for the Executive Committee and the various Committees.
- Other business brought forward with the permission of the Chairperson.

5.3.3 Every notice calling meeting of the Governing Body shall state the date, time and place at which such meeting will be held and shall be served upon every member of the Governing Body not less than twenty one clear days before the date appointed for the meeting. Such notice shall be under the hand of the Executive Secretary and shall be accompanied by an agenda of the business to be placed before the meeting provided that accidental omission to give such notice to any member shall not invalidate any resolution passed at such meeting. In the event of any urgent business the Chairperson may call the meeting of the Governing Body at clear ten days notice.

5.3.4 The Chairperson shall take the Chair at the meetings of the Governing Body. In his/her absence, the Co-Chair or in his/her absence, the Vice-Chairperson will chair the meeting, failing which the Governing Body shall elect one from among the members present as Chairperson of the meeting.

5.2.5 One third of the members of the Governing Body, including the substitutes nominated under Rule 5.2.7 present in person, shall form a quorum at every meeting of the Governing Body.

5.2.6 All disputed questions at the meeting of the Governing Body shall be determined by votes. Each member of the Governing Body shall have one vote and in case of any equality of votes the Chairperson shall have a casting vote.

5.2.7 Should any official members be prevented for any reason whatsoever from attending a meeting of the Governing Body the Chairperson of the Society shall be at liberty to nominate a substitute to take his place at the meeting of the Governing Body. Such, substitute shall have all the rights and privileges of a member of the Governing Body for that meeting only.

5.2.8 Any member desirous of moving any resolution at a meeting of the Governing Body shall give notice there of in writing to the Executive Secretary of not less than ten clear days before the day of such meetings.

5.2.9 Any business which it may become necessary for the Governing Body to perform except such as may be placed before its Annual meeting may be carried out by circulation among all its members and any resolution so circulated and approved by majority of the members signing shall be as effectual and binding as if such resolution had been passed at a meeting of the Governing Body provided that at least one third members of the Governing Body have recorded their consent of such resolution.

5.2.10 In the event of any urgent business, the Chairperson of the Society may take a decision on behalf of the Governing Body. Such a decision shall be reported to the Governing Body at its next meeting for ratification.

5.2.11 A copy of the minutes of the proceedings of each meeting shall be furnished to the Governing Body members as soon as possible after completion of the meeting.

5.4 POWERS OF THE GOVERNING BODY

5.4.1 The Governing Body will have full control of the affairs of the Society and will have authority to exercise and perform all the powers, acts and deeds of the Society consistent with the aims and objects of the Society.

5.4.2 In particular and without prejudice to the generality of foregoing provision, the Governing Body may:

- Make, amend, or repeal any bye laws relating to administration and management of the affairs of the Society subject to the observance of the provisions contained in the Act.
- Consider the annual budget and the annual action plan, its subsequent alternations placed before it by the Executive Secretary from time to time and to pass it with such modifications as the Governing Body may think fit.
- Monitor the financial position of the Society in order to ensure smooth income flow and to review annual audited accounts.
- Accept donations and endowments or give grants upon such terms as it thinks fit.
- Delegate its powers, to the Chairperson, Chief Executive Officer, Executive Secretary or other authorities of the Society as it may deem fit.
- Appoint committees, sub-committees and boards etc. for such purpose and on such terms as it may deem fit, and to dissolve / remove any of them.
- Develop and adopt its own rules and regulations for recruitment and appointment of experts and administrative / technical staff and set its own

compensation package for such experts / staff to be recruited from the open market and/or deputation basis.

- Develop and adopt its own procurement procedures for procurement of goods and services.
- • Authorise the Executive Secretary to execute such contracts on behalf of the Society as it may deem fit in the conduct of the business of the Society.
- Do generally all such acts and things as may be necessary or incidental to carrying out the objectives of the Society or any of them, provided that nothing herein contained shall authorize the Governing Body to do any act or to pass any bye-laws which may be repugnant to the provisions hereof, to the powers hereby conferred on the Governing Body and other authorities, or which may be inconsistent with the objectives of the Society.

5.5 POWERS AND FUNCTIONS OF THE CHAIRPERSON OF THE GOVERNING BODY

5.5.1 The Chairperson shall have the powers to call for and preside over all meetings of the Governing Body.

5.5.2 The Chairperson may himself/herself call, or by a requisition in writing signed by him/her, may require the Executive Secretary to call, a meeting of the Governing Body at any time and on the receipt of such requisition, the Executive Secretary shall forthwith call such a meeting.

5.5.3 The Chairperson shall enjoy such powers as may be delegated to him by the Governing Body.

5.5.4 The Chairperson shall have the authority to review periodically the work and progress of the Society and to order inquiries into the affairs of the Society and to pass orders on the recommendations of the reviewing or inquiry Committee.

5.5.5 Nothing in these Rules shall prevent the Chairperson from exercising any or all the powers of the Governing Body in case of emergencies in furtherance of the objects of the Society. However, the action taken by the Chairperson on such occasions shall be reported to the Governing Body subsequently for ratification.

5.6 EXECUTIVE COMMITTEE

5.6.1 The Governing Body will constitute an Executive Committee which will be responsible for acting for and doing all deeds on behalf of the Governing Body and for taking all decisions and exercising all the powers, vested in the Governing Body except those which the Governing Body may specifically specify to be excluded from the jurisdiction of by the Executive Committee.

5.6.2 The composition of the Executive Committee shall be as follows:

Sl. No.	Name / designation	Status in Executive Committee
1	Principal Secretary (HFW)/ Secretary, (FW)	Chairperson, Executive Committee.
2	Principal Secretary (Health)/Secretary (FW)	Co-Chairperson
3	Director, Health & FW	Vice Chair
4-7	Programme Managers/Project Directors of	Joint Secretaries

	National Disease Control Programme	
8-10	Secretaries/technical officers from NRHM related sectors	Members
11	Director, AYUSH	Member
12	Representative of Development Partners	Members
13	Representative of Ministry of Health & FW, Govt of India	Member
14	Regional Director of Health & FW, GoI	Member
15	Mission Director/Executive Director of the Society	Convenor

5.6.3 The Executive Committee may co-opt additional members and/or invite subject experts to its meetings from time to time.

5.6.4 Meetings of the Executive Committee shall be convened by the Convenor by giving clear seven days notice in writing alongwith the Agenda specifying the business to be transacted, the date, time and venue of the meeting.

5.6.5 Meetings of the Executive Committee shall be held at least once a month or more frequently if necessary.

5.6.6 The minutes of the Executive Committee meetings will be placed before the Governing Body at its next meeting.

5.6.7 The various Committees constituted by the Governing Body shall submit their reports to the Executive Committee who shall be empowered to take decisions on their recommendations.

5.7 SOCIETY SECRETARIAT AND MISSION DIRECTOR/EXECUTIVE DIRECTOR

5.7.1 A Senior Officer of the State Government of the rank of Special Secretary/Additional Secretary (an IAS Officer of JAG/Selection Grade) shall be nominated as the Mission Director. Governing Body, with the assistance of the Joint Secretary and officials such as Director/DG Health Services/Executive Director, will establish a Secretariat of the Society consisting of technical, financial and management professionals to serve as the implementation arm of the Society.

5.7.2 The Secretariat shall consist of all such technical / management units put together and as may be determined by the Governing Body with due regard to the scope of functions as set out in Article 5 of the Memorandum of Association.

5.7.3 The Executive Committee of the Society will have overall responsibility for planning and executing the work of the Secretariat, for supervising the work of the technical/management units of the Secretariat, directing and overseeing implementation through the Secretariat.

5.8 POWERS AND FUNCTIONS OF THE SECRETARIAT

5.8.1 The Secretariat of the Society shall consist of the Mission Director and Staff of the Society, including experts and consultants.

5.8.2 As the implementation arm of the Society, the Secretariat will be responsible for day-to-day management of the Society's activities. In particular, it will be responsible for performing all functions of the Society as set out in article 5 of the MoA.

5.8.3 As a support structure for assisting Department of Health & FW of the State Government, the Secretariat shall:

- cause its experts and staff to be subjected to such operational arrangements with the Directorate (including seating and reporting arrangements) as to generate synergies,
- host external experts within its premises, and
- provide such logistic support to the officers and staff of the Directorate and Department of Health & FW of the State Government as may be determined by the Governing Body.

6 FUNDS OF THE SOCIETY

6.1 6.1 The funds of the Society shall consist of the following:

- Cash assistance received from the Government of India.
- Grants-in-Aid from the State Government.
- Grants and donations from trade, industry, institutions and individuals.
- Receipts from disposal of assets.

The assets and liabilities of all Societies merged into the Integrated Society shall be subsumed within the new Society.

7 ACCOUNTS AND AUDIT

7.1 The Society shall cause regular accounts to be kept of all its monies and properties in respect of the affairs of the Society.

7.2 The Executive Committee may cause separate Bank Accounts in respect of each scheme or separate ledgers for each scheme under one account. In such an event, the Governing Body shall prescribe written instructions relating to submission of Statement of Expenditure (SoE) for each scheme. The separate Accounts of different Programmes could be audited by different auditors, and submitted to Programme Units separately. However, the SPMSU will ensure one integrated audit of the State Health Society.

7.3 The accounts of the Society shall be audited annually by a Chartered Accountant firm included in the panel of Comptroller and Auditor General of India or any qualified person appointed by the Government of India/State Government and any expenditure incurred in connection with such audit shall be payable by the Society to the Auditors. The Office of the Accountant General of State may also, at its discretion, audit the accounts of the society.

7.4 The Chartered Accountant or any qualified person appointed by the Govt. of India/State Government in connection with the audit of the accounts of the Society shall have the same rights, privileges and authority in connection with such audit as the Auditor General of the State has in connection with the audit of Government accounts and in particular shall have the right to demand the production of books, accounts, connected vouchers and other necessary documents and papers.

7.5 The report of such audit shall be communicated by the auditor to the Society, which shall submit a copy of the Audit Report alongwith its observation to the State Government.

7.6 The Auditor shall also forward a copy of the report to the Chairperson of the Society and representative(s) of the Government of India on the Governing Board.

8 BANK ACCOUNT

8.1 The account of the Society shall be opened in a nationalised bank approved by the Executive Committee or in a scheduled commercial bank as may be specified by the MoHFW, Government of India. All funds shall be paid into the Society's account with the appointed bank and shall not be withdrawn except through a cheque, bill note, other negotiable instruments or through electronic banking (e-banking) procedures signed/electronically authorised by such authorities of the Society Secretariat as may be determined by the Executive Committee.

8.2 The Society shall switch over to e-banking procedures as and when the MoHFW, Government of India directs the Society to do so as the principal donor to the Society.

8.3 The Executive Committee shall authorise the Executive Director (Mission Director) to operate the accounts of the Society in conjunction with another senior official as may be decided by the Committee.

9 ANNUAL REPORT

9.1 A draft annual report and the yearly accounts of the Society shall be placed before the Governing Body at next meeting for consideration and approval. A copy of the annual report and audited statement of accounts as finally approved by the Governing Body shall be forwarded within six months of the closure of a financial year to the Chairperson of the Governing Body and Government of India representatives on the Governing Body.

10 SUITS AND PROCEEDINGS

10.1 The Society may sue or be sued in the name of Society through its Mission Director.

10.2 No suit or proceedings shall abate by the reason of any vacancy or change in the holder of the office of the Chairperson or Executive Secretary or any oofice bearer authorised in this behalf.

10.3 Every decree or order against the Society in any suit or proceedings shall be executable against the property of the Society and not against the person or the property of the Chairperson, Executive Secretary or any office bearer of the Society.

10.4 Nothing in sub-rule 10.3 above shall exempt the Chairperson, Executive Secretary or office bearer of the Society from any criminal liability or entitle him/her to claim any contribution from the property of the Society in respect of any fine to be paid by him/her on conviction by a criminal court.

11 AMENDMENTS

11.1 The Society may alter or extend the purpose for which it is established and/or the Rules of the Society.

11.2 The proposition for any alteration or extension to the objectives of the Society and / or the Rules must be circulated to all members of the Governing Body and must be included in the written agenda of the ensuing meeting of the Governing Body or a special meeting of the Governing Body.

11.3 No amendments shall be effective unless the proposals in this regard have been endorsed by $3/5^{th}$ of the members of the Governing Body provided that such proposals have been endorsed in writing by the GoI representatives on the Governing Body either during the meeting of the Governing Body or through a written communication.

12 DISSOLUTION

12.1 The Governing Body may resolve to dissolve the Society by bringing a proposal to that effect in a special meeting to be convened for the purpose.

12.2 Upon the dissolution of the Society, all assets of the Society, after the settlement of all its debts and liabilities, shall stand reverted to the State Government of Bihar for such purposes as it may deem fit.

13 MISCLELLANEOUS

13.1 CONTRACTS

13.1.1 All contracts and other instruments for and on behalf of the Society shall be subject to the provisions of the Act, be expressed to be made in the name of the Society and shall be executed by the persons authorised by the Governing Body.

13.1.2 No contracts for the sale, purchase or supply of any goods and material shall be made for and on behalf of the Society with any member of the Society or his/her relative or firm in which such member or his/her relative is a partner or shareholder or any other partner or shareholder of a firm or a private company in which the said member is a partner or director.

13.2 COMMON SEAL

13.2.1 The Society shall have a common seal of such make and design as the Governing Body may approve.

13.3 COMPLIANCE OF STATUTORY REQUIREMENTS

13.3.1 The Society shall register itself with relevant government agencies for the purpose of complying with the statutory requirements including regulations governing deduction of tax at source relating to the staff, consultants and experts employed by it and/or consultancies / contracts awarded by it in the course of performance of its tasks.

13.4 GOVERNMENT POWER TO REVIEW

13.4.1 Notwithstanding anything to the contrary contained in these Rules, the Ministry of Health & FW, Government of India, as the principal donor to the Society, may appoint one or more persons to review the work and progress of the Society and hold enquiries into the affairs thereof and report thereon, get the accounts of the society audited by the internal audit parties of the Chief controller of Accounts, MoHFW, GoI, and issue directions, as deemed appropriate, to the Society.

13.4.2 The Chairperson of the Governing Body shall have the right to nominate one or more persons to be part of the review / enquiries.

13.4.3 The progress review reports and / or enquiry reports shall be included in the written agenda of the ensuing meeting of the Governing Body.

We, the undersigned being three of the members of the first Governing Body of the State Health Society, ... (State name) certify that the above is a correct copy of the Rules and Regulations of the said Society.

Sl. No.	Name and address	Signature
1		
2		
3		

Dated :_____

Appendix-III

(Generic) Bye-laws of the State Health Society, ...(State name)

A Procurement Policy and Procedures

Procurement of goods and services to be financed from funds received from Government of India shall be done as per the procedures recommended by the Government of India.

In all other cases, including where the GoI allows the State a choice, following order of preference shall be applied for procurement of goods and services:

Procurement of Goods:

A. A. Rate contracts of the DGS&D, failing which,
B. B. Rate contracts of other GoI agencies, failing which,
C. C. Tender procedure as recommended by GOI.

Procurement of services: Procedure as recommended by the GOI.

B Procedure for release of funds and Financial Powers of the Office Bearers of the Governing / Executive Committee

I Classification of Items of Expenditure and Financial powers of the bodies and office bearers of the Society

- *(For ensuring smooth flow of funds for the approved plans and activities, it is necessary that proper delegation of administrative and financial powers is made at each level. A model delegation is suggested below, which each State/UT may consider keeping in view their existing systems and procedures and suitably modify/add for meeting State's own requirements and all relevant aspects)*

Type of expenditure	Authority	Extent of power
A: Approval of District /City plans.	Governing Body / Executive Committee	Full powers
B: Release of funds for implementation of plans / allocations which have been approved by Governing Body / Executive Committee.	Mission Director/DHS*	Full powers.
C: Expenditure proposals not covered under categories A and/or B		
C-1: Procurement of goods	Chairperson, Executive Committee	More than Rs 5.00 lakh and upto Rs. 10.00 lakh per case.
C-2: Repairs and minor civil works C-3: Procurement of services for specific tasks including outsourcing of support services for the Directorate.	Mission Director	Upto Rs. 5.00 lakh per case.
C-4: Hiring of contractual staff, including sanction of compensation package.	Chairperson, Executive Committee	Full powers, provided that the contracts shall be for a period not exceeding 11 months at a time.

Type of expenditure	Authority	Extent of power
	Mission Director	Full powers in respect of Clerical / Class-IV equivalent positions, subject to compensation package approved by the Governing / Executive Committee, provided that the contracts shall be for a period not exceeding 11 months at a time.
C-5: Miscellaneous items not mentioned above such as hiring of taxis, hiring of auditors, payments relating to documentation and other day-to-day services, meetings and workshops, training, purchase of training material/ books and magazines, payment of TA/DA and honoraria to resource persons and guest speakers invited to meetings / workshops, and payment of TA/DA allowances for contractual staff and/or non-official invitees to Governing Body /Executive Committee meetings and/or Government / Society staff deputed to meetings outside the State.	Chairperson, Executive Committee	Upto Rs. 5.00 lakh at a time subject to a maximum of Rs. 50 lakh per annum.
	Mission Director	Upto Rs 2.00 lakh at a time, subject to a maximum of Rs. 25.00 lakh per annum.

*as authorized by the State Government.

II Procedure for release of funds

The Society funds shall be drawn through cheques and/or bank drafts and/or through e-banking instruments as and when the same is introduced.

All cheques shall be signed by two authorised signatories of the Society Secretariat on the basis of a written authorisation from Executive Committee of the Society in this behalf.

Wherever releases are decided to be made through bank drafts and/or through e-banking, the authorisation letter to the bank shall be signed by the concerned authorised signatories.

Wherever, under e-banking procedures, releases are to be made through electronic authorisation to the bank to issue cheque/draft/account transfer on behalf of the Society, the electronic authorisation will be executed by the same two authorised functionaries of the Society Secretariat who have been authorised to sign cheques on the basis of a written authorisation in this behalf.

III Review / revision of financial powers

The Executive Committee may review and revise the financial powers of the office bearers of the bodies of the Society on an annual basis and revise the same, if considered necessary.

C Human Resources Policy and Procedures

Recruitment and Appointment

Appointments for the Society can be made only against vacant posts prescribed for the Society in accordance with the conditions in this regard prescribed by the Govt. of India from time to time, (such as the overall programme management costs not to exceed 6% of the total programme costs).

Recruitment would be through either of the following three routes:

- Appointments from open market: all such appointments will be on contractual basis for a fixed tenure.
- Appointments on "Deputation" basis : all such appointments will be regulated in terms of the State Government rules relating to Deputation of its officers / staff.
- Individuals recruited and paid for by an outside agency [e.g. Government of India and/or Development Partners] but posted to work within the Society Secretariat: all such persons shall be governed by the terms of employment of the organisation agency concerned. However, they shall be required to report to the Director / Executive Secretary as may be decided by the Chairperson, Executive Committee.

All appointments would be temporary and would be made for the contract / deputation period as determined by the Executive Committee.

Leave rules

Holidays, Casual Leave, Medical Leave: The Society staff and the full time consultants shall be governed by the State Government rules, in so far as observance of holidays and grant of casual / medical leave is concerned.

Leave without pay: The Society staff (including full time consultants) shall be entitled to take leave without pay in exceptional circumstances. This can be sanctioned by the Executive Secretary after recording the reasons. For the Executive Secretary, this would have to be endorsed by the Chairperson, Executive Committee.

Training and capability development:

Full time consultants and staff of the Society (including staff on deputation) would be encouraged to take up skill development courses and even correspondence courses which further their employment prospects, enhance their skills, and build up Society capabilities.

Travelling / Dearness Allowance (TA/DA) Rules

Travel within State: Travel of Society staff (including those who are employed by the Society on deputation basis) within the State shall be governed as per the entitlements given in the table below.

	Executive Secretary and senior officers on 'deputation' to the Society	Full time senior consultants	Junior / clerical staff
Entitlement for rail travel	2nd AC / AC Chair Car	2nd AC / AC Chair Car	3rd AC / AC Chair
Entitlement for road travel [1]	Taxi	Taxi	Bus/Shared taxi [2]

Per-diem when hotel is not used	Rs. 300/- per day	Rs. 200/- per day	Rs. 300/- per day
Per-diem when hotel is used [3]	Rs. 1000/- per night [4]	Rs 500/- per night [4]	Rs. 500/- per night [4]

Notes: [1]: The Society shall create a panel of accredited taxi operators through open tender for hiring the taxis for the travel of Society staff.
[2]: The Executive Secretary can allow the junior staff to use a taxi for undertaking travel as per an approved itinerary.
[3]: The Society shall identify and negotiate a standard/discounted tariff for its staff / employees with the State Tourism Corporation, guest houses of PSUs and budget / hotels in the State.
[4]: Maximum, subject to actuals.

Travel outside the State: Travel outside the State shall be regulated on a case to case basis in accordance with delegated financial powers as indicated in Section-B above (Financial Powers, item C-5).

Deduction of Tax at Source: Tax will be deducted at source as per income tax rules and the Society shall register itself with the relevant authorities in this regard.

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National Rural Health Mission: Institutional Setup at the District level

District Health Mission and the District Health Society

On the lines of the State Health Mission, every district will have a 'District Health Mission' headed by the Chairperson, Zila Parishad. It will have the District Collector as the Co-Chair and Chief Medical Officer as the Mission Director.

-

To support the District Health Mission, every district will have an integrated District Health Society (DHS) and all the existing societies as vertical support structures for different national and state health programmes will be merged in the DHS. The DHS will be responsible for planning and managing *all* health and family welfare programmes in the district, both in the *rural as well as urban* areas. There are two important implications of this requirement. Firstly, DHS's planning will have to take note of both treasury and non-treasury sources of funds, even though it may not be handling all sources directly. Secondly, its geographical jurisdiction will be greater than those of the Zilla Parishad and /or Urban Local Bodies (ULBs) in the district[2[2]].

Ensuring Inter-sectoral convergence and integrated planning should be a specific task for the Governing Body of the DHS. However, the DHS is not meant to take over the executive functions of the ZP / ULBs and/or the district health administration. On the contrary, DHS is meant to provide the platform where the three arms of governance – ZP, ULBs and district health administration and district programme managers of NRHM sectors get together to decide on health issues of the district and delineate their mutual roles and responsibilities.

The DHS may also be viewed as an addition to the district administration's capacity, particularly for planning, budgeting and budget analysis, development of *operational policy*[3[3]] proposals, and financial management etc. Because it is a legal entity, the DHS can set up its own office which has adequate contingent of staff and experts and can evolve its own rules and procedures for hiring the staff and experts both from the open market as well as on deputation from the Government.

In other words, the DHS is not an implementing agency; it is a facilitating mechanism for the district health administration as also the mechanism for joint planning by NRHM related sectors.

B Governance structure

B.1 District Health Mission

Chairperson:	Chairman, Zilla Parishad
Co-Chair:	District Collector/DM
Vice Chair:	CEO Zila Parishad

2[2] The 74th Amendment provides for creation of a District Planning Committee to consolidate the plans prepared by Panchayats and Municipalities in the district and to prepare a draft development plan for the district as a whole. However, the DPC's role is limited to planning only and does not include management functions.

3[3] At the district level, operational policy will relate to decisions about procedures, priorities etc. which set the precedent about what management actions are to be followed by the programme managers. For example, the DHS may be authorised to relocate all or some categories of staff within the district. The DHS will be required to evolve and approve a procedure to be followed by the programme managers in this regard.

* The State may decide to designate Convenor of the District Health Mission as Mission Director in respect of the District Health Mission

Convener*:	Chief Medical Officer/CDMO/CMHO/Civil Surgeon
Members:	MPs, MLAs, MLCs from the district, Chair-persons of the Standing Committees of the Zilla Parishad, Project Officer (DRDA), Chair-persons of the Panchayat Samitis and Hospital Management Societies, District Programme Managers for health, PHED, ICDS, AYUSH, education, social welfare, Panchayati Raj, State representative, representatives of MNGO/SNGO, etc.

B.2 District Health Society

The overall governance structure of the Society may be as depicted in Diagram-1 below.

Diagram-1: Governance Structure of the DHS

Governing Body

Chair:	District Collector/DM/CEO Zilla Parishad
Co-Chair:	DDC cum CEO, Zilla Parishad
Chief Executive Officer:	Chief Medical Officer/CDMO/Civil Surgeon
Members:	Project Officer (DRDA), District Programme Managers for Health, AYUSH, Water and Sanitation [under Total Sanitation Campaign (TSC)], DPMSU, PHED, ICDS, education, social welfare, Panchayati Raj, a State representative, Sub-Divisional Officer, CHC In-charge; representatives of Medical Association/MNGO/SNGO and Development Partners

Executive Committee

Chair :	DDC cum CEO Zilla Parishad (CMO in case no Post of DDC/CEO Zilla Parishad is notified in the district
Co-chair :	CMO/CDMO/CMHO/CS
Chief Executive Officer and Convener :	District Programme Manager/District RCH Officer
Members:	Superintendent-District Hospital, All District Programme

DHS Secretariat
District Programme Manager**, programme managers for projects sponsored by Development Partners and support staff

↔

Programme Committees for the health sector

**** Presently, 3 posts at each District level have been sanctioned by GoI in EAG States. However, in other States also, these may be provided by the States themselves within 6% of the overall programme costs for the State as a whole. Till such time these are provided and actually recruited, a Dy. CMO level officer may be designated as such to function as the District Programme Manager.***

C Role of the District Programme Manager, DHS Secretariat

S/he is seen as the key player not only in setting up and operationalising the DHS secretariat, but also in arranging managerial and supportive assistance to the district health administration, including general management and logistic support. It is because of the twin responsibility that s/he is been made the Convenor of both the Governing Body as well as the Executive Committee. In the Programme Committees, however, s/he will be a simple member.

The specific responsibilities of the District Programme Manager, DHS will include, but not be limited to the following:

A: Management of DHS Secretariat

(a) (a) Facilitate the working of the DHS as per the bye-laws of the Society.
(b) (b) Organise recruitment of personnel for the DHS.
(c) (c) Maintain records of the Society.
(d) (d) Organise meetings of the Governing Body and Executive Committee including preparation of agenda notes, circulation of minutes and compilation of action taken reports etc.
(e) (e) Organise audit of the Society funds and preparation of annual report of the DHS as required under the Bye-laws.

B: Planning, Monitoring and Evaluation

(a) (a) Create and maintain district resource database for the health sector including manpower, buildings, equipments and other support infrastructure.
(b) (b) Assist the Civil Surgeon and district programme managers in developing the 'District Work Plan' based on the National & State goals.
(c) (c) Undertake regular monitoring of initiatives being implemented in the district and provide regular report and feedback to the Society and others who are entitles to receive Annual Report of the Society [District Collector, Chairperson, Zila Parishad, designated authority State Government].
(d) (d) Ensure compilation, analysis & presentation of relevant information in meaningful formats and assist the Civil Surgeon in making informed discussions.
(e) (e) Develop strategies/plans to improve the quality of services and present to the Society for approval.

B: Inventory management, Procurement & Logistics

(a) (a) Facilitate preparation of District Logistics Plan for optimal allocation of resources at each facility.
(b) (b) Ensure timely collection and compilation of 'demands' and their timely dispatch.

D DHS Secretariat

Initially, the Society Secretariat will have a core team of 3 full time persons, consisting of the following:

- District Programme Manager (who have been prescribed to be appointed by GoI in EAG States) or Dy. CMO (in the case of other States, designated as such) since actual programme implementation will remain with the programme managers under district
- Finance / Accounts Manager, and
- Data Assistant.

Once the Society Secretariat is operationalised (i.e., the above core staff is in place and the office is set up), the district programme officer posts sponsored under the Centrally Sponsored Schemes and the contractual staff/consultants under the various Health Programmes and bilateral/multi-lateral funding programmes may be brought under the District Health Secretariat.

Eventually (that is, after integration of the posts sponsored under the Centrally Sponsored Schemes with the DHS), the DHS will have a number of functional units including technical officers belonging to State Medical Services posted on deputation to the District Society Secretariat. This will not only allow the DHS to exercise a choice in the selection of district programme managers, the tenure issue will also be addressed since all deputation postings will be for a minimum period of 3 years.

E Procedure for recruitment and appointment of contractual staff

Recruitment can be facilitated by the State Society as this would allow economies of scale and save time.

However, offer letters should be issued by the District Society on the basis of a specimen offer letter (see Appendix-IV, State Society).

The recruitment of the specialists for the hospitals can be similarly organised by the State Society or the District Society. After recruitment, however, the offer letters should be issued by the Hospital Management Society.

F Process of merger of existing societies into integrated District Health Society

After the District Health Society has been registered, a special meeting of the Governing Body of existing district societies in the health sector has to be convened to adopt the following resolutions:

> " Resolved that the ..... (name of the society) be dissolved with immediate effect and that all assets and liabilities of the said society shall stand transferred to the District Health Society, district ..... (district name)."

A signed copy of the above resolution has to be then filed with the Registrar of Societies to complete the process of merger.

Appendices to facilitate creation and functioning of Integrated District Societies

- Model Memorandum of Association (**Appendix-I**)
- Model Rules and Regulations (**Appendix-II**)
- Generic Bye-laws (**Appendix-III**)

Appendix-I

(Model) Memorandum of Association for the District Health Society

1. Name of the Society	The Name of the Society shall be "District Health Society, District.....or DHS (district name)".
2. Area of operation	The area of operation of the Society shall be whole of district ..... (district name)
3. Location	The Society shall have its office at the office of Chief Medical Officer/ Civil Surgeon / Chief Medical and Health Officer / Chief District Health Officer, ... district, situated at ..... (postal address)
4. Objectives	The Society shall assist district health administration in the implementation of various health programmes and projects in the district, with special emphasis on priority sectors like reproductive and child health, population control, control of malaria, TB and leprosy and prevention of blindness and malnutrition etc.
5. Scope of functions	To achieve the above objectives, the Society shall direct its resources towards performance of the following key tasks: • • To act as the nodal forum for all stake holders – line departments, PRI and NGOs- to participate in planning, implementation and monitoring of the various health and family welfare programmes and projects in the district. • • To receive, manage and account for the funds received from the State Government (including State level Societies in the health sector) for implementation of Centrally Sponsored Schemes in the district. • • To strengthen the technical / management capacity of the District Health Administration through recruitment of individual / institutional experts from the open market. • • To facilitate preparation of integrated district health development plans, for health and its various determinants like sanitation, nutrition and safe drinking water, etc. • • To guide the functions related to 'Total Sanitation Campaign' at the District level. • • To mobilise financial and non-financial resources for complementing/supplementing the health and family welfare activities in the district. • • To assist hospital management societies in the district. • • To undertake such other activities for strengthening health and family welfare activities in the district as may be identified from time to time, including mechanisms for intra and inter-sectoral convergence of inputs and structures.
6. First members of	The names, addresses, occupations and designations of the

	the Governing Body	First Members of the Governing Body of the Society to whom by the rules and regulations of the Society, the management of the affairs of the Society is entrusted as required under section 2 of the Societies Registration Act, 1860 (No. XXI of 1860) are as follows:-

Sl. No.	Name / Designation	Status in the Governing Body
1.	District Collector/DM	Chair-person
2.	DDC	Co-Chair
3.	Civil Surgeon/Chief Medical Officer	Chief Executive Officer (CEO) r
4.	Project Director, DRDA	Member
5.	District Social Welfare Officer	Member
6.	District Programme Officer (ICDS)	Member
7.	District Programme Officer (AYUSH)	Member
8.	District Programme Officer (Primary Education)	Member
9.	District Programme Officer (Rural Development)	Member
10.	District Programme Manager	Convenor

A copy of the rules of the Society certified to be a correct copy by three members of the Governing Body is filed along with this Memorandum of Association.

7. Declaration

We, the several persons whose names and addresses are given below having associated ourselves for the purpose described in this Memorandum of Association do hereby subscribe our names to this Memorandum of Association and set our several and respective hands hereunto and form ourselves into a Society under the Societies Registration Act, 1860 (Act, No.XXI of 1860): this.....day of 2005 at .....

Sl.	Name	Occupation and address	Status in Society	Signature	Attested by
1					
2					
3					
4					
6					
7					
8					
9					

Appendix-II

(Model) Rules / Regulations of the District Health Society

1. SHORT TITLE

1.1 These Rules and Regulations shall be called "The Rules and Regulations of the District Health Society (District .....), 2005".

1.2 These Rules shall come into force with effect from the date of registration of the Society by the Registrar of Societies.

2. DEFINITIONS

2.1 In the interpretation of these Rules and Regulations, the following expressions shall have the following unless inconsistent with subject or context:

"Act" means Societies Registration Act, 1860.
"Central Government" means the Government of India.
"DHS" means the District Health Society
"Executive Committee" means the Executive Committee as referred to in these Rules.
"District Programme Manager" means the Programme Manager cum Convenor of the Society as referred to in these Rules.
"Governing Body" means the Governing Body of the Society as referred to in these Rules.
"Member" means the Member of the Society as referred to in these Rules.
"Rules" means these Rules and Regulations registered along with the memorandum of Association & as may be amended by the Governing Body of the Society from time to time.
"Secretariat" means the Secretariat of the Society as referred to in these Rules.
"State Government" means the Government of .....
"Year" means the financial year, namely from 1st April of a calendar year to 31st March of the next calendar year.

3 OFFICE AND JURISDICTION

3.1 Registered office of the Society shall be situated at the Office of the Civil Surgeon / Chief Medical Officer / Chief Medical and Health Officer, ... District having its office at ....

3.2 The jurisdiction of the Society shall be the whole of ..... (district name)

4 MEMBERSHIP

4.1 The following shall be the members of the Society:

- First members of the Governing Body.
- Following additional ex-officio members of the Governing Body:
    - Programme Managers / District Officers in charge of national / centrally sponsored health & FW schemes / programmes and ex-officio office-bearers of the vertical programme / project societies in the health & FW sector (e.g. District Blindness Control Society, District RCH Society, District

TB Control Society, District Malaria Society etc.), which existed before the formation of this Society, AYUSH and In-charge of 'Total Sanitation Campaign' in the District.
    - Superintendents of District, Sub-Divisional and other hospitals in the district, including Nagar Nigam hospitals, railway hospitals, ESI hospitals and other public hospitals in the district.
    - Elected representatives (MLAs/MPs) from the district.
- District Programme Manager to be appointed under these Rules.
- Representatives of Development Partners supporting health and family welfare activities in the district, if any.
- NGO representatives of the vertical programme / project societies in the health & FW sector (e.g. District Blindness Control Society, District RCH Society, District TB Control Society, District Malaria Society etc.) which existed before the formation of this Society.
- Local representatives of professionals' associations (e.g. IMA, FOGSI, IAP etc.).
- Representatives of other organisations as may be determined by the Governing Body from time to time.
- Individuals as may be nominated by the Governing Body from time to time.

4.2 The membership of an ex-officio member of the Society and of the Governing Body shall stand terminated when he/she ceases to hold the office by virtue of which he/she was member and his/her successor to the office shall become such member.

4.3 Non-official members of the Society will be nominated by the Chair-person with the approval of the Governing Body. Nominated members shall hold office for a period of three years from the date of their nomination by the Chair-person. Such members will be eligible for re-nomination for another period of 3 years.

4.4 The Society shall maintain a roll of members at its registered office and every member shall sign the roll and state therein his/her rank or occupation and address. No member shall be entitled to exercise rights and privileges of a member unless he/she has signed the roll as aforesaid.

4.5 All members of the Governing Body shall cease to be members if they resign, become of unsound mind, become insolvent or be convicted of a criminal offence involving moral turpitude or removal from the post by virtue of which s/he was holding the membership.

4.6 Resignation of membership shall be tendered to the Governing Body in person to its Executive Secretary and shall not take effect until it has been accepted on behalf of the Governing Body by the Chairperson.

4.7 If a member of the Society changes his/her address he/she shall notify his/her new address to the Executive Secretary who shall thereupon enter his/her new address in the roll of member. But if a member fails to notify his/her new address the address in the roll of members shall be deemed to be his/her address.

4.8 Any vacancy in the Society or in the Governing Body shall be filled by the authority entitled to make such appointment. No act or proceedings of the Society or of the Governing Body shall be invalid merely by reason of the existence of any vacancy therein or of any defect in appointment of any of its members.

4.9 No member of the Governing Body, except the Executive Secretary to be appointed as per these Rules, shall be entitled to any remuneration.

5 AUTHORITIES OF THE DHS

5.1 The following shall be the bodies and authorities of the Society:

- Governing Body
- Executive Committee
- Sub-Committees of the Executive Committee, such as Programme Committees

5.2 GOVERNING BODY

5.2.1 All members of the Society as set out in para 4.1 shall constitute the Governing Body of the Society.

5.2.2 The first members of the Governing Body of the Society shall be those mentioned in Clause 6 of the Memorandum of Association. They shall hold office until a new Governing Body is appointed according to these Rules.

5.2.3 The management of the affairs of the Society shall be entrusted to Governing Body and the property of the Society shall be vested in the Governing Body.

5.2.4 The Society may sue or be sued in the name of the Executive Secretary of the Society or of such other members as shall, in reference to the matter concerned, be appointed by the Governing Body for the occasion.

5.3 PROCEEDINGS OF THE GOVERNING BODY

5.3.1 The meetings of the *Governing Body* shall be held *at least twice a year* and at such time and place as the Chair-person shall decide. If the Chair-person receives a requisition for calling a meeting signed by one-third members of the Governing Body, the Chair-person shall call such a meeting as soon as may be reasonably possible and at such place as s/he may deem fit.

5.3.2 Following minimum business shall be brought forward and disposed off in every meeting of the Governing Body:

- Annual report of the Society relating to last financial year, including (a) income and expenditure account, (b) balance sheet and (c) audit report.
- Physical and financial progress of the programmes / projects in the current year.
- Work Plan (including budget) for the next financial year.
- Other business brought forward with the assent of the Chair-person.

5.3.3 Every notice calling meeting of the Governing Body shall state the date, time and place at which such meeting will be held and shall be served upon every member of the Governing Body not less than twenty one clear days before the date appointed for the meeting. Such notice shall be issued by the Executive Secretary of the Society and shall be accompanied by an agenda of the business to be placed before the meeting provided that accidental omission to give such notice to any member shall not invalidate any

resolution passed at such meeting. In the event of any urgent business the Chair-person may call the meeting of the Governing Body at clear ten days notice.

5.3.4 The Chair-person shall Chair the meetings of the Governing Body. In his/her absence, the Governing Body shall elect one from among the members present as Chair-person of the meeting.

5.3.5 One third of the members of the Governing Body, including the substitutes nominated under Rule 5.3.7 present in person, shall form a quorum at every meeting of the Governing Body.

5.3.6 All disputed questions at the meeting of the Governing Body shall be determined by votes. Each member of the Governing Body shall have one vote and in case of a tie, the Chair-person shall have a casting vote.

5.3.7 Should any official members be prevented for any reason whatsoever from attending a meeting of the Governing Body, the Chair-person of the Society shall be at liberty to nominate a substitute to take his place at the meeting of the Governing Body. Such, substitute shall have all the rights and privileges of a member of the Governing Body for that meeting only.

5.3.8 Any member desirous of moving any resolution at a meeting of the Governing Body shall give notice there of in writing to the Executive Secretary of not less than ten clear days before the day of such meetings.

5.3.9 Any business which it may become necessary for the Governing Body to perform, except the agenda prescribed for the full meeting as set out in para 5.3.2 above, may be carried out by circulation among all its members and any resolution so circulated and approved by majority of the members signing shall be as effectual and binding as if such resolution had been passed at a meeting of the Governing Body provided that at least one third members of the Governing Body have recorded their consent of such resolution.

5.3.10 In the event of any urgent business, the Chair-person of the Society may take a decision on behalf of the Governing Body. Such a decision shall be reported to the Governing Body at its next meeting for ratification.

5.3.11 A copy of the minutes of the proceedings of each meeting shall be furnished to the Governing Body members within 2 weeks after completion of the meeting.

5.4 POWERS OF THE GOVERNING BODY

5.4.1 The Governing Body will have full control of the affairs of the Society and will have authority to exercise and perform all the powers, acts and deeds of the Society consistent with the aims and objects of the Society.

5.4.2 In particular and without prejudice to the generality of foregoing provision, the Governing Body may:

- Make, amend, or repeal any bye laws relating to administration and management of the affairs of the Society subject to the observance of the provisions contained in the Act, provided that such amendments are brought to the Governing Body *after obtaining endorsement / approval from the State Government*[4[4]].

4[4] This provision is being made to ensure that the DHSs in other districts also benefit from avenues of improvements identified in a district.

- Consider the annual budget and the annual action plan, its subsequent alternations placed before it by the Executive Secretary from time to time and to pass it with such modifications as the Governing Body may think fit.
- Monitor the financial position of the Society in order to ensure smooth income flow and to review annual audited accounts.
- Accept donations and endowments or give grants upon such terms as it thinks fit.
- Delegate its powers, other than those of making rules, to the Chair-person, Executive Secretary or other authorities as it may deem fit.
- • Authorise the Executive Secretary to execute such contracts on behalf of the Society as it may deem fit in the conduct of the business of the Society.
- Appoint committees, sub-Committees and Boards etc. for such purpose and on such terms as it may deem fit, and to remove any of them.
- Recruit administrative / technical staff for the Society secretariat as per the Operational Manual of the Society.
- Procure goods and services in accordance with the procedures laid down in the Operational Manual of the Society.
- Do generally all such other acts and things as may be necessary or incidental to carrying out the objectives of the Society or any of them, provided that nothing herein contained shall authorize the Governing Body to do any act or to pass any bye-laws which may be repugnant to the provisions hereof, to the powers hereby conferred on the Governing Body and other authorities, or which may be inconsistent with the objectives of the Society.

5.5 POWERS AND FUNCTIONS OF THE CHAIR-PERSON OF THE GOVERNING BODY

5.5.1 The Chair-person shall have the powers to call for and preside over all meetings of the Governing Body.

5.5.2 The Chair-person may himself/herself call, or by a requisition in writing signed by him/her, may require the Executive Secretary to call, a meeting of the Governing Body at any time and on the receipt of such requisition, the Executive Secretary shall forthwith call such a meeting.

5.5.3 The Chair-person shall enjoy such powers as may be delegated to him by the Society and the Governing Body.

5.5.4 The Chair-person shall have the authority to review periodically the work and progress of the Society and to order inquiries into the affairs of the Society and to pass orders on the recommendations of the reviewing or inquiry Committee.

5.5.5 Nothing in these Rules shall prevent the Chair-person from exercising any or all the powers of the Governing Body in case of emergencies in furtherance of the objects of the Society. However, the action taken by the Chair-person on such occasions shall be reported to the Governing Body subsequently for ratification.

5.6 EXECUTIVE COMMITTEE AND ITS SUB-COMITTEES (Programme Committees)

5.6.1 The Governing Body will constitute an Executive Committee which will be responsible for acting for and doing all deeds on behalf of the Governing Body and for taking all decisions and exercising all the powers, vested in the Governing Body except those which the Governing Body may specifically specify to be excluded from the jurisdiction of by the Executive Committee.

5.6.2 The composition of the Executive Committee shall be as follows:

Sl. No.	Name / designation	Status in Executive Committee
1	DDC cum CEO, Zila Parishad	Chairperson
2	CMO/CDMO/CMHO/CS	Co-Chair
3		Member
4	District Programme Managers for health & FW	
5	programmes (6)	Member
6		Member
7		Member
8		Member
9	District Programme Manager (ICDS)	Member
10	Chief Executive Officer, Urban Local Body (Nagar Nigam)	Member
11	Superintendent(s), District Hospital(s)[5[5]]	Member
12	Representative, Mother NGO for the district	Member
13	Three Governing body members belonging to	Member
14	NGOs / charitable hospitals from the district,	Member
15	nominated by the Chair-person of the Governing Body	Member
16	District Programme Manager/District RCH Officer	Convenor

5.6.2 Till such time a regular incumbent to the post of District Programme Manager has been appointed, the District may decide to designate one of the Dy. CMOs to function as Convenor of the Governing Body / Executive Committee.

5.6.3 The Executive Committee may co-opt additional members and/or invite subject experts to its meetings from time to time.

5.6.4 Meetings of the Executive Committee shall be convened by the Member Secretary by giving clear seven days notice in writing along with the Agenda specifying the business to be transacted, the date, time and venue of the meeting.

[5[5]] In districts having District Hospital (Male) and District Hospital (Female), Superintendents of both should be included as members of the Executive Committee.

5.6.5 Meetings of the Executive Committee shall be held at least once every month or more frequently as necessary.

5.6.6 The minutes of the Executive Committee meetings will be placed before the Governing Body at its next meeting.

5.6.7 The Executive Committee may appoint one or more programme-committees for the purpose of day-to-day execution of the various programmes.

5.6.8 The programme committees will submit a monthly performance / progress report to the Executive Committee which shall incorporate these into the consolidated progress reports to be placed before the Governing Body.

5.7 SOCIETY SECRETARIAT AND EXECUTIVE SECRETARY

5.6.1 Governing Body, with the assistance of the Executive Secretary, will establish a Secretariat of the Society consisting of technical, financial and management professionals to serve as the District Programme Management Support Unit (DPMSU) to assist the district health administration.

5.6.2 The Secretariat shall consist of such technical / management units as set out in the Operational Manual prescribed by the State Government.

5.6.3 The district level officers appointed under on-going projects sponsored by development partners, if any, shall be physically co-located in the Society Secretariat office[6[6]].

5.8 POWERS AND FUNCTIONS OF THE SECRETARIAT

5.8.1 The Secretariat of the Society shall consist of the Executive Secretary and Staff of the Society.

5.8.2 The Secretariat will be responsible for day-to-day management of the Society's activities. In particular, it will be responsible for performing all functions of the Society as set out in article 5 of the MoA.

5.8.3 The Secretariat will provide Technical Support to the District Health Mission. It will also be responsible for financial management of funds of the Society.

5.8.4 The funds sanctioned by the Governing Body/Executive Committee shall be released by the two authorized signatories and a copy of the sanction order marked to the DPMSU for financial management of the same.

6 FUNDS OF THE SOCIETY

6.2 6.2 The funds of the Society shall consist of the following:

- Grant-in-aid from the State Government and/or State Health Society
- Grants-in-aid from the Central Government, if it decides to give the whole or part of grants directly to District Society.
- Grants and donations from trade, industry, institutions and individuals.
- Receipts from disposal of assets.

[6[6]] These include NPSP Medical Officers (WHO), District Programme Managers of the Border District Cluster Scheme (UNICEF) and District Programme Manager for the nutrition projects of the CARE etc.

- The assets and liabilities of all Societies merged into the integrated Society shall be subsumed within the new Society.

7 ACCOUNTS AND AUDIT

7.1 The Society shall cause regular accounts to be kept of all its monies and properties in respect of the affairs of the Society.

7.2 The Executive Committee may cause separate Bank Accounts in respect of each scheme or separate ledgers for each scheme under one account. In such an event, the Governing Body shall prescribe written instructions relating to submission of Statement of Expenditure (SoE) for each scheme. The separate Accounts of different Programmes could be audited by different auditors, and submitted to Programme Units separately. However, the DPMSU will ensure one integrated audit of the District Health Society.

7.3 The accounts of the Society shall be audited annually by a Chartered Accountant firm included in the panel of Comptroller and Auditor General of India or any qualified person appointed by the Government of India/State Government and any expenditure incurred in connection with such audit shall be payable by the Society to the Auditors. The Office of the Accountant General of State may also, at its discretion, audit the accounts of the society.

7.4 The Chartered Accountant or any qualified person appointed by the Govt. of India/State Government in connection with the audit of the accounts of the Society shall have the same rights, privileges and authority in connection with such audit as the Auditor General of the State has in connection with the audit of Government accounts and in particular shall have the right to demand the production of books, accounts, connected vouchers and other necessary documents and papers.

7.5 The report of such audit shall be communicated by the auditor to the Society, which shall submit a copy of the Audit Report along with its observation to the State Government.

7.6 The Auditor shall also forward a copy of the report to the following:

- A designated authority of the State Society as may be determined by its Governing Body / Executive Committee.
- The District Collector.
- Chair-person of the Governing Body of the Society and State Government or a designated authority of the State level society.

8 BANK ACCOUNT

8.1 The account of the Society shall be opened in a nationalised bank approved by the Executive Committee or in a scheduled commercial bank as may be specified by the MoHFW, Government of India. All funds shall be paid into the Society's account with the appointed bank and shall not be withdrawn except through a cheque, bill note, other negotiable instruments or through electronic banking (e-banking) procedures signed/electronically authorised by such authorities of the Society Secretariat as may be determined by the Executive Committee.

8.2 The Society shall switch over to e-banking procedures as and when the MoHFW, Government of India directs the Society to do so as the principal donor to the Society.

9 ANNUAL REPORT:

9.1 A draft annual report and the yearly accounts of the Society shall be placed before the Governing Body at next meeting for consideration and approval. A copy of the annual report and audited statement of accounts as finally approved by the Governing Body shall be forwarded within six months of the closure of a financial year to the following:

- District Collector/DM,
- Chair-person, Governing Body, and
- Designated authority of the State Government.

10 SUITS AND PROCEEDINGS

10.1 The Society may sue or be sued in the name of Society through its Executive Secretary.

10.2 No suit or proceedings shall abate by the reason of any vacancy or change in the holder of the office of the Chairperson or Executive Secretary or any office bearer authorised in this behalf.

10.3 Every decree or order against the Society in any suit or proceedings shall be executable against the property of the Society and not against the person or the property of the Chairperson, Executive Secretary or any office bearer of the Society.

10.4 Nothing in sub-rule 10.3 above shall exempt the Chairperson, Executive Secretary or office bearer of the Society from any criminal liability or entitle him/her to claim any contribution from the property of the Society in respect of any fine to be paid by him/her on conviction by a criminal court.

11 AMENDMENTS

11.1 The Society may amend these Rules provided that such changes shall not alter the nature and /or the objectives and/or the purposes for which it has been set up. The proposals for any amendments shall be carried out only through the following process:

11.1.1 Proposals for amendments have been circulated to all members of the Governing Body and have been duly included in the written agenda of the ensuing meeting of the Governing Body or a special meeting of the Governing Body;

11.1.2 The Governing Body has endorsed the proposal at least $3/5^{th}$ of the members of the Governing Body; and

11.1.3 The State Government has communicated, in writing, its endorsements to the Governing Body resolution for the amendment.

12 DISSOLUTION

12.1 The Governing Body may resolve to dissolve the Society by bringing a proposal to that effect in a special meeting to be convened for the purpose, provided that the proposal for dissolution has been duly approved /endorsed through the process prescribed for amendment as set out in para 11.1 of these Rules.

12.2 The dissolution proceedings shall be made in accordance with the provisions of the Act as amended from time to time in its application in the State.

12.3 Upon the dissolution of the Society, all assets of the Society, after the settlement of all its debts and liabilities, shall stand reverted to the State Government for such purposes as it may deem fit.

13 MISCLELLANEOUS

13.1 CONTRACTS

13.1.1 All contracts and other instruments for and on behalf of the Society shall be subject to the provisions of the Act, be expressed to be made in the name of the Society and shall be executed by the persons authorised by the Governing Body.

13.1.2 No contracts for the sale, purchase or supply of any goods and material shall be made for and on behalf of the Society with any member of the Society or his/her relative or firm in which such member or his/her relative is a partner or shareholder or any other partner or shareholder of a firm or a private company in which the said member is a partner or director.

13.2 COMMON SEAL

13.2.1 The Society shall have a common seal of such make and design as the Governing Body may approve.

13.3 GOVERNMENT POWER TO REVIEW

13.3.1 Notwithstanding anything to the contrary contained in these Rules, the State Government and/or Ministry of Health & Family Welfare may appoint one or more persons to review the work and progress of the Society and hold enquiries into the affairs thereof and report thereon. The Central Government may also cause the accounts of the Society to be audited by the internal audit parties of the Chief Controller of Accounts, MoHFW, GOI or do Management Audit through the Financial Management Group, and issue directions, as deemed appropriate, to the Society.

13.3.2 The Chair-person of the Governing Body shall have the right to nominate one or more persons to be part of the review / enquiries.

13.3.3 The progress review reports and / or enquiry reports shall be included in the written agenda of the ensuing meeting of the Governing Body.

We, the undersigned being three of the members of the first Governing Body of the District Health Society, certify that the above is a correct copy of the Rules and Regulations of the said Society.

Sl. No.	Name and address	Signature
1		
2		
3		

Dated :_____

Appendix-III

(Generic) Bye-laws of the District Health Society

A Procurement Policy and Procedures

Procurement of goods and services will be organized as per the procedures recommended by the State Society. Commitments made to multilateral/bilateral donor agencies with regard to Procurement Procedures under different Projects would be honoured.

B Procedure for release of funds

Funds would be ordinarily released from State Health Society to District Health Society in two tranches. The Society funds shall be drawn through cheques and/or bank drafts or through e-banking mechanism as and when the same is introduced.

All cheques shall be signed by two authorized signatories comprising of Accounts Manager and Member-Secretary of the concerned programme committee.

All releases will be made on the basis of a written authorization from the Member-Secretary of the concerned programme committee.

Wherever releases are decided to be made through bank drafts and/or through e-banking, the authorization letter to the bank shall be signed by the concerned authorized signatories.

Note: Wherever, under e-banking procedures, releases are to be made through electronic authorization to the bank to issue cheque/draft/account transfer on behalf of the Society, the electronic authorization will be executed by the same two authorized functionaries of the Society secretariat who have been authorized to sign cheques on the basis of a written authorization from the concerned programme manager and/or consultant and/or Head of concerned Programme Division and/or Executive Secretary and/or Chief Medical Officer.

C Financial Powers of the Office Bearers of the Society (Governing Body, Executive Committees, Programme Committees), Executive Secretary and District Programme Managers

Type of expenditure	Authority	Extent of power
A: Release of funds to Hospitals/ hospital societies, block Medical Officers and other implementing agencies as per State Government approved norms and/or proposals approved by State Government.	District Programme Manager (DHS)/ Member-Secretary of the concerned Programme	Full powers.

B: Release of funds for implementation of plans / allocations approved by Governing Body / Executive Committee, as approved by the Executive Committee.	Committee	
C: Expenditure proposals not covered under categories A and/or B		
C-1: Procurement of goods C-2: Repairs and minor civil works C-3: Procurement of services for specific tasks including outsourcing of support services.	Chair-person, Governing Body	More than Rs 2.00 lakh and upto Rs. 5.00 lakh per case.
	Chair-person, Executive Committee	Upto Rs. 2.00 lakh per case.
C-4: Miscellaneous items not mentioned above such as hiring of taxis, hiring of auditors, meetings and workshops, training, purchase of training material/ books and magazines, payment of TA/DA allowances for contractual staff and/or non-official invitees to DHS meetings and/or officials deputed to meetings outside the district.	Chair-person, Governing Body	Upto Rs. 1.00 lakh at a time subject to a maximum of Rs. 10 lakh per annum.
	Chair-person, Executive Committee	Upto Rs 50,000 at a time, subject to a maximum of Rs. 5.00 lakh per annaum.
	Member-Secretaries of the Programme Committees	Upto Rs 5,000/- at a time subject to a maximum of Rs. 1.00 lakh per annum.

D Human Resources Policy and Procedures

D-1: Recruitment and Appointment

Recruitment would be through either of the following two routes:

- Appointments from open market: all such appointments will be on contractual basis for a fixed tenure.
- Appointments on "Deputation" basis: all such appointments will be regulated in terms of State Government rules relating to Deputation.

Recruitment may either be made by the State Society [e.g. recruitment of Executive Secretary from the open market or recruitment of District Programme Managers on deputation basis] OR by the DHS [e.g. recruitment of support staff for the District Programme Manager] OR a combination of both a may be determined by the State Society.

All appointments would be temporary and would be made for the contract / deputation period as may be determined by the State Government.

D-2: Terms of appointment (applicable to Society staff and Consultants)

The terms of appointment of the staff of the Society shall be regulated in terms of the guidelines that may be provided by the State Government.

D-3: Compliance of Statutory Requirements:

The Society shall register itself with relevant government agencies for the purpose of complying with the statutory requirements including regulations governing deduction of tax at source relating to the staff, consultants and experts employed by it and/or consultancies / contracts awarded by it in the course of performance of its tasks.

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GUIDELINES FOR VILLAGE HEALTH AND SANITATION COMMITTEES, SUB CENTRES, PHCS AND CHCS

MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA

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GUIDELINES REGARDING CONSTITUTION OF VILLAGE HEALTH AND SANITATION COMMITTEES AND UTILIZATION OF UNTIED GRANTS TO THESE COMMITTEES

GUIDELINES REGARDING CONSTITUTION OF VILLAGE HEALTH AND SANITATION COMMITTEES AND UTILIZATION OF UNTIED GRANTS TO THESE COMMITTEES

The detailed Implementation Framework of the National Rural Health Mission [NRHM] approved by the Union Cabinet in July, 2006 provides for the constitution and orientation of all community leaders on Village Sub Centre, Primary Health Centre and Community Health Centre Committees. The NRHM implementation has been planned within the framework of Panchayti Raj Institutions [PRIs] at various levels. The Village Health and Sanitation Committee envisaged under NRHM is also within the overall umbrella of PRI.

2. Composition of the Village Health & Sanitation Committee

To enable the Village Health & Sanitation Committee to reflect the aspirations of the local community especially of the poor households and women, it has been suggested that:

- At least 50% members on the Village Health & Sanitation Committee should be women.
- Every hamlet within a revenue village must be given due representation on the Village Health and Sanitation Committee to ensure that the needs of the weaker sections especially Scheduled Castes, Scheduled Tribes, Other Backward Classes are fully reflected in the activities of the committee.
- A provision of at least 30% representation from the Non-governmental sector.
- Representation to women's self-help group etc. on these committees etc. will enable the Committee to undertake women's health activities more effectively.
- Notwithstanding the above, the overall composition and nomenclature of the Village Health & Sanitation Committees is left to the State Governments as long as these committees were within the umbrella of PRIs.

3. Orientation & Training

Every Village Health & Sanitation Committee after being duly constituted by the State Governments needs to be oriented and trained to carry out the activities expected of them.

Village Health Fund

Every such committee duly constituted and oriented would be entitled to an annual untied grant of Rs.10,000/-, which could be used for any of the following activities: -

(i) As a revolving fund from which households could draw in times of need to be returned in installments thereafter.

(ii) For any village level public health activity like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc.

(iii) In extraordinary case of a destitute women or very poor household, the Village Health & Sanitation Committee untied grants could even be used for health care need of the poor household.

(iv) The untied grant is a resource for community action at the local level and shall only be used for community activities that involve and benefit more than one household. Nutrition, Education & Sanitation, Environmental Protection, Public Health Measures shall be key areas where these funds could be utilized.

(v) Every village is free to contribute additional grant towards the Village Health & Sanitation Committee. In villages where the community contributes financial resources to the Village Health & Sanitation Committee untied grant of Rs.10,000/-, additional incentive and financial assistance to the village could be explored. The intention of this untied grant is to enable local action and to ensure that Public Health activities at the village level receive priority attention.

4. Maintenance of Bank Account

The Village Health & Sanitation Committee fund shall be credited to a bank account, which will be operated with the joint signature of ASHA/Health Link Worker/Anganwadi Worker along with the President of the Village Health & Sanitation Committee/Pradhan of the Gram Panchayat. The account maintenance of this joint account shall be the responsibility of the Village Health & Sanitation Committee especially the ASHA/AWW [wherever no ASHA]. The Village Health & Sanitation Committee, the ASHA/AWW shall maintain a register of funds received and expenditure incurred. The register shall be available for public scrutiny and shall be inspected from time to time by the ANM/MPW/Gram Panchayat.

5. Accountability

- Every Village Health & Sanitation Committee needs to maintain updated Household Survey data to enable need based interventions.

- Maintain a register where complete details of activities undertaken, expenditure incurred etc. will be maintained for public scrutiny. This should be periodically reviewed by the ANM/Sarpanch.

- The Block level Panchayat Samiti will review the functioning and progress of activities undertaken by the VHSC.

- The District Mission in its meeting also through its members/block facilitators supporting ASHA [wherever ASHA's are in position] elicit information on the functioning of the VHSC.

- A data base may be maintained on VHCSs by the DPMUs.

GUIDELINES FOR USE OF SUB-CENTRE (SC) FUNDS UNDER NRHM

GUIDELINES FOR USE OF SUB-CENTER (SC) FUNDS UNDER NRHM

1. As part of the National Rural Health Mission, it is proposed to provide each sub center with Rs.10,000 as an untied fund to facilitate meeting urgent yet discrete activities that need relatively small sums of money.

2. The fund shall be kept in a joint bank account of the ANM and the Sarpanch

3. Decisions on activities for which the funds are to be spent will be approved by the Village Health Committee (VHC) and be administered by the ANM. In areas where the sub center is not co-terminus with the Gram Panchayat (GP) and the sub center covers more than one GP, the VHC of the Gram Panchayat where the SC is located will approve the Action Plan. The funds can be used for any of the villages, which are covered by the sub center.

4. Untied Funds will be used only for the common good and not for individual needs, except in the case of referral and transport in emergency situations.

5. Suggested areas where Untied Funds may be used include:

    - Minor modifications to sub center- curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level
    - Ad hoc payments for cleaning up sub center, especially after childbirth.
    - Transport of emergencies to appropriate referral centers
    - Transport of samples during epidemics.
    - Purchase of consumables such as bandages in sub center
    - Purchase of bleaching powder and disinfectants for use in common areas of the village.
    - Labour and supplies for environmental sanitation, such as clearing or larvicidal measures for stagnant water.
    - Payment/reward to ASHA for certain identified activities

6. Untied funds shall not be used for any salaries, vehicle purchase, and recurring expenditures or to meet the expenses of the Gram Panchayat.

GUIDELINES FOR UTILIZATION OF UNTIED FUND AND ANNUAL MAINTENANCE GRANT FOR PRIMARY HEALTH CENTRES (PHCs)

GUIDELINES FOR UTILIZATION OF UNTIED FUND AND ANNUAL MAINTENANCE GRANT FOR PRIMARY HEALTH CENTRES (PHCS)

Health sector reforms under the National Rural Health Mission (NRHM) aims to increase functional, administrative and financial resources and autonomy to the field units under which every PHC will get Rs. 25,000/- p.a. as untied grant for local health action. Similarly every PHC will get an Annual Maintenance Grant of Rs.50,000/- for improvement and maintenance of physical infrastructure. Provision of water, toilets, their use and their maintenance has to be the priorities. In addition, every PHC is being strengthened with provision of three staff nurses as against one at present and provision of two doctors (one male, one female) and Ayush practitioner.

2. Necessity of untied fund has been felt mainly due to unavailability of funds for undertaking any innovative Centre-specific need-based activity, as the allotment of funds to the States has traditionally been of the nature of tied funds for implementing a particular activity / scheme and this hardly left any funds with the public health facilities. This centralized management and schematic in-flexibility in the use of funds allotted to the States, did not provide any scope for local initiative and flexibility for local action at block and down below level. Also it has been observed that most of the Primary Health Centres have not been maintained properly due to lack of steady fund, available locally for repair/refurbishing of infrastructure and basic facilities.

3. Since there would be substantial fund flow to the districts to be utilized for the Centres under NRHM / RCH-II and other programmes, the untied funds should not duplicate what is / can be taken up under other programmes. Each activity planned by the Centre should have clear rationale so that the impact of the untied fund can be distinctively assessed. A separate register be maintained in the PHC giving sources of funds clearly for various activities.

4. PHC untied fund shall be kept in the bank account of the concerned Rogi Kalyan Samitti (RKS)/ Hospital Management Committee (HMC). PHC level Panchayat Committee/Rogi Kalyan Samiti will have the mandate to undertake and supervise the work to be undertaken from Annual Maintenance Grant. Both the funds will be spent and monitored by RKS.

5. Suggested areas where Untied Fund may be used include:

- Minor modifications to the Center- curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level

- Patient examination table, delivery table, DP apparatus, hemoglobin meter, copper-T insertion kit, instruments tray, baby tray, weighing scales for mothers and for newborn babies, plastic/rubber sheets, dressing scissors, stethoscopes, buckets, attendance stool, mackintosh sheet

- Provision of running water supply

- Provision of electricity

- Ad hoc payments for cleaning up the Center, especially after childbirth.

- Transport of emergencies to appropriate referral centers

- Transport of samples during epidemics.

- Purchase of consumables such as bandages in the Center

- Purchase of bleaching powder and disinfectants for use in common areas

- Under the jurisdiction of the Centre.

- Labour and supplies for environmental sanitation, such as clearing or

- Larvicidal measures for stagnant water.

- Payment/reward to ASHA for certain identified activities

- Repair/operationalising soak pits

6. The following nature of expenditures **should not be incurred** out of the untied fund:

- Purchase of Office Stationery and equipments, training-related equipments, Vehicles etc.

- Engagement of full time or part time staff and payment of honorarium / incentives / wages of any kind.

- Purchase of drugs, consumables and furniture.

- Payments towards inserting advertisements in any Newspaper / Journal / Magazine and IEC related expenditure.

- Organizing "Swasthya Mela" or giving stalls in any Mela for ostensible purpose of awareness generation of health schemes / programmes.

- Payment of incentives to individuals / groups in cash / kind.

- Meeting any recurring non-plan expenditure.

- Taking up any individual based activity except in the case of referral and transport in emergency situations.

7. The Centers are not required to take prior approval before implementing the schemes from the untied funds but shall have to send quarterly SOE and UC.

SUGGESTED GUIDELINES FOR IMPLEMENTATION OF INDIAN PUBLIC HEALTH STANDARDS (IPHS) IN SUB-CENTRES (SC), PRIMARY HEALTH CENTRES (PHCS) AND COMMUNITY HEALTH CENTRES (CHCS)

SUGGESTED GUIDELINES FOR IMPLEMENTATION OF INDIAN PUBLIC HEALTH STANDARDS (IPHS) IN SUB-CENTRES (SC), PRIMARY HEALTH CENTRES (PHC) AND COMMUNITY HEALTH CENTRES (CHC)

Although a large number of Sub-centres, Primary Health Centres and Community Health Centres have been established to provide comprehensive promotive, preventive and curative services to the rural people in the country, most of these institutions, at present are not able to function up to the level expected of them due to varied reasons. National Rural Health Mission (NRHM), launched by the Hon'ble Prime Minister on 12 April 2005, envisages to get these institutions raised to the level of optimum availability of infrastructure, manpower, logistics etc. to improve the quality of services and the corresponding level of utilization. Through wide consultation with various stakeholders, Indian Public Health Standards (IPHS) for these centres have been framed. The key aim of the Standards is to underpin the delivery of quality services which are fair and responsive to clients' needs, which should be provided equitably and which deliver improvements in health and well being of the population. Each PHC and CHC, as part of IPHS, is required to set up a Rogi Kalyan Samity / Hospital Management Committee, which will bring in community control into the management of public hospitals with a purpose to provide sustainable quality care with accountability and people's participation along with total transparency.

To bring these centres to the level of Indian Public Health Standards, is no doubt, a challenge for most of the States and also may require a detailed institution specific facility survey to find out the gaps. However, considering the dynamic process of setting up of the standards and the current manpower availability, there is a need to bring these centres to IPHS in a phased manner as the existing institutions are having different level of functional status. Some are at very rudimentary stage, some are just functioning minimally and the others with little more input could come up to the level of IPHS. Taking these points into consideration, a set of guidelines has been framed to enable the States / UTs to bring these centres gradually to the IPHS level.

National Rural Health Mission (NRHM) envisages a fully functional sub-centre in coordination with the village level functionaries such as Anganwadi workers, ASHA, and the Village Health and Sanitation Committee. Similarly, all the PHCs should function as 24-hour PHCs in a gradual manner. NRHM also envisages a functional 30-bedded rural hospital at the block level providing emergency obstetric care and neonatal care in the first instance as FRU and gradually strengthen further to provide other specialists services as per the details in the IPHS. The guidelines for achieving standards for IPHS centre wise are as below:

Sub-centre:

- Conduct a facility survey and identify the gaps.

- Ensure that all the existing Sub-centres should be posted with one ANM immediately. The vacant post may be filled up on contractual basis. There should be an in-built plan to take care of vacancies arising out of retirements, long leave, and other emergency situation so that the services of ANM are available without any interruption.

- The appointment of second ANM as envisaged in the IPHS for each Sub-centre is to be made locally on contractual basis as per the demand, phase wise. The most difficult areas such as hilly and tribal areas may be given priority.

- The services of a Male Health Worker (MPW-M) is also necessary at the Sub-centre. The states should take steps to fill up the post of these MPWs (M) in a phased manner. The training capacity in the State for these MPWs also need to be enhanced.

- Utilization of untied fund for strengthening the functioning of Sub-centres.

- All the existing Sub-centres buildings should be made environment friendly, disabled friendly, with a good source of water supply, electricity / solar power / other alternative energy sources. This can be ensured with the help of Panchayat and related sectors.

- Utilization of Annual Maintenance Grant for strengthening of infrastructure and basic necessities of the Sub-centres.

- The States may declare the names and the number of existing Sub-centres that have been made functional as per the IPHS for the purpose of showing achievements under NRHM and information to the public.

Primary Health Centre (PHC) - 24 Hours Service Delivery Centre with emphasis on Institutional Delivery:

NRHM envisages that all the Primary Health Centres (20,000-30,000 population) should function as a 24x7 centre in a phased manner to improve the institutional deliveries conducted at these centres. The steps that may be needed are as follows:

- Conduct an institution specific facility survey and identify the gaps.

- In order to make the PHC 24x7 delivery of services, the services of Staff Nurses are essential. It must be ensured that there should be at least 4 Staff Nurses to perform rotation duties round the clock. In order to improve the institutional deliveries, appointment of at least three Staff Nurses may be recruited on contractual basis to fill the gaps. A labour room with appropriate equipments and drugs with round the clock referral transport support either managed by the PHC or by the NGOs / CBOs for referring patients in case of emergency is essential. The States may take stock of the situation of the training capacity and the facilities available in the training institutions for turning over the required number of Staff Nurses.

- Appointment of two Medical Officers (MBBS) (preferably one lady MO), and one AYUSH practitioner, either by relocation or on contractual basis. All effort should be made, such as contractual appointment or walk-in interviews, making the District Cadre for Medical Officers and even appointment of retired MBBS doctors on contractual basis, and other incentives provided by the State government to see that all the PHCs have the Medical Officers.

- All the existing Primary Health Centres buildings as far as possible should be made environment friendly, disabled friendly, with a good source of water supply, electricity / solar power / other alternative energy sources and telephone. Rain water harvesting should also be promoted in the PHC building. This can be ensured with the help of Panchayat and related sectors such as water supply sanitation, horticulture etc. All the proposed new buildings should have these components in their construction plan.

- Utilization of untied fund for strengthening the functioning of PHCs.

- Utilization of Annual Maintenance Grant for strengthening the infrastructure and basic necessities

- Each PHC must have a Rogi Kalyan Samity and display of the Citizens' Charter.

- Once a specific PHC has achieved the 24x7 / IPHS status, the district authority / state authority should declare the institution as 24x7 / IPHS.

Community Health Centre (CHC) – First Referral Unit (FRU)
Assured Services:

NRHM envisages a 30-bedded fully functional block level rural hospital. The greatest challenge of bringing these CHCs to FRU / IPHS is the non-availability of the specialists especially the critical ones like obstetric/gynecologist, anesthetist and pediatrician. The following steps may be taken up:

- Conduct an institution specific facility survey and identify the gaps.

- The bringing up the CHC to the level of the IPHS may be carried out in stages. First stage:- It must be ensured that all the CHCs provides 24x7 services with appropriate referral transport service. The basic requirement for making it 24x7 service delivery, there should be four General Duty Medical Officers and seven Staff Nurses, one ANM and one LHV along with other support services and physical facilities. Each CHC must be certified by the State Government / District Authority that this is functioning as a 24x7 service delivery.

  Second stage:- All the CHCs, declared as 24x7 may be upgraded to First Referral Units (FRUs). The Minimum requirement of FRUs including manpower, i.e. gynecologist, anesthetist, pediatrician, and round the clock services of nurses and general duty officers should be ensured. Blood storage facility and other supportive services such as laboratory, X-ray, OT, labour room, laundry, diet, waste management system, referral transport etc. must be ensured. Each CHC should be clearly demarcated as FRU. CHCs, as FRU, will provide the 24 Hours delivery services including normal and assisted deliveries, emergency obstetric care including surgical intervention like cesarean section and other medical intervention, newborn care, emergency care of sick children, full range of family planning services including laparoscopic services, safe abortion services, treatment of STI/RTI, availability of blood storage unit or effective linkage facilities with blood banks, and referral transport services.

  Third stage (IPHS):- Once the CHCs are qualified for FRU, next step would be to post adequate number of other specialists and support manpower as per the IPHS. Once these existing gaps in relation to manpower, equipments, drugs, supplies and other support services, are filled up, the CHCs can be declared to have achieved IPHS. The CHCs declared as IPHS, apart from above mentioned services by FRU, also must provide the following services:

  - Care of routine and emergency cases in surgery

- Care of routine and emergency cases in medicine
- Services of a Public Health Manager
- Delivery of all National Health Programmes including communicable and non-communicable diseases and RCH services.

Manpower:

- Appointment of specialists may be made on contractual basis. All out efforts should be made, such as contractual appointment or walk-in interviews, making the specialist cadre in the State and even appointment of retired specialists on contractual basis, public private partnership, and other incentives provided by the State government. Short term training course on anesthesiology and emergency obstetric care to the existing serving general duty doctors may also be undertaken, to see that all the CHCs have requisite manpower depending on the bed occupancy level.
- Appointment of Public Health Programme Manager on contractual basis.
- Appointment of Eye Surgeon (one for five CHCs) on contractual basis.
- Appointment of nine Nurses Midwives / Staff Nurses on contractual basis.
- All the existing Community Health Centres buildings as far as possible should be made environment friendly, disabled friendly, with a good source of water supply, electricity / solar power / other alternative energy sources and telephone. Rain water harvesting should also be promoted in the CHC buildings. This can be ensured with the help of Panchayat and related sectors such as water supply sanitation, horticulture etc. All the proposed new buildings should have these components in their construction plan.
- Dislocation of the existing centres for the sake of achieving the Standards may not be required, unless compulsory due to unavoidable circumstances. In that case, they could be resettled to an accessible place where the original client group could easily get the services.

As far as manpower is concerned, optimum strength should be taken into consideration.

Others

- Utilization of untied fund for strengthening the functioning of CHCs
- Utilization of Annual Maintenance Grant for strengthening the infrastructure and basic necessities
- Utilization of fund for up-gradation of CHCs to IPHS

Implementation of achieving the Standards should keep into account the linkage of the referral system right from Sub-centre to Community Health Centres and to higher up institutions from CHCs.

Manual on
Community based Monitoring of Health services
under
National Rural Health Mission

Drawing from

NRHM Framework of Implementation

Prepared by

Task force on Community Monitoring

Of

Advisory Group on Community Action

Based on the Proposal Sanctioned by Mission Directorate of NRHM, MoHFW, Government of India

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Preface

The National Rural Health Mission (NRHM) was launched on the 12th of April 2005 with the goal of improving the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. . In order to ensure that the services reach those for whom they are meant the NRHM proposes an intensive accountability framework that includes Community-based Monitoring as one of its key strategies.

The NRHM Framework for Implementation outlines the composition and broad roles of monitoring and planning committees at various levels. These outlines were to be subsequently elaborated for developing the process of community monitoring. The Advisory Group for Community Action (AGCA) is a standing committee within the NRHM, constituted to support and advise the MoHFW in the implementation and review of the NRHM across the country. The AGCA took a lead in initiating discussions with the MoHFW to develop a detailed proposal on how "Community Monitoring" could be rolled out in a phased manner across the country. Through a process of discussions and deliberations the AGCA developed a comprehensive proposal for decentralized 'Community Monitoring" with the active partnership of the Department and Civil Society institutions. The proposal was then forwarded Union Ministry of Health and Family Welfare (MoHFW) for implementation on a national scale. The MoHFW has approved this first phase of the " Community Monitoring" proposal and has suggested that the AGCA for a special Task Group for overseeing the implementation.

The AGCA has established a Task Group for the technical support and oversight in implementing the project and it is being Chaired by Mr A R Nanda of PFI. the convenor of AGCA. A Secretariat has also been established jointly by Population Foundation of India and Centre for Health and Social Justice at New Delhi

This Manual is based project proposal that has been approved being presented through this manual for different stakeholders in the community.

Introduction to NRHM

There is an increasing recognition that despite significant improvements in health parameters like life expectancy at birth of and the reduction of infant mortality there are large parts of the country where people continue to have very poor access to health care services and their health status continues to be abysmal. A high proportion of the population continues to suffer from and die of preventable conditions like maternal deaths, malaria and tuberculosis. Persistent malnutrition and high levels of anemia amongst children and women is widespread. Due to the poor status of public health systems people are also facing poverty and indebtedness from the costs incurred in seeking health care. Public spending on health in India, especially on preventive and promotive health is also very low in India. On the other hand the private, out of pocket, expenditure on health is very high, about three times higher than the public expenditure. Thus there is an urgency to deal with the multiple health related crisis that the rural poor in the country are faced with. There is also the need to transform the health system into an efficient, transparent and accountable system delivering affordable and quality services.

The National Rural Health Mission has been conceptualized and is being implemented to bring about these fundamental changes in the way health care services are being delivered to the rural poor. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

GOALS

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance. In this process, the Mission would help achieve goals set under the National Health Policy and the Millennium Development Goals.

The Vision of the Mission

- To provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- 18 special focus states are Arunachal Pradesh, Assam, Bihar, Chattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur , Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa , Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.
- To raise public spending on health from 0.9% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling.
- To undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.
- To revitalize local health traditions and mainstream AYUSH into the public health system.
- Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.
- Address inter State and inter district disparities.
- Time bound goals and report publicly on progress.
- To improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.

In order to achieve its goals and objectives the Mission seeks to forge effective partnerships between the Central State and Local governments. There are flexible mechanisms built into the Mission so that local needs and priorities can be identified and addressed and local initiatives promoted. Intersectoral convergence is also seen as a key strategy of the mission for improving interventions in preventive and promotive health. The Panchayati Raj institutions and the community have been given key roles in the management of primary health care programmes as well as infrastructure.

Some of the key areas that have been identified for concerted action within the NRHM framework of action are the following :

- Well functioning health facilities;
- Quality and accountability in the delivery of health services;
- Taking care of the needs of the poor and vulnerable sections of the society and their empowerment;
- Prepare for health transition with appropriate health financing;
- Pro-people public private partnership;
- Convergence for effectiveness and efficiency.
- Responsive health system meeting people's health needs.

The expected outcomes from the Mission are:

1. Reduction of Infant Morality rate to 30/1000 live births by 2012.
2. Reduction of Maternal Mortality to 100/100,000 live births by 2012.
3. Reduction of Total Fertility Rate to 2.1 by 2012.
4. Reduction of Malaria Mortality Rate by 50% up to 2010 and an additional 10% by 2012.
5. Reduction of Kala Azar Mortality Rate by 100% by 2010 and sustaining elimination until 2012.
6. Reduction of Filaria/Microfilaria Rate by 70% by 2010 by 80% by 2012 and elimination by 2015.
7. Reduction of Dengue Mortality Rate by 50% by 2010 and sustaining at that level until 2012.
8. Increasing Cataract operations to 46 lakhs until 2012.
9. Reducing Leprosy Prevalence Rate from 1.8 per 10,000 in 2005 to less that 1 per 10,000 thereafter.
10. Maintain 85% cure rate in the Tuberculosis DOTS series through the entire Mission Period and also sustain planned case detection rate.
11. Upgrading all Community Health Centers to Indian Public Health Standards.

12. Increase utilization of First Referral units through increased bed occupancy by referred cases from less than 20% to over 75%.
13. Engaging 4,00,000 female Accredited Social Health Activists

At the community level it is expected

- that there will be increased awareness about preventive health including nutrition
- that there will be a trained worker available at the community level with a drug kit for common ailments
- a monthly health day will be organised where services related to maternal and child health eg. immunization, ante-natal checkups and nutritional services will be available

How to trigger Community action?

- Through household and health facility survey that involve Village Health Teams and discuss findings locally.
- Through Health Camps that bring a range of health services to the community and makes them aware of their entitlements.
- Through "Public Hearings" or Jan Sunawai oganized periodically where people share their experience of seeking health care. Such Jan Sunwais may be organized twice a year, or at least once a year at PHC, block and district levels.
- Through training and orientation of village Health Teams for community action.
- By building team of Community Workers like Aangan Wadi Sevika , ASHA, School Teacher, Mahila Samakhya worker, PTA/MTA' members, etc.
- By involving group like SHGs, Community based organizations, MTAs, PTAs, literacy volunteers, Containing Education Centre volunteers, etc. who have motivation for Community action.
- By making local level health functionaries visit households frequently.
- By making Block and District level Health Mission teams, including NGOs, organize a series of activities like health camps, public hearings, etc.

- generic drugs for common ailments will be available at the Sub-centre and good hospital care will be assured through availability of doctors, drugs and quality services at PHC/CHC level
- there will be improved facilities available for instutitional deliveries and the Janani Suraksha Yojna will also provide opportunities for subsidized hospital care for those below the poverty line
- Mobile medical units will ensure availability of

services to remote underserved areas

- There will be provision of safe drinking water and household toilets

In order to ensure that these outcomes are achieved and quality and accountable health services which are responsive and are taking care of the needs of the poor and vulnerable sections of the society, community ownership and participation in management has been seen as an important pre-requisite within NRHM. Community monitoring is an important component for achieving these results.

Community Monitoring in NRHM

Introduction to Community Monitoring - The accountability framework proposed in the NRHM is a three pronged process that includes internal monitoring, periodic surveys and studies and community based monitoring. Community Monitoring is also seen as an important aspect of promoting community led action in the field of health. The provision for Monitoring and Planning Committees has been made at PHC, Block, District and State levels. The adoption of a comprehensive framework for community-based monitoring and planning at various levels under NRHM, places people at the centre of the process of regularly assessing whether the health needs and rights of the community are being fulfilled.

The community monitoring process involves a three way partnership between health care providers and managers (health system); the community, community based organizations and NGOs and the Panchayati Raj Institutions. The success of the community monitoring process will depend upon the ownership of the process by all three parties and a developmental spirit of 'fact-finding' and 'learning lessons for improvement' rather than 'fault finding'.

The objectives Community Based Monitoring can be seen as follows:

- It will provide regular and systematic information about community needs, which will be used to guide the planning process appropriately
- It will provide feedback according to the locally developed yardsticks, as well as on some key indicators.
- It will provide feedback on the status of fulfillment of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.
- It will enable the community and community-based organisations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health

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

- It can also be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

Process of Community Monitoring - The exercise of "Community monitoring" involves drawing in, activating, motivating, capacity building and allowing the community and its representatives e.g. community based organizations (CBOs), people's movements, voluntary organizations and Panchayat representatives , to directly give feedback about the functioning of public health services, including giving inputs for improved planning of the same. The community and community-based organisations will monitor demand / need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. The monitoring process will include outreach services, public health facilities and the referral system.

The key institutions for community monitoring as laid out in the Framework of Implementation are the

- Village Health and Sanitation Committee
- The PHC Planning and Monitoring Committee
- The Block Planning and Monitoring Committee
- The District Planning and Monitoring Committee and
- The State Planning and Monitoring Committee

Guidelines regarding the composition, roles and powers of these committees have been laid out in detail in the Framework of Implementation and are reproduced in Annexure XX.

The monitoring process will begin with a village report being prepared by the Village Health and Sanitation Committee after consulting village records (eg. ASHA records or ANM records or the Village Health Register) and also conducting interviews and meetings with potential beneficiaries (like women who are pregnant or have undergone childbirth in the recent past, or those with small children) to understand the community members experiences and problems faced as well as assess the extent to which key

services are being delivered effectively. The Monitoring committee at each subsequent level would review and collate the reports coming from the committees dealing with units immediately below it. For example, Block Committee will receive and review the VHSC reports while the District committee would receive and review the reports from all Block committees. However the Monitoring committees would not only rely on reports, but would also make its own independent observations on selected key parameters. Each committee would appoint a small team drawn from among its civil society and PRI representatives who would visit on a quarterly / six monthly basis a small sample of units (say one facility or two villages) under their purview and directly review the conditions there. This will enable the committee to not just rely on reports but to also have a first-hand assessment of conditions in their area. For example, the PHC committee representatives would visit two villages and conduct Group discussions there, in each trimester selecting different villages by rotation. Similarly the Block committee representatives would visit one PHC by rotation in each trimester. The monitoring committees at PHC / Block / District levels will be responsible for making an assessment of the functioning of the major Health care facility at their respective level (PHC / CHC / District Hospital).

Sharing of the findings of monitoring committees will not only take place through the periodic report submitted to the next level of monitoring committee but also through periodic public sharing . Monitoring committees at PHC, Block and District level will be involved in six-monthly or annual Jan Samvads or Public hearings at their respective levels, where committee members would get share the results of their findings and also get direct feedback of the situation including possible presentation of cases of denial of health care. Similarly, it is State Planning and Monitoring Committee will conduct an annual public meeting open to all civil society representatives where the State Mission report and independent reports will be presented and various aspects of design and implementation of NRHM in the state, including State specific health schemes, would be reviewed and discussed enabling corrective action to be taken.

A broad outline of the ambit and scope of community monitoring at different levels is given below in the Table below.

Community Monitoring Committee	Periodicity of Monitoring	Activities to be undertaken
Village Health and Sanitation Committee	Quarterly	a. Reviews Village Health register, Village health calendar b. Reviews performance of ANM, MPW, ASHA c. Reviews communities own experiences as beneficiaries of services d. Sends brief three monthly report to PHC committee
PHC Monitoring and Planning Committee	Quarterly	a. Reviews and collates reports from all VHSCs b. An NGO / PRI sub team conducts FGDs in three sample villages under PHC c. Visit PHC, review records, discuss with RKS members d. Send brief three monthly report to Block committee
Block Monitoring and Planning Committee	Quarterly	a.Reviews and collates reports from all PHCs b.NGO / PRI sub team visits at least one PHC of the block, conduct interviews with MO and make observations c.Visit CHC and review records, discuss with RKS members d. Send brief three monthly report to District committee
District Monitoring and Planning Committee	Quarterly	a. Reviews and collates reports from all Blocks b. An NGO / PRI sub team visits at least one CHC of the District, conducts interviews with Incharge, meets Block committee members and RKS members, makes observations c. Visits District hospital and reviews records, discuss with RKS members c. Send brief three monthly report to State committee
State Monitoring and Planning Committee	Six Monthly	a. Reviews and collates reports from all Districts b. An NGO / PRI sub team visits 3 to 5 Districts, conducts interviews with DHO and District Committee members, makes observations on DH c. Sends six monthly report to NRHM / Union Health Ministry

First Phase of Community Monitoring

The outlines of Community Monitoring process provided within the Framework of Implementation have been developed and elaborated upon by the Advisory Group on Community Action. The first phase is being seen as a learning phase because no similar community monitoring activity, either in the health sector or in other social sectors has been implemented on a country wide scale before. Thus in the first phase the implementation will be supervised at a national level by a specially constituted Secretariat and Task Group constituted under the supervision of the Advisory Group. It has been decided that the first phase will be of eleven months (March 07- Jan 08) and cover eight states.

Some reasons because of which it would be desirable to start with a learning phase are as follows:

Learning from experiences and mistakes on a smaller scale, then moving to a larger scale: This is probably the first time in the country that the official health system is institutionalizing community monitoring of health services on a major scale. There is scope for many kinds of experiences and even deviation from objectives, so it is thought to be desirable to try out the process on a smaller scale and make corrections before moving to a state-wide scale

The need to pool expertise and build an initial critical mass: The number of organizations with experience in rights-based and accountability oriented work related to the Health sector may not be very large in many states. Similarly, expertise and commitment related to this activity within Health departments may also be limited to begin with. It would be desirable for facilitating agencies both within and outside the Health department to come together, share expertise, help launch pilots in a few areas, and analyse experiences, before going to scale at the state level. This would also strengthen ownership of the process within the Department. Starting directly with a widely generalized model would demand very extensive involvement of comparatively few facilitators from day one, they would have to immediately spread themselves thin – not allowing much space for initial development of methodologies and building a critical mass.

The process of developing community monitoring is a delicate process **that** needs to be handled carefully. Community mobilization experiences in the Health sector show that the initial response of community representatives is often to assertively point out a whole range of problems, deficiencies, gaps and even alleged cases of denial of health care which may be quite difficult for the Health officials to digest and take in the right spirit – which could even at times, lead to a virtual breakdown of dialogue. Maintaining the vitality and authenticity of the process, but not allowing complete polarization which would disrupt the dialogue and convergence process itself is a delicate task. Starting by launching the community monitoring process all over the state on a large scale may conceivably lead to potentially disruptive situations and even demotivation of Health functionaries – which could be avoided by first working out the process in pilot areas and building appropriate checks and balances in the methodology before moving to generalization.

Scale of Implementation of the First Phase - The first phase of the Community Monitoring component of NRHM will be implemented in 30 selected districts of 8 states of the country. These are

# Assam	***# Chhattisgarh***
# Jharkhand	***# Madhya Pradesh***
# Maharashtra	***# Orissa***
# Rajasthan	***# Tamil Nadu***

In each of these states a number of districts will be selected (between three and five depending upon the number of districts in the state) on the basis of regional diversity as well as the presence of a credible district level NGO/ Civil Society Organisation which can facilitate the implementation. In each of these districts 3 blocks will be chosen for the first phase, and from among these three blocks the operational area of 3 PHCs will be selected. Five villages will be selected for initiating Community Monitoring in each of the 3 PHC areas. The total numbers of districts, blocks, PHCs and villages is summarised below

- For States with 15 to 29 districts: 3 pilot districts to be selected
- For States with 30 to 39 districts: 4 pilot districts to be selected

- For States with 40 and above districts: 5 pilot districts to be selected
- This will lead to a total of 30 districts spread across these eight states.
- In each district, three blocks shall be identified giving a total 90 blocks
- In each of these blocks, three PHCs shall be identified giving a total 270 PHCs
- In each PHC area, five revenue villages shall be identified giving total 1350 villages

Need for involving Civil Society Organisations/ NGOs in the first phase – NGOs or Civil Society Organisations have been given crucial roles in the NRHM. It is envisaged that besides providing services in selected areas, they will not be members in institutional arrangement at all levels, but will also act as resource organizations and provide support for evaluation, monitoring and social audit. These organizations will have a crucial role to play in the first phase of Community Monitoring to ensure its success. Although State health departments would play an extremely important role in developing community-monitoring activities, however the facilitation of Community based monitoring has not been left to State health departments. Some of the reasons for this are as follows:
It is largely the Health department functionaries themselves who would be monitored; hence for the monitoring to be robustly independent, it is not sufficient to leave the entire task of developing the monitoring framework to the Health department alone.
For effective Community monitoring, *capacity building of a whole set of actors like* beneficiary representatives, community based organizations (CBOs), people's movements, voluntary organizations and Panchayat representatives, who will eventually do the monitoring ,is imperative. Hence involvement of networks, organizations and individuals with experience of community mobilization and community based monitoring to facilitate involvement in the health system of this whole new set of actors is needed.
To facilitate change in the balance of power in the Health sector, in favour of people.
The exercise of community monitoring carries meaning only if ordinary people and their spokespersons in form of both Panchayat representatives and Community based organizations, gain a degree of authority to identify gaps and correspondingly propose priorities and influence decision making regarding the Health system.
The *kind of capacity required to develop a participatory community monitoring system is quite different* from programme implementation and training usually conducted by the

Health department; hence involving voluntary sector agencies with some experience of accountability building and health rights work would be desirable to help facilitate this process.

Role of Civil Society Organizations in the First Phase - Civil society organizations i.e. Community based organizations (CBOs) and Non Governmental Organizations (NGOs) would have three kinds of roles in the process of Community based monitoring

- As members of monitoring committees e.g.
- As resource groups for capacity building and facilitation
- As agencies helping to carry out independent collection of information.

As members of monitoring committees, social organizations working in close, regular contact with communities on health related issues, especially from a rights-based perspective, would be able to present in various monitoring committees the community concerns, experiences and suggestions regarding improving public health system functioning.

As resource groups for capacity building and facilitation, NGOs and CBOs will have the responsibility for overall facilitation of the initial process of committee formation and capacity building of Community Monitoring committee members about the process of Community based monitoring including the roles of members, at different levels, including peripheral committees at PHC and village levels.Based on national model material, training modules and materials for orientation of Community Monitoring committee members would be adapted and published at state level and used for this capacity building process. All three types of members – Panchayat representatives, civil society organisations and health system functionaries would benefit from such capacity building.

As agencies helping to carry out collection of information, NGOs and CBOs would contribute to the collection of information relevant to the monitoring process at all levels – from the village to state level. In these processes, an element of community

mobilisation may be involved. Specific teams would dialogue with communities and would collect and process community-based information. These teams could be sub-groups drawn from the larger Monitoring committee at specific levels, but could also include some persons from beyond the Monitoring committee. Formation of such teams should be encouraged especially at the PHC and Block levels. Each team should include members from one or more facilitating NGOs and PRI members, and could also include representatives from among the Health care providers. Such teams should undergo a short orientation exercise before they undertake the community monitoring exercise.

Implementing the first phase of Community Monitoring

The first phase of the Community Monitoring process is being implemented under the overall supervision of the specially constituted Task Group of the Advisory Group on Community Action. A National Secretariat has been set up in Delhi through the collaboration of Population Foundation of India and Centre for Health and Social Justice.

Preparatory Phase - The activities that are to be undertaken during the first phase and the persons responsible at each level are given in the table below. The preparatory phase will last from March 07 to June 07.

Activity	**Responsibility**	**Support from**
Setting up Task Group	AGCA	MoHFW. GOI
Setting up National Secretariat	AGCA- Task Group	
Contacting State Secretaries in the 8 states	MoHFW	
Contacting Civil Society Organisations in the 8 states	Task Group	
Preparation of necessary Materials, Curricula and Modules	National Secretariat	Task Group
Meeting with state CSOs and identifying State Nodal organization	AGCA- Task Group	National Secretariat
Meeting with State Health Secretary and NRHM Directorate and setting up State Community Monitoring Mentoring Group	AGCA- Task Group	National Secretariat

State Mentoring Group – The State Mentoring group would be formed involving representatives of the State Health department and state level Health sector voluntary networks. Based on experience and demonstrated interest, the State Mission Director and the state designated AGCA members would suggest the names for this mentoring team. This team would have definite responsibilities to develop community monitoring in the state during the first phase and beyond, which would be clearly spelt out. This team would have seven to eleven members, of which at least four to seven would be civil

society representatives. In addition, the designated national AGCA members would be permanent invitees to the State mentoring team.

State Nodal Organisation - One of the State level NGOs with membership in the State mentoring team would be selected to work as the state nodal NGO during the pilot phase. This state nodal NGO would work under the direction of the State mentoring team.

Other state level activities to be carried out in the preparatory phase are as follows:

Activity	**Responsibility**	**Support from**
Selection of districts and blocks for implementing the project	State C M Mentoring Group	Task Group – National Secretariat
Selecting organizations which will be implementing activities at the district and block level	State C M Mentoring Group	Task Group – National Secretariat
State level workshop to finalise the districts and modalities of district and block level activities	State C M Mentoring Group	Task Group – National Secretariat
State level TOT	State C M Mentoring Group	Task Group – National Secretariat
Adapting and translating materials, curricula and modules for the state	State C M Mentoring Group	Task Group – National Secretariat

A State level workshop will be organised by the State mentoring team and State Health Mission involving all stakeholders (State Mission officials, District health officials and PRI representatives from selected districts, NGO networks and civil society organizations from these districts) along with NRHM GoI representatives. The activities of the first phase will be shared and the process would be finalised. Detailed timetable for District level meetings, formation and orientation of committees could be worked out in this two-day State level workshop.

State level Training of Trainers for the facilitating teams from all pilot districts would need to be conducted primarily by voluntary sector facilitators in the pilot phase, since Government officials may not have adequate experience in community monitoring activities. However State Health department officials would be present and would be involved in these workshops, enabling them to actively participate in further such trainings.

Outcomes of the Preparatory Phase:

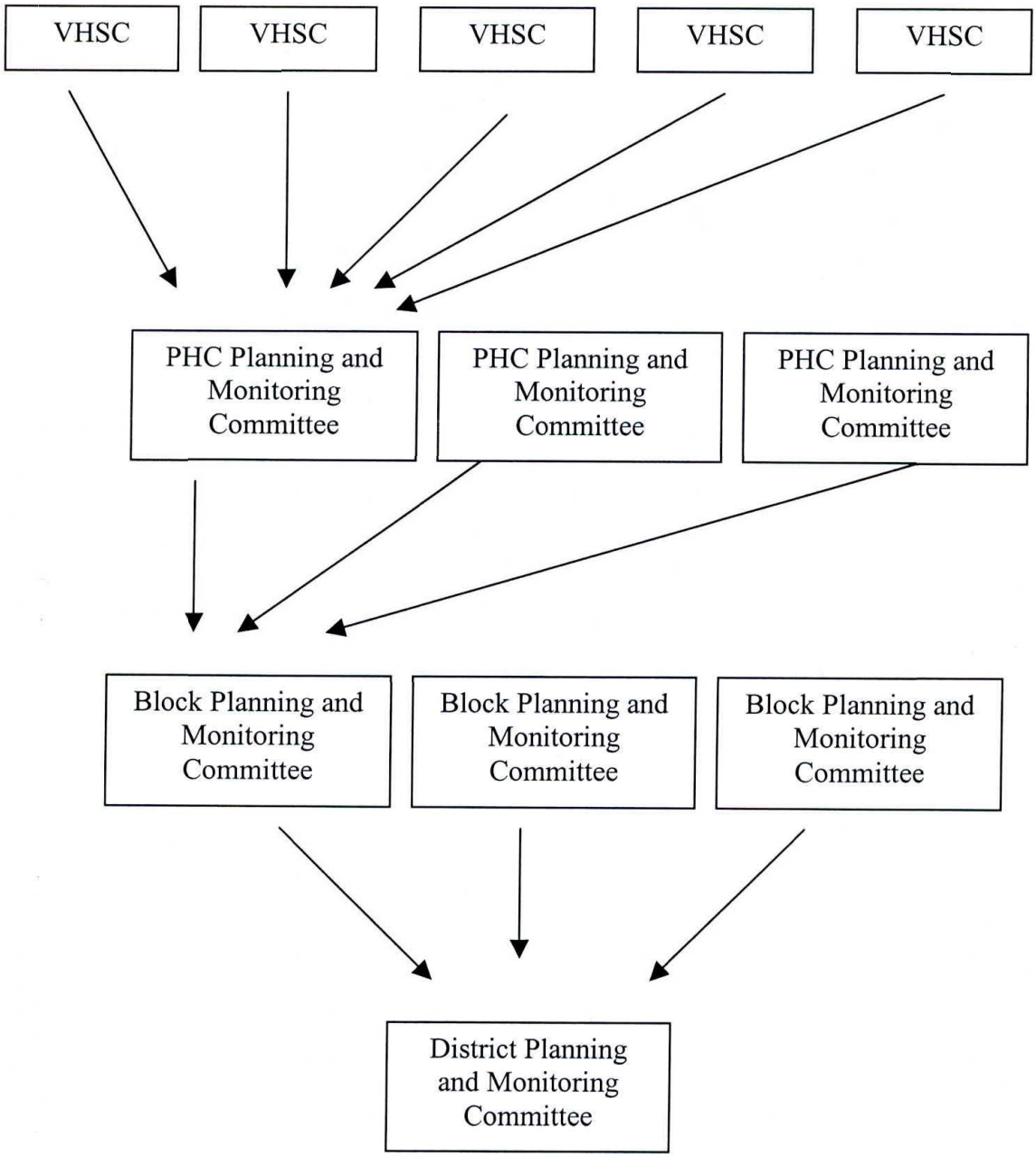
- National Secretariat has been established
- State Community monitoring mentoring groups have been established in all eight states
- State Nodal Organisation has been established in all eight states
- State level workshops have been organised in all states
- State level TOT has been organised in all states
- Draft of materials, curriculum and modules have been prepared
- State level adaptation has begun

District level implementation phase - Once the District and block level facilitating organizations have been trained and selected the key activities will shift to the district and block levels. The time allocated for these activities is July 07 to December 07 in the first phase.

The activities at the district and block level will proceed in the following manner:

Getting Ready for Community Montoring - District processes would be facilitated by NGOs taking responsibility in the first phase districts along with the District health officials and PRI representatives. A *District mentoring team* (including representatives of each of the three groups) to facilitate the Community monitoring process will be put in place, which would facilitate the orientation activities in this and subsequent stages. In each district one NGO would need to take responsibility as the District nodal NGO. This NGO would be assisted by other civil society organisations that would take specific responsibility in various blocks. The process could start with a *District level workshop* to share the concept, identify Blocks and PHCs, involving key district health officials, PRI members and civil society organisations. Three blocks within the district could be selected for pilot implementation. Block nodal civil society organisations would take up responsibility for specific blocks in coordination with the District nodal NGO.

There would be a need to conduct a *Block level training* for at least a four member Block Community Monitoring facilitation team, including at least two NGO/CBO members. Preferably half of the Block team should be women. These Block facilitation team members would be responsible for the subsequent committee formation and orientation processes. It is anticipated that these activities could be completed in the month of July 07.



Formation of Committees - During the next four months (Aug. – Nov. 07), there would be formation of committees at Village, PHC, and Block levels in the selected blocks (in that order), along with organising primary orientation of their members. Formation of Community Monitoring committees would start from village committees, then PHC, then Block, and then District committees. A few members from VHCs would be included in the PHC committee; similarly a few PHC committee members would be included in the Block committee. Therefore it would be important to constitute the committees from village level upwards in such a sequential order. CBOs / NGOs and Panchayat representatives who have shown leading initiative in organising community monitoring activities at any level should find representation in the next higher level committees. Adequate representation of women, Dalits and Adivasis should be ensured in various committees.

Following committee formation at the peripheral levels, the District level committee could also be finalised and would become functional by Nov. 07. In the pilot phase, at the state level a provisional committee could be formed by Dec. 07. This would be given final shape only after the next phase of 'Extended implementation' is completed and at least half of the Districts of the state have in place Community monitoring committees, which could send representatives to the State committee.

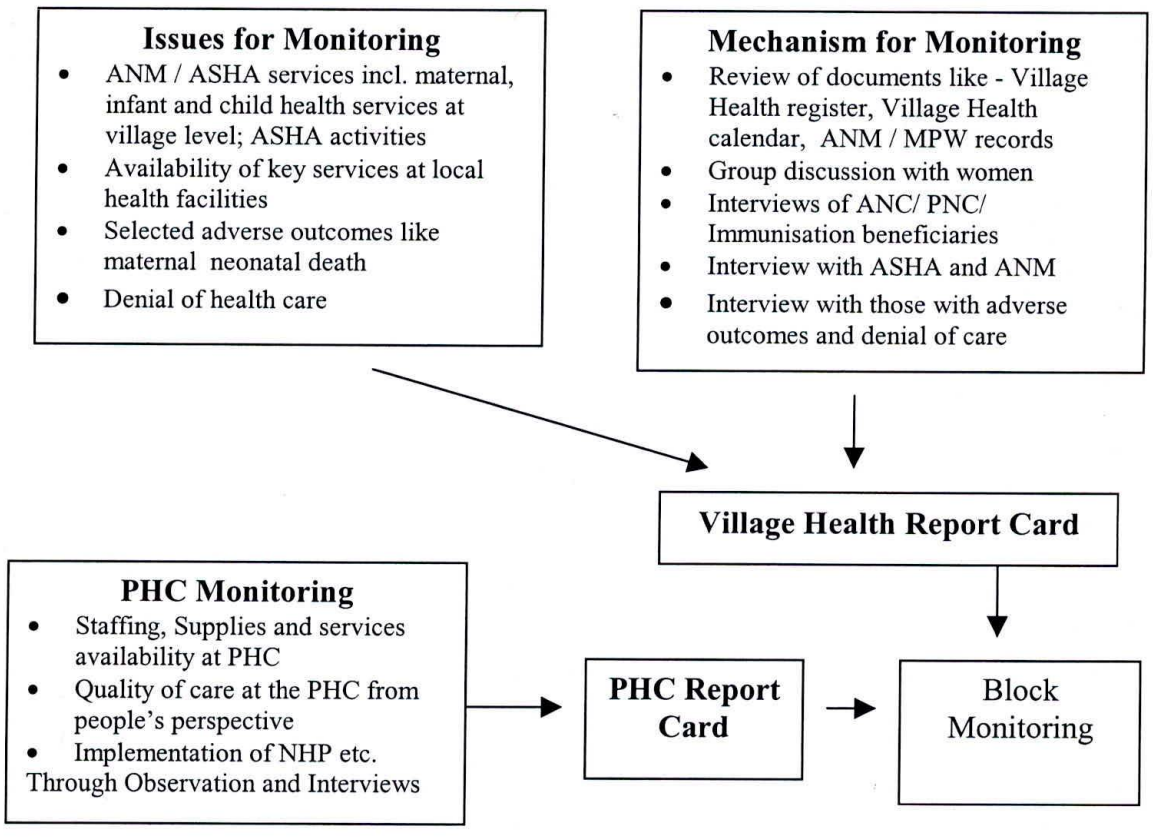
Community Monitoring - The community and community-based organisations will monitor demand / need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. The monitoring process will include outreach services, public health facilities and the referral system. The Community Monitoring exercises and collation of information should be organised village wise, PHC wise, Block-wise, District wise. In this way these exercises should aggregate information upwards. The monitoring results should also be shared at the Village level, Block and District level in the appropriate PRI fora. Some of the frameworks on which Community Monitoring may be done, and which are included within the NRHM are as follows:

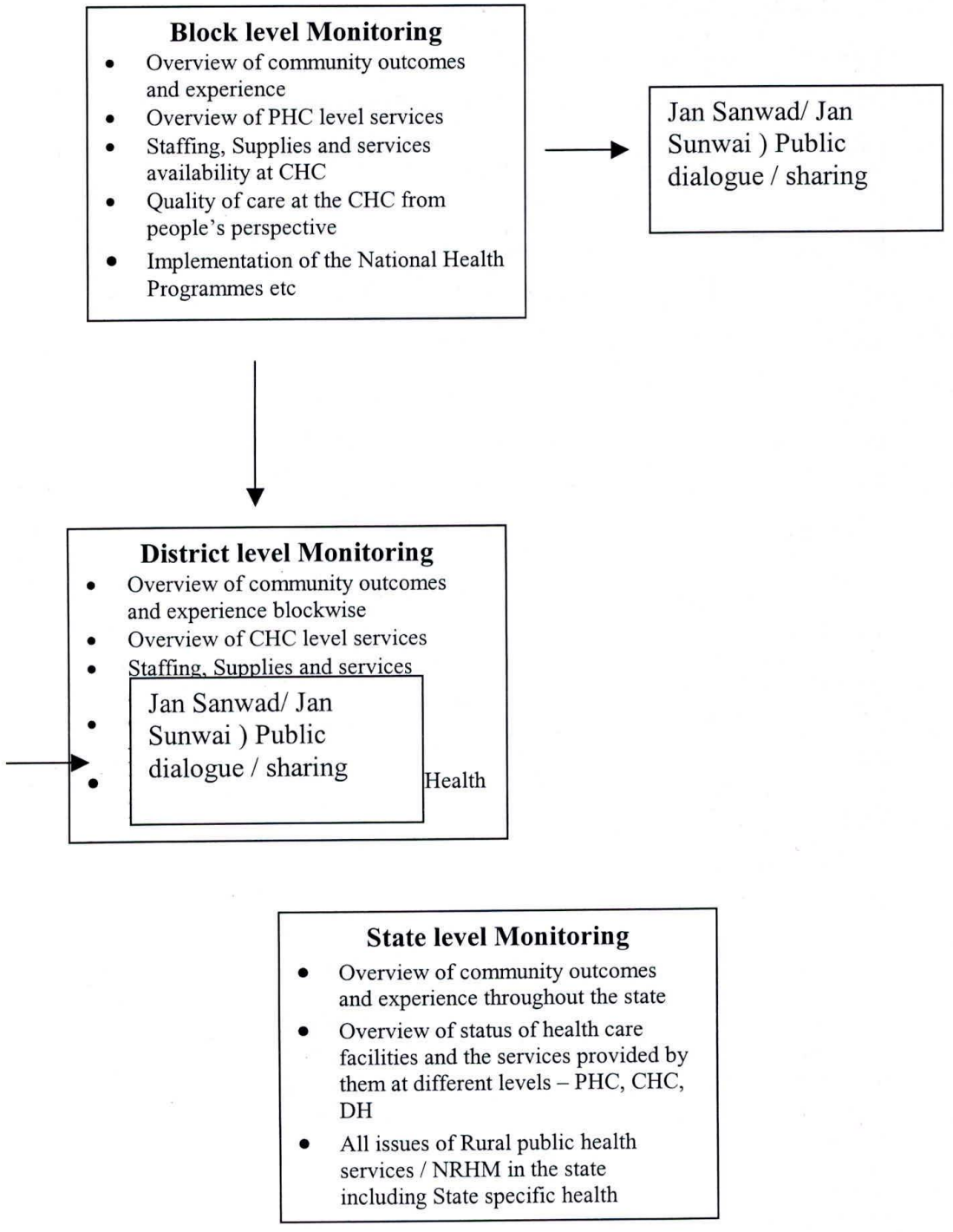
1. Village Health Plan, District Health Plan

2. Entitlements under the Janani Suraksha Yojna
3. Roles and responsibilities of the ASHA
4. Indian Public Health Standards for different facilities like SubCentre, PHC, CHC
5. Concrete Service Guarantees
6. Citizen's Charter and so on.

Activities that have to be undertaken at the village level for community monitoring have already been Table x Section y Page z.

PHC and Block level community monitoring exercises would include a *public dialogue* ('Jan Samvad') or *public hearing* ('Jan Sunwai') process by Dec. 07. Here individual testimonies and assessments by local CBOs / NGOs would be presented. Individual testimonies could be identified through the adverse outcome recording process. These Public dialogues should be moderated / facilitated by the District and Block facilitation groups in collaboration with Panchayat representatives and CBOs / NGOs working on the issue of Health rights.





The Monitoring committee at each level would review and collate the summary reports coming from the committees dealing with units immediately below it. This enables it to make an assessment of the situation prevailing in all the units under its purview, and to

make a report at its level. For example, the District committee would receive and review the reports from all Block committees.

However ***Monitoring committees would not only rely on reports, but would also directly interact in the field situation and get feedback***. Firstly, each committee would appoint a small sub-team drawn from its NGO and PRI representatives who would *visit on a quarterly / six monthly basis a small sample of units* (say one facility or two villages) under their purview and directly review the conditions there. This enables the committee to not just rely on reports but to also have a first-hand assessment of conditions in their area. For example, the PHC committee representatives would visit two villages and conduct Group discussions there, in each trimester selecting different villages by rotation. Similarly the Block committee representatives would visit one PHC by rotation in each trimester.

Secondly, monitoring committees at PHC, Block and District level would be involved in six-monthly or annual *Jan Samvads or Public hearings* at their respective levels, where committee members would get direct feedback of the situation including possible presentation of cases of denial of health care. Similarly, it is suggested that the State health mission could conduct an annual public meeting open to all civil society representatives where the State mission report and independent reports would be presented and various aspects of design and implementation of NRHM in the state, including State specific health schemes, would be reviewed and discussed enabling corrective action to be taken.

Screening Civil Society Organizations for involvement in Community Monitoring

In order to screen civil society organizations for their capacity to partner in community monitoring activities, and to participate in monitoring committees at various levels, a simple questionnaire will be used. Such organisations may include Community Based Organisations (including self-help groups and people's organisations) as well as NGOs working at the respective level, with documented activity in the area since at least three years. In addition to other questions about the organization, the following issues will be included in the questionnaire.

Activity Profile	Community Mobilisation	Women's Empowerment Activities	Rights based Activities
A1- Income Generation A2 - Environment / Natural Resource Mgmt A3 - Education A4- Health	C1- Self Help Groups C2- Village Level Committees C3- Federations C4- Community Leadership training C5- Work with PRIs C6 – Village based organisation and mobilisation on specific issues	W1- Village level women's groups W2 – Women's leadership development and training W3 – Women and PRI	R1- Right to Healthcare R2- Right to Food R3- Right to Information R4- Right to Employment R5- Livelihood rights e.g. rights related to Forest, Land, Wages, Displacement etc. (specify)

On the basis of their responses to their questionnaire the following screening table will be used and any organization that has at least one entry in all the four aspects (with brief report of the activity carried out in that aspect) may be considered as having qualified. Any organisation with demonstrated experience of monitoring Public services, organising public dialogues or public hearings should be given priority to participate in the Community Monitoring committees.

Name of CSO	Activity Profile				Community Mobilisation Activities					Women's Empowerment Activities			Rights based Activities		
	A1	A2	A3	A4	C1	C2	C3	C4	C5	W1	W2	W3	R1	R2	R3

Key considerations while making a selection- To ensure wide participation diverse group of civil society networks and organizations involved in promotion of Health rights and monitoring shall be involved at various levels

The process of selecting civil society organisations to be involved in monitoring committees at all levels could be facilitated by the mentoring team of the respective level, with guidance from the mentoring team of the higher level. For example, the district mentoring team could suggest the names of civil society organisations to be involved in the District monitoring committee, with inputs from the state mentoring team as relevant. This should be a participatory process including various civil society networks and

organisations. It should not be limited to NGOs, and should also definitely involve Community based organisations and people's organizations

Civil society involvement in monitoring should not be focussed only on 'mother NGOs' which are often deeply involved in implementation and who may not always be the most objective monitors of work which they themselves are involved in implementing. Particularly for the Community monitoring process in NRHM, it is imperative that the idea is not confined to just 'leave it to mother NGOs' but rather that organizations with experience of rights based activities and accountability enforcing activities be given adequate space and responsibility at all levels.

Process documentation and review

Since the first phase of the Community Monitoring process is a learning phase it will include process documentation and review as an important component. This will include the following three distinct stages:

Process Documentation: To ensure uniformity of recording the activity, each activity of the project that has been mentioned above will include a documentation procedure. These documents will be filled in by the responsible agency at different levels and collated at the state level. The state mentoring team will be responsible for analyzing these documents and will prepare a review report on the state implementation, reporting what interventions worked and why and suggesting changes.

Evaluation of the state level intervention: There will be an independent evaluation of the different interventions and their impact on different stakeholders by a team of two experts. The evaluation will include review of the documentation process, interviews with different stakeholders, including members of the community in a limited number of locations across each of the 8 states.

***State level review workshops*:** The third component of the review process will comprise of an endline workshop with those involved in implementing the pilot phase to review the process of the pilot in each state.

Organisational responsibilities

The entire range activities during the first phase would need to be supported by NRHM Mission Directorate from the Union Health Ministry level for rapidity of execution, given the compressed timeframe available. Responsibilities for handling funds and ensuring activities at various levels may be allocated as follows:

Level	Responsibility
National	Overall facilitation by AGCA (in consultation with NRHM officials). Financial responsibilities and coordination handled by AGCA secretariat along with sub-group of AGCA
State	State Nodal NGO under guidance of State Mentoring team (which would include State Mission Director)
District	District nodal NGO under guidance of District mentoring team (which would include District Health Officer)
Block and below	Block nodal civil society organisation (in coordination with District nodal NGO)

National Secretariat on Community Action – NRHM

At the national level, the Task Group of the Advisory Group on Community Action (AGCA) will be facilitating the entire process of community action in consultation with the Ministry of Health and Family Welfare. The Population Foundation of India is the Secretariat for the AGCA. A National Secretariat will be set up under the leadership of PFI along with Centre for Health and Social Justice at New Delhi. The Secretariat will be undertaking special facilitation of the community monitoring process at the national level in consultation with the MOHFW and NRHM Mission. The National Secretariat would function within the framework formulated by the AGCA for community based monitoring of programmes under NRHM.

The National Secretariat would have the following role and responsibilities:

- Coordinating activities of the national preparatory phase, which includes developing tools, model curriculum, workshops, awareness materials and documentation formats for the programme.

- Assist the AGCA members and the state NRHM Directorates and NGO networks for the state preparatory stage.
- Facilitate process documentation and review of the pilot implementation phase in consultation with AGCA members.
- Develop a website on community based monitoring of processes and access to services under NRHM
- Manage the financial responsibility of the pilot programme
- Prepare progress reports, field visits and the national dissemination workshops of the programme at the national level
- Conduct quarterly review of AGCA for review of the pilot programme.

Staffing - The National Secretariat would be managed by two officers responsible for the overall programmatic and financial coordination of the programme. The coordinators would report to the Task Group of AGCA.

Organogram

Ministry of Health and Family Welfare (GoI)- NRHM *(The pilot project on community based monitoring of health services under NRHM is a GOI initiative. The fund for the pilot phase facilitation and implementation would be given by the NRHM. Supported by the MoHFW, the State health departments have a central role in developing the Community monitoring framework)*
Advisory Group on Community Action (AGCA)
National Secretariat on Community Action- NRHM
State Monitoring and Planning Committee
State Mentoring Team *(At the State level, the State Mentoring team would be formed involving representatives of the state health department and state level health sector voluntary networks. This team would have definite responsibilities to develop community monitoring in the state. It will organize State level workshop with State Health Mission)*
State Nodal NGO *(Out of the state mentoring team, one NGO Member will designated as State NodalNGO)*
District mentoring Team (This team will include PRI representatives, district Health Officials and NGO representatives)
District Nodal NGO *The District level and Block level funds in the pilot phase in each state would be given to designated District nodal NGO to enable a fast start-up and adequate flexibility in the process)*
District Monitoring and Planning Committee
Block nodal civil society organizations *(The District nodal NGO would collaborate with Block nodal civil society organisations for execution of activities in specific blocks)*
Block Community Monitoring Facilitation Team (Responsible for subsequent committee formation and orientation processes)
Block Monitoring and Planning Committee
PHC Monitoring and Planning Committee
Village Health and Sanitation Committee

Budget Break Up for Community Monitoring

Activity Budgets

Block Level

	Level	Number of unit activity	Participants in each unit activity	Cost per activity	Budget
1	**Orientation of members of community monitoring team**				
	Block	1	20 members per block committee	15000	15000
	PHC	3	15 members per PHC committee.	16500	49500
	Villages	5	10 VHC members per village	16750	83750
			Total		148250
2	**Formation of commmunity monitoring Committees**				
	Block	1	30 participants (panchayat members, NGO/ CBO members and PHC committee members)	3000 per block meeting	3000
	PHC	3	30 people	1000 per PHC meeting	3000
	Village	5	2 facilitators	1000 per village for 2 preparatory visits and 1 meeting	5000
			Total		11000
3	**Conduction of Jan Samvad / Jan Sunwai in each of the pilot PHCs and blocks**				
	Block Jan Samvad	1	5 panelists / experts, 200 participants	18000 per block Jan Samvad	18000
	PHC Jan Samvad	3	5 panelists / experts, 100 participants	10000 per PHC Jan Samvad	30000
			Total		48000
			Block budget total		207250

District Level

	Budget- Of one District				
	Type of Activity	**Number of unit activity**	**Participants in each unit activity**	**Cost per activity**	**Budget**
1	**District facilitation, training of trainers**				
	District workshop – one in each district, one day	1	25 participants	22,000	22,000
2	**Formation of Community Monitoring committees**				
	District	1	20 participants	7000 per district meeting	7000
3	**Orientation of members of Community Monitoring committees**				
	District	1	20 members per district committee @ Rs. 6000/- for 2 meetings	23,000	23,000
4	**Training of Block level Trainers**	3		42,000	126,000
5	**Facilitation costs for dist. NGO**				
			One middle level staff member full time for 7 months.	226000	226000
			3 Field staff full time for six months (one in each block.		
6	Budget for each district				404,000
7	**Budget for each block**		3 Blocks	207250	621,750
	Total Budget Allotted for one district (including the Block budget)				1025,750

State Level Budget

Activity	Budget	Total Budget With 3 districts	Total Budget With 4 districts	Total Budget With 5 districts
State level workshop(2 days) – leads to selection of districts	110000	110000	110000	110000
State Training of trainers (5 days)	187500	187500	187500	187500
State level facilitation by State nodal NGO	250000	250000	250000	250000
District level budget Including Block Budget	1025,750	3077,250	4103,000	5128,750
Total Budget		**36,24,750**	**46,50,500**	**56,76,250**

Annexure 1 : NRHM STRATEGIES

(a) Core Strategies:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).
- Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.
- Technical Support to National, State and District Health Missions, for Public Health Management.
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of Human Resources for health.
- Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.
- Promoting non-profit sector particularly in under served areas.

(b) Supplementary Strategies:

- Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.
- Promotion of Public Private Partnerships for achieving public health goals.
- Mainstreaming AYUSH – revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.
- Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

Annexure 2 : MONITORING AND EVALUATION

- Health MIS to be developed upto CHC level, and web-enabled for citizen scrutiny
- Sub-centres to report on performance to Panchayats, Hospitals to Rogi Kalyan Samitis and District Health Mission to Zila Parishad
- The District Health Mission to monitor compliance to Citizen's Charter at CHC level
- Annual District Reports on People's Health (to be prepared by Govt/NGO collaboration)
- State and National Reports on People's Health to be tabled in Assemblies, Parliament
- External evaluation/social audit through professional bodies/NGOs
- Mid Course reviews and appropriate correction

(NRHM – Mission Document)

Monitoring outcomes of the Mission

Right to health is recognized as inalienable right of all citizens as brought out by the relevant rulings of the Supreme Court as well as the International Conventions to which India is a signatory. As rights convey entitlement to the citizens, these rights are to be incorporated in the monitoring framework of the Mission. Therefore, providing basic Health services to all the citizens as guaranteed entitlements will be attempted under the NRHHM.

Preparation of Household specific Health Cards that record information on the following - record of births and deaths, record of illnesses and disease, record any expenditure on health care, food availability and water source, means of livelihood, age profile of family, record of age at marriage, sex ratio of children, available health facility and providers, food habits, alcohol and tobacco consumption, gender relations within family, etc, (by ASHA/AWW/Village Health Team).

Preparation of Habitation/Village Health Register on the basis of the household Health Cards. (By the Village Health Team)

Periodic Health Facility Survey at SHC, PHC, CHC, District level to see if service guarantees are being honoured.[By district /Block level Mission Teams/ research and resource institutions].

Formation of Health Monitoring and Planning Committees at PHC, Block, District and State levels to ensure regular monitoring of activities at respective levels, along with facilitating relevant inputs for planning.

Sharing of all data and discussion at habitation/ village level to ensure full transparency.

Display of agreed service guarantees at health facilities, details of human and financial resources available to the facility.

Sample household and facility surveys by external research organizations/NGOs.

Public reporting of household and health facility findings and its wider dissemination through public hearings and formal reporting.

(From : NRHM Framework for Implementation)

Annexure 3 : COMMUNITY MONITORING FRAMEWORK

124. We have discussed the overall monitoring framework in an earlier section (IV L). The basic change that NRHM wishes to bring about in the monitoring framework is to involve local communities in planning and implementing programmes with a framework that allows them to assess progress against agreed benchmarks. While external institutions will also assess progress, they will do so on benchmarks that have been agreed with local communities and health institutions. The intention is to move towards a community based monitoring framework that allows continuous assessment of planning and implementation of NRHM. Besides the issues already mentioned earlier on the monitoring framework, the broad principles for community based monitoring are listed below.

125. Given the overall objective that people should have complete access to rational, appropriate and effective health care, community based monitoring should preferably fulfill following objectives:

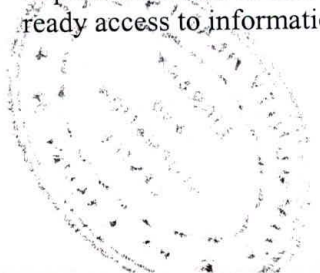
- It should provide regular and systematic information about community needs, which would guide related planning
- It should provide feedback according to the locally developed yardsticks for monitoring as well as key indicators. This would essentially cover the status of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.
- It should enable the community and community-based organisations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system. The community should emerge as active *subjects* rather than passive *objects* in the context of the public health system.
- It could be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

(i) *Ownership of Community monitoring process*

- The health department functionaries need to be involved in the preparation and mobilization phase of the initiative so as to enable 'ownership' of the process and outcomes among the providers and users.
- PRIs, community based organizations and NGOs, along with health department functionaries should be involved in the preparation and mobilization phase of the initiative so as to enable ownership of the process and outcomes among the providers and users.
- The government can enable such interactive processes through issuing relevant Government Orders, and by ensuring effective communication to all levels of public health functionaries
- All the members of any committee that is formed (for example the Village Health Committee) must have their roles and responsibilities clearly defined and articulated.

(ii) *Powers and capacity building*

126. The committees that are formed at various levels **must have concomitant authority i.e. they must have the power to initiate action**. The capacities of the members of a village level committee have to be built continuously for them to be able to function effectively. This would require allocation of resources and capacity building inputs. This process must begin with full and ready access to information.



127. The intent of the newly launched NRHM as mentioned in the core strategy is that it will promote community ownership and decentralised planning from village to district level. This is supposed to be through participatory processes, by strengthening evidence based effective monitoring and evaluation. In order to actually do so it will be imperative that:

- The government should enable such interactive processes by issuing relevant Government Orders. One example of such orders is the one passed by the Government of Rajasthan for the formation of Convergence Committees at the district and PHC level. A similar example is the response of the Gujarat Government to the National Human Rights Commission, wherein coordination bodies at various levels of the Public Health System are proposed for operationalising a State level health services monitoring mechanism.
- All the members of any committee that is formed must have their roles and responsibilities clearly defined and articulated.
- Effective and quality monitoring requires institutional mechanisms at various levels beginning at the community and going upwards. Adequate investment (time and resources) must be made in capacity development at various levels.
- Analysis of the collected information must be undertaken at various levels so as to enable prompt action and corrections. The committees that are formed at various levels must have concomitant authority i.e. they must have the power to take action.
- The monitoring system must be directly linked to corrective decision making bodies at various levels. The information and issues emerging from monitoring must be communicated to the relevant official bodies responsible for taking action (from PHC to state level) so that monitoring results in *prompt, effective and accountable remedial action.*

(iv) *Further, some overall points to be kept in mind are*:

- Effective Community Monitoring would change the status of community members from passive beneficiaries to active rights holders, enabling them to more effectively access health services.
- We must be realistic in setting indicators and planning activities. Communities need few and simple indicators for monitoring, and the time devoted by members, especially community representatives involved in various committees must be utilized optimally.
- Community Monitoring must be seen as an integral part of the Public Health System at all levels and for all activities, and not as a stand-alone process.
- Panchayati Raj Institutions are not synonymous with the community. For community ownership and effective monitoring, even if PRI representatives are involved, one still needs to involve user groups and beneficiaries, and to include Community Based Organisations.

(v) Involvement of the general public by means of regular 'Public dialogue' or Public hearing (Jan Samvad / Jan Sunwai)

128. Most of the public participation in the monitoring process would be mediated by representatives of the community or community-linked organisations. However, to enable *interested community members to be directly involved* in exchange of information, and to improve transparency and accountability of the health care system, 'Public dialogues' (Jan Samvad) or Public hearings ('Jan Sunwai') would be need to organised at regular intervals (once or twice in a year, depending on the initiative of the local organisations) at PHC, block and district levels (see section V-I).

What should the community monitor?

129. The community and community-based organisations should monitor demand / need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. This should be monitored related to outreach services, public health facilities and the referral system.

Annexure 4 : COMPOSITION, ROLES AND RESPONSIBILITIES OF MONITORING COMMITTEES

Composition of the Village Health committee

This committee would be formed at the level of the revenue village (more than one such villages may come under a single Gram Panchayat).

Composition: The Village Health Committee would consist of:

- Gram Panchayat members from the village
- ASHA, Anganwadi Sevika, ANM
- SHG leader, the PTA/MTA Secretary, village representative of any Community based organisation working in the village, user group representative

The chairperson would be the Panchayat member (preferably woman or SC/ST member) and the convenor would be ASHA; where ASHA not in position it could be the Anganwadi Sevika of the village.

Some yardsticks for monitoring at the village level

- Village Health Plan
- NRHM indicators translated into Village health indicators

Some roles of the Village Health Committee

Activities

- Create Public Awareness about the essentials of health programmes, with focus on People's knowledge of entitlements to enable their involvement in the monitoring.
- Discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community
- Analyse key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present an annual health report of the village in the Gram Sabha
- *Participatory Rapid Assessment*: to ascertain the major health problems and health related issues in the village. Estimation of the annual expenditure incurred for management of all the morbidities may also be done. The mapping will also take into account the health resources and the unhealthy influences within village boundaries. Mapping will be done through participatory methods with involvement of all strata of people. The health mapping exercise shall provide quantitative and qualitative data to understand the health profile of the village. These would be Village information (number of households – caste, religion and income ranking, geographical distribution, access to drinking water sources, status of household and village sanitation, physical approach to village, nearest health facility for primary care, emergency obstetric care, transport system) and the morbidity pattern
- Maintenance of a *village health register and health information board/calendar:* The health register and board put up at the most frequented section of the village will have information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc. Similarly dates of visit and activities expected to be performed during each visits by health functionaries may be displayed and monitored by means of a Village health calendar. These will be the most important document maintained by the village community about the exhibition of health status and health care services availability. This will also serve as the instrument for cross verification and validation of data
- Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW

• Get a bi-monthly health delivery report from health service providers during their visit to the village. Discuss the report submitted by ANM and MPW and take appropriate action
• Take into consideration of the problems of the community and the health and nutrition care providers and suggest mechanisms to solve it.
• Discuss every maternal death or neonatal death that occurs in their village, analyze it and suggest necessary action to prevent such deaths. Get these deaths registered in the Panchayat.
• Managing the village health fund.

Some tools for monitoring at the village level

- Village Health Register
- Records of the ANM
- Village Health Calendar
- Infant and maternal death audit
- Public dialogue (Jan Samvad)

Powers of the committee

- The convener will sign the attendance registers of the AWWs, Mid-Day meal Sanchalak, MPWs, and ANMs.
- MPWs and ANMs will submit a bi-monthly village report to the committee along with the plan for next two months. Format and contents of the bi-monthly reports would be decided village health committee.
- The committee will receive funds of Rs.10,000 per year. This fund may be used as per the discretion of the VHC.

2. PHC Health Monitoring and Planning Committee

Role and Responsibilities of the Committee

• Consolidation of the village health plans and charting out the annual health action plan in order of priority. The plan should clearly lay down the goals for improvement in health services and key determinants.
• Presentation of the progress made at the village level, achievements, actions taken and difficulties faced followed by discussion on the progress of the achievements of the PHC, concerns and difficulties faced and support received to improve the access to health facilities in the area of that particular PHC. The discussion could include:

- Sharing of reports of Village Health Committees
- Reports from ANM, MPW about the coverage of health facilities
- Any efforts done at the village level to improve the access to health care services
- Record and analysis of neonatal and maternal deaths.
- Any epidemic occurring in the area and preventive actions taken.

• Ensure that the **Charter of citizen's health rights** is disseminated widely and displayed out side the PHC informing the people about the medicine facilities available at the PHC, timings of PHC and the facilities available free of cost. A suggestion box can be kept for the health care facility users to express their views about the facilities. These comments will be read at the coordination committee meeting to take necessary action.
• Monitoring of the physical resources like, infrastructure, equipments, medicines, water connection etc at the PHC and inform the concerned government officials to improve it.
• Discuss and develop a PHC Health Plan based on an assessment of the situation and priorities identified by representatives of village health committees and community based organisations

• Share the information about any health awareness programme organized in the PHC's jurisdiction, its achievements, follow up actions, difficulties faced etc.
• Coordinate with local CBOs and NGOs to improve the health scenario of the PHC area.
• Review the functioning of Sub-centres operating under jurisdiction of the PHC and taking appropriate decisions to improve their functioning
• At the end of the meeting brief minutes of the meeting will be developed along with the action plan emphasizing the actions to be taken by different committee members, which will be shared at the District level committee. The minutes will also serve as a reference point, while sharing the progress done between two committee meetings.
• Initiate appropriate action on *instances of denial of right to health care* reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The report may become a part of the performance appraisal of the concerned staff member. The committee may recommend corrective measures to the next level (block/ district). The decisions taken in the committee need to be forwarded to higher concerned officials and a copy to the corresponding health committee of that level who will be responsible to take necessary decision for action to be taken on the inquiry within a period of three months.

Constitution of the PHC Health committee

The PHC Health committee would function as the health monitoring and planning arm of the Panchayats coming under the PHC area. It is recommended that the PHC Committee have the following broad pattern of representation, including members from Panchayats, health care service providers and civil society:

- 30% members should be representatives of Panchayat Institutions (Panchayat samiti member from the PHC coverage area; two or more sarpanchs of which at least one is a woman)
- 20% members should be non-official representatives from the village health committees, coming from villages under the jurisdiction of the PHC, with annual rotation to enable representation from all the villages
- 20% members should be representatives from NGOs / CBOs and People's organizations working on Community health and health rights in the area covered by the PHC
- 30% members should be representatives of the Health and Nutrition Care providers, including the Medical Officer – Primary Health Centre and at least one ANM working in the PHC area

The chairperson of the PHC committee would be one of the Panchayat representatives, preferably a Panchayat Samiti member belonging to the PHC coverage area. The executive chairperson would be the Medical officer of the PHC. The secretary of the PHC committee would be one of the NGO / CBO representatives.

Power of the committee

• Contribute to annual performance appraisal of Medical officer / other functionaries at the PHC.
• Take collective decision about the utilization of the special funds given to PHC (say Rs.25,000) for the repairs, maintenance of equipments, health education etc and any other aspects, which will facilitate the improvement of access to health care services. The MO can utilize this fund after the discussion and approval from the committee.

Some yardsticks for monitoring at the PHC level

- Charter of Citizens Health Rights

- IPHS or similar standards for PHC (this would include continuous availability of basic outpatient services, indoor facility, delivery care, drugs, laboratory investigations and ambulance facilities)
- PHC Health Plan

Some tools for monitoring at the PHC level

- Village health registers / calendars
- PHC records
- Discussions with and interviews of the PHC committee members
- Public dialogue (Jan Samvad) or Public hearing (Jan Sunwai)
- Quarterly feedback from village Health Committees
- Periodic assessment of the existing structural deficiencies

Block Health Monitoring and Planning Committee

Role and Responsibilities:

- Consolidation of the PHC level health plans and charting out of the annual health action plan for the block. The plan should clearly lay down the goals for improvement in health services.
- Review of the progress made at the PHC levels, difficulties faced, actions taken and achievements made, followed by discussion on any further steps required to be taken for further improvement of health facilities in the block, including the CHC.
- Analysis of records on neonatal and maternal deaths; and the status of other indicators, such as coverage for immunization and other national programmes.
- Monitoring of the physical resources like, infrastructure, equipments, medicine, water connection etc at the CHC; similar exercise for the manpower issues of the health facilities that come under the jurisdiction of the CHC.
- Coordinate with local CBOs and NGOs to improve the health services in the block.
- Review the functioning of Sub-centres and PHCs operating under jurisdiction of the CHC and taking appropriate decisions to improve their functioning
- Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The committee may also recommend corrective measures to the district level.

Constitution of the Block committee

It is recommended that the Block Committee have the following broad pattern of representation, including members from Panchayats, health care service providers and civil society:

- 30% members should be representatives of the Block Panchayat Samiti (Adhyaksha / Adhyakshika of the Block Panchayat Samiti or members of the Block Panchayat samiti, with at least one woman)
- 20% members should be non-official representatives from the PHC health committees in the block, with annual rotation to enable representation from all PHCs over time
- 20% members should be representatives from NGOs / CBOs and People's organizations working on Community health and health rights in the block, and involved in facilitating monitoring of health services
- 20% members should be officials such as the Block Medical Officer, the Block Development Officer, selected Medical Officers from PHCs of the block
- 10% members should be representatives of the CHC level Rogi Kalyan Samiti

The chairperson of the Block committee would be one of the Block Panchayat Samiti representatives. The executive chairperson would be the Block medical officer. The secretary would be one of the NGO / CBO representatives.

Yardsticks for monitoring at the Block level

- IPHS or similar standards for CHC (this would include continuous availability of basic outpatient services, indoor facility, community outreach services, referral services, delivery and antenatal care, drugs, laboratory investigations and ambulance facilities)
- Charter of Citizens Health Rights for CHC
- Block Health Plan

Some tools for monitoring at the Block level

- PHC and CHC records
- Discussions with and interviews of the CHC RKS members
- Report of Public dialogue (Jan Samvad)
- Quarterly feedback from village and PHC Health Committees
- Periodic assessment of the existing structural and functional deficiencies

District Health Monitoring and Planning Committee

Role and Responsibility

- Discussion on the reports of the PHC health committees
- Financial reporting and solving blockages in flow of resources if any
- Infrastructure, medicine and health personnel related information and necessary steps required to correct the discrepancies.
- Progress report of the PHCs emphasising the information on referrals utilisation of the services, quality of care etc.
- Contribute to development of the District Health Plan, based on an assessment of the situation and priorities for the district. This would be based on inputs from representatives of PHC health committees, community based organisations and NGOs.
- Ensuring proper functioning of the Hospital Management Committees.
- Discussion on circulars, decisions or policy level changes done at the state level; deciding about their relevance for the district situation
- Taking cognizance of the reported cases of the denial of health care and ensuring proper redressal.

Constitution of the District committee

It is recommended that the District Committee have the following broad pattern of representation, including members from Panchayati Raj Institutions, health care service providers and civil society:

- 30% members should be representatives of the Zilla Parishad (esp. convenor and members of its Health committee)
- 25% members should be district health officials, including the District Health Officer / Chief Medical Officer and Civil Surgeon or officials of parallel designation, along with representatives of the District Health planning team including management professionals
- 15% members should be non-official representatives of block committees, with annual rotation to enable successive representation from all blocks
- 20% members should be representatives from NGOs / CBOs and People's organizations working on Health rights and regularly involved in facilitating Community based monitoring at other levels (PHC/block) in the district
- 10% members should be representatives of Hospital Management Committees in the district

The chairperson of the District committee would be one of the Zilla Parishad representatives, preferably convenor or member of the Zilla Parishad Health committee. The executive chairperson would be the CMO / CMHO / DHO or officer of equivalent designation. The secretary of the PHC committee would be one of the NGO / CBO representatives.

Some yardsticks for monitoring at the District level

- Charters of Citizens Health Rights
- District Action Plan
- NRHM guidelines
- Indian Public Health Standards

Some tools for Monitoring at the District level

- Report from the PHC Health committees
- Report of the District Mission committee
- Public Dialogue (Jan Samvad)

State Health Monitoring and Planning Committee

Role and Responsibilities

The main role of the committee is to discuss the programmatic and policy issues related to access to health care and to suggest necessary changes.

This committee will review and contribute to the development of the State health plan, including the plan for implementation of NRHM at the state level; the committee will suggest and review priorities and overall programmatic design of the State health plan.

Key issues arising from various District health committees, which cannot be resolved at that level (especially relating to budgetary allocations, recruitment policy, programmatic design etc) would be discussed an appropriate action initiated by the committee. Any administrative and financial level queries, which need urgent attention, will be discussed.

Institute a health rights redressal mechanism at all levels of the health system, which will take action within a time bound manner. Review summary report of the actions taken in response to the enquiry reports

Operationalising and assessing the progress made in implementing the recommendations of the NHRC, to actualize the Right to health care at the state level.

The committee will take proactive role to share any related information received from GOI and will also will share achievements at different levels. The copies of relevant documents will be shared.

Composition of State Health Monitoring and Planning committee

30% of total members should be elected representatives, belonging to the State legislative body (MLAs/MLCs) or Convenors of Health committees of Zilla Parishads of selected districts (from different regions of the state) by rotation

15% would be non-official members of district committees, by rotation from various districts belonging to different regions of the state

20% members would be representatives from State health NGO coalitions working on Health rights, involved in facilitating Community based monitoring

25% members would belong to State Health Department:

Secretary Health and Family Welfare, Commissioner Health, relevant officials from Directorate of Health Services (incl. NRHM Mission Director) along with Technical experts from the State Health System Resource Centre / Planning cell

- 10% members would be officials belonging to other related departments and programmes such as Women and Child Development, Water and Sanitation, Rural development.
- The Chairperson would be one of the elected members (MLAs).
- The executive chairperson would be the Secretary Health and Family Welfare.
- The secretary would be one of the NGO coalition representatives.

Some yardsticks for monitoring at the State level

- NHRC recommendations and National Action Plan on Right to Health Care; responses of state health departments and actions to which the State Government has committed itself
- NRHM state level plan and the State Health Mission guidelines
- IPHS

Tools for monitoring at the State level

- Reports of the District Health committees
- Periodic assessment reports by various taskforces / State level committees about the progress made in formulating policies according to IPH Standards, NHRC recommendations and its implementation status etc.

Annexure 5 : CONCRETE SERVICE GUARANTEES

Concrete Service Guarantees that NRHM will provide:

- Skilled attendance at all Births
- Emergency Obstetric care
- Basic neonatal care for new born
- Full coverage of services related to childhood diseases / health conditions
- Full coverage of services related to maternal diseases / health conditions
- Full coverage of services related to low vision and blindness due to refractive errors and cataract.
- Full coverage for curative and restorative services related to leprosy
- Full coverage of diagnostic and treatment services for tuberculosis
- Full coverage of preventive, diagnostic and treatment services for vector borne diseases
- Full coverage for minor injuries / illness (all problems manageable as part of standard outpatient care upto CHC level)
- Full coverage of services inpatient treatment of childhood diseases / health conditions
- Full coverage of services inpatient treatment of maternal diseases / health conditions including safe abortion care (free for 50% user charges from APL)
- Full coverage of services for Blindness, life style diseases, hypertension etc.
- Full coverage for providing secondary care services at Sub-district and District Hospital.
- Full coverage for meeting unmet needs and spacing and permanent family planning services.
- Full coverage of diagnostic and treatment services for RI/STI and counseling for HIV – AIDS services for adolescents.
- Health education and preventive health measures.

Framework for developing health insurance programmes

Some suggestions for States

Ministry of Health & Family Welfare

Government of India

New Delhi

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BACKGROUND:

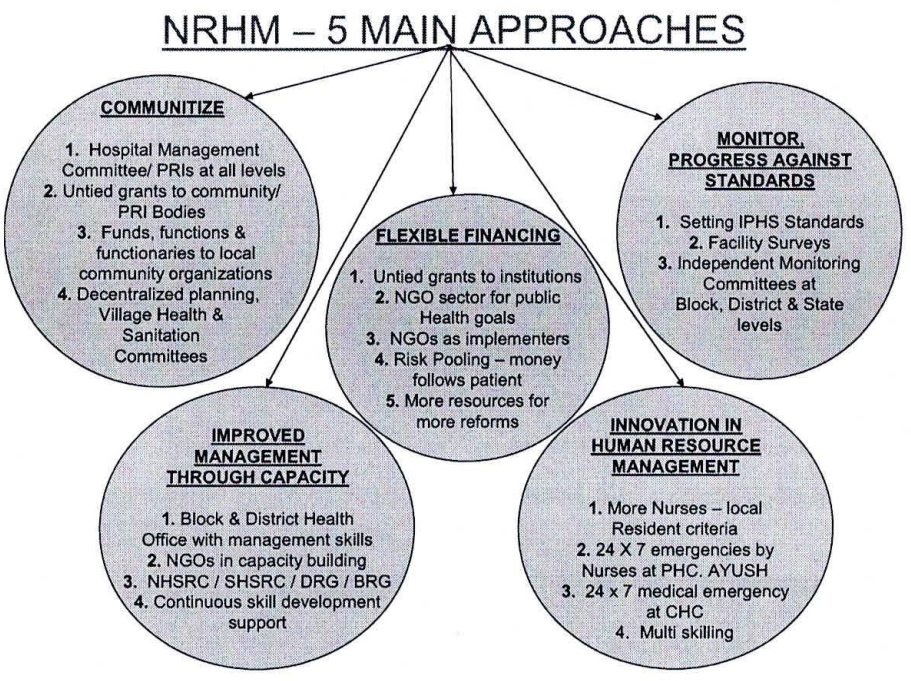
The Hon'ble Prime Minister launched the NRHM on 12th April, 2005 throughout the country with special focus on 18 States, including eight Empowered Action Group (EAG) States, the North-Eastern States, Jammu & Kashmir and Himachal Pradesh.

The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. It also seeks to reduce the Maternal Mortality Rate (MMR) in the country from 407 to 100 per 1,00,000 live births, Infant Mortality Rate (IMR) from 60 to 30 per 1000 live births and the Total Fertility Rate (TFR) from 3.0 to 2.1 within the 7 year period of the Mission.

IMPLEMENTATION FRAMEWORK & PLAN OF ACTION FOR NRHM

The key features in order to achieve the goals of the Mission include making the public health delivery system fully functional and accountable to the community, human resources management, community involvement, decentralization, rigorous monitoring & evaluation against standards, convergence of health and related programmes from village level upwards, innovations and flexible financing and also interventions for improving the health indicators.

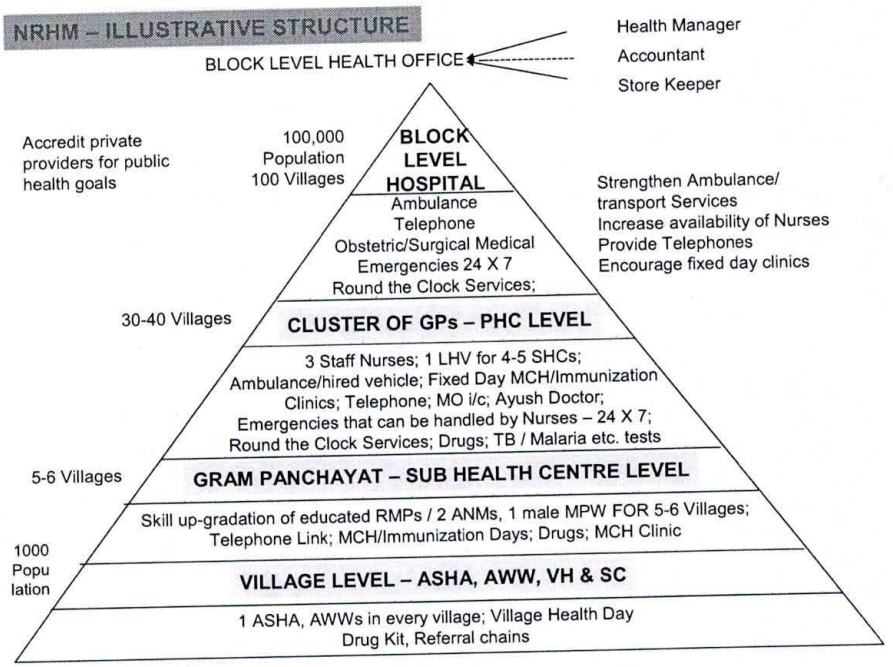
The Diagrammatic Representation of the 5 Main approaches of NRHM is illustrated below:



IMPROVING THE PUBLIC HEALTH DELIVERY SYSTEM

Given the status of public health infrastructure in the country, particularly in the EAG and the North Eastern States, it will not be possible to provide the desired services till the infrastructure is sufficiently upgraded. The Mission seeks to establish functional health facilities in the public domain through revitalization of the existing infrastructure and fresh construction or renovation wherever required. The Mission also seeks to improve service delivery by putting in place enabling systems at all levels. This involves simultaneous corrections in manpower planning as well as infrastructure strengthening. The Mission would provide priority to both these aspects.

A generic Public Health Delivery System envisioned under NRHM from the Village to the Block Level is illustrated below:



PUBLIC HEALTH INFRASTRUCTURE

The Central Govt. has so far supported only the construction/up gradation of sub-centres. Because of their difficult financial conditions, the States have usually not provided sufficient funds for construction / up-gradation of Primary Health Centre [PHC]/Community Health Centre [CHC]/District Hospitals etc. As a result, health infrastructure is in poor condition in most of the states. NRHM allows the expenditure for construction subject to the condition that it should not be more than 33% of the total NRHM outlay in the case of high focus States, and, 25% in the case of non-high focus States. NRHM also provides for upgradation of District Hospitals.

In the first Cabinet approval, provision had been made for setting up of Indian Public Health Standards (IPHS) only for Community Health Centres (CHCs)/PHCs. The Mission now provides for IPHS at all levels i.e., sub-centres PHC/CHC and district hospitals.

As per the original Cabinet approval, untied grants were to be made available only to sub-centres. However, the Mission now proposes provisions for untied funds at PHC/CHC/district levels. A provision for funds for taking up innovative schemes at district/State/Central level has also been made.

Having Rogi Kalyan Samitis for managing health facilities has already been approved by the Cabinet. Now funds would be released as corpus grants to these Samitis as 100% grant by GOI during 2006-07, while it would be in the ratio 2 : 2 : 6 with regard to State / Internal / GOI from 11th Plan onwards.

The Mission also seeks to ensure the availability of requisite equipments and drugs at all the public health care facilities. Procurement of equipments/ drugs would be progressively decentralized and a road map prepared.

It is proposed to improve outreach activities in un-served and underserved areas specially inhabited by vulnerable sections through provision of Mobile Medical Units [MMU] in every district under this proposal. The MMUs would also cover Anganwadi centres.

IMPROVING AVAILABILITY OF CRITICAL MANPOWER

The issue of availability of critical manpower in the rural areas is proposed to be addressed through initiatives like introduction of a trained voluntary community Health Worker (**ASHA)** in every village of the 18 high focus states, additional ANM at each sub-centre, three staff nurses at the Primary Health Centres (PHC) to make them operational round the clock and additional specialists and paramedical staff at the Community Health Centres (CHC). The condition of local residency is proposed to ensure that the staffs stay at their place of posting. In the North-east, keeping in view the difficulty in availing services of doctors and specialists, the emphasis is on recruitment, training and skill upgradation of locally recruited ANMs/nurses/midwives/ para medics. It is also proposed to supplement the availability of critical manpower across the States through contractual appointment/local level engagement of medical and paramedical manpower upgrading and multi-skilling of the existing medical personnel. Innovations in Public private participation for service provision, franchising of service providers, licensing and training of Rural Medical Practitioners (RMP), rationalization of existing manpower are few of the innovations/options being explored. Stringent monitoring at all levels, involvement of the PRIs and monitoring by the Rogi Kalyan Samits should ensure presence of doctors & paramedicals in the rural areas. Besides compulsory posting of doctors in the rural areas, better cadre management & personnel policies would also help to improve manpower availability.

CAPACITY BUILDING

In order to provide managerial support, for tracking funds and monitoring activities under the Mission, provision has been made for setting up Programme Management Units at the State/District level. Over 500 professionals have already been recruited. The successful implementation of the Mission would require health sector reforms and development of human resources. Capacity building at all levels is a huge challenge under NRHM. In order to provide technical support to the Mission for achieving this objective, it is proposed to set up National Health System Resource Centre [NHSRC] at the Central and State levels (SHSRC) with an annual corpus support of Rs. 15 crore and Rs. one Crore at the Central and State levels respectively. The NRHM also emphasizes the setting up of fully functional Block and District level Health Management systems, as under NRHM 70% of the resources would be utilized at Block and below Block levels and 20% at the district level. Given the large army of ASHAs, ANMs, Nurses, Rural Medical Practitioners continuous skill development is needed. Strengthening nursing institutions, linking medical colleges for providing skill development support to rural health workers, involving the voluntary sector in skill development are few key interventions to be taken up.

To make the health facilities more accountable, their control would be gradually shifted to the PRIs and civil society. The Sub-centres are proposed to be placed exclusively under the control of the Panchayat. The PHCs and CHCs are also to be managed by the Panchayat Block Samitis (PBS) and Rogi Kalyan Samitis (RKS).

COMMUNITY HEALTH WORKERS

As per the approval of the Cabinet dated 4.1.2005, one female Accredited Social Health Activist (ASHA) is to be provided for every village with a population of 1000 (with provision for relaxation in the eight EAG States, Jammu and Kashmir and Assam) in each of the high focus states. She would be the link between the community and the health facility and would be the first port of call for any health related demand. Now under the Mission, it is proposed to have an ASHA in all the 18 high focus States. Besides, based on the recommendations of the Committee of Secretaries (COS) in its meeting held on 20.10.2005, it is also proposed to support ASHAs in tribal districts of all the remaining States. In case the other States would like to extend the scheme in remaining districts as well, it would be possible for them to do so under the RCH II. ASHA along with Anganwadi workers (AWW) & the Auxiliary Nurse Midwife (ANM), Self Help Groups & community based organizations, preraks of continuing education centres through their coordinated action at the village level & through combined organization of monthly Village Health, Nutrition & Sanitation day at the Anganwadi centres would be expected to bring about perceptible changes in the health status of the community.

CONVERGENT ACTION ON OTHER DETERMINANTS OF HEALTH

The PRIs and a large range of community based organizations like Self Help Groups, School, water, health Nutrition & Sanitation Committees, Mahila Samakhya Groups, Zila Saksharta Samitis provide an opportunity for seeking local levels accountability in the delivery of social sector programmes. Schools and Anganwadis would form the base of these activities. NRHM provides for School Health Check-ups and School Health Education to be worked out in consultation with the States. Convergence of programmes would be at the village and facility levels.

Table 2: Specific strategies for specific populations

Type of population	Strategy to be used
Formal sector – employed	Mandatory – Social health insurance
"Unorganised" informal sector	Voluntary – Private health insurance. Subsidy where necessary.
"Organised" informal sector.	Voluntary – Community health insurance. Subsidy where necessary.
Poor	Social assistance

How does one identify the poor? Most states have distributed BPL cards for this category of the population. However, each state has used its own definition of BPL and so there is no homogeneity. It is recommended that the government uses the Planning commission guidelines for identifying the BPL families.

- The Employees' State Insurance Scheme (ESIS) provides benefits for the low paid workers. On the other hand, the Central Government Health Scheme (CGHS) covers the civil servants and members of Parliament, judges etc. Most established enterprises either provide health services for their employees or reimburse medical expenses.
- The Tribhuvandas Foundation covers dairy farmers who are members of the local dairy cooperative societies in Anand, Gujarat.
- Vimo SEWA covers members of the SEWA union and their dependents in Gujarat.
- The Student's Health Home in Kolkata, provides health insurance cover for all the students in West Bengal.
- The trader's association in Palakad district, Kerala are covered under a health insurance programme that covers their members and dependents.
- Karuna Trust provides insurance cover for all the BPL families in T. Narsipur taluk.

Defining the benefit package?

Once the community is identified, then one can look at their requirements. The possible benefit packages commonly used in our country are

- **Hospitalisation expenses** with or without exclusions. This fits into the insurance logic, of covering rare but costly events. However, because it is rare, people may not be keen to have it. They may feel that the insurance scheme will benefit only a few people. However, this maybe the need of the planners, who would prefer that the people be protected from high medical costs.
  In India, most hospitalization packages are riddled with exclusions, e.g. chronic illnesses, pre-existing illnesses, TB, HIV etc. This is undesirable and ideally one should have a package that includes most common illnesses. Many insurance companies are recognizing this and are providing comprehensive packages now.
  Also to limit outflow, many insurance companies usually put an upper limit to the hospitalization cover e.g. Rs 10,000 per patient per year.

- **OP cover**, either as a stand alone package or with hospitalization. This is the most common demand of the people. This will ensure that they get some benefit for the premium paid. However, it is difficult to administer and monitor. There is a great danger that all headaches will land up in the doctor's clinic, increasing the cost of health care as well as of the insurance programme. Also it is difficult to verify each event and release funds. One way out is to have a voucher system, say 5 vouchers for a family of 5. This will be used for OP care among empanelled doctors. The doctor has to provide care (consultation and medicines). The doctor then needs to submit these vouchers at the end of the month and get reimbursed @ Rs 50 per voucher. Remember that OP cover is costly and increases the premium by at least 50%.

- **Transport costs** for bringing the patient to the hospital. This is usually linked to hospitalization cover and meets the transport expenses of the patient in coming to the hospital for treatment. This is a necessity in remote areas where transport costs are high and form an effective barrier.
  One simple way out is to pay the patient a flat rate (e.g. Rs 250 or Rs 500) when the patient is admitted in the hospital. This can be paid by the hospital and can be reimbursed by the insurer later.

- **Loss of wages** for the patient or attender. If one is insuring BPL families, this benefit becomes imperative. This is because most BPL households cannot afford unemployment. A hospitalization episode is a triple burden for them, as they have to suffer the distress of the illness, to raise money for the treatment and also undergo a loss of income. To compensate for this, some schemes have included loss of wages compensation into the benefit package. This is paid during the hospitalization period, usually @ Rs 50 per patient per day for a maximum of 15 days.

- **Other** products like life insurance, asset insurance, personal accident insurance.

These can be used as a comprehensive package or in various permutations and combinations. The final choice depends on four factors

The disadvantages are:

- The insurance company will not be as flexible as desired
- Changes in the scheme will require necessary clearances at various levels and will take time
- The objective of the insurance company is "profits" and not necessarily access to health care. This conflict of interest may lead to tension between the organizer and the insurance company
- The insurance company will of course add to the administrative costs and hence load the premium
- Any balance, left over from the premium will be deemed as profits by the insurance company. On the other hand, if the government is managing the funds themselves, this money can be used as reserves or carried over to the next year.

Thus the government will have to decide on one way or the other, depending on the circumstances. If it has the financial and technical capacity, it may be better off managing the funds on its own. On the other hand, if the above is limited, then it may be better off seeking the help of insurance companies.

Administration of the scheme

Normally the organizer takes on the insurance function as well as the administration function of an insurance programme. However, given the wide range of tasks involved, it is better to outsource this to another body, e.g. a third party administrator (TPA) or a NGO. This would be better than trying to do everything. The TPA need not be one registered with the IRDA. It could be any organisation that has the capacity to do the work. Even a district federation of SHG members, or a district cooperative society (with adequate technical inputs) can play this role. They need to have accounting skills, social skills and technical skills. The last maybe lacking even among TPAs. One way out is for the organiser to provide this support either directly or through existing technical organisations. In the long run, capacity building of these district bodies will be required.
While short listing a TPA, one must ensure that they are willing to:

- **Enrol members** - The TPA should make the list of insured members and issue them the necessary insurance cards. These could range from ordinary cards to smart cards, depending on the availability of funds. Currently a laminated photo card costs about Rs 10 per card.
- **Create awareness** - Creating awareness is not a one time activity. It definitely needs to be initiated before the introduction of the health insurance scheme. It should also continue on a regular basis, even after the scheme has been implemented. The messages should be simple and should answer the queries that the people have about health insurance and their experiences with it.

- **Monitor the flow of premium funds** - The TPA should ensure that the funds collected reach the end point without leakages. This is an important task and enhances the credibility of the entire scheme. People will trust an initiative that has checks and balances. However, one must be wary of introducing too much bureaucracy also.

- **Empanel providers –** Negotiating with the providers, ensuring that they accept the prescribed terms and conditions and then empanelling them is an important task that should be the TPA's main activity.

- **Fixing tariffs** – once the hospitals have been empanelled the TPA needs to discuss tariffs with them. This can be done using various ways. One simple way is to do it on a district basis. Invite the hospitals and classify them into three broad categories; <25 beds, 25 – 75 beds and 75 – 150 beds. Rarely there may be a fourth category of > 150 beds.
  Ask each provider to list out the common conditions that they treat in their hospitals. Once this list is available, a tariff can be fixed, based on average costs for each category. This would be a case based tariff. To make things easier, one could divide the conditions into broad categories like minor medical admissions, major medical admissions, minor surgical admissions, major surgical admissions, normal obstetrical admissions, surgical obstetrical admissions etc. Average tariffs could be fixed for each of these categories.

- **Provide pre-authorisation services** – To prevent demand side moral hazard, one needs to ensure that patients are treated at the appropriate level. One way is to have a pre-authorisation service that will screen patients and clear admissions to those patients who require it. This is an important activity and needs to be performed scrupulously. This is the place where the TPA interacts with the patients and if it is unsatisfactory, then the renewal rates may be affected. The main issue to monitor here is the turnover time between the receipt of application from the provider and the response.

- **Process claims and reimbursements** – The cashless system is the optimum method of processing claims and reimbursements. In this, the insured patient goes to the provider and receives care. At discharge, the patient walks out without paying any money. The bills and necessary documents[11[11]] are submitted to the TPA who reimburses the hospital. The TPA then submits the same to the insurer (be it the organizer or the insurance company) who then reimburses the TPA. However, the TPA and the provider needs to monitor the amounts closely, so that wherever the patient has exceeded his / her limits, the balance money is recovered from the patient at the time of discharge.

- **Minimise fraud –** The TPA should keep a strict tab on fraud and prevent it wherever and whenever possible. Some of the sources of fraud are –

[11[11]] Minimum documents could be discharge summary, list of all the medicines prescribed and investigations performed (with results) and the final bill with detailed breakdown.

abuse of the insurance card by a non-insured, wrong diagnosis, high bills, false bills, etc.

- **Develop a management information system** – the TPA should develop the reporting system so that data flows from the field to the organizers. This includes reports from the premium collectors, to data from the hospitals, to data from the insurers about claims. Of course other than this, the TPA should interview patients and community representatives to get feedback on their perceptions. A mix of quantitative and qualitative data is required.

- **Provide regular reports to the monitoring committee** – for details, see later

Monitoring the programme

This is an oft neglected element in the implementation of any health insurance programme. At the maximum, fund position is monitored. But there are many important indicators that require to be monitored. Some of these are given below:

INDICATOR	DEFINITION	Monthly	Annual
Coverage rate	Number of people enrolled in a defined population		+
Penetration rate	Number of people enrolled from among the target population		+
Distribution rate	Number of people enrolled per distributor		+
Enrolment trend	Trend over the years		+
Renewal rate	The number of people who are renewing their membership		+
Member satisfaction	The number of members who are satisfied with the services	+	
Insurance card rate	The number of members with an insurance card		+
Quality of claims	The number of claims with the proper documents at the first instance	+	
Utilization rate	The number of members who fell sick and required care	+	
Claims rate	The number of members who fell sick, and have claimed insurance benefits for their illness episode	+	
Reimbursement rate	The number of members who have been reimbursed their claims	+	
Top diseases	The top five disease conditions for which claims are being made		+
Top providers	The top five providers from where the maximum number / amount of claims are being made		+
Median Medical costs	The median costs of hospital bills	+	
Referral rate	The number of patients who were given pre-	+	

	authorisation		
Quick ratio	The ratio between the liquid assets and the liabilities	+	
Administrative expenses ratio	The ratio between the administrative expenses and the total expenses		+
Claims ratio	The ratio between the amount of claims reimbursed and the amount of premium collected		+
Turn over time for pre-authorisation	The time taken between receipt of pre-authorisation and the decision conveyed	+	
Turn over time for claims settlement	The time taken between receipt of claims and reimbursement	+	

A monitoring cell (nominated by the organizers) need to meet monthly and look at these indicators. This monitoring cell can be at the district level (if there is capacity), however, it definitely has to be at the state level. Action should be taken as soon as any discrepancy is seen. This is an excellent motivator for the staff as they realise that their actions are being scrutinised.

Managing risks

Minimising adverse selection, moral hazard, fraud and cost escalation are very important for the success of any health insurance programme. Some of the measures to achieve this is given below.

Risk	Measures to manage risk
Adverse selection	• Have a large unit of enrolment, e.g. a family, a village, a self-help group • Have a definite collection period • Have a definite waiting period • Have a compulsory enrolment as opposed to a voluntary enrolment • Exclude pre-existing diseases
Supply side moral hazard	• Have a flat/case-based payment mechanism as opposed to a fee for service mechanism • Preferably pay the providers a fixed salary – this will minimise incentives for interventions • Insist on standard treatment guidelines • Insist on medical / chart audits
Demand side moral hazard	• Have a referral system or a pre-authorisation system • Introduce co-payments
Fraud	• Introduce photo identity cards for the insured • Use social audits to identify fraudulent admissions • Take strict action against fraudulent events • Keep proper registers and records
Cost escalation	• Try different provider payment mechanisms • Insist on standard treatment guidelines • Insist on generic medicines

These measures as stand alone methods as well as in combination are powerful tools to enhance the chances of success.

Values in health insurance

The four values in health insurance – equity, solidarity, risk pooling and community empowerment have been discussed in the above text. Community empowerment will take place when the community pays the premium and requests for better quality services. Risk pooling is enhanced when there is risk sharing between not just the healthy and the sick, but also between the rich and the poor. Equity is strengthened when people pay according to their ability and get benefits according to their need. And this is possible only when people are bonded in solidarity. As it is difficult to promote solidarity solely through a health insurance mechanism, it is important that health insurance programmes be piggy backed on existing institutions that have inherent solidarity e.g. a trade union or a SHG federation.

Conclusions

The above framework is a guideline to help planners develop appropriate health insurance plans. The main inputs are from the local situation. The final plan will depend on this. Most of the important elements have been covered in this document. Details like cost, prevalence etc have been suggested, but ultimately the planner has to use local and regional data. It is not difficult to access this data, most are available. All it requires is a little effort to collate the same.

Section 2

Some schemes

In this section, we present a few health insurance schemes that are 'readymade' and can be implemented directly in a region or amongst a specific population. Please note that the theoretical basis for each 'scheme' is provided in Section 1.

DECENTRALIZATION

As the indicators of health depend as much on drinking water, nutrition, sanitation, female literacy, women's empowerment as they do on functional health facilities, NRHM seeks to adopt a convergent approach for interventions under the umbrella of the district plan which seeks to integrate all the related initiatives at the village, block and district levels. The **District Health Action Plan would be the main instrument for planning, Inter-sectoral convergence, implementation and monitoring of the activities under the Mission.** Rather than funds being allocated to the states for implementing programmes designed and approved at the GOI level, the States would be encouraged to prepare their perspective and annual plan which in turn would be based on the District Plans. Even though village is envisaged as the primary unit for planning, looking at the extensive capacity building required before it would be in a position to take up the exercise, the Mission would not insist on the village plans at least during the first two years. The District Health Mission under the Zilla Parishad would get the district plan prepared covering health as well as the other determinants of health. Household and Facility Surveys would define the baseline. Periodic surveys would thereafter be taken up on an annual basis to track the improvements in the facilities as well as in the reduction in health indicators. The District Plans would be collated into a State Plan which would be appraised and approved by the Mission at the national level. As far as the other determinants of health are concerned, the funds for them would continue to flow through the existing channels but the District Plan would clearly bring out the convergent action being taken at the district level. NRHM recognizes that delegation of financial and administrative powers at various levels would be necessary for the successful implementation of the decentralized plans.

MAINSTREAMING OF AYUSH

Provision has been made for State specific proposals for mainstreaming AYUSH, including appointment of AYUSH doctors/paramedics on contractual basis, providing AYUSH Wings in PHCs and CHCs. As envisaged under NRHM vision and goals, efforts will be made to integrate AYUSH in primary health delivery.

FLEXIBLE FINANCING

The programmes under the erstwhile Departments of Health and Family Welfare and Department of AYUSH were not being run in an integrated manner. As a result the transfer of funds to the states under different budget heads at different points of time vertically hampered flexibility. It also led to duplication of efforts, and, thereby, wastage of scarce resources. For improved delivery, the Mission attempts to bring the schemes of the Ministry of Health & Family Welfare within the overarching umbrella of NRHM as approved earlier by the Cabinet. Therefore, under the Implementation Framework, from the Eleventh Plan onwards, it is proposed to have a single budget head for the activities under the Mission. This would provide the States much needed flexibility to direct the funds to those areas where they are needed the most. However, a minimum amount would be earmarked for various disease control programmes to ensure that the national objectives and commitments are met. The funds under the NRHM budget head would flow through the integrated health society at the State and the District levels. The norms under which the funds would be allocated by the Centre to the States and by the States

to districts on the basis of Integrated State/District Health Activity Plans have been clearly spelt out in the Implementation Framework.

NORMATIVE FRAMEWORK

The District Health Action Plans would be prepared based on a normative framework. The cost norms have been derived from three sources. First, existing norms of the schemes brought under the umbrella of the NRHM. Secondly, norms developed by the NCMH. Thirdly, norms developed and approved as new interventions under NRHM.

MONITORING AND ACCOUNTABILITY FRAMEWORK

The NRHM Framework is based on a rights based approach. The Framework proposes accountability at every level through a three pronged process of community based monitoring, external surveys (SRS, DLHS household surveys by ASHA, facility surveys in the district level) and stringent internal monitoring. The process of community involvement of the health institutions itself would enhance accountability and the NRHM would facilitate this process by wide dissemination of the results. For effective monitoring a strong MIS is being put in place. The Citizen Charter would help the public to know their rights and entitlements at each facility. The setting up of IPHS at each level of health delivery system would be instrumental in provision of minimum service guarantees at those levels. Monitoring also would be in terms of service guarantees provided by each facility, utilization of such services by the community {especially weaker sections} changes in their health seeking behavior, etc. The Facilities Survey is expected to create a baseline for each health facility and assist in monitoring annual progress against the baseline in terms of services guaranteed. The MOUs signed with the States would enable monitoring of progress under NRHM in terms of the agreed milestones. Independent evaluation would ensure midcourse corrections.

PRO-PEOPLE PARTNERSHIPS WITH THE VOLUNTARY SECTOR

Investments by voluntary Organizations are critical for the success of NRHM. The Mission provides for partnerships with the voluntary groups/ organisations for advocacy, building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services and working together with community organizations. It is proposed to provide people friendly regulatory framework that promotes ethical practice through accreditation, standard treatment protocols and training and upgradation of skills of non-government health providers. 5% of the total NRHM outlay is proposed to be the resource allocation to voluntary organizations on the basis of approved guidelines & norms.

REDUCING IMR/MMR/TFR AND THE DISEASE BURDEN

Reproductive and Child Health Programme (RCH-II) was launched in 2005 as a part of the Mission as the principal vehicle for reducing IMR, MMR and TFR as envisaged in the original Cabinet Note. Upgradation of Community Health Centres as First Referral Units (FRUs) for dealing with Emergency Obstetric Care, 24x7 delivery services at the PHCs, operationalising of Sub-Centres multi-skilling of doctors, contractual appointments of MOs and AMOs, training medical officers in Anesthetic skills, training doctors/ANMs/Nurses as Skilled Birth Attendants (SBA) permitting ANMs

to administer certain drugs in emergency, partnerships with voluntary organizations, RCH camps accreditation of non profit organizations, IEC activities are the major interventions in reducing MMR. For reducing neo natal mortality programme for Integrated Management of Childhood illnesses (IMNCI) is being extended at the community and facility levels. Activities of ASHAs, Anganwadi workers and ANMs, preraks of continuing Education Centres and SHG groups at the village level with focus on both preventive and promotional aspects of health care accelerated immunization programme, advocacy on age of marriage/ against sex selection, spacing of births, institutional delivery, breast feeding, meeting unmet demands for contraception, besides providing a range of RCH services are to have impact on reducing the health indicators. Efforts are being made to integrate HIV AIDS programme with the RCH at the district and sub-district levels. Convergence of disease control programmes, integration of services, combined awareness generation, education and the advocacy at community and facility levels, taking care of preventive, promotive and curative health care are expected to bring down IMR/MMR/TFR and the disease burden as stated in the proposal.

RISK POOLING AND THE POOR

The Mission recognizes that in order to reduce the out of pocket expenditure of the rural poor, there is an imperative need for setting up effective risk pooling systems as already envisaged. State specific, community oriented innovative and flexible insurance policies need to be developed and disseminated. While the first priority of the Mission is to put the enabling public health infrastructure in place, various innovative models would be pilot tested to assess their utility.

FINANCING OF NRHM

The National Commission on Macroeconomics and Health (NCMH) has worked out an additional requirement of non recurring expenditure of Rs. 33811/- crores per annum and additional recurring expenses of Rs. 41006 crores at current prices for delivering functional health care in the public domain. This outlay, which would be shared by the Centre and the States would push the expenditure on Public Health care to nearly 3% of GDP. As some of the elements included in this computation of fund requirement relate to activities which are not strictly covered under the NRHM (like setting up of medical colleges etc) and if allocations to be made on such activities are excluded, then the additional capital and recurring requirements come to Rs. 30,000 crores and Rs. 36,000 crores per annum respectively over and above the current allocations. It may, however, be mentioned that with growth in GDP, in order to maintain the same percentage level of health expenditure vis-à-vis GDP, the expenditure would have to go up in the same proportion.

Given the absorptive capacities of the States and the time it may take up to build their capacities, it is projected in the implementation framework that there would be a 30 % annual increase in the central allocation for health till 2007-08, which, thereafter is envisaged to grow at the rate of 40 %. If the projected funds, become available, the public health expenditure is likely to reach 2% of the GDP from the current level of 0.9%.

In order to step up the expenditure on public health over the next 5 years, the states also have to very significantly increase the allocation for the health sector in their budgets, since they contribute almost 4/5th of the current total expenditure. The EFC has agreed that under the NRHM, 100 % grant be provided to the states during the 10th Plan which could be phased downwards to 85% in the 11th and 75% in the 12th Plan.

The approach to health insurance for vulnerable groups

NRHM is a serious effort to provide quality health care in rural areas that is accessible, affordable and accountable. The principal thrust of NRHM is to make the public system fully functional at all levels. Along side the efforts at strengthening the public system, NRHM also envisages partnerships with non – governmental providers for public health goals. Health insurance, under the over all NRHM framework is largely an effort to reduce the distress and duress of households in seeking health care, by reducing out of pocket expenditures through risk pooling. As NSSO 60th Round data reveals, there are out of pocket expenditures that households incur even when they go to a public hospital. The effort of the NRHM is primarily to improve the services of the public hospital but even then there would be out of pocket expenditures. It is on this count that NRHM strategy for health insurance for vulnerable groups is primarily to reduce out of pocket burden of poor families when they go to a government hospital. This will also improve the utilization of government hospitals. The intent of health insurance under NRHM is not to weaken the public system in any manner. It also tries to address the issue of non availability of services in the public sector in many areas. While NRHM will make all efforts to make publicly funded health services accessible, there may still be a need to seek partnerships with non governmental sectors as service providers as per mutually agreed standard of services, procedures and costs. Service guarantee to the poor households is the prime objective of NRHM and all efforts will be made to use the instrument of community health insurance to reduce the duress of households on account of high out of pocket expenditures.

This document is aimed primarily at the government officers who are planning a health insurance programme in their state - the Health secretary, the Director of Health services etc. It gives a step by step approach to introducing health insurance in their state / districts, within the overall framework of strengthening the public health system and improving the utilization of services from them. Starting from the rationale for introducing health insurance, it explores the communities that need to be covered, the packages that can be offered, the premium that should be collected and finally the administrative details. While the first section is more generic and gives guidelines for the framework, the second section is more prescriptive.

Some of the key messages are

- Be clear why you want to start health insurance
- Appoint a body that will take the responsibility of organising the health insurance programme. It may be an independent Health Insurance Corporation, or a cell in the Dept. of H & FW, or a separate trust, or a NGO.
- Start with covering 'organised' sections of the informal sector first. BPL families would be another option, but as they are poor, it would not be equitable to make

them pay. We have not tackled the option of involving the formal sector in this paper.

- The basic package should be a hospitalisation cover (upto a maximum of Rs 15,000) with no exclusions. For the BPL families, transport and wage loss compensation could also be included.

- The premium for this package is about Rs 250 for a family of five. A subsidy of Rs.150 - 200/- from the NRHM could be admissible with balance coming from State/beneficiary.

- An independent body should be appointed to administer the scheme. This could be a TPA or a NGO with the necessary technical and administrative skills.

- A monitoring cell should monitor specific indicators to ensure that the programme is on track.

There is currently a lot of interest in rural health insurance as it is realized that this is necessary to provide for basic health needs of the poor. Planners and policy makers in the Centre and States, all are interested in health insurance programmes. Although there has been a governing body of literature on this subject and several projects across the country, unfortunately, due to various reasons, including the fact that it is a new and complex subject, there is very little clarity on how to go about it. This document presents a framework which highlights some of the main steps and elements in developing a health insurance programme which will hopefully help in designing effective health insurance programmes. This document is aimed at the planner at the state level who wants to start a health insurance programme. However, it can also be used by district level staff or by national level planners who want to introduce health insurance schemes for their target group. The emphasis is on the **process** rather than on a product.

The document is divided into 2 broad sections. In the first section, each element is taken and developed in detail, keeping in mind the diversity in our country. This section gives the rational to choose a particular option for each of the elements. In the second section, we outline some of the products suited for specific segments of population. This will help the planner who wants a readymade programme.

Some years ago the Ministry of Finance had started the Universal Health Insurance Scheme (UHIS) which was to be implemented by Public Sector Insurance Companies. This had a defined package of inclusions and exclusions, high premium and substantial subsidy for BPL families. However, this has had poor response for a variety of reasons – no ownership of States; high premium; many exclusions; criteria about providers; absence of TPA mechanisms; no marketing. Clearly, all these issues need to be examined and addressed. Lessons need also to be learnt from many successful but small social insurance schemes. Costs, and consequently premium and subsidy, need to be reduced to ensure sustainability while addressing minimum but basic needs. Health seeking behaviour and savings habit needs to be encouraged but costs of provision and administration need to be driven down. This requires decentralization of basic functions and the existence of structures for spread, trust and management. The State must also share the subsidy burden to impart ownership and accountability.

A meeting of State Health Secretaries had been called on 28th April, 2006 to discuss these issues. Some reading material was also provided. States have since been showing interest and taking initiatives. This document is a further steps to facilitate the work of States.

The Ministry of Health and Family Welfare would like to thank Dr. N. Devadasan of the Institute of Public Health, Bangalore and Dr. S.P. Goswamy, Consultant (Health Insurance) for their efforts in putting this volume together.

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Section 1

The framework

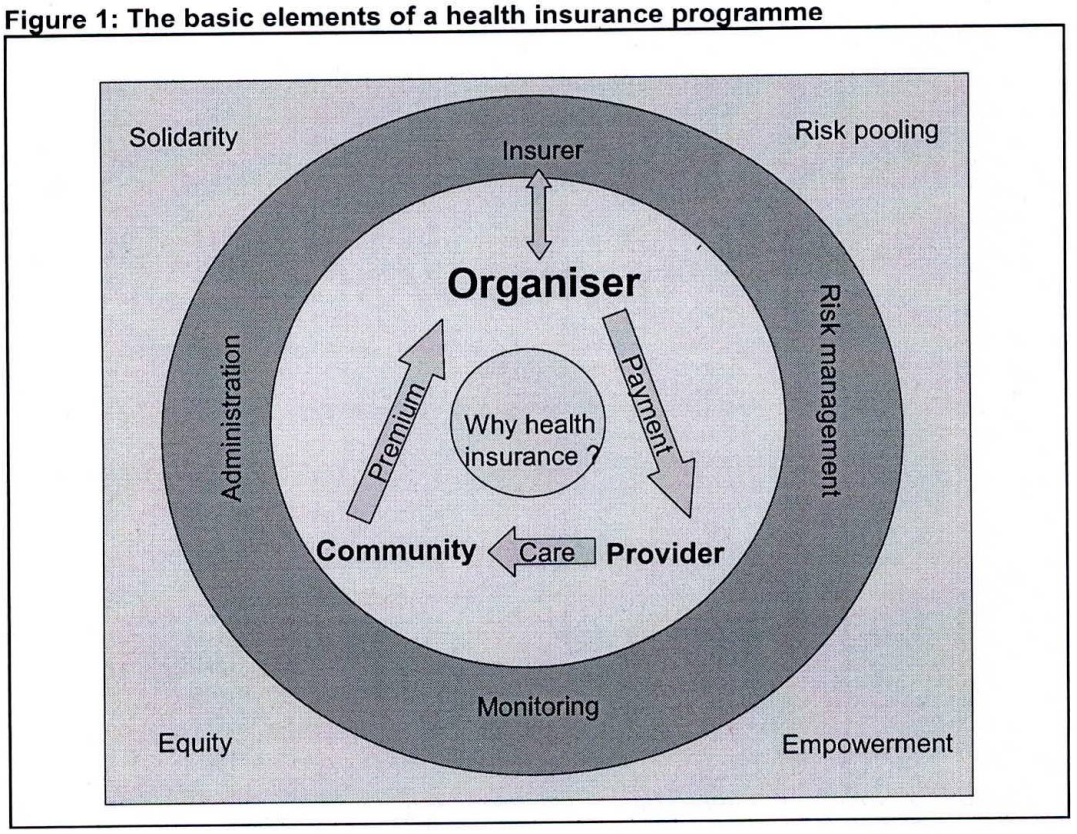
In our country, health insurance is still seen as a financial instrument and the major perspective is that of the insurance industry. This has various implications, including the stress on the balance sheet, profit margins and the claims ratio. Products are designed to enhance these components. In the process, the objectives of health insurance are totally neglected.

This document has been written from **a health systems perspective**, rather than a financial one. The focus is on using health insurance to improve access to health care and protect households from catastrophic health expenditure.

Yet another focus is on the **process** of designing and implementing health insurance plans, rather than just developing a single product. Products are easily developed, but more important is the need to market and service this product in the Indian context. This is the challenge that most companies face today.

This entire section is based on the framework that is shown in Figure 1. These are the elements that are required for developing a health insurance programme.

Figure 1: The basic elements of a health insurance programme



Why health insurance?

This is the first question that a planner needs to ask and answer. Why does the planner want to introduce health insurance at National / state / district / regional level? What is the need?

- Is there a problem of access to health care? Is the target population finding it difficult to access health care (primary or secondary)? Is there a problem of access because of financial barriers? Are the bills too high and the people too poor to pay these bills? **Health insurance could be a way of removing financing barriers and improving access to health care.**

- Is there a problem of impoverishment due to medical expenses? The population is able to pay the bills, but in the process has to borrow or sell their assets to meet these medical costs. This means that they may be pushed into poverty because of medical expenses. **Health insurance could be a way of providing financial protection against high medical expenses.**

- Is there a problem of quality of health care? People have the capacity to pay, but are not getting good quality health care. **Health insurance could be a way of negotiating with the providers for better quality health care.**

- Is there political pressure to start a health insurance programme? Is the Health Minister wanting to start a health insurance programme? This could be the wrong reason for starting health insurance in the state, but it could then be used to meet the above objectives – improving access and financial protection. Especially since there is high out of pocket payments by individual households in most of our states.

- The ACCORD health insurance programme was started because the tribals did not have financial resources to access hospital care. They preferred to lie down in their huts and die. After introducing health insurance, the tribals now pay a small premium when they are healthy and avail of benefits when they are sick. They do not have to worry about money at the time of illness.
- The DHAN foundation discovered that the single largest reason for indebtedness among their SHG women was loans to meet medical expenses. After starting their health insurance programme, women no longer have to take a loan when they are sick, as they are protected by the health insurance programme.
- With elections looming, the Assam government introduced a health insurance programme for its citizens. Unfortunately it was so poorly designed that it did not meet the needs of the people, especially the poor. Thus a golden opportunity to protect the poor was lost.

These questions need to be answered based on evidence. The latest NSSO data (60th round) gives information on the extent of out of pocket (OOP) payments in the states (Table 1). This could be analysed to understand the extent to which people are facing barriers to health care, or are becoming indebted. The common dilemma facing policy makers is "We are providing 'free' government health services. In such a scenario, should we introduce health insurance?" The fact is that the 'free' government health services are not meeting the needs of the community. This is why they are using the private health services and paying out of pocket. Of course, ideally the state and the central government should make higher budgetary allocations so that the government spending is doubled and the quality of health care in government health services is enhanced. This would mean that the government facilities are used and the households are protected from OOP.

Table 1: Out of pocket payments and indebtedness in some states in India (rural).

	All India	Poorest	Low income	Middle income	High income
% of people who do not use health services	18	24	24	18	11
% of people who use government services for OP	22[1[1]]	30	26	22	18
% of people who use government services for IP	42[2[2]]				
Average OOP payments made for OP (Rs)	257	191	237	243	426
Average OOP payments made for OP in Government facilities	11	9	19	9	12
Average OOP payments made for OP in private facilities (Rs)	246	163	190	211	377
Average OOP payments made per hospitalization (Rs)	5695				
Average OOP payments made per hospitalization in Government facilities (Rs)	3,238	2530	2950	3017	6374
Average OOP payments made per hospitalization in private facilities (Rs)	7,408	5431	5777	6781	10749
% of people who are indebted due to OP care	23	21	31	32	20
% of people who are indebted due to IP care	52	64	65	60	52

Source: NSSO 60th round 2004. Govt. of India.

[1[1]] Bihar (5%), Jharkhand (13%), Maharashtra (16%), AP (21%), Assam (27%), Kerala (37%), Rajasthan (44%), Orissa (51%) and HP (68%).

[2[2]] Bihar (14%), Haryana (21%), Maharashtra (29%), Gujarat (31%), Kerala (35%), Karnataka (40%), MP (58%), Orissa (79%), JK (91%).

But this may not be a feasible option, given the state government's fiscal situation. So a health insurance scheme could be an alternative to convert the existing OOP into a risk pooling mechanism. This would protect the households and improve access to health services.

From the above table, it is evident that there is a high OOP for both OP as well as medical reasons. There is not much inter-state variations on the last figure and it is a clear indication to introduce some financial protection measures like health insurance.

Pre-requisites for health insurance

Given the evidence that there is a need for improving access to health care and protecting the households, the next main concern is – are there situations conducive for introducing health insurance? There are some pre-requisites that need to be in place before one should consider health insurance as an option.

1. There must be a body that will be able to organize the health insurance programme. This could be the health ministry or the state health department. More important, it should have the basic capacity to organize the programme. This includes managerial, administrative, technical and social skills.

    - Managerial skills – to manage the entire programme
    - Administrative skills – to manage finances and the funds
    - Technical skills – to understand the complexities of health insurance
    - Social skills – to understand the community's needs

2. There must be a network of health care providers (public or private). Without this, it is not wise to talk about health insurance. Unlike in a tax based system, where the supply side can always defend the lack of supply by quoting the poor financial resources, in a health insurance scheme, the organizer cannot use this excuse.

3. The people must have the capacity to pay the premium. Especially in a contributory programme where the people are expected to pay the premium. However, well the programme is designed, if the people cannot afford it, there will be no takers.

4. There must be some basic data available regarding the demographic profile of the community, the morbidity rates, the utilization rates, the cost per unit utilized etc. There is adequate secondary data in our country for this (Census, NCMH, NSSO etc) and can be used till primary data is collected.

There are many more conditions that need to be satisfied, but at least these need to be in place before initiating a health insurance programme. The others could be developed along the course of the programme.

- In states with scanty provider networks, health insurance programmes may be difficult to implement, as people will not be able to access health care even though the programme takes care of the financial aspects.
- Most departments of health are busy implementing health care programmes e.g. RNTCP, RCH, hospitals etc. So there is no time or capacity to manage a fully fledged health insurance programme that requires different expertise and skills. To burden these staff with additional responsibility may not be a feasible option.
- In some states and regions, the people do not have the capacity to pay premium. They do not have ready cash because they depend on a subsistence economy. In such circumstances, the government needs to pay the premium on their behalf or organize innovative mechanisms for collecting premium e.g. in kind, etc.

Who will organize the health insurance programme?

This is one of the key elements in any health insurance programme? Who is the organizer? It could be

- An autonomous body – "The State Health Insurance Corporation" or
- The state government's dept of health or
- A ministry or a department for its target population, e.g. the Ministry of Textiles initiated a health insurance programme for the weavers, or
- A NGO for the community it works with, e.g. RAHA for the tribals, or
- A hospital for the people living in the catchment area e.g. VHS for the people living in the outskirts of Chennai, or
- A cooperative society for its members, e.g. the Mallur dairy cooperative in Karnataka, or
- A trade union, a driver's association etc, e.g. The Palakkad trader's association's health insurance programme.

Basically any group can take the initiative and organize a health insurance programme. The organizer must meet some criteria to be effective:

1. It must be **a credible and trustworthy organization**. People must have faith in the organizer and believe that it is organizing it for their welfare. Which is why when insurance companies try and introduce health insurance into a community, there few takers. The classic example being the Universal Health Insurance Scheme (UHIS). People are wary about such companies. On the other hand, when it is done through NGOs who have been working with the community for long periods of time, then they are willing to enroll.

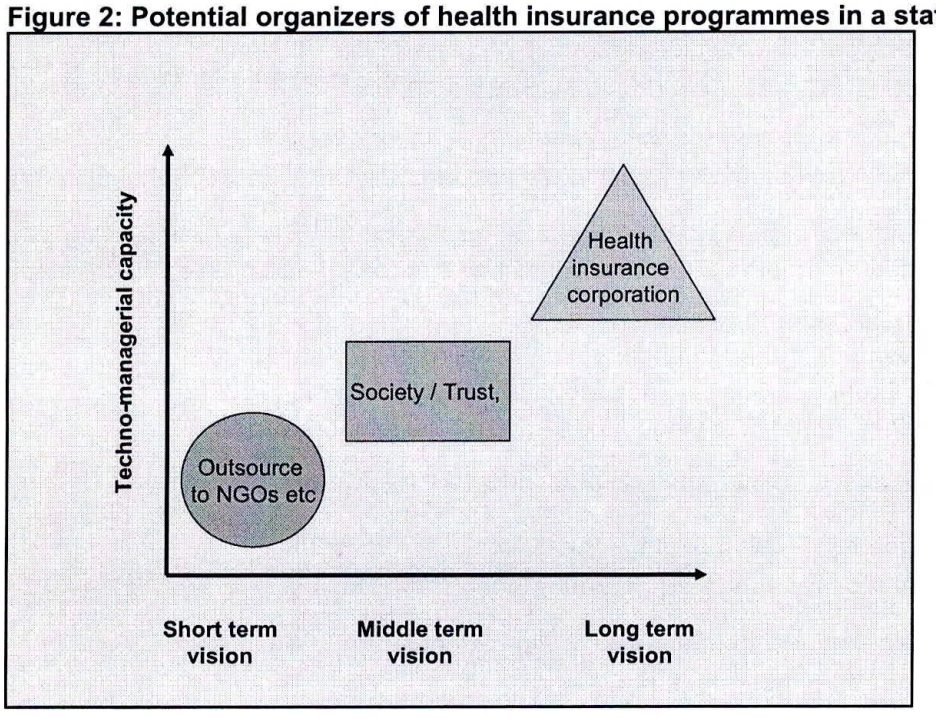
2. This organization **must have three basic skills:**

   - It should have technical skills to understand the insurance concepts. Then it will be able to design a programme that is technically sound. Also this will help in negotiating with the insurance companies and the providers.
   - It should have social skills to be able to discuss with the community and understand their needs.
   - It should have the administrative capacity to organize the health insurance programme.

However, in larger organizations e.g. the government, the last two skills may be outsourced to independent administrators e.g. a third party administrator or a NGO.

The decision to identify the organizer may depend on various factors, e.g. if a state government wants to do a pilot for a couple of years, then it would be better to identify a NGO or a CBO who will organize the programme. However, if the state wants to cover larger populations and for a longer period of time, then an interim body like a "trust" could be given the responsibility of organizing the health insurance programme. On the other hand, if the health insurance programme is part of the health department's drive to systematically cover its population, then it should develop a "**State Health Insurance Corporation**." This autonomous body should incorporate related departments[3[3]] as its members and be given the responsibility of steadily covering the entire population under some form of health insurance.

Figure 2: Potential organizers of health insurance programmes in a state



[3[3]] e.g. labour, rural development, panchayat raj, women and child, finance etc as well as representatives from the community, hospital owner's association and the insurance companies

This autonomous body has many advantages, one being that it will be an independent body that will be working for a specific purpose. Secondly it will not have the 'reputation' of the existing government departments. And finally being a single purpose unit, it will be able to achieve universal coverage at a faster rate. Some of its activities could include governing, organizing and monitoring the scheme, capacity building of the stakeholders, negotiating with the providers and the insurance companies, However, the ultimate decision will depend on the vision of the state government and the available capacity. If the state does not have the techno-managerial capacity, it could try and access the same from other sources, e.g. academic institutions, NGOs who have experience in implementing community health insurance programmes, representatives from the insurance industry, etc. One word of caution here, most of the resource persons from the insurance industry are used to the "profit" motive, whereas in a state government sponsored health insurance programme, the motive is improving public health indicators. So there may be divergent views if one relies solely on the industry inputs.

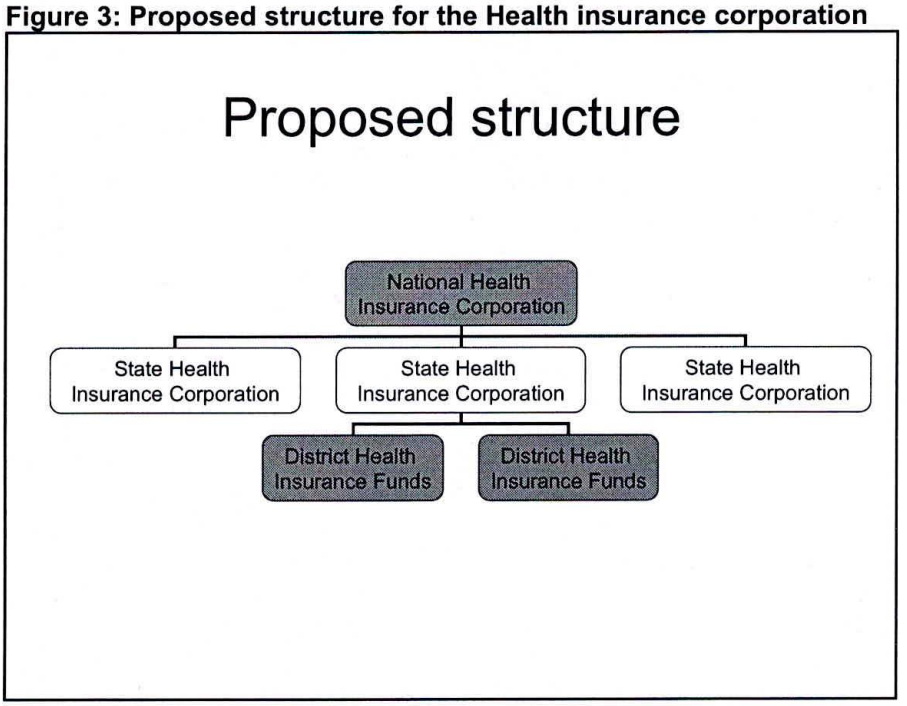
The Yeshasvini Trust organizes the Yeshasvini Farmer's Cooperative Health Scheme. The trust is a combination of Government officers and doctors. The members of the trust govern this scheme by deciding on the package, the premium and the target groups, monitor it monthly and negotiate with the hospitals. Being an independent body, the trust has the necessary credibility and is not associated with the suspicion that the Dept of Cooperatives is usually subjected to.

Role of the Health Insurance Corporation

- To provide the oversight for health insurance in the country / state.
- To explore measures to cover the population in an incremental manner.
- To ensure that the technical requirements for implementing health insurance are in place, e.g. legal framework, regulatory framework, administrative network, monitoring cell, etc.
- To manage the insurance funds (if it is the insurer) effectively.
- To provide technical and managerial support to the next level e.g. state / district.
- To liaison with the other ministries / departments.

A proposed structure is given in Figure 3

Figure 3: Proposed structure for the Health insurance corporation



Which community should be covered under the health insurance programme?

Ideally one should consider the entire population for health insurance. But given the improbability of doing this in the short to medium term, one should prioritise and select specific groups. Universal coverage can be done in an incremental way over time. This can be done either through:

- A population strategy
- A geographic strategy

Population strategy

If one looks at other country examples one notices two distinct approaches. The first is a "formal to informal" approach wherein the government initially covers the formal sector e.g. civil servants, employees in enterprises, industries and mines etc. This is an easy way to improve insurance penetration and also gives the government the time to gain experience. Once the formal sector is covered, then they progress to the informal sector. The other approach is the "indigent to formal" approach. Here the government initially covers the poor in their society by paying the premium on their behalf. Once this is done and they are able to manage this programme, they then move to the formal sector. There are of course advantages and disadvantages in each and a lot depends on the political environment.

In the Indian context, one can stratify the society into four broad categories for health insurance purposes.

1. Employees in the formal sector and their dependents. This includes employees in large corporate offices, industries, shops, etc.

2. People in the informal sector

    a. Who are organized, e.g. farmers, traders, SHGs, etc.
    b. Who are unorganized, e.g. vendors, maid servants, landless labourers, subsistence farmers etc.

3. The indigent e.g. BPL families, destitute, etc.

Of course this is a suggestion and one can decide on different ways to stratify society. The main advantage of stratifying the population is that one can use appropriate strategies for each stratum.

For example, the formal sector could be insured using a social health insurance mechanism. This would be easy as they are organized and can be approached through their employer. On the other hand, the indigent may be difficult to insure as they have neither the financial capital to pay premiums nor the social capital of organized groups. In such instances, it may be better to provide social assistance to this group and insure them by paying the premium on their behalf. However, the main difficulty in this measure is to ensure that they are aware of their insurance status. Many such schemes have shown that it has taken a few years before people are aware about the health insurance scheme and the benefits that are available.

Existing strata that are "organized" e.g. dairy cooperatives, driver's associations, religious organizations, members of self help groups (SHGs), NGO communities, caste based organizations etc are excellent entry points to introduce health insurance. These are existing groups and have the advantage of inbuilt solidarity and channels for communication and premium collection. Estimates suggest that there are about 10 crore people in the informal sector who are 'organised' in groups e.g. traders, drivers, beedi workers etc.

The unorganized groups are difficult to insure and it is better to cover them at a later stage.

The community that should be covered depends on the local needs. However, in terms of ease of coverage, it is easier to cover the informal "organized" sector, the formal sector, the BPL families and then the informal "unorganized" sector.

Geographical strategy

Yet another approach to covering a population is to have a geographical approach. For example, one can cover an entire district. This is a feasible option, provided the organizer is proficient and is capable of designing and managing many insurance products. This is because the need of the population varies. For example, in a district, there are different groups of people; farmers, labourers, traders, civil servants, etc. Each may have different needs and requirements. One scheme will not benefit all. So it will be necessary to design different schemes for these different groups. This, naturally, is a difficult task and requires some level of expertise.

1. The needs of the community. If the community lives in remote villages and finds it difficult to reach hospitals; a hospitalization package per se will not meet their needs. One may need to include transport costs also.

2. The cost of the final package and whether it is affordable for the target population. Naturally a package that has all the above components will be very costly and may not be affordable to most communities. So one would have to prioritise and choose the most relevant benefits – a balance between the community needs and the technical needs.

3. The administrative burden in delivering this benefit package. Hospitalization is a rare event and can be easily administered. On the other hand, OP cover is more difficult to administer, and requires innovative mechanisms.

4. Availability of these services. It naturally does not make sense to cover hospitalization expenses, if there are no reasonable hospitals in the locality.

We propose a stratified benefit package that will meet the needs of varied population groups.

An essential package (Blue card)	Basic hospitalization cover, with no exclusions. Includes maternity. Maximum limit upto Rs 15,000 per family per year. Patients admissible only in general wards.	Includes transport expenses upto Rs 300 per episode of hospitalization.	Includes loss of wages upto Rs 50 per person per day for a maximum of 10 days in a year.
An optimum package (Silver card)	Basic hospitalization cover, with no exclusions. Includes maternity. Maximum limit upto Rs 30,000 per family per year. Patients admissible in semi-private wards only.		
An enhanced package (Gold card)	Basic hospitalization cover, with no exclusions. Includes maternity. Maximum limit upto Rs 50,000 per family per year. Patients allowed to use single rooms.		

The upper limits can be changed, depending on the costs of admissions in the region[4[4]].

The stratified benefit package can be open to all those who want to subscribe.

4[4] One simple way to do it is to visit some of the providers and get a list of admission bills in the past one year. Sort this by the bill amount from low to high. Find out the figure for the 90th percentile and this could be the upper limit. This means that the insurance cover will protect 90% of the insured patients. It will be even more if one introduces cost containment measures (see later). Do not try to cover all 100% as a few outliers will skew the figure for the rest of the population.

The premium

The premium is the amount that needs to be paid by either the households or the government to become insured. While of course the premium should be affordable, there are many other issues that need to be considered while deciding the premium.

Calculating the premium

To calculate the premium, one requires some basic data. While this is usually done by actuarials in an insurance company, it is desirable that the planners / managers of the insurance scheme also have some idea about calculating the same. This will ensure that informed negotiations take place with the companies.

Some of the basic data that is required are:

1. The details of the benefit package.
2. The cost of each unit of the benefit package e.g. average cost of hospitalization, cost of each episode of transportation etc.
3. The probability of this event occurring in an individual. This can usually be obtained from secondary sources e.g. NSSO data etc.
4. The approximate administrative costs.

We use an example to cost the blue card

	Cost per event	**Probability**	**Rupees**
Hospitalisation	5000[5[5]]	30[6[6]]	150000
Transport	300[7[7]]	30	9000
LoW	300[8[8]]	30	9000
Premium			168000
Admin cost[9[9]]			16800
Total premium for 1000 individuals			184800
Total premium per individual			184.80
Premium / family[10[10]]			**211.00**

[5[5]] The median cost of all hospitalizations in the set of providers.

[6[6]] The probability of hospitalization / 1000 individuals; based on NSSO figures. The upper limit has been calculated, anticipating higher hospitalization rates due to insurance.

[7[7]] Amount reimbursable per hospitalisation

[8[8]] Rs 50 per day, for an average hospitalization of 6 days.

[9[9]] Approximately 10% of the total premium

[10[10]] 120% of the individual premium

Estimated premiums for the three packages

Benefit package	Premium amount* (per family of five per year)	
Basic	Rs 200*	Rs 150#
Optimum	Rs 400*	Rs 500
Enhanced	Rs 750*	Rs 600

*** From actual data and based on a software**

 # Calculated by an actuarial

There are various other ways of calculating the premium. The above is also called "community rated" premium and is usually a flat rate for all the members. Income rated premiums, where the premium increases with the economic status of the individual (though the package remains constant) is ideal in a social health insurance programme like ESIS etc. On the other hand, most insurance companies in our country advocate the risk rated premium. This varies depending on the medical history of the individual. While it is ideal for individual policies, it is totally inappropriate where one is insuring large numbers. Mainly because the risks are pooled and so the effect of the high risk is diluted within the larger pool of low risks. And of course operationally it is impossible and costly to assess the risks of each and every individual.

Ways of reducing the premium to make it affordable are

- Reducing the package, so that it costs less. For example one could exclude treatment of TB, or of family planning operations, or RTI treatment saying that these are available "free" in the government sector.
- Reducing administrative costs
- Enrolling as a family unit

- At ACCORD, the tribals pay Rs 30 per person per year for a comprehensive benefit package with a maximum limit of Rs 3000 per patient per year.
- At DHAN foundation, the premium is Rs 150 for a family and the benefit package is a comprehensive cover (excluding deliveries) with a maximum limit of Rs 10,000 per patient per year.
- The Yeshasvini scheme covers surgeries for an upper limit of Rs 2,00,000 per patient per year for a premium of Rs 120 per person per year.
- The Universal Health insurance charges Rs 248 for a family of five and provides cover upto a maximum of Rs 30,000 per family per year. However, this policy has all the standard exclusions.

Collecting the premium

While fixing the premium is a technical matter, collecting it depends on the target population and how close the organizer is with the community. The easiest way to collect premium is to use existing channels.

- Membership payments - if one is insuring SHG members, then one can use the existing channels to collect the premium. The same can apply for association members, union members etc.
- Deducting at source - if one is insuring cooperative society members, then one can instruct the district officer to deduct the premium amount annually from the member's dues and send it to the organizer.

In the case of BPL members, the government may want to pay the premium upfront on behalf of the families. This has the least administrative costs.

In the case of unorganized sectors, e.g. landless labourers, or vendors etc, it may be very difficult to collect premiums. The only way out is to have a voluntary enrolment mechanism which is easy enough for the people.

Enrolment unit

While the common unit for enrolment is the individual, this not a good option, as it promotes adverse selection. On the other hand, it would be better to enrol as large a unit as possible. If one is enrolling SHG members, then one could say that all the members of the SHG should enrol. Or if cooperative society members are enrolling, then at least 50% of the society members should enrol for this society to become insured. In the beginning, this may be difficult, as people may have a lot of scepticism about the

programme. So it may be reasonable to enrol all the family members as one unit. This way, one can ensure that adverse selection is minimized.

- JRHIS in Wardha has family as the enrolment unit.
- Student's health home has the school as the enrolment unit.
- SEWA has the individual as the enrolment unit.

Collection periods and waiting periods

There are two possibilities while collecting premium. One is to collect it during a fixed period. The other is to collect it continuously. The latter is difficult as one has to keep continuous watch on renewal periods etc. Also it encourages adverse selection as people will tend to join when a family member is sick. So a fixed collection period (of two or three months) is more desirable. However, it is necessary to fix this when the community's finances is the highest, so that they can use their disposable income to pay the premium.

Waiting periods are used – again to prevent sick people from joining and using the benefits immediately. Usually the waiting period is for a month after paying the first premium. This applies only to those who are joining for the first time or joining after a break. Obviously, a person who is renewing his insurance on time does not have to wait any more.

How to empanel the providers?

Providers are an essential element for any health insurance programme. Without this, one cannot even consider a health insurance programme. So before any organizer contemplates a health insurance programme, he should review whether there is an adequate distribution of providers.

The providers could be public or private or NGO providers, could be clinics or hospitals, could be practitioners of allopathic or AYUSH. The choice depends on the benefit package. For example, if one is covering OP and IP, then one should empanel a set of clinics and hospitals. On the other hand, if one is covering only IP, then it makes sense only to empanel hospitals.

Identifying providers requires a balance between technical capacity and people's choice. So ideally one should do it with representatives of the target population. There are two options:

- One is a free for all – allow people to choose any hospital, as long as it meets the minimum criteria, e.g. more than 15 beds, registered with local body etc. The advantage of this is that the patient has total freedom to choose. However, it is difficult to monitor many institutions. And worse, one cannot introduce any quality measures as there is no MoU between the organizer and the hospitals.

- Empanel according to set criteria – develop a set of criteria and then empanel the hospitals only if they meet these criteria. It may be advisable to have reasonably strict criteria, so that quality is assured. Many hospitals may refuse to cooperate if the criteria are too strict. So one must maintain a balance. The advantage here is that one can negotiate for quality health care, for cost control measures and anti-fraud measures. Also the patient should understand that by empanelling providers their choice may be limited, but they get additional benefits like cashless service, assured quality and low costs (leading to low premiums).

It is not necessary to empanel all the providers, rather only those who meet the criteria. One of the bargaining points for the organizer would be the additional income that the provider would make if they are empanelled. Hospitals in Gujarat who were empanelled under the Chiranjeevi scheme had a turnover of a few lakhs every month, just from the insured patients.

The most important aspect is to **purchase** care. For this, the government needs to change its mindset from providing to purchasing health care. Providers in the government also need to have a change in mindset as they need to compete with the private sector providers for patients. This could be an excellent opportunity to improve the health services, both the government as well as the private and make them accountable to the larger good.

Some suggestions for empanelment are given below:

- be registered with the local administration
- be acceptable to the local community
- have a resident medical officer (allopathic or ayurvedic or homeopathic or sidha or unani) available round the clock
- have at least 3 nurses (or nursing assistants), one for each shift
- have facilities to admit at least 10 patients at a time
- have its own pharmacy or access to an independent pharmacy that will supply medicines to the patients
- have its own laboratory or access to an independent laboratory where investigations will be done on a credit basis for the insured patients
- be willing to use generic medicines for the treatment of the insured patients
- be willing to follow standard treatment guidelines for the treatment of the insured patients
- be willing to provide cashless services to the insured patients
- not charge any money from the patient. All services (medicines, investigations and consumables will be supplied by the hospital)
- accept the tariff rate developed by the insurance organizer
- maintain necessary records and registers (e.g. IP register, OT register, Labour room register, pharmacy register, accounts register) as per the prescribed format
- allow inspection of its records by prescribed representatives including medical audits, chart audits etc.
- be willing to change its treatment practices if some indicators (e.g. infection rates, Caesarean rates, admission rates, investigation rates, etc) are found to be higher than average.
- be willing to submit claims as per the requirements
- be willing to wait for at least 30 days for reimbursements
- bear the cost of the fraudulent bills in the event of any fraud or any wrong billing

Negotiating with the providers

While empanelling providers, the organizers need to negotiate for some benefits. These include:

- Development of MIS so that the records of the insured are identified easily.
- A cashless system for the patient,
- Cost containment measures like
  - Essential drugs
  - Generic medicines
  - Standard treatment guidelines for common conditions
- Quality of care measures like
  - Medical audits
  - Chart reviews
  - Appropriate evaluation protocols
- Special privileges for the insured like
  - Different queues
  - A special desk for the insured (this may be manned by volunteers or representatives of the TPA).
  - Adhering to the referral system
  - Accepting only cases that have a pre-authorisation (unless it is an emergency)
- Fixed tariffs and payment systems (see later)
- Submitting claims in standard formats

Once the terms and conditions are negotiated, it is advisable to have a written MoU with the providers highlighting what are the responsibilities of each stakeholder. This way, misunderstandings are reduced to a minimum and the patients benefit the maximum.

Public versus private

This is a major issue in most health insurance schemes started by the states. Should one empanel only public providers, only private providers or both? The issues for each are discussed below:

Only public providers (as in Karuna trust).

- Plus points
  - Government health services are strengthened
  - Quality can be easily improved
  - Can be used as a tool to motivate government staff
  - More benefits at lower costs

- Minus points
    - Choice for the patient is limited
    - The insurance plan may appear meaningless as the patient anyway gets 'free' or subsidized care at the government hospitals
    - Most governments do not have directives on how to use the user fees, leave along insurance reimbursements. This means that the money collected will stagnate in bank accounts.

Only private providers (as in most CHIs)

- Plus points
    - More choice for the patients
    - Improved access as there are many more providers
    - More services will be available for the patient

- Negative points
    - Cost control, anti-fraud measures and quality are difficult to enforce
    - Criticism that public money is being used to fuel the private sector

Ideally one should have both public and private providers. But for this certain conditions need to be in place:

1. The public sector hospitals should be able to receive the insurance reimbursements. Currently most states permit user fees. So this should be broadened to include reimbursements. However a few studies and anecdotal evidence suggests that most of the user fees languish in bank accounts as the concerned officers are reluctant to spend this money without written instructions. So if the insurance reimbursements are to be used for the benefit of the patients, then clear cut guidelines on their use should be developed.

2. The public sector should be allowed to compete with the private sector. This means that powers be devolved to the district medical officer, so that he / she can take decisions that will improve the performance of the government hospitals. This could include incentives for the staff, so that they are motivated to provide good quality care.

3. The mindset of the government doctors should change from salaried employees to private practitioners.

Paying the providers

This is a much neglected element in the entire health insurance programme. On the other hand, it can be a very powerful tool with the organizer to reduce costs. The most common method currently used to pay providers is "**fee for service**". For example, a patient goes to a doctor, gets care and pays the consultation fees, goes to the pharmacy and pays for her medicines. This means that the patient pays the entire cost of health care at the time of use. It is a very inefficient manner of paying providers for two reasons:

- It places a burden on the patient at the time of illness. And there is no risk pooling. The entire burden has to be met by the patient.

- It encourages the doctors to provide more services (whether necessary or not) so that he can maximize his profits.

There are other efficient payment mechanisms that can be introduced and will help contain costs. An effective measure is the "**payment per case**" method. In this a particular diagnosis is paid a previously decided flat rate, irrespective of the costs incurred. Thus a delivery could be reimbursed Rs 1000 even if the actual cost of the treatment is Rs 1200 or Rs 800. This has tremendous administrative benefits, as the organizer does not have to scrutinize individual bills. Also the incentive for the provider to prescribe extra services does not exist any more. The only drawback is that it can compromise quality of care, as providers may actually skimp on relevant treatment to make profits. This is also called "**diagnosis related groups**" (DRGs).

Yet another measure is the "**capitation**" method. Useful when reimbursing OP services, providers receive payment according to the number of people registered with them, not for the actual services given. Under-prescription can be countered by introducing competition between the providers. Thus only those providers who are providing good quality care will have people registering with them.

A third method is to pay providers a fixed "**budget**." The providers have to provide all the required services within this budget. Useful, if the budget is just right. If budgets are calculated based on past utilization, there maybe a tendency for over using the budget, so that the provider gets higher allocation in the subsequent year.

More details are given in the Appendices. It is clear that the organiser requires considerable technical skills to introduce alternate systems of provider payment.

Who is the insurer?

Who will take the risk of managing the insurance funds, ensuring that it is enough to meet the needs of the programme? One option is to link up with existing insurance companies, either private or public. This has many advantages:

- Management is in professional hands

- Risk pooling is increased as the funds are merged into the larger pool of "non-life" insurance

- The organizer is free to manage the programme

- The company has enough capital reserves to provide buffer, in case the claims ratio exceeds 100%

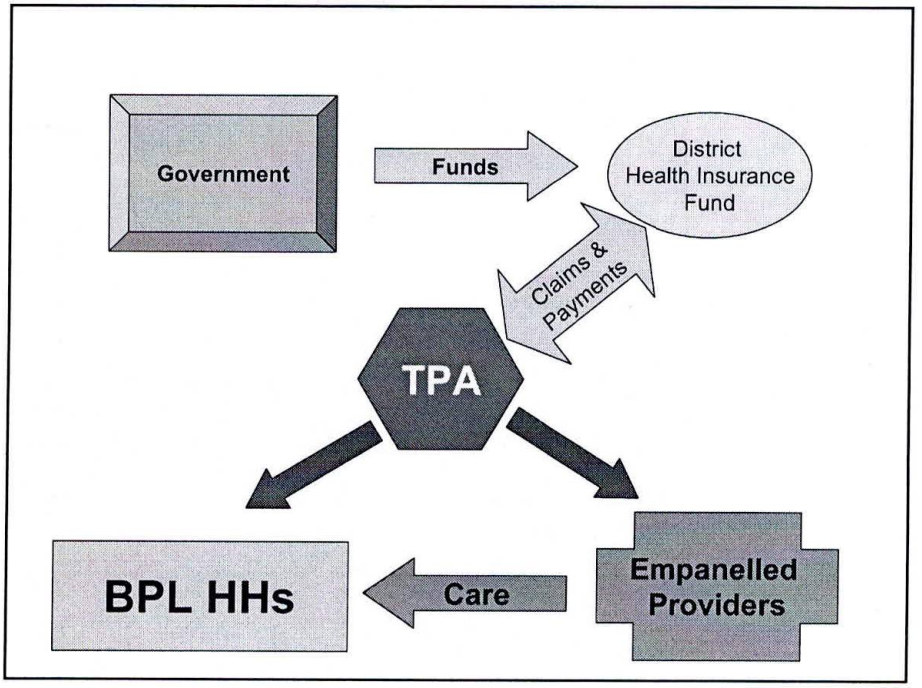
- It is legally acceptable by all concerned

Health insurance programme for BPL families

People living below the poverty line (BPL) have difficulty meeting basic needs like food, shelter and clothing. Health care for them becomes a luxury and many are not able to access the health services for want of financial resources. These are the groups who require protection when they are ill. Unfortunately the current government health services are not able to meet their requirements, due to various reasons. So one may need to address their needs on a priority basis.

In their case, one would prefer to use social assistance rather than a traditional health insurance programme. The basic design is given in Figure 4

Figure 4: Possible design for developing a social assistance programme for BPL households.



Organizer of the programme

The state government or the district government organizes the programme, with the help of NGOs.

The community

In this case, the community to be insured is the BPL families in a district or the state. They can easily be identified by the BPL cards. While there may be many objections to the validity of the BPL cards, if the margin of error is not too much, one can accept it as an initial identifier. Later, one can refine it with time and experience. The list of BPL families can be obtained from the Rural Development dept, or from the Panchayat Raj Dept, or from the Revenue Dept.

The benefit package

In this case, as most of this population will be suffering from communicable diseases, a low end package will easily meet their needs. So the basic package with hospitalization, transport cover and loss of wages cover would be the optimal package for them. OP cover may be considered, but organizing it may be difficult and also expensive.

Hospitalisation cover for all conditions, upto a maximum of Rs 15,000 per family per year;
Transport costs of Rs 300 per hospitalisation episode;
Loss of wages compensation of Rs 50 per patient per day hospitalised (maximum limit of 10 days).

The premium

The premium as calculated would be about Rs 250 for a family of five. This maybe unaffordable to many BPL families. So there are two options possible:

- Totally subsidise the premium
- Partially subsidise the premium

These two options have various implications. In total subsidy, the government will pay the premium on behalf of the families to the insurer. So the people are insured at one go. However, from varied experiences, it is clear that most of such families are not aware of their insurance status. It takes at least 2 – 3 years of concerted effort to create awareness in all the families. Thus this option should be considered only if the government has the funds to cover the BPL families consecutively for 3 – 5 years. Else the entire money will be wasted and there will be nothing to show for the effort and resources spent.

The second option is however a difficult one to implement. The government can subsidise the premium and collect only an affordable amount from the BPL families. However, the difficulty is in collecting this premium. As is clear from the UHIS experience. One way out is to request all the ANMs, the ASHA and the Anganwadi workers to collect the premiums from the BPL families and pass this to the District Health Insurance fund. They may be given a performance based incentive for collecting the premium. However, in such a case, they should be empowered to distribute the insurance cards to the insured families. A second or third step in distributing these cards may not be feasible and desirable.

The enrolment unit should be the family, nothing less and the premium (if collected) should be during a definite collection period. Given the difficult enterprise, waiting periods may be waived in this instance.

Providers

As the government providers have not been successful in meeting the needs of the BPL families, it may be necessary to have a combination of public and private providers. The latter should be empanelled keeping in mind the preferences of the families. The TPA (or similar local body) should do the empanelling. The criteria for empanelling are given earlier (Section 1). The providers should be willing to

- Provide cashless hospitalization service for the insured card holder
- Provide all the facilities, including medicines and laboratory investigations at the hospital
- Accept the tariffs and payment mechanisms

Public providers who are empanelled should be willing to accept the insurance reimbursements. This money may be used partly to finance the essential requirements in the hospital and partly as an incentive to motivate the staff.

Insurer

In this case, and especially in the early years, the claims ratio will be very low. So it is better that the government is the insurer. The government transfers funds to a district health insurance fund who then manages it. Any premium collected from the people is deposited into this fund.

Administration

Independent TPAs could be appointed to manage the scheme. As stated above, they could be given specific tasks, especially in creating awareness among the BPL families. Where available, local NGOs could be appointed as the TPAs. Their main roles would be create awareness, enrol members, issue id cards, maintain lists of members, empanel providers, negotiate with them for quality services, low cost and administrative conveniences; process claims and reimbursements and monitor the entire programme. Further details are given in Section 1.

Indicators to be monitored

The main indicators to be monitored are given above (Section 1). The most important indicator to be monitored is the utilization rates, especially in the first few years. If premium is being collected, then coverage rates also need to be monitored. Renewal rates give an idea about the satisfaction of the programme.

Risk management

As entire populations are insured upfront, adverse selection does not have any role here. On the other hand, moral hazard may be an important risk to be minimized. Some of the ways out are:

- Have a flat/case-based payment mechanism as opposed to a fee for service mechanism
- Insist on standard treatment guidelines
- Insist on medical / chart audits
- Have a referral system or a pre-authorisation system
- Introduce photo identity cards for the insured
- Use social audits to identify fraudulent admissions

Conclusions

The challenge in this model is to identify the BPL families. While many criticise the existing BPL cards for their inaccuracy, it could be a good enough starting point. With time and with specific interventions, the BPL lists could be refined so that false positives and false negatives are minimised. More important, such schemes should not be reduced to populist measures, flash in the pans that appear during election times. To be a sustainable model, such schemes should be functional for at least 3 years with full subsidy and then with a tapering subsidy over the next five years. This way, the people will have faith in the scheme and will also get into the habit of purchasing health insurance.

Health insurance programme for members of SHGs

The author uses SHGs just as an example. The same model can be used for cooperative societies, for associations, for trade unions, for beedi worker's associations etc.

In most southern states, and in some northern states, self help groups (micro credit groups / micro finance groups) are well established. These are usually formed of women in low income and middle income strata, who meet once a month to save. Many of these groups have federated into large district level structures and control crores of rupees.

Evidence, from recent times, indicates clearly that the main reason for taking loans are medical expenses. So many of them are willing to take the next step of microfinance i.e. micro health insurance.

Community

The SHG members and their dependents are the eligible members who should be able to enroll in this HI programme. To reach out to them, it is better to tackle the larger federations who are well established. For example in Kerala, the government decided to introduce health insurance through the Kudumbashree – a government sponsored federation of SHG women. At last count, they had 25 lakh women members.

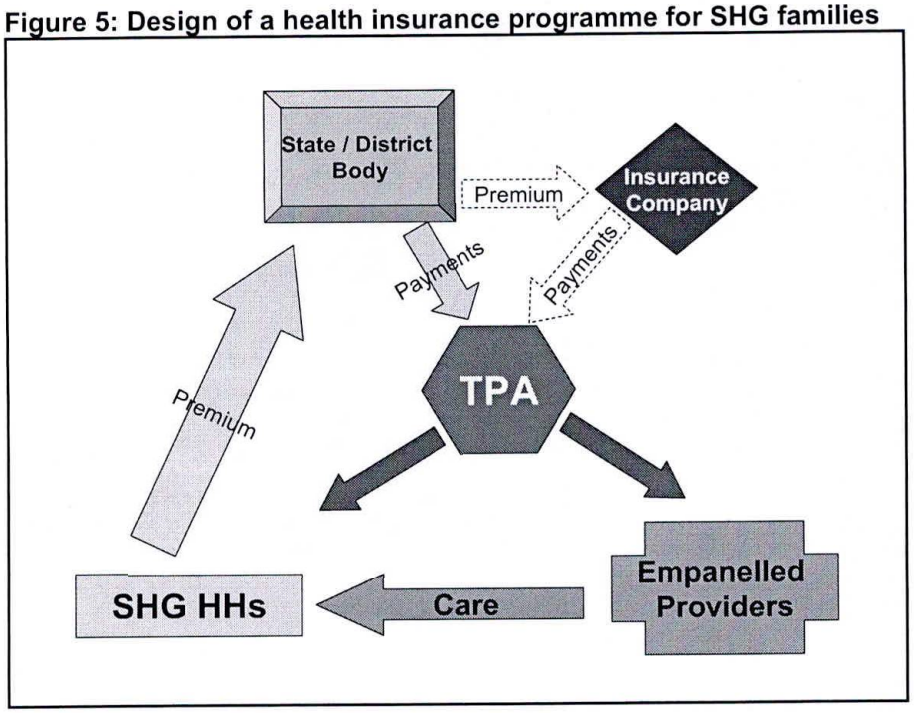
Organizer of the HI programme

Depending on the state's interest, the size of membership and vision, the options are:

- The State Health Insurance Corporation
- A trust / society initiated by the state government for health insurance
- The district health society
- A NGO
- The Dept of H&FW

The advantages of each are given in Section 1. The last would be the most undesirable option, as then this activity would be diluted amongst hundred other activities. The proposed design is given in Figure 5.

Figure 5: Design of a health insurance programme for SHG families



The benefit package

This segment of population is categorised as "near poor", usually above the poverty line. They have some assets and are able to save, even if only small amounts. More important, they have access to credit when needed. So in this case the optimum package (silver card) would be an ideal benefit package for them. This includes hospitalization cover upto a maximum of Rs 30,000, with no exclusions. The premium would be between Rs 350 to Rs 400 per family per year, depending on the state.

The premium

The premium as calculated is Rs 400 per family of five. This may seem a high premium for a low income family. However, given their practice of meeting once every month, the premium can be collected in monthly instalments and paid at one point in time to the local collection agent.

While most SHGs identify only the women as members, for the sake of the health insurance programme, the member and her dependents should be insured. It would even be better if the entire group could be insured rather than individual families. The premium could be collected through existing SHG channels – from individual members to the group, from the group to the cluster; from the cluster to the Block level federation and from there to the district. The money can be deposited into the District Health Insurance Fund.

The providers

Where such health insurance programmes are implemented, one must empanel government as well as private sector providers. This can be done after discussing with the community and the relevant local district officers. The criteria for empanelment are given in Section 1.

The providers will be paid on a case base mechanism or a DRG mechanism. Tariffs will be formulated earlier itself, based on local prices. Later, after conducting costing exercises, one may arrive at more exact tariffs.

Insurer

If the size of the pool is large, e.g. an entire state, the programme may be able to manage the funds on its own as a stand alone health insurance fund. However, if it is small e.g. a district, then it maybe advisable to link up with an insurance company. The insurer in this case will be a health insurance company. The company could be selected after floating a tender with the requirements and choosing a company that provides the lowest premium and also agrees to the conditions laid out.

Administration

The Health Insurance corporation and the insurance company will together decide on a TPA. This could be an organisation registered with the IRDA or an independent NGO that has the capacity to manage. The TPA has to have the capacity to service the programme at the district and sub-district level. The main activities that the TPA should do are given in Section 1. The indicators that need to be monitored by the Health Insurance corporation are also given in Section 1.

Risk management

The main risks to be managed here are adverse selection, moral hazard and fraud. Measures for these are clearly given in Section 1.

Conclusions

As stated earlier, this model can be used for various 'organised' groups in the 'informal sector'. And depending on the scale of the programme, it could be at the district or state level. Once this programme has been established, it could be expanded to cover other groups in the locality. And more important, it could be used to cover groups like landless labourers, subsistence farmers etc, who normally are out of any formal activities. These groups could be allowed to join the scheme on a voluntary basis.

OP care in areas where there are no hospitals

In some of the states, especially the northern states and NE states, where hospitals are not available in the rural areas, a hospitalisation based health insurance may not be feasible. In these regions, people use the existing "unqualified" medical practitioners as well as qualified medical practitioners to meet their health care needs. But because of various reasons, even these practitioners are very costly and people are not able to access them because of financial barriers. So in such a situation, providing a cover for OP and transport would be a reasonable option.

Community

The people living in these regions. Where possible, try and use the existing organised groups e.g. those communities working with NGOs, SHG members, religious groups, etc.
Since it is a voluntary health insurance, the danger of adverse selection is high. To minimise this, the family should be enrolled.

Organiser of the health insurance

As a pilot programme, this should be outsourced to a credible NGO in this region. The NGO should be given the technical inputs and the managerial freedom to cover this population.

Benefit package

The main benefits would be OP care. Each enrolled family would be given an insurance card along with 5 pre-printed vouchers. These vouchers can be exchanged at empanelled providers for health care during the year.
Other than this, the family will also be reimbursed travel costs for one episode of hospitalisation, up to a maximum limit of Rs 500. This can be obtained from the NGO organiser who will verify the hospitalisation status and the validity of the insurance card before reimbursing the money.

Premium

The premium for this package will be about Rs 300 per family (of 5) per year. As most of these families would be very poor, the government could subsidise the premium by 50%, paying the NGO directly for each family insured. So the NGO has to collect only Rs 150 from the families.

Providers

As stated earlier, most of these regions will not have hospitals and even qualified doctors. In such circumstances, one may have to empanel "unqualified" medical practitioners, or AYUSH practitioners. This should ideally be done in consultation with the local community, and only credible practitioners who provide some modicum of quality care should be enrolled. Preference should be given to those practitioners who live in the villages and are available 24 X 7.

The NGO should reimburse the providers on the basis of the vouchers, Rs 50 for each voucher. This would limit the unnecessary medication and injectables that is the wont of such practitioners. The other way of paying the providers is through a capitation system. The community should be asked to register with a particular practitioner. The NGO pays the practitioner Rs 50 per patient registered. With this money, the practitioner should provide OP care to the registered patients. This mechanism has limited tendency for fraud, the only drawback is that the practitioners may restrict the treatment given. However, if there is a possibility of competition between the providers, then this will also be taken care of.

Insurers and the administrators

The NGO becomes the insurer, as it is collecting funds (from the people and the government) and managing the funds. This may not be acceptable with the IRDA which does not recognise such stand alone models of health insurance. So other options should be considered e.g. simplest would be to call it a "Health Fund" rather than a health insurance programme.

The NGO should reimburse the providers on a monthly basis (if voucher system) or pay the capitation fees in three monthly advances. They should however monitor the scheme closely, especially monitor the extent of fraud. Social audits should be used for minimising this and the community representatives should be available in the claims committee. Random checks on claims should also be made, to verify that vouchers are not being misused by the insured community.

The NGO should also negotiate with the providers for empanelling them and providing the desired quality of care. It should of course create awareness among the population about the benefits of health insurance and the possibility of improving their access to health care.

Risk management

The main risk here is that of moral hazard and fraud. Every headache may land up at the doctor's clinic for treatment. The people should be informed about the price of abuse. If they use their vouchers for frivolous conditions, then when they really fall sick, there may not be any vouchers for their health care. This may reduce moral hazard. Also if people save vouchers, then it may be carried over for one year. This would be an incentive for patients not to abuse the system.

Fraud is a potential problem as anybody can borrow their neighbour's voucher and seek care. Of course, one can introduce some identification mechanism e.g. a ration card, or a voter's id card, or a BPL card etc. But as stated earlier, social audit is more effective. Responsible members of the community / NGO field staff should verify random claims.

Monitoring

The main indicators to monitor are the coverage rates and the utilisation rates. This will give an idea about the inflow and outflow and will allow the NGO to plan for the next financial year.

Conclusions

This programme should be a pilot to test whether insuring OP services is feasible in poor rural areas. The programme should be monitored closely to understand what are the other measures that need to be introduced to make it run successfully.

Using UHIS

The UHIS was launched with much fanfare, but unfortunately was not accepted by the people due to various reasons. Latest data (Sept 2005) suggests that only 45,118 families have been insured and the claims ratio is about 11%

While we shall not go into the reasons for its failure, we suggest some measures to make more acceptable to the community.

Organiser of the health insurance plan

The department of health could be the main organiser of the plan. It can take on the governance of the programme, and outsource the administrative functions to independent agencies. For example, it could appoint a TPA (or a large NGO) who would market the product among NGOs, SHG groups etc. This same TPA would administer the scheme.

There are other possibilities,

- One is for the State Health Insurance Corporation (or the Trust) to organise the marketing and servicing of the UHIS; or
- The other is to identify a NGO with significant presence in the districts and who is involved in health; or
- The federation of SHG at the state level, e.g. Kudumbashree (in Kerala).

Community

The community is restricted to BPL families.

Benefit package

The benefit package is the standard UHIS. However, this package would be more acceptable if maternity was included. The government may have to pay an additional amount – in the range of Rs 50 per family.

While this package does exclude pre-existing illnesses, if one is insuring in large numbers, it will not be feasible for all the insured to undergo a medical check up. Thus this condition will become non-functional. Also many of the conditions that come under pre-existing illnesses and chronic illnesses like diabetes, hypertension, IHD etc do not affect BPL families. So one should not be unduly worried by this clause.

The other elements of the package, i.e. personal accident cover and wage loss compensation cover can remain as it is.

Premium

The premium will be as per the current guidelines. However, one may need to add Rs 50 to the family premium if one has covered maternity also.

	Actual premium	Subsidy by GoI	Premium payable by household
For an individual	Rs 365	Rs 200	Rs 165
For a family of 5	Rs 548	Rs 300	Rs 248
For a family of 7	Rs 730	Rs 400	Rs 330

The family should be the enrolment unit. However, the package is restrictive when it describes the family of 5 and 7. These restrictions can be waived and anybody in the family can be insured.

The premium of Rs 248 (or Rs 330) can be collected in its entirety or the state government can also add to the subsidy. If the state government plans to provide a 100% subsidy, it should recognise two aspects. One is that as the people have not contributed, they will not be aware of their insurance status. So it is necessary to invest considerably on insurance education and awareness building. The second is that in the long run, this may not be sustainable. So it may be desirable in the initial years, till people become accustomed to the insurance mechanism. Once the demand is created, the subsidy can be progressively reduced.

The administrator of the scheme will collect the premium from the designated groups and hand it over to the government health insurance fund. This premium will then be handed over to the insurance company.

Premium collection will be during a fixed period. And as per the policy, there will be a waiting period of 30 days.

> Kudumbashree is the federation of all government sponsored Self Help Groups in Kerala. There are about 22 lakh women who are members. The department of panchayat raj introduced the UHIS through this organisation. The premium was subsidised by the government of India (Rs 300), the state government and the local panchayats. The individual household had to pay only Rs 33

Providers

One must empanel the providers. This is the work of the administrator of the scheme. The TPA should use the guidelines given in Section 1 and empanel the providers in the districts and sub-districts.

Payment mechanisms for the providers are clarified in Section 1. The department through a decentralised District Insurance Fund can reimburse the hospitals directly. However, the payment should be on a case basis or DRG basis.

Insurers

The four public sector non-life insurance companies are the insurers of the product and they take the risk. While the insurance company will receive the premium, it will also distribute 50% of the premium to a designated government account as a rolling fund. This fund will then be used to settle claims. The insurance company will top up this amount as and when necessary. At the end of the year, if there is any balance, then it is transferred back to the insurance company.

Administration

The government needs to appoint a TPA for this scheme. This could be a registered TPA (as per IRDA guidelines) or it could be a large NGO with significant presence in the districts. They should be given the responsibility of

- Creating awareness about the plan
- Marketing the plan to groups (NGOs who work with BPL / SC / ST families; SHGs with significant BPL memberships; LAMP societies; employee welfare associations with significant BPL employees etc).
- Issuing identify cards and developing and maintaining enrolment registers
- Collecting the premium from the people and depositing the same in the designated insurance fund
- Empanelling hospitals
- Developing STGs, tariffs
- Developing a referral / pre-authorisation system
- Having a desk in some of the important hospitals to receive the insured patients
- Processing claims and passing it to the district insurance fund
- Tracking reimbursements
- Monitoring the programme as per the indicators (Section 1)
- Conducting medical / chart audits on a random basis

The TPA / NGO would be paid fees (5% of premiums collected) for administering the plan. This could be an indirect subsidy of the scheme by the state government.

Risk management

The various measures to reduce risk are

- Family as the enrolment unit
- Referral / pre-authorisation system
- STGs, audits, essential drugs etc.

Appendices

Appendix 1

Some definitions

Adverse selection: It occurs when those who anticipate needing health care choose to buy insurance more often than others. It is because insurance suppliers lack full information about the risk of individual insured persons. Adverse selection may result from the tendency among patients to seek or continue insurance coverage to a greater extent than healthy people. An example of adverse selection is when only the baby in a family is insured. This is done because the family knows that the chances of the baby falling ill are higher. Adverse selection needs to be prevented, else it affects the financial sustainability of the insurance programme. *It can be controlled to a certain degree by making the insurance mandatory and/or by enlarging the subscription unit, e.g. if the entire family is insured rather than an individual.*

Benefits: Benefits are the sum of money received by an insured or an assignee (e.g. a hospital) as reimbursement for medical costs incurred due to illness. Benefits may also be in the form of health services received. These benefits are in lieu of a premium paid to an insurance provider.

Cap: A limit of the benefit amount that an insurance company will pay. The cap may be an overall maximum, such as an maximum of Rs 10,000 per patient per year, or may apply to specific services, such as a cap of Rs 500 per year for outpatient services.

Claim: A request to an insurer by an insured person (or by the provider of a good or service on behalf of the insured individual) for payment of benefits according to the terms of an insurance policy.

Exclusions: Specific conditions listed in an insurance or medical care policy that are not covered by benefit payments. Common exclusions include pre-existing conditions, such as heart disease, diabetes, hypertension, or asthma which began before the policy was in effect. Because of exclusions, persons who have a serious condition or disease are often unable to secure insurance coverage either for a particular disease or in general. Sometimes conditions are excluded only for a defined period after coverage begins, such as nine months for pregnancy or one year for illnesses. Exclusions are often permanent in health insurance coverage for individuals and temporary (e.g., one year) for small group insurance. They are uncommon in large group plans that are capable of absorbing extra risk.

Fee-for-service: A method of charging whereby a physician or other practitioner bills each encounter or service rendered. E.g. separate fees for consultation, medicines, laboratory, procedures etc. This is the usual method of billing by the majority of India's private physicians. Under a fee-for-service payment system, expenditures increase not only if fees go up, but also if charges are made for more units of service or more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or prepayment systems, where by payments do not change according to the number of services actually used or if none are used.

Health Insurance: A financial instrument that, in return for payment of a contribution (or premium), provides members with a guarantee of financial compensation or service on the occurrence of specified events. The members renounce ownership of their contributions. These are primarily used to meet the costs of the benefits.

Moral hazard: The tendency of individuals, once insured, to behave in such a way as to increase the likelihood or size of the risk against which they have insured. Can be classified into 'supply side Moral Hazard' (when the doctor provides unnecessary care because the patient is insured) or 'demand side Moral Hazard' (when the patient demands unnecessary care because he is insured).

Out-of-pocket payments or costs: Costs borne directly by a patient who lacks insurance benefits; sometimes called *direct costs.* Unless covered by insurance, they include patient payments under cost-sharing provisions.

Pre-authorisation Certification: A procedure whereby the insured or his doctor is required to contact the insurance company before admission to a hospital, and get the latter's permission.

Third-Party Administration: Administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

Underwriting: The process by which an insurer determines whether or not to accept an insurance application and on what basis/terms it will be accepted.

Appendix 2

Some health insurance products in the government / NGO sector

NGOs

	Community	Organiser	Insurer	Administrator	Provider	Premium	Benefit package	Risk management
ACCORD	Tribals	ACCORD	Royal Sundaram Insurance Company	ACCORD	ACCORD hospital	Rs 30 per person per year	Hospitalisation expenses upto a maximum limit of Rs 3000. No exclusions.	Collection period, Salary for providers, essential medicines and STGs
Karuna Trust	SC / ST population in T' Narsipura taluk of Mysore district	Karuna Trust	National Insurance company	Karuna Trust	Government hospitals	Rs 20 per person per year	Medicine cost @ Rs 50 per inpatient day. Loss of wages @ Rs 50 per inpatient day	Collection period, Flat rate
Yeshasvini	Members of the cooperative societies	Yeshasvini trust	Yeshasvini trust	Family Health Plan Ltd.	Private hospitals	Rs 120 per person per year	Cover for surgeries upto a maximum of Rs 200,000 per patient per year.	Collection period, Only surgical conditions, Pre-authorisation, Tariffs fixed for procedures, photo id card,
RAHA	Tribals	RAHA	RAHA	RAHA	Network of "mission" clinics and hospitals	Rs 20 per person per year	Unlimited OP cover, Hospitalisation cover for a maximum of Rs 1250	Collection period, Salary for providers, Strict referral system, co-payments.
JRHIS	Farmers	JRHIS	JRHIS	JRHIS	MG Medical College	Rs 100 per family per year.	OP cover by VHWs, Hospital cover at medical college	Family as the enrolment unit, collection period, referral system,

	Community	Organiser	Insurer	Administrator	Provider	Premium	Benefit package	Risk management
DHAN foundation	Members of SHG and their dependents	KKVS – the SHG federation	KKVS – the SHG federation	KKVS – the SHG federation	6 empanelled hospitals	Rs 150 for a family	Hospitalisation expenses upto a maximum of Rs 10,000. Some exclusions	Family as the unit, co-payments, referral system, collection period.
SEWA	Self employed women and their dependents	SEWA	ICICI – Lombard	SEWA	Public and private hospitals	Rs 85 per person per year	Hospitalisation expenses upto Rs 2000 per patient per year.	Collection period,
Student's Health Home	Students	SHH	SHH	SHH	SHH	Rs 5 per student per year	Unlimited OP and IP at SHH run facilities	School is the enrolment unit, providers paid fixed salaries. Definite collection period, referral system,
VHS	Rural population	VHS	VHS	VHS	VHS	Rs 100 per person per year	Hospitalisation expenses upto maximum limits	Nil

Government

	Community	Organiser	Insurer	Administrator	Provider	Premium	Benefit package	Risk management
Universal Health Insurance Scheme	BPL families	?	4 public sector insurance companies	?	Any hospital	Rs 548 for a family of five (Rs 300 subsidised by the GoI.	Hospitalisation cover upto a maximum limit of Rs 30,000 per family per year. Personal accident upto Rs 25,000 Loss of wages @ Rs 50 per patient day.	Family as the enrolment unit, waiting period.
Kudumbashree (proposed)	SHG members and their dependents who belong to BPL families.	Kudumbashree and Govt of Kerala	ICICI Lombard	SHGs	Empanelled hospitals	Rs 399 per family per year, Rs 366 subsidised by government	Hospitalisation upto a maximum of Rs 30,000 per family per year. No exclusions Personal accident upto Rs 100,000 Loss of wages @ Rs 50 per patient day for a week.	Family as the enrolment unit.
AP scheme (proposed)	BPL families	AP Government	4 public sector insurance companies	A TPA	Empanelled hospitals	Rs 548 for a family of five (Rs 400 subsidised by the Government.	Hospitalisation expenses upto 25,000 for surgical conditions and Rs 75,000 for serious conditions. But only for the first three days for medical conditions.	Waiting period. Co-payments after 3 days for medical conditions.

	Community	Organiser	Insurer	Administrator	Provider	Premium	Benefit package	Risk management
Karnataka scheme (proposed)	BPL families	Karnataka government	4 public sector companies	Dept of Health staff (for collection of premium).	Any hospitals, especially public sector hospitals.	Rs 548 for a family of five. Rs 300 subsidy from GoI.	Hospitalisation cover upto a maximum limit of Rs 30,000 per family per year. Personal accident upto Rs 25,000 Loss of wages @ Rs 50 per patient day.	Waiting period, family as the enrolment unit.
Assam scheme	All Assam citizens except government servants/ those with more than Rs. 2 lakh per annum income	Assam Government	ICICI Lombard	?	?	?	Hospitalisation expenses upto a maximum of Rs 25,000 for select disease conditions e.g. cancer, IHD, Renal failure, stroke etc.	Mandatory cover of the entire population.

Appendix 3

Prices of some common conditions

Minor medical conditions

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices		
			< 25 beds	26 – 75 beds	76 – 150 beds
AGE	2000				
Acute abdominal pain	2000				
Acute asthma	2000				
Pleural effusion	2000				
Amoebic hepatitis	2000				
Amoebic abscess	2000				
Typhoid	2000				
Heat stroke	2000				
Allergic disorders	2000				
Acute psychosis	2000				
Acute fevers	2000				
Seizure disorders	2000				
ARI e.g. Bronchopneumonia, Bronchiolitis.	2000				

Medium medical conditions

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices		
			< 25 beds	26 – 75 beds	76 – 150 beds
Acute upper GI bleed	4000				
Acute cholecystitis with medical management	4000				
CCF	4000				
Acute HT encephalopathy	4000				
Cardiac arrhythmias	4000				
Acute myocarditis	4000				
Status epilepticus	4000	2500			
Acute paraplegia	4000				
Acute meningitis	4000				
Acute encephalitis	4000				
Acute Coma	4000				
Acute pneumonia	4000	4500			
Acute pneumothorax	4000				
Acute nephritis	4000				
Diabetic ketoacidosis	4000				
Thyrotoxic crisis	4000				
Hypoglycemic coma	4000				
Cerebral malaria	4000	1000			
H'agic fevers	4000				
Acute arthritis	4000				
Neonatal sepsis	4000	7000			
Severe anaemia		2400			

Major Medical conditions

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices		
			< 26 beds	26 – 75 beds	76 – 150 beds
Acute pancreatitis	8000				
AMI	8000				
Cardiogenic shock	8000				
Cerebro vascular accidents	8000	10,000			
Acute respiratory failure	8000				
Acute renal failure	8000				

Minor Surgical admissions

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices		
			< 26 beds	26 – 75 beds	76 – 150 beds
Normal delivery	1500	500			
Septic abortion		1100			
Delivery with APH		4750			
Delivery with PPH		3500			
Delivery with Eclampsia		8000			
Delivery with obstruction		2200			
Excision biopsy	1200				
Closed reduction of long bones	3500				
Minor amputations	1000				
Closed reduction of dislocations	1500				
Circumcision	1000				
Dilatation of urethra	1000				
Hydrocoele	4000				
Tonsillectomy	3500				
FB removal – trachea, oesophagus	1500				
Polypectomy	3500				
Cataract	2500				
Angiogram	4500				
Lumpectomy	4000				
Haemorrhoidectomy	4000				
Herniarapphe	5000				

Medium Surgical conditions

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices		
			< 26 beds	26 – 75 beds	76 – 150 beds
Hysterectomy	8000				
LSCS	7500	2200			
Oopherectomy	5500				
Gastrectomy	20000				
Pyloroplasty	13000				
GI with Vagotomy	7000				
Gastro duodenostomy	13000				
Cholecystostomy	9000				
Laproscopic Chole	13000				
Appendectomy	5500				
Intestinal resection	9000				
Colectomy	6000				
Inguinal hernia	6000				
Amputation	7000				
Arthrodosis	9000				
Open reduction	9000				
Fracture neck of femure	12000				
Nephrostomy	13000				
Uretero-lithotomy	9000				
TURP	10000				
Thyroidectomy	9000				
Tympanoplasty	7000				
Laryngotomy	12000				
Radical mastectomy	9000				
Pacemaker implantation	10000				
Cataract surgery		1800			

Major surgical procedures

Name of condition	AP prices – maximum (Rs)	NCMH prices	Local prices
Open heart surgery	75000		
Closed heart surgery	45000		

Appendix 4

Utilisation rates of some common conditions

Name of condition	Cases per lakh population[12[12]]
Birth asphyxia	25
Neonatal sepsis	25
LBW	570
ARI	322
Normal delivery	2108
Puerperal sepsis	18
Septic abortion	5
APH	12
PPH	21
Eclampsia	25
Obstructed labour	32
LSCS	92
Severe anemia	248
Complicated malaria	40
Diabetes mellitus (without insulin)	2065
Hypertension	1714
COPD	1461
Asthma	2330
Major surgeries	438
Accidents	438
IHD (prevalence)	3353
Stroke	118
Schizophrenia (without hospitalisation)	289
Mood disorders	1543
Epilepsy	913

[12[12]] Source: Report of the National Commission on Macro-economics and health.

Note: all the cases in the community will not land up at the hospital. So one will have to reduce the same to the appropriate level depending on local circumstances, while calculating premium.

Appendix 5

Provider payment mechanisms[13][13]

The manner in which health care providers are paid can significantly affect both the cost and quality of care, and in these ways helps in optimal use of resources[14][14]. Once a patient has taken the step of contacting the provider, it is thereafter the provider who determines, to a large extent, the demand for his or her own services, and the kind and quantity of treatment required15[15]. Thus, the provider payment mechanisms determine the quantity of services consumed as well as their costs. They are an important component in the strategic purchasing of health services by insurers, with the other component being negotiating and contracting with providers so that they agree to provide health services according to the requirements and conditions of the insurers16[16]. Negotiating and contracting have been discussed in another module.

It must be remembered that like any other provider of services, the health provider would also like to maximize his income. He could do this by attracting more patients, over-treating these patients, increasing the number of visits by the same patients, or by charging more for his services. The provider payment mechanisms chosen by the insurer must contain costs, but also give the provider an opportunity to earn a reasonable income to motivate them to provide quality services. Commonly used provider payment mechanisms are discussed below.

Fee-for-service

The providers are given a fee for each service, procedure or act provided to a patient. It provides an incentive to providers to provide health services, and this could be perceived as leading to better quality. However, this incentive effect could itself lead to overproduction of health services (supplier-induced demand), a tendency to reduce the time spent per activity and to encourage repeat visits as they generate fresh fee. It has been suggested that the overproduction can be counteracted by combining this mechanism with fixed fee schedules, ceiling budgets, or by co-payments for patients. By far, this is the pre-dominant provider payment mechanism in our country, though it is also perhaps the most expensive, and has high administrative costs for processing claims and prevention of fraud.

Daily (per diem) payment

This is a simple and easy to administer method for inpatient treatment, but like the fee-for-service method, it has a weak capacity for cost-containment because there is a similar incentive to expand the length of stay of patients, and/or to increase the number of admissions. The hospitals also have an incentive to cut down on the inputs to limit

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[13][13] Copied from "Empanelling Providers" (Dr Somil Nagpal) in "Training Manual for health insurance managers." Institute of Public Health, Bangalore. 2006.

[14][14] Carrin G, James C. Reaching universal coverage via social health insurance: key design features in the transition period. WHO, Geneva. Discussion Paper, 2004.

[15][15] Normand C, Weber A. Social Health Insurance- A Guidebook for Planning. WHO and ILO, 1994.

[16][16] WHO, Geneva. Community based Health Insurance Schemes in Developing Countries: facts, problems and perspectives. Discussion paper, 2003.

their costs. Attempts have been made to provide a progressively reducing per diem payment, which could remove the incentives to prolong the inpatient stay. A ceiling budget for the hospital could also be used, like that in fee-for-service.

Case payment

This is based on managing the whole case, rather than a single act as in fee-for-service, and can be used for both ambulatory and inpatient care. The system is easy to administer, and could be a flat rate system where all types of cases are paid the same flat rate, or a system where the type of case determines the quantum of payment. An important example of the latter is the Diagnosis Related Group (DRG) payment method followed in many countries, where hospitals are paid an all-inclusive flat payment for a patient's treatment according to his/her diagnostic group. The system encourages efficient providers, but the effect could be offset by encouraging increased admissions and by the "DRG creep", the tendency to record a more complicated diagnosis if that qualifies for a higher DRG slab. There could also be an incentive for providers to transfer the more complicated (and thus more expensive) cases towards other providers, particularly public providers, rather than managing them.

Capitation

Under the capitation system, providers receive payment according to the number of people served and cover services for each enrolled member for the entire enrolment period for a pre-specified sum. There is no incentive to provide excessive health services, but it could give rise to the opposite problem of potential underproduction. Further, referral of cases to higher levels of care could affect the potential of this method in containing costs. Competition amongst providers may also help lessen the problem of under-production, as providers' income is dependent on the number and type of people served and people, once given the choice to select their provider, are likely to enrol with the providers who provide due care. The administrative costs of this method are very low, and are especially suited in primary care settings.

Budgets

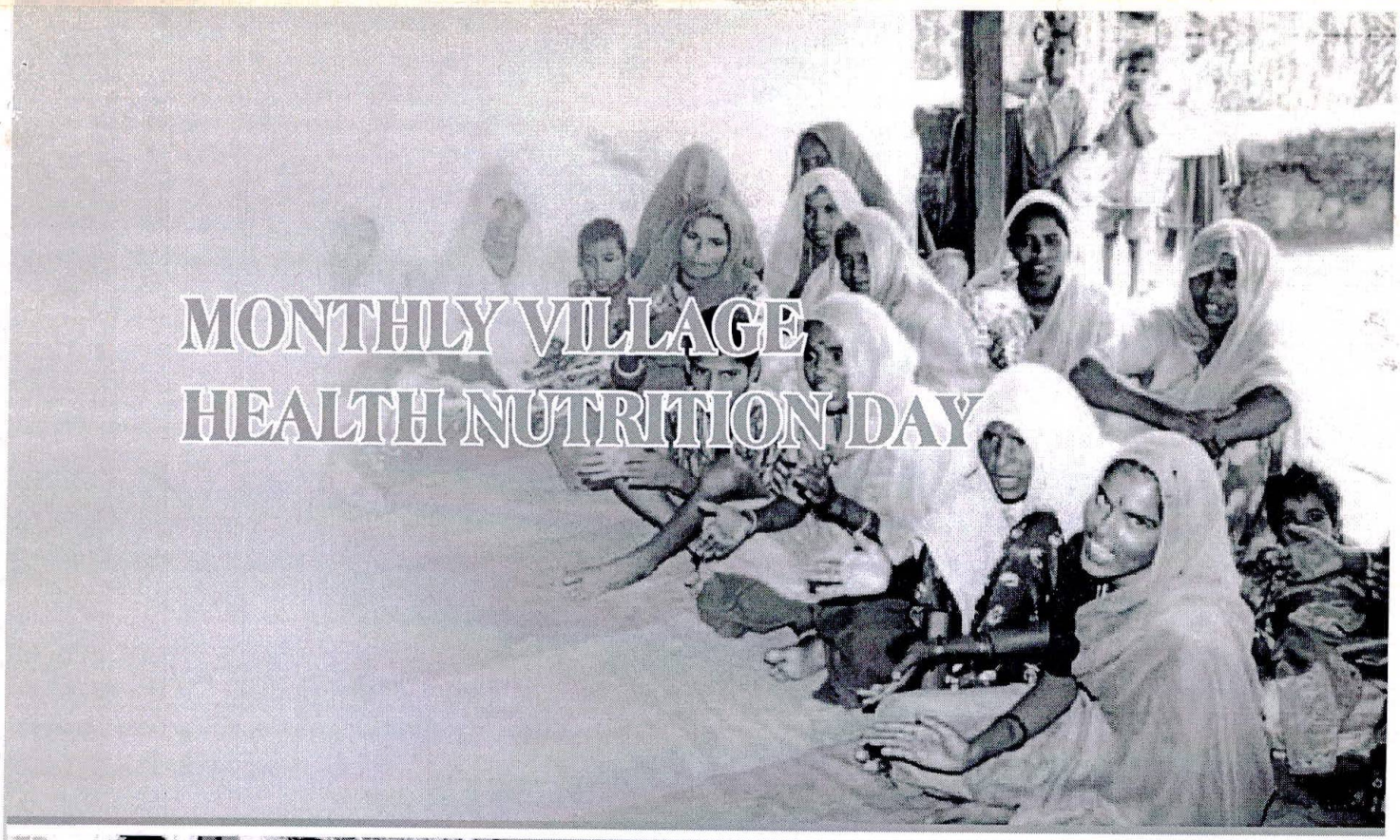
Budgets are the predominant method of funding the government health system in our country. As with capitation, there is no link between the quantity and mix of health services given to the individual patient and the total amount received by providers. However, if the budget is insufficient or utilized inefficiently, not enough services may be produced and this results in other providers having to provide the necessary care. Also, when budgets are not very strict, and as they are often based on historical costs, there is no incentive for providers to minimize costs, and there is even a perverse incentive to exceed the budget ceiling as it implies a higher provision in the next year. Underproduction and waiting lists are thus common where budgets are the sole mode of financing services.

Salaries

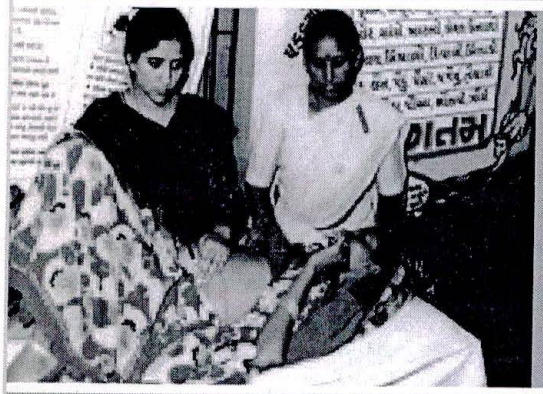
This is where the insurer employs personnel to provide health services and pays these personnel a salary, unlinked to workload handled. Here again, overproduction is unlikely but underproduction is, because fixed salaries may not provide sufficient motivation for sustained good performance. Administrative costs are low, but it may be difficult to

encourage and retain good personnel. Ensuring variable, performance-related factors in the salary could be an important way of ensuring better quality.

Combinations of these payment mechanisms can also be attempted. For example, the NHS in the UK uses capitation for paying its general practitioners, but they are also paid fee-for-service for certain specified activities, bonus payments for certain performance targets etc. Different mechanisms can also be combined at different levels of care, to optimize the cost-quality balance.

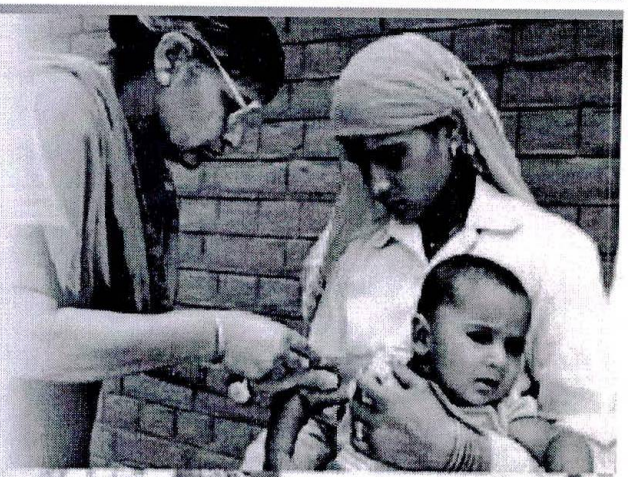


MONTHLY VILLAGE HEALTH NUTRITION DAY



GUIDELINES FOR AWWs/ASHAs/ANMs/PRIs

February 2007



NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
(2005-2012)

सत्यमेव जयते
Ministry of Health and Family Welfare
Government of India

PREFACE

The NRHM guarantees better health outcomes for millions of people in rural areas, especially those belonging to marginalized and vulnerable communities. The VHND promises to be an effective platform for providing first-contact primary health care.

Quite often, programme managers, service providers, community-based organizations, and PRI representatives do not share a common understanding about the activities to be undertaken and how these are to be operationalised while organizing the VHND. This manual provides information about organizing the VHND in a simple and lucid manner.

It is hoped that this manual will serve the needs of all concerned, including medical officers, ANMs, MPWs, and ASHAs. A clear understanding of the relevant procedures and operations will lead to the effective organization of the VHND, which is an important tool under NRHM for the convergence of all activities. I take this opportunity to thank the Maternal Health Division (GOI) and United Nations Population Fund (UNFPA) for providing technical support in preparation of this document.

S. Jalaja
Additional Secretary and Mission Director,
NRHM
Ministry of Health & Family Welfare
Government of India

Date: 26 February 2007

ABBREVIATIONS

AD	Auto Disposable
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi centre
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy
BCC	Behaviour Change Communication
BF	Blood Film
DPMU	District Programme Management Unit
DPT	Diphtheria Pertussis and Tetanus
ECP	Emergency Contraception Pills
ENBC	Essential Newborn Care
GOI	Government of India
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IFA	Iron Folic Acid
JSY	Janani Suraksha Yojna
LHV	Lady Health Visitor
MCH	Mother and Child Health
MO	Medical Officer

MP	Malarial Parasite
MPW	Multi Purpose Worker
MTP	Medical Termination of Pregnancy
NRHM	National Rural Health Mission
OCP	Oral Contraceptive Pills
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salt
PHC	Primary Health Centre
PPTCT	Prevention of Parent-to-Child Transmission
PRI	Panchayati Raj Institution
RCH II	Reproductive and Child Health Programme-Phase II
RMP	Rural/Registered Medical Practitioner
RTI	Reproductive Tract Infections
SC	Scheduled Castes
ST	Scheduled Tribes
STI	Sexual Tract Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
VCTC	Voluntary Counselling and Testing Centre
VHND	Village Health Nutrition Day
VHSC	Village Health and Sanitation Committee
VVM	Vaccine Vial Monitor

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1 INTRODUCTION

The VHND is to be organized once every month (preferably on Wednesdays, and for those villages that have been left out, on any other day of the same month) at the AWC in the village. This will ensure uniformity in organizing the VHND. The AWC is identified as the hub for service provision in the RCH-II, NRHM, and also as a platform for inter-sectoral convergence. VHND is also to be seen as a platform for interfacing between the community and the health system.

Keeping in view the significance of holding the VHND, the important steps that need to be taken while organizing the event have been put together in this manual. The roles of the ANM, ASHA and AWW should be well defined. The quality of the VHND needs to be improved, and hence the outcomes should be measured and monitored.

This document will help AWWs, ASHAs and PRI members to understand their respective roles in providing their services effectively to the community during the monthly VHND and will also help in educating them on matters related to health. VHND if organized regularly and effectively can bring about the much needed behavioural changes in the community, and can also induce health-seeking behaviour in the community leading to better health outcomes.

Programme managers at district/block level should ensure availability of necessary supplies and expendables in adequate quantities during the VHNDs. Similarly, supportive supervision by Programme Managers at different levels will result in improved quality of services.

2 WHY ORGANIZE A MONTHLY HEALTH NUTRITION DAY IN EVERY VILLAGE

On the appointed day, ASHAs, AWWs, and others will mobilize the villagers, especially women and children, to assemble at the nearest AWC. The ANM and other health personnel should be present on time; otherwise the villagers will be reluctant to attend the following monthly VHND. On the VHND, the villagers can interact freely with the health personnel and obtain basic services and information. They can also learn about the preventive and promotive aspects of health care, which will encourage them to seek health care at proper facilities. Since the VHND will be held at a site very close to their habitation, the villagers will not have to spend money or time on travel. Health services will be provided at their doorstep. The VHSC comprising the ASHA, the AWW, the ANM, and the PRI representatives, if fully involved in organizing the event, can bring about dramatic changes in the way that people perceive health and health care practices.

A) SERVICES TO BE PROVIDED:

- All pregnant women are to be registered.
- Registered pregnant women are to be given ANC.
- Dropout pregnant women eligible for ANC are to be tracked and services are to be provided to them.

- All eligible children below one year are to be given vaccines against six Vaccine-preventable diseases.
- All dropout children who do not receive vaccines as per the scheduled doses are to be vaccinated.
- Vitamin A solution is to be administered, to children.
- All children are to be weighed, with the weight being plotted on a card and managed appropriately in order to combat malnutrition.
- Anti-TB drugs are to be given to patients of TB.
- All eligible couples are to be given condoms and OCPs as per their choice and referrals are to be made for other contraceptive services.
- Supplementary nutrition is to be provided to underweight children.

B) ISSUES TO BE DISCUSSED WITH THE COMMUNITY:

- Danger signs during pregnancy
- Importance of institutional delivery and where to go for delivery
- Importance of seeking post-natal care
- Counselling on ENBC
- Registration for the JSY
- Counselling for better nutrition
- Exclusive Breastfeeding
- Weaning and complementary feeding
- Care during diarrhoea and home management
- Care during acute respiratory infections
- Prevention of malaria, TB, and other communicable diseases
- Prevention of HIV/AIDS
- Prevention of STIs
- Importance of safe drinking water

- Personal hygiene
- Household sanitation
- Education of children
- Dangers of sex selection
- Age at marriage
- Information on RTIs, STIs, HIV and AIDS
- Disease outbreak
- Disaster management

C) IDENTIFICATION OF CASES THAT NEED SPECIAL ATTENTION:

- Identify children with disabilities.
- Identify children with Grade III and Grade IV malnutrition for referral
- Identify severe cases of anaemia.
- Identify pregnant women who need hospitalization.
- Identify cases of malaria, TB, leprosy, and Kala Azar.
- Identify problems of the old and the destitute.
- Pay special attention to the SC, ST, the minorities, and the weaker sections of society.

D) COLLECTION OF DATA:

- Compile data on the number of children with special needs, particularly girl children with disabilities.
- Report outbreaks of disease.
- Report/audit deaths of children and women.
- Compile data pertaining to the SCs, the STs, the minorities, and weaker sections of society that need services.

8 CHECKLISTS

It would be useful to have checklists for ASHAs, AWWs, and ANMs to ensure that all the activities for which they are responsible are planned properly and carried out effectively, step by step. The following checklists are to be used by these workers for organizing the VHND.

ASHA

Actions to be taken before the Village Health and Nutrition Day:

- Visit all households and get to know all the families. Make it a point to visit all poor households, especially SC/ST families.
- Make a list of pregnant women.
- Make a list of women who need to come for ANC for first time or for repeat visits.
- Make a list of infants who need immunization, were left out or dropped-out.
- Make a list of children who need care for malnutrition.
- Make a list of children who were missed during the pulse polio round.
- Make a list of children with special needs, particularly girl children.
- Make a list of TB patients who need anti-TB drugs.
- Coordinate with the AWW and the ANM.

On the day:

- Ensure that all listed women come for services.
- Ensure that all listed children come for services.

- Ensure that malnourished children come for consultation with the ANM.
- Ensure supplementary nutrition to children with special needs.
- Ensure that all listed TB patients collect their drugs.
- Assist the ANM and the AWW.

AWW

- Ensure that the AWC is clean.
- Ensure availability of clean drinking water during the VHND.
- Ensure a place with privacy at the AWC for ANC.
- Keep an adequate number of MCH cards.
- Coordinate activities with the ASHA and the ANM.

ANM

- Ensure that the VHND is held without fail. Make alternative arrangements in case the ANM is on leave.
- Ensure that the supply of vaccines reaches the site well before the day's activities begin.
- Ensure that all instruments, drugs, and other materials as listed in the annexure are in place.
- Carry communication materials.
- Ensure that adequate money is available for disbursement to the ASHA.
- Ensure reporting of the VHND to the MO in charge of the PHC.
- Coordinate with the ASHA and the AWW.

PRIs

- Ensure that the members of the VHSC are available to support the sessions.
- Ensure participation of schoolteachers and PRI members.
- Ensure availability of clean drinking water, proper sanitation, and convenient approach to the AWC for participating in the VHND by all.

4 SERVICE PACKAGE FOR THE VILLAGE HEALTH NUTRITION DAY

MATERNAL HEALTH

- Early registration of pregnancies.
- Focused ANC.
- Referral for women with signs of complications during pregnancy and those needing emergency care.
- Referral for safe abortion to approved MTP centres.
- Counselling on:
  - Education of girls.
  - Age at marriage.
  - Care during pregnancy.
  - Danger signs during pregnancy.
  - Birth preparedness.
  - Importance of nutrition.
  - Institutional delivery.
  - Identification of referral transport.
  - Availability of funds under the JSY for referral transport.
  - Post-natal care.
  - Breastfeeding and complementary feeding.
  - Care of a newborn.
  - Contraception.

- Organizing group discussions on maternal deaths, if any, that have occurred during the previous month in order to identify and analyse the possible causes.

CHILD HEALTH

Infants up to 1 year:

- Registration of new births.
- Counselling for care of newborns and feeding.
- Complete routine immunization.
- Immunization for dropout children.
- First dose of Vitamin A along with measles vaccine.
- Weighing.

Children aged 1-3 years:

- Booster dose of DPT/OPV.
- Second to fifth dose of Vitamin A.
- Tablet IFA - (small) to children with clinical anaemia.
- Weighing.
- Provision of supplementary food for grades of mild malnutrition and referral for cases of severe malnutrition.

All children below 5 years:

- Tracking and vaccination of missed children by ASHA and AWW.
- Case management of those suffering from diarrhoea and Acute Respiratory Infections.
- Counselling to all mothers on home management and where to go in even of complications.
- Organizing ORS depots at the session site.
- Counselling on nutrition supplementation and balanced diet.
- Counselling on and management of worm infestations.

FAMILY PLANNING

- Information on use of contraceptives.
- Distribution - provision of contraceptive counseling and provision of non-clinic contraceptives such as condoms and OCPs.
- Information on compensation for loss of wages resulting from sterilization and insurance scheme for family planning.

REPRODUCTIVE TRACT INFECTIONS AND SEXUALLY TRANSMITTED INFECTIONS

- Counselling on prevention of RTIs and STIs, including HIV/AIDS, and referral of cases for diagnosis and treatment.
- Counselling for perimenopausal and post-menopausal problems
- Communication on causation, transmission, and prevention of HIV/AIDS and distribution of condoms for dual protection.
- Referral for VCTC and PPTCT services to the appropriate institutions.

SANITATION

- Identification of households for the construction of sanitary latrines
- Guidance on where to go and who to approach for availing of subsidy for those eligible to get the same under the Total Sanitation Campaign.
- Avoidance of breeding sites for mosquitoes.
- Mobilization of community action for safe disposal of household refuse and garbage.

COMMUNICABLE DISEASES

- Group communication activities for raising awareness about signs and symptoms of leprosy, suspected cases, and referrals.
- Group communication activities for elimination of breeding sites for mosquitoes, management of fever cases, i.e. importance of collection of blood film for MP and presumptive treatment.

- Awareness generation about symptoms of TB (coughing for more than three weeks), importance of continued treatment, referral of symptomatics for sputum examination at the nearest health centre.
- Provision of anti-TB drugs to patients.
- Reporting of unusual numbers of cases of any disease or disease outbreak in village.

GENDER

- Communication activities for prevention of pre-natal sex selection, illegality of pre-natal sex selection, and special alert for one-daughter families.
- Communication on the Prevention of Violence against Women, Domestic Violence Act, 2006.
- Age at marriage, especially the importance of raising the age at marriage for girls.

AYUSH

- Home remedies for common ailments based on certain common herbs and medicinal plants like tulsi found in the locality.
- Information related to other AYUSH components, including drugs for treating conditions like anaemia.

HEALTH PROMOTION

Chronic diseases can be prevented by providing information and counseling on:

- Tobacco chewing
- Healthy lifestyle
- Proper diet
- Proper exercise

NUTRITION

Diseases due to nutritional deficiencies can be prevented by giving information and counseling on:

- Healthy food habits.
- Hygienic and correct cooking practices.
- Checking for anaemia, especially in adolescent girls and pregnant women; checking, advising, and referring.
- Weighing of infants and children.
- Importance of iron supplements, vitamins, and micronutrients
- Food that can be grown locally.
- Focus on adolescent pregnant women and infants aged 6 months to 2 years.

Please see the following annexures for more details:

Annexure 1: Requirements for Organizing VHND

Annexure 2: Publicity for VHND

Annexure 3: Supervisory Arrangements

Annexure 4: Supervisory Checklist

Annexure 5: Outcomes

Annexure 1

REQUIREMENTS FOR ORGANIZING VHND

WHO ARE NEEDED

- ASHA
- AWW
- PRI member
- Helper of AWW
- Staff to come from outside the village:
  - ANMs
  - Male MPW (if available)
  - ASHA facilitators (if available)

INSTRUMENTS, EQUIPMENT, AND FURNITURE

- Weighing scale-adult, child
- Examination table
- Bed screen/curtain
- Haemoglobin metres, kits for urine examination
- Gloves
- Slides
- Stethoscope and blood pressure instrument
- Measuring tape
- Foetoscope
- Vaccine carrier with ice packs

If these items are not available, their provision could be arranged by using the untied fund of Rs 10,000/- available with the ANM or with the VHSC. These items should be kept under the safe custody of the ANM/ AWW/ ASHA as the case may be.

SUPPLIES

- Supplies such as vaccines, IFA tablets, Vitamin A, condoms, OCPs, (ECPs), ORS, and Cotrimoxazole
- Anti-helminthic drug
- Chloroquin
- Anti-TB drugs
- Paracetamol
- Stains for fixing BF
- AD syringes in sufficient quantity
- IEC material for communication and counseling

Annexure 2

PUBLICITY FOR VHND

PUBLICITY

- Day and time
- Site
- Key services

KEY COMMUNICATION OBJECTIVE

To make the community, especially women from vulnerable sections and other stakeholders in the community, aware of service availability right in the village on fixed days at AWC.

WHOM TO INVOLVE

- PRI members
- SHG members
- Teachers and other informal leaders
- Schoolchildren
- All beneficiaries
- TBAs and other RMPs

MEDIA AND METHODS

- Wall writings in the local language
- Hoardings at one or two prominent places in the village
- Handbills and pamphlets

Resources for publicity activities can be accessed through the untied funds available with the VHSC or through the sub-centre joint fund.

Annexure 3

SUPERVISORY ARRANGEMENTS

SUPERVISION AND MONITORING

The proper organization of the VHND is the most crucial component of NRHM for guaranteeing service provision at the village level. Hence, at all programme meetings at the state, district, and block levels, one should ensure the review of the VHND and the problems encountered should be addressed promptly and effectively. Each district and block should maintain a record of the number of VHNDs planned and the number actually held. The quality of the services offered and available during the VHND will depend on the quality of the supervision and leadership. The LHV and the AWW Supervisor should jointly visit the pre-identified centres as per the roster and submit their joint report, which will be discussed at the monthly meeting convened by the MO in charge of the PHC.

During the supervisory visits, special attention should be given to the following elements:

1. Women and children from vulnerable communities should come forward to seek services.
2. ASHA should be available at the session site and should be engaged in the tracking of women and children, especially those from vulnerable communities, for complete coverage.
3. All resources (human resources and materials) should be in place.
4. The quality of the services available should be satisfactory.
5. Issues related to the clients' satisfaction with the services should be addressed properly and promptly.
6. BCC methods should be employed.

The holding of the VHND should be discussed at the monthly meetings convened by the MOs at the PHC level at the executive committee meetings of the District Health Society, of which the District CMO is the convener. The DPMUs will monitor it, and will also compile data on it.

Annexure 4

SUPERVISORY CHECKLIST

SUPERVISORY CHECKLIST

(to be used by the different cadres of supervisors during visits to the VHND sites)

1. General information: Session site, availability of staff, timings displayed
2. Cold chain: Vaccine carrier with ice packs, VVM's status on vaccine vials
3. Availability of essential supplies in adequate quantities
4. Procedure of vaccination, especially injection safety
5. Availability of communication and counselling materials
6. Record review for
   a. Women and children from vulnerable communities
   b. Immunization for children scheduled to arrive
   c. Follow-up activities for ANC
   d. Blood films collected for MP
7. Disposal of AD syringes
8. Client satisfaction: Exit interviews with some clients about the dates of repeat visits for immunization, birth preparedness, and the institution identified for delivery
9. Disbursement of incentives to ASHA for mobilizing clients to get immunization

Annexure 5

OUTCOMES

OUTCOMES

The organization of the Village Health and Nutrition Day on a regular basis as per the guidelines will result in the achievement of the following outcomes:

- Hundred per cent coverage with preventive and promotive interventions, especially for pregnant women, children, and adolescents
- Preventive and promotive coverage for the National Disease Control Programmes
- Increased awareness about the determinants of health such as nutrition, sanitation, timely care, etc.
- Improved knowledge about the services offered under the various Nutritional Health Programmes
- Greater emphasis on the community's role in making the health system responsive to the health needs of the community and in demanding and ensuring accountability

JANANI SURAKSHA YOJA

NATIONAL RURAL HEALTH MISSION
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(2005-2012)

FEATURES
&
FREQUENTLY ASKED QUESTIONS AND ANSWERS

Government of India

As in October 2006

Government of India
Ministry of Health and Family Welfare
Maternal Health Division
Nirman Bhavan
New Delhi

JANANI SURAKSHA YOJANA (JSY)

Janani Suraksha Yojana **(JSY)** is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The Yojana, launched on 12th April 2005, by the Hon'ble Prime Minister, is being implemented in all states and UTs with special focus on low performing states.

2. JSY is a 100 % centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care. The success of the scheme would be determined by the increase in institutional delivery among the poor families

3. The Yojana has identified ASHA, the accredited social health activist as an effective link between the Government and the poor pregnant women in l0 low performing states, namely the 8 EAG states and Assam and J&K and the remaining NE States. In other eligible states and UTs, wherever, AWW and TBAs or ASHA like activist has been engaged in this purpose, she can be associated with this Yojana for providing the services.

3.1 **Role of ASHA or other link health worker associated with JSY** would be to:

- ☞ ☞ Identify pregnant woman as a beneficiary of the scheme and report or facilitate registration for ANC,
- ☞ ☞ Assist the pregnant woman to obtain necessary certifications wherever necessary,
- ☞ ☞ Provide and / or help the women in receiving at least three ANC checkups including TT injections, IFA tablets,

- ☞ ☞ Identify a functional Government health centre or an accredited private health institution for referral and delivery,
- ☞ ☞ Counsel for institutional delivery,
- ☞ ☞ Escort the beneficiary women to the pre-determined health center and stay with her till the woman is discharged,
- ☞ ☞ Arrange to immunize the newborn till the age of 14 weeks,
- ☞ ☞ Inform about the birth or death of the child or mother to the ANM/MO,
- ☞ ☞ Post natal visit within 7 days of delivery to track mother's health after delivery and facilitate in obtaining care, wherever necessary,
- ☞ ☞ Counsel for initiation of breastfeeding to the newborn within one-hour of delivery and its continuance till 3-6 months and promote family planning.

Note: *Work of the ASHA or any link worker associated with Yojana would be assessed based on the number of pregnant women she has been able to motivate to deliver in a health institution and the number of women she has escorted to the health institutions.*

4. Important Features of JSY:

4.1 The scheme focuses on the poor pregnant woman with special dispensation for states having low institutional delivery rates namely the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and Jammu and Kashmir. While these states have been named as Low Performing States **(LPS), t**he remaining states have been named as High performing States **(HPS)**.

4.2 **Tracking Each Pregnancy:** Each beneficiary registered under this Yojana should have a JSY card along with a MCH card. ASHA/AWW/ any other identified link worker under the overall supervision of the ANM and the MO, PHC should **mandatorily prepare a micro-birth plan**. Please see **Annexure – I**. This will effectively help in monitoring Antenatal Check-up, and the post delivery care.

4.3 Eligibility for Cash Assistance:

LPS States	**All pregnant women** delivering in Government health centres like Sub-centre, PHC/CHC/ FRU / general wards of District and state Hospitals or accredited private institutions
HPS States	**BPL pregnant women**, aged 19 years and above
LPS & HPS	**All SC and ST women** delivering in a government health centre like Sub-centre, PHC/CHC/ FRU / general ward of District and state Hospitals or accredited private institutions

Note: BPL Certification – This is required in all HPS states. However, where BPL cards have not yet been issued or have not been updated, States/UTs would formulate a **simple criterion** for certification of poor and needy status of the expectant mother's family by empowering the gram pradhan or ward member.

4.4 Scale of Cash Assistance for Institutional Delivery:

Category	Rural Area		Total	Urban Area		Total
	Mother's Package	ASHA's Package	Rs.	Mother's Package	ASHA's Package	Rs.
LPS	1400	600	2000	1000	200	1200
HPS	700		700	600		600

Note 1: Importantly, such woman in both LPS and HPS states, choosing to deliver **in an accredited private health institution** will have to produce **a proper BPL or a SC/ST certificate** in order to access JSY benefits. In addition she should **carry a referral slip from the ASHA/ANM/MO and the MCH - Janani Suraksha Yojana (JSY) card.**

Note 2: ANM / ASHA / MO should make it clear to the beneficiary that Government is not responsible for the cost of her delivery. She has to bear cost, while choosing to go to an accredited private institution for delivery. She only gets her entitled cash.

4.5 While mother will receive her entitled cash, the scheme **does not provide for ASHA package** for such pregnant women choosing to deliver **in an accredited private institution.**

4.6 **Limitations of Cash Assistance for Institutional Delivery:**

In LPS States	**All births**, delivered in a health centre – Government or Accredited Private health institutions. Refer to para (b).
In HPS States	**Upto 2 live births.**

4.7 **Disbursement of Cash Assistance:** As the cash assistance to the mother is mainly to meet the cost of delivery, it should be disbursed **effectively at the institution itself.**

4.7.1 For pregnant women going to a public health institution for delivery, entire cash entitlement should be disbursed to her **in one go,** at the health institution. Considering that some women would access accrediting private institution for antenatal care, they would require some financial support to get atleast 3 ANCs including the TT injections. In such cases, atleast **three-fourth (3/4) of the cash assistance under JSY should be paid to the beneficiary in one go,** importantly, at the time of delivery.

4.7.2 **To Beneficiary:**

a. a. The mother and the ASHA (wherever applicable) should get their entitled money at the heath centre immediately on arrival **and** registration for delivery.

b. b. Generally the ANM/ ASHA should carry out the entire disbursement process. However, till ASHA joins, AWW or any identified link worker, under the guidance of the ANM may also do the disbursement.

4.7.3 **At accredited private institution:** Disbursement of cash to the mother should be done through the ANM/ASHA/ Link worker channel and the money

available under JSY should be paid to the beneficiary only and **not to any other person or relative. Also refer to para (e).**

✓ ✓ **Should ensure that:**

- Such accredited private institution would also be responsible for any postnatal complication arising out of the cases handled by them.
- They should not deny their services to any referred targeted expectant mother.

Note: Every month, accredited private health centers would prepare a statement of JSY - delivery / ANC/ obstetric complication cases handled by them and send it to the Medical officer, along with the referral slips for **sample verification by the concerned ANM / ASHA.**

4.7.4 **In the District / Women's Hospital / State Hospital etc :**

- State / District should allocate sufficient amount of money (based on the load of deliveries in these institutions) for each of these institution. This money should be kept **in a separate account under the supervision of the Rogi Kalyan Samity**.

- The residency of the beneficiary would determine entitlement of cash benefit in such institutions, to be verified based on the referral slip from the ANM, carried by the beneficiary.

Format of Referral Slip: State should prepare a format of the referral slip, which should mainly indicate, identification details of the beneficiary, JSY registration number in the register of the ANM, reason for referral (including medical complications), name of ASHA, amount already disbursed, amount due, including referral transport money (if applicable), amount due to ASHA and to be paid, signature of MO/ANM.

- It is therefore, essential that all targeted expectant mother should carry a referral slip from the ANM/MO where she generally resides. This will, infact, help all such pregnant woman who go to her mother's place for delivery.

- Disbursement of money to expectant mother going to her mother's place for delivery should be done at the place she delivers. **The entitlement of cash should be determined by her referral slip carried by her and her usual place of residence.**

- A **voucher scheme** may be introduced in such a way that along with admission slip for delivery, a voucher amounting to mother's package plus the transport assistance money is given to the expectant mother and that she should be able to encash the same at the Hospital's cash counter, at the time of discharge.

4.8 **Flow of Fund:**

i. i. State/ District authorities would advance Rs. 5000/- and Rs. Rs.10,000/- to each ANM in HPS /LPS States respectively as a recoupable impressed money from the JSY fund.

ii. ii. This money could be kept in the joint account of ANM and Gram Pradhan, as in case of untied fund placed with sub-centers so that the ANM could 'roll' the entire amount by advancing Rs.1500 to Rs. 2,500/- to ASHA / AWW per delivery and later she could recoup it from the PHC or CHC, where JSY fund is parked by the authorities.

Expenditure Monitoring: ASHA / AWW should provide an expenditure statement of money advanced to her in previous month to the ANM in the monthly meeting held by ANM.

iii. iii. There should be a clear authority for ANM to withdraw cash from this account for advancing it to the ASHA or AWW / any other health link worker, needed for ready use towards disbursement to the pregnant and also for arranging the referral transport for escorting the pregnant women to the institution.

Note: Where an elected body of the Panchayati Raj Institution (PRIs) exists, the State Governments/Health society may keep the money in a joint account of the Gram Pradhan and the ANM (like that of the untied fund). The process of recoupment of fund should be so simple to be able to disburse the cash to the pregnant women in time.

4.9 **ASHA Package**: This package, as of now, is available **in all LPS, NE States and in the tribal districts of all states and UTs**. In **rural areas** it includes the following three components:

- • **Cash assistance** for **Referral transport** to go to the nearest health centre for delivery. The state will determine the amount of assistance **(should not less than Rs.250/- per delivery)** depending on the topography and the infrastructure available in their state. It would, however, be the duty of the ASHA and the ANM to organize or facilitate in organizing referral the transport, in conjunction with gram pradhan, Gram Sabha etc.

  Note: This assistance is over and above the Mother's package.

- • **Cash incentive to ASHA: This should not be less than Rs.200/- per delivery** in lieu of her work relating to facilitating institutional delivery. Generally, ASHA should get this money after her postnatal visit to the beneficiary and that the child has been immunized for BCG.

- • **Transactional cost** (Balance out of Rs.600/-) is to be paid to ASHA in lieu of her stay with the pregnant woman in the health centre for delivery to meet her cost of boarding and lodging etc.. Therefore, this payment should be made at the hospital/ heath institution itself.

Note 1: In Urban areas, ASHA package consists of only the incentive for ASHA, for providing the services, as at para 3.1

Note 2: In case ASHA fails to organize transport for the pregnant woman to go to the health institution, transport assistance money available within the ASHA's package should be paid to the pregnant woman at the institution, immediately on arrival **and** registration for delivery.

Note 3: In case ASHA is yet to join, transport assistance money may be kept with the institution and a voucher scheme may be introduced for disbursement.

4.10 **Payment to ASHA:** ASHA should get her-

- ✓ ✓ **First payment** for the transactional cost **at the health centre** on reaching the institution along with the expectant mother.
- ✓ ✓ The **second payment** should be paid after she has made postnatal visit and the **child has been immunized for BCG.**

All payments to ASHA would be done by the ANM only. In this case too, a voucher scheme be introduced in such a manner that for every pregnant woman she registers under JSY, ANM would give two vouchers to ASHA, which she would be able to encash on certification by ANM.

Important: It must be ensured that ASHA gets her second payment within 7 days of the delivery, as that would be essential to keep her sustained in the system.

4.11 **Special Dispensation for LPS states:**

- ✓ ✓ **Age restriction removed**
- ✓ ✓ **Restricting benefits of JSY up to 2 births removed.** In other words, the benefits of the scheme are extended to all pregnant women in LPS states irrespective of birth orders.
- ✓ ✓ **No need for any marriage or BPL certification provided woman delivers in Government or accredited private health institution.**

Important: The state / UTs would be responsible for instituting an appropriate monitoring mechanism and ensure that a proper accounting procedure is put in place for all transactions.

4.12 **Subsidizing cost of Caesarean Section or management of Obstetric complications:** Generally PHCs/ FRUs / CHCs etc. would provide emergency obstetric services free of cost. Where Government specialists are not available in the Govt's health institution to manage complications or for **Caesarean Section**, assistance up to Rs. 1500/- per delivery could be utilized by the health institution **for hiring services of specialists from the private sector. If a specialist is not available** or that the list of empanelled specialist is very few, specialist doctors working in the **other Government set-ups** may even be empanelled, provided his/her services are spare and he/she is willing. In such a situation, the cash subsidy can be utilized to pay honorarium or for meeting transport cost to bring

the specialist to the health centre. It may however be remembered that **a panel of such doctors from private or Government institutions need to be prepared beforehand in all such health institutions** where such facility would be provided and the pregnant women are informed of this facility, at time of micro-birth planning.

Important: *State Governments would ensure that this assistance is not misutilized and would exercise adequate control and monitor expenditure under this component.*

4.13 **Assistance for Home Delivery:** In LPS and HPS States, BPL pregnant women, aged 19 years and above, preferring to deliver at home is entitled to cash assistance of Rs. 500/- per delivery. Such cash assistance would be available only upto 2 live births and the disbursement would be done **at the time of delivery or around 7 days before the delivery by ANM/ASHA/ any other link worker**. The rationale is that beneficiary would be able to use the cash assistance for her care during delivery or to meet incidental expenses of delivery. It should be the responsibility of ANM/ASHA, MO PHC to ensure disbursement. It is very important that the cash is disbursed in time. Importantly, such woman choosing to deliver at home should have a BPL certificate to access JSY benefits.

5. **Compensation Money:** If the mother **or** her husband, of their own will, undergoes sterilization, **immediately** after the delivery of the child, compensation money available under the existing Family welfare scheme should also be disbursed to the mother at the hospital itself.

6. **JSY Benefits in Accredited Private Health Institution:** In order to increase choice of delivery care institutions**, at least two willing private institutions per block** should be accredited to provide delivery services**. State and the district authorities should draw up a list of criterion / protocols for such accreditation. (Please see a model criterion at Annexure-2)** Such beneficiaries delivering in these institutions would get the cash benefits admissible under the JSY.

7. **Equip Sub-centers for Normal delivery**: For women living in tribal and hilly districts, it becomes difficult to access PHC/CHCs for maternal care or delivery. A well-equipped sub-center is a better option for normal delivery. Deliveries conducted in sub-centers, which are accredited by the state / district authorities will be considered as institutional delivery and therefore, women delivering in these centers would be eligible for all cash assistance under JSY.

Important: *All States and UTs to undertake a process of accreditation of all such sub-centre located in Govt. buildings and having proper facility of light, electricity, water, and other medical requirements of basic obstetric services including drugs, equipments and services of trained mid-wife for the purpose of conducting normal deliveries in these institutions.*

8. **Provision of Administrative Expenses**: Upto 4 % and 1% of the fund released could be utilized towards administrative expenses like monitoring, IEC and office expenses for implementation of JSY by the district and state authorities respectively.

9. **Essential Strategy**: While the scheme would create demand for institutional delivery, it would be necessary to have adequate number of 24X7 delivery

services centre, doctors, mid-wives, drugs etc. at appropriate places. Mainly, this will entail

- Linking each habitation (village or a ward in an urban area) to a functional health centre- public or accredited private institution where 24X7 delivery service would be available,

- Associate an ASHA or a health link worker to each of these functional health centre,

- It should be ensured that ASHA keeps track of all expectant mothers and newborn. All expectant mother and newborn should avail ANC and immunization services, if not in health centres, atleast on the **monthly health and nutrition day, to be organised in the Anganwadi or sub-centre**:

    - Each pregnant women is registered and **a micro-birth plan** is prepared **(please see Annexure-1)**
    - Each pregnant woman is tracked for ANC,
    - For each of the expectant mother, a place of delivery is pre-determined at the time of registration and the expectant mother is informed,
    - A referral centre is identified and expectant mother is informed,
    - ASHA and ANM to ensure that adequate fund is available for disbursement to expectant mother,
    - ASHA takes adequate steps to organize transport for taking the women to the pre-determined health institution for delivery.
    - ASHA assures availability of cash for disbursement at the health centre and she escorts pregnant women to the pre-determined health centre.

10. **Possible IEC strategy:**

- To **associate NGO and Self Help Groups** for popularizing the scheme among women's group and also for monitoring of the implementation.

- To provide wide publicity to the scheme by:

    ✓ **Promoting JSY as a component of total package of services** under RCH along with programmes like Pulse polio programme, Monthly Village Health Day, Health Melas etc,

    ✓ ✓ Printing and distributing JSY guidelines, pamphlets, notices in local languages at SC/PHCs/CHCs/ District Hospitals/ DM's and Divisional Commissioner's office and even in at the accredited Pvt. Nursing Homes, in abundance,

    ✓ ✓ Supporting printing of state's stationery, specially for State's Health Secretary, DMs / SDMs/ Block/ PHC/ CHC/ District Hospital, advocating on Institutional Delivery and cash benefits of JSY,

    ✓ ✓ Facilitate organizing workshops and meetings in villages / blocks - by women's group, local leaders (PRIs), Opinion Maker, at functional health institutions on promoting maternal health in general, Institutional Delivery and JSY,

    ✓ Undertaking wall painting in all sub-centers, PHCs and CHCs, District & State Hospitals and the accredited private institutions,

    ✓ **Supporting** women self help Groups and NGOs for promoting the scheme,
    ✓ **Facilitating** woman Panchayat member to take review of Janani Suraksha Yojana (JSY)

11. **Establish a grievance redressal cell** in each district, **under the District Project Management Unit**, mainly to facilitate meeting people's genuine grievances on -

- ✓ ✓ Eligibility for the scheme,
- ✓ ✓ Quantum of cash assistance,
- ✓ ✓ Delays in disbursement of the cash assistance,

An officer, supported by an assistant, if necessary, may be made responsible to supervise the grievance cell. However, proper information about the grievance cell, giving the officer's name, postal address and his telephone number should be displayed prominently at all health centers and institutions. If necessary, fund available under administrative expenses could be utilized for this purpose.

12. **Display of names of JSY beneficiaries**: The list of JSY beneficiaries along with the date of disbursement of cash to her should **mandatorily be displayed** on the display board at the sub-center, PHC/CHC/District Hospitals (from where beneficiaries have got the benefit), being updated regularly on month-to-month basis. **Wherever necessary, display boards may be procured.**

13. **Guidelines For urban areas:** The state shall prepare detailed guidelines by stating a simple procedure of implementing the Janani Suraksha Yojana (JSY) in the urban areas through the Municipalities/local bodies ((where an elected body exits) and quickly obtain approval of the state Government/SHS. The guidelines should bring out clearly, the chain of fund flow as well as disbursement of the benefits to the ultimate beneficiaries. The quantum of grants to be placed at the disposal of the Municipalities shall be in proportion to the BPL families in the Municipal area. **The district annual plan will also include the plan of the municipalities in the districts wherever applicable.** The Chief medical Officer of such an authority should be the implementing authority. It must be ensured that basic objectives and the scale of disbursements are not altered. A copy such plan along with necessary Government's order should be sent to the GOI.

14. **Monitoring:**

14.1 Monthly Meeting at Sub-centre Level: For assessing the effectiveness of the implementation of JSY, monthly meeting of all ASHAs / related health link workers working under an ANM should be held by the ANM, possibly on a fixed day (may be on the third Friday) of every month, at the sub-center or at any of Anganwadi Centres falling under the ANM's area of jurisdiction. If Friday is a holiday, meeting could be held on following working day.

14.2 **Prepare Monthly Work Schedule:** In the monthly meeting, the ANM, besides reviewing the current month's work vis-à-vis envisaged activities, should prepare a Monthly Work Schedule for each ASHA / village level health worker of following aspects of the coming month:

- • **Feed back on previous month's schedule -**

(a) Number of pregnant women missing ANCs,
(b) No. of cases, ASHA/link worker did not accompany the pregnant women for Delivery,
(c) Out of the identified beneficiary, number of Home deliveries,
(d) No. of post natal visits missed by ASHA,
(e) Cases referred to Referral Unit (FRU) and review their current health status,
(f) No. of children missing immunization.

- **Fixing Next Month's Work Schedule (NMWS):** To include -

(i) (i) Names of the identified pregnant women to be registered and to be taken to the health center/Anganwadi for ANC,
(ii) (ii) Names of the pregnant women to be taken to the health center for delivery (wherever applicable),
(iii) (iii) Names of the pregnant women with possible complications to be taken to the health center for check-up and/or delivery,
(iv) (iv) Names of women to be visited (within 7 days) after their delivery,
(v) (v) List of infants / newborn children for routine immunization,
(vi) (vi) To ensure availability of imprest cash,
(vii) (vii) Check whether referral transport has been organized.

Note 1: While no target needs to be fixed, but for the purpose of monitoring, some monthly goal of institutional delivery for the village may be kept.

Note 2: A format of monthly work schedule to be filled by the ANM /ASHA incorporating the physical and financial aspect may be printed.

15. **Reporting:** For the purpose of reviewing the progress of implementation and also for allocating fund to the state, under the RCH-flexi Pool, all States would provide

- Annual District-wise report as per **Annexure IV, reaching MoHFW in the month of April of the following financial year**
- Quarterly Report as per **Annexure V, reaching MoHFW in the month following the end of the Quarter.**

However, depending on the requirement of the Ministry, special reports may also be sought.

Most Important:

16. 16. Any deviation from the above process will not be accepted by the Central Government and that such expenditure will not be treated as legitimate utilization of the fund given under JSY. It may be noted that all payments before or after seven days of delivery will be treated as illegitimate subject to audit objection.

Annexure-I

MICRO-BIRTH PLAN FOR JSY BENEFICIARIES

STEP	Activity	To be undertaken by	Proposed Time Line
1	**Identification and Registration of beneficiary**	**ANM/ASHA/AWW** or any link worker	Atleast 20-24 weeks before the expected date of delivery.
2	**Filling up of Maternal and Child card** (In duplicate – one each for mother and ASHA/Link worker) (This will form part of the JSY'S Registration Card).	**ANM/ASHA/AWW** or an equivalent link worker	Immediately on registration
3	**4 I-s':** **Inform** dates of 3 ANC & TT Injection (s) **Identify** the health center for all referral **Identify** the Place of Delivery **Inform** expected date of delivery	**ANM/ASHA/AWW** or an equivalent link worker **Provide the 1st ANC** immediately on Registration. **ASHA to follow up** the ANCs at the Anganwadi Centres/Sub-center (SC) and **ensure** that the beneficiary attends the SC/Anganwadi centre /PHC for ANC on the indicated dates **Motivation: ANM should call the beneficiary** to the Anganwadi/SC to participate in the Monthly meeting and **explain enhanced cash** and Transport assistance benefits for Institutional delivery.	Immediately on registration
4	**Collecting BPL or necessary proofs /certificates** Wherever necessary from	**ANM/ASHA/AWW or** an link worker	Within 2-4 weeks from Registration

	Panchayat / local bodies / Municipalities		
5	**Submission of the completed JSY card** in the Health center for verification by the authorized/Medical officer. **II.** Take necessary steps toward **arranging transport or making available cash to** the beneficiary to come to the Health Centre **III.** Ensure **availability of fund** to ANM/Health worker/ASHA etc.	**MO, PHC** ANM/ASHA/AWW/link worker ANM/ MO, PHC	Atleast 2-4 weeks before the expected date of delivery
6.	**Payment of cash benefit / incentive to the mother and ASHA**	ANM/ MO, PHC	At the institution.

For complicated cases or those requiring cesarean section etc:

Ac –1	Pre-determine a Referral health center and intimate the pregnant women	**By ANM/ASHA/link worker**
Ac –2	Familiarize the woman with the referral centre, if necessary carry a letter of referral from MO PHC	**ANM/ASHA/link worker**
Ac –3	Pre-organize the transport facility in consultation with family members/community leader	**ANM/ASHA/Community**
Ac –4	**Arrange for the medical experts** if the same is not available in the referred heath center	**MO, PHC**

Annexure-II

CRITERIA FOR ACCREDITATION OF 24 HOURS COMPREHENSIVE EMERGENCY OBSTETRIC CARE

Casualty services

- A pregnant woman in labour or distress on entering the hospital at any time during the day or night is directly taken to the obstetric casualty and immediately examined by a professional with midwifery skills and decision taken within fifteen minutes.
  - If there are signs or bleeding, convulsions or shock, she should be immediately attended by the Obstetrician on duty and necessary treatment to be initiated.
  - Send the mother to the labour room, ward or operation theatre, depending on the signs and symptoms.

- No pregnant woman in labour or distress should be turned away from the hospital for any reason at any time of the day or night.
- Casualty should be located close to the labour room and theatre.
- Casualty to receive advance intimation about the arrival of the mother and keep the specialist team ready with blood, if needed.
- Casualty should have the following round the clock:
  - An obstetrician
  - Life saving drugs and IV fluids
  - Facility for examining the patient (including pv)

List of Officers of Ministry of Health & Family Welfare/ Prog. Deptts.

Sl. No.	Name	Designation	Department	Address	Room No	Extension No.	Telephone	Fax	E-mail ID
1	**Dr Anbumani Ramadoss**	**HFM**		**N.B.**	**348-A**	**101**	**23061647 23061751 23061661**	**23061647 23061751 23061661**	hfm@alpha.nic.in
2	**Smt Panabaka Lakshmi**	**MOS**		**N.B.**	**250-A**	**102**	**23061016 23061551 23061157**	**23061157**	Panabaka@nic.in
				Secretary, Additional Secretary, ADG					
3	**Shri Naresh Dayal**	**Secretary(H&FW)**		**N.B.**	**150-A**	**201**	**23061863 23063221 23062432**	**23061863 23063221 23062432**	secyhlth@nb.nic.in secyfw@nb.nic.in
4		**AS**		**N.B.**	**244-A**	**305**	**23061451**	**23061451**	as-mohfw@nic.in
5	**Shri Raghubir Singh**	**AS & FA**		**N.B.**	**258-A**	**302**	**23061673**	**23061673**	asfa@nic.in
6	**Shri Deepak Gupta**	**AS(DG)**		**N.B.**	**254-A**	**202**	**23063809,**	**23063809**	asdg-mohfw@nic.in
7	**Ms K Sujatha Rao**	**AS&DG(NACO)**		**N.B.**	**145-A**	**308**	**23061066**	**23061066**	asdg@nacoindia.org
8	**Shri S. K. Sinha**	**ADG(Stat)**		**N.B.**	**243-A**	**435**	**23061334**	**23061334**	
				JS					
15	Shri B.K. Prasad	JS(BKP)		N.B.	155-A	337	23061723	23061723	
16	Smt Bhavani Thyagrajan	JS(BT)		N.B.	343-A	2695/345	23061481	23061481	jsbt@nb.nic.in
17	Ms Aradhana Johri	JS(AJ)		N.B.	155-A	2656/511	23061195	23061842	aradhana.johri@nic.in
18	Shri K Ramamoorthy	JS(KR)		N.B.	147-A	2510/304	23061706	23061706	Kr.moorthy@nic.in
19	Shri Amarjeet Sinha	JS(AS)		N.B.	242-A	312	23062157	23062157	amarjeet.sinha@nic.in
20	Shri Vineet Choudhary	JS(VC)		N.B.	147-A	2690/329	23062579	23062579	vineetchaudhry@hotmai
21	Shri Debasish Panda	JS(DP)		N.B.	146-A	307	23062857	23061447	
				PS TO JS					
22	Sh. N. Satish	PS to JS(AS)		N.B.	259-A	332	23062157	23062157	
23	Sh. Deepak Kukreja	PS to JS(DP)		N.B.	103-A	2630/564	23062857	23061447	
24	Sh. Sanjay Tomar	PS to JS(AJ)		N.B.	159-A	2656/496	23061195	23061842	
25	Sh. Sharma	PA to JS(VC)		N.B.	148-A	2690/442	23062579	23062579	
26	Sh. N.K. Neelakantan	PA to JS()		N.B.	158-A	2630/500	23061447	23061447	
27	Sh. S. Ramesh	PS to JS(KR)		N.B.	157-A	2510/512	23061706	23061398	
28	Sh. M. K. Saxena	PS to JS(KR)		N.B.	157-A	2510/512	23061706	23061398	
29	Sh. Mahender Rao	PS to JS(BKP)		N.B.	160-A	2669/428	23061723	23061723	
				CD/CCA/EA/DC					
30	Shri J. P. S. Chawala	CCA		N.B.	145-A	2716/306	23061126	23061126	cca@mohfw.delhi.nic.in
31	Shri Partha Chattopadhyay	CD(Stat)/ CD(M&E)		N.B.	243-A	2641/429	23062699	23062699	cdstat@nb.nic.in
32	Smt Gangamurthy	EA		N.B.	244B-A	335	23061730	23061730	g.murthy@nic.in

List of Officers of Ministry of Health & Family Welfare/ Prog. Deptts.

Sl. No.	Name	Designation	Department	Address	Room No	Extension No.	Telephone	Fax	E-mail ID
33	Dr. I.P. Kaur	DC(MH)		N.B.	206-D	2570/416	23062193	23062193	ip.kaur@nic.in
34	Dr M S Jayalakshmi	DC(RSS)		N.B.	311-D	2547/414			jaya.ms@nb.nic.in
35	Dr R N Rai	DC(ID)		N.B.	407-D	2587/417	23061281	23061281	rnrrai@yahoo.com
36	Dr N Namshum	DC(Trg)		N.B.	212-D	2573/316	23062791	23062791	n.namshum@yahoo.co
37	Vacant	DC(NGO)		1st Floor, CGHS Dispensary, Sect-12, R.K. Puram, N. Delhi			26166874 26105456	26166874	
				Dir/AC/DS/JD/US/DD					
38	**Dr Tarun Seem**	**Dir(NRHM-II/ NGO)**		**N.B.**	**210-D**	**411**	**23061360**	**23061360**	tarun.seem@nic.in
39	Shri Vinayak M Prasad	Dir (CHS)		N.B.	243-B/A	331	23061120	23061120	Vinyayak63@hotmail.com
40	Shri Arun Baroka	Dir (AB)		N.B.	106-D	535	23061033	23061033	arunbaroka@yahoo.co.in
41	Smt Aastha S Khatwani	Dir(ASK)			209-D	2527/410	23064495	23064495	Dirme-mhfw@nic.in,dirif@nic.i
42	Shri A P Singh	Dir(DC)		N.B.	207-D	2727/328	23061262	23061262	ap.singh@nic.in
43	Shri P K Aggarwal	Dir (NRHM-Fin)		N.B.	349-A	2688/549	23062205	23062205	Pk.aggarwal@nb.nic.in
44	Shri Parveen Srivastav	Dir (Stat)		N.B.	518-A	2777/459	23061238	23061238	
45	Shri Vikram Singh	Dir (V&T)		N.B.	404-D	2502/313	23062091	23062091	routineindia@rediffmail.co
46	Shri Ravinder Singh	Dir (NCP)		N.B.	405-D	2527/424	23062108	23062108	singhravendra@hotmail.co
47	Shri J.S. Choudhary	Dir (SSM)		N.B.	401-D	2501/418	23061640	23061640	dirssm-mohfw@nic.in
48	Shri K D Maiti	Dir (MH)		N.B.	529-A	336	23062667	23062667	dirmh@nb.nic.in
49	Dr. Vishwa Jeet Ringe	Sr. Tech. Dir(NIC)		N.B.	145-A		23062146	23062146	ringe@nic.in
50	Shri Chaitanya Prasad	Dir(IEC)		N.B.	204-D	2557/327	23061333	23061333	Chatty111@hotmail.com
51	Shri Hari Ram Joshi	DS(A&G)		N.B.	202-D	2571/415	23062642	23062642	hrjoshi@nic.in
52	Ms Archana Varma	DS(NRHM.I/UH/AP)		N.B.	301-D	2629/314	23061656	23061656	archanavarma321@gmail.
53	Shri Amardeep Singh Bhatia	DS(NE)		N.B.	520-A	449	23063523	23063523	asbhatia@nic.in
54	Shri J K Trikha	DS(ID & RSS)		N.B.	307-D	2516/509	23061669	23061669	jktrikhya@yahoo.co.in
55	Shri D.R. Sharma	DS(Imm.)		N.B.			23062666		
56	Dr Sangeeta Gopal Saxena	AC(CH)		N.B.	431-C	2728/423	23061218	23061218	sgsaxena@nic.in
57	Dr. Sandeep Kumar	AC(CH-II)		N.B.			23062677	23062677	acch2_mohfw@nic.in
58	Dr Manisha Malhotra	AC(MH-I)		N.B.	410-D	2541/426	23063479	23063479	acmh1-mohfw@nic.in
59	Dr Himanshu Bhushan	AC(MH-II)		N.B.	505-A	2787/315	23062930	23062930	dr_hbhushan@nic.in,bhim
60	Dr P Biswal	AC(Imm)		N.B.	106-D	543	23062728	23062728	pbiswal@hub.nic.in
61	Dr Naresh Goel	AC(UIP)		N.B.	106-D	361	23016126, 23062728		drngoel@yahoo.com
62	Shri S K Sikdar	AC(RSS)		N.B.	452-A	2528/420	23062427		sk.sikdar@nic.in

List of Officers of Ministry of Health & Family Welfare/ Prog. Deptts.

Sl. No.	Name	Designation	Department	Address	Room No	Extension No.	Telephone	Fax	E-mail ID
63	Dr Dinesh Baswal	AC(Trg)		N.B.	505-A	2787/315	23062930	23062930	dinesh126@hotmail.com
64	Shri Rajeshwar Prasad	JD(BoP)		N.B.	514-D	458	23062391	23062391	rajeshmrt@gmail.com
65	**Shri Ganga Kumar**	**DD(NRHM)**		**N.B.**	**425-C**	**560**	**23063426**	**23063426**	kumar.ganga@nic.in
66	Sh. Rakesh Maurya	DD(BoP)		N.B.	105-D	525	23063543	23061730	rakeshiss@gmail.com
67	Shri Rajesh Bhatia	DD(ID)		N.B.	429-C	2505/468	23061255		itsrajesh44@yahoo.co.in
68	Sh. S. K. Gupta	DD(DC)		N.B.	353-A	2595/409	23061960	23061960	sanjeev.gupta@nic.in,skgupta22@yahoo.com
				MEDIA OFFICERS					
69	Shri K Syama Prasad	Chief Media		N.B.	206-D	2526/447	23061540		cm_iec@nb.nic.in
70	Shri Rakesh Bhatia	PO(AV)		N.B.	511-A	2777/465	23061155		poav@nb.nic.in
71	Shri R K Sarkar	Editor (E)		N.B.	409-D	2512/463	23019466, 23062466		rajusarkar@gmail.com
72	Shri R S Meena Kalky	Editor (H)		N.B.	524-A	2774/425	23061487		poiec@nb.nic.in
73	Shri Raman Prasad	AVMO		N.B.	353-A	2595/409	23017960, 23061960		
				DEPTT OF AYUSH, RED CROSS BUILDING					
74	Ms. Anita Gulati	PPS to Secretary		Red Cross Building, New Delhi-1		225	23715564	23327660	
75	Shri Shiv Basant	JS(AYUSH-I)		R.No. 220, 2nd Floor, Red Cross Building, New Delhi-1			23327187	23731846	jsismh@nic.in
76	Shri Verghese Samuel	JS(AYUSH-II)		R.No. 220, 2nd Floor, Red Cross Building, New Delhi-1			23716704	23359914	verghese.samuel@nic.in
77	Shri Bala Prasad	Dir (AYUSH)		Red Cross Building, New Delhi-1	206-A	205	23327669	23327669	balapasad@hotmail.com balaprasad@nic.in
78	Smt Sangeeta Goyal	Dir (AYUSH)		Red Cross Building, New Delhi-1			23731755	23070994	sangeet-goel@nic.in
79	Dr. D.C. Katoch	Deputy Adviser (AYUSH)		Red Cross Building, New Delhi-1		11	23731025	23351885, 23731846	dc.katoch@nic.in dckatoch@rediffmail.com
80	Sh. Sudhir Arora	PS to JS(AYUSH-I)				226	23327187	23731846	

List of Officers of Ministry of Health & Family Welfare/ Prog. Deptts.

Sl. No.	Name	Designation	Department	Address	Room No	Extension No.	Telephone	Fax	E-mail ID
				DTE GENERAL OF HEALTH SERVICES					
81	Shri R.K. Srivastava	DGHS		N.B.	446-A	601	23061438, 23061063	23062924	dghs@nb.nic.in, rakeshsrivastava789@hotmail.com
82	Dr M Venkatateswarlu	DCG(I)		N.B.	342-A	667	23061806		dci@nb.nic.in
83	Prof P H Ananthnarayanan	DDG(M)		N.B.	343-B 'A' Wing	660	23063220		ddgm@nb.nic.in
84	Dr G P S Dhillon	DDG(Lep)	Leprosy	N.B.	341-A	687	23062401	23062401	ddgl@nb.nic.in
85	Dr L S Chauhan	DDG(RNTCP)	TB Control Prg	N.B.	522-C	624	23063226	23063226	ddgtb@tbindia.org,ddgtb@nb.nic.in
86	Dr (Mrs) R Jose	DDG(Opth)/ DDG(NCBP)		N.B.	343-A	599	23061594	23061594	ddgo@nic.in
87	Dr. P.L. Joshi	Dir(NVBDCP)	Vector Borne DC Prg	22, Shamnath Marg, Delhi-110054			23967745, 23967780	.....	.....
88	Dr Brij Bhushan	DADG(O)		N.B.	453-A/ 756-A	605	23062366		
89	Dr A K Puri	DADG (Leprosy Eradication Prg)		N.B.	531-C	672	23061109	23061109	
90	Dr D M Thorat	DADG (Leprosy Eradication Prg)		N.B.	341-A	632	23061148	23061148	dmthrorat@rediffmail.com
91	Dr P K Srivastava	JD(NVBDCP)	Vector Borne DC Prg	22, Shamnath Marg, Delhi-110054			23967745, 23967780	23918576, 23968329, 23972884	pkmalaria@yahoo.co.in
92	Dr. Ichhpujani, IDSP	NPO(IDSP)		IDSP Division, 3rd Floor, 22, NICD, Shamnath Marg, DELHI- 110054			23934517	23935530	idsp-npo@nic.in,ichhpujani@hotmail.com
93	Dr. Jagvir Singh	Coordination Divison	NICD	NICD, 22 Shamnath Marg, Delhi-110054			23928700	23928700	idsp_coord@nic.in
94	Dr B K Tiwari	Adv. (Nutrition)/ Adv.(NIDDCP)		N.B.	355-A	666	23062113	23062113	advnut@nb.nic.in